सत्यमेव जयते

Government of West Bengal

HEALTH SECTOR REFORMS

2003 – 2007

DEPARTMENT OF HEALTH & FAMILY WELFARE
GOVERNMENT OF WEST BENGAL

ডাঃ সূর্য্যকান্ত মিশ্র
মন্ত্রী
স্বাস্থ্য ও পরিবার কল্যাণ,
পঞ্চায়েত ও গ্রামোন্নয়ন,
ই. এস. আই এবং জৈব প্রযুক্তি বিভাগ
পশ্চিমবঙ্গ সরকার

Dr. Surjya Kanta Mishra
Minister - in - Charge
Departments of
Health & Family Welfare,
Panchayats & Rural Development,
ESI and Bio Technology
Government of West Bengal

Dated .....07..06..... *200*..8..

We, in the Department of Health and Family Welfare, are constantly striving to achieve our mission to improve health status of all the people of the state. It is our endeavour to ensure equitable and universal access to quality health services for all, especially poor and neediest.

Our approach of promoting health, particularly maternal and child health and confronting disease challenges has required actions across a range of activities including policies to promote sustainable and efficient delivery of services. The DoHFW has introduced considerable reforms in its systems and processes over the last few years. Notable among these are collaborating with the Panchayati Raj Institutions. The PRIs have been assigned a very important role in health care and some of their responsibilities include maintenance of all properties in the primary sector, constructions and monitoring at community level. Several initiatives, which will help to reduce the out of pocket expenditure of the poor and encourage them to utilize services, have been piloted and even taken to scale. The state is continuously reviewing and enhancing the management of its human and financial resources.

This document is a compilation of policy and reforms that have been undertaken over the period 2003-2007. The process and the quest for innovative and effective solutions to the emerging health challenges facing the state will, I am sure, continue.

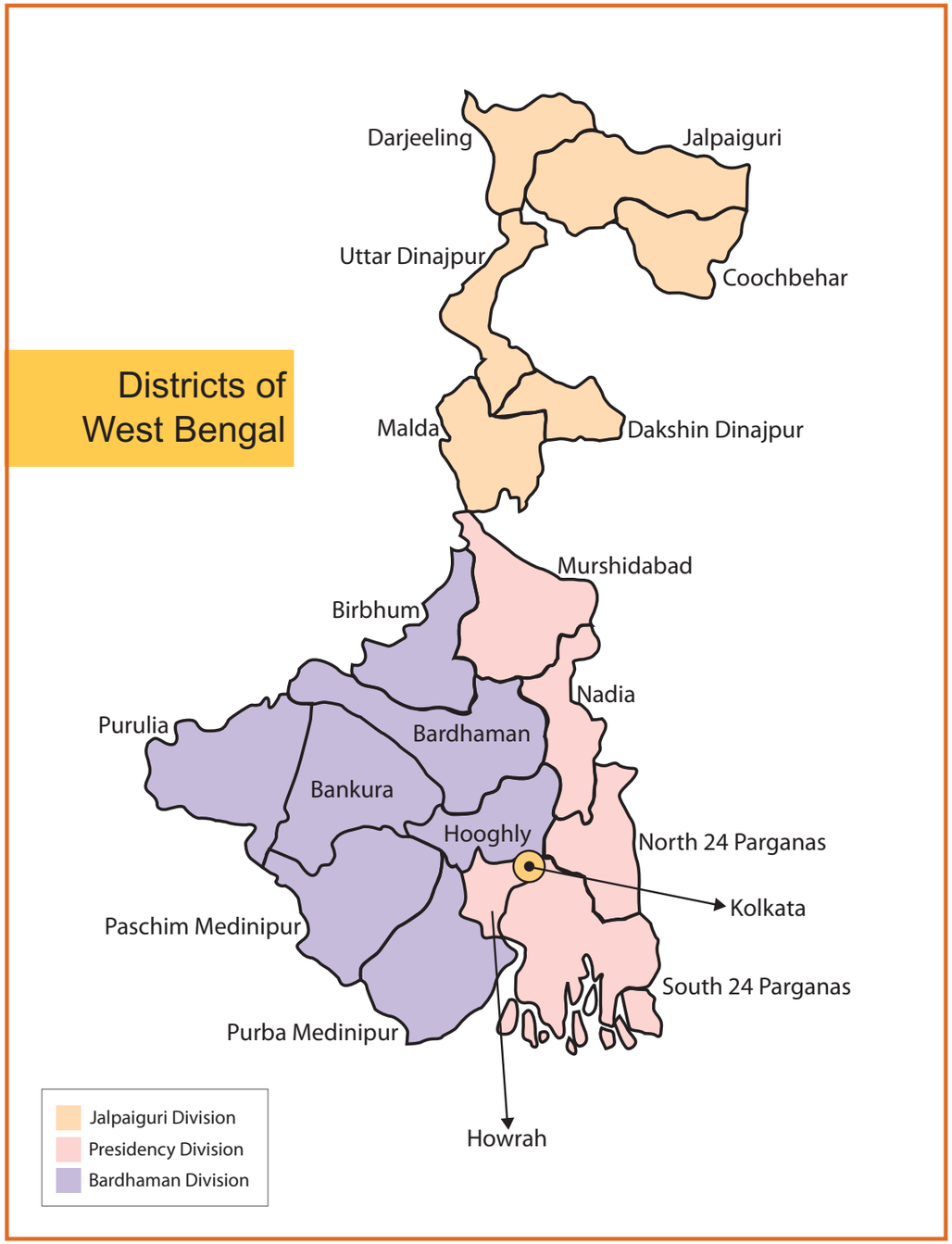
Dr. Surjya Kanta Mishra
Minister-in-Charge
DoHFW, GoWB

মহাকরণ, কলকাতা - ৭০০ ০০১, দূরভাষ ঃ ২২১৪ ৩৬০০, ফ্যাক্স ঃ ২২১৪ ৫৩০৬
স্বাস্থ্য ভবন, জি এন - ২৯, সেক্টর ৫, সল্টলেক, কলকাতা - ৯১, দূরভাষ ঃ ২৩৫৭ ৩৬০০, ফ্যাক্স ঃ ২৩৫৭ ৭৯১০
E-mail : mic@wbhealth.gov.in

TABLE OF CONTENTS

HEALTH SECTOR REFORMS

HEALTH SECTOR REFORMS



INTRODUCTION

What are Health Sector Reforms?

Reform means change for the better or 'positive change', but health sector reforms imply more than just any improvement in health or health care systems [1]. Health sector reform is not only a technical issue, but also reflects the social values and political processes of a country or state, which creates the context for and direction of change. A commonly agreed upon definition of health sector reforms is

"a significant, purposive effort to improve the performance of the health-care system" [2].

A definition by WHO (1997) states that health sector reform is, 'a sustained process of fundamental change in policy and institutional arrangements of the health sector; usually guided by the government'[3].

In all definitions, the common aspect is that such reforms or changes should be 'sustained' i.e. it shouldn't be a one-shot temporary effort that will not have any enduring impact; it should be 'purposive' i.e. it should emerge from a deliberative process that employs rational analytic methods and hard evidence; and it should be 'fundamental' in the sense that it addresses significant, strategic areas of health systems.

The World Health Report 2000 identified the following five goals of health sector reform, which can be used to orient discussions about the purpose of reform, and the measurement of its outcomes: (i) Access (ii) Equity (iii) Quality/responsiveness (iv) Efficiency and (v) Sustainability. The track record of health sector reform's impact on these goals is mixed, in part reflecting the complexity of the reform process and agenda [4].

Health Sector Reforms in West Bengal

The Department of Health and Family Welfare (DoHFW) of the Government of West Bengal (GoWB) has embarked on a process of improving the health systems and services within the State, through a strategic planning process [5]. The Health Sector Strategy (HSS) lays down the framework for the strategic planning process in the state.

A Strategic Planning and Sector Reform Cell (SPSRC) has been formed within the DoHFW to spearhead the change process. SPSRC is envisaged to assist in framing policies and recommending strategic options for various reform initiatives. The Technical Assistance Support Team (TAST) has been contracted by DFID in 2006 on behalf of the DoHFW, to strengthen and provide support to the SPSRC.

Department of Health and Family Welfare, Govt. of West Bengal

A medium-term reform and investment programme was launched on August 16, 2005 named the Health Systems Development Initiative (HSDI). This programme operationalises the HSS. The National Rural Health Mission (NRHM), also launched in 2005 is a seven years (2005 -2012) reform programme of the Government of India. NRHM aims to enhance comprehensive primary health care services especially for the poor and vulnerable sections of the society. It operates as an omnibus broadband programme by integrating all vertical health programmes. The reform goals of HSDI and NRHM are consistent with the HSS[6].

The HSS provides the overall framework for reforms in the state for a 10-year period (2004-2013). Short-term strategic priorities have been identified which would enable the DoHFW to attain the overall health outcome goals. The HSS states the priorities for the the Phase I (2003-05) of the reform process as[7]:

- Reducing neonatal and maternal mortality.
- Strengthening and developing the HMIS.
- Exploring opportunities for strengthening decentralisation and other partnerships.
- Reviewing and restructuring HRD systems.
- Reviewing budgets, patterns of fund flow and financial systems.
- Strengthening and broadening the Strategic Planning Process.

Reforms in line with these strategic priorities have already been initiated, but there is no proper documentation of all these endeavours. In early 2002, a book titled, "Health Sector Reforms" was published , which summarized the department's priorities and the activities and actions taken to date. A second edition of this book was published in September 2002. Thereafter there has not been any updated information on reforms in the health sector in West Bengal. This document is an attempt to consolidate all major reform measures undertaken by the state in the health sector in the last few years (2003 – 2007).

Organisation of the document

The document is organised in six sections, identified as broad areas of reforms in the state. Attention has been given to categorise reform measures and activities in concurrence with the strategic priorities stated above. The categorisation of the reforms in these broad areas will enable a better understanding of the reform process:

1. Decentralisation
2. Convergence
3. Monitoring & Quality assurance
4. Organizational development and human resource management
5. Service provision
6. Financial management

" The mission of the Department of Health and Family Welfare, Government of West Bengal, is to improve the health status of all the people of West Bengal, especially the poorest and those in greatest need"

DECENTRALISATION

A generic definition of decentralisation is transfer of authority and power from a higher level of government to a lower level of government, agency, parastatal body etc. Rondinelli and Cheema (1983) identify four main forms of decentralization as: deconcentration, devolution, delegation and transfer.

Four forms of decentralisation as defined by Rondinelli and Cheema (1983), (i) Deconcentration i.e redistribution of administrative responsibilities from central agencies to field offices of the same agency at lower levels; (ii) delegation to semi-autonomous or para-statal organizations which are under the control of the central government; (iii) devolution through creation or strengthening of independent levels or units of government, outside the control of central government; and (iv) transfer of functions from government to non-government organizations.

In the context of the reforms in health sector of West Bengal, there has been a mix of all the four forms of decentralisation, albeit with two major trends: (i) deconcentration of power and resources to the district and lower levels of health administration and (ii) devolution of powers and resources to local bodies, i.e Panchayats.

