सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

# HANDBOOK FOR MEMBERS OF ROGI KALYAN SAMITI

MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA

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# PURPOSE OF THE HANDBOOK

Rogi Kalyan Samitis (RKS) are health facility based committees established under the National Rural Health Mission (NRHM) and continued under the National Health Mission (NHM). The main purpose of RKS is to hold hospital administration and management accountable for ensuring access to equitable high quality services without financial hardship to service users and to enable community oversight in functioning of health facilities.

To date, despite a decade of implementation, progress in institutionalizing and strengthening RKS is variable across the states. Results of evaluation studies on RKS, Common Review Mission Report and field monitoring visits indicate several challenges. These challenges relate to governance and training of members, limited understanding of members on their roles and responsibility, lack of effective citizen feedback mechanism and no-use or inappropriate use of funds.

The **'Guidelines for Rogi Kalyan Samitis in Public Health Facilities'** were published in June 2015. These guidelines described the objectives of RKS, constitution of the Governing Body, Executive Committee and other governance committees, financial management and accounting, modalities to monitor quality and performance, create and foster mechanisms for grievance redressal and citizen feedback. The guidelines contained the mechanisms to steer RKS functioning in enabling appropriate responses to local needs, improving accountability and transparency, creating opportunities and building partnerships with civil society and other stake holders and improving service delivery.

In this handbook, the important chapters from the guidelines have been incorporated along with new chapters to make it comprehensive. This handbook sets out the key features and structure of the public health system, challenges to health care service delivery, the role of RKS in enabling quality health care services, and in ensuring equity, inclusion and preventing financial hardship. This handbook will help you as a member of RKS to build clarity on RKS functioning.

The training will enhance your understanding of the following topics:

- Public health system in India, NHM (NRHM and **National Urban Health Mission**) and their key components.
- National Health Programmes.
- Roles and Responsibilities of RKS.

- Resource mobilisation and funds management.
- Hospital management and facility development.
- Quality Assurance.
- Monitoring of services at health facilities.
- Patient rights and accountability mechanisms.
- Intersectoral linkages.

The States should contextualize and adapt this handbook to the local needs and situations.

CHAPTER 1

# HEALTH CARE SERVICE DELIVERY IN INDIA

## 1.1 HEALTH CARE SYSTEMS IN INDIA

The health care delivery system in India is a mixed one. It comprises of health facilities or individual providers, through the government, the private for profit sector or the non-governmental, not for profit sector. India has a dominant private sector providing care through single doctor clinics, dispensaries, nursing homes, poly-clinics and large corporate hospitals for tertiary care. Health facilities and practitioners of other indigenous systems of medicines such as- Ayurveda, Unani, Siddha, and Homeopathy also exist in both public and private sector.

In several parts of the country, particularly in remote areas, health care is provided by certain unregistered practitioners or informal providers.

## 1.2 STRUCTURE OF INDIA'S PUBLIC HEALTH SYSTEM

India's public health system is designed as a three tier health care system and this is seen in all states. This system is well defined in rural areas. In urban areas, the distinctions between the tiers are not very clear. There are several differences between the structure and functioning of urban and rural health facilities. Figure 1.1 and 1.2 demonstrates the structure of rural and urban health care facilities.

The pattern of staffing, population coverage and service availability at each of these tiers varies widely between states. However, there are a set of standards referred to as the Indian Public Health Standards (IPHS) that lay out the norms and standards of infrastructure, services, staff, and equipment at each level. The IPHS guidelines are good tools for normative planning.

The tables in **Annexure I** (Table I.a- I.d) encapsulate the service details for different types of health facilities PHCs/UPHCs, CHCs, Sub-Divisional Hospitals and District Hospitals under NRHM and **NUHM** both. The norms included here have been excerpted from the Indian Public Health Standards Guidelines 2012[1] and are presented for your understanding in a simplified format. The IPHS standards are also revised and updated periodically.

1 Training Programme for RKS members for each level of health care facility will cover specific norms for the particular facility type in greater details.

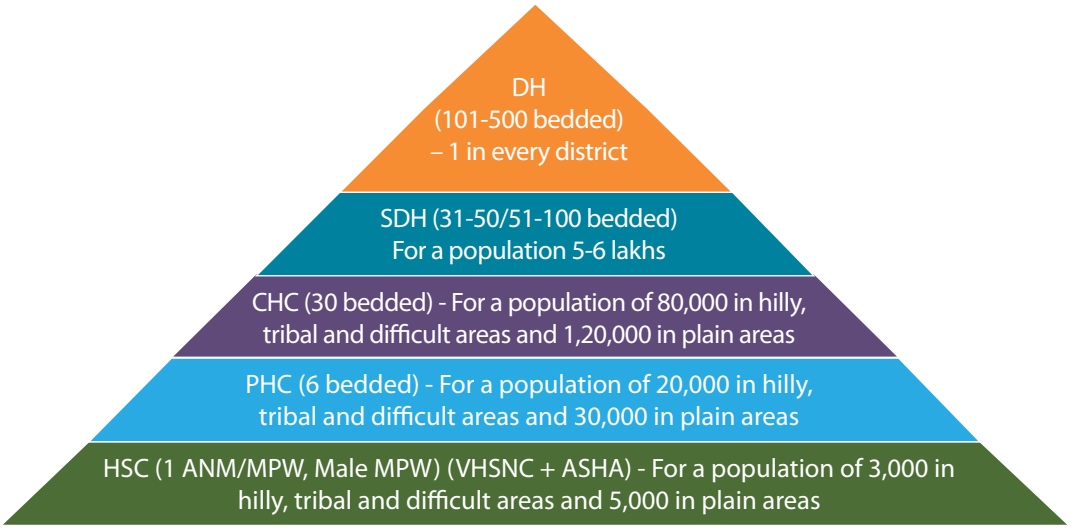



*Fig. 1.1 Rural Health Care Facilities*

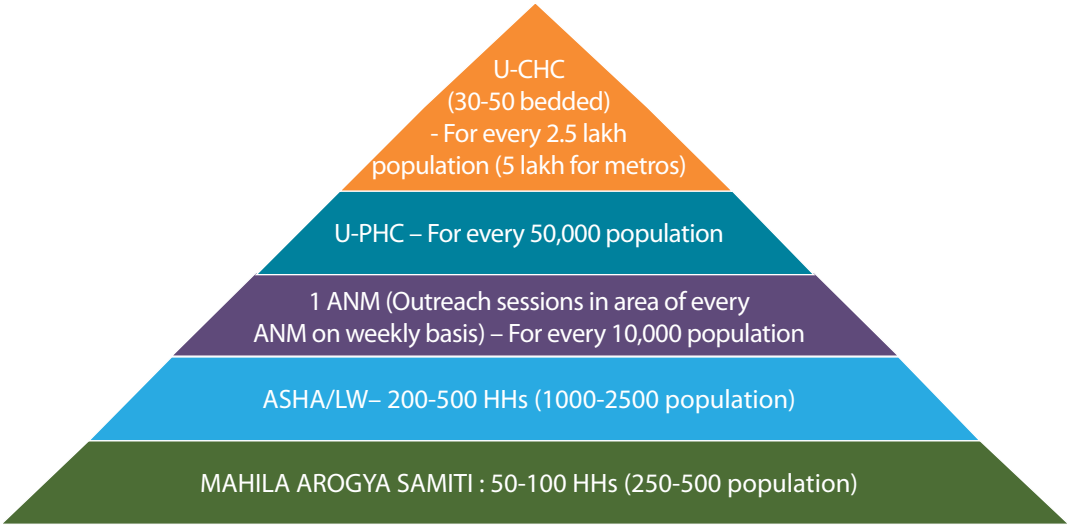



*Fig. 1.2 Urban Health Care Facilities*

## 1.3 CURRENT SITUATION OF HEALTH CARE SYSTEMS IN INDIA

- Changing disease patterns: There is growing burden of non-communicable diseases and re-emergence of some infectious diseases along with existing communicable diseases.[2] Non communicable diseases, like hypertension, diabetes, chronic vascular diseases and cancer etc. account for 60% of all deaths and significant morbidity. Maternal and child mortality has declined, but the rate of decline in still births and neonatal mortality is slow. More than a quarter of India's under five children suffer from malnutrition. Apart from this, we also have unaddressed areas like, geriatric care, palliative care, occupational health etc.
- Health care seeking behaviours: Owing to the presence of large private health care sector, it is seen that private doctors are the most common source of seeking treatment in both rural and urban areas. More than 70% (72%- rural and 79%- urban areas) of illness episodes are treated in the private sector (consisting of private doctors, nursing homes, private hospitals, charitable institutions, etc.). In the rural areas, 42% hospitalisations take place in public hospitals, and

2 Key indicators are presented in Table 1.2

58% in private hospitals. The corresponding percentages in urban India are 32% and 68% respectively.[3] This indicates that, use of public health facilities is lower than private, despite higher cost of treatment in private sector.

