PART II

Discussion Paper:

District Health Societies

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DISCUSSION PAPER ON SOCIETIES IN HEALTH SECTOR

1 BACKGROUND OF SOCIETIES

In a democracy, societies play a vital role in the establishment, progress and all-round development of the welfare state. These societies are the complementing institutions in promoting urges for social service, people's awareness, expansion of education and self-reliance. The societies function in a variety of sector domains, including interalia, education, social, literature, culture and welfare. These institutions provide the platform for transforming the cherished urges into positive social actions. Originally, the Societies Registration Act, 1860 **(Annexure-I)** was enacted for the registration of literary, scientific and charitable societies. This Act was created to facilitate the formation of legal entities to propagate science, literature and the arts and to provide for a large membership organisation like an association of professionals. The states have, subsequently, adopted amendments through appropriate state legislations.

The Madhya Pradesh Society Adhiniyam, 1973 aims to give legal status to such societies through their constitution and registration under the Act. The Societies derive a host of benefits from the registration. They are perceived as viable and stable entities commanding respect and credit-worthiness. Such registered bodies can own movable-immovable property and move the court of law. The members of the societies cannot draw any pecuniary gains from them nor they can cause any harm to them. **The key job of the members is to manage the society well and in order.**

Effective from 1st December 1973, the Madhya Pradesh Society Registration Adhiniyam, 1973, (No. 44 of 1973), the Act, seeks to consolidate and amend the law relating to registration of literary, scientific, educational, religious, charitable or other societies, in MP The Act applies to societies formed for a host of purposes **(Annexure-II)**. The list of purposes was expanded in 1998 pursuant to MP (Amendment) Act No. 29 of 1998 to include the following:

- Promotion and implementation of the different schemes sponsored by the state government or central government.
- Promotion of Commerce, Industries and Khadi.
- Any SEVEN or more persons associated, for any literary, scientific, educational, religious, educational or charitable purpose described under the Act may, by subscribing their names to a memorandum of association and filing the same with the Registrar, form themselves into a Society under this Act.
- Pursuing the stated objects, the Societies operate within the ambit of memorandum, rules and regulations and are required to submit annual returns to the Registrar of Societies and have the audit and inspection conducted in accordance with provisions of the Act. The Societies are liable to be superseded by the state government if in the opinion of the state government, the governing body of any state-aided society persistently makes default or is negligent in the performance of the duties imposed on it by or under this Act, regulations or bylaws of the society or by any lawful order passed by the state government or Registrar or is unwilling to perform such duties; or commits acts which are prejudicial to the interests of society or its members; or is otherwise not functioning properly.

The main advantage of a society is that it can be more independent than a committee and can be held accountable to law as a corporate body, with the ability to have a broad membership with a governing body for managing its affairs. The Governing Body is accountable to the general membership and can delegate its functioning to an Executive Committee for routine functioning. The Society also has scope for changing its terms of reference from time to time by getting approval by convening a general body meeting.

2 DISTRICT LEVEL MANAGEMENT SOCIETIES IN H & FW SECTOR

Creation of district level societies in India started with the advent of the District Rural Development Agencies (DRDAs) in the seventies. Subsequently, several district level societies have been constituted for both donor and government funded programmes in the social sector.

The primary function of these societies is to ensure a smoother flow of funds to local level for implementation of the programmes, often hampered by complex procedures of the government. SCOVAs (Standing Committees on Voluntary Action) have shown that they can achieve this function effectively. However, financial autonomy alone without appropriate management systems and managerial skills is not sufficient for efficient and effective implementation of the programmes. Besides, the membership of these societies is predominantly bureaucratic which restricts improved management and governance practices. It has also been observed that multiple societies functioning in the health and family welfare sector, depending on the same public health delivery infrastructure, have rather been diluting the efficiency of the various health programmes.

2.1 Some Examples of Existing Societies/Committees in the Health and Family Welfare and Related Sectors

- RCH Societies
- Integrated Population Development Projects Societies
- District Blindness Control Societies
- District Leprosy Societies
- District AIDS Control Societies
- District TB Control Societies
- Pulse Polio Media Committee
- Zila Swasthya Samiti

District Blindness Control Societies:

The National Program for Control of Blindness (NPCB) has established 470 District Blindness Control Societies (DBCS) in consonance with the national policy of decentralization for effective implementation and monitoring of the programme and co-ordination among NGOs at the district level.

The major difference between the DBCS and other health programme societies is that while the others are primarily implementing agencies, the DBCS have a wider scope vis-a-vis planning and decision making at the district level and have assumed an important role in district level planning and management.

The NPCB is the only programme in the H&FW sector, which piloted 5 District Blindness Control Societies supported by Danish assistance in 1990, before establishing them in 470 districts in the country between 1993 and 1996.

2.2 UNFPA Integrated Population And Development Project Societies:

UNFPA has been funding state level Integrated Population Development projects (IPDP) providing comprehensive reproductive health services with complementary advocacy and gender activities at the district and urban slum levels in 33 districts in 6 states in India. For effective implementation of these projects UNFPA facilitated the establishment of District Societies.

Unlike other district level societies the IPDP societies have both managerial and financial functions. However these have met with mixed success in implementation of the projects in different states.

UNFPA has ensured that the Governing Council of the Society has a wide membership and includes NGOs, UNFPA, PRIs and eminent persons from the social sector for effective governance and management.

In order to ensure inter-sector collaboration at the district level, 25% of the project funds have been earmarked for co-ordination activities and 75% for project inputs.

UNFPA supported District Reproductive Health Projects

According to the end-of-the-project evaluations of District Reproductive Health Projects (DRPHs) of the GoI supported by the UNFPA, the District Society mechanism for project implementation was first tried in the DRHPs. The DRPH was initiated in 1995, and it was the first effort to operationalise the principles enunciated at the ICPD. The focus of these projects (Wardha in Maharashtra, Patna in Bihar, Sirmour in Himachal Pradesh, Bundi in Rajasthan and Mallapuram), which ended in July 2000, was to initiate implementation of five selected services in a district on an intensive scale and the emphasis was on decentralised implementation. The Report notes:

- The Project design provided for creation of a women's forum at the district level, comprising of women members of PRIs, members of NGOs, private gynaecologists, and female health personnel. This women's forum was to be actively involved in project monitoring and would also be represented in the governing council of the district society. The mechanisms for incorporating feedback from women's groups, however, could not be institutionalised.
- Participation of stakeholders from other government departments and NGOs was limited, in almost all cases.
- Fiscal accountability appears to have been paramount in the minds of project implementers including the chairpersons of the societies. Private auditors were engaged to conduct annual audits.
- Since Collector is in charge of a multitude of issues, which often need his immediate and sole attention, the DRPH was not given the attention and focus it deserved.

- Though society memorandum of understanding is adequately detailed, there has been lack of clarity of roles and responsibilities among the key position holders causing confusion and tension among them.
- The flow of funds from the GoI through the SCOVAs has often been delayed even though the funds from the GoI were provided upfront.

The District Collectors/Chief Executive Officers of Zila Parishad headed the district societies. It was expected that the dispensation would enhance inter-sector collaboration. However, level of ownership among governing council members has been varied with participation of non-health departments and NGOs having been limited. The Report leaves an unanswered question: How can a society maintain its autonomy and be as little affected by disruptions in the government system as possible and yet enjoy ownership and high stakes in the government?

3 RCH PROJECT DESCRIPTION

The project aims to assist the GOI to improve the performance of its Family Welfare Program in terms of the following dimensions:

1. implementation of policy change for decentralised planning and institutional strengthening;
2. improved quality, coverage and scope of reproductive and child health (RCH) services; and
3. improved access and utilisation of RCH services in selected disadvantaged districts.

It was thus conceptualised in two main thrusts: First, it seeks to establish the policy dialogue to assist in achieving transition toward a RCH Program approach. Second, it seeks to translate this policy change into actual practice by providing a wider choice of RCH services. At the request of GOI, the project was revised and expanded in May 1999 to emphasize immunisation activities through support for polio vaccine and social mobilisation for national and sub-national immunisation days.

The project is implemented at central, state and district levels. The Center is responsible for monitoring of policy implementation, advocacy, financial management, and bulk procurement of basic drugs and equipment. States are responsible for ensuring implementation of training, financial management and monitoring of activities implemented in districts. Districts are the point of implementation of all project activities. Technical support for programme implementation is provided at center and state levels. The GoI Programme Mangers state that the state Governments have been asked to constitute unified bodies for an integrated management of all health and family welfare programmes both at the state as well as district levels.

4 SOCIETY UMBRELLA FOR RCH PROGRAM IN MP

The Reproductive Child Health (RCH) Program in Madhya Pradesh is managed under the umbrella of 'Reproductive & Child Health Society of Madhya Pradesh'. Its area of jurisdiction covers the state of MP in all 45 districts.

4.1 Aims of the Society

1) Raise the health status of people and bring about improvements in the activities of health and family welfare.
2) Reduce infant and maternal mortality rates through improvements in the status of health services and bring down the rate of population growth.
3) Bring about human resource development in health services.
4) Promote reproductive and child health activities, publicize them and undertake research and endeavor for community participation in the health programmes.
5) Management of other medical services activities.
6) Provide for Family Life Education, uplift and empowerment of women and adolescent girls.
7) Undertake necessary activities for family health security in the districts, as and when required.
8) Review the policies for bringing about requisite reforms in health and family welfare sector; and take action for implementing the policy decisions.
9) Mange the externally aided projects and increase the participation of non-government organisations.