1.1 Integration of Health Societies

Nationally funded programmes including RCH, Control of Vector borne diseases, Revised National Tuberculosis Control Programme (RNTCP), Leprosy eradication, control of blindness, favoured a vertical programming approach. Early decentralisation reforms in the country introduced the practice of constituting societies at State and districts, mainly to hasten the process of funds transfer and improve management by involving different stakeholders. Timeline for the reform within different programmes was different and each programme formed its own society. Thus, it was difficult to manage and monitor this extra budget state expenditure, as it was not reflected in the treasury-controlled system.

In the initial phase in 2002, all the different health societies at district level were merged into one District Health and Family Welfare Samiti. Sabhadipati of Zilla Parishad (Chairman of the District Panchayat Board) is the president of governing body of the Samiti and the Chief Medical Officer of Health is the Secretary. The District Magistrate as the Executive Vice-President oversees management of the Samiti. Other members include local elected representatives, NGO representatives and government functionaries.

By 2003, all existing societies on public health programmes were merged to form the West Bengal State Health and Family Welfare *Samiti*[8]. This has enabled the state to have common implementing, financial management and monitoring for all

programmes since the national and state public health programmes with off budget funding are now implemented through this state level samiti.

To further devolve health planning and management functions, Block Health and Family Welfare Samitis (BH&FWS) have been constituted in each block. The BH&FWS is responsible for implementation, review and monitoring of all activities, schemes, projects and programmes in the block. BH&FWS is also involved in management of health institutions situated in the block.

NRHM launched in 2004, has now made it mandatory for the states to merge all health societies into one single body at all levels State, District and Block, with a view to introducing transparency in the process and improving management and monitoring.

1.2 Strengthening Sub Centre Functioning

a) Gram Panchayats supervise sub-centres

Gram Panchayat (GP) is the third tier elected body in the Panchayati Raj institution for a population of roughly 17-1,80,000. Usually there are three sub centres in a GP area. As a first step to involve the community in monitoring health services, all sub centres and health workers located in a GP area have been placed under the direct supervision of the GP.

b) Realigning boundaries

To enhance GP and Sub centre coordination, the state has taken an initiative to relocate sub-centres in a way that, there would be one Sub-Centre (SC) in each GP Head Quarter; to be known as Head Quarter Sub centre (HQSC). This is done to align the service area of the SC with the existing administrative boundary and is seen as a major step towards decentralisation. A HQSC has been identified in all GPs across the state. In case the existing SC is located in a rented building, it was shifted to the GP building. If the GPHQ did not have any SC within its boundary, then the SC located at the nearest village was relocated at the GPHQ. SCs located in BPHCs and PHCs, however were not considered for relocation / shifting.

GP Head Quarter Sub Centre construction

c) Supervision of Sub Centre[9]

The GP level supervision of SCs has been strengthened by positioning a Health supervisor male or female at each GP headquarter (GPHQ) sub centre. All health supervisors in second and third tier supervision have been redeployed to GPHQs. Any vacancies at this level were filled up by upliftment from amongst eligible health assistants male/ female. The GPHQ supervisors are responsible for supervision of sub centres and health assistants in all sub centres located within the respective GP area.

The GP has the power to issue working certificates to these officials. The salary/honorarium/wages of the concerned official is drawn and disbursed on the basis of working certificate issued by the GP. GPs have been provided with copies of job definitions of Health Assistant, list of all sub centres in the district and names of Health Assistants placed at the sub centres. In case the GP is unable to issue certificate due to litigation or otherwise, the Block Development Officer is empowered to issue working certificates.

d) Enhanced monitoring[10]

The GPHQ sub centre has been made the centre of monitoring public health activities. Monitoring is jointly done by the GP Health and Education Upasamiti and health department functionaries. The GP health supervisor prepares the monthly review report by compiling monthly reports from all sub centres and Anganwadi worker (AWW) reports. This forms the basis for discussion at the monthly review meeting usually convened on the 4th Saturday of each month. Members of panchayat and a medical officer from the block also attend the review meeting. The state has also formed Sub Centre and PHC level health committees with PRI functionary (Gram Pradhan) as the chairman for better monitoring and supervision.

4th Saturday GP meeting under progress

e) A hub for Primary Health care

Having relocated and staffed the GPHQ SC, the state subsequently proceeded to develop them as a hub for primary health care. Buildings are being constructed on a priority basis and the sub centre are being equipped to provide clinical and delivery services. There are provisions for making an MO available periodically.

1.3 PRI responsible for Infrastructure

One of the major efforts towards decentralisation is the transfer of responsibility for Primary Health Care infrastructure (BPHC, PHC, SC) in the state from PWD to the PRIs. At present, the PRI is responsible for construction and maintenance of all primary health care infrastructures within its jurisdiction. PRIs receive funds from DoHFW to undertake the construction, maintenance and repair works in these facilities. This reform helps to foster greater ownership and participation of PRI and the community in affairs of health facilities in their neighbourhood.

1.4 Decentralised management of health institutions[11]

A Rogi Kalyan Samiti (RKS) has been constituted in every health facility from District Hospitals to the Primary Health Centres for improved functioning of the institutions leading to better services to patients. The RKS at each level consists of representatives from health and general administration, local elected leaders (from panchayats, municipalities, MLAs etc), hospital administration (in case of

hospitals) local NGOs, Medical Associations.

These RKSs are mandated to look into all aspects relating to the management and proper functioning of a health institution. The RKS are a sub-unit of the respective BH&FWS or DH&FWS. RKS of each health facility receive untied funds annually for meeting emergency needs at the facility, @ Rs. 5.00 lakh per District Hospital and @ Rs. 1.00 lakh per Sub-divisional Hospital/State General Hospital / Rural Hospital / BPHC.

1.5 District Health Planning[12]

Decentralising health planning was the underlying principle for introducing District Health Planning to the State in 2006-07. Consequently all 18 districts prepared District Health Plan for the first time, for the year 2007-08. The task was huge and the state took two key decisions which enabled the process to be completed despite the challenge – one was to consolidate village planning into GP plans and second to start planning for year 2007/8 and not attempt to produce plans for 2006/7; given the short time period.

The process started from April 2006, with consultations at the state level to work out the details of the planning steps and procedure. Development of planning templates (including field testing and revisions), facilitation and training guidelines were prepared before the actual planning process started. An external agency facilitated the process at the district, block and GP level. Plans developed in the districts were appraised at the state and finalised taking into account available resource envelopes and policy guidelines.

The DHPs evolved through a participatory and consultative process with involvement of a wide range of stakeholders. The community engagement was through the interface with the PRIs. Other stakeholders included representatives from Department of Women & Child Development (DWCD), Public Health Engineering Department (PHED) and NGOs. The district planning process used a bottom up approach with planning of health actions at GP level as the first level of planning. Following consultations at each level a plan was developed which was incorporated into the next level of plan i.e. a GP plan fed into the respective Block Health Plan, which coalesced into the District Plan.

DHP's field

1.6 Additional support for poor performing District/blocks

a) Additional resources

The six districts, which have the lowest score on the Human Development Index[13], are being prioritised for additional support. During district health planning these districts had higher outlays for facilitation to the planning process. In practical terms this translated to having additional facilitators in these districts, as compared with better performing ones, in the ratio 3:1 (see section 1.5). These districts also have a higher resource allocation in terms of per capita allocation – Rs 82.34 versus Rs 61. 43.

b) ASHA's in poor performing blocks

Accredited Social Health Activist (ASHA) is a village level worker who will work closely with the community to motivate and support them to utilise services. NRHM has introduced the concept of ASHA to strengthen the reach of sub centres into the community, for universal coverage in Empowered Action Group (EAG) states (See section 5.11). Though, West Bengal is not included in the EAG states, but it has still adopted the ASHA concept to provide additional support to poor performing blocks. The DoHFW has identified 135 poor performing blocks based on two critical indicators – estimated birth rate and female literacy rate. These blocks will have additional field workers – ASHA and will be focussed for intensive promotion of institutional deliveries. Over the next year, the DoHFW has plans to introduce ASHAs in another 100 blocks in the state.

CONVERGENCE

The main aim of convergence is to facilitate integration of various services to meet simultaneously the various felt needs in diversified areas of the targeted groups. One of the main objectives of convergence is the coordinated delivery of some or all services in view of the complementarity of their objectives. Convergence can be 'intra', i.e integration of the various health societies for management of disease control programmes and 'inter' i.e with other departments (women and child development, water and sanitation) etc, which have a direct relation to health status of population.

2.1 Monitoring by Gram Panchayats

"Community's health in the community's hand" is the guiding principle behind the state wide 4th Saturday meeting held in every GP (see section 1.2). The meeting is convened by the GP Pradhan to monitor the status of programme delivery in the area. Service providers of health, nutrition and sanitation at the GP level have to report on the status of the population vis-à-vis their programmes. This is emerging as a significant platform for sharing and exchange of information and preparing strategies to tackle local problems. All GPs prepare a report, which is collated at the block and sent to the SDO. The SDO sends a consolidated report of the district to the ADM (Health) at the Zilla Parishad. The ADM then takes necessary actions in consultation with the CMOH of the district. State reports compiled by PRDD are shared regularly with DoHFW.

2.2 Village Health and Sanitation Committee

In West Bengal, the PRI bodies and functionaries have been participating in local matters related to health and nutrition for a long time. This was mostly done at the GP level. Recently, the state has moved one step ahead and given the existing Gram Unnayan Samitis (GUS) the additional role of Village Health & Sanitation (VH&S) Committee, a platform for inter-sectoral convergence under NRHM. Untied grants have been provided to 28,770 VH&S Committees @ Rs.10,000/- per VH&S Committee. Members of the VH&S Committee/GUS are the ANM, AWW, Secretary/ Treasurers of local SHGs, ASHA (wherever available) and PRI members. The VH&S Committee is required to regularly collect, update, use and maintain data relating to health and nutrition status of the population in its area.

Gram Unnayan Samiti (GUS), established in 2003, acts like a standing committee of the Gram Sansad and is accountable for its functions and decisions to the Gram Sansad. The GUS has the responsibility of ensuring active participation of the people in implementation, maintenance and equitable distribution of benefits under different programmes.

2.3 Village Health and Nutrition (VH&N) Day

Monthly VH&N day, a strategy under NRHM, is being organised at all the Anganwadi Centres to ensure convergence of ICDS, health and sanitation programmes at community level. At the village level the GUS organises the VH&N day with support from AWW and ANM. The respective Block Medical Officers and CDPOs jointly plan the programme for VH&N day, in consultation with Sabhapati of the concerned Panchayat Samiti, Block Development Officer and Pradhans of the GPs. The ANM, AWW and ASHAs attend and assist in conducting discussions and activities. The AWW and ASHA (where available) are responsible for mobilization of beneficiaries for the VH&N Day through SHGs, Mothers' committees etc.

A total amount of Rs.21.60 crore has been committed in the NRHM PIP for the year 2007-08 for this purpose. This programme will be implemented by the DH&FW Samitis, with active participation of ICDS and health functionaries.

2.4 Collaborating with PHED

Incidence of waterborne diseases in rural West Bengal is fairly high. One of the main reasons is lack of access to safe drinking water. The situation is worse in the districts where there is Arsenic and Fluoride contamination in water. A programme for quality testing of drinking water in the districts has been initiated with the cooperation of the PHED. The programme aims at strengthening the 'Drinking Water Quality Testing' units in different districts of the State. An amount of Rs. 2.5 crore has been committed for this purpose in 2007-08.

