TO EVALUATE THE FUNCTIONING OF JDS UNDER NRHM IN CHAATTISGARH

NRHM, CHHATTISGARH

A dissertation submitted in partial fulfillment of the requirements for the award of

Post Graduate Diploma in Health and Hospital Management

By

Dr. shailendra Mishra

ROLL NO.PG/10/101

International Institute of Health Management Research NEWDELHI

New Delhi -110075
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Office Of the National Rural Health Mission
(State Programme Management Unit, Raipur, Chhattisgarh)
Old Nursing Hostel, Mantralaya Campus, Chhattisgarh, Raipur
(Telephone No–0771–4079200, Fax no.–4079255)

Certificate of Internship Completion

Date: 25/04/2012

TO WHOM IT MAY CONCERN

This is to certify that Dr. Shailendra Mishra has successfully completed his 3 months internship in our organization from January 7, 2012 to March 7, 2012. During this intern he has worked on Program Implementation Plan (PIP) under the guidance of me and my team at National Rural Health Mission (NRHM). We appreciate his sincere effort in making this study successful.

The overall rating for his performance during the study is good. We wish him good luck for his future assignments.

(Signature)

Mr. Urya Marg (Name)

SPM NRHM CG. Designation

Certificate of Approval

The following dissertation titled "**TO EVALUATE THE FUNCTIONING OF JDS UNDER NRHM CHAATTISGARH**" is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

Name Signature

RAJIB DASGUPTA Rajib Dasgupta

NITISH DOGRA Dr Dogra

Certificate from Dissertation Advisory Committee

This is to certify that **Mr. Shailendra Mishra** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. He is submitting thisdissertation titled "**TO EVALUATE THE FUNCTIONING OF JDS UNDER NRHM CHAATTISGARH**" in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management**.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Faculty Mentor Dr. SK. Patel
Designation Assistant Professor
IIHMR
New Delhi
Date

Organizational Advisor Mr. Uryanag
Designation State programme manage
Organization NRHM
Address Raipur
Date 25/04/2012

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राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
रायपुर (छ.ग.)

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Dr. Shailendra Mishra
PGDHHM (IIHMR, New Delhi)

Abbreviation:

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BPL	Below Poverty Line
BPO	Block Programme Officer
CBO	Community- Based Organization
CMHO	Chief Medical and Health- Officer
DHAP	District Health Action Plan
DPM	District Programme Manager
DRP	District Resource Person
EB	Executive Body
FGD	Focus Group Discussion
FRU	First Referral Unit
GPEO	Gram Panchayati Extension Officer
GB	Governing Body
HMS	Hospital Management Society
I/C	In charge
IPD	Indoor Patient Department
MPW	Multipurpose Workers
MO(Ic)	Medical Officer In-Charge
NGOs	Non Government Organization
NIHFW	Nation Institute of Health& Family Welfare
NRHM	National Rural Health Mission
OBC	Other Backward Caste

OPD	Outdoor Patient Department
PHC	Primary Health Centre
PPP	Public Private Partnership
PRI	Panchayati Raj Institution
RMA	Rural Medical Assistant
RCH	Reproductive and Child Health
RKS	Rogi Kalyan Samiti
SC	Scheduled Castes
ST	Scheduled Tribes

Content:

Organization Profile:

NRHM, Chhattisgarh

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centres into functional hospitals meeting Indian Public Health Standards in each Block of the Country.

The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

Objectives and Guidelines

- To improve access to rural people to equitable, affordable, accountable and effective primary health care.
- To raise public spending on health from 0.9% GDP to 2-3% of GDP
- Improve arrangement for Community financing and risk pooling
- To promote policies that strengthens public health management and service delivery in the UT Chandigarh
- Increase Community Ownership of Public Health.
- Prevent Communicable and non Communicable and locally endemic diseases.
- Increase utilization, quality of care, acceptability and efficacy

Goals

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR).
- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
- Access to integrated comprehensive primary healthcare.
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH.
- Promotion of healthy life styles.

Strategies

(a) Core Strategies:

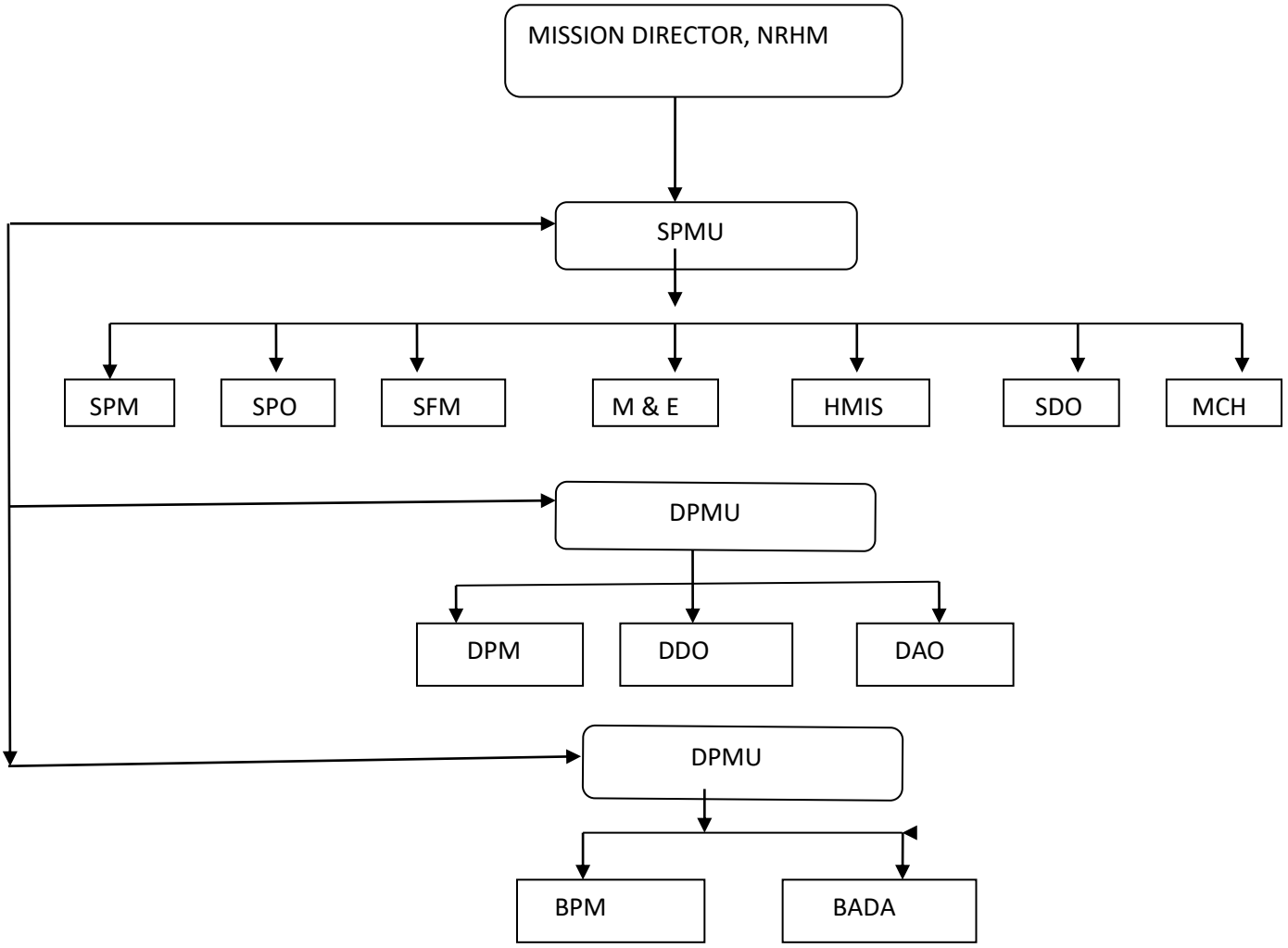
- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved healthcare at household level through the female health activist (ASHA).
- Health Plan for each village through Village Health Committee of the Panchayat.
- Strengthening sub-centre through an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).
- Strengthening existing PHCs and CHCs, and provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards).
- Preparation and Implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation & hygiene and nutrition.
- Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels.
- Technical Support to National, State and District Health Missions, for Public Health Management.
- Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.

- Formulation of transparent policies for deployment and career development of Human Resources for health.
- Developing capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol etc.
- Promoting non-profit sector particularly in under served areas.

(b) Supplementary Strategies:

- Regulation of Private Sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost.
- Promotion of Public Private Partnerships for achieving public health goals.
- Mainstreaming AYUSH – revitalizing local health traditions.
- Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics.

Organizational Structure:



Executive Summary:

The State Programme Implementation Plan for the National Rural Health Mission (2012-13) is based on the experiences of implementing the Programmes primarily during 2011-12 and collectively from all previous years. The plan has been drawn up with the objective of operationalizing facilities to the optimum level for service delivery, identifying specific local problems and arriving at locally feasible solutions to the identified problems. It tries to generate and involve local resources, strengthen coordination linkages. This document therefore attempts to analyze the present situation of health facilities in the district and the constraints in providing quality health care even in the outreach areas. It lays down the strategies to be followed, the activities to be undertaken . It tries to make the optimum utilization of the available resources-infrastructure, manpower and finance.

The primary constraint in the first phase of the project has been in terms of skilled manpower in programme execution. Therefore the primary attempt in 2012-13 is four fold-

- Engaging manpower at remote facilities through contractual services and enhanced performance based incentives.
- Infrastructure development through up gradation of facilities, provision of residential units for assured service personnel at the facility, improving training institutions.
- Skill development of available manpower for optimum utilization and quality services through in- service training.
- Technical support structure for various programmes viz. outsourcing, revised management structure at all levels.

Assignment Execution:

1. Understanding the planning process

The Programme Implementation Plan (PIP) of the state is a task undertaken by the state NRHM unit in the month of October effectively. The process involves the making of plans at village and block levels which are compiled at the district level. All the district level plans are consolidated at the state NRHM office with addition of other state components which are not in the purview of the district plans. The main task of the state Unit is to ensure the following of the bottoms up approach as well as ensure the true representation of the demands rose from the block and district levels. Further, the exercise also involves the approval of the respective nodal officers of the Directorate component wise thereby certifying the district demands as genuine and correct. In this connection the state NRHM unit has appointed consultants of various specializations who will provide assistance as well as technical support to the nodal officers. These consultants are the part of PIP facilitation team lead by a person. Having opportunity to be part of the PIP facilitation team at Chhattisgarh attached with specified roles of assisting the Team leader in the entire exercise.

2. Taking of the roles in the process

There are precise roles and responsibilities for each team member i.e. assigned by the team leader under the guidance of Mission Director, NRHM as well as the State Programme Manager,NRHM. I was assigned the role of providing assistance to the team leader who facilitates the process with his team members. A broad look of the major task of the team leader is to – Finalize the budget limit for the state as well as the district with due consultation of the Mission Director and an analysis undertaken to review the plan of the previous year. Further the Team leader attaches the members to districts for ensuring timely submission of the district plan as well as provide guidance to the district for making the plan as per the format prescribed by the GOI. The team leader maintains constant communication with the district facilitators as well as district officers for addressing any operational or technical difficulties. Then the team leader attaches some more team members to the respective nodal officers to facilitate the submission of the plans from various departments. The team collects and provide the information to the state office for compiling the plan and doing the rationalization exercise to ensure due compliance of all the norms prescribed by the NRHM office, GOI.

Since I am attached to the Team Leader and the nature of his work involves at every step , my role is derived from the task which include – Facilitating the communication between the members and the team leader, updating the status of work on daily basis , doing the basic analysis work in the previous plan, clerical work in designing the formats, facilitating the communication between the nodal officers and the team leader, and doing all those peripheral work entrusted by the Mission Director and the Team leader time to time as per the need.

Observation:

The following are the steps involved in the planning process as observed by me during my attachment. They are -

- Brainstorming meeting and responsibility sharing: As a first step a brainstorming meeting is done where the guidelines, provisions and limitations are explained to the nodal officers in making their plan . Also they are provided with all related formats developed in connection with the plan.. A similar attempt is also made where the district programme managers were given an orientation in district PIP makings. I have attended the meeting as a silent observer.
- Review of district & district plans for former year: The district plans of previous year was reviewed and assessed the component share of the plan. In this exercise my duty was to assist the Team leader in the review process
- Assessment of Resource pocket at district & State level: Before the plan is prepared, the district resource pocket was assessed with the information provided by the district officer and the state under the guidance of Mission Director. In this step, My involvement was limited to compile the district information in the financial management and providing this to the team leader. . I discussed the gaps with the respective district officer.
- Fixing the budget limitation to state & Districts: Based on on the previous years plan and the next years priorities, the budget limitation for state and district are set under the guidance of the Secretary and Mission Director. In this exercise, my role was limited to extract the percentage share of districts component wise such as – Maternal health, Child Health, Family planning, Trainings, Management, IEC, Procurements, incentives etc.
- Fixing the golas, objectives and targets for the programme for a year: In t his step the goals and objectives with the targets for the next year are finalized with a series of meetings undertaken by MD.
- Facilitation of District planning process & Review: As mentioned above , the district planning process is facilitated by the members attached by the team leader. My role was to ensure communication between the district facilitator and the team member.
- Facilitation of planning for nodal agencies and review : Again similar exercise is undertaken for the state nodal officers where my role was almost similar in nature thereby serving the coordinating link between the nodal officers and the Team Leader.