- Out Of Pocket Expenditure (OOPE): OOPE refers to the payments made by individual to health care provider at the time of receiving service. Sometimes patients pay upfront, but are covered under insurance schemes from which they claim reimbursements. OOPE means that, the person has to pay at the point of service delivery and is not protected from financial hardship. In India, OOPE occurs on drugs, diagnostics and consultations. OOPE exists both in public and private health care facilities. In public health facilities, all services are supposed to be free and patients are not supposed to incur OOPE, but latest National Sample Survey Organisation (NSSO) data shows that patients are incurring OOPE even in government health facilities. In 2011-12, the share of out of pocket expenditure on health care as a proportion of total household monthly per capita expenditure was 6.9% in rural areas and 5.5% in urban areas. This led to an increasing number of households facing catastrophic expenditures due to health costs (18% of all households in 2011-12 as compared to 15% in 2004-05).An increased care seeking in private sector, failure of public hospitals to meet the health care needs of people comprehensively and low coverage of population under schemes for financial protection has led over 63 million persons to face poverty every year due to health care costs alone.

## Table 1.1 Cost of Health Care in India (in Rs.)

| | Rural | | Urban | |
|---|---|---|---|---|
| | Public sector hospital | Private sector hospital | Public sector hospital | Private sector hospital |
| Non hospitalized treatment | 383.75 | 685 | 379 | 808 |
| Hospitalized treatment | 5,636 | 21,726 | 7,670 | 32,375 |

*Source: Social Consumption in India Health, National Sample Survey 71st Round, January to June 2014.*

**Challenges in health care delivery in the public health system**

- Perceived poor quality of services.
- Non-availability of staff in rural & remote areas.
- Absenteeism among doctors and other Para medical staff.
- Weak referral system.
- Low levels of public financing.
- Focus on provision of limited range of services, etc.

Effectiveness of care is further compromised due to lack of adherence to standards and protocols. The private health sector in India suffers from issues such as poor regulations, excessive/irrational medications, interventions, overcharging and unnecessary interventions, major variations in quality, violation of patients' rights etc.

## 1.4 IMPORTANCE OF STRENGTHENING OF PUBLIC HEALTH SYSTEM

It is important for us to recognize that in spite of the huge expansion of private sector and inadequacies of public health sector, **the vision of Health for All can be achieved only with an effective, efficient and accountable public health system**. National and international experiences highlight that public

3 Key Indicators of Social Consumption in India Health, NSS 71st Round, January to June 2014.

health services are the backbone of any system that guarantee access to quality health care services to all citizens of the country.

Some factors which necessitate continued strengthening of public health system are:

- Public sector service delivery is the only source of care in remote and hard to reach areas, while private sector reach is incentive driven and often does not prioritize covering these areas.
- Provision of health care by the public sector allows citizens to hold the Government accountable and to meaningfully demand of health as a fundamental right.
- The presence of a strong and reliable public health system also guards against the monopoly of private sector.
- Services for health promotion, prevention and health education activities are often not prioritized by private health providers.
- Services to the vulnerable and marginalized sections of the community can be assured better through public sector interventions.

**Table 1.2 Key Indicators**

| Indicator | Definition of Indicator | NFHS*-3 (2005-06) | NFHS-4 (2015-16) |
|---|---|---|---|
| Infant Mortality Rate (IMR) | Infant (0-1 year) deaths per 1000 live births. | 57 | 41 |
| Under 5 mortality Rate | Children (0-5) deaths per 1000 live births. | 74 | 50 |
| Unmet need for family planning | Percentage of currently married women of age 15-49 years, who are not using contraception, but who wish to postpone the next birth (spacing) or stop childbearing altogether (limiting). | 13.9 | 12.9 |
| Full Immunization | Children age 12-23 months fully immunized (BCG, measles and 3 doses each of polio and DPT) (%). | 43.5 | 62 |
| Children under 5 years who are wasted | Percentage of under five children with below the standard range of weight/ height for age. | 19.8 | 21 |
| Mothers who had full antenatal care | Full antenatal care is at least four antenatal visits, at least one tetanus toxoid (TT) injection and iron folic acid tablets or syrup taken for 100 or more days. (%) | 11.6 | 21 |
| Births in public health facility | Percentage of births in public health facility out of total births. | 18.0 | 52.1 |

**NFHS: National Family Health Survey*

*Doctor/population ratio: India has one doctor per 1674 population.*

*Bed/population ratio: Average population served per Government hospital bed is 879.*

CHAPTER 2

# NATIONAL HEALTH MISSION AND COMMUNITY OWNERSHIP

## 2.1 THE NATIONAL HEALTH MISSION

National Rural Health Mission was launched in 2005 to provide accessible, affordable and quality health care to people living in rural areas of our country. The Mission aimed to reduce maternal and child deaths and provide better access to health services especially to the vulnerable sections. In 2013, the NRHM was subsumed under National Health Mission, which now has another sub-mission **National Urban Health Mission**, to address health care needs of people living in urban areas. The vision of the National Health Mission is "Attainment of Universal Access to Equitable, Affordable and Quality health care services, accountable and responsive to people's needs, with effective inter-sectoral convergent actions to address the wider social determinants of Health".

All implementation strategies of NHM rest on the following core values:

| | |
|---|---|
| SAFE GUARDING HEALTH FOR POOR | • Reaching the vulnerable and disadvantaged sections and moving towards a right based approach through guaranteeing services and entitlements |
| STRENGTHENING PUBLIC HEALTH SYSTEMS | • As a basis for universal access<br>• For social protection against rising costs of health care |
| BUILDING TRUST | • Between Service Providers and People seeking care |
| EMPOWERING COMMUNITY | • To become participants in attainment of highest possible level of health care |
| IMPROVING EFFICIENCY | • For optimum use of resources |
| INSTITUTIONALIZING TRANSPARENCY AND ACCOUNTABILITY | • In Processes and implementation Mechanisms |

## 2.2 IMPORTANCE OF COMMUNITY PARTICIPATION

Community Participation as a strategy for health system strengthening includes identification of health problems and measures to address these problems by the members of the community while social inclusion ensures that, equitable and inclusive health services are accessible to all sections of society.

The National Health Mission lays emphasis on institutionalizing community led action for health. Such an action is possible when the community is sufficiently empowered to voice its health needs, takes ownership and participates in the management of public health systems. Globally, studies have shown that communities with high rates of participation in decision making and monitoring of health facilities are able to ensure increased accountability and equity and achieve better health outcomes. A major issue in improving public sector service delivery is lack of accountability and transparency. Community Participation and involvement of members from the community in RKS platforms is an important measure to address this issue.

The key features of the National Health Mission which facilitates this publicaction are:

- Decentralized Health planning involving Panchayats, Urban Local Bodies and representatives at district, block and village levels.
- Creating arrangements as facility for community involvement in planning, management and monitoring of the Mission through setting up of Community based Planning and Monitoring Committees at State, district, block level; Rogi Kalyan Samiti at District Hospitals, CHCs and PHCs; Village Health and Sanitation Committees or Mahila Arogya Samitis in every village/ ward level.
- Fostering community health workers in the form of ASHAs.
- Health standards for health facilities like Primary Health Centers, Community Health Centres, Sub-Divisional and District Hospitals.
- Enabling adherence convergence between various departments like Rural development (RD), Local self-governments, Health, Public Health Engineering (PHE), Women and Child Development (WCD) in order to improve access to public services.
- Using grievance redressal mechanism for increased accountability.

## 2.3 SOCIAL ENTITLEMENTS AND COMMUNITY/PATIENT BENEFIT PACKAGES

Various central government programmes including the National Health Mission and state initiatives (which vary from one state to another) provide welfare schemes for people seeking health care. As an RKS member you need to be aware of all such schemes. An indicative list of the schemes available under the central government is as follow:

- Janani Suraksha Yojana (JSY)
- Janani Shishu Suraksha Karyakram (JSSK)
- Navajat Shishu Suraksha Karyakram (NSSK)
- Rashtriya Kishor Swasthya Karyakram (RKSK)
- Pradhan Mantri Swasthya Suraksha Yojana (PMSSY)
- Rashtriya Arogya Nidhi

- Rashtriya Bal Swasthya Karyakram (RBSK)
- Rashtriya Swasthya Bima Yojana (RSBY)
- Antyodaya Anna Yojana (AAY)
- Deendayal Disabled Rehabilitation Scheme
- Indira Gandhi Matritva Sahyog Yojana
- Pradhan Mantri Suraksha Bima Yojana
- Pradhan Mantri Jeevan Jyoti Bima Yojana

CHAPTER 3

# PURPOSE AND OBJECTIVES OF THE ROGI KALYAN SAMITI

## 3.1 WHY ROGI KALYAN SAMITIS?

To ensure community involvement, NHM has created institutional structures at various levels. These structures have representatives of the community, civil society and other stakeholders. ASHA and Village Health Sanitation and Nutrition Committees serve as village level structures for enabling community involvement in implementing, monitoring and planning health programmes at village level. At the health facility level, RKS was made functional as a registered society, to manage the day to day affairs of health facilities in consonance with the principle of patients' welfare, decentralization and devolution of administrative and financial powers. It consists of members from Panchayati Raj Institutions (PRIs), NGOs, persons of eminence, and officials from Government sector including health, who are responsible for proper functioning and management of the facilities. RKS has been given autonomy to prescribe, generate and use its funds as per its best judgment for smooth functioning and maintaining the quality of services. The NHM also provides a budgetary allocation to the RKS at all facility levels.