Aims at Sr. No. 6-9 have been added vide amendment memorandum dated 15th November 2000.

Further, the Society has been reconstituted and its Empowered Committee includes the following:

1) Chief secretary, The government of MP	Chairman
2) *Principal Secretary, Health*	*Vice Chairman*
3) Principal Secretary, Women & Child Development	Member
4) Principal Secretary, Panchayat & Rural development	Member
5) Principal Secretary, School Education	Member
6) Principal Secretary, Finance	Member
7) Principal Secretary, Medical Education	Member
8) Principal Secretary, Tribal welfare Department	Member
9) Commissioner, Public Relations	Member
10) Chairman, Family Planning Association of India, Bhopal	Member
11) Chairman, Indian Medical association, Bhopal	Member
12) Health Commissioner	Member Secretary
13) Director, Public health & Family Welfare	Member
14) Joint Director, RCH	Member
15) Representative of UNFPA	Member
16) Representative of ECTA (European Commission)	Member
17) Representative of GoI	Member
18) Member Secretary, Sector Reform Bureau	Member
19) Joint Director, IPD	Member

The general body of the Society is required to meet at least once in a year. It would have a quorum of 2/3 of members.

4.2 Responsibilities and powers of the general body

- Approve the progress report of the Society for the preceding year.
- Provide for good management of funds and assets.
- Appoint account auditors for the coming year.
- Consider such issues as are brought before it by the Executive Committee.
- Notify income and expenditure statements of the agencies supported by the Society.
- Approve the budget.

For the routine management of the programme, an Executive Committee has been constituted. Following is the membership of the Committee:

1)	Principal Secretary, Health	Chairman
2)	Health Commissioner	Member
3)	Director, Public Health & Family Welfare	Member Secretary
4)	Nodal Officer, RCH, Joint Director, Family Welfare	Member
5)	Deputy Commissioner, Ministry of Health, GoI, New Delhi	Member

4.3 Some salient features

- The views of the Chairman or the Vice Chairman in the general body meetings shall signify the decisions.
- The Chairman, Executive Committee shall have powers to give sanction for one time expenditure up to a value of Rs.25 lakhs beyond which the Executive Committee shall sanction the same.
- The view of the Chairman, Executive Committee shall be deemed to be decisive in the Committee meetings while considering the matters placed before it. However, this rider shall not apply to the approved works under the provisions of the Project or those that have the approvals of the GoI or the the government of MP.
- Hospital construction shall be done as per the government's sanction. The buildings, after construction shall be handed over to and maintained by the public works department.
- Generally, there shall be no virement for shifting expenditure from one budget head to another.
- The Local Self Auditors shall audit the Society accounts and the fee for the same shall be paid from the Society's funds. Maintenance of accounts shall be done by securing contract services and the fee for the same shall be met from the Society's funds and not from that of the state government.

5 CONSTITUTION OF DISTRICT RCH SOCIETIES

The government of MP issued an order on 20th Sept. 98 constituting the branches of state RCH Society in the districts. The copy of the Order is placed at **Annexure IV**. The Order provides for the constitution of the District RCH Society comprising the following:

Sr. No.	*Designation*	*Position in RCH Society*
1)	Collector	Chairman
2)	Chief Medical & Health Officer	Member Secretary
3)	District Family Welfare Officer	Member
4)	District Immunisation Officer	Member
5)	Civil Surgeon	Member
6)	Distt. Women & Child Dev. Officer	Member
7)	C.E.O. Zila Panchayat	Member
8)	Executive Engineer (PWD)	Member
9)	Distt. Education Officer	Member

It may be observed from the constitution of the District Society that it is essentially bureaucratic bringing together only the officials from different sectors. Generally, the Chief Medical & Health officer is the Member Secretary in all the district level societies in the health sector.

The structure of District RCH Society at Tikamgarh is entirely bureaucratic with officials from different departments being represented on it while the Society at Damoh has 2 non-government members also. When asked about Panchayat representation on the Society, the nomination of Chief

Executive Officer, Zila Panchayat is cited.

The consultations with the district officials lead to the following conclusions:

- The Society is not considered as a body entity as is the spirit of the Societies Act.
- The Society members do not have the requisite technical capacity and autonomy to be able to reposition the Society as a health body entity capable of pursuing a corporate plan of action. On the contrary, there are severe shortfalls in spending even against the allotments. While Tikamgarh reports nil spending against an allotment of Rs.34,04,440/-; Damoh has spent only Rs.13,17,335/- as against the allotment of Rs.48,38,777/-
- The only worthwhile aspect is the bypass availability of funds to the Program functionaries. However, what appears to be ignored is the fact that these funds routed through the "Society" do not get reflected as part of the overall input to the health system with the result that no meaningful resource utilisation and its monitoring can be put in place.
- By and large, the same sets of members are there in all the health related societies. Even then, effective pooling of resources and convergent actions does not occur.
- The Member Secretary does not have adequate autonomy. The proposals initiated by the CMHO often get blocked at the CEO, Zila Panchayat (Tikamgarh).
- Lack of functional management skills and non-involvement of Panchayat representatives and the community casts a lingering shadow on the programmes and interventions.
- The linkages with District Planning Committee are poor.
- The Societies do not have operational linkages with Panchayats.

- Functional linkages with Zila Saksharta Samitis (ZSS) are poor. The ZSS generally operate as 'stand alone' bodies charged with responsibility of implementing their proposals.
- Unlike other health societies, the RCH Society does not have specific staff and earmarked unit and resources (like Blindness Control and Malaria Control societies); the officials point out. However, the officials did not have a Plan of Action either.
- Linkages with inter-sector functionaries are weak.
- The RCH Programme does not provide flexibility within the individual budget heads.
- The district societies have been meeting once in six months or lesser often.

The Aide-Memoir, November 2000 of the World Bank Mid Term Mission notes that the mechanism of autonomous state level societies (SCOVAs) established by the project has proved very satisfactory. The SCOVAs serve as conduits for funds released by the center thereby bypassing state activities. It adds that all the 22 states established SCOVAs in the year 1 and did not experience funds flow problems. However, several of the other 10 states that had not been required to establish SCOVAs reported significant problems in receiving funds, and subsequently almost all states voluntarily adopted the SCOVA mechanism. The report, however, brings out very poor submission of claims by the implementing agencies (the district societies), both in terms timeliness and completeness. Another notable gap pertains to the dissatisfactory experience with the Zila Saksharta Samitis (ZSS) that were set up to undertake a major IEC programme for social mobilisation for RCH in the districts. These ZSSs are in addition to the District RCH Societies. There have been delays in release of funds from the state SCOVAs and submission of Statement of Expenditures (SOEs) by the districts. **The notes from the External Reviews suggest that inadequate local capacity for planning and management is a matter of concern, an area where several involved donors would like to render strong support to see that the desired change could take place. It calls for the capacity building to occur in an institutional mode.**

The Progress Report of RCH Programme (up to March 2000), Department of Family Welfare, Donor Coordination Division, GoI on the other hand notes that response from Zila Saksharta samitis (ZSSs) has been encouraging in taking initiative to have district level IEC relating to RCH and population control undertaken through the mobilisation of neo literates. These Samitis need to work closely with the District RCH Societies. The Report notes that the district level committees under the chairmanship of District Collectors were requested for meeting at least once in three months.

6 OTHER DISTRICT SOCIETIES IN HEALTH

While blindness control societies constitution provides for contractual appointment of District Program Manager, now the arrangement has given way to one of the officials in the Dept. of Health & Family Welfare to officiate as the nodal officer.

Both at Tikamgarh and Damoh, trained eye surgeons are not in position.

The participation of community in Rogi Kalyan samitis in district hospitals at Damoh and Tikamgarh is improving.

Linkages amongst the different societies are missing.

The allocations to district societies (centrally supported) have greater flexibility within their individual budget heads and are more amenable to pooling across budget heads under common purpose fund pools through a merger of such societies.

7 SINGLE SOCIETY

Experience indicates that a diverse number of societies, all of which rely on the same public sector health delivery infrastructure, creates internal contradictions and fragments efforts. Since much of the official membership is common, there is also no logic in preserving the independent identities of these societies.

The Sector Investment Programme (SIP) of the Government of India supported by the European Commission, therefore, envisaged that an integrated 'District H & FW Agency' should be set up in each of the demonstration districts under the Programme. This Agency is expected to plan and manage local services according to the (Community Needs Assessment approach) CNAA planning and resources available to it. It may receive on-going consultancy and institutional support, and be granted special status by the state Government in regard to identified and agreed areas of authority and expenditure. *In other words, the district agency is expected to discharge management functions rather than being a mere funds-flow mechanism.*

The SIP does not recommend that an additional society be set-up. Nor is it recommended that all districts create an identical structure. Following considerations, however, have been proposed by the Government of India to guide the organisational set-up for the district body:

- The Agency will be responsible for managing all health and family welfare programmes in the district.
- The Agency will also have to create conditions conducive to involving the private sector as well as the NGOs present in the district.
- It may have to generate additional resources to supplement those available from the State and Centre.
- It must have sufficient decision-making powers (e.g., for recruitment and deployment of staff, introduction of cost recovery measures, procurement of emergency drugs, construction and maintenance of health facilities, etc.).
- It should have sufficient representation from the community (e.g., prominent private practitioners and other citizens; representatives of Rotary, Lions Clubs, and other NGOs and consumer activists/forum etc.). Options for the structure of district agency.