- Compilation of the process : This is the most important part of the making as the main deliverable in this state is the first draft of concise draft along with the financial estimation. My role was to make the documentation of the components and formatting the report. The documentation includes the justification of the demand raised by the nodal officers.
- Downsizing exercise through priorities : This is another most important task where the state planned for a total budget estimation of Rs 718 crores including the state component enrooted through treasury. But in actual, the total plan compiled emerged to 890 crores. This necessitated the downsizing exercise to bring down the plan to the acceptable limit. In this exercise, the components were analyzed and as per the priority the budget was streamlined basing on the priorities and actual need for the year. My role was to take care of components such as Jeevan Deep Samitis, SHRC component and IEC. My task was well accepted and appreciated.
- Preparation of the first draft of the state plan: After the downsizing the budget and final compilation, the first draft ready to be submitted to the GOI was prepared. My role was more on the cross matching and documentation of the plan.
- Component wise review basing on the feedback received from GOI: After the submission of the plan at GOI, there were comments raised from the GOI on certain components suggesting changes and complying the norms of NRHM framework. The exercise was made by the Team with the guidance of MD and the SPM. My role was again the same as the draft preparation phase.

DEVIANCE CHART

Slno	Particulars	Guidelines	Actual implementation	Deviation	Remarks
1	Approach	Should be bottoms up	It was bottom up	No deviation	The approach was seen from district to state.
2	Priorities	State priorities along with need based	State priority with need based	Very limited	
3	Budget	15 % increments in previous ROP	-	-	Due to taking up new initiatives and increased number of Districts

DISSRETATION REPORT

(TO STUDY EVALUATE THE FUNCTIONING OF JDS/RKS UNDER NRHM IN SIX DISTICTS OF CHAATTISGARH)

ABSTRACT

INTRODUCTION -The study was conducted with an objective to study the structure and functioning of JDS , their utilization of funds as well as study the improvements made at the facilities and services provided

DESIGN – It is a cross sectional descriptive study done in the 6 district hospital of Chhattisgarh state. Predesigned interview schedule was used for data collection in 6 district hospital. The study subjects were JDS member (District programme manager) and OPD and IPD patient. Out of 300 , 175 old patients patient randomly selected for study (20 OPD and 30 IPD patients from each district hospital).there are 3 types of rating (Excellent, good, poor) have been used for measuring the satisfaction level of patients.

FINDINGS - One sided decision with 50% was the most frequently cited problem in smooth functioning of the JDS. NRHM is the main source of fund for the DH as well as user fees Cycle stand charges and other Rental charges. Major activity conducted under JDS was, provide subsidized medicine and diagnostic facility to the patients .The other worked was renovation and construction of hospital building ,infrastructure development of hospital, Cleanliness and renovation of bathroom , insure availability of drinking water, provide Specialization services through doctors, etc . 8. It was observed that less number of clients (14 % patients) in districts hospital know about JDS. Korba and Rajnandgaon shows a high quality in services provided by district hospital where higher number of patients(more than 40%) highly satisfied by the services in hospital. Kanker and Raipur shows a average performance in health care services where approximately 40% patients highly satisfied with the services provided in district hospital Baster and Koriya shows a low performance in health services where less than approximately 20% patients satisfied with the services provided from hospital and given the excellent remarks.

KEY RECOMMENDATIONS -

1. Ongoing and regular updates and orientation to the members of RKS about the objectives and their roles and responsibilities within it.
2. Proper guidelines for expenditure of funds should be framed, and audit mechanism defined.
3. The barriers to the effective functioning of RK S may be identified at the earliest and effective measures to eliminate those may be initiated.
4. Ensure the public participation and accountabilities through orientation of JDS members.

Introduction:

Provision of basic preventive, promotive and curative healthcare services is a major concern of the state. It is part of the social contract between the citizen and the state. However, with ever-increasing population and advancement in the medical technology and increasing expectation of the people especially for quality curative care, it has now become imperative to provide quality health care services through the established institutions. At district level the district hospitals provide the range of curative care services while at sub-district levels, the care (curative and preventive) is being provided through Community Health Centers and Primary Health Centers with specialist services of physicians, pediatricians, Obstetrics & Gynecology specialists and surgeons et al being made available. However, these services could gain public confidence only when provided optimally with specialist support, facilities and in a transparent and accountable manner, which calls for adequacy of resources, power to use the same in the most patient-welfare-centric ways and with involvement of the citizens.

Directly linked with consumer satisfaction requires the need for strengthening the health facilities by providing financial and technical autonomy. As part of the health sector reforms under National Rural Health Mission the aims is to increase functional, administrative and financial resources in the health facilities. The JDS scheme ideally works as an innovative strategy for improving facility based health actions with the support of the untied funds. It will be providing quality care in public health facilities requires that the prevalent gaps in the health facility are assessed by the facility management committee and plan to strengthen the services which can enhance the health care coverage of the health unit.

RKS (Patient Welfare Committee) is a management structure. This committee acts as a group of trustees for the hospital to manage the affairs of the hospital. Other than the facility staff, it consists of members from local Panchayati Raj Institutions (PRIs), legislative body, civil society and officials from Government sector who are responsible for proper functioning and management of the hospital / Community Health Centre / First Referral Units. RKS is free to prescribe, generate and use the funds with it as per its best judgement for smooth functioning and maintaining the quality of services for patient welfare. While donation would be the most important modus of fundraising, user charges could be levied with adequate safety nets for the socially and economically backward groups and disadvantaged communities. The amount donated by Chief Minister, Other Ministers MLAs, MPs and Other Civil Society Representative from their allotted funds also contributes to RKS funds. The donor’s membership in the RKS (across the tiers) would be for three years at the most.

The Ministry had set the goal of constituting Jeevan Deep Samiti/Rogi Kalyan Samitis/Hospital Development Committees established in all CHCs/Sub Divisional Hospitals/ District Hospitals 50 per cent by 2007 and 100 per cent by 2009.

In Chhattisgarh JDS/RKS introduced in 2006-2007 under NRHM is a form of commoditisation/public participation, adopted as part of a strategy to improve the quality of management and therefore facility outcome and as a form of providing flexible funds for facility improvement. Currently there are 27 DS, 137 CHC and 741 PHC Jeevan deep samiti's functional in the state. These samiti's in the state setting up quality criteria for the health facilities. NRHM allocate the fund in District hospital (5 Lakhs) and in CHC & PHC(each 1 Lakhs), under JDS in Chhattisgarh.

REVIEW OF LITERATURE:

Jeevan Deep Samiti plays a crucial in management of health facilities like district hospital, Community health centres and primary health centres .In Chhattisgarh states Rogi Kalyan Samittee is known as Jeevan Deep Samiti.

2.1 Concept of decentralization:

Decentralization has been defined in multiple ways but primarily it means transfer of authority and responsibility from higher level to lower levels or from national level to sub national units. It is a process not a static state or a final objective.

Saltman (2007) has defined the decentralization as the transfer of formal responsibility and power to make decisions regarding the management, production, distribution and financing of health services, usually from smaller to a larger number of geographically or organizationally separate actor.

Rondinelli (1983) has classified decentralization in four forms from public administration perspective. These are: 1) Deconcentration; 2) Delegation; 3) Devolution; and 4) Privatization. Deconcentration transfers the authority and responsibility to lower administrative structures within same unit. In Devolution transfer takes place from central unit to separate administrative structures in public administration e.g. Municipalities, districts. Delegation refers this transfer to lower organizational structures like e.g. Semi autonomous bodies, nongovernmental organization. Privatization means private organization takes responsibility and authority to carry out activities.

According to WHO (2005) report on the 'Decentralization of Health System and its Management' the decentralization in health can take place for three main reasons, technical political and financial. The technical decentralization aims at improving the efficiency and effectiveness of the health care service delivery. Political decentralization ensures redistribution of power, the local community participation and to decrease regional disparities. Financial decentralization mobilizes the local resources, resource allocation in hands of local people and improves the accountability and transparency.

Thus the objectives of decentralization in health systems are to empower the local government and facilitate the community participation to improve the quality of health services. It also helps to achieve the technical and allocative efficiency in the functioning of Health system. It

narrows the unmet health need of community. It also improves the accountability and equity in health service delivery.

Rifkin (2003) has provided the evidence from Catholic Relief Service in Cambodia which has successfully implemented two pilot projects in health services. The project involved the active community participation as tool to improve the accountability and utilization of health services. The communities were actively involved in determining their own needs and had the autonomy in decision making and resource allocation. This whole process resulted in improvement in transparency and accountability of health care services. Thus active community participation is important to check on the disadvantages of decentralization.

In RKS, the decentralization process is ensured by allotting decision making power to the RKS members. The participation of diverse interest group is also ensured through allotting representation in the different structures of RKS.

2.2 Community participation: Prerequisite for effective decentralization

WHO (2002) report on European sustainable development and health services has defined the community participation as a process by which people are enabled to become actively and genuinely involved in a defining the issues that concerns to them, in making decision about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change.

Active community participation is the most important building block of the sustainable development. It helps to mobilize the untapped resources within communities, target the resources more efficiently and effectively. It helps the people to gain control over the things that affect their own life and to build the capacities within the communities. Thus community participation ultimately aims at empowering the community.

Community participation is achieved when participation is inclusive and diverse i.e. participating communities are open to involve and actively facilitate the involvement of all the stakeholders in community with diverse interest areas without discrimination and opinion of any of the member is respected. The participating communities do not push forward a specific agenda or philosophy.

Carnwall and Gaventa (2001) have argued that investment of intangible assets like time and energy by community members in the administration of the health care intervention are critical to improve the quality and responsiveness of the health care services.

Nelson and Wright (1995) has questioned on the process of community empowerment in which powerful entities initiate the process of giving power to the powerless people. It is considered as the attempt by the powerful entities to remain in power by controlling the process of giving power.

Rifkin (2003) had argued the same by stating that power cannot be given to those without power. The community empowerment takes place only when community themselves take control over the resources and make the decisions that affect their lives. To achieve such community empowerment, capacity building plays an important role in developing the potential within powerless people to decide their own lives.

RKS has been tailored to engage the community to invest their time and energy to determine their own need and decide on the resource allocation. But this community participation has been channeled through representatives of the different groups within the community. So it is interesting to see in reality to what extent RKS has achieved the accountability, transparency and community empowerment objectives.

2.3 History of Decentralization and Community Participation in health service system

The centrally managed health care system has resulted in inefficient heath care delivery widening the gap between health status of urban – rural population and rich – poor people. Increased bureaucratization and lack of political will to focus on health system originated the need of people centered health system. The Alma-Ata declaration in 1978 on "Health for All by 2000" initiated the process of decentralization in health services by developing countries. Later on the donors agencies promoted the decentralization as a tool to improve the performance of National health systems.

Decentralization in Mexico showed improvement in efficiency of health care while in case of china where after decentralization local government entered into competition to provide high end technology health solutions to its population resulted in increase in health care cost. This affected utilization of healthcare by poor people.

According to UNDP (1997) report decentralization in Brazil did not serve its purpose initially because of higher level personnel resistance to shed the authority to lower level and weak governance capacity at local level. The Belo Horizonte of Brazil proved as one of the successful examples of decentralization and community participation. The municipal

corporation implemented participation management strategy which resulted in improvement in accountability of health sector of Belo Horizonte. This initiative resulted in a better and wider awareness of the constraints and possibilities of solving the problems in the sector and facilitated the negotiations among the segments involved with health policies on more a realistic basis.

Bossert (2000) found out that the better relationship among the key local actors was associated with better performance. It also demonstrated that local institutional capacities are essential to effective decentralization. Further the head of the local institution act as a catalyst in the success of the decentralization. The head who knew and respected the laws of decentralization and took special initiatives in the health sector performed better.

India has a long history of centrally managed healthcare system. The decentralization in India started in real sense only after 1992 when parliament passed the 73rd and 74th constitutional amendment acts to create local government in India. After that continuous effort are going on to promote decentralization in health sector through Panchayati Raj System. The National Population policy 2000 and National health policy 2002 has reiterated importance of decentralization and community participation in the health system governance.

Recently under NRHM various initiatives are directed to ensure active community participation and decentralization in health services to improve the efficiency and effectiveness of health service delivery. These are preparation of District Health Action Plan, Community Based Monitoring of health services and formation of Rogi Kalyan Samiti.

2.4 Patient Satisfaction Measures:

One factor that can account for variation in patient perceptions of hospital care is differences in the measures of satisfaction. Some hospitals focus on "experience of care" and take a problem-oriented approach, asking questions about what did or did not happen during the hospitalization with regard to various aspects of care (Cleary, et al., 1991). Other satisfaction surveys take a "satisfaction with care" approach, asking the individual to rate their satisfaction with various aspects of care while they were hospitalized (Finkelstein, et al., 1998; Kane, et al., 1997; Marshall, et al., 1996). These two approaches to assessing patients' views of their hospital experiences may reflect the two complementary but sometimes conflicting goals for developing such information: quality improvement by hospitals and public reporting for use by consumers. To help hospitals direct their quality improvement efforts, specific questions identifying problem areas have been used (Cleary, et al., 1991; Hargraves, et al., 2001).