2.5 Outreach Health services at AWC

Outreach sessions are being conducted by ANMs at AWCs to serve the population in areas, which are difficult to access from the neighbouring Sub-centre. These outreach sessions are organised once a month in the hard to reach areas and are mainly focussed on immunisation of children and mothers. This initiative helps to improve access for families who are unable to travel to the Sub centre for these services.

2.6 Medicine kits for Angan Wadi Workers (AWWs)[14]

As a step towards convergence and ensuring better access for target population, medicine kits are being provided to the AWWs for distribution through ICDS centres. The kit contains: 3000 IFA adult tablets, 80 Albendazole tablets, 40 packets of ORS and 2 bottles of Vitamin A syrup. For rural areas, the kit is distributed by the BMOH, and for urban areas, it is through CDPOs. The AWW is required to send monthly reports to the ICDS Supervisor, who in turn sends a consolidated report to the CDPO. The CDPO reports to the DPO. The AWWs also have to share the data on distribution of these kits to respective ANMs on a monthly basis.

Medicines distributed by AWWs

MONITORING & SUPERVISION

Mechanisms for monitoring and supervision exist in the state, but most of these are specific to programmes or projects. The National Disease Control Programmes have their specific monitoring formats and systems, and so also the state led initiatives like PPP schemes (Ambulance, diagnostics etc), which have individual monitoring systems in place. The department also has monitoring officers designated for each district. However there is a need to develop an overall framework for monitoring performance in the health sector.

3.1 Enhanced supervision at Gram Panchayat level[15]

Sub centre reforms (see Section 1.2) were accompanied with reorganisation of Health assistants male and female and health supervisors. The staffing pattern of the GPHQ sub centre included one health assistant female (in charge), one health assistant male and one health supervisor.

The Health Supervisor located at the HQ sub centre has replaced the second and third tier of monitoring, which existed earlier. The Health Supervisor is responsible for monitoring and supervision of Health Assistants of all sub centres within that particular GP. This reform has vastly improved services and supervision at GP level. It is this set up, which made it possible to introduce a bottom up district health planning process in the state starting at GP level. The Health Assistant (male & female) and the Health Supervisor are also members of the GP Health and Education Upasamiti of the PRI. This link helps to introduce community monitoring of health programmes.

Furthermore the new set up provides for an honorary male volunteer at those non-HQ sub centres to be appointed by the GP. To encourage community participation in health programmes at the village level, guidelines for involving self-help groups at village level have also been laid down. Staff, officers, volunteers as well as members of PRI and SHGs who are involved in the implementation of multipurpose health programme scheme have received training to perform their new roles.

GP supervision is backed up by the first tier monitoring and supervision, which is under taken by the Block Medical Officer of Health with assistance from medical officers of other health institutions in the block.

3.2 Maternal/Infant Death Reporting[16]

The ultimate health goal of the state is to reduce MMR and IMR. To achieve this it is important that alongwith other measures, maternal and infant deaths be tracked to ascertain the causes of death and take measures to overcome them. Death audits have been introduced, which require that every maternal and child death be investigated for cause and reported. At the field level, the GP based Health Supervisor is entrusted with the responsibility to report, every maternal and infant death occurring within her area indicating the apparent cause, to the BMOH and Pradhan of the GP. The BMOH, after investigation has to send a report to state health department on every such event.

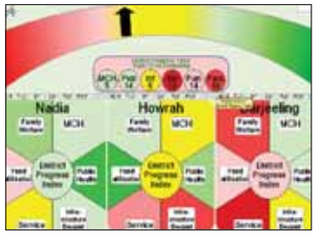
3.3 Quality Assurance in Health Care Institutions

Quality assurance (QA) is a planned and systematic approach to monitoring, assessing and improving the quality of health services on a continuous basis within the existing resources[17]. It is a relatively new concept as far as West Bengal is considered. The state has plans to introduce Quality Assurance (QA) programme in all health care institutions in a phased manner. With this objective in mind, a Working Group on Quality Assurance has been formed in 2006 with 5 officials from the department as members of the working group. The group is conceived as an interim arrangement, which would provide leadership to the QA initiative in the state and prepare the ground for setting up more permanent institutional set up for consolidation and sustenance of the QA activities across the state.

3.4 Quarterly review meetings

The DoHFW introduced "Quarterly health review" in 2006, as a tool to monitor its programmes and to forge linkages between policy makers and implementers. Quarterly reviews are held at Division level. The state team is lead by Health minister and Principal Secretary Health. Members include Commissioner Family Welfare, Mission Director NRHM, Executive Director Samitis and other senior Health officers. In addition to key health officials, the district teams also include District Magistrate and District head of PRI. The review includes a broad range of issues from coverage of services to progress on infrastructure development, to find out status at various levels. The reviews are useful in bringing accountability to the system and providing first hand information to policy makers. Performance analysis is done using indicators like monthly delivery rates, bed occupancy, outpatient attendance etc. Districts have also been sensitised to use similar monitoring framework for blocks.

3.5 Innovative tools for monitoring



Dashboard view

Variation across districts

A unique monitoring tool has been designed by the state - a Dashboard. Just as a car driver, an Airbus pilot, or a captain of a cruise ship, has a dashboard in front of them, which helps them to take decisions; similarly Program Leaders need tools to steer the development process; so that they can understand, review and make plan for actions.

The dashboard is a very simple, user-friendly tool, which gives an overview of the state and districts' performance and health status. It has a pictorial interface, which makes it easy to handle and understand.

The dashboard summarizes information on six major indicators to present a state/ district overview. The indicators are (i) maternal and child health (ii) health services (iii) public health (iv) infrastructure (v) fund utilisation and (vi) family welfare. A total of 30 indicators have been clubbed into 6 Groups to get the major indicators. A colour code signals performance relative to others: green means "good", red means "bad". Program managers at different levels can use the dashboard to monitor the performance of the state/ district. The state plans to develop the same system for the blocks, which can be used by district level staff to monitor downwards.

3.6 Computerisation of District Reserve Stores

The state provides drugs free of cost to all patients in primary health care facilities and poor and underprivileged patients in the secondary and tertiary facilities. The management of drugs at the District Reserve Stores is a critical link in the supply chain for drugs across the state. With time the stores are managing ever-increasing volumes and modernising the storekeeping process was an important step towards improving the efficiency of the drug procurement and supply. Thus, computers were provided to District Reserve Stores. Specially designed software has been installed and storekeepers and accounting staff trained in the use of the new software.

In March 2007, districts were evaluated for computerised processing in various areas of warehouse management including basic inventory management tools like opening balance, ordering, goods receipt note, quality, vendor payment advice and perpetual inventory and Uttar Dinajpur, Bankura and Paschim Medinipur were adjudged as better performing districts.

3.7 Internet and Mobile Connectivity

Effective monitoring is possible only when all layers of the health delivery system can be reached / communicated with easily and efficiently. A process of connecting health service providers and managers at different levels through mobile and internet has been started. Health officials across the state from State to district to Block level have been included in a Common Users' Group (CUG) agreement with a leading telecom agency. Members of CUG are provided mobile phones and connections and special rates and services. The scheme will be extended to the level of the ANM Supervisors and PHC Medical Officers. Block managers (especially the BMOH) and state level managers will be given a mobile phone with internet connection (GPRS), which they can use to send reports and records as and when required. The mechanism is envisaged to improve accountability at different levels. An effective use of this service has been to inform all key officers of the state of important directives through SMS.

ORGANISATIONAL DEVELOPMENT AND HUMAN RESOURCE MANAGEMENT

Human resources are the most important assets of any health system, because the performance of health systems and services depends on qualified and motivated workers. Health workforce problems have for decades limited the efficiency and quality of health system. The support of the workforce is crucial to ensure successful implementation of reforms.

A number of reforms in this arena has been undertaken to improve the functioning of the health systems.

4.1 West Bengal Public Health Administration Service

The West Bengal Health Services (WBHS) was primarily responsible for providing clinical services, medical education, public health services and administration and management of health systems. However, growing population and changing public health priorities often resulted in conflicting priorities with one or other function being neglected. Each domain of responsibility needed a different skill-set especially at senior levels. Thus in 2004 the state reorganised the WBHS with a view to rationalise roles and responsibilities and to have a better match of skills and experience for the different job sets. The state undertook reorganisation of WBHS cadres in the DoHFW in 2004 splitting it into three cadres, namely:

- West Bengal Health Services (WBHS)
- West Bengal Public Health-cum-Administration Services (WBPHAS)
- West Bengal Medical Education Services (WBMES)

The WBHS would be responsible for provision of clinical services in medical institutions across the state, WBMES would be involved in imparting medical education and WBPHAS would take over administrative and public health in the state.

The WBPHAS cadre was constituted with effect from the 23rd of June 2004. Incentives offered to officers opting for WBPHAS included advance increments linked with length of service and non-practicing allowance. This reform encourages medical officers to consider and choose their individual career paths, depending on their skills, aspirations and choices available. Further it allows reorienting and focusing of HR and training plans towards the specialised roles selected by the officers.

4.2 Appointment of Accounts Officer in CMOH office

Traditionally in West Bengal, the CMOH is the administrative in-charge of all health service delivery activities in the district including financial and accounting transactions. All the major financial powers are vested with the CMOH to be carried out with assistance from the Assistant CMOH (Medicine & Administration) who supported the CMOH in accounting matters and is a medical professional. The situation posed a dual dilemma of diverting scarce medical professionals to non-

medical tasks and not having access to skilled finance and accounts personnel. This is especially significant considering that programme priorities are becoming more demanding and complex, requiring technical personnel in both medical and financial domains.

As part of its drive to strengthen and streamline financial systems and procedures at all levels, Accounts Officers from the Accounts, Audit and Verification (AA&V) wing, have been deployed at all district health offices to support the CMOH in finance and accounting related work. Contractual appointments have been made in places where there was a dearth of personnel from the AA&V wing. In 6 districts the accounts team have already been trained on fund management and accounting procedures and the training is now being held in other districts.

This has helped in:

a. Bridging the gaps in office accounting systems and regularising the flow of information.
b. Posting persons with skills matching the job requirements.
c. Freeing the CMOH for programme related work.
d. Helped in strengthening the existing district health administration.

4.3 Assistant superintendent for hospitals

Superintendents of hospitals, as the head of the institution, are responsible for the overall management of the hospital and liaison with the district health administration, general administration and PRIs. In addition to these they are required to perform IPD duty in emergency situations. The varied roles assigned to the superintendents of hospitals include administrative duties, clinical duties, financial and accounting functions, supervision of staff etc. is viewed as an unreasonable workload.

The post of Assistant Superintendent has been created in all hospitals District, sub divisional and rural. Assistant Superintendents are personnel qualified in hospital management. This initiative is expected to improve efficiency of hospitals.

4.4 Block Level Public Health Officers

To ensure effective public health services in the districts and blocks, the DoHFW has initiated a process of engaging Block Level Public Health Officers to compliment the function of BPHNs and act as coordinators, supervisors and networking personnel. The Block PH officers are science graduates, engaged on a contractual basis. In the financial year 2007-08 an amount of Rs. 1.64 crore has been proposed in the NRHM PIP for their remuneration of six months.