Several options may be available for creating the district body:

- The Zila Panchayat may itself take up the role of overall co-ordinating body even while the vertical management structures continue for the various schemes and programmes;
- A committee can be set up by an executive order to take up the role of co-ordinating body;
- A statutory body could be created by an Act of the legislature with a mandate to manage all health and family welfare schemes in the district, including measures for involvement of NGOs and private sector;
- A corporation or a company may be set up; or,

- A District Health & Family Welfare Society could be created by merging all existing health and family welfare societies and providing it with sufficient functional and financial autonomy.

Merger of all existing societies would appear to be an optimal solution simply because every district already has a large number of societies which mainly function as a mechanism for flow of funds. ***Their merger will, therefore help in focusing on the 'people' rather than the requirement of the programmes (e.g., that there must be a district society for it to receive the funds). Another distinct advantage of a Society is that it can raise resources and own assets.***

8 CONSIDERATION OF INTEGRATED DISTRICT HEALTH & FAMILY WELFARE AGENCY

It is frequently asserted that there is insufficient capacity at district level to plan and manage effectively. This may mean lack of know-how, lack of facilities such as phones and vehicles, lack of staff, lack of time, lack of money, but often the real lack is the authority to make local decisions. In such circumstances, it is vital that duplication and time consuming ways of working are minimised, and that authority and resources are delegated to the lowest appropriate level for effective action to occur. The District Health & Family Welfare Agencies have been proposed to enhance local capacity and make decentralization a reality.

What should be stressed at the outset is that what has been proposed is not only congruent with practice in all western countries providing public health care services, it is what the WHO has been advising (in fact, assuming as axiomatic) for all countries for years (e.g. Towards a healthy district:

Organising and managing district Health Systems based on primary health care. E. Tarimo, Geneva, 1991). One could go further and say that as Tarimo assumes districts will range in size from 50,000 to 300,000 population, and district in India can have populations of several million, then the proposals in this paper are too conservative, and larger districts should seriously consider setting up taluk level or block level H&FW Agencies, and delegating powers even further.

A commonly expressed worry is that this is yet another society that must be co-ordinated. A second basic point, therefore, is to appreciate that these proposals argue for just the opposite. The proposal is to take the existing societies with their various different functions (some are merely SCOVAs for flow of funds, others have some planning and management functions) and converge them. One agency will now be able to co-ordinate work (and budgets, staff, equipment, etc) to best address the needs of the community.

The third point to be stressed that 'agency' is a generic term chosen to provide maximum local discretion of approach. No prescription is being made as to the name or nature of the agency to be set up – there is a wide variety of options. The emphasis is on functions to be carried out, and the powers and resources needed to carry out those functions effectively. It is necessary for states and districts to determine what is most practicable, and likely to be most effective, in each local context.

8.1 The need for a district Health & Family Welfare Agency

Public sector health and family welfare services are provided though three means at present:

- Routine operations provided by medical officers, ANMs, male multipurpose health workers (MPWs), etc.; including working in PHCs, CHCs and secondary level hospitals.
- Occasional 'camps' or campaigns (either local initiatives or national such as the Pulse Polio Campaigns);
- Centrally funded vertical programmes for specific disease prevention.

The camps, campaigns and vertical programmes have the advantages of being very focused, and delivering high quantity services across narrow ranges of services. Their success and appropriateness in some situations must be acknowledged. However, in many respects they indicate a failure of the routine, day-to-day services of health workers. Some Programme Mangers argue that they do more

harm than good in the long run because they disrupt the discipline of routine work on which public and primary health service depend, adding to uncertainty, for example, about when and where health workers can be found. They have their place, especially where the alternative is no service at all, but they should always be considered a temporary expedient, not a permanent way of organising health care.

Vertical and episodic service delivery has two particular drawbacks, one clinical the other administrative. Clinically, health is best delivered in a holistic manner, taking the patient (perhaps the family) as an integrated being. The Cairo Conference's advocacy that reproductive health was best treated as part of the wider issue of improved quality of care for women and children, is an illustration of the principle (ICPD, 1994). People are not just a sterilisation case, or a body to be immunised. Integrated assessment of their needs by local family oriented generalists is the foundation for all good primary health care, and cost effective referral to secondary services. Similarly, it is impossible to properly plan services for the health priorities of communities without looking at the broad spectrum of housing, communications, educational nutritional, hygiene and health problems and resources available. The words 'health' and 'holistic' have common roots, and a broad approach is required.

Administratively, managers are faced with the need to have multiple meetings, be aware of multiple rules and regulations, provide multiple reports, maintain multiple records, and cope with multiple enquiries from above, instead of being able to address matters more systematically. As only a handful of people are the same decision makers for all, this places unnecessary burdens on them. Furthermore, they may have responsibility for a small budget for, say, training or IEC for each of the programmes, but be unable to merge the funds to deal with several matters at once, or use funds at different times of the year to do worthwhile activities appropriate to the season. Again they may have to cope with staff members, or equipment and vehicles, which are earmarked for specific use not generic use. At worst, conflicting demands and priorities may end up jeopardising the routine work of these functionaries, and diverting attention from local priorities to satisfy external agendas. In a situation where local conditions need maximum freedom of action to use scarce resources effectively, managers are tied up by inappropriate restrictions.

With the best will in the world, a district Magistrate, Zila Panchayat President, or Chief Medical & Health Officer can not be everywhere at once, making decisions on the whole range of services they oversee. There is a need to do far more supervision and site visiting than occurs currently, more training and counselling of staff, etc. good decisions will be based on these visits. Good management of health care needs a considerable amount of dedicated time and effort simply not available to people like District Collectors or who are responsible for many other sectors.

The problem is worse if the argument above is accepted that health care depends on activities in other sectors e.g., education, housing, nutrition, local industrialists, tribal development specialists, etc. There is a need to meet with representatives from cognate sectors to ensure the sort of convergence talked about in the national Population policy, for example. A decision-making forum is needed. Joint activities will be required.

By setting up one body for looking after planning, implementation and reporting of all health & family welfare services holistically, there is clearer accountability towards and out to the community. Responsibility is clearer, and at the same time less personalized so less risky for individuals. Transparency is enhanced in decision making of all types, so staff appointments, service contracts, purchases, new project priorities may be carried out locally and with accountability. Budgets can be used more holistically and activities such as IEC and training can be tackled generically. Meetings are reduced to fewer, more regular sessions at which decisions can be made in a timely way, recorded, and followed up. All of these benefits have been seen in states and sectors where such approaches have been tried.

The setting up of an agency attempts also to deal with the problem of frequent transfers that undermines the institutionalisation of progress throughout the public sector at all levels. This has a significant impact on slowing down decision-making and implementation. New officers naturally take time to identify priorities and to master their new responsibilities, especially technical issues, and may feel overwhelmed by the number of new activities they must cope with. However, they may also feel it necessary to emphasize new activities in order to stamp their own identity on a district, and distance themselves from predecessors' achievements. As one physician respondent expressed it recently. " We prefer to build personal reputations than institutions ".

It is a truism that health care indicators are affected by most sectors other than the health sector. Education, nutrition, housing, etc, all have major impact on people's health status. The need for inter-sector co-ordination is recognised in the recent Indian national Population Policy 2000. The WHO guidance states that " the objectives of primary health care can only be achieved if each sector makes an appropriate contribution. For this to happen effectively, *a mechanism for inter-sector co-ordination and co-operation must be established*". The agency is, therefore, entirely congruent with good health policy principles.

8.2 Functions of District health & Family Welfare Agency

As in architecture, organisational design should obey the maxim "form follows function". The primary questions are not "who should run it?" "Who should be involved?' " What is the minimum change we can get away with?" The primary issue is how can we ensure that all relevant services are provided in an effective, efficient, accountable manner appropriate to

the local social and health context? The WHO guidance referred above highlights the functional areas as making up primary health care as follows:

- Provision of essential drugs;
- Immunisation;
- Maternal & child care;
- Treatment of common diseases and injuries;
- Adequate supply of safe water and basic sanitation;
- Communicable disease control;
- Food supply and proper nutrition.

There is no hierarchy of priority, all these functional areas need to be considered holistically if the health of a community is to be safeguarded and indicators such as IMR and MMR are to improve. In a particular locality at a particular time there may be a pressing need, such as controlling a polio outbreak, but over time all must be addressed systematically. There is no point a country investing in better antenatal and birthing services only to allow children to die before they reach school because of inadequate disease control, or to reach school too undernourished to learn properly.