Whether results of these questions are more easily understood by the public in a report on hospital quality than questions asking patients to evaluate their satisfaction or rate the care received (e.g., excellent, good, fair, poor) is a methodological issue that has not been resolved.

2.5 Patient Characteristics

Most studies of the relationship of patient characteristics to hospital satisfaction scores have found that several key variables were significantly related to reports of satisfaction, most consistently patient age and self-reported health status. Virtually every study reviewed found these two characteristics to be strongly related to hospital satisfaction, and this finding held for VA hospital patients (Rosenheck, et al., 1997; Young, et al., 2000), for obstetrical patients (Finkelstein, et al., 1998), for different satisfaction measures (Marshall, et al., 1996), and in different countries (Thi, et al., 2002). In general, older patients tended to report greater satisfaction, and sicker patients tended to be less satisfied (Finkelstein, et al., 1998; Hargraves, et al., 2001; Rogut, et al., 1996; Rosenheck, et al., 1997; Thi et al., 2002; Young, et al., 2000). Other patient characteristics that have been significantly related to hospital patient satisfaction include: race/ethnicity (Finkelstein, et al., 1998; Rogut 1996; Young, et al., 2000), gender (Hargraves, et al., 2001; Rosenheck, et al., 1997), education level (Hargraves, et al., 2001), insurance status (Finkelstein, et al., 1998; Rogut, et al., 1996), income (Rogut, et al., 1996; Young, et al., 2000), having a regular physician (Rogut, et al., 1996), and past hospital experience (John, 1992).

A few studies found that hospital characteristics were related to patient reports of satisfaction. For example, differences by hospital service have been noted, with obstetrical patients most satisfied and surgical patients more satisfied than medical patients (cleary, et al.,1991; Rogut et al 1996; young et al 2000), rural location(Young, et al., 2000), and nurse staffing levels(Rogut, et al., 1996).

Demography of Chhattisgarh state:

Chhattisgarh is situated between 17 to 23.7 degrees north latitude and 8.40 to 83.38 east longitude. Chhattisgarh is the 10th largest state of India and is spread across an approximate area of 135,194 sq km. Nearly half the state is covered with forest and accounts for 12% of India's forests. According to the 2001 Census, Chhattisgarh's population is 20.7 million people with a population density of 154 persons per square kilometre.

It receives an annual average rainfall of 60 inches. Rice is the principal crop of the State. A predominantly tribal state (32% tribal population) endowed with rich mineral and forest wealth, Chhattisgarh has about 35 big and small tribes inhabiting the State.

Almost 98.1per cent of population lives in the rural areas and only 1.9 per cent in urban Chhattisgarh. Among the larger states in India, Chhattisgarh has the highest percentage of population of people from the scheduled tribes. The state has mega industries in steel, aluminum and cement. Agriculture and allied activities forms the base of the state's economy and provides livelihood to 80% of the rural population.

Rationale of the study:

- To assess the functioning of Jeevan Deep Samiti in health facilities .
- The understand the work environment of Jeevan Deep Samiti.
- Determination of quality improvement standard at every level of hospital.
- To identify the gaps existing in structure as well provide possible solution to the strengthening of health facility

Objectives:

- To study the structure and functioning of JDS in health facilities.
- To assess the facilitating and inhibiting factors affecting the functioning of JDS.
- To study the utilization of funds provided by state as well as self generated fund
- To study the improvements made at the facilities and services provided. .

Data and Methodology:

Study design - The study is a cross sectional descriptive design both quantitative and qualitative tools. Data for the study will be collected from primary as well as secondary sources.

Study subject - Primary data collected from members of the JDS. Predesigned interview schedule was used for data collection from the study subjects. The study subjects were JDS member (District programme manager) and OPD and IPD patient. There are total 300 patient randomly selected for this study (20 OPD and 30 IPD patients from each district hospital).there are 3 types of rating (Excellent, good, poor) have been used for measuring the satisfaction level of patients.

Area of study - present study conducted in 6 districts Korba, Baster, Rajnandgaon, kanker, Koriya, Raipur in Chhattisgarh. The selection of the blocks will be done on the easy geographical accessibility.

Sampling Design - selection of district through random sampling. In present study there was 6 district hospital selected on the basis of high OPD and IPD patients.

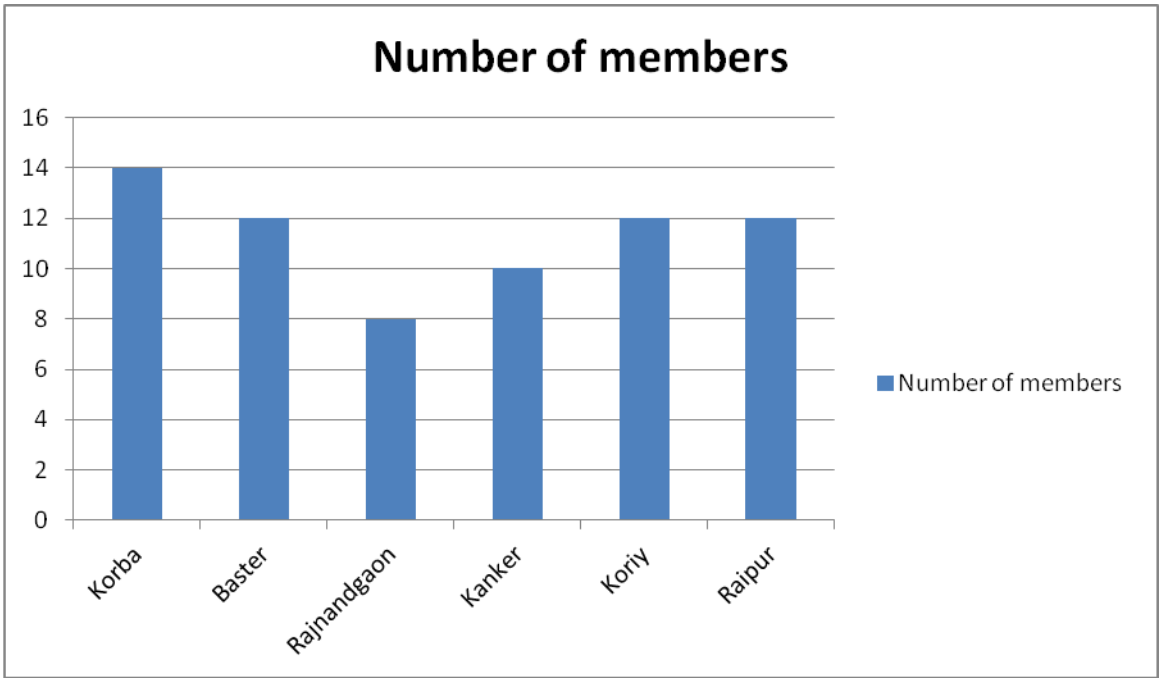
Findings:

A. Structure and Composition of RKS

1. Registration and Guidelines of RKS

The JDS was registered during the year 2006-07 in all the districts hospitals. Written guidelines of JDS were present in all the district hospitals.

2. Members of RKS



Regarding the number of members in JDS, it was observed that korba district had 12 members, another 3 district had 12 members, and remaining 2 district kanker and Rajnandgaon had 10 and 8 members. The selections of all these members in JDS at the district hospital were as per written guidelines available.

3. Meetings

Meeting of governing body

TABLE NO. 1						
	Korba	Baster	Rajnandgaon	Kanker	Koriy	Raipur
Number of meetings organized in a year	4	2	3	2	1	3

It was found that in korba district hospital 4 JDS meetings had been conducted so far, and in rajnandgaon and Raipur district hospital 3 meeting had been conducted Whereas in the remaining hospitals shown 2 & less than 2 meeting in a year.

Meeting of executive body

TABLE NO. 2						
	Korba	Baster	Rajnandgaon	Kanker	Koriya	Raipur
Number of meetings-Organized	Every month	Every 3month	Every 2 month	Every 2 month	Every 2 month	Every month

In korba, Raipur district hospital executive meetings was conducted every month and in 3 district Rajnandgaon , Koriya and Kanker district hospital meeting was conducted every 2 months and remaining Baster district hospital meeting was conducted every 3 months.

All the district program manager(Member of JDS) reported that agenda for the JDS meeting was prepared in advance and circulated. The minutes of the meeting were prepared and circulated among the members.

The attendance of the members attending the meeting was recorded in a meeting register. Generally 8 to 10 members attend the meeting.The meetings were held at the district hospital itself.

The meetings were chaired by the chairman and the member -secretary. During the meetings, leading community members, Chief Executive Officer, Municipal Corporation , ICDS officials, local health officers, PWD officers ,hospital administrator and others donors were regularly present.

Prior information regarding the meeting was sent to the members 3 -4 days before.

4 .Average Time of meetings

TABLE NO. 3						
	Korba	Baster	Rajnandgaon	Kanker	Koriya	Raipur
Number of meetings-Organized	60 minutes	45 minutes	90 minutes	60 minutes	30 minutes	60 minutes

B. Factors Affecting the Functioning of RKS (Basis on observation)

TABLE NO. 4								
S. No.	**Barrier**	**Korba**	**Baster**	**Rajnandgaon**	**Kanker**	**Koriya**	**Raipur**	**% of District hospital**
1.	Members not serious about RKS objectives	✓		✓	✓			50
2.	Tendency of members to avoid meeting					✓		17
3.	Confrontation among members		✓			✓		33
4.	Some members do whatever they like during meeting (one sided decision)		✓		✓		✓	50
5.	No consensus for purchasing					✓	✓	33
6.	Decisions not implemented in time		✓					17

Above table shows that one sided decision was the most frequently cited problem in smooth functioning of the JDS. This was followed by the indifferent attitude of the JDS members, where they were not serious about the objectives of the JDS. Frequent confrontations amongst members and decision for purchasing of goods from common consensus during meeting and laissez faire attitude of the members during meeting have been cited as other barriers to the smooth functioning of JDS. It was also seen in 17% of cases that the members had a tendency to avoid the meetings or made excuses not to attend meetings. These barriers hamper the goals of conducting a meeting, and decisions are not made or not followed/implemented as a result.

C. Funds available and Revenue Generated by the JDS(Basis on observation)

TABLE NO. 5								
S. NO.	**SOURCE OF FUND**	**Korba**	**Baster**	**Rajnandgaon**	**Kanker**	**Koriya**	**Raipur**	**% OF DISTRICT HOSPITALS**
1	NRHM	✓	✓	✓	✓	✓	✓	100
2	User fees(Charges)	✓	✓	✓	✓	✓	✓	100
3	Cycle stand charges	✓		✓	✓	✓	✓	84
4	Rental charges (canteen and others shops)	✓	✓		✓		✓	67
5	Charges from organized various institutional programs		✓	✓	✓		✓	67
6	Donations	✓	✓	✓	✓		✓	84

It was found that all the district hospitals received funds (Rs-500000/ district hospital)from the government through the CMO office . In addition, the CHCs also generated funds through user charges.

Table 6 also describes the others source of generation of funds for JDS like donations from non government institutions and others stakeholders (84%), cycle stand charge (84%) rental charges (67%).

D.Activities Conducted at district hospitals under JDS (Basis on observation)

Table no. 6								
S.NO.	**ACTIVITIES**	**Korba**	**Baster**	**Rajnandgaon**	**Kanker**	**Koriya**	**Raipur**	**% OF DISTRICT HOSPITALS**
1	Payment of JDS staff	✓	✓	✓	✓	✓	✓	100
2	National Health Programs at the hospital				✓		✓	33
3	Organize outreach services / health camps	✓			✓	✓	✓	67
4	construction and expansion in the hospital building	✓		✓	✓	✓	✓	84
5	scientific disposal of hospital waste	✓		✓			✓	50
6	Training for doctors and staff	✓		✓				33
7	Subsidized medicine	✓	✓	✓	✓	✓	✓	100
8	Diagnostic facilities	✓	✓	✓	✓	✓	✓	100
9	Transport facility				✓	✓		33
10	subsidized food			✓	✓			33
11	Availability of drinking water	✓		✓	✓		✓	67
12	Cleanliness and renovation of ward and bathroom	✓	✓	✓	✓	✓	✓	100
13	Infrastructure development (computer repair, electrics and electronic items	✓	✓	✓	✓		✓	84
14	Renovation of hospital building	✓		✓	✓	✓	✓	84
15	Making posters in hospitals	✓		✓			✓	50
16	Specialization services through doctors	✓	✓	✓	✓	✓	✓	100
17	(POL)Petrol allowance	✓		✓	✓	✓	✓	84

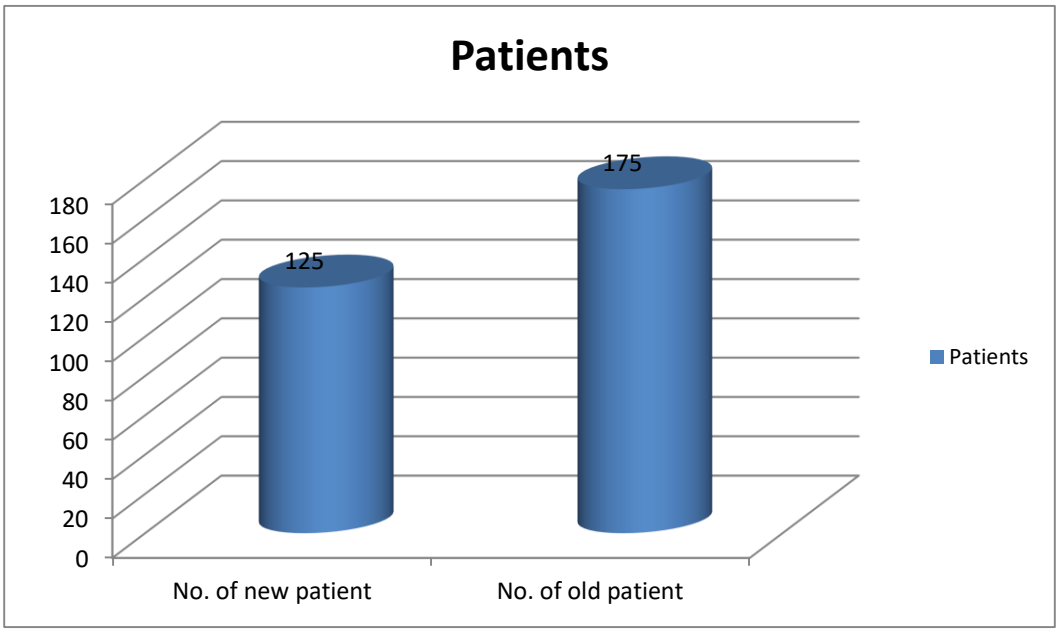
The main functions performed by the JDS, as reported by the Member , were JDS members salary , ensuring the provision of Subsidized medicine and Diagnostic

facilities to the patients, construction and expansion of hospital infrastructure, Renovation of hospital building.