4.5 District Programme Management Units[18]

The state has set up District Programme Management Units (DPMU) in all 18 districts, in the office of the CMOH. DPMU staff consists of a District Programme Coordinator (DPC), a District Accounts Manager (DAM) and a District Statistical Manager (DSM). The CMOH is the controlling and supervising officer of the DPMU while the District Magistrate and Executive Vice-Chairman of District Health and Family Welfare Samiti render overall guidance for effective functioning of the DPMU.

The DPC assists the CMOH in all aspects of health programming in the district including planning, coordination, implementation and monitoring. He / she also helps to coordinate the affairs of District Health and Family Welfare Samiti, preparation of District Health Plan and scheduling the training calendar and organizing district level training. The DAM supports the CMOH office in financial management and accounting while the DSM is responsible to strengthen the MIS system in the district and dovetail it with financial MIS. DPMU supports the MIS in several ways, it ensures regular flow and checks the quality of data, computerises data, analyses information, identifies weak pockets for additional inputs and prepares monthly reports.

4.6 Block Programme Management Units[19]

Block Programme Management Unit (BPMU) staffed by a Block Accounts Manager, has been established in each block in the office of the BMOH. This will facilitate smooth implementation of health programmes in the blocks. The BPMU works under the direct control and supervision of the BMOH of the respective block. The Block Health and Family Welfare Samiti (BH&FWS) gives overall guidance for effective functioning of the BPMU. Major responsibilities of the Block Accounts Manager includes: accounting and financial management of the BH&FWS, assist all functionaries of DoHFW and PRIs (for funds related to DoHFW) in the block in maintaining Cash Books, Ledgers, other registers etc., facilitate disbursement of funds to the PRIs and Sub-Centres/other organizations, assist in audit of the Samiti accounts, assist in budgeting and planning for programme implementation, maintain records including receipt and expenditure of BH&FWS account, RKS and monitor and supervise accounting work in all units through regular field visits.

4.7 Computerization of Block Health Offices

Computerisation has been initiated in all 341 offices of the Block Medical Officer of Health (BMOH). Initially a fund of Rs 1 lakh per BMOH office has been sanctioned for buying and setting up computer units. Two Data Entry Operators have been engaged in each BMOH office on a contractual basis to operationalise the computer set up. The posts are contractual in nature with initial appointment of 1 year, renewable for further period depending upon the performance of the candidate.

4.8 Additional capacity for Training ANMs

The state is in the process of appointing second ANMs in all 10,356 Subcentres across the state. This is being done in a phased manner by 2010, owing to lack of training capacity of such large number of ANMs. The existing ANM training schools have an intake capacity of 520 ANMs in each training course of 18 months duration. To enhance state training capacity, seat capacities of the existing 25 ANM Training Schools have been increased and set up 12 new ANM training schools have been set up. All the new Training Schools have been set up on PPP basis. These new institutions have received recognition from

the West Bengal Nursing Council.

The state conducts regular supervisory visits to these institutes to monitor quality and ensure smooth functioning. At present a batch of 3,200 women are undergoing ANM training in the state, 484 of these are being trained in the newly recognised private institutions.

ANM Training Centre

4.9 Appointment of GNMs

Nursing staff

The state faced an acute shortage of Nursing staff, one main reason was the long and complex recruiting procedure. Rules for appointment of new GNMs to vacant posts have been relaxed and made simpler on the one hand and on the other hand the government has also created and sanctioned an additional 3924 posts of GNMs. The combined action is expected to have a more equitable deployment of nurses in the state.

4.10 Enhancing availability of medical personnel

In the past few years the State has increased its intake of students in medical courses and training institutes in order to enhance the availability of medical personnel in the state. Some of the recent initiatives related to this are:

- A new medical college with an annual student intake of 100 is being set up at Kalyani. DoHFW has already released funds for this.
- During the last five years, student intake has increased in existing Medical Colleges by 300.
- An increase in the number of seats for postgraduate medical degree and diploma courses.
- Student intake capacity for B. Sc, Nursing has been doubled and an advanced Nursing course - M.Sc has been introduced.
- Four new Nursing College will be set up – two of which will be in Kolkata and two in the districts of Darjeeling and Burdwan.
- Many new courses have been started, like: M.Sc in Medical Biotechnology, B. Sc courses in OT, Perfusion technology and Critical Care Technology, para-medical training courses etc,
- Student intake capacity in dental colleges has also been increased.

To cater to the increased seats, more than 150 teaching posts and 224 Trainee Reserve posts has been created in different medical teaching institutions/ hospitals.

4.11 Enhancing Knowledge and Information Management

Established in 2007, the State Resource Centre (SRC) is an initiative of the state to highlight the importance of knowledge and information management. The SRC supports the SPSRC through its different activities, including documentation, dissemination of information and encouraging discussion on different issues. The SRC helps to establish the evidence base necessary to plan and sustain reforms in the state. (for more details on SRC refer to page 38-39)

SERVICE PROVISION

Provision of health services is the most important function of the health systems and hence most of the actions taken by government are linked to better the service provision related aspects. In this section we have discussed various initiatives, which has helped it to improve the provision of health services in the state.

5.1 Upgradation of PHCs[20]

An upgraded PHC in North 24 Parganas

Primary Heath Centres of the state are being upgraded with an aim to increase in-patient capacity, improve access to in-patient services and reduce pressure of service on higher (block and district) level facilities. A phase wise plan has been made for upgradation of PHCs. 356 PHCs have been identified, which would function as 10 bedded 24x7 facilities. The staffing pattern of the 24x7 PHCs will be as follows:

Categories of posts	No. of posts for 10 beds
Medical Officer	2
Pharmacist	1
Nurse of the WBNS	4
Medical Technologist (Lab)	1
Clerk	1
GDA	6
Sweeper	3

5.2 Upgradation of BPHCs[21]

The state has started the process of upgrading services at Block Primary Health Centres (BPHCs) to function as Rural hospitals. 176 BPHCs, spread across the state, are being converted into 30-bedded, 24 hours round the clock facilities. Additional staff to these facilities includes specialist doctors and nurses. Funds for the purpose are being provided out of NRHM, HSDI, BHP and RIDF-IX programmes.

a BPHC being upgraded

5.3 Increasing First Referral Units (FRUs)

Enhancing FRU availability is one of the strategic interventions taken up to improve access to Comprehensive EmOC (C-Section for 24 hours and blood bank) services. Currently Comprehensive EmOC is available in 57 Medical Institutions including Medical Colleges, 15 DHs and a majority of SDHs in the state. C-sections are also conducted in many SGHs but these are not 24 hour

facilities. The state has plans to upgrade 60 facilities including rural hospitals to FRUs, in a phase-wise manner. Of these 60 facilities, 29 are already functional as FRUs.

Blood Bank Refrigerator

Operationalization of FRUs is a challenging and time consuming process as it involves coordination of a variety of inputs including infrastructure, equipment & logistics deployment of staff, training etc. Basic infrastructure requirements for the FRU includes (i) Minimum bed strength of 20-30 (ii) Fully functional operation theatre equipped for undertaking anaesthetic and emergency (iii) Surgical procedures including Caesarean Sections (iv) Fully operational Labour Room (v) New-born Care and emergency care for sick children (vi) functional laboratory with facilities for essential investigations and (vii) Blood storage facility.

5.4 Sick New Born Care Units (SNCU)


Sick New Born Care Unit at Birbhum District Hospital

Sick New Born Care Units (SNCU) offering Level II[22] care is functioning in five districts, namely, Purulia, Birbhum, Coochbehar, Uttar Dinajpur, and Bankura. At present, SNCUs are being established at Barasat, Nadia and Siliguri.

Establishment of sick newborn stabilization units for level I care at BPHCs has been initiated. These will be linked to SNCUs in district hospitals. Sick newborns will be referred to the SNCU after stabilization at the BPHC, if needed. In 2007-08 stabilisation units in 4 BPHCs in each of the five districts will be established, where SNCUs with level II care are already functional. For each SNCU, posts of 4 Medical Officers and 10 GNMs have been sanctioned.

Level II care is usually referred to as being suitable for care of sick neonates above 1500 g (some times upto 1250 g as well) birth weight and does not include Mechanical Ventilation, Total Parenteral Nutrition (TPN) & complicated procedures and major neonatal surgery.

5.5 Exemption of user fees for pregnant women & infants[23]

User fees for various services, including MCH are being collected in all Teaching Hospitals, District Hospitals, Sub-Divisional and State General Hospitals in the state. However, since October 2006, all pregnant women and infants (0-1 year), irrespective of economic status, (BPL/APL) have been granted full exemption of user fees. The exemption is applicable to all facilities in the state for institutional delivery as well as for curative treatment. However, this does not apply to infants who are admitted to the Sick Newborn Care Units (SNCU).

5.6 Free beds for BPL patients[24]

The state has made provision of free beds for BPL patients in hospitals. Hospital authorities have been asked to maintain a priority list of all BPL patients admitted in paying bed in their hospital, and in case a free bed is not available at the time of admission, the patient must be shifted to a free bed, as soon as one is available. In allotting free beds, preference should be given to BPL in-patients occupying paying beds and not to newly arrived BPL patients. Hospital authorities are directed to reimburse the expenditure incurred by a BPL patient due to non-availability of free bed.


Free beds for BPL patients in hospital

5.7 Referral transport scheme[25]

The referral transport scheme is an innovative programme to facilitate and encourage institutional delivery. Under this, poor pregnant women receive monetary support, to hire transport to reach the health institution/facility for delivery. This scheme complements the Janani Suraksha Yojana, which is a cash benefit scheme for encouraging institutional delivery.

Some key features that make this scheme user friendly are

- All poor women coming to institutions for delivery, are eligible, irrespective of their age and number of children
- Beneficiaries of JSY are automatically eligible for this scheme
- Entitlement accrues on presentation of proof of economic status including BPL certificate/ certification from GP or proof that the woman or her family is a beneficiary of Annapurna, Antyodaya scheme
- No certificate/undertaking is required regarding the type of transport used for travel by the recipient.
- All SC/ST women, irrespective of their economic status are eligible for the benefit.

Earlier, beneficiaries were given monetary benefit @ Rs 4.00 per km for to and fro journey from home to the facility subject to a maximum amount of Rs 240. The norm has been revised in 2006, and at present is as below:

- For women accessing a health facility within 0-10 kms – Rs. 150
- For women accessing a health facility within 10-20 kms – Rs. 250
- For women accessing a health facility at a distance more than 20 km – Rs. 350

5.8 Voucher scheme for transport of pregnant women

A Voucher Scheme for transportation of pregnant women, primarily JSY beneficiaries belonging to BPL/SC/ST, is being piloted in Bankura district. The voucher scheme is meant to complement the JSY and ensures free transport to the beneficiaries and is yet another step to encourage institutional delivery.

The modified JSY card has vouchers attached to it as perforated add-ons, this ensures automatic distribution of vouchers with the JSY card. The three attached vouchers are to be used for specific needs. Part 1 is meant for transportation from home to hospital for delivery, part 2 is for travelling back from hospital to home and part 3 is for referral to the higher hospitals from RH/BPHC, where necessary.