Community Participation in context of RKS implies - communities participating in pre-planned schemes and programmes of the government, empowering communities (or their representatives) and active community involvement in all stages of- planning, implementation, monitoring and evaluation of any process, programme or such initiative. Of course community members may not have the technical knowledge regarding a particular programme, but this does not mean they do not have valuable resources to contribute. They have a much deeper understanding of the local context, dynamics, health behaviours and motivations and preferences that any health official can hope for.

## 3.2 OBJECTIVES OF THE ROGI KALYAN SAMITIS

The following are the broad objectives of the RKS:

1. The RKS serves as a consultative body to enable active citizen participation for the improvement of patient care and welfare in health facilities.
2. Ensure that essentially no user fees or charges are levied for treatment related to care in pregnancy, delivery, family planning, postpartum period, new born and care during infancy, or related to childhood malnutrition, national disease control programmes such as Tuberculosis,

Malaria, HIV/AIDS, etc. and other government funded programmes which are provided as assurance or service guarantees to those accessing public sector health facilities.

3. Decide on the user fee structure for outpatient and inpatient treatment, which should be displayed in a public place and be set at, rates which are minimal and do not become financial barrier to accessing health care.
4. Ensure that those patients who are Below Poverty Line, vulnerable and marginalized groups and other groups as may be decided by the state government, do not incur any financial hardship for their treatment, and create mechanisms to cover part/full costs related to transport, diet, and stay of attendant.
5. Develop mechanisms to guard against denial of care to any patient who does not have the ability to pay, especially for services that are being provided at the government's expense.
6. Ensure provision of all non-clinical services and processes such as provisioning of safe drinking water, diet, litter free premises, clean toilets, clean linen, help desks, support for navigation, comfortable, patient waiting halls, security, clear signage systems, and prominent display of Citizens' Charter in the local language.
7. Ensure availability of essential drugs and diagnostics, and use of standard treatment protocols/ standard operating procedures, patient safety, effective mechanisms for maintaining patient records, periodic review of medical care/deaths.
8. The RKS, as a part of the endeavour to enable assured health services to all who seek services in the government health facility will allow the hospital in charge to procure essential drugs/ diagnostics not available in the health facility out of the RKS funds. Such local purchases must be made only as a short term interim measure. The Executive Committee will review such purchases in each meeting and ensure that the rationale for the purchase is justified and that this is not undertaken repeatedly.
9. Promote a culture of user-friendly behaviour amongst service providers and hospital staff for improved patient welfare, responsiveness and satisfaction through inter-alia organizing training/orientation/sensitisation workshops periodically.
10. Operationalize a Grievance Redressal Mechanism including a prominent display of the" Charter of Patient Rights" **(Annexure II)** in the Health facility and address complaints promptly thus building confidence of people in the public health facilities.
11. Create mechanisms for enabling feedback from patients, at least at the time of discharge and take timely and appropriate action on such feedback.
12. Undertake special measures to reach the unreached/disadvantaged groups e.g. Campaigns to increase awareness about services available in the facility.
13. Ensure overall facility maintenance to ensure that the facility conforms/aspires to conform to the IPHS.
14. Supervise, maintain, and enable expansion of hospital building for efficient and rational use and management of hospital land and buildings.
15. Facilitate the operationalization of National and State Health programmes as appropriate for the level of the facility.
16. Proactively seek out participation from charitable and religious institutions, community organisations, corporates for cleanliness and upkeep of the facility.
17. Facilitate participation and contribution from the community in cash/kind (drugs/equipment/ diet), labour including free professional services.

CHAPTER 4

# STRUCTURE AND COMPOSITION OF RKS

The RKS would comprise of a Governing Body (GB) and an Executive Committee (EC). The GB will be responsible for broad policy formulation and oversight and the EC for implementing policy decisions and facilitating operation of patient centric services.

## 4.1 GOVERNING BODY

### 4.1.1 Composition of Governing Body (GB) of RKS at District Hospital

**Chairperson:** In-charge Minister/ local MP/President Zila Panchayat/ District Magistrate.

**Member Secretary:** Medical Superintendent/Civil Surgeon/Hospital- in- charge.

Members (Ex-officio):

1. District Magistrate, (if not chairperson).
2. Local MLA, in whose jurisdiction the health facility is located.
3. Chairperson-Zila Panchayat.
4. Mayor/Chairperson of the Urban Local Body at the District Hospital headquarters.
5. Chief Executive Officer, District Panchayat.
6. Commissioner/Chief Municipal Officer, Municipal Corporation/Council.
7. Chief Medical and Health Officer.
8. Medical Superintendent In-charge of DH- Member Secretary.
9. District AYUSH Officer.
10. District Officer of Departments of Women and Child Development, Water and Sanitation, Education, Social Welfare, Public Health Engineering Department, Public Works Department, (including Electrical and Mechanical), Electricity Board.
11. Individuals/Institutional donors who contribute equal to or more than the stipulated amount for associate membership.

Nominated Members (names to be recommended by Member Secretary/District Magistrate)

1. Three eminent citizens, of whom one must be a female, nominated by the Chairperson from the names recommended by Member Secretary/District Magistrate.
2. Two Civil society representatives.
3. One Representative of local medical college, if any.

The senior specialists in-charge of different wards and DPHN/Nurse Matron should be invited as permanent special invitees.

**Composition of Sub-District Hospital/Community Health Centre RKS:**

**Chairperson: Member of Legislative Assembly/Sub District Magistrate/Block Development Officer Panchayat Samiti**

**Member Secretary: Medical Superintendent/MO in-charge of the facility.**

1. Members would include Block Medical Officer, AYUSH doctor from CHC, Block Development Officer, Programme Officer, ICDS, Block Education Officer, block level representatives of Education, Drinking Water and Sanitation, Social Welfare.
2. Two eminent citizens and two civil society representatives.

**Composition of Primary Health Centre RKS:**

Members would include AYUSH Medical Officer, Anganwadi Supervisor, two eminent citizens, two civil society representatives, Chairperson/member of Janpad Health Sub-Committee, School headmaster.

*Associated Members:*

An individual who makes a one time donation of a Rs. 100,000 for District Hospital, Rs. 50,000 for a Sub-district hospital/CHC or Rs. 25,000 to PHC shall be offered an associated membership for period of two years. State could adapt the donation amount appropriate to their context.

*Institutional Members:*

Any institution, which donates Rs. 2,50,000/- or more for District Hospital, Rs. 1,25,000 in case of Sub-district hospital/CHC and Rs. 50,000 in case of PHC or adopts a ward of the hospital and bears the cost of its maintenance in case of District Hospital, may be made eligible to nominate a person from the institution as a member of the GB of the society. The institution/nominated person shall be offered an associate membership for a period of two years. However, they would not have voting rights and the adopted ward shall function within the overall ambit of the public health facility.

## 4.1.2 Roles and Functions of the Governing Body (GB)

1. The GB will have full control of the affairs of the Society and will have the authority to exercise and perform all the powers, acts and deeds of the Society consistent with the aims and objects of the Society.
2. The GB shall take policy decisions related to overall functioning of the RKS which would be implemented by EC of RKS.

3. The GB may formulate, 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 submitted to the State Government for its consideration and approval.
4. The GB shall review income & expenditure statements, consider the annual budget and the annual action plan of the committee, subsequent alternations placed before it and pass it with such modifications as the GB may think fit.
5. The GB shall monitor the financial position of the Society in order to ensure smooth income flow and review annual audited accounts.
6. The GB shall accept donations, endowments, contribution in terms of equipment, goods and services etc.
7. The GB shall 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.
8. The GB shall review compliance to Indian Public Health Standards, and performance of public grievance redressal at facility level. It will also review compliance to standards and protocols, and reports of the monitoring committee on quality assurance.
9. The GB shall undertake measures to increase transparency in financial and operational management of the hospital.
10. The GB shall provide the guidance for setting of user fees for inpatient and outpatient treatment, for proposals to raise revenues through use of hospital buildings and land such as, renting/ leasing land to credible, not for profit groups working for patient welfare and commercial activities of a nature that contribute to the interest of patients (fruit shops, shops selling daily amenities, etc).
11. The GB shall consider and approve financial proposals that are beyond the powers of the Executive Committee; i.e. over Rs. 10 lakhs at the level of the DH, Rs. 7 lakhs at the CHC, and Rs. 2 lakhs at the PHC.
12. The GB shall have powers to engage Chartered Accountant for audit purposes for a period not exceeding three years.
13. The GB shall have powers to constitute sub committees for specific purposes such as new constructions, commercial use of land etc.
14. All assets created by the RKS shall be considered the property of the facility which shall then be required to undertake maintenance of the said asset.