The others functions were Organize outreach services / health camps ,drinking water and cleanliness of facilities for the patients, and Specialization services for patients , disposal of hospital waste, Making posters in hospitals, organized National Health Programmes at the hospital, Training for doctors and staff, provide subsidized food and Transport facility.

E. Perception of clients regarding JDS

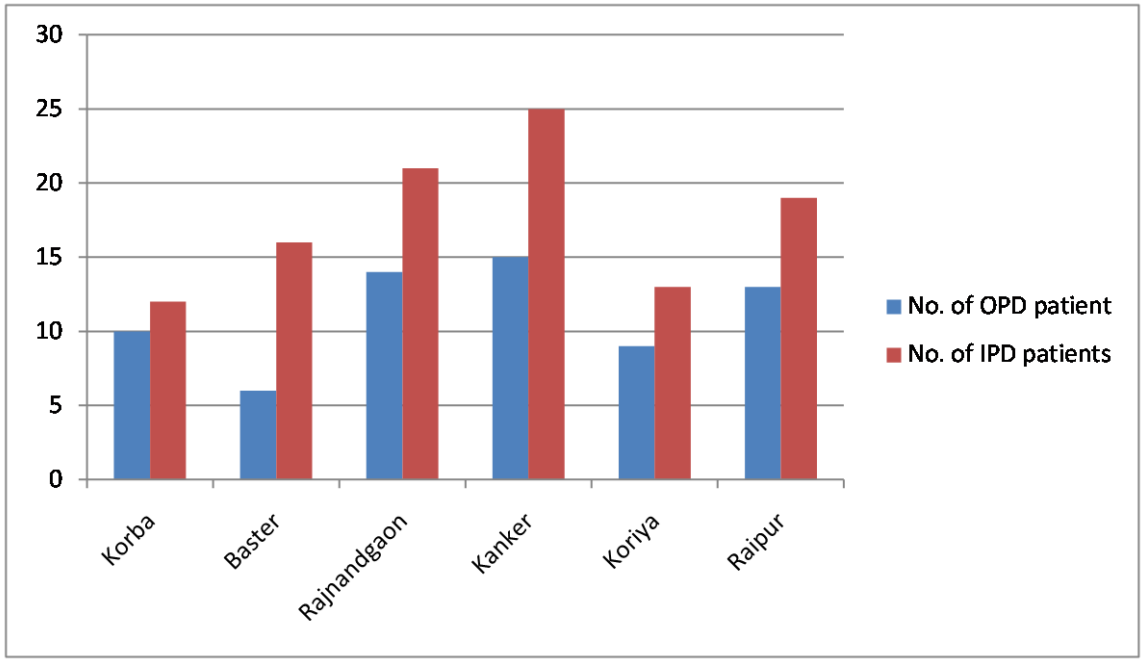
1. Number of old and new patients



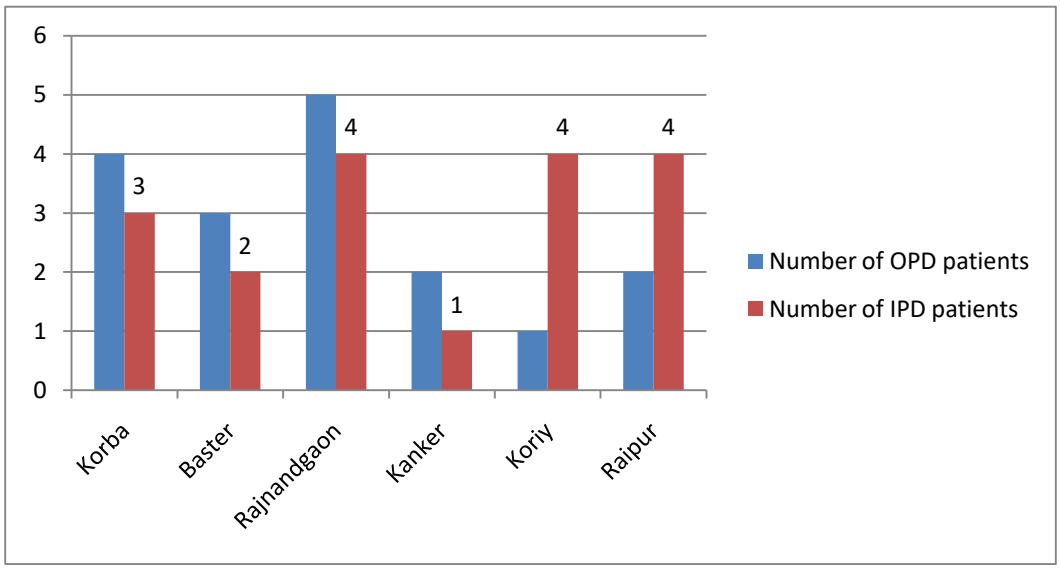
2. No. of old OPD/IPD patients

Table no. 7

	Korba	Baster	Rajnandgaon	Kanker	Koriya	Raipur
Number of OPD patients	10	10	14	15	9	13
Number of IPD patient	12	16	21	25	11	19
TOTAL	22	26	35	40	20	32



3. Awareness level of Clients (OPD/IPD patients)Regarding JDS



It was also revealed by interview in the community that almost all respondents were not aware about JDS therefore, they have no knowledge about functioning and structure of JDS. Out of 175 patients only 35 patients were aware regarding JDS scheme.

4. Perception of old Clients (OPD and IPD) Regarding Improvements at the Hospitals

Most of the patients were not aware about RKS. But majority over half of the patients felt that quality of health services have been improved for 2 -3 years.

I. Hygiene (Cleanliness) condition of Rooms in district hospital

Table No.8							
Response of clients	Korba	Baster	Rajnandgaon	Kanker	Koriy	Raipur	**Total**
Excellent	12	6	20	14	6	15	73
Good	7	6	9	17	4	9	52
Poor	3	14	6	9	10	8	50
Total no of Patients	22	26	35	40	20	32	175

Out of 175 respondents (old patients) 73 were agreed that hygiene condition of rooms in district hospital is excellent whereas 52 were agreed that condition of rooms is good and 50 were agreed that hygiene condition of rooms is poor.

II Cleanliness of Toilet in district hospital

Table No.9							
Response of clients	Korba	Baster	Rajnandgaon	Kanker	Koriy	Raipur	**Total**
Excellent	12	6	13	17	4	14	66
Good	6	8	10	11	5	11	51
Poor	4	12	12	12	11	7	58
Total no of Patients	22	26	35	40	20	32	175

Out of 175 respondents (old patients) 66 were agreed that cleanliness condition of toilet in district hospital is excellent, whereas 51 were agreed that condition of toilet is good and 58 were agreed that cleanliness condition of toilet is poor.

III Medicine provided from the Hospital

Table No. 10							
Response of clients	Korba	Baster	Rajnandgaon	Kanker	Koriy	Raipur	**Total**
Excellent	10	5	12	16	5	9	57
Good	8	8	10	13	6	14	59
Poor	4	13	13	11	9	9	59
Total no of Patients	22	26	35	40	20	32	175

Out of 175 respondents (old patients) 57 were highly satisfied with medicine facility provided in district hospital , whereas 59 were agreed that medicine facility is good and also 59 were agreed that this facility is not up to the mark.

VI Investigation facility provided from the Hospital

Table No .11							
Response of clients	Korba	Baster	Rajnandgaon	Kanker	Koriy	Raipur	**Total**
Excellent	10	5	14	16	4	10	59
Good	7	6	10	13	5	12	53
Poor	5	15	11	11	11	10	63
Total no of Patients	22	26	35	40	20	32	175

Out of 175 respondents (old patients) 59 were highly satisfied with investigation facility provided in district hospital , whereas 53 were agreed that investigation facility is good and also 63 were agreed that this facility is not up to the mark.

V Satisfaction with the Facilities Provided (emergency services during night hours)

Table No. 12							
Response of clients	Korba	Baster	Rajnandgaon	Kanker	Koriy	Raipur	Total
Excellent	10	6	17	18	4	13	68
Good	7	`10	10	14	5	10	46
Poor	5	20	8	8	11	9	61
Total No. of patients	22	26	35	40	20	32	175

Out of 175 respondents (old patients) 68 were highly satisfied with emergency services provided in district hospital , whereas 46 were agreed that this facility is good and also 61 were agreed that this facility is not up to the mark.

VI satisfied with the transport facility provided from the Hospital

Table No. 13							
Response of clients	Korba	Baster	Rajnandgaon	Kanker	Koriy	Raipur	Total
Excellent	10	4	14	15	4	10	57
Good	8	6	13	14	3	16	60
Poor	4	16	8	11	13	6	58
Total No. of patients	22	26	35	40	20	32	175

Out of 175 respondents (old patients) 57 were highly satisfied with transport facility provided in district hospital , whereas 60 were agreed that this facility is good and also 58 were agreed that this facility is not up to the mark.

VI I Improvements Felt in the Present Services (availability of doctors in hospitals)

Table no. 14							
Response of clients	Korba	Baster	Rajnandgaon	Kanker	Koriy	Raipur	Total
Excellent	10	8	13	14	4	9	58
Good	6	6	13	18	5	13	61
Poor	6	12	9	8	11	10	56
Total no. of patients	22	26	35	40	20	32	175

Out of 175 respondents (old patients) 58 were highly satisfied with the service provide by doctors in district hospital , whereas 61 were agreed that this facility is good and also 56 were agreed that this facility is not up to the mark

F. DISTRICT WISE SATISFACTION LELVEL OF PATIENTS (CLIENTS) REGARDING VARIOUS SERVICES PROVIDED BY DISTRICT HOSPITAL

1. Satisfaction level of Patients in Baster District

Name Of the District	Types of responses	Total no. of Remarks	Percent of Satisfaction
BASTER			
	Excellent	40	22
	Good	40	22
	Poor	102	56
Total		**182**	**100**

In baster district hospital only 22 % patients gave excellent and 22% gave good remarks for the services provided from hospital whereas more than half patients (56%) were gave poor remarks which shows that they are not satisfied with the services provided from district hospital.

2. Satisfaction level of Patients of Korba District

Name Of the District	Types of responses	Total no. of Remarks	Percent of Satisfaction
KORBA			
	Excellent	74	48.1
	Good	49	31.8
	Poor	31	20.1
TOTAL		**154**	**100**

In korba district hospital approximately 49 % patients gave excellent remarks which shows highly satisfaction level of the patients regarding services provided from hospitals and 31% gave good remarks for the services whereas 20% were gave poor remarks which shows that 20% patients are not satisfied with the services provided from district hospital.