Beneficiaries may use the ambulance available at BPHCs, under PPP scheme. Services from other ambulance operators, who are willing to participate and agree to follow the terms and conditions of the scheme, can also be utilised. The beneficiary, on using transport, will hand over the voucher to the ambulance operator; who then has to get it encashed from the Superintendent/ BMOH in the manner prescribed in the Standard Operating Procedure (SOP).

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. Launched on 12th April 2005, it is a 100 % centrally sponsored scheme and integrates cash assistance with delivery and post-delivery care.

5.9 Bridging the gap for anaesthetists

There is an acute shortage of aneasthetists in the state. A certificate course on anaesthesia for doctors already in –service has been started to fill-in this shortage. The course will enable the doctors to administer anaesthesia services for Emergency Obstetric Care. In addition to this, the state also has plans to appoint anesthetists through walk-in interviews. The target is to provide qualified anaesthetists in all FRUs that are under development in various parts of the state. Medical Officers interested in either option can apply through their district's CMOH.

5.10 Appointment of Second ANMS

The state has developed a plan under NRHM to engage second ANMs in all the Sub-centres in the State. The second ANM would be a married woman in the age group of 25-35 years and a resident of one of the villages served by the Sub-centre. BH&FWS will appoint the second ANM on a contractual basis.

The process is being taken up in a phased manner (see section 4.8), the first phase blocks were selected on the basis of weak RCH indicators and high disease load. The first batch of 2nd ANMs, around 3,500 in number is expected to join in 2008. Other blocks will be taken up in a phased manner during the next 2-3 years depending on the training capacity.

5.11 Appointment of ASHA in backward blocks

Another major initiative to strengthen service provision is the appointment of Accredited Social Health Activists (ASHA) in the rural areas. ASHA worker is expected to work in close coordination with AWW in providing health and counselling services to the communities and help in social mobilisation at village level.

One ASHA is appointed for every 1000 population to serve as a link between the community and the rural health system. Married/divorced or widowed women within the age group of 30-40, are selected as ASHA (relaxable to 25 years in case of ST categories) and she should be a resident of the same village for which she is selected. Preference is given to Grade I and Grade II SHG members/ Trained Dais/ link workers. Areas where majority of the population belongs to SC/ST, ASHA has to be selected from within the community.

The selection committee for ASHA comprises of the GP Pradhan, Health Supervisor, Upasanchalak of GP Swasthya Samity, ANM of the concerned Sub Centre and one representative of Block Development Officer. ASHA has to report to the ANMs of the concerned sub centres in which the village is situated. She is accountable to the Gram Panchayat, which has full authority to monitor and supervise her functions. ASHAs will be provided an honorarium of Rs.800.00 per month. Also, based on her performance, to be assessed by the ANM; she will be eligible for certain incentives to motivate

her to work efficiently towards meeting targets for immunization, registration and full ANC & PNC of pregnant women. She also has to escort pregnant women to institutions for delivery and ensure that they receive benefits of referral transport.

As of now, ASHA's will be deployed in the 135 backward blocks of the state (see section 1.6b)

5.12 School Health Program expanded

The School Health Program in the state is mainly targeted at primary school students and completely ignored school students, in the age group of 10 - 19 years. A comprehensive framework for School Health Program was developed in 2007 , which includes secondary and higher secondary school students.

The programme is being introduced in a phase wise manner starting with the more backward areas. Thus initially, the program has been launched in 147 blocks selected on the basis of low female literacy rate.

The objectives of the School Health Program is to improve the health of school-going children through:

- Promotion of health education including adolescent health arising out of physical, emotional and stress and strain prevailing in the present social psyche
- Prevention of diseases and promotion of immunization
- Early detection, diagnosis and treatment of diseases
- Provision for referral services to higher health centres
- Building health awareness in the community
- Development of habits on personal hygiene and cleanliness

In each block two GNMs hired on contractual basis will be assigned specifically for the school health programme. The programme envisages active involvement of students, principals, teachers, parents and community representatives (SHGs/CBOs/ASHAs etc). The implementation process will include awareness generation among other stakeholders like ICDS functionaries, PRI representatives and NGOs.to enlist their support.

5.13 Support for malnourished children & women

According to NFHS-III, malnutrition in West Bengal is still widespread and 43.5% children (0-3 years) are undernourished. Keeping this in mind, the state has initiated a pilot scheme in Karimpur-II block of Nadia district with the aim to bring all children in the area to malnourishment – free status. The pilot project was implemented in collaboration with ICDS in the block.

Key interventions included

- Identifying and grading malnourished children (<5 years old) in project areas,(with help from AWW)
- Training local self help groups to produce nutritious baby food (wheat and mung dal in 4:1 proportion, roasted/ fried, ground and packed)
- All malnourished children grades II-IV provided locally prepared 2 kg baby food per month, (with help from AWW) for 6 months.
- Pregnant and nursing mothers also receive the additional food supplement for six months.

Provision of mobility support and minor incentive to the Anganwadi workers and SHG members was made in the scheme. Preliminary results from the pilot are very encouraging. The state has decided scale-up of the programme in selected blocks of Nadia and Murshidabad, which are known to have a high prevalence of malnutrition.

5.14 CT Scan services at Government Hospitals

CT scans and MRI are high investment and expensive diagnostic tests and ensuring their availability at public facilities is a challenging task. The department has entered into public private partnership to install these services in selected hospitals. Under the joint-venture, the private partner is provided rent-free accommodation for installation of equipment along with power, water supply and sewerage connection. The private partner installs the equipments and incurs all recurring & maintenance cost. The DoHFW determines specifications of the plant machinery; modality of functioning and private partner has to strictly adhere to these specifications. DoHFW also prescribes the rates at which these services will be provided.

At present, CT scan services are provided in 7 medical colleges and MRI in one hospital. CT scan units are being set up in district hospitals of 12 districts. The medical college hospitals in North Bengal and Burdwan already have CT Scan facilities, set up by the state government.

These centres cater to a fixed number of paying patients and free patients referred from the government hospitals. The centres are allowed to offer services to private patients on the condition that they pay 25% of revenue earned from each patient to the government. To further improve access to these diagnostics, a mechanism is being developed, under which, patients from government health facilities can be referred to selected private MRI units to avail the service at government prescribed rates.

5.15 Diagnostic Units In Rural Hospitals [26]

Availability of diagnostic facilities in PHCs/ BPHCs is minimal across the state. As a result, doctors and patients in rural areas have to go to private laboratories for diagnostic services. These private laboratories are largely unregulated, expensive and their quality of service is a cause of concern. The state has invited private partners to set up diagnostic facilities in rural hospitals to provide good quality service at an affordable cost to the patients.

Diagnostic centres are operating in 14 rural hospitals. The state has approved establishment of further 72 diagnostic centres for Rural Hospitals and 74 units for BPHCs. For wider reach, the private partner has set up pathology sample collection centres in the PHCs of the BPHC/ Rural Hospital, functioning as points where samples are collected and reports of tests delivered. The government determines both the list of diagnostic services to be provided and charges applicable for


X-ray techician at work

each. BPL families and emergency cases are exempted from charges. Cost free cases account for 20 % of total tests in each category.

An agreement is signed between the District Health and Family Welfare Samiti (DH&FWS) and the private partner. The government provides rent-free space in the BPHC/Rural Hospital and for sample collection centre in PHCs. The ACMOH is in-charge of overall monitoring of the diagnostic facility and receives the monthly reports submitted by the operators. Superintendents/BMOHs and other doctors of BPHC/Rural Hospitals have been asked to refer patients to these diagnostic centres.

5.16 Dialysis services at reduced rates[27]

The state has entered into an agreement with AMRI, a health facility in Kolkata; for providing Hemo-Dialysis services to patients referred from State Government hospitals at a lower rate than the market rate. AMRI was set up as a joint venture with the State Government. The charges are Rs 1075 per occasion, which is inclusive of AC day-care bed charge, full meal (lunch/dinner) and all consumables required for the dialysis. The arrangement started from 2005, and it helps the state hospitals to meet with the increasing demand for dialysis from clients. The DoHFW has a proposal to include five more private hospitals in this scheme.

5.17 Enhancing Institutional Delivery through Ayushmati Scheme[28]

The Ayushmati scheme has been designed to encourage institutional deliveries in the state by addressing both access and demand issues. It augments availability of institutions for safe delivery by partnering with private sector facilities; this also provides beneficiaries an additional option on the choice of an institution for delivery. The scheme aims to cut down out of pocket expenditure by promoting cash free institutional delivery.

The beneficiaries are pregnant women from BPL and SC/ST families who have proof of identity such as BPL Card / Gram Panchayat certificate / JSY Card / MCH card / SC or ST certificate / SC or ST certification by the Gram Panchayat. However, clients are entitled to free delivery at any empanelled private facility only if they have been registered with the ANM and have had three antenatal check-ups.

Norms/ eligibility criteria have been laid down for selecting private partners for the Ayushmati scheme. The DoHFW has entered into a Service Agreement with the empanelled private facility for provision of Comprehensive Emergency Obstetric Care services. The empanelled facility/institution is reimbursed at a fixed rate for conducting delivery and carrying out diagnostic tests. The reimbursement package amounts to Rs 1790 for each delivery, of which Rs. 1515 is for the delivery and Rs 275 for conducting routine investigations relating to delivery. The payments are made for a batch of 100 deliveries irrespective of normal or caesarean.

In the Initial phase, the scheme has been launched in 11districts of West Bengal: Uttar Dinajpur, Malda, Murshidabad, Bankura, Nadia, Purulia, Paschim Medinipur, Coochbehar, Birbhum, Dakshin Dinajpur, and Jalpaiguri. The process of introducing Ayushmati to the remaining 8 districts is ongoing.

5.18 Ambulance Scheme for rural areas


Ambulance services with NGOs

An Ambulance Scheme has been launched to meet the demand for emergency transportation services in rural areas, especially in the remoter areas. The department has partnered with reputed NGOs/CBOs/Trusts for this scheme. Under the partnership, the department provides the ambulances to the private partner and the partner agency is responsible for the day-to-day operational management and maintenance of the services. Initial contract period is five years. Standard Operating Procedure (SOPs) manual has been prepared for the scheme to enable smooth functioning of the services. Private partners are required to adopt the SOPs.

In the first phase, the scheme was introduced in 8 districts namely Bankura,, Birbhum, Coochbehar, Darjeeling, Jalpaiguri, Paschim Medinipur, Purba Medinipur and Purulia. 133 ambulances were handed over to the NGOs in these districts for running them at the BPHC level, in 2005.

Following the success of this scheme, it has been extended to cover all BPHCs in the state. Thus in 2006-07, 201 ambulances were procured and handed over to NGOs. The department has plans to expand the scheme to the PHC level.

5.19 Mechanised Laundry Units in Hospitals[29]

Mechanised laundry units have been installed in three hospitals in the state. Two of these units are in district South 24 Parganas– these are meant to service all the 30 hospitals in Kolkata This is yet another initiative in the public private partnership venture and the initial agreement with the private partner has a duration of five years.