### 4.1.3 Powers and Functions of the Chairperson of the GB

1. The Chairperson shall have the powers to call for and preside over all meetings of the GB.
2. The Chairperson shall enjoy such powers as may be delegated to him by the Society and the GB.
3. 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.
4. All disputed questions at the meeting of the GB shall be determined by votes. Each member of the GB shall have one vote and in case of a tie, the Chairperson shall have a casting vote.
5. Should any official members be prevented for any reason whatsoever from attending a meeting of the GB, the Chairperson of the Society shall be at liberty to nominate a substitute to take his place at the meeting of the GB. Such substitute shall have all the rights and privileges of a member of the GB for that meeting only.

6. Any business which may become necessary for the GB to perform, except the agenda prescribed for the full meeting 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 GB provided that at least one third members of the GB have recorded their consent of such resolution.
7. In the event of any urgent business, the Chairperson of the Society may take a decision on behalf of the GB at the recommendation of Vice-Chairperson and Member Secretary. Such a decision shall be reported to the GB at its next meeting for ratification.
8. A copy of the minutes of the proceedings of each meeting shall be furnished to the Chairperson as soon as possible after completion of the meeting.

### 4.1.4 Member Secretary of the GB

Member Secretary of the GB shall facilitate all meetings of the GB or any subcommittee, record proceedings and resolutions and act upon them. The annual plan must be based on the gaps identified in providing quality health services in the respective institutions and in villages under its jurisdiction. It should be in tune with the funds available at respective institutions. It can be revised after review in GB meeting.

**Powers of Member Secretary-GB**

1. All executive and financial powers of the society shall vest in the Member Secretary who shall be responsible for following functions:
   i. Manage day to day administration of society.
   ii. Conduct all correspondence on behalf of society on all matters.
   iii. Arrange for custody of all records and movable properties of society.
2. To determine and make arrangements as to who shall be entitled to sign on behalf of society bills, receipts, vouchers, contracts and other documents whatsoever.
3. To form a subcommittee to perform some task and delegate any of the powers to these subcommittees.
4. Take action on urgent important matters in consultation with Vice – Chairperson and Chairperson and place before GB in next meeting.
5. Exercise such powers and discharge such functions as may be delegated to him by the GB.
6. For day-to-day work decisions, the EC will guide Member Secretary.

### 4.1.5 Proceedings of the GB

1. The members in the committee should meet the eligibility criteria for membership.
2. The GB must meet as often as required, but at least bi-annually to review the progress and functioning of RKS.
3. One third of the members of the GB, present in person, shall form a quorum at every meeting of the GB.
4. The proceedings of the meeting should be recorded in writing.
5. No member of the Society or its GB shall be entitled to any remuneration.

## 4.2 EXECUTIVE COMMITTEE-RKS

### 4.2.1 Composition of the Executive Committee (EC) of the RKS at District Hospital

**Chairperson:** District Magistrate.

**Member Secretary:** Civil Surgeon/ Hospital in charge.

**Members (Ex-officio):**

1. Chairperson of Standing Committee on Health of Zila Panchayat.
2. Chief Executive Officer, District Panchayat.
3. Commissioner/Chief Municipal Officer, Municipal Corporation/Council.
4. Chief Medical and Health Officer.
5. District AYUSH Officer.
6. District Officer of Departments of Women and Child Development, Water and Sanitation, Education, Social Welfare, Public Health Engineering Department, Public Works Department, (including Electrical and Mechanical), Electricity Board.
7. Individuals/ institutional donors who contribute equal to or more than the stipulated amount for associate membership.
8. Senior specialists in-charge of different wards and DPHN/Nurse Matron.

**Nominated Members:**

1. Three eminent citizens, of whom one must be a female, nominated by the Chairperson.
2. Two Civil society representatives.
3. One Representative of local medical college, if any.

**Structure at Sub-District Hospital/Community Health Centre RKS: (Sub district level- covering more than one block)**

1. Chairperson should be Sub-District Magistrate and Member Secretary should be the Medical Superintendent/MO in-charge of the facility.
2. Members would include one PRI representative who should be Chairperson of the Health Sub- Committee of the Janpad Panchayat/Block Panchayat.
3. Block Medical Officer, Block level officers of ICDS, Water and Sanitation and Education.
4. Two eminent citizens and two civil society representatives that are GB members.
5. Individuals/institutional donors who contribute equal to or more than the stipulated amount for associate membership.

Chairperson may call such other Officer/person as special invitee.

**Structure at Primary Health Centre RKS: (at block level)**

1. Chairperson should be Medical Officer and Member Secretary AYUSH MO or Staff nurse nominated by the MO I/C.
2. Members would include one nominated Pharmacist, the CDPO, block staff of DWS, and Education, Chairperson/Member, Janpad Panchayat-Health Sub-committee.

### 4.2.2 Powers and functions of Executive Committee (EC)

1. Meetings of the EC 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.
2. The EC will meet at least once in two months.
3. The quorum will be 50% members. The presence of the Chairperson will be essential.
4. Executive Committee will implement the decisions taken by the Governing Body and will function within its powers.
5. The minutes of the Executive Committee meetings will also be communicated to the members of GB.
6. Executive Committee can delegate some of its financial powers to the Member Secretary.
7. The EC may constitute the following committees:
   - Committees on Quality assurance,
   - Purchase Committee (**Annexure III**),
   - Committee for Emergency management,
   - Financial Audit Committee,
   - Medical Audit Committee,
   - Committee for Information, Education and Communications (IEC).
8. Review compliance to the Patient's Charter displayed in the Hospital, establish a system of public grievance redressal at facility level and monitor the effectiveness of the Grievance Redressal Mechanisms, especially feedback and take corrective action to ensure non recurrence of grievances.
9. Facilitate a process to collect feedback from outpatients and inpatients through a feedback form **(Annexure IV &V)**, which will be reviewed with the hospital staff, for timely action including rewards, punishments and appropriate capacity building.
10. Review the service performance of the Out Patient Department and Inpatients Department on a quarterly basis.
11. Review the quality and range of services provided to patients, particularly the poor and marginalized and ensure that financial hardships are minimal to all patients.
12. Review the Key Performance Indicators (KPIs) (**Annexure VI**) and the action plan prepared by the Quality Team of the health facility and monitor the improvements on reduction of gaps pointed out by the Team. RKS members are not supposed to collect the primary data on the KPI. Completing the KPI formats is the task of nodal officer/hospital manager who is responsible for the process of quality assessment. The task of the RKS members is to review the KPI and assess facility performance on a quarterly basis.
13. Review and monitor the Patient Satisfaction Score prepared by the Quality Team.
14. Review the status of utilization of funds, equipment, drugs and any other assistance received under different programmes of the Government (State and centre).
15. Be authorized to raise funds for the activities approved by Governing Body.
16. Work towards securing tax exemption and requisite clearances from the IT department and other concerned state and central departments.

17. While the RKS cannot make regular permanent appointments, it can contract in the services of specialists, Medical/Para medical staff, professional counsellors. Such contracting in could also include specific specialist services: anaesthesia, radiology, obstetrics, etc. The contracts would be approved by the EC and reviewed periodically (say one year) and renewed if appropriate.
18. RKS may outsource the cleanliness, security, laundry and other supportive services. It may contract-in services of individuals for supportive service functions on a short term basis only and decide the remuneration of the maintenance and other support staff engaged out of RKS funds.
19. Organize periodic camps for medical and surgical services and follow up care, provided by super specialists to improve patient access for care requiring consultation/surgical procedures by super specialists.
20. Collect user charges as per the GB's decision from those who are not poor.
21. Purchase equipment, drugs, furniture, Pathological reagents, X-ray films in consultation with the Senior Medical Officer and ensure that all purchases are to be made in case of emergency only and should not substitute the existing process of purchase.
22. Ensure rational allocation of resources to patient welfare i.e giving priority to needs of poor and vulnerable population by providing free drugs and supplies, diagnostics (within hospital or through an empanelled facility), diet, transport etc.
23. Ensure smooth functioning including scientific disposal of bio-medical waste & maintenance of equipment etc.
24. Hospital maintenance i.e minor repair, construction, amenities for patients like waiting area, drinking water provisioning, dietary services for patients (with and sans payment), etc, will be funded out of RKS funds.
25. The primary objective of RKS funds is for patient welfare. Funding for staff welfare amenities and incentives for service providers/facility teams for high levels of performance above expected, should be taken only from revenue generated by service provision and it should not exceed, 15% of such funds in a DH, 25% in a CHC and 40% in a PHC. In no event shall less than two thirds of revenue derived from service provision be spent on patient welfare. These revenue earnings should be from user fee from non- poor/earnings on account of service provision under insurance/insurance like scheme/reward on account of quality certification. However, higher incentives may be provided where it is specifically so provided under a government programme/government funded insurance scheme. No incentives to service providers are to be provided on a percentage basis on income earned through rentals, leases, donations etc.
26. Enter into partnerships, if necessary, for contracting the provisioning of sophisticated diagnostic procedures such as Sonography, CT Scan, MRI, dialysis, etc. for such duration as appropriate and ensuring transparency of tendering and contracting.
27. Enable wide dissemination of the facilities provided by the RKS for patient welfare.
28. Open RKS account in a scheduled commercial bank.
29. Ensure annual audit of financial accounts of RKS.
30. The EC could carry out any other activities/functions to fulfill the mandate of the RKS excepting those that are specifically not permitted under the National Guidelines/State Government orders e.g. regular recruitments, remuneration to members or office bearers of GB and EC of RKS.