3. Satisfaction level of Patients in Rajnandgaon District

Name Of the District	Types of responses	Total no. of Remarks	Percent of Satisfaction
Rajnandgaon			
	Excellent	103	42.0
	Good	75	30.6
	Poor	67	27.3
Total		**245**	**100**

In Rajnandgaon district hospital 42 % patients gave excellent remarks which shows that approximately half of the patients satisfied with the services provided from hospitals and 30% gave good remarks for the services whereas 27% were gave poor remarks which shows that 27% patients are not satisfied with the services provided from district hospital

4. Satisfaction level of Patients in Kanker District

Name Of the District	Types of responses	Total no. of Remarks	Percent of Satisfaction
KANKER			
	Excellent	110	39.3
	Good	100	35.7
	Poor	70	25.0
Total		**280**	**100**

In Kanker district hospital approximately 40% patients gave excellent remarks which shows higher satisfaction level of the patients regarding services provided from hospitals and 36% gave good remarks for the services whereas 25% were gave poor remarks which shows that 25% patients are not satisfied with the services provided from district hospital

5. Satisfaction level of Patients in Koriya District

Name Of the District	Types of responses	Total no. of Remarks	Percent of Satisfaction
KORIYA			
	Excellent	31	22
	Good	33	24
	Poor	76	54
Total		**140**	**100**

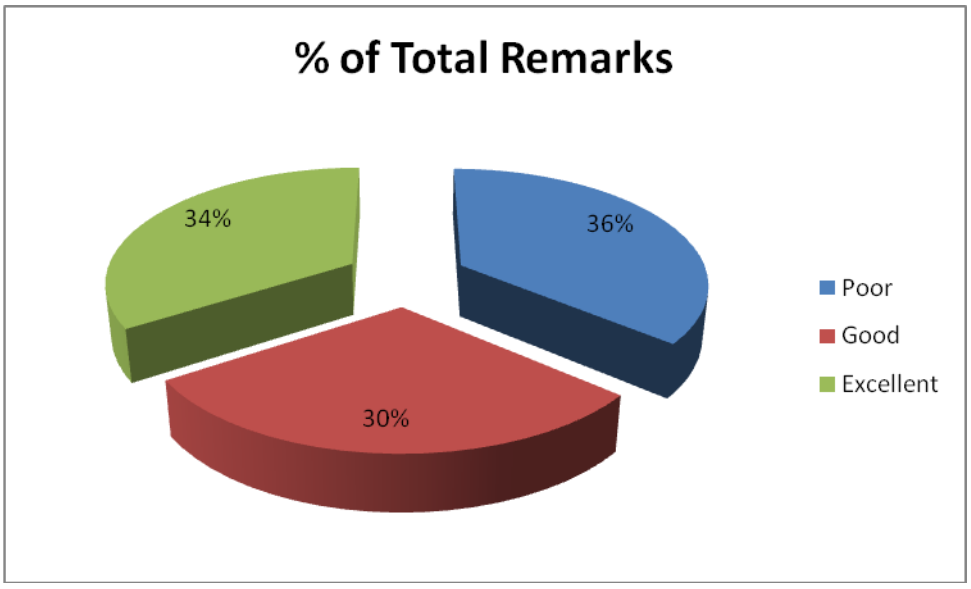
In Koriya district hospital approximately 22% patients gave excellent remarks and 24% gave good remarks for the services whereas 54% were gave poor remarks which shows that poor performance of hospital where more than half of the patients are not satisfied with the services provided from district hospital

6. .Satisfaction level of Patients in Raipur District

Name Of the District	Types of responses	Total no. of Remarks	Percent of Satisfaction
RAIPUR			
	Excellent	80	36
	Good	85	38
	Poor	59	26
Total		**224**	**100**

In Raipur district hospital 36% patients gave excellent remarks regarding services provided from hospitals and 38% gave good remarks for the services whereas 26% were gave poor remarks. The overall rating shows average performance of district hospital regarding services provided from district hospital.

G OVERALL PERCENTAGE OF SATISFACTION FOR ALL THE DISTRICT HOSPITAL FOR ALL THE SERVICE FACILITY



Discussion:

Jeevan Deep Samiti/Rogi Kalyan Samiti (Patient Welfare Committee) /Hospital Management Society is a simple yet effective management structure. It consists of members from local Panchayati Raj Institutions (PRIs), NGOs, local elected representatives and officials from government sector who are responsible for proper functioning and management of the hospital/Community Health Centre/FRUs. RKS/H MS are free to prescribe, generate and use the funds with it as per its best judgement for smooth functioning and maintaining the quality of services.

The study made some important revelations pertaining to JDS –

1. It was seen that the RKS has been formed at all places according to the NRHM guidelines and within the proposed time –frame. All
2. The JDS were headed by a member secretary and constituted of up to 14 members.
3. According to guideline of JDS, meeting of all the members are essential in every months with some agenda. In our study, it was found that these meeting are not being held at every month.
4. The average time of meetings was 1 hours .
5. The functioning of JDS is influenced by many factors. one sided decision was the most frequently cited problem in smooth functioning of the JDS where members were not participated or not serious about the objectives of the JDS. The other factor was frequent confrontations amongst members.
6. For smooth functioning of JDS, there is provision of funds generation through the government and non-government agencies. In our study, funds for JDS are gathered through regular government activity and user charges. The others sources of funds was commercial use of institution(district hospital) for organized institutional programs , Rental charges (canteen and others shops) as well as donations in cash .
7. The main functions performed by the JDS, as reported by the Member , were JDS members salary , ensuring the provision of Subsidized medicine and Diagnostic facilities to the patients, construction and expansion of hospital infrastructure, Renovation of hospital building.
8. It was observed that almost all the clients (patients) in districts hospital did not know about JDS. Hence to facilitate proper understanding, the questions were modified to gain insight about the functioning of JDS, and the perceived benefits to the community.

9. Regarding Hygiene (Cleanliness) condition of Rooms in district hospital approximately half of the patients (73) given excellent remarks and 52 were given good remarks which shows improvement in services.
10. Regarding Cleanliness of Toilet in district hospital 66 were given excellent remarks and 51 were given good remarks which also shows satisfactory level of improvement in services.
11. Regarding the availability of medicine 57 were given excellent remarks and 59 given good remarks whereas 59 were given poor remarks .Approximately half of the respondents admitted that more medicine are available but only cheap medicine, majority over half stated that doctors instead of dispensing, prescribe costly medicine to be bought from the market.
12. Regarding investigation facility 59 and 53 were given excellent and good remarks. And 63 were given poor remarks approximately half stated that investigations like blood, urine testing, x -ray is available but costlier investigation like ultrasound is not available.
13. Regarding emergency facility 68 were highly satisfied with emergency services provided in district hospital , whereas 46 were agreed that this facility is good and also 61 were agreed that this facility is not up to the mark.
14. Regarding transport facility 57 were highly satisfied with transport facility provided in district hospital , whereas 60 were agreed that this facility is good and also 58 were agreed that they are not satisfied with the transport facility.
15. Regarding availability of doctors in district hospital 58 were highly satisfied with the service provide by doctors in district hospital , whereas 61 were agreed that this facility is good and also 56 were agreed that this facility is not up to the mark. Nearly half of the respondents also pointed out that although doctors' availability has improved as compared to previous time but in spite of that they felt lack of caring and sympathetic behavior.
16. According to raking table korba and Rajnandgaon shows a high quality in services provided by district hospital where higher number of patients(more than 40%) highly satisfied by the services in hospital.
17. Kanker and Raipur shows a average performance in health care services where approximately 40% patients highly satisfied with the services provided in district hospital.
18. Baster and Koriya shows a low performance in health services where less than approximately 20% patients satisfied with the services provided from hospital.
19. Majority over half of the patients felt that quality of health services have been improved for 2 -3 years. Regarding changes at the DH,.

Conclusion:

The JDS was constituted with the objective of ensuring compliance to minimal standard for facility, hospital care and protocols of treatment as issued by the government; ensure accountability of the public health providers to the community; introduce transparency with regards to management of funds and upgrade and modernize the health services and infrastructure of the hospital. Thus it is pertinent to assess the effective functioning of JDS which plays a critical role in bettering the quality of health care services.

1. The JDS has been formed at all DH as per the guidelines. The number of members constituting JDS was however, less in some DH.
2. The meetings of the JDS were not regular in almost all the cases.
3. There is apparently no obstacle in the flow of funds pertaining to collection of central grants for JDS and other Income generation through setting up of commercial complexes, shops and user fees. The utilization of these funds for infrastructural strengthening and patients support also appears adequate.
4. More number of clients (patients) is not aware about JDS at the studied in DH, but they felt better changes in services compared to previous two three years. They wanted more improvement in the quality of health care, in relation to availability of medicines, basic and specialist doctors, availability of basic facilities and investigations.
5. The main inhibitors to the effective functioning of JDS are poor awareness of the members regarding the objectives of JDS, and the lack of motivation/interest in meetings, as also delayed or non implementation of decisions .
6. Korba and Rajnandgaon shows a high quality in services provided by district hospital where higher number of patients(more than 40%) highly satisfied by the services in hospital. Kanker and Raipur shows a average performance in health care services where approximately 40% patients highly satisfied with the services provided in district hospital Baster and Koriya shows a low performance in health services where less than approximately 20% patients satisfied with the services provided from hospital and given the excellent remarks.

Recommendation of the study:

1. state need to conduct specific capacity building trainings or workshops for the Committee members.
2. A system may need to be developed to ensure regular JDS meetings.
3. An effective monitoring mechanism may be established to provide support of the JDS.The state nodal officer should be appointed for strengthening the implementation and monitoring of the samiti.
4. A system may need to be developed to ensure regular facilitation of JDS meetings
5. To ensure effective monitoring of the funds disbursed under the scheme all districts should be instructed to provide facility wise action plan for all JDS, grants for effective implementation and documentation for dissemination and records. For this the state will provide detailed plan formats to the respective district nodal officers. This format will contain all details of previous expenditure, available balance as well as the future plan of work activity and projected expenditure.
6. Awareness generation activities in the community need to be strengthened.there is a need for involving the local electronic and print media to create awareness regarding the JDS.
7. There is a need to Utilize technical experts for health care through hiring of specialist doctors and out sourcing lab services etc. Also JDS funds being utilized for life saving activities like hiring of private vehicles for transportation of patients in times emergencies and complications.
8. Ensure the public participation and accountabilities through orientation of JDS members.
9. Special incentives to the members be provided to increase their motivational levels.
10. More number of ASHAs are to be engaged to share the increased burden.

Limitations of the Study:

1. The sample size for the study was inadequate, So it may not generalize the findings for all the district hospital of Chhattisgarh.
2. The research study was confined to Chhattisgarh only. So it may not generalize the findings for all the JDS in other state.
3. The information received from the respondents may have the biasness. Because the important information related to funds utilization, audit reports and meeting procedures etc; was collected more through the interview technique than observation.

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36. A Review of Survey Methods and Statistical Approaches- By Qualidgm, Judith K. Barr, D.sc (Senior Scientist) and Sara Banks, MPH, Ph d. (Senior Analyst)

37. Prepared for the Rhode Island Department of Health Quality Performance Measurement and Reporting System.

ANNEXURE:

GUIDELINES FOR CONSTITUTION OF JEEVAN DEEP SAMITI/ ROGI KALYAN SAMITI / HOSPITAL MANAGEMENT SOCIETY

1. Introduction

In most developing countries, provision of basic preventive, promotive and curative services is a major concern of the Government and decision makers. With growing population and advancement in the medical technology and increasing expectation of the people especially for quality curative care, it has now become imperative to provide quality health care services through the established institutions. In public Sector 15,393 allopathic hospitals (Health Information of India 2003) are functioning. In the rural areas, the secondary level care is being provided through 3222 CHCs (Bulletin on Rural Health Statistics in India 2005) with 30 beds each with specialist services of physicians, pediatricians, O & G specialists, and surgeons being made available. However, these services have not been successful in gaining the faith and confidence of the people because of lack of specialists, facilities and accountability, along with the paucity of resources and non-involvement of the community.

Upgradation of CHCs to Indian Public Health Standards (IPHS) is a major strategic intervention under the National Rural Health Mission (NRHM). The purpose is to provide sustainable quality care with accountability and people's participation along with total transparency. However, there is a general apprehension that this may not be possible unless a system is evolved for ensuring a degree of permanency and sustainability. This requires the development of a proper management structure which may be called as Rogi Kalyan Samiti (RKS) (Patient Welfare Committee) / Hospital Management Society (HMS). We have some experience of these Rogi Kalyan Samities functioning in some of the States like Madhya Pradesh with good results and feasibility of replication. The project in Madhya Pradesh was started on a pilot basis and it has now been adopted in over 450 institutions across the State and has proved equally successful in extremely backward tribal and rural areas, which proves its replicability cutting across the regions. To take the concept across sections of the community, local representatives and political regime, the project concept has to be simple, appealing and easy to replicate across the State.

2. Concept

Rogi Kalyan Samiti (Patient Welfare Committee) / Hospital Management Society is a simple yet effective management structure. This committee, which would be a registered society, acts as a group of trustees for the hospitals to manage the affairs of the hospital. It consists of members from local Panchayati Raj Institutions (PRIs), NGOs, local elected representatives and officials from Government sector who are responsible for proper functioning and management of the hospital / Community Health Centre / FRUs. RKS / HMS is free to prescribe, generate and use the funds with it as per its best judgement for smooth functioning and maintaining the quality of services.