Again, as WHO declares "district planning is crucial if primary health care is to be improved." Consequently, each agency is given the task of preparing a 5-year rolling plan, in co-operation with all the stakeholders in the district, giving due regard to national and state objectives and the views of local communities, 'Community needs assessment' is part of the GOI's policy shift of adopting a national RCH strategy, and this is taken to mean more than well-meaning health professionals paternalistically deciding what's good for other people. With a 5-year vision based on a detailed analysis of local health priorities and the resources (NGO and private sector as well as public sector), each Agency sets out how it plans to implement its plans, focusing closely on the next year's plan, intermediary targets, benchmarks etc. each year the plan is refined for the following year, and the 5-year vision updated. The plan includes the resources it will need and who is responsible for each task as well as reforms it will undertake in ways of working, and delegated authority etc it will need to achieve the plan. Resources (not just money but things like technical assistance and information) may come from GOI (including the EC-provided money in the Sector Reform Fund), state, other development partners, cognate ministries, and locally raised finance through user charges or PRI sources. In effect, the agency produces a "business plan" saying what it plans to do, how it will do it, where the resources will come from, and how it can be judged. Next the agency is responsible for implementing the plan, and reporting on progress to the community, the higher governmental levels, and to development partners. As far as possible, plans should be prepared as consistently as possible so that reporting mechanisms do not involve unnecessary duplication, so, for example, as far as possible common reporting arrangements should be sufficient for all higher level departments or ministries any for external development partners/donor.

Through the planning process the agency sets out its anticipated performance, and in this way can be made more accountable both vertically to those funding programmes, and horizontally to the community and to users of the service. Consideration is needed to build effective reporting mechanisms, such as Annual Reports and Joint Consultative Committees. In addition, further consideration is called for an effective controls where performance is inadequate, and on protecting the agency from outside influence and interference.

8.3 Structure

Essentially, a District Health & Family Welfare Agency is a legal entity that can plan and control resources and be held for performance. It must be empowered, and should command the respect of those it serves, manages, and reports to. It should not be dominated by public sector officials (although there may be an inevitable trend towards this at the outset) but should be representative of all stakeholders in the community with an interest in health 7 family welfare services. Ideally, it will represent all the key stakeholders needed to ensure effective convergence, without being unwieldy. It should consist of people independent enough to resist external pressure, and with a sufficient range of skills to be able to discharge its skills appropriately. It should be the body that supervises technical officers responsible for providing services, and not confuse its role with operational management activities. It should take corporate policy decisions so that individuals are not pressured to make decisions favorable to some third party, but as a group the decisions will be taken for the good of the whole community. It will have its own bank accounts and in that respect will subsume the role of a SCOVA and similar organisations set up primarily as channels for funds.

Structurally, the Agency could take any of a number of forms permitted by the law, such as:

- A Board / Agency / Authority set up either under a specific state legislation or an enabling Central law;
- A registered Society;
- A committee constituted under executive orders (Government Order / Resolution);
- The Zila Parishad itself or a body constituting part of the Panchayat Raj structure, including representation of the Municipal bodies in the district;
- A company.

In order to ensure compliance with principles of proper governance there should be a clear differentiation between policy making, policy implementation (which includes formulating instructions, regulating and monitoring, and resource allocation), and management of services. Thus, technical officers ideally would not be members (or not a majority) but should be accountable to the board of the agency for the performance of their duties, with the Board made up of disinterested lay people and specialists e.g. a representative of the women's self-help groups, a professor from the local medical schools, a retired judge or an industrialist, who would set the policy level direction (within State and National guidelines). Technical staff should be accountable to these community representatives, and ideally reports on performance from the Board should be considered when technical officers are considered for promotions and transfers. This represents a major change of approach, but is an area where the H&FW could start to take the leads for necessary reforms in public sector governance.

The membership of the agencies is clearly of crucial importance and needs much thought. There are at least two types of 'cronyism' to avoid. One is where members are chosen by one person or group in power, so that they can be re-selected or de-selected in ways that effectively control them. They dare not be outspoken about irregularities of performance or regulations, or they follow instructions from outside sources about whom to recruit or promote. When the person(s) in power change, there is wholesale change of members and no institutional consistency is allowed to develop. The other type of cronyism gives so much autonomy to the agency's board that they carry on re-selecting themselves or their friends.

They thus become self-perpetuating, unresponsive to the external world, either the community they serve or the proper agencies of government.

There are several ways of dealing with this. One is through the mix of members and the qualities for which they are chosen: independence; representing a stakeholder group; knowledge and experience of health, law, financial management, or whatever; integrating and impartiality. Another is in the selection methods used e.g. the Board could recommend three candidates and the Minister selects one of those named; or it is left to the stakeholder to select (a community or the medical school) and there is no right of veto; another is invite candidates and set up an independent commission to select new members; another is to have a mix of members, some chosen by, let say, the Minister, others chosen independently; and clear rules on how long a person may be appointed will help prevent interference. Prior agreement on who the ex officio members will be (who ideally will never be the Chairperson), and the mix of male-female, dalit-non-dalit, medical-non-medical, etc., should be built into the agency's charter (e.g. articles of incorporation).

One area for states to consider is whether they wish to bring secondary hospitals under the agency's supervision (making Hospital Management Boards accountable to them, perhaps with shared membership of Boards), or to restrict the Agency to the primary level. The decision ideally depends on the nature of the hospital. Hospitals up to District General Hospital level should be included within the responsibility of the Agency, and the Civil Surgeon (or equivalent) made an ex officio member. Hospitals serving as state level teaching hospitals or research institutions might have a separate management Board, although good liaison mechanisms will be required.

8.4 Delegated powers and accountability

Ideally, the agency should have full powers for appointment of all staff, expenditure within set budget limits, powers of virement or fundability (i.e. authority to re-allocate resources) between budget heads (within limits), configuration of service delivery, etc. It should be free to obtain services from the open market for contracted clinical services, architectural or equipment services, etc. rather than having to use PWD or other state apparatus. states may consider how far it can delegate these powers on pilot basis, with a view to increasingly decentralising within the principle of subsidiary (i.e. every level should only decide what is most appropriate at that level) on the one hand and probity on the other.

Although essentially a non-profit making organisation, the agency might be allowed to raise money through cost recovery and income generating activities, and be allowed to retain the money for reinvestment or extended service delivery. The commercial principle of building up reserves can be used by the agency for investments, for tackling emergencies, for handling costs of litigation etc.

There should be a formal Annual Report, and annual audit by the state Accountant General and/or a chartered accountant. An annual meeting between the Agency members and appropriate state/ Central officials is also recommended, to enable dialogue about problems, state/ Central concerns and priorities, etc.

Meetings should be held in public as far as possible and poor performance by the agency should lead to removal of the Chairman or members. The publicity attendant on such public removal from office should itself act as both motivator and control. Ideally, it will be seen as

an honour to be a member of the agency, and board members will feel that the powers they have to appoint, award tenders, etc., are sufficient to single them out as contributing to the public good. It should become a cause of shame to be removed from such a position because of irregular use of those powers.

For this to occur, there should be total transparency and accountability of decision making, even to the extent of inviting observers and the press to meetings. This would also ensure proper frequency of meetings, professional standards of agendas, minutes, and procedural adherence, etc. Auditing and reporting arrangements should also be clear and consistent. The habit of last minute calling (or canceling) of meetings to suit the convenience of the Chairperson should be obviated by clear rules that if the Chairperson is unavailable the Vice-Chair or another member takes over and business continues smoothly. Agendas should be circulated at an agreed time (perhaps at least 72 hours) before scheduled meetings, so that members may acquaint themselves with the topics to be discussed. Similarly, minutes should be circulated within, say, 72 hours of the meeting closing.

If set up as corporate legal entities, the agencies could become employers of their own staff. For workforce management rules, as well as for procedures like letting contracts for services or purchasing equipment, there need to be established rules and appeals mechanisms. These must be congruent with state and national laws and codes of practice. As a legal entity the agency and its board members would be open to legal action by employees., Government regulators or other third parties, but wherever possible that should be the last step. Ideally, agencies will take the opportunity to set up clear and fair systems for appeal, so that if legal action is taken the courts may see that due process has occurred. Appeal mechanisms to state level and/or a regulatory body at state level may be set up as thought appropriate.

States and Central departments may consider drawing up model guidance on such procedural matters. Parliamentary procedure and legislation for the corporate sector provide examples of procedures, and advice could be taken from NGOs or academics concerned about improved governance. Training for the members should also be encouraged, and institutions identified in each state to provide this.

With a switch to greater reliance on district agencies to manage the sector, there will be considerable implications for functionaries at state level. Many of the time consuming tasks that state level officials now get embroiled in will no longer be their concern. They do have to consider new ways of facilitation and monitoring the work of the agencies to ensure that the aspirations for them are realized. One important change will be that states and National level should begin to frame advice and guidance in ways that allow for local discretion by the agencies and their staff. Another area to consider is how far, and how quickly, state cadres can become District or Agency cadres or contracted personnel, and in the meantime how far procedures for length of tenure and for transfers can agreed between state and District level authorities.

8.5 Sub-structures and Relationship to Technical Programmes

The 'Agency' will need a permanent 'secretariat' with its own office and staffed with accountants, public health experts and so on. Programme managers for the existing vertical programmes may become a part of the secretariat. While the overall control of the secretariat

should remain with the officer in-charge of public health, it may be useful to engage a full-time public health specialist.

The 'agency' should have a common bank account but may need to maintain separate ledgers for the vertical programmes financed from above (Centre, state, direct funding from donors), so long as such vertical programmes continue to exist. The Sector Reform Fund (SRF) will then be one of the ledgers. There may be a ledger in respect of the resources that the agency generates through its own efforts (user charge collections, donations etc.)