## 4.3 MONITORING COMMITTEE

A Quality Assurance and Monitoring Committee may be constituted by the Governing Body. The Committee should have representation of non-official members also. These committees will be trained in monitoring and conducting assessments, conduct exit interviews of a predefined sample of Out-patients and In-patients, collect patient feedback on a fixed day of the month. The Committee would send a monthly monitoring report to the District Magistrate with copy to Superintendent.

The monitoring committee shall work under the overall supervision of RKS. The members of the committee shall be selected by the GB through its periodic meetings. The committee shall consist minimum of three members and maximum of five members.

- At least one of the members shall be from the EC/GB of the RKS.
- At least one of the members shall be from a Civil Society Organisation (CSO).
- At least one of the members shall be a female for a three-member monitoring committee and at least two members shall be female for a five-member monitoring committee.

A representative list of activities that shall be undertaken by the monitoring committee are below:

- The committee shall conduct periodic (preferably monthly) surveys through feedback forms both at IPD and OPD.
- The committee shall review the Key Performance Indicators of the hospital.
- The committee shall collect information regarding attendance of hospital staff.
- The committee shall collect information of stocks available in the hospital.
- The committee can also interview patients/attendants on a random basis.

In the latter part of the handbook in Chapter 5, there is a session on 'Monitoring Service Delivery Quality in Health Care Facilities'. The monitoring committee shall conduct all these activities on behalf of the RKS to assess service quality and patient satisfaction.

The committee is responsible for providing a monthly monitoring report to the EC marking a copy to the GB. The monitoring report shall have two sections:

1. The findings of the monitoring committee.
2. Recommendations of the monitoring committee.

The EC is bound to discuss the findings and recommendations of the monitoring committee during its periodic meetings. All members of monitoring committee shall receive a copy of the EC/GB meeting minutes.

CHAPTER 5

# FUNCTIONS OF RKS

All health care facilities undertake activities for the delivery of health services. Members of RKS **are not expected** to participate in the day to day administrative functions of the health care facilities but, to facilitate the process of improvements in hospital management/facility development, so as to enable people centred health care.

The functions of health facilities providing outpatient and inpatient care are:

1. **Clinical Activities**: Clinical consultation by doctors, doctors and nurses treating patients in wards, surgical procedures, handling of acutely ill patients and emergency patients, dispensing of drugs, diagnostic procedures, counselling services, patient referral, blood bank and transfusion related services, etc.
2. **Administrative Activities**: Patient registrations, managing flow of patients, supporting patient navigation, maintenance of health records, accounting/fund management activities, inventory management, procurement and outsourcing, supervision of clinical, paramedical, administrative or support staff by hospital in-charges, training of administrative and clinical staff, etc.
3. **Supporting Activities**: Maintenance of sanitation and cleanliness in health facility, management of bio-medical waste including liquid waste, amenities in waiting area, maintenance/upkeep of inpatient wards-clean beds and surroundings, maintenance of equipment at the facility, infrastructure, transport related activities, provision of diet, provision of potable water, provision of medical gases, regular power supply, information to patients, activities related to safety and security of patients, staff and premises.

**Functions of the RKS Members:**

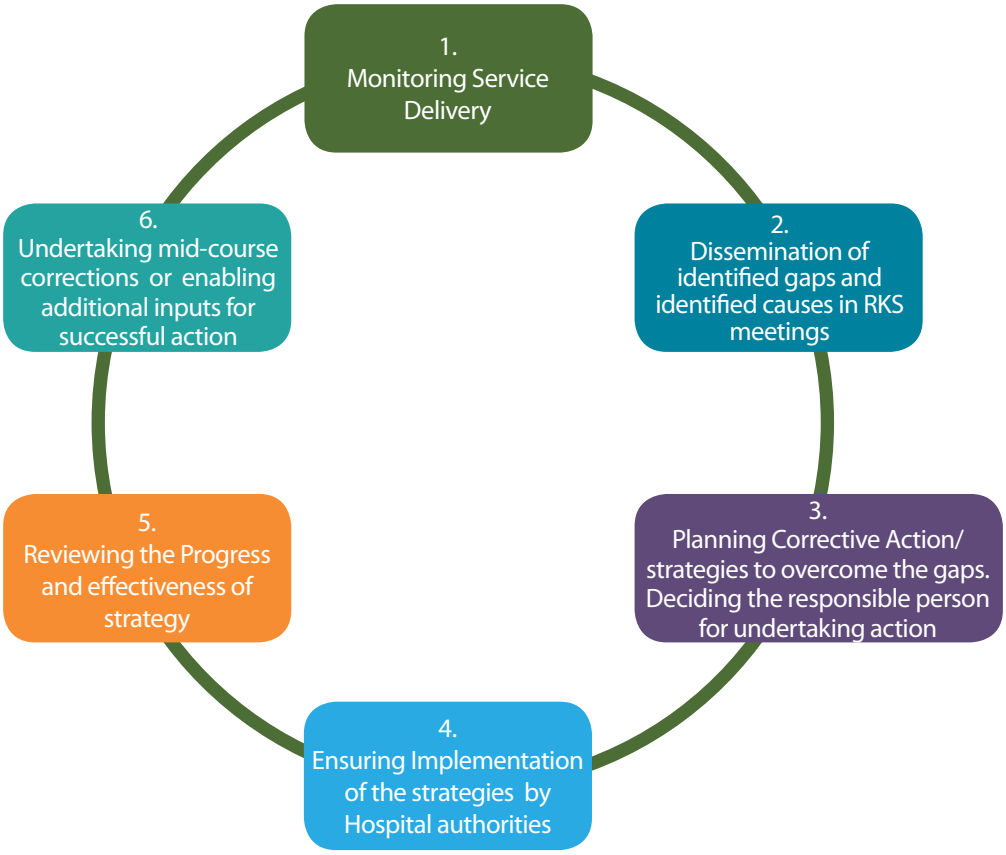
1. Monitoring the health care facilities for-service performance, quality and range of services being provided, reach of services to the marginalized and vulnerable sections, status of utilization of funds, optimum use of equipment, drugs and any other assistance received.
2. Identifying gaps, informing management and follow up of implementation of corrective measures.
3. Understanding patients' perception about the services being provided.
4. Setting up Grievance Redressal systems with feedback and prompt action.
5. Increasing patient awareness on health rights and entitlements.
6. Ensuring equity and social inclusion in delivery of health services. (Refer Chapter 6)
7. Ensuring appropriate utilization of RKS funds. (Refer Chapter 7)

Let us now discuss each of these in details.

## 5.1 MONITORING SERVICE DELIVERY QUALITY IN HEALTH CARE FACILITIES

One of the key functions of RKS member is to monitor service delivery quality in health care facilities. Quality Assurance and Monitoring Committee of RKS is expected to undertake systematic facility based monitoring.

*Fig 5.1 Process of Monitoring and Planning by RKS Members*




RKS members will monitor quality of following areas of service delivery:

### 5.1.1 Areas of performance assessment for RKS:

1. Range of services available as appropriate for PHC/CHC/DH.
2. Adequacy of staff strength.
3. Utilization of services by different social groups.
4. Use of clinical protocols.
5. Status of utilization and availability of drugs, equipments.
6. Cleanliness in health facility.