3. Basic Structure

The suggested composition of RKS / HMS is as follows:

RKS / HMS would be a registered society set up in all District Hospitals / Sub District Hospitals / CHCs / FRUs. It may consist of the following members:-

- People's representatives – MLA / MP
- Health officials (including an Ayush doctor)
- Local district officials
- Leading members of the community
- Local CHC/ FRU in-charge
- Representatives of the Indian Medical Association
- Members of the local bodies and Panchayati Raj representative
- Leading donors

The RKS/HMS will not function as a Government agency, but as an NGO as far as functioning is concerned. It may utilize all Government assets and services to impose user charges and shall be free to determine the quantum of charges on the basis of local circumstances. It may also raise funds additionally through donations, loans from financial institutions, grants from government as well as other donor agencies. Moreover, funds received by the RKS / HMS will not be deposited in the State exchequer but will be available to be spent by the Executive Committee constituted by the RKS/HMS. Private organizations offering high tech services like pathology, MRI, CAT SCAN, Sonography etc. could be

permitted to set up their units within the hospital premises in return for providing their services at a rate fixed by the RKS/ HMS.

4. Need for Devolution of Responsibility

Participation of local staff along with representatives of local population is considered of prime importance to improve accountability and keep pace with rapidly growing service requirements. It is also necessary to evolve a suitable framework within which the existing staff and local population along with administration can establish such a motivated performing asset. The new body or the apex entity has to be responsible for the singular aspect of provision of services to all classes of the society. The right of independence for performance and management has to be provided in order to boost performance.

5. Framework For Rogi Kalyan Samiti (RKS)/Hospital Management Society(HMS)

Objectives the RKS / HMS

The following could be the broad objectives of the HMS

- Ensure compliance to minimal standard for facility and hospital care and protocols of treatment as issued by the Government.
- Ensure accountability of the public health providers to the community;
- Introduce transparency with regard to management of funds;
- Upgrade and modernize the health services provided by the hospital and any associated outreach services;
- Supervise the implementation of National Health Programmes at the hospital and other health institutions that may be placed under its administrative jurisdiction;
- Organize outreach services / health camps at facilities under the jurisdiction of the hospital;
- Display a Citizens' Charter in the Health facility and ensure its compliance through operationalisation of a Grievance Redressal Mechanism;
- Generate resources locally through donations, user fees and other means;
- Establish affiliations with private institutions to upgrade services;
- Undertake construction and expansion in the hospital building;
- Ensure optimal use of hospital land as per govt. guidelines;
- Improve participation of the Society in the running of the hospital;

- Ensure scientific disposal of hospital waste;
- Ensure proper training for doctors and staff;
- Ensure subsidized food, medicines and drinking water and cleanliness to the patients and their attendants;
- Ensure proper use, timely maintenance and repair of hospital building equipment and machinery;

5.2. Functions and Activities

To achieve the above objectives, the Society shall direct its resources for undertaking the following activities / initiatives

- Identifying the problems faced by the patients in CHC/PHC;
- Acquiring equipment, furniture, ambulance (through purchase, donation, rental or any other means, including loans from banks) for the hospital;
- Expanding the hospital building, in consultation with and subject to any Guidelines that may be laid down by the State Government;
- Making arrangements for the maintenance of hospital building (including residential buildings), vehicles and equipment available with the hospital;
- Improving boarding / lodging arrangements for the patients and their attendants;
- Entering into partnership arrangement with the private sector (including individuals) for the improvement of support services such as cleaning services, laundry services, diagnostic facilities and ambulatory services etc.;
- Developing / leasing out vacant land in the premises of the hospital for commercial purposes with a view to improve financial position of the Society;
- Encouraging community participation in the maintenance and upkeep of the hospital;
- Promoting measures for resource conservation through adoption of wards by institutions or individuals; and,
- Adopting sustainable and environmental friendly measures for the day-to-day management of the hospital, e.g. scientific hospital waste disposal system, solar lighting systems, solar refrigeration systems, water harvesting and water re¬charging systems etc.

5.3. Constitution of the RKS / HMS

Governing Body:

Chairperson	:	District Magistrate
Member-Secretary	:	Medical Superintendent of the hospital

Members:

- Chief Executive Officer, Municipal Corporation
- Chief Medical and Health Officer
- Director, AYUSH of the District
- Up to 2 representatives of PRIs
- Up to 3 eminent citizens nominated by the District Collector
- MNGO representative
- Representative of local Medical College
- Representative of corporate sector / NGO hospitals in the city as may be nominated by District Collector
- Local MP/MLA
- Associate members : An individual who makes a one time donation of.a specified amount [e.g. Rs 5,000/- or as may be determined by the District Health Society], may be made eligible to become a Member of the Governing Body of the Society.
- Institutional members: Any institution, which donates a specified amount [e.g. Rs. 50,000/- or more or as may be determined by the District Health Society] or adopts a ward of the hospital and bears the cost of its maintenance, may be made eligible to nominate a person from the institution as a member of the Governing Body of the society.

5.4 Proceedings of the Governing body

5.4.1 The meetings of the Governing Body shall be held at least once in every quarter and at such time and place as the Chairperson shall decide. If the Chair-person receives a requisition for calling a meeting signed by one-third members of the Governing Body, the Chair-person shall call such a meeting as soon as may be reasonably possible and at such place as s/he may deem fit.

5.4.2 Following minimum business shall be brought forward and disposed off in every meeting of the Governing Body:

- Compliance to Standards and Protocols issued by Government.
- Review of the OPD and IPD service performance of the hospital in the last quarter and service delivery targets for the next quarter.
- Review of the outreach work performed during the last quarter and outreach work schedule for the next quarter.
- Review of efforts in mobilizing resources from the community, trade / industry and local branches of professional associations like IMA and FOGSI etc.
- Review the reports submitted by the Monitoring Committee.
- Review the status of utilization of funds, equipment and drugs received under different programmes of the Government.
- Review compliance to Citizens' Charter displayed in the Hospital and the effectiveness of the Grievances Redressal Mechanism.

5.4.3 In addition to the above regular items, the Annual Report of the Society relating to last financial year shall also be taken up for discussion in the quarterly meeting falling due after the close of every financial year.

5.4.4 Every notice calling meeting of the Governing Body shall state the date, time and place at which such meeting will be held and shall be served upon every member of the Governing Body not less than twenty one clear days before the date appointed for the meeting. Such notice shall be issued by the Member Secretary of the Society and shall be accompanied by an agenda of the business to be placed before the meeting provided that accidental omission to give such notice to any member shall not invalidate any resolution passed at such meeting. In the event of any urgent business the Chair-person may call the meeting of the Governing Body at clear ten days notice.

5.4.5 The Chairperson shall Chair the meetings of the Governing Body. In his/her absence, the Governing Body shall elect one from among the members present as Chair-person of the meeting.

5.4.6 One third of the members of the Governing Body, including the substitutes nominated under Rule 5.3.8 present in person, shall form a quorum at every meeting of the Governing Body.

5.4.7 The membership of an ex-officio member of the Society and of the Governing Body shall stand terminated when he/she ceases to hold the office by virtue of which he/she was member and his/her successor to the office shall become such member.

5.4.8 Nominated members shall hold office for a period of three years from the date of their nomination. Such members will be eligible for re-nomination for another period of 3 years.

5.4.9 The Society shall maintain a roll of members at its registered office and every member shall sign the roll and state therein his/her rank or occupation and address. No member shall be entitled to exercise rights and privileges of a member unless he/she has signed the roll as aforesaid.

5.4.10 A member of the Society shall cease to be members if s/he resigns, becomes of unsound mind, becomes insolvent or is convicted of a criminal offence involving moral turpitude or removal from the post by virtue of which s/he was holding the membership.

5.4.11 Resignation of membership shall be tendered to the Governing Body in person to its Member Secretary and shall not take effect until it has been accepted on behalf of the Governing Body by the Chairperson.

5.4.12 If a member of the Society changes his/her address he/she shall notify his/her new address to the Member Secretary who shall thereupon enter his/her new address in the roll of member. But if a member fails to notify his/her new address the address in the roll of members shall be deemed to be his/her address.

5.4.13 Any vacancy in the Society or in the Governing Body shall be filled by the authority entitled to make such appointment. No act or proceedings of the Society or of the Governing Body shall be invalid merely by reason of the existence of any vacancy therein or of any defect in appointment of any of its members.

5.4.14 No member of the Society or its Governing Body shall be entitled to any remuneration.

5.5. Powers of the Governing Body

5.5.1 The Governing Body will have full control of the affairs of the Society and will have authority to the exercise and perform all the powers, acts and deeds of the Society consistent with the aims and objects of the Society.

5.5.2 In particular and without prejudice to the generality of foregoing provision, the Governing Body may:

- Make, amend, or repeal any bye laws relating to administration and management of the affairs of the Society subject to the observance of the provisions contained in the Act, provided that:

- proposals for amendments shall be placed before the Governing Body of the District Health Mission for its consideration and endorsement;

- proposals for amendment shall also be sent to the designated authority of the State Government for endorsement; and

- proposals shall be brought to the Governing Body after completing the above endorsement / approval process.

- Consider the annual budget and the annual action plan, its subsequent alternations placed before it and to pass it with such modifications as the Governing Body may think fit.

- Monitor the financial position of the Society in order to ensure smooth income flow and to review annual audited accounts.

- Accept donations and endowments or give grants upon such terms as it thinks fit.

- Delegate its powers, other than those of making rules, to the Chair-person, Vice-Chair-person or other authorities as it may deem fit.

- Authorize the Member Secretary to execute such contracts on behalf of the Society as it may deem fit in the conduct of the business of the Society.

- Recruit medical and paramedical staff for the hospital and execute such other contracts for the improvement of hospital services as it may deem fit.

- Do generally all such other acts and things as may be necessary or incidental to carrying out the objectives of the Society or any of them, provided that nothing herein contained shall authorize the Governing Body to do any act or to pass any bye-laws which may be repugnant to the provisions hereof, to the powers hereby conferred on the Governing Body and other authorities, or which may be inconsistent with the objectives of the Society.
- Ensure compliance to Indian Public Health Standards and to Citizens' Charter.
- Establish a system of public grievance redressal at facility level.
- Undertake measures to increase transparency in financial and operational management of the hospital.

5.6 Powers and functions of the Chairperson of the Governing Body

5.6.1 The Chairperson shall have the powers to call for and preside over all meetings of the Governing Body.

5.6.2 The Chairperson may himself/herself call, or by a requisition in writing signed by him/her, may require the Member Secretary to call, a meeting of the Governing Body at any time and on the receipt of such requisition, the Member Secretary shall forthwith call such a meeting.

5.6.3 The Chairperson shall enjoy such powers as may be delegated to him by the Society and the Governing Body.

5.6.4 The Chairperson shall have the authority to review periodically the work and progress of the Society and to order inquiries into the affairs of the Society and to pass orders on the recommendations of the reviewing or inquiry Committee.

5.6.5 Nothing in these Rules shall prevent the Chairperson from exercising any or all the powers of the Governing Body in case of emergencies in furtherance of the objects of the Society. However, the action taken by the Chairperson on such occasions shall be reported to the Governing Body subsequently for ratification.

5.6.6 All disputed questions at the meeting of the Governing Body shall be determined by votes. Each member of the Governing Body shall have one vote and in case of a tie, the Chairperson shall have a casting vote.

5.6.7 Should any official members be prevented for any reason whatsoever from attending a meeting of the Governing Body, the Chairperson of the Society shall be at liberty to nominate a substitute to take his place at the meeting of the Governing Body. Such substitute shall have all the rights and privileges of a member of the Governing Body for that meeting only.

5.6.8 Any member desirous of moving any resolution at a meeting of the Governing Body shall give notice there of in writing to the Member Secretary of not less than ten clear days before the day of such meetings

5.6.9 Any business which it may become necessary for the Governing Body to perform, except the agenda prescribed for the full meeting as set out as above may be carried out by circulation among all its members and any resolution so circulated and approved by majority of the members signing shall be as effectual and binding as if such resolution had been passed at a meeting of the Governing Body provided that at least one third members of the Governing Body have recorded their consent of such resolution.

5.6.10 In the event of any urgent business, the Chairperson of the Society may take a decision on behalf of the Governing Body. Such a decision shall be reported to the Governing Body at its next meeting for ratification.

5.6.11 A copy of the minutes of the proceedings of each meeting shall be furnished to the Governing Body members as soon a possible after completion of the meeting.

5.7 Executive Body

Chair-person : Medical Superintendent of the hospital

Member-Secretary : Senior Medical Officer of the District Hospital, nominated by Superintendent of the hospital

Members:

- PRI representative to the Governing Body
- District Collector's nominees to the Governing Body
- Representatives of institutional members, if any
- Additional members as may be co-opted by the executive Body

5.7.1. Meetings of the Executive Committee shall be convened by the Member Secretary by giving clear seven days notice in writing along with the Agenda specifying the business to be transacted, the date, time and venue of the meeting.

Frequency of meetings: Once every month

5.8 Regular Agenda

• Review of the OPD and IPD service performance of the hospital in the last month and service delivery targets for the next month.

• Review of the outreach work performed during the last month and outreach work scheduled for the next month.

•Consider reports of the Monitoring Committee for remedial action

• Implementation of the Citizens' Charter

The minutes of the Executive Committee meetings will be placed before the Governing Body at its next meeting.

5.9 Monitoring Committee

A Monitoring Committee could be constituted by the Governing Body to visit hospital wards and collect patient feedback. The Committee would send a monthly monitoring report to the District Collector and Chairperson, Zilla Parishad.