The private partner is responsible for setting up the mechanized laundry unit and bears all expenses for installation as well as recurring cost for maintenance and running of the unit. The private partner also collects soiled linen from the hospitals within its service area on a daily basis; and delivers the same washed, ironed and packed, within 48 hours.


Mechanised Laundry Unit

5.20 Diet services in Hospitals

The GoWB had been providing free diet to all in-patients in public hospitals. The diet used to be prepared by hospital staff within the hospital premises. However, there was lot of wastage of food as many people preferred not to consume the hospital diet. In April 2002, the system for hospital diets was overhauled.. The preparation and supply of diet in government hospitals since then has been outsourced to private agencies selected through an open tender process. The existing facilities for preparation of diet are being used by the selected agency. Further, at present only in- patients belonging to BPL families receive diet free of cost. Non-BPL families opting for hospital diet get it at subsidised rates (50% of cost).

Diet supply by private agencies

It is expected that this new system will be more efficient and result in less wastage. The government has issued guidelines for ensuring quality of diet and an illustrative diet schedule has been prepared and sent to CMOH/ Superintendent of the hospital for their knowledge and supervision.

5.21 Diet supply by Self-Help-Groups (SHGs)

A decision has been taken to engage local SHGs to supply diet to indoor patients of Rural Hospitals, BPHCs and PHCs in the state. The SHGs will supply cooked food to the facilities for distribution to patients. The RKS of the facility will be responsible for monitoring the quantity and quality of the diet supplied and managing the SHG. The Block Health & Family Welfare Samiti in consultation with the respective RKS will select the SHG. The following guidelines have to be followed for SHG selection:

- Only women SHGs who have passed Grade I are eligible
- Minimum savings of SHGs should be Rs. 5000
- SHGs who have utilised successfully at least one cycle of cash credit/ bank credit not less than Rs. 25,000 are eligible. Groups having higher access and utilisation of cash credit will be given preference.
- SHGs who have defaulted in repayment of bank loan will not be considered for selection
- There should be at least two educated members in the group with minimum qualification up to class VIII
- The SHG members should agree to undergo training on hospital diet
- There should be strong group cohesion among the members of the team
- Preference will be given to SHGs who have participated in CHCMI and other health programmes

5.22 Mobile Health Clinic Services in Sunderbans

The Sunderbans region in South and North 24 Parganas is one of the most remote and under served areas in the state. It is a difficult terrain, with jungles, creeks and estuaries, making it a tangled network of waterways. Providing health services is a challenge in these areas. A Mobile Health Clinic Service was launched in 1999 in partnership with 5 NGOs for providing basic health services in the region. Service delivery contracts were drawn up with these NGOs, which have local base in the area. The main objective of this partnership was to improve primary health care services in the hard to reach areas of the Sunderbans. The mobile health clinics provide basic primary health care, like immunisation, ANC, PNC.

Mobile boat dispensaries are used to reach remote islands in the region. A boat dispensary travels to these islands with adequate stock of medicines, provision for conducting basic diagnostic tests (X-ray, blood test etc), Doctors and other medical support staff. Ambulances are used in villages, which can be reached by land.

5.23 GP based mobile health camps[30]

Mobile health camps are being organized in all GP Head Quarter Sub Centres throughout the state, on a fixed day and fixed time every week. The prime objective being, to enhance access of poor to primary health care services and extending the reach of RCH, immunization, family welfare and clinical services to larger population and underserved areas.

One camp is organized every week in each GP Headquarter Sub-Centre, except those which operate from PHC or any other health facility where regular OPD services are available. In places where construction of the GP headquarter Sub-Centre is not yet complete, it is the responsibility of the GP Pradhan to provide a room for clinic with provision of privacy for examination of female patients and waiting space for patients.

The mobile camp is conducted by the Medical Officer of the concerned PHC /BPHC along with two/three other Para-medical persons (preferably GNM/ANM),Supervisor (male and female), Health Assistant (male and female) and one GDA, as per availability. In case the regular Medical Officer entrusted to attend the camp is on leave, it is the responsibility of the BMOH to make alternative arrangements.

Services provided in the mobile health camps are:

- ante-natal/post natal check up,
- immunization of children, including Vitamin A supplementation,
- treatment of minor ailments & minor injuries; supply of drugs to patients,
- promotion of contraceptive services including IUD insertion, prophylaxis
- treatment of Anaemia with IFA Tablets, and
- appropriate referral services for patients.

A budget of Rs. 1100/- per camp is earmarked for purchase of drugs, mobility support and contingency as per the following break-up:

a) Purchase of drugs per camp - Rs. 500/-
b) Mobility Support per camp - Rs. 500/-
c) Contingency - Rs. 100/-

5.24 Hospital Management - Malda District Hospital

Several reforms have already been undertaken to improve hospital management (see Section 4.3), increased manpower, new positions etc but there was still scope for a significant breakthrough in hospital management. A six-month hospital management initiative was piloted in Malda District Hospital with the objective of improving the efficiency of hospital management.

At the outset, a situation analysis was carried out to identify key bottlenecks and sort them into categories that could be addressed locally and those that required State intervention. The key areas for intervention were housekeeping, kitchen, management of drug stores, wards and pay clinics, general maintenance (plumbing & electrical), maintenance of biomedical equipments.

A hospital site manager was specially recruited for the project. He played a crucial role in implementing the project. He worked closely with the Medical Superintendent, extending support in implementing the initiatives to improve service & management. Significant improvements took place in the following areas

- Housekeeping. Kitchen services and general hospital cleanliness improved mainly due to better supervision and monitoring of external agencies (since many functions are outsourced) and introducing specifically designed tools and formats to aid efficient management of services. Improved management of biomedical waste and establishing regular system of cleaning and scavenging, introducing concept and protocols for preventive and general maintenance.
- Staff nurses and other relevant staff became familiar with the computerised data entry and management system, this resulted in better ward, clinic and drug store management
- RKS funds for patient welfare were used to provide patient's conveniences e.g bedside stools for patient's attendants.
- Increased awareness and knowledge of the procedures for maintenance of Biomedical equipment.

Maldah District Hospital - Before

Maldah District Hospital - Now

5.25 Focused attention and rapid response in public health

Centrally Sponsored Schemes addresses major public health programs and have clear and detailed guidelines for implementation from GoI. The guidelines are worked out through a consultative process involving experts, state and central Govt. officials. The State Governments are required to implement these programs as per the guidelines and GoI has a monitoring role, but the existing monitoring mechanism does not generate appropriate information to capture threats to public health safety early during disease occurrence because of poor surveillance and scanty laboratory support.

In addition several important diseases having epidemic potential are not covered through Centrally sponsored schemes. The result is frequent occurrence of disease outbreaks. If disease outbreaks are reported in time and rapid response is mounted, avoidable morbidity and mortality could be reduced substantially.

The department has recently brought in strategic changes to address public health problems through targeting and ensuring a rapid response system in case of outbreaks. For targeting, blocks and areas with highest disease load were identified and funds were allocated according to the priority (for example in Malaria, more attention was given to Jalpaiguri). The information on public health indicators was used for focussed targeting; to identify disease trends and forecast outbreaks, investigate causes for breakout/ event and mitigate them (for example, infant and maternal death audit), profiling of patients (example, age-wise analysis of diarrhoea deaths).

Rapid response teams have been formed in all the districts to tackle emergency situations. The state has also started a daily reporting system of deaths caused due to malaria from vulnerable blocks. Tracking of diarrhoea deaths, measles cases, TB and Leprosy is also being done and reported regularly. The benefits of this system are: districts are alert and aware of possible outbreaks and can respond better and faster. Targeted funding has improved effectiveness of disease control programmes. Integrated Disease Surveillance Program, a centrally sponsored program has been launched recently and will further strengthen the system.

FINANCIAL MANAGEMENT

Reform in financial management systems is one of the important components in health sector reforms worldwide. Decentralisation and changes in service delivery models necessitate devolution and delegation of financial powers. Health sector reforms have to be complemented with changes in financial management systems for better planning and allocating resources across the sector, against competing needs.

6.1 Medium Term Expenditure Framework (MTEF)

Traditional planning and budgeting practices required the DoHFW to concentrate only on immediate priorities and actions. However, in order to realise the health sector strategy, a multi-year financial planning process was necessary, with multi-year priorities, need based planning, integration of funding sources and identification of resource gaps. This required a change in perspective in the DoHFW.

Accordingly, a sector Medium Term Expenditure Framework for the period 2006-07 to 2010-11 was developed in 2006. To facilitate the process of developing MTEF, a MTEF and Annual Plan Working Group was set up. The working group decided to follow a participatory and consultative approach. Though this has consumed great deal of process time but nevertheless; wider consultation was necessary for creating greater awareness about the MTEF. The Working Group considered four stages of development of MTEF - (i) need-based initiatives/activities (ii) budget estimates (iii) estimating resource envelop and prioritisation and (iv) deciding about output formats.

Medium-term expenditure framework is a rolling multi-year (usually three to five year) public expenditure planning exercise. It sets out the medium-term expenditure priorities, taking into account both the ongoing and new developmental programmes. It also defines the budget constraints, commonly referred to as resource envelope, against which the sector plans need be developed. The MTEF must be realistic, comprehensive and facilitate fixing responsibilities and accountability in terms of output/outcome indicators. It should provide resource guidelines for developing 'annual plan'. Being a rolling plan, the MTEF needs be updated annually.

Inputs from various programme units as well as discussions with finance department helped to identify the resource needs and availability over the next 5 years, to implement the HSS. Considering realistic plans and a conservative resource envelope, the MTEF projects significant investments in primary sector, drugs availability and infrastructure development with a resource gap of 6-11%. The un-predictability of funding support from the state, centre and the external donor agencies is recognised as a major constraint in developing MTEF.

6.2 Integrated Annual Plan (2006-07)

The department for the first time, developed an Integrated Annual Plan (IAP) for the year 2006-07. Till recently, the practice was to develop and monitor individual Program Implementation Plans for the 44 different functional units in the department; including the national vertical programs such as RCH II, HIVAIDS, RNTCP, Malaria, Leprosy etc. As a first step, the Department decided to formulate an annual plan for 2006-2007, which encompasses all activities of the Department, in a holistic and integrated fashion, wherein the logical flow of outcomes – outputs, strategies and activities are established. The plan links the various schemes together, exhibits the links between the activities to the various health outcomes, and health outcomes to the strategies spelt out by the department.

The Annual Plan 2006/2007 has been developed by a Core Group of Department staff, constituted by the department, in conjunction with an external team of consultants. The Plan was developed through three rounds of interaction of the Core Group with key managers of the Department. The process also involved reviewing of all available Program Implementation Plans and strategy documents, best practice documents and in-depth discussions with some key officials. The key focus has been on introducing planning processes and production of a useful plan, which is readable and usable and has an inbuilt monitoring component.

6.3 Retention of user charges[31]

The state has imposed user charges in Secondary Hospitals for certain services, like OPD tickets, paying beds, diagnostics tests etc. Users of lower level facilities are exempt from user charges. From 2006 onwards, facilities collecting user charges from patients are allowed to retain a portion of the total user charges collected by it. Out of total user charges collected in each facility, 40% is retained by the facility and the rest 60% is deposited in the Corpus fund of the District Health & Family Welfare Samiti.