For day to day purposes and to handle different aspects of its agenda the agency will probably need to set up sub-committees to ensure decisions can be taken quickly (perhaps an executive team that meets weekly and whose decisions must be ratified at monthly full-board meetings); handle technical issues in depth (finance committee, or malaria committee), or interface with others (a Joint Consultative Committee for community relations, or staff relations). The aim should be to share functions and powers so that delays do not occur when the empowered officer is called to the state capital or is away on a training course.

As hinted in the previous section, there is also no reason why the technical officers responsible for programmes should be automatically members of the Board, indeed a better model of governance is for them to. However, they could be ex officio members, or be in attendance, or have one of their members be a full member on a rotational basis. And/or they might constitute a technical task force committee accountable to the agency.

There is no reason why smaller communities such as villages, slums, or municipal slums should not have their own health committees, feeding into block or *taluka* committees, feeding into the district agency. These could be entirely voluntary representative bodies, or more formal, organized around the Block Medical Officers, for example. In fact, given the size of Indian districts this would be highly desirable. The District H&FW "agency" would be the integrating the various inputs from such community based organisations, other voluntary organizations and stakeholders, hospital management boards, etc.

8.6 Demonstration Districts

Two districts in M.P. are demonstration districts for Single Agency experimentation as well as for district strategy/district action plan formulation and implementation. Copies of the orders constituting the single agency are placed at Annexures VII and VIII. It may be observed that while in Guna, it is the Zila Health Women And Child Development Committee of the Zila Panchayat which is the implementing agency for all health and family welfare programmes in the district; the committee comprising of the officials is the executive and implementing committee is the designated body in district Sidhi. Both the districts, have however, opted to have a similar District Health & Family welfare Board to direct the implementing agencies. Further, there are operational linkages provided for the Boards with the respective District Governments (through the District Planning Committees both in Guna and in Sidhi. The functions of District Planning Committees are placed at **Annexure III.**

Further, at the instance of the GoI, the state has been exploring the possibility of creating a single society at the district level to ensure effective co-ordination and implementation of the programme by giving a unified body responsibility for planning and managing all health and family welfare services as a holistic package. Besides benefits to be accrued from economies of scale a single society will also provide a platform for a tighter management

structure and facilitate the reform process. The proposed structures and their Terms of Reference at the state and district levels are under development. It is hoped that the evolved structures take the following into consideration:

8.6.1 Management Function of the Societies

Besides empowering the district societies with financial autonomy there should be ample scope for the societies to contribute effectively to the management of the programmes. It is crucial for the district level societies to have specific terms of reference to indicate their managerial functions besides the role they play as funding agencies. *The society should be an instrument of strategic planning for the successful implementation of the programmes and not merely an agency for channeling funds.*

8.6.2 Management of Change

It is imperative to orient the existing and proposed new district level societies to management of change with an emphasis on shared decision making and stakeholders participation if they have to play their role as agents of reform effectively.

8.6.3 Institutional Strengthening

The district level societies/committees should have a wider membership for more effective management and better governance. They should invite members from as many government departments as possible as well as from the PRIs, NGOs, donors and the private sector to promote inter sectoral collaboration. A society/committee is a powerful decentralised decision-making body and should be able to attract the best representatives.

8.6.4 Capacity Building

It is crucial for the district level societies to have effective conveners for the successful implementation of the programmes. The conveners should be provided training in preparation of the agenda, recording the minutes with action points and responsibilities, and reporting on the process and outputs indicators of the programmes.

8.6.5 Training of the Members of the Society

Need based training in managerial and financial skills should be provided to the members of the society. Professional updating on the constitution and memorandum of articles and association of the society should be provided to all members at regular intervals.

8.6.6 Governance and Management

It is important to clearly delineate roles and responsibilities of the key functionaries of the district society. It has been observed that often the Chairpersons tend to take all decisions and give direction to the programmes while the conveners who are the actual programme implementers seem to take back seat in the meetings of the society.

8.6.7 Role of NGOs

Relationship between NGOs and the district societies need to be clarified and strengthened. They should be encouraged to provide regular feedback to the societies in regard to the performance of the programmes at the grass root level. The current perception is that there are not many effective NGOs at the district level, and if there are, they are already overloaded.

8.6.8 Transparency

It is recommended that the district societies conduct open sessions with the public and press be invited to build confidence and encourage transparency as it has been observed that he general awareness levels amongst the community in regard to the content and implementation of the programmes are low. It is equally important to sensitize the politicians to gather support for the programmes.

Annexure-I

REGISTRATION OF HEALTH SOCIETIES UNDER THE 1860 ACT

A society can be registered with the Registrar of Societies by filing a Memorandum of Association(MOA) providing the following details:

- The name of the Society
- The names, addresses and occupations of at least seven members of the Society and
- The names, addresses and occupations of the members of the proposed Governing Body who will be responsible for managing the affairs of the Society.

The Memorandum of Association should also have the rules and regulations of the Society giving the following details:

- Name and address of the registered office of the Society
- Manner, criteria and procedure for enrolment and removal of different categories of members and their rights and obligations
- Period of membership, criteria, manner and procedures for forming the Governing Body, conduct of its meetings, notice period and quorum
- Designation, manner of appointment or election and removal of its office bearers, their powers and rights
- Procedure for conduct of annual general body meetings or any special meetings
- Procedures for accounts and audits
- Manner in which objects and rules and regulations of the Society can be changed
- Definitions and interpretations of the terms used in the MOA
- Institution of suits by or against the Society
- Provisions governing alterations and amendments and Procedure for dissolution
- Other provisions as per the requirements of the Act

On receipt of all these details the Registrar of Societies issues a certificate of registration to the Society. It is mandatory for a Society to conduct an annual general meeting of the Society and furnish details of the members of the managing body annually to the Registrar.

The Society Act has the following provisions:.

- Membership is open to all those who subscribe to the aims and objects of the Society
- The Society is allowed to charge membership fees
- A Governing Body can be elected, selected or nominated from the general body of members
- The property of the Society is vested in the Governing Body, and can be used only for the furtherance of the objects of the society and not for the private benefit of any member. However this does not prevent any member from being compensated for any services rendered
- The Society is a legal corporate body and can sue and be sued in its name by and on behalf of the governing body

The liability of the members of the Society and the governing body is limited and the rules and regulations provided for various roles and responsibilities are the basis for routine functioning of the Society.

MANDATE:

The formation of the district society/committee is either authorised by way of a government order or through operational guidelines usually issued by the state government.

CONSTITUTION:

The district society/committee is constituted as per the government orders or the guidelines set in the operational guideline manual of the programme. The convenor who is usually the programme officer responsible for implementing the programme sends a proposal for the formation of the society to the District Collector (Chairman). All the related ex-officio members of the society are nominated against the posts mentioned in the government order and for the rest of the members blank spaces with suggestions are made and the Chairman decides whom to nominate. It is preferable for the nominated members to be from NGOs, the academic community, social workers of repute, and marginalised groups. A copy of the guidelines describing their roles and responsibilities is sent to all members by the district collector once the society has been constituted.

GOVERNANCE:

All societies usually have a Governing Body and an Executive Committee, the constitution of which may vary. The Governing Body is responsible for managing the affairs of the society in accordance with the annual plan as well as for the timely release and effective utilisation of funds. As the Governing Body is unable to meet regularly which may cause a delay in the implementation of the programme, most societies prefer to appoint an Executive Committee. An Executive Committee has three to five key functionaries and is empowered with managerial and financial authority by the Governing Body in order to function effectively.

The Governing Body meets at least once every quarter for monitoring the progress of activities, utilisation of funds and inter-institutional co-ordination. The Executive Committee however meets more frequently and these meetings vary from once a week to once a month. The Executive Committee reports to the Governing Body on project progress and related issues.

TERMS OF REFERENCE:

All societies/committees have specific terms of reference or bylaws and a Memorandum of Association/Understanding. The terms of reference can be changed when required by convening a special general body meeting and getting approval from at least two-thirds of the members present in the meeting. Changes when made need to be communicated to the Additional Registrar of the Societies within one month of their acceptance by the Governing Body.

Modifications in the terms of reference are permissible such as:

- If a member is not participating actively in the meeting or is not able to provide time the society can replace that member.
- The duration and frequency of the meetings can be modified (i.e. meet more frequently during
- planning and less frequently afterwards as per the need).
- The society is permitted to form sub-committees whose members would be available at short notice and would have the authority to take decisions.
- Invitation to persons other than members to attend the meeting is permitted by the chairman e.g. state government officials or external resource persons who could provide useful inputs to the programmes.

REPORTING AND PERFORMANCE REVIEW MECHANISMS:

During the meetings of the societies/committees, quarterly plans are agreed, time bound targets set and progress on the implementation of activities reported. The convenor reports the problems, failures and successes encountered during the implementation and solutions to the problems are discussed and agreed by the members.

The meeting date is agreed in advance and communicated to the members of the society along with the agenda well before the meeting, to ensure the presence of as many members as possible and to facilitate a meaningful discussion.

An annual report of the proceedings of the Societies and a report on progress on all activities undertaken during the year are prepared by the Governing Body for the information of the Societies.

This report and the audited accounts are placed before the Societies at the Annual General Meeting. Periodic reports regarding activities of the Societies are also prepared and sent to the states.

Within 30 days after holding an annual general meeting, the following documents have to be filed with the Registrar of Societies:

- a list of the names, addresses and occupations of the office bearers of the Society
- an annual report of the previous year Both the list and the annual report have to be certified by the Chairman and the Executive Secretary and
- a copy each of the balance sheet and of the auditor's report certified by the auditor.