There are certain standards and guidelines which can help you in the monitoring activity. These are:

**Indian Public Health Standards (IPHS) Guidelines**

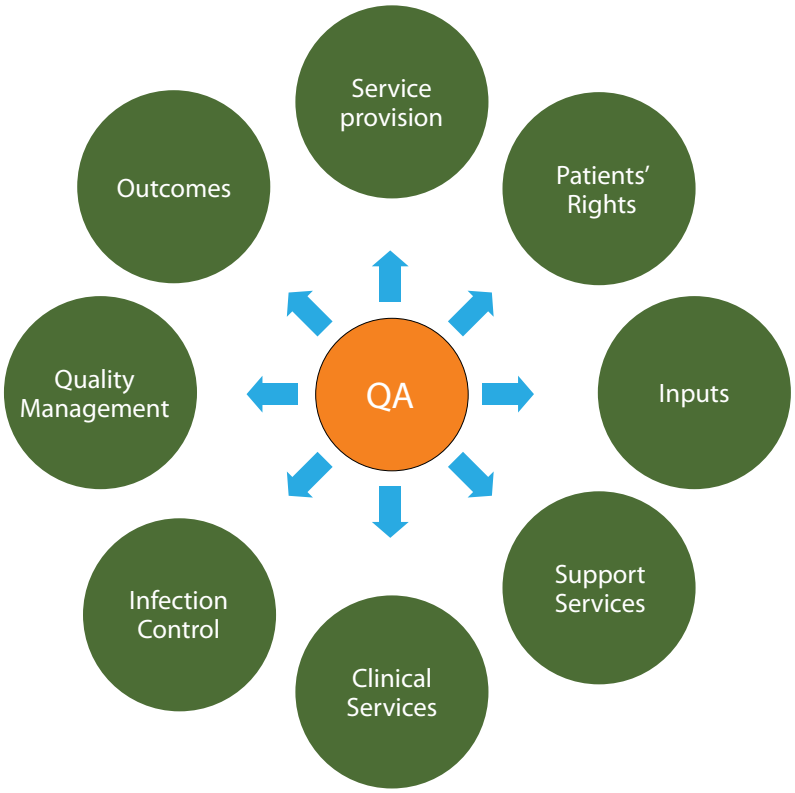
IPHS guidelines set the standards to which facilities must conform (Annexure I). The guidelines will enable RKS members in identification of gaps related to physical infrastructure, services (essential and desirable), human resources (HR), equipments, drugs and diagnostics at public health facilities.

### National Quality Assurance Standards (NQAS)

The National Quality Assurance Program under the National Health Mission has developed standards for DH, CHC, PHC and the Urban Primary Health Centers (UPHCs). The Quality Standards under the QA program are based on eight areas (Fig. 5.2). There are 70 Quality Standards for the district hospitals, 65 for CHC and 50 for PHC. The QA programme revolves around finding gaps in each area, and in each department of health care facility. State & District Quality Assurance Committee (SQAC & DQAC) & Quality Units support the activities of QA program. The program consists of:

- Continuous assessment at facility level, district level and state level.
- Quality Certification against explicit criteria.
- Reporting of Key Performance Indicators (30 indicators DH, 25 for CHC and 20 for PHC).
- Incentivisation on QA certification. (Annexure VII).

*Figure 5.2: Eight Areas of National Quality Assurance Standards*




### KAYAKALP

Ministry of Health & Family Welfare, Government of India has launched an Award Scheme of Clean Health Facilities – 'KAYAKALP'. The awards are distributed based on performance of the facility on six parameters (Fig 5.3). Assessment is done through a three tier process:

a. Internal assessment
b. Peer assessment and
c. External assessment

*Fig. 5.3 Six Parameters of Kayakalp*


Monitoring by RKS members involves review of Key Performance Indicators (KPI) other tools, like patient feedback forms for identification of gaps in delivery of health care services. Monitoring of service delivery quality and patient satisfaction will tell you about the overall functioning of the health care facility.

The data from KPI, patient feedback forms and exit interviews will also help you assess service quality, productivity, clinical quality and efficiency. The Monitoring committee could use these indicators on a monthly basis for identification of gaps and action. Lack of progress or decline in the rate of improvements on a particular variable should alert RKS members and form the basis for further enquiry to identify the problems and take corrective measures.

## 5.1.2 Monitoring Cleanliness in Health Facility

RKS members have a significant role in promoting and maintaining the cleanliness in Public Health Facilities. The members should regularly undertake monitoring of following seven areas.

**Table 5.1: Areas for monitoring cleanliness in health facility**

| | |
|---|---|
| 1. Promotion of cleanliness in Public Health Facilities | Enabling well maintained open spaces (lawn, roads, etc.), cattle-free campus, scientific & eco-friendly disposal of street (general) waste, no-spitting by the visitors, Biomedical Waste Management, clean and rodent free kitchen, etc. |
| 2. Management of Solid Waste (General Waste) | Provision of composting/vermicomposting of biodegradable waste including kitchen & food waste. Recycling of plastic waste. |
| 3. Management of support services | Arrangement of kitchen/canteen, laundry, night shelters for the attendants, public toilets for the attendants and visitors within the premises of large public hospitals, etc. |
| 4. Hygiene Promotion | Take an active role in hygiene promotion in the community such as - pledge taking for cleanliness in households, neighbourhood, and public places (schools, sub centres, Anganwadi centres etc.). |
| 5. Developing area specific Information Education Communication (IEC) and Behaviour Change Communication (BCC) strategy | Undertake various IEC activities required for creating awareness on healthy and hygienic behaviour, which promotes cleanliness, like Swachhta Pakhwara (Fortnight) at Hospitals, awareness on health hazards of spitting, covering mouth & nose while sneezing etc.<br>Complementing facilities' efforts in developing appropriate BCC strategies. |
| 6. Monitoring of toilets in Health Facilities | Promote and maintain cleanliness of toilets. |
| 7. Assessment of Health Facilities for the Awards | RKS member could be in Peer or External assessment team of Kayakalp. |

### 5.1.3 Monitoring Reports

RKS members will compile the information obtained from KPI, feedback forms, exit interviews, reports/ assessments by other local committees and feedback from PRI representatives. All assessment findings should be presented at RKS meetings.

## 5.2 IDENTIFYING GAPS, INFORMING AUTHORITIES, PLANNING AND IMPLEMENTING CORRECTIVE MEASURES

The main platform for sharing the monitoring reports and planning corrective measures with the hospital authorities and higher officials will be through the monthly meetings of EC of RKS and the annual general body meetings. Apart from this, the monitoring committee members will meet with key hospital authorities at any time to bring to their notice urgent matters for their consideration.

RKS meetings will be used as a forum for planning and fixing the responsibility for suitable action. The actions planned are further periodically reviewed by RKS members for their effectiveness and success in enabling gap mitigation. Members can also suggest any mid-course corrections or additional strategies for further improvement.

### 5.2.1 Discussion of Gaps in EC/GB

During EC/GB meeting, RKS members can conduct following activities for planning based on gap assessment.

**Table 5.2: Activities for gap assessment and planning during EC/GB meeting**

| S. No. | Activity | Points to keep in mind |
|---|---|---|
| 1. | Sharing positive and successful stories | Share stories of other RKS that have been successful in bringing about some positive change. |
| 2. | Review of progress of last action plan | A member is given the responsibility to ascertain that all planned activities of RKS are rolled out. Progress on action is shared by the member concerned. |
| 3. | Members of Quality Assurance and Monitoring Committee of RKS share their report on PSS, and basic analysis of complaints/Grievances. | The actions towards these complaints are prioritized. |
| 4. | Brief report generated from health facility survey and monitoring checklists are shared | Gaps and its causes are tabulated. |
| 5. | Formulating action plan: This includes details of identified gaps, causes of gaps, action needed, fund requirement, person responsible for enabling action, time for completion of action. | ◗ Most important gaps are given priority for action.<br>◗ Gaps which can be corrected easily at the level of RKS are also taken for immediate correction.<br>◗ The related strategy has to be written along with any applications to be forwarded.<br>◗ Copy to be kept with the Member Secretary of RKS. |
| 6. | Review the status of utilization of funds, equipment, drugs and any other assistance received under different programmes of the Government. | Utilization Certificate should be sent to Chief Medical and Health officer (in case of DH/SDH) and to Block Medical Officer (in case of CHC and PHC) on quarterly basis as per the prescribed format. It is mandatory to present the detailed half yearly expenditure to the GB of RKS. |
| 7. | Information about next meeting | Date, time and venue of next meeting to be fixed. |

**Response to Monitoring**

While we have dealt extensively with various issues pertaining to monitoring, it is important to note that this process is completely voluntary by the committee members who are involved. Thus in order to ensure that the process is sustained and that the community members who are giving such voluntary time are not frustrated, the health facility authorities, as well as the departmental authorities at higher levels have to be committed to taking serious note of the suggestions, feedback and other information collected by the RKS and brought to their notice. There needs to be a commitment that, the issues raised will be reflected not only in the Action Plan of the RKS, but more importantly in the routine budget of the district hospital. Appropriate recommendations for actions should be made to other committees/authorities with mandate to change. It is also important for the RKS itself to regularly monitor action on its recommendations.