The District Health & Family Welfare Samiti allocates funds from this Corpus to different Rogi Kalyan Samitis of hospitals in the districts on the basis of need of each facility. RKS at each level has the flexibility to spend a certain minimum amount of this fund for improving service delivery at the facility.

6.4 Flexible Fund Pool for the Districts[32]

The allotment of funds to districts has traditionally been of the nature of tied funds to be used strictly as per centrally generated guidelines. This did not allow the field units any freedom for undertaking any innovative area-specific need-based activity. The District Health and Family Welfare Samiti have been allotted flexi funds to enable them to carry out additional activities based on district specific need for achieving the goals of the HSS. The districts are free to utilize these funds for devising innovative schemes for improvement of hospital facilities, for patient welfare, mobilization of community and beneficiaries for participation in all the

on-going health programmes through extensive IEC activities, engagement of NGOs/local clubs for public health and RCH activities, taking up community-based schemes like organizing special camps in remote and difficult areas etc.

The funds can also be utilized to support any additional requirement in the existing schemes/programmes to make them more effective. In using these funds, special attention should be given to areas, which are difficult to reach or are underserved; so that better health services can be extended to these areas.

During 2006-07, 10 large districts (North 24-Parganas, South 24-Parganas, Murshidabad, Malda, Purba Medinipur, Paschim Medinipur, Burdwan, Howrah, Nadia and Hooghly) have been allotted Rs. 25 lacs each and the remaining districts were allotted Rs. 15 lacs each. Subsequent releases will depend on the effectiveness of the utilization of these funds.

6.5 Untied Funds to Health Facilities [33]

Untied fund utilised to furnish Sub Centre

Untied funds are being provided to all health facilities in the state, to enable service providers at each level to meet expenses of urgent and miscellaneous activities that need relative small sums of money. Depending on the scale and associated needs of the facilities, an amount is given as untied funds.

Level of facility	Amount of untied fund (per annum)
Sub-centre	Rs 10000
PHC	Rs 25000
BPHC/RH	Rs 50000

Suggested areas where the untied fund may be used include: minor modifications to the facility, minor repairs which can be done at local level, purchase of consumables, adhoc expenses for labour and supplies for cleaning, transport of emergencies to referral centres, transport of samples during epidemics, payment of electricity charges. Untied funds are not to be used for payment of salaries, vehicle purchase and recurring expenditures, or to meet the expenses of the GP. The funds are allotted to the District Health and Family Welfare Society, which distribute it downwards.

6.6 Annual Maintenance Grants to Facilities

The state is giving an Annual Maintenance Grant to PHCs, BPHCs & RHs since 2006-07. Amount of grant is Rs 50,000 for PHCs and Rs 1 lakh for BPHCs/RHs, per annum. The fund is meant for improvement and maintenance of physical infrastructure of the facilities, with priority on provision of water, electricity and toilet. There should be no duplication of activities taken up under other programmes/ funds. RKS at each level approves the expenditure done from the maintenance grant.

6.7 Guidelines for Utilisation of Funds [34]

In order to decentralise financial powers, untied and flexible funds have been allotted to lower tiers. These lower tiers of service facilities also get an annual maintenance grant and can retain a portion of the user charges collected at the facility. However, it was observed that these lower tiers were unable to utilise the funds allocated to them, mainly due to two reasons: (i) lack of knowledge and awareness on how to use the funds and (ii) procedural delays. In this light, the DoHFW has developed a set of guidelines for the RKS at each level of facility to enable them to utilise their funds for improvement of health services.

The RKS has been asked to review the services/ equipments available in its facility in reference to the Essential Services Package and Essential Equipment List specified by the state. RKS can use the funds available to it to meet the specifications laid out in the above-mentioned lists. The guideline also provides a detailed list of items and services, not included in these two lists; which can be procured from these funds.

It is also suggested that the RKS can seek the advice and suggestions from users and other groups on probable use of the funds. A requisition form inviting suggestions can be prepared by the RKS, for use of patients visiting the facility. A suggestion box can be kept in an appropriate location, where patients can drop the requisition forms.

Some steps to rationalise the process of utilisation of funds has been suggested:

- The Sub-Centre untied fund bank account can be operated by any two of the following: concerned BMOH, Pradhan and ANM. In case there is a vacancy in the ANM post, the Health Supervisor has to take on this role.
- Approval of expenditure to be incurred can be done through a note sheet in emergency cases. For PHC level, the Zilla Parishad member and for BPHC/RH the BDO can give approval on a note sheet, if meeting of the RKS cannot be held immediately.

The RKSs in its meetings should seek suggestion from various groups for activities, which can be done to enhance the facility efficiency and patient welfare. This can done by:

- Preparing requisition form inviting suggestions from various groups such as patients and staff of the hospital
- Providing adequate copies of these forms to facility staff who can make requests in it before the RKS meeting
- Providing a box and the form at appropriate places (inpatient ward, outpatient ward, registration counter, X-ray clinic etc) for patients to write their suggestions
- Formats inviting suggestions from hospital staff

6.8 Internal Audit set up[35]

It has been decided that internal audit of health institutions would be conducted through external CA firms. Local CA firms in districts were empanelled for the purpose and formats / templates developed for their quarterly reporting. The purpose was to identify weaknesses and provide assistance to improve the accounting and financial management system.

The audit started from April 2006 and initially 18 CMOH Offices, 14 District hospital and 4 Medical Colleges were covered. From the 3rd quarter of the FY 2006 -07, 21 Medical Colleges in Kolkata, all Sub Divisional Hospital and all State General Hospitals were covered. From September 2007 onwards, there is a proposal to include at least 2 rural hospitals and 2 PHCs from each district for the audit exercise.

An Audit Committee has been constituted to review, analyse and take corrective remedial measures based on the Internal Audit reports submitted by the CA firms. The Committee meets once in every quarter and is authorized to initiate appropriate remedial measures based on the review of Internal Audit reports.

6.9 Electronic transfer of funds

Remittance of funds to District Health and Family Welfare Samities were earlier made by the State Health and Family Welfare Samity, issuing cheques drawn on a bank branch situated in Kolkata. Considerable time was lost in cheque collection, deposit clearance. The process was long, expensive and cumbersome. Since February 2006, the department has switched over to electronic fund transfer mode and has made an arrangement to initiate online transfer of funds, free of charge, from state to districts through a leading bank in Kolkata. The system has been functioning to the fullest satisfaction of both state and district officials.

6.10 Financial autonomy in procurement

The state has given greater financial autonomy to the DoHFW in procuring equipments for government hospitals. Earlier the DoHFW had to take permission from the Finance Department prior to procuring any equipment. In order to cut short the delay in procurement, the Health Secretary has been delegated powers to be exercised in consultation with the Technical Advisory Committee (TAC) to approve purchase of equipments for hospitals. Procurements made in this manner are subject to budget provision. The TAC is headed by the Health Secretary and has a member from the Finance Department, not below the rank of a Joint Secretary/ Special Secretary. If additional allocation, over and above the budget provisions is necessary the process requires that Finance Department must be consulted.

6.11 Financial autonomy in project/scheme approval

The Finance Department of the Government of West Bengal has given autonomy to all departments in the state, including DoHFW, to approve projects/ schemes worth upto Rs 3 crore. Earlier, each department had to seek permission from the Finance Department for any project/ scheme. This new arrangement is in effect from March 2007. The DoHFW has to constitute a Departmental Approval Committee (DAC) comprising of the following: (i) Additional Chief Secretary as the Chairman (ii) Special Secretary/ Joint Secretary in charge of the administrative group of the Finance Department as a member (iii) Technical head of the Department/ Directorate entrusted with the implementation of the scheme and (iv) Special/ Joint Secretary of the department (nominated by the Additional Chief Secretary) as a Convener of the DAC.

It is mandatory for the DAC to have a member from the Finance Department (either a Special Secretary or Joint Secretary) as the Financial Adviser (F,A) of the administrative department of the DAC. The FA is a key person in the DAC and no meeting can be held of the DAC in his absence. The department cannot approve any project/ scheme without his consent, and the opinion of the F.A has to be recorded in the proceedings of the meeting. In case the F.A disagrees with any project/scheme, the DoHFW can still pursue it with the Finance Department, but in that case, the reason/s for disapproval by the F.A has to be cited in writing.

In case of projects/ schemes, for which the project cost exceeds Rs 3 crore but does not exceed Rs 20 crore, the department has to send the proposal to Finance Department for approval. For projects worth more than Rs 20 crore, the proposal has to be sent to the State Planning Board and thereafter to the Finance Department for approval.

6.12 Illness Assistance Fund to districts

The West Bengal State Illness Assistance Fund was established in the year 1999, in view of the recommendation of the GoI. The objective behind formation of the fund was to provide financial assistance to patients living Below Poverty Line (BPL) and suffering from major life-threatening diseases. The fund would enable them to receive necessary medical treatment at any super specialty hospital/institutions or other government/private hospital. This fund was initially managed and disbursed from the state, which was a time consuming process for the districts. Moreover, assistance was provided for major illnesses, which required sophiscated and expensive treatment.

In order to ensure better and more access to the fund, a District Illness Assistance Fund was set up under the District Health & Family Welfare Samity in 2004. The fund provides financial assistance to BPL patients (from the district), who have to apply for the same; for minor/major surgeries and medical treatment. The amount of one-time grant is Rs.2,000/- per patient, with the exception that, in case of orthopaedic cases, maximum grant can be Rs. 5000. Significant increase is noticed in fund utilisation (33% in 2006-07 to 48% in 2007-08), which is attributable mainly due to (i) making the fund accessible to patients for minor treatments and (ii) decentralising management of the fund to the districts.

END NOTE

1) Berman, P and Bossert, T (2000): A Decade of Health Sector Reform in Developing Countries, What Have We Learned?, Data for Decision Making Project, International Health Systems Group, Harvard School of Public Health.

2) Roberts MJ, Hsiao, W Berman, P and Reich MR (2004): Getting health reform right: a guide to improving performance and equity, Oxford University Press Inc., New York as in http://www.who.int/reproductive-health/tcc/ docs/ health_sector_reform_flyer.pdf

3) Health Sector Reforms in India: Initiatives from Nine States, Bureau of Planning, Ministry of Health and Family Welfare, Government of India

4) http://www.who.int/reproductive-health/tcc/docs/health_sector_reform_flyer.pdf

5) Department of Health and Family Welfare, Government of West Bengal: The Health Sector Strategy 2004-2013.

6) Linkages of HSDI with NRHM, RCH II and other health programmes, May 2005, SPSRC, DoHFW, GoWB.

7) Department of Health and Family Welfare, Government of West Bengal: The Health Sector Strategy 2004-2013.

8) Samiti is a registered society.

9) Notification No. H/FW/467/3S-31/2002

10) G.O. No. H./FW/276/705/CFW/2004 dated October 1, 2004

11) Memo No. HSL(Misc)-307/05 dated: 07.11.2005, Memo No. HFW/NRHM/103/06 dated: June 23, 2006, Memo No. HFW/NRHM/165/06, dated: 5th October, 2006

12) West Bengal District Health Planning: Decentralising for Better Healthcare, Department of Health and Family Welfare, Government of West Bengal, 2008.