AGENDA:

The discussions on the agenda items are recorded, agreed and signed by all the members at the end of the meeting if the Chairperson is not present at the meeting, then the minutes are sent to her/ him for approval before circulating them to the members and others. Action points emerging from the meeting are sent to the persons identified as responsible for action in the form of local orders or circulars by the Chairperson. Disciplinary action may taken in case of non-compliance.

FINANCING AND BUDGET ARRANGEMENTS:

The financing and budgeting arrangements have to conform to the guidelines of the national programmes.

The funds are channeled through the society bank account which is operated jointly by the convenor and the chairman as authorised by the members of the society. The responsibility of maintaining the accounts lies with the convener of the programme. Drawing and disbursing powers can be delegated to other members of the society to facilitate the implementation of the programmes.

Cash assistance requirements of the districts are usually assessed by the state project steering committee and are based on the annual programme plans. Imprest amounts are then advanced to the district societies as prescribed by the project steering committees. A request for replenishing the imprest account is sent to the state by the district society once the imprest account is near depletion.

The depletion limits for sending a request for the next tranche of funds is agreed at the time of formulating the bylaws for the society. District societies have to send quarterly audited expenditure reports to the state.

AUDIT:

The district societies receiving more than Rs 2.5 lakhs are subject to audit by the. Comptroller and Auditor General of India provided this amount is not less than 75% of the total expenditure of the society. The accounts that receive more than Rs 10 lakhs in a year are also subject to audit. Under the Chartered Accountants Act of 1949, the societies are required to appoint external certified chartered accountants.

POWERS AND AUTHORITY FOR EMPLOYMENT:

One of the several reasons why societies were established was the flexibility available to them for undertaking transactions with the private sector. A society can therefore appoint contract staff for the implementation of the programmes as per the guidelines formulated by the governing body. The societies can also enter into contracts for counseling, advocacy and IEC activities as well as for materials and supplies. The societies also have the powers to terminate the contracts if required. The rules and regulations of the societies can be amended whenever necessary by calling a special meeting of the governing body.

DISSOLUTION:

A District Society can be dissolved at any time subject to the conditions stated in the Societies Registration Act. A minimum of two thirds of the total members of the Society have to agree to the dissolution and no assets of the Society can be acquired by any of the members. Any property that remains after settlement of the debts and liabilities has to be transferred to a society or organisation having the same objects or to the state department of health and family welfare.

M. P. SOCIETY-REGISTRIKARAN ADHINIYAM, 1973
(No. 44 of 1973)
Societies to which Act applies

This Act applies to societies formed for all or any of the following purposes:-

1. promotion of science, education, literature or fine arts;
2. diffusion of useful knowledge
3. diffusion of political education;
4. foundation or maintenance of libraries or reading rooms for general use among the members or upon to the public;
5. establishment and maintenance of galleries of Paintings and other works of arts;
6. establishment and maintenance of public museums;
7. collection of natural history, mechanical and philosophical inventions, instruments or designs;
8. promotion of social welfare;
9. promotion of religious or chartable purpose including establishment of funds for welfare of military orphans welfare of political sufferers and welfare of the like;
10. promotion of gymnastics;
11. promotion and implementation of the different schemes sponsored by the state Government or the Central Government.*
12. promotion of Commerce, Industries and Khadi.*

District Planning Committee *

There shall be constituted in each district a District Planning Committee, to consolidate the plans prepared by the Panchayats and Municipalities in the district and to prepare a draft development plan for the district as a whole and to exercise such other powers as may be entrusted to it by the state Government from time to time.

Every Committee shall, preparing the draft development plan: -

a. Have regard to: -

   i) Matters of common interest between the Panchayats and Municipalities including spatial planning, sharing of water and other physical and natural resources, the integrated development of infrastructure and environmental conservation.
   ii) The extent and type of available resources whether financial or otherwise.

b. Consult such institutions and organisations as the state Government may, by order, specify.

Functions of the Committee

The Committee shall perform the following functions:

1. Identification of local needs and objectives within the framework of national and state level objectives.
2. Collection, compilation and updation of information relating to natural and human resources of the district to create a sound database for decentralised planning, preparation of district and block resource profiles.
3. Listing and mapping of amenities at village, block and district levels.
4. Determination of policies, programmes and priorities for development of the district, in order to ensure maximum and judicious utilisation and exploitation of available natural and human resources.
5. Formulation of draft Five-year and Annual Development plans of the district in their Socio-economic, temporal and spatial dimensions, consolidating the plans prepared by the Panchayats and Urban bodies submission thereof to the state Government for incorporation in the state Plan.
6. Preparation of an employment plan for the district.
7. Estimation of financial resources for financing the district plan.
8. Allocation of sector and sub-sector outlays within the overall framework of the district development plan.
9. Monitoring, evaluation and review of progress under the schemes and programmes being implemented in the district under the decentralised planning framework including central sector and centrally sponsored schemes, and the Local Area Development Schemes of Parliamentary Constituencies and Assembly Constituencies.

* Excerpts from the Madhya Pradesh Zila Yojana Samiti Adhiniyam, 1995

10. Submission of regular progress reports to the state Government in respect of schemes included in the District Plans.
11. Identifying schemes and programmes, which require institutional finance, devising appropriate linkages with the district plans and ensuring requisite flow of such investment.
12. Ensuring participation of voluntary organisations in the overall development process.
13. Making suggestions to the state Government with regard to the state Sector Schemes having significant bearing on the process of development of the district.
14. Any other functions, which may be entrusted by the state Government.

Annexure-IV

GOVERNMENT OF MADHYA PRADESH
DEPARTMENT OF PUBLIC HEALTH & F. W.
MANTRALAYA, BHOPAL

ORDER

NO. RCH/98/PC5/14681 DATED 20/9/98

(COPY)

The Reproductive & Child health project has been implemented in the state with the sanction of President of India vide DO. Letter no. M. 14015/7/97/UIP B&A, 20th December 97, sanction is hereby accorded for the implementation of the RCH project in all the districts of the state as per guidelines of Govt. of India.

The sanction is hereby accorded for the implementation of the Reproductive & Child Health Project in all the districts through the district branches of the state Reproductive & Child Health society. It is hereby ordered that the district branch of RCH society should be constituted under the chairmanship of the collector. The Chief Medical & Health Officer of the district shall be designated as the member Secretary of the district branch. The district branch will follow the bye-laws of the state Reproductive & Child Health Society. Following structure of the society is suggested for the district branch: -

Sr. No.	DESIGNATION	POSITION IN RCH SOCIETY
1.	Collector	Chairman
2.	Chief Medical & Health Officer	Member Secretary
3.	District Family Welfare Officer	Member
4.	District Immunisation Officer	Member
5.	Civil Surgeon	Member
6.	Distt. Women & Child Dev. Officer	Member
7.	C.E.O. Zila Panchayat	Member
8.	Executive Engineer (PWD)	Member
9.	Distt. Education Officer	Member

The district branch of the Reproductive & Child Health society will have a joint bank account in the state bank of India in the name of Collector & Chief Medical & Health Officer. The drawal will be made by joint signatures of both of these officers.

The project shall be implemented by the district branch of RCH Society as per the guidelines issued by the Govt. of India as well as the state RCH Society. The department of Public health & F.W. shall be the nodal department for implementation of the project. The secretary of the Distt. RCH Society shall maintain the account of the society in the ledger & will submit the monthly statement of expenditure in stipulated time. This project is assisted by the World Bank & other donor agencies, therefore, all the rules & regulations of procurement will be in accordance with the World Bank guidelines.

(Ashok Das)
Secretary
Public Health & F.W.

Endt. No./7/RCH/98/PC-5/14682-14796 Dated, Bhopal, 26th Sept.'98
Copy to:-
Director Public Health & F.W., Madhya Pradesh.
Director Medical Services, Madhya Pradesh.
All Commissioners, Madhya Pradesh.
All Collectors, Madhya Pradesh.
All Divisional Joint Directors, Health Services, Madhya Pradesh.
All Chief Medical & Health Officers, Madhya Pradesh.

(Ashok Das)
Secretary
Public Health & Family Welfare

Annexure-V

DISTRICT BLINDNESS CONTROL SOCIETIES

I OBJECTIVE OF DBCS

The main objective of the DBCS is to achieve the maximum reduction in avoidable blindness in the district through optimal utilization of available resources.

II RATIONALE FOR ESTABLISHING DBCS

The main reasons for the formation of DBCS were:

1. The eighth five-year plan stated emphatically the government's policy to promote the districts as the key units for implementing development programmes.
2. The private sector spending for curative care has been increasing progressively and significantly during past few years. Since a large part of services provided under the NPCB are curative, co-ordination of efforts between the government, voluntary and private sectors is essential to implement the programme effectively. Such co-ordination is possible and most relevant at the district level, which have an average population of 15 to 20 lacs. The DBCS would be able to provide a forum for co-ordination of the activities amongst the government, voluntary and private sector.
3. Administrative and financial procedures in the government systems continue to be tedious. There have been innumerable occasions where a pending decision or lack of sanction has resulted in inactivity for long periods rendering costly resources ineffective and service providers frustrated and demotivated. It was envisaged that through the DBCS quick and timely decisions would streamline the services and optimise the outputs.
4. At the national and state levels, it is usual practice to frame policies, guidelines, norms and broad strategies for action, but at the district level only the district officials and the community are the best deciders of how to implement the programmes and fulfill their needs. The diversity in economic status, population sizes, terrain and communication between districts makes it imperative for the districts to adopt different and locally relevant strategies to achieve their objectives. It was proposed that the DBCS would assist the communities in achieving this.
5. Community participation – Community groups and local voluntary organisations like to take part and even steer an activity when they find that good quality services are provided at the district level. The DBCS would be a platform for catalysing community participation.