### 5.2.2 Examples of possible gaps and actions which could emerge from monitoring service delivery of health care facilities

Table 5.3 presents illustrative examples of gaps emerged in monitoring, identification of cause and actions by RKS members.

**Table 5.3: Example of possible gaps and actions**

| Example of Gaps | RKS identifies causes for the gap | Corrective Measures by RKS |
|---|---|---|
| 1. The hundred bedded Sub-Divisional Hospital shows a Bed Occupancy rate of 20% in the last six months. This means that on an average only 20 in-patient beds are being used.<br>Indicates low utilization of in-patient services | It is found that doctors are not present during the night hours and nurses alone cannot manage the patients admitted in case they develop serious complications.<br>Most patients are thus being referred out. | EC directs the Medical Superintendent to prepare a Duty Roster for Doctors and Nurses indicating name, designation, duration and place of posting.<br>A follow up for action is done by EC. If gaps persist, Chairperson of EC can issue notices to staff showing non-compliance. |
| 2. 10/50 mothers who delivered in the health facility last month left within the first 48 hours. | Mothers and attendants do not feel comfortable because the hospital environment is not conducive for both mothers and attendant, toilets are unclean, there is lack of waiting shelter for attendants at night and also absence of security and deputation of nurses at night. | RKS ensures existing, unused space inside the hospital to be used as waiting area for the attendants.<br>Prepares a plan to modify or renovate this area using RKS funds.<br>Ascertains shift wise deployment of nurses and sanitary staff is in coordination with hospital authorities. |
| 3. The CHC has been designated as FRU, but a fully functional blood storage unit is not available. | Refrigerator has been provided but blood storage provision is not there due to- lack of renewal of licence by District Drug Controller.<br>24 hours' power back up through generators is also presently unavailable. | EC of RKS can write to Drug Controller to expedite the formalities of issuing licence.<br>A detailed plan including the details of infrastructure and other human resources needed for operationalizing BSU is prepared in coordination with Hospital authorities.<br>RKS funds can be leveraged towards the purchase of generator. |

| Example of Gaps | RKS identifies causes for the gap | Corrective Measures by RKS |
|---|---|---|
| 4. While an ICU has been set up in the district hospital, it is not functioning. | Additional anaesthetist and trained staff nurses are required for operationalizing the ICU and are presently not available. Request to deploy this additional staff is pending with the Directorate for the last one year. Attempts to locally hire anaesthetist for ICU duty have failed as none are ready to take the full time charge of ICU. | RKS can suggest contractual hiring for undertaking responsibilities of OT. Full time regular anaesthetist can be given the charge of ICU.<br>RKS can hire doctors willing to join on contractual basis and follow up with CS/CMO so that they are trained on the management of ICU at an appropriate centre (such as teaching hospitals of the nearby medical college). |

**Some other Situations for Practice:**

1. Entry to Obstetrics-Gynaecology Operation Theatre and Labour Room is not restricted. The facilities should have a visitor policy in place to restrict the visitors not only in the critical care areas but also in general wards.
2. Health, Safety and Hazard Messages are not displayed prominently within the hospital.
3. Hospital Pharmacy does not have a well-defined inventory-management system leading to limited tracking of availability of essential drugs, presence of expired drugs etc.
4. While numbers of institutional deliveries are high in the District Hospital, numbers of C-section are low and HMIS shows most patients going to the private sector for institutional delivery.
5. There is no evidence of maintenance and upkeep of ambulances and other hospital vehicles.

## 5.3 UNDERSTANDING PATIENT PERCEPTION ABOUT SERVICES BEING PROVIDED

To improve the services, we need to know what people's expectations are, how well the health facility is currently meeting them, and the extent to which the health facility can meet them. Gaps in the management and/or resource availability can be identified, based on mismatch between the patient's expectations and services available and corrective measures will be planned. In Table 5.4, we provide examples of activities to be identified.

**Table 5.4 Examples of actions to be undertaken by RKS**

| Activity | Actions by RKS members |
|---|---|
| Patient/service user's complaints through Complaint/suggestion box at the OPD/IPD | ◗ Institutionalise a mechanism for opening of the box at pre-defined interval say- once a fortnight.<br>◗ Identify the root cause of each complaint.<br>◗ Undertake corrective and preventive action for addressing the complaint.<br>◗ It is expected that complainants would be provided a communication from the RKS, which acknowledges the receipt of complaint and its redressal or actions planned to address the complaint. |
| Communicating directly with patients/service users | ◗ To be undertaken during hospital inspection and also with the patients informally outside the hospital premises.<br>◗ Time consuming, but it is an excellent way of getting to know the needs of patients.<br>◗ The method itself can contribute to raising patient satisfaction. |

| Activity | Actions by RKS members |
|---|---|
| Patient Satisfaction Surveys (PSS) | ◗ Includes questionnaires that can be filled by Quality Monitoring and Assessment Committee of the RKS.<br>◗ While conducting the patients' satisfaction, confidentiality and privacy need to be respected.<br>◗ RKS members work in close coordination with Quality Monitoring and Assessment Committee of the health care facilities and obtain analyzed results of these surveys to draw their findings. If there is no Monitoring Committee constituted under the Rogi Kalyan Samiti, then a Quality team can be formed under the National Quality Assurance Program to carry out the Patient Satisfaction Survey and analyse the results of the survey to draw the findings. It can also work on the Corrective and Preventive measures.<br>◗ This is a relatively cost effective way of measuring customer satisfaction. |
| Group Discussions (GDs) with users. | ◗ RKS members can form homogenous groups of not more than six-ten service users. For instance, patients from surgical wards, maternity wings, family members/parents of paediatric patients, etc.<br>◗ GDs save time and provide both a broad and an in-depth overview of issues limiting good quality service provision. |
| Reports from consumer organizations/civil society organizations/various media. | ◗ Serve as valuable source of information.<br>◗ RKS members should be alert and look out for these reports in local media.<br>◗ Seek support of hospital/district health authorities in sharing any survey reports related to their health care facilities conducted by NGOs or other consumer organizations. |

### 5.3.1 Actions to be taken after Patient's Feedback/Complaints

After the information is obtained through above mentioned sources, RKS members will identify the possible gaps and will take appropriate and timely measures.

**Table 5.5: Examples of possible gaps actions which can emerge from information on patient's satisfaction**

| Gaps which can emerge from Patients' Complaints/FGDs/PSS/Reports | Corrective Measures by RKS |
|---|---|
| Doctors report late on duty, this leads to long waiting time and overcrowding of patients at OPD, leading to arguments and patient hardship. | Issue is discussed in the upcoming EC meeting and Chairperson of EC of the RKS can issue a warning notice to the concerned doctors, and ensure that this is not repeated. |
| Medicines prescribed by the doctors are not available in the hospital pharmacies and patients are asked to purchase drugs from outside.<br><br>Doctors prescribe the drugs outside EDL. | The members need to assess if the drugs are part of the Essential drug list, and if the drugs in short supply are as per EDL. EC/GB, the purchase committee of the RKS can leverage RKS funds for local purchase of drug as per the rates fixed by state government. This would depend on the value of drugs to be purchased.<br><br>RKS members in coordination with Quality Assurance Monitoring Committee try to identify the causes of such instances, arrange for prescription audits, and sensitize doctors to use EDL based prescription and resolve the issue. |
| Health facility lacks basic amenities like clean toilets, fresh drinking water and other facilities in the OPD/IPD. | RKS can bring up this issue in EC meeting.<br><br>Use the RKS funds for renovation/construction of new toilets, installing drinking water facility.<br><br>Contract out/outsource cleaning services to an agency which is ready to provide round the clock provision of sanitary staff. |

| Gaps which can emerge from Patients' Complaints/FGDs/PSS/Reports | Corrective Measures by RKS |
|---|---|
| Routine blood tests and diagnostics are available but many patients have to go to private diagnostic centres to get ultrasound conducted. This leads to out of Pocket Expenditure (OOPE). | In centres where Ultrasound machine is available at the health care facility, RKS funds can be utilized for hiring the services of a private radiologist for two/three days in a week basis. Further, signage displaying time, place and name of the doctor providing this service can be arranged by the Information Education, Communication (IEC) committee of the RKS. |
| There is incidence of gender based violence/ sexual harassment at health facility. | RKS members should institute an immediate inquiry. RKS should ensure a functional 'Committee Against Sexual Harassment' (CASH) at the facility. |

## 5.4 SETTING UP GRIEVANCE REDRESSAL SYSTEMS WITH FEEDBACK AND PROMPT ACTION

Complaints and compliments are valuable sources of information that hospitals can use to improve service delivery. Patients are much more likely to have confidence in the health facility if their complaints are addressed quickly and appropriately.

An effective complaint management system plays an essential role in improving quality of public-sector services and contributes in better hospital management. It is important to institutionalize an effective redressal mechanism for taking action towards overcoming patients' complaints. Such a mechanism requires:

- A well established and systematic process for obtaining complaints.
- Resources to enable analysis on the nature of complaints in time bound manner.
- Classification of complaints and identifying the appropriate level of action for redressal.
- Undertaking appropriate, timely action and communication to the complainant.