5.10 Bodies of the Society for sub-district level hospitals

5.10.1 Governing Body

Chairperson : Sub Divisional Magistrate / Block Development Officer, Panchayat Samiti

Co-chair : District programme officer (deputy CMO or equivalent) in charge

Member-Secretary : A Senior Medical Officer of the Hospital, nominated by Officer-incharge of the hospital Superintendent of the Hospital

Members:

- Officer-in-charge of the hospital
- An AYUSH doctor from a CHC
- Block level officers of ICDS, rural development, Panchayati Raj, Water and sanitation, education and social welfare
- Representative of health sector NGO working in the area
- An eminent citizen from the town / city, nominated by the District Collector
- An eminent citizen from the town / city, nominated by the Chairperson, Panchayat Samiti, Chief Executive Officer, Nagar Nigam (if applicable)
- Associate members/Institutional members: Same as for District Hospital Society
- PRI representative

Frequency of meetings and regular agenda: Same as for district hospital society

5.10.2. Executive Committee

Chairperson : Officer in charge of the hospital

Member secretary : Member Secretary of the Governing Body (Medical

Officer of the Hospital, nominated by officer in charge Superintendent of the Hospital

Members:

- Two PRI representatives to the Governing Body
- District Collector / SDM's nominee to the Governing Body
- Block level officers of ICDS, Water and sanitation and education
- Representatives of institutional members, if any

Frequency of meetings and regular agenda: Same as for district hospital society

5.10.3 Monitoring Committee

Could be on the same pattern as in District Hospital.

5.11 Provision of enabling rights, vesting assets & authorizing services

The Govt. may authorize transfer of existing facilities and assets free of cost and without any liability to the RKS / HMS of the concerned hospital. In most hospitals, the principle reasons for malfunctioning and deteriorating services are the inability to spend on new infrastructure for upgradation & modernization, paucity of funds for emergencies, gross mismanagement of resources and lack of motivation. Being a service oriented facility, it needs to permit and grant specific rights to allow freedom for operations and management. The RKS / HMS should be enabled with the decision making right to invest in order to meet service requirements. As mentioned above, user charges should be introduced, as it is believed that excellent health care on a continuous basis cannot be ensured without adequate financial provisions. Appropriate relaxations for BPL patients to be ensured, as per State policy.

5.12 Resource Mobilization

The funds of the Society shall consist of the following:

- Grant-in-aid from the State Government and/or State level society (societies) in the health sector and/or District Health Society.
- Grants and donations from trade, industry and individuals.
- Receipts from such user fees as may be introduced for the services rendered by the hospital.
- Receipts from disposal of assets.

5.13 Accounts and Audit

- The Society shall cause regular accounts to be kept of all its monies and properties in respect of the affairs of the Society.
- The accounts of the Society shall be audited annually by a Chartered Accountant firm included in the panel of Chartered Accountants drawn by the designated authority of the State Government.
- The report of such audit shall be communicated by the auditor to the Society, which shall submit a copy of the Audit Report along with its observation to the District Collector.

• Any expenditure incurred in connection with such audit shall be payable by the Society to the Auditors.

• The Chartered Accountant or any qualified person appointed by the Govt. of India/State Government in connection with the audit of the accounts of the Society shall have the same rights, privileges and authority in connection with such audit as the Auditor General of the State has in connection with the audit of Government accounts and in particular shall have the right to demand the production of books, accounts, connected vouchers and other necessary documents and papers.

5.14 Bank Account

The account of the Society shall be opened in a bank approved by the Governing Body. All funds shall be paid into the Society's account with the appointed bank and shall not be withdrawn except by a cheque, bill note or other negotiable instruments signed by the Member-Secretary of the Society and such one more person from amongst the Executive Committee members as may be decided by the Governing Body.

5.15 Annual Report

A draft Annual Report and the yearly accounts of the Society shall be placed before the Governing Body at its ensuing meeting that may be held in the first quarter of every financial year.

A copy of the annual report and audited statement of accounts as finally approved by the Governing Body shall be forwarded within six months of the closure of a financial year to the following:

- District Collector.
- Chair-person, Governing Body.
- Chair-person, Executive Body.
- Chair-person, Zilla Parishad.
- Chair-person, Urban Local Body [Nagar Nigam].

5.16 Suits and proceedings

• The Society may sue or be sued in the name of Society through its Member Secretary.

• No suit or proceedings shall abate by the reason of any vacancy or change in the holder of the office of the Chair-person or Member Secretary or any office bearer authorized in this behalf.

• Every decree or order against the Society in any suit or proceedings shall be executable against the property of the Society and not against the person or the property of the Chair-person, Member Secretary or any office bearer of the Society.

• Nothing in sub-rule as above shall exempt the Chair-person, Member Secretary or office bearer of the Society from any criminal liability or entitle him/her to claim any contribution from the property of the Society in respect of any fine to be paid by him/her on conviction by a criminal court.

5.17 Amendments

The Society may alter or extend the purpose for which it is established and/or the Rules of the Society, provided that such amendment shall only be carried out through the procedure set out in rule as above.

5.18 Dissolution

• The Governing Body may resolve to dissolve the Society by bringing a proposal to that effect in a special meeting to be convened for the purpose, provided that the proposal for dissolution has been duly approved /endorsed through the process prescribed for amendment as set out in rule as above.

• The dissolution proceedings shall be made in accordance with the provisions of the Act as amended from time to time in its application in the State.

• Upon the dissolution of the Society, all assets of the Society, after the settlement of all its debts and liabilities, shall stand reverted to the State Government for such purposes as it may deem fit.

5.19 Contracts

•All contracts and other instruments for and on behalf of the Society shall be subject to the provisions of the Act, be expressed to be made in the name of the Society and shall be executed by the persons authorized by the Governing Body.

•No contracts for the sale, purchase or supply of any goods and material shall be made for and on behalf of the Society with any member of the Society or his/her relative or firm in which such member or his/her relative is a partner or shareholder or any other partner or shareholder of a firm or a private company in which the said member is a partner or director.

5.20 Common seal

The Society shall have a common seal of such make and design as the Governing Body may approve.

5.21 Government power to review

The District Health Society shall review, monitor and evaluate the performance of the Rogi Kalyan Samities at the District/Sub District levels.

1. QUESTIONNAIRE (For Management level)

1. How many members in JDS ?
2. Who are the members in your samiti ?
3. How many times meeting of governing body were held in a year ?
4. How many times meeting of executive body were held in a month ?
5. How many members present in meeting?
6. What is the average time spent in a meeting ?
7. What are the facilitating and inhibiting factors affecting the functioning of Rogi Kalyan Samiti?

    a. Members not serious about JDS objectives
    b. Tendency of members to avoid meeting
    c. Confrontation among members
    d. Some members do whatever they like during meeting (one sided decision)
    e. No consensus for purchasing
    f. Decisions not implemented in time

8. What is the source of availability of funds and Revenue Generated by the JDS ?

    a. NRHM
    b. User fees(Charges)
    c. Cycle stand charges
    d. Rental charges (canteen and others shops)
    e. Charges from organized various institutional programs
    f. Donations

9. What is the pattern of utilization of funds made available to Rogi Kalyan Samiti?

    a. Payment of JDS members
    b. National Health Programmes at the hospital
    c. Organize outreach services / health camps
    d. construction and expansion in the hospital building
    e. scientific disposal of hospital waste
    f. Training for doctors and staff
    g. Subsidized medicine

h. Diagnostic facilities
i. Transport facility
j. subsidized food
k. Availability of drinking water
l. Cleanliness and renovation of bathroom
m. Infrastructure development (computer repair, electrics and electronic items
n. Renovation of hospital building
o. Making posters in hospitals
p. Specialization services through doctors
q. (POL)Petrol allowance

Questionnaire regarding Perception of clients (For Clients /old patients)

1. Were you satisfied with the cleanliness of the room of the district hospitals?
2. Were you satisfied with the cleanliness of the toilet of the district hospitals?
3. Were you satisfied with the transport facility provided from the Hospital?
4. Were you satisfied regarding availability of medicine in district hospital?
5. Were you satisfied with the investigation facility which is provided from the Hospital?
6. Were you satisfied with the Facilities Provided (emergency services) during night hours in the district hospital?
7. Were you satisfied with the Present Services (availability of doctors in hospitals) in the hospital?