III FORMATION OF DBCS

1. The DBCS is a body or association of persons formed by mutual consent and or by certain common programmes based on the guidelines of the state/central programmes,

to deliberate, determine and act jointly for the common purpose mentioned in the MOA for NPCB.

2. The DBCS is collectively responsible for all the NPCB activities in the district. It functions through the machinery of the state, central, quasi govt. and NGO health infrastructure. It is the supportive hand of the NPCB at district level with the direct assistance from the GOI.
3. The DBCS is formed as per Societies Registration Act 1860 and as per guidelines of GOI letter No. T-19011/1/90-CCD dt. 3rd July 1990. It is registered with the competent authority for registration, usually the registrar or inspector if societies and / or Charity commissioner of respective state Govt. thus acquiring legal status required for:

    a. Opening a bank account
    b. Obtaining registration and approval under Income Tax act
    c. Lawful vesting of properties of the societies and
    d. Recognition of society at all for a and by all authorities.

4. Only one DBCS can be formed for one district. The following steps are required to form a DBCS by the District Ophthalmic Surgeon or the Chief Medical Officer of the District:

    1) Contact the district collector/magistrate or the deputy commissioner of the district along with the GOI letter asking the district to form DBCS.
    2) Discuss the procedure with the Collector/ Deputy Commissioner/ District Magistrate. Apply formally to the nearest competent authority in the prescribed format with MOA, list of 7 proposed members with names and designations, members of the proposed Governing body and their designation in the DBCS, laws and bye-laws along with the registration fee and other documents.
    3) Obtain the registration number from the authority along with the relevant certificate of registration, approved MOA and other documents as mentioned in point 2 above.
    4) Open a savings bank account in any nationalized bank (Bank of Baroda preferred, as it is also the accredited bank for GOI health ministry). The account should be in the name of DBCS and should have three specimen signatories for DBCS transactions.
    5) Initiate process for selection of suitable District Programme Manager (DPM) for the DBCS as per the guidelines.
    6) Send the copies of all documents to DDG (0), Nirman Bhavan, New Delhi for record which would help initiate the process of releasing the first installment of Grants to DBCS from the GOI.

IV FUNCTIONS OF DBCS

The DBCS has the following three major functions:

Administrative: The administrative responsibilities include day to day functioning of the DBCS, preparation, maintenance and submission of appropriate monthly accounts and appropriate reporting and feedback.

Implementation: The implementation function includes situational analysis, planning, coordination, resource mobilization, and facilitation of service delivery, monitoring and concurrent evaluation.

Statutory: The statutory function includes submission of accounts, audit, proper upkeep of minutes, proceedings, resolutions and compilation of reports for central and state governments.

V MEMBERS OF DBCS

The DBCS has two types of members viz., ex-officio and nominated and the total strength of DBCS members does not exceed 20. Since the DBCS is formed as per the guidelines of GOI with a specific purpose to implement the NPCB through the existing system, there have to be some officers from the district health and local administration as ex-officio members. Key functions of the DBCS are to liaise with NGOs, mobilize community participation and seek support from ophthalmic professionals in the district for which each DBCS have adequate nominated representation from the community and NGOs.

Only the member secretary is contractually appointed by the DBCS. The member secretary is a full time person who is designated as District Programme Manager (DPM) for all administrative, statutory and implementation functions.

VI MEMBERSHIP OF DBCS

1)	District Collector/ District magistrate/ Deputy Commissioner	Chairman
2)	Chief Executive Officer, ZP or *Reputed NGO office bearer or* Chief Medical Officer (DHO) or Civil Surgeon (DS)	*Vice Chairman**
3)	District Ophthalmic surgeon	Technical Advisor
4)	State Programme Officer	Advisor
5)	State programme coordinator (if any)	Advisor
6)	District Health Officer	Member
7)	District Education Officer(s)	Member(s)
8)	District Mass Media Officer	Member
9)	Media Representative	Member
10)	Rep. Of IMA	Member
11)	Lions/Rotary/Giant clubs President by rotation	Member
12)	Prominent Private eye surgeon	Member
13)	Rep of active Social organization(s)	Member(s)
14)	Popular People's representative	Member
15)	Industrial Unit representative(s)	Member(s)
16)	Professor of Ophthalmology if available (by rotation)	Member
17)	Other NGOs active in eye care	Member(s)
18)	District Programme Manager	Member Secretary

Note * There can be more than one Vice Chairman..

Annexure-VI

UNFPA INTEGRATED POPULATION AND DEVELOPMENT PROJECT SOCIETIES

MEMORANDUM OF ASSOCIATION

1. NAME OF THE SOCIETY

The name of the Society will be District Society for Integrated Population & Development Project (IPD)

2. OBJECTIVES

The objectives for which the Society is formed are primarily to achieve the objectives of the IPD project which are:

a. To enable individuals and couples, particularly women to achieve their personal reproductive intentions.
b. To initiate activities in other development sectors having an impact on achieving objectives.
c. To improve the quality of Maternal Health Services, Child Health Services, Family Planning Services, prevention and management of complications of unsafe abortion, RTI/STD management Services and promotion of Breast Feeding.
d. To enhance community participation in planning and implementing development programmes.
e. To contribute to improved social and economic status of women and towards the empowerment of women.

Any other activities which shall impact on the objectives mentioned above.

3. MANAGEMENT OF THE SOCIETY IS ENTRUSTED UNDER THE SOCIETIES REGISTRATION ACT TO THE GOVERNING COUNCIL OF WHICH THE FIRST MEMBERS WILL BE THE FOLLOWING:

S.No.	Address & Occupation	Designation
1.	District Collector/ Chairperson Zila Parishad/ CEO Zila Parishad	Chairperson
2.	Chief Medical & Health Officer	Vice-Chairperson
3.	District Women & Child Welfare Officer	Member
4.	Chief Executive Officer of the Zila Parishad	Member
5.	District Education Officer	Member
6.	District Officer looking after Panchayati Raj	Member
7.	Dy. CM&HO (Family Welfare)	Member
8.	Representative of the non-government organization	Member
9.	Representative of the non-government organization	Member
10.	Representative of the United Nations Population Fund	Member
11.	Two eminent persons from the field of health, population, gender or education	Members
12.	Pradhans of all Panchayat Samities of the district	Members
13.	Senior most officer in the district looking after MCH/FP (e.g. District Mother & Child Health Officer)	Member Secretary

Functions:

The following major functions would be undertaken by the Society to fulfill its objectives:

a. To undertake relevant training activities as defined in the approved project
b. *document to improve the knowledge, skills and attitudes of various levels of* functionaries in the district to provide good quality Maternal Health, Child Health, MTP, RTI/STD, Family Planning Services and to promote Breast Feeding.
c. To construct suitably repair, renovate and upgrade various types of service
d. institutions in the district as per the approved project document.
e. To purchase and supply different equipment and supplies needed to provide good quality services.
f. To initiate and undertake communication activities to increase the demand and utilization of the identified Reproductive Health Services in the District, to increase girls' education and to move towards the empowerment of women.
g. To define and initiate the various management interventions to improve the quality of RCH services and other human resource development services.
h. To improve the service provision in the district with respect to identified RCH Services.
i. To support activities for increasing female education and awareness and women's empowerment.
j. To encourage more effective community participation and participation of women PRI members in the development process.
k. To initiate/conduct various surveys and operations research as defined in the project document.
l. To issue guidelines/directions to the Secretary of the Society, for proper and effective functioning of the society with regard to its administration and finance.
m. To ensure observance of the financial rules framed by the governing council including statutory audit of records of the Society on an Annual basis.
n. In addition to the above, to undertake any other activity which will contribute to the attainment of any of the objectives of the society.

4. MEMBERSHIP

There shall be the following categories of members of the Society:

a. Founder Members: All the members who have signed and authenticated the memorandum of association and rules and regulations of the society will be treated as founder members.
b. Donor members: Any Government or Institution or body or a person who contributes to the corpus of the society not less than Rs. 1 lac at time will be a donor member of the society.
c. Honorary Member: Governing Council of the Society may on the recommendation of the Executive Committee approve the name of any individual or institution as honorary member of the Society for a period of two years at a time which may be extended further by the resolution of the governing council.
d. Special Member: The Governing Council of the Society may co-opt any individual who commands prestige in training or research in the field of Health & Family Welfare or Women's development as special member but they would not have voting rights.