13) Human Development Report 2004 UNDP

14) GO No 876/1(18)/Pr Secy/wcd&sw, dated 05/09/07

15) G.O.No. H/FW/467/3S-31/2002 dated October 14, 2003

16) Memo No. H/FW/408(18)/3S-31/02, date: 5.9.2006

17) http://www.liv.ac.uk/lstm/hsr/hsrqapb.html

18) Memo No. HFW/NRHM/31/06(59), date: March 16, 2006

19) Memo No. HFW/NRHM/167/06, date: October 09, 2006

20) Notification No. HF/O/MS/196/06, Date: June 06, 2006

21) Memo No. HF/O/MS/338/4H-18/06, date: September 7, 2006

22) For more details see " A Generic Plan for Development of Near Level – II District Level Sick Newborn Care Units for West Bengal", Society for Applied Studies, Kolkata.

23) Memo No.HF/O/MS/314/W-12/95(Pt.), date: August 30, 2006

24) GO No. HF/O/MS/351/W-74/06, dated September 15, 2006.

25) No. H/SFWB/WBHHFWS/RCH/341/06/359, dated: 02.03.06, No H/487/(54)/ CFW/SFWB/ WBSHFWS/RCH / 341/06, dated: December 13, 2006

26) Memorandum No.PPP/829 dated April 1 2004: Scheme 'Establishing Diagnostic Services in Rural Hospitals/BPHCs through Public Private Partnerships Basic Health Project, West Bengal", Department of Health and Family Welfare Government of West Bengal

27) Memo No: HF/MERT/SS-114/2004/PPP/287, date: January 21, 2005

28) Guidelines for Ayushmati Scheme, GO No. HFW/NRHM/263/2006, date: November 29, 2006

29) Memo No HAD/OM-71-03/PPP/238, date: December 29, 2004

30) Memo No: H/SNC 5/CFW/2006, date: 13 June 2006

31) Memo No.HFW/NRHM/10/05/05/06, February 13, 2006, Memo No. HFW/NRHM/142/06, August 22, 2006

32) No. HFW/HSDI/144/06, Date: May 19, 2006

33) No. HFW/NRHM/224/06, November 13, 2006, No. HF/NRHM/101/06/2005, November 14, 2005, No. HF/NRHM/102/18/2005, December 9, 2005

34) GO No HFW/HSDI/206/91/07, dated June 27, 2007

35) No. HFW/HSDI/325/06, date: September 8, 2006.

LIST OF ABBREVIATIONS

AA&V	Accounts, Audit and Verification
ACMOH	Assistant Chief Medical Officer of Health
ADM	Additional District Magistrate
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
APL	Above Poverty Line
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BDO	Block Development Officer
BH&FWS	Block Health & Family Welfare Samity
BHP	Basic Health Project
BMOH	Block Medical Officer of Health
BPHC	Block Primary Health Centres
BPHN	Block Public Health Nurse
BPL	Below Poverty Line
BPMU	Block Programme Management Unit
CBO	Community Based Organisation
CHCMI	Community Health Care Management Initiative
CMOH	Chief Medical Officer of Health
CUG	Common Users Group
DAC	Departmental Approval Committee
DAM	District Accounts Manager
DH	District Hospital
DH&FWS	District Health and Family Welfare Samity
DHP	District Health Planning
DoHFW	Department of Health and Family Welfare
DPC	District Programme Coordinator
DPMU	District Programme Management Unit
DSM	District Statistical Manager
DWCD	Department of Women and Child Development
EAG	Empowered Action Group
EmOC	Emergency Obstetric Care
FA	Financial Advisor
FRU	First Referral Unit
GDA	General Duty Attendant
GNM	General Nurse Midwife
GoI	Government of India
GoWB	Government of West Bengal
GP	Gram Panchayat
GPHQ	Gram Panchayat Head Quarter
GUS	Gram Unnayan Samiti
HMIS	Health Management Information System
HQSC	Head Quarter Sub Centre
HRD	Human Resource Development
HSDI	Health Sector Development Initiative
HSS	Health Sector Strategy
IAP	Integrated Annual Plan
ICDS	Integrated Child Development Scheme
IMR	Infant Mortality Rate
JSY	Janani Suraksha Yojana
MCH	Mother/ Maternal and Child Health
MIS	Management Information Systems
MLA	Member of Legislative Assembly
MMR	Maternal Mortality Ratio
MO	Medical Officer
MTEF	Medium Term Expenditure Framework
NFHS	National Family and Health Survey
NGO	Non Governmental Organisation
NRHM	National Rural Health Mission
ORS	Oral Rehydration Solution
OT	Operation Theatre
PHC	Primary Health Centre
PHED	Public Health Engineering Department
PIP	Project Implementation Plan
PNC	Post Natal Care
PPP	Public-Private Partnerships
PRDD	Panchayat and Rural Development Department
PRI	Panchayati Raj Institutions
PWD	Public Works Department
QA	Quality Assurance
RCH	Reproductive and Child Health
RH	Rural Hospital
RIDF	Rural Infrastructure Development Fund
RKS	Rogi Kalyan Samity
RNTCP	Revised National Tuberculosis Control Programme
SC	Sub Centre
SC/ST	Schedule Caste/ Schedule tribe
SDH	Sub Divisional Hospital
SDO	Sub Divisional Officer
SH&FWS	State Health and Family Welfare Samity
SHG	Self Help Group
SNCU	Sick Newborn Care Units
SOP	Standard Operating Procedure
TAC	Technical Advisory Committee
VH&S	Village Health & Sanitation
WBHS	West Bengal Health Services
WBMES	West Bengal Medical Education Services
WBNS	West Bengal Nursing Services
WBPHAS	West Bengal Public Health-cum-Administration Services
WHO	World Health Organisation

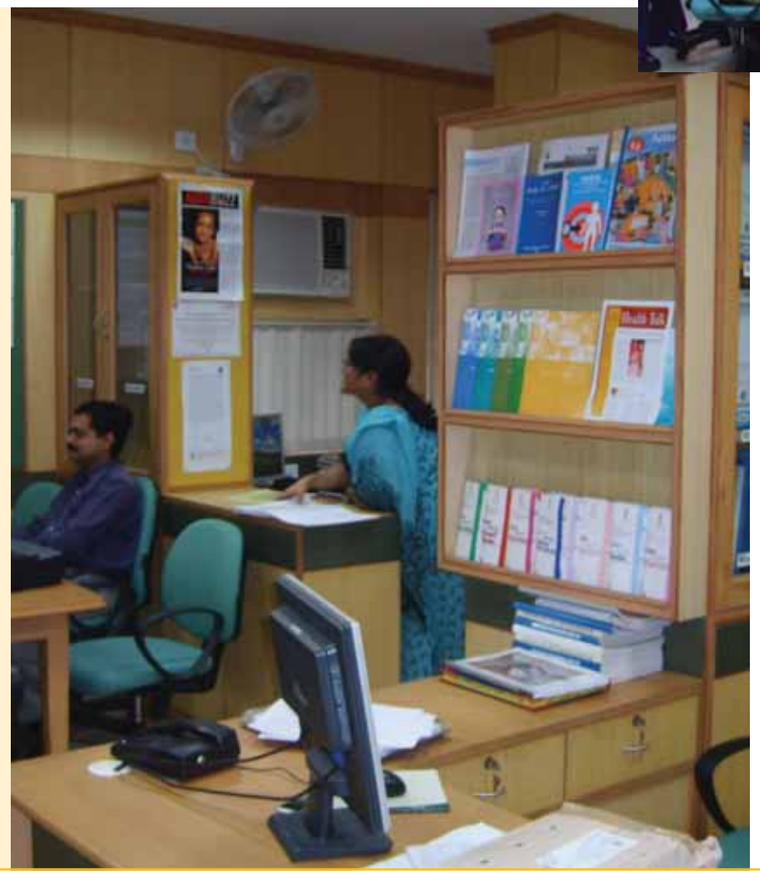
STATE RESOURCE CENTRE

The State Resource Centre (SRC) is the knowledge base of the DoHFW. Established in 2007, with the vision to develop it as a focal point for information collection, dissemination and discussion; the SRC has come a long way in just one year. It acts as a repository of departmental documents, reports, other relevant national and international publications; which are easily accessible to users. The SRC has also been able to develop the much needed interface between the government (department) and the academia in the state. Documentation and dissemination of information necessary for health reform is the focus of SRC's function.

Health Dialogue, a half-day debate and discussion session on current and relevant health reform, policy and programme issues, is held on the last week of every month. The forum provides a platform for inter and intra sectoral dialogue. Participants include senior officials of the DoHFW, all programme managers, eminent academicians, representatives from medical college & hospitals, NGOs, donors etc. Depending on the topic of the dialogue, district officials are also invited to participate. So far, 10 Health Dialogues have been organized since June'2007, on a variety of issues.

Health Dialogues till date:

- Significance of State Resource Centre & Health Reforms
- Hospital Management
- Health Financing & Equity
- Decentralization & Convergence in Health Care
- Burden of Disease in West Bengal - Significant Aspects
- Women Deliver in West Bengal – A Discussion on Maternal Health
- Health Care Management Initiatives in West Bengal: An Overview of FRUs & CHCMIs
- Medical Ethics – Its Relevance in Present Health Care System
- Medical Records - Its Importance in Health Planning
- Communication Skills- Its Importance in Health Services
- Experience sharing by the Programme Officers of DoHFW, GoWB
- Bridging the Gaps in Health Services: Task Ahead



Recently, an Action Initiative Platform has been started to push forward actions based on the recommendations of the health dialogue.

Some periodic publications of SRC

- Media Watch – published weekly is a compilation of health related news published in 9 regional and national dailies.
- Synopsis of research articles – every week a research article is reviewed, summarized and sent to departmental officials. Articles are selected based on certain themes relevant to health systems and reforms. Over 100 articles have been reviewed till now.
- Demographic Notes – short notes on key demographic indicators, trends and analysis is prepared occasionally (usually half-yearly).
- Bird Flu Coverage: SRC on the formal request of West Bengal State AIDS Prevention & Control Society (WBSAPCS) has covered a detailed media reporting on bird flu in West Bengal.

Some recent initiatives:

- OPD Surveys conducted in two medical college hospitals of Kolkata. It is a pilot observational study on the overall status of OPD beneficiaries, their need, institution's capacity to fulfill the same, areas of major gaps between need and service delivery etc.

For More details contact:

State Resource Centre, Government of West Bengal
Institute of Health & Family Welfare Building
GN-29, Sector - V, Salt Lake City, Kolkata - 700091, West Bengal
Phone: 033 40012004, Fax: 033 40012005, E-mail: srcwob@gmail.com
Website: www.srcwb.org

HEALTH REFORM COMMUNICATION

A two-day symposium **Implementing Health Sector Reforms– Sharing National and International Best Practice**, 18-19th April, 2007, Kolkata

A full day reform communication workshop titled **Health Sector Reforms: The Way Forward**, January 2008, Kolkata

A two-day workshop on **Making Health Services Accessible**, March 2008, Kolkata

Newsletter - **'Health Talk' / 'Swasthya Katha'**

STRATEGIC PLANNING AND SECTOR REFORM CELL

DEPARTMENT OF HEALTH & FAMILY WELFARE

GOVERNMENT OF WEST BENGAL