2. GRAPHICAL INTERPRETATION

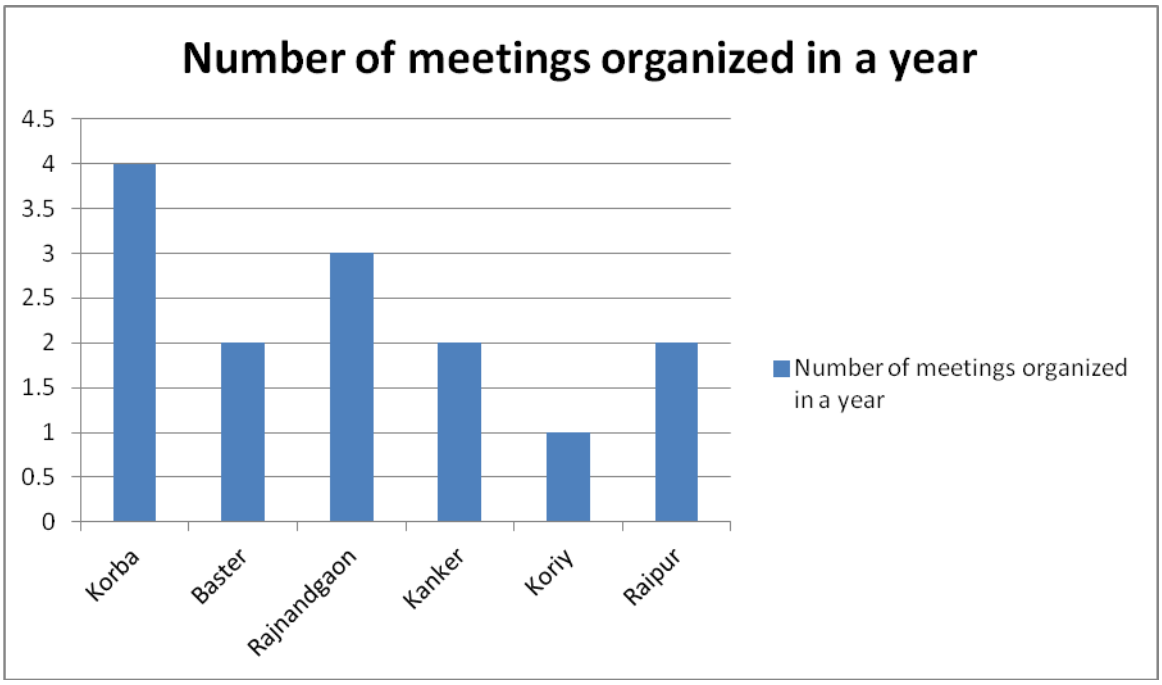

Figure 1 NO. OF MEETINGS ORGANIZEED IN A YEAR

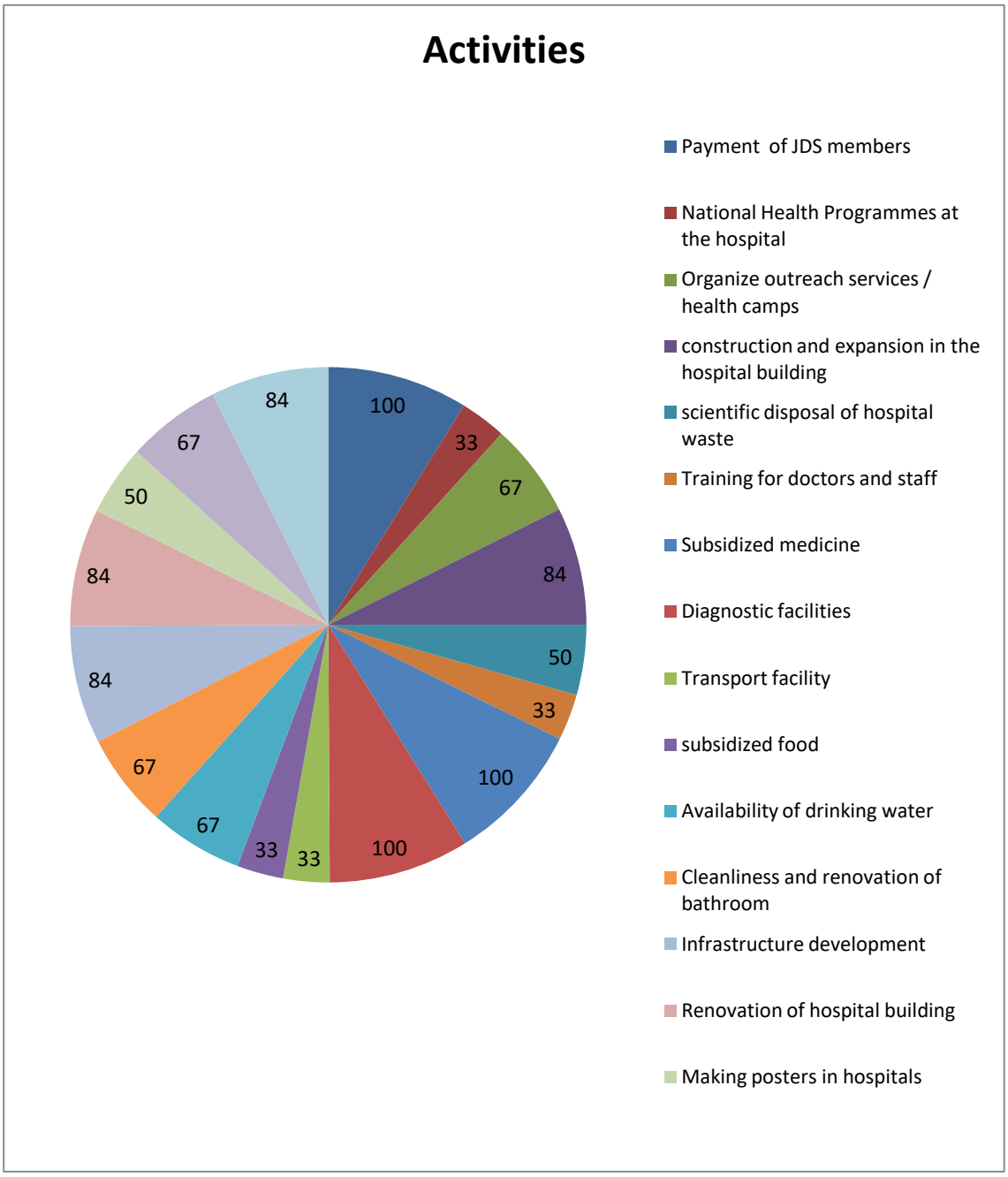

Figure 2 NO. OF ACTIVITY ORGANIZEED IN THROUGH JDS FUND

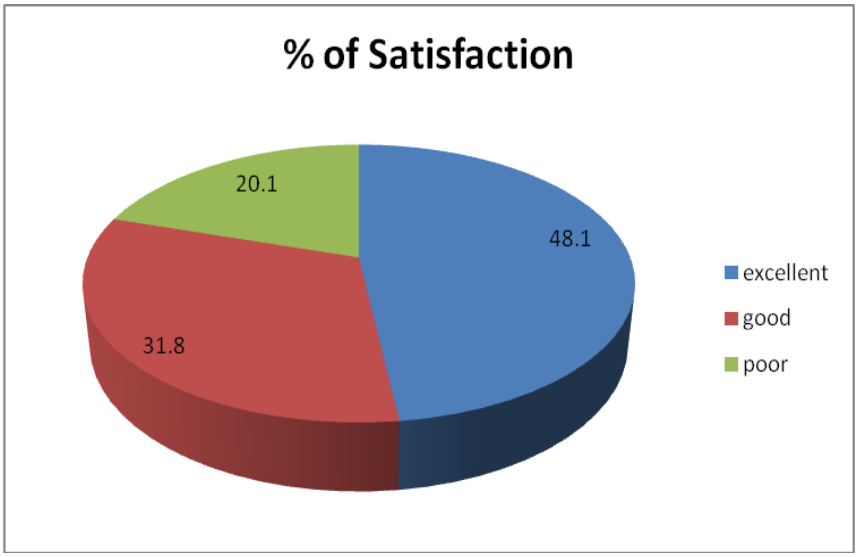

Figure 3 PERCENTAGE OF SATISFACTION LEVEL IN KORBA DISTRICT

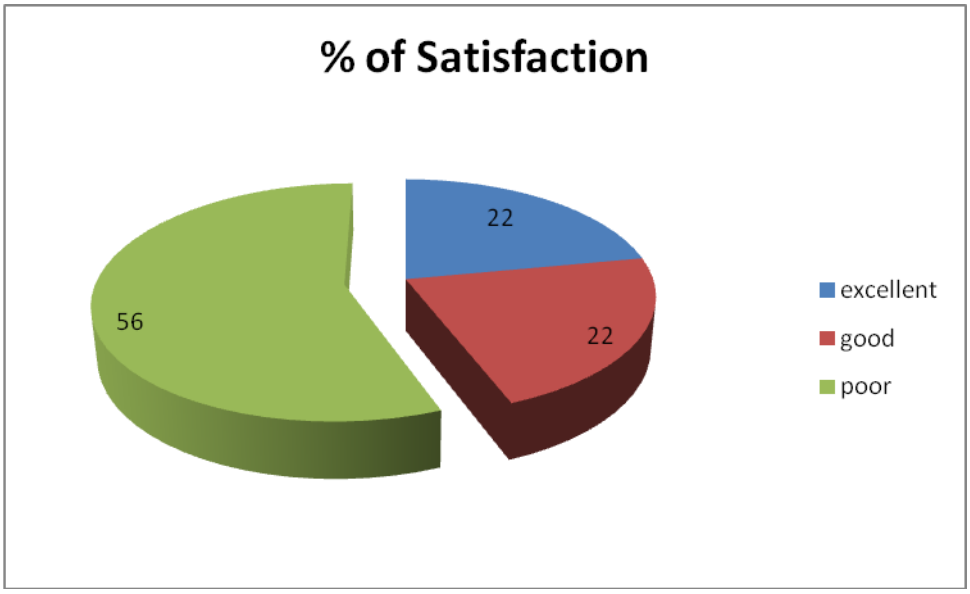

Figure 4 PERCENTAGE OF SATISFACTION LEVEL IN BASTER DISTRICT

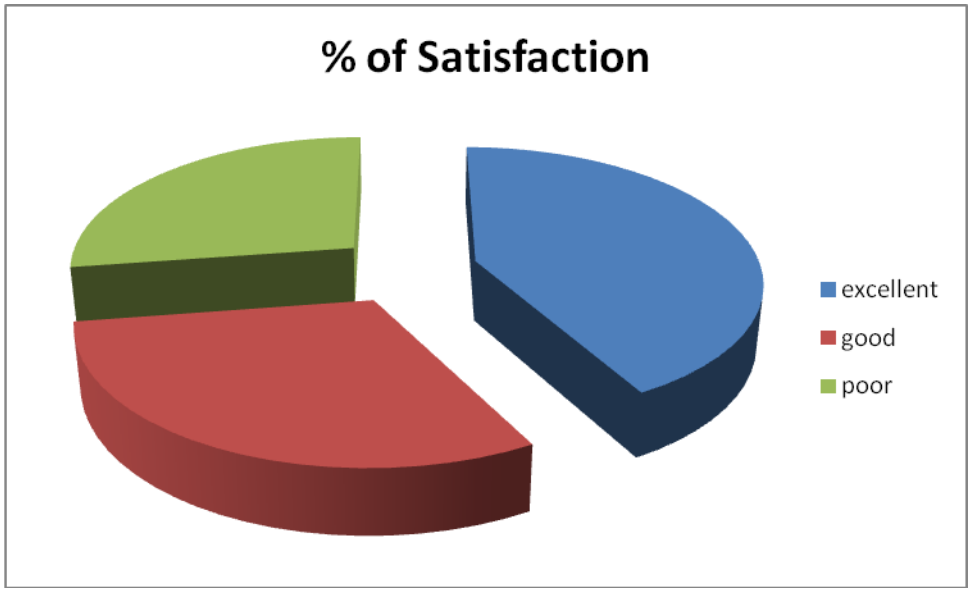

Figure 5 PERCENTAGE OF SATISFACTION LEVEL IN RAJNANDGAON DISTRICT

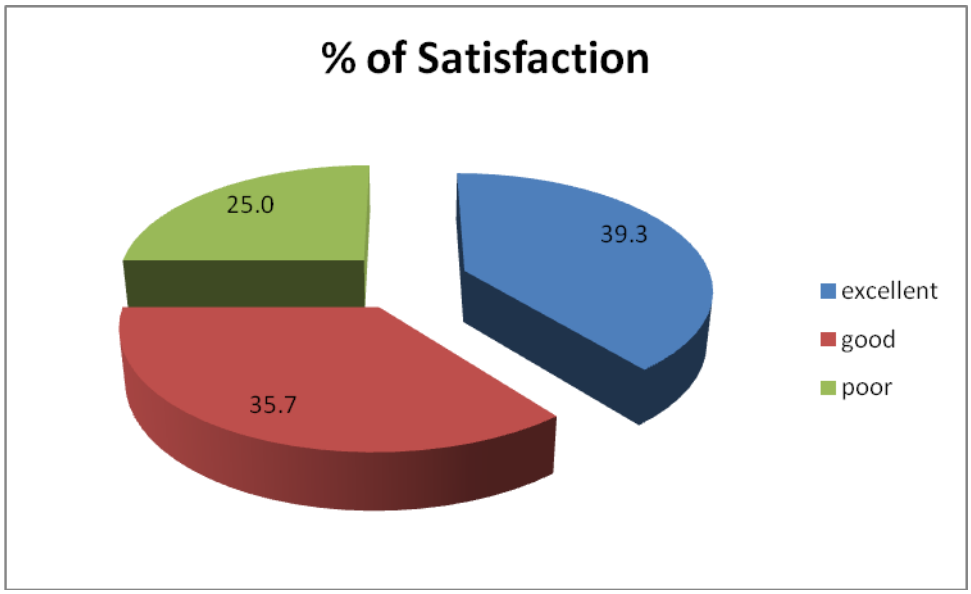

Figure 6 PERCENTAGE OF SATISFACTION LEVEL IN KAKNER DISTRICT

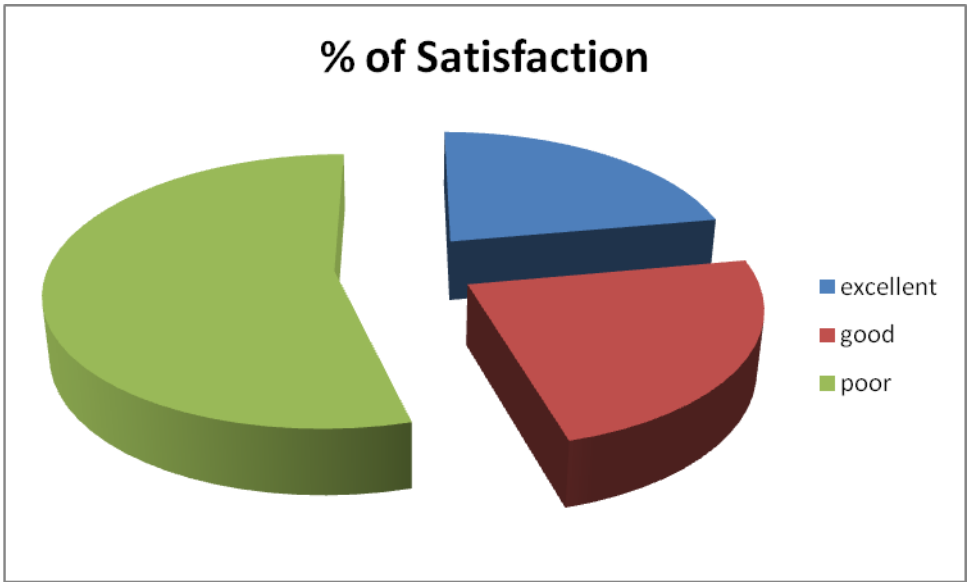

Figure 7 PERCENTAGE OF SATISFACTION LEVEL IN KORIYA DISTRICT

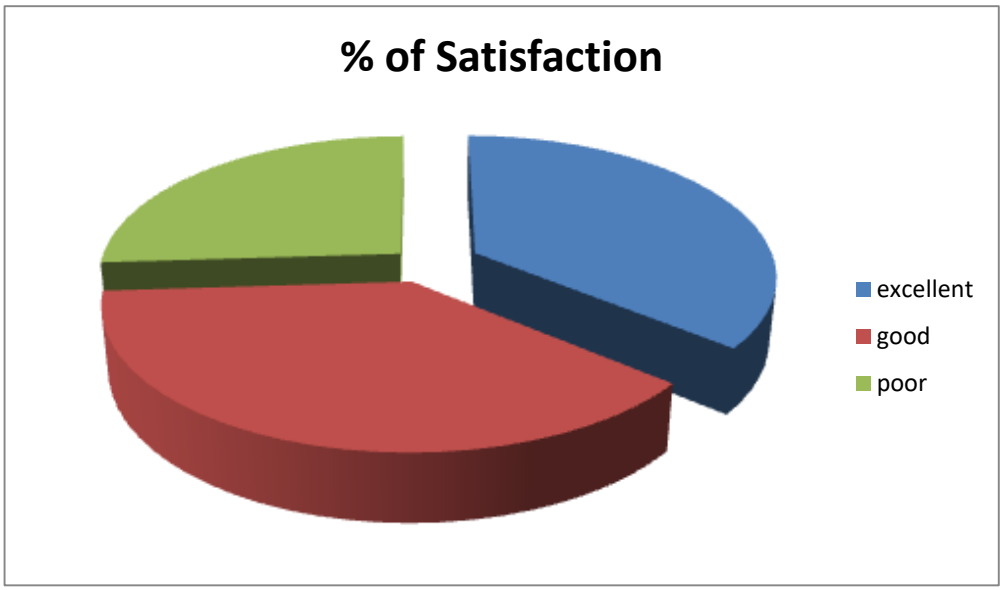

Figure 7 PERCENTAGE OF SATISFACTION LEVEL IN RAIPUR DISTRICT