5. COMPOSITION OF THE GOVERNING COUNCIL

1) The Governing Council of the Society for the District society for IPD Project shall ipso – facto comprise of all the Founder members, all the Donor members, honorary members and all the special members.
2) In addition to the above the Chairperson, on the suggestion of the Director (Family Welfare), shall have powers to nominate upto two members either from serving or retired officers who are renowned expert in the field of Health & family Welfare or Social Service.
3) Thus the constitution of the governing council shall be as follows:

S.No.	Address & Occupation	Designation
1.	District Collector/Chairperson Zila Parishad/ CEO Zila Parishad	Chairperson
2.	Chief Medical & Health Officer	Vice-Chairperson
3.	Dy. Chief Medical & Health Officer (FW)	Member
4.	District Women & Child Dev. Officer	Member
5.	District Education officer	Member
6.	Representative of the non-government organisation	Member
7.	Representative of the non-government organisation	Member
8.	Representative of the United Nations Population Fund	Member
9.	Pradhans of all Panchayat Raj Samities of the district	Member
10.	Two eminent persons from the field of health, population, gender or education	Members
11.	Two nominees of the Director (FW)	Members
12.	Senior most officer in the district looking after MCH/ FP (e.g. District Mother & Child Health Officer)	Member Secretary

Note: Nominations of NGO representatives shall be made for a period of two years. Depending on the particular activities proposed in the IPD for the district, other district officers like Police, Rural Development etc. can be included as members.

Annexure-VII

Office of The Collector, Guna (M. P.)
Order

With a view to integrate the management off all health & family welfare programmes in the district including the Sector Investment Programme. **District Health & Family Welfare Board (DHFWB)** is hereby constituted as follows:

Chairman - Minister -In - Charge of the District.

Secretary - Collector, Guna

Members-

1. All MP's MP - Guna - Shivpuri, MP - Rajgarh - Guna.
2. All six MLAs.
3. President Zila Panchayat, Guna.
4. Vice-President, Zila Panchayat, Guna.
5. Representative of ECTA, UNICEF and Govt. of India - one each.
6. One Representative of Health Directorate, Govt. of M. P.
7. President of all local bodies - Nagar Palika / Nagar Panchayat and Janpad Panchayats.
8. All members of Zila Panchayat Health, Women & Child development committee.
9. Two representatives of NGOs, active in the field of health.
10. Two private doctors.
11. Officials - CEO/ZP, Civil Surgeon, ADC, Ashoknagar, PO (WCD), EE/PHE, DEO,
12. Head of District Information and Resource Centre.
13. Convenor - CMHO.

Terms of Reference & Specific Roles: -

1. The District Health & Family Welfare Board will meet once in every three months (quarterly). The decision will be taken by simple majority of members present in the meeting.
2. The DHFWB will formulate the policies, modalities for implementation & management of all health & family welfare programmes including sector investment programme.
3. The DHFWB will be empowered to assign, delete, add or modify the policies and rules for implementation of District Action Plan (DAP) except the basic features.
4. The DHFWB will monitor, supervise and review the implementation of health & family welfare programmes, including DAP quarterly and if progress is not satisfactory then it can change the implementing agency.
5. In the absence of the Chairman, the quarterly meeting of DHFWB will be chaired by any non-official member, to be decided by simple majority of non-official members among themselves.
6. DHFWB shall be empowered to take decision which do not required prior approval of the District Planning Committee / State Government. However, the DHFWB shall propose such issues, as it may consider necessary to be decided by any such authority.

2. Executive Committee of District Health & Family Welfare Board

Collector – Chairman

CEO Zila Panchayat - Vice Chairman

CMO(H) – Secretary

Members-

District Education Officer
Civil Surgeon
District Project Officer (Women & Child Development)
Secretary, District Blindness Control Society
Secretary, District Leprosy Eradication Society
Secretary, District AIDS Control Society
Secretary, District malaria Control Society
Secretary, District Tuberculosis Control Society

Terms of Reference & Specific Roles:

1. The Executive Committee will analyse any changes proposed by any for a for effective implementation of Health & Family Welfare Programmes in the District.
2. It will act as technical & management support to DHFWB and Zila Panchayat Health Women & Child Development Committee (ZPHWCDC). The support shall also include District Information & Resource Centre consisting of one Programme Manager, two Assistant Managers, one Computer Operator & one Attendant. In addition, the Executive Committee may also hire technical / management capacity either on part time or full time basis. It will also translate the vision of DHFWB into implementable form for action by the ZPHWCDC.
3. The Executive Committee will meet at least once in a month and will be answerable to and report to District Health & Family Welfare Board in all the matters regarding health & family welfare programmes including sector investment programme.

3. The Implementing Agency:

The Zila Panchayat Health Women & Child Development Committee (ZPHWCDC) shall implement and monitor all health & family welfare programmes in the district including Sector Investment Programme. The Committee shall draw upon powers and authorities as vested in it by The Madhya Pradesh Panchayat Act 1993.

The Committee consists of the following: -

Chairman -Chairman, Health, Women & Child Development committee of Zila Panchayat

Members -All members of Zila Panchayat Health, Women & Child Development Committee

Co-ordinator -CEO, ZP, Guna

Secretary -CMHO, Guna

Terms of Reference & Roles: -

1. Zila Panchayat Health, Women & Child Development Committee (ZPHWCDC) will be responsible for implementation of all health & family welfare programmes and Sector Investment programme.
2. The Committee will monitor the progress of various health programme through the secretaries of District Leprosy Society, District AIDS Control Society & District Malaria Society, District Blindness Control Society.
3. The ZPHWCDC will not be empowered to deviate from District Action Plan.
4. The execution of SIP shall be done by ZPHWCDC in the district.

4. The Flow of Funds

The European Commission's grant-in-aid shall be credited into Sector Reform Fund (SRF). A separate bank account named 'Sector Reforms Fund' shall be maintained by Zila Panchayat, Guna. The account shall be jointly operated by Chief Executive Officer Zila Panchayat and Chief Medical & Health Officer of the district. The account shall be audited as laid down in the existing rules.

Annexure VIII

Office of The Collector, Sidhi (M.P)
Order

No./EC/DAP/2000

Sidhi Dated 11-8-2000

With a view to integrate the management off all health & family welfare programmes in the district including the Sector Investment Programme. **District Health & Family Welfare Board (DHFWB)** is hereby constituted as follows:

Chairman - Minister -In - Charge of the District.
Secretary - Collector, Sidhi
Members-

1. Two member of Parliament from District Sidhi.
2. All six MLAs of Sidhi District
3. President Zila Panchayat, Sidhi
4. One representative from Directorate of Health Services, Govt. of M.P
5. President, Municipal Council, Sidhi
6. President, Health, Women & Child development committee of Zila Panchayat and President, Health Committee of District Planning Committee
7. One NGO representative, active in the field of health
8. One private doctor
9. Officials - CEO/ZP, Civil Surgeon, ADC, Waidhan, PO (WCD), EE/PHE, DEO
10. Convenor - CMHO.

Terms of Reference & Specific Roles: -

1. The District Health & Family Welfare Board will meet once in every three months (quarterly). The decision will be taken by simple majority of members present in the meeting.
2. The DHFWB will formulate the policies, modalities for implementation & management of all health & family welfare programmes including sector investment programme.
3. The DHFWB will be empowered to assign, delete, add or modify the policies and rules for implementation of District Action Plan (DAP) except the basic features.
4. The DHFWB will monitor, supervise and review the implementation of health & family welfare programmes, including DAP quarterly and if progress is not satisfactory then it can change the implementation plan & process.
5. In the absence of the Chairman, the quarterly meeting of DHFWB will be chaired by any non-official member, to be decided by simple majority of non-official members among themselves.
6. DHFWB shall be empowered to take decision which do not required prior approval of the District Planning Committee / State Government. However, the DHFWB shall propose such issues as it may consider necessary to be decided by any such authority.

2. Executive and Implementing Committee of District Health & Family Welfare Board: -

Collector - Chairman
CEO Zila Panchayat - Vice Chairman
CMHO - Secretary

Members-

Civil Surgeon
District Education Officer
District Programme Officer (Women & Child Development)
Secretary, District Blindness Control Society
Secretary, District AIDS Control Society
Secretary, District malaria Control Society
Secretary, District Tuberculosis Control Society
Secretary, District Rogi Kalyan Samiti

Terms of Reference & Specific Roles: -

1. The Executive Committee will analyse a proposal received from any fora for effective implementation interventions and suggest to DHFWB.
2. It will act as technical & management support to DHFWB and will translate the vision into implementable form for action.
3. DHFWB shall be supported by contractual staff as agreed in DAP
4. The Executive Committee will meet at least once in a month and will be answerable to and report to District Health & Family Welfare Board in all the matters regarding health & family welfare programmes including sector investment programmes.
5. The committee will be responsible for implementation of all health & family welfare programme and Sector investment Programme
6. The Committee will monitor the progress of various health programmes through programme officers of various societies constituted for health programmes
7. Executive Committee will have power to recruit the staff on contract basis
8. The Executive Committee shall implement all health & family welfare programme in the district as an umbrella management body. All health & family welfare related societies shall be integrated into the DHFWB which will represent their common operational platform

3. The Flow of Funds

The European Commission's grant-in-aid shall be credited into Sector Reform Fund (SRF). A separate bank account named 'Sector Reforms Fund' shall be maintained by DHFWB Sidhi. The account shall be jointly operated by Collector, Sidhi and Chief Medical & Health Officer of the district. The account shall be audited as laid down in the existing rules.

(S.N.Mishra)
Collector & Dy. Secretary to
Department of Health &
family
Welfare, Govt. of M.P. Sidhi
(M.P.)