RKS members should undertake following steps to operationalize an effective Grievance Redressal:

1. Put in place a grievance redressal desk with a nominated person preferably from reputed NGO/CSO with a dedicated landline number and email id, which should be displayed in each facility.
2. Print these details on OPD/IPD slip/discharge paper so that the patient may lodge a complaint even after leaving the premises of facility.
3. Staff should be instructed to receive the complaint telephonically or in writing.
4. The desk may be merged with help desk in absence of sufficient staff or infrastructure or can be developed with the help of RKS funds. The desk should be functional 24X7 at least in district hospitals. The grievance redressal/help desk manager will maintain a register of grievances in a format which will include the name, date of receipt of grievance and specific complaint and action taken.
5. The help desk manager/operator shall try to classify the nature of complaints and forward them to appropriate responsible authority/officer for early redressal.
6. The number of complaints, list of commonly filed complaints and serious complaints will be presented in the EC meeting for appropriate action.
7. In special cases, the confidentiality/anonymity of complainant should be maintained.
8. States have set up grievance redressal helpline and a system to address such issues, you need to find out what system is operational in your state.

Grievance Redressal mechanism helps in overcoming many systemic or recurring problems in the hospital. Depending on the nature of complaints the actions and corrective measures can be planned at the appropriate level.

1. **Issues which can be sorted at the level of health facility:** Eg. lack of display of signage, charters revealing information to patients, sanitation staffs not maintaining the premises clean, privacy for patient examination not being maintained in the OPD etc.
2. **Issues that need to be reported to EC/GB meetings for higher level action:** Lack of availability of drugs in EDL, or non-functional equipment, inadequate beds leading to crowding of wards etc. can be sorted out by enabling local purchase using RKS funds.
3. **Issues that call for policy modifications and cannot be resolved by hospital RKS**: For instance, parents complain lack of Nutrition Rehabilitation Centre for SAM children in the CHC. The facility is currently available only in the district hospital and cannot be accessed easily by children of this remote and far off block. RKS cannot open NRC at their level but can forward and follow up with district health officials for action in this regard.

## 5.5 INCREASING PATIENT AWARENESS ON HEALTH RIGHTS AND ENTITLEMENTS

As an RKS member, it is important for you to ensure that patients know their rights and responsibilities. It is also vital that citizens are made aware about the services/schemes they are entitled to. An informed patient is better empowered to- demand the services as appropriate for the particular facility and highlight gaps.

To build bridges between citizens and hospital management, a systematic effort in the form of Citizen's Charter is needed to be put in place by RKS members. When a patient arrives at any point of service (e.g. district hospital), he/she can see clearly see displayed information about topics such as types of emergency care available, service provisions of the particular facility, the nature of outpatient and inpatient care, the availability of drugs, and the number of service providers at any point.

This exercise can enthuse and enable RKS and health facilities to tune their planning, policy and performance to the needs and concerns of citizens/community. Sample of Citizen's Charter on Services at Health Care Facilities is at Annexure II.

CHAPTER 6

# ENSURING EQUITY AND SOCIAL INCLUSION IN DELIVERY OF HEALTH CARE SERVICES

The vision of the NHM framework for implementation is the "Attainment of Universal Access to Equitable, Affordable, and Quality Health Care services, accountable and responsive to people's needs with effective Intersectoral convergent action to address the wider social determinants of Health." Equity in health care means social justice or fairness in delivering health care services without any disparities among the different groups of people. It relates to social inclusion which envisages the 'inclusion' of all groups, which are vulnerable or marginalized based on social circumstances, in the benefits of any program or intervention. The NHM thus, commits to equity and social inclusion.

## 6.1 HOW DOES LACK OF EQUITY OR SOCIAL INCLUSION MANIFEST IN HEALTH FACILITIES?

- **Discrimination and negligence based on caste/gender/poverty:** It is often reported, that patients (and their attendants) who belong to lower castes, women and especially those of sexual minorities, religious minorities and those belonging to the lower socio-economic status are made to feel unwelcome by staff at health facility. Sometimes there are alleged instances of discrimination against these groups, which is against all principles of rights and against professional ethics. It prevents members of these communities from going to the health facility. The discrimination can manifest itself in lack of attention, rude behaviour, using derogatory terms when communicating, and a victim blaming approach when treating the patient. Such behaviour by the staff needs to be taken into account seriously and all steps to avoid such behaviour need to be taken.
- Service providers often attribute rude behaviours to factors such as overwork, working in under-resourced settings, hierarchical and oppressive working conditions. However, while not justifying such behaviour by staff at any level, such systemic issues also need to be taken into account while searching for solutions to such discriminatory behaviour by staff.
- **Victim blaming:** By victim blaming we mean the attribution of individual blame on a patient (group or community) for risky/dangerous behaviour as a cause of the disease condition, without taking into account the larger socio-economic-cultural causes of such patterns of behaviour. In such a situation the patients who are blamed feel demoralized and invariably stop seeking care. While it is a duty of all health workers to clearly mention the harmful effects of risky behavior, it is equally important for them to be sensitive to socio-economic-cultural

contexts (where they exist) when dealing with patients and their treatment. This is even more important when dealing with stigmatizing conditions like HIV/AIDS and Tuberculosis etc.

## 6.2 HOW TO ENSURE EQUITY AND SOCIAL INCLUSION IN A HEALTH FACILITY?

Ensuring equity and social inclusion are one of the key aspects of the work/functions of the members of the RKS. For this some of the possible steps that may be taken are listed below:

- **Mapping of manifestations of inequity and social exclusion in the health institution:** The first step that RKS members can do is to attempt a mapping of the ways in which inequity and social exclusion manifests itself in the particular health facility, and the particular groups. This can be done in many ways, by analysis of the complaints/suggestions received, by discussion with members of known marginalized groups who are members of the RKS, by discussion with patients and attendants belonging to these groups who visit or are admitted to the health facility in question. Such a mapping exercise will result in a list of groups who are discriminated against (or who have complaint) and possible ways that this manifests. This can be discussed both in subsequent RKS meetings and the staff in order to evolve solutions.
- **Orientation to staff:** It is very important that RKS members facilitate the orientation of staff of the hospital about the findings of the mapping exercise and also about the need for non-discriminatory behaviour as well as social inclusivity in the health facility. This may be done by inviting members of NGOs working in the district on developmental issues or in the field of rights among the marginalized populations.
- **Audits and patterns/disaggregated statistics and complaints:** Members of the RKS could request the hospital authorities to maintain disaggregated statistics (especially for maternal mortality, child mortality, patients leaving the hospital 'Against Medical Advice' and those referred out) based on categories identified by the mapping exercise described. This does not have to be too complicated, and can easily be done on a monthly basis.
- **Observations by monitoring committee:** The monitoring committee members will, as part of their routine monitoring activities record and investigate all complaints which invoke discriminatory and negligent behaviour on the part of the staff.
- Wherever Community based monitoring and planning/Community action for health processes are underway, these should be synergised with the RKS planning processes. Regular inputs from CBMP/CAH committees at PHC and Block levels may be provided to the concerned RKS at PHC and CHC levels.
- **Information about RKS/VHSNC/MAS** etc.: There should also be a prominently displayed in the health facility about the details of RKS/VHSNC/MAS, so that community members even from vulnerable sections can link up and connect with local bodies in their areas. This will greatly enhance the accountability of the facility.
- **Discussion in Gram Sabha**: It is important that the RKS at the level of the PHC share reports with all the Panchayats in its catchment area. These reports can be triggers for regular discussions on the various health institutions in the Gram Sabha and other panchayat meetings and fora. Issues and concerns related to specific health facility (concerned PHC or CHC) which have been discussed in Gram Sabhas of the villages in their catchment area could be communicated to the RKS of the concerned facility. The RKS committee may then take decisions and carry out planning for various RKS funds while giving priority to the issues which have been communicated by Gram Sabhas.

- **Invitation to participate in RKS meetings**: The citizens' charter can also list the ways in which patients and attenders in the health institution can take part in the RKS of the particular institution with clear contact information of nodal persons within the particular health institution who can be contacted. Some active members of VHNSCs and local civil society groups such as representatives of Women's self-help groups, youth groups may be invited on rotation basis to the RKS meeting at the PHC level as invitees. These invitees could actively contribute to the participatory review and planning processes mentioned above. The responsibility of proposing names of such representatives could be given to representative of CSO who is the member of RKS, and ASHAs from various villages.

## 6.3 STEPS THAT THE MONITORING COMMITTEE ITSELF CAN TAKE IN ITS FUNCTIONING

There are few suggested steps that the monitoring committees can take to ensure they are sensitive to and give adequate space for the discussion of and the resolution of issues based on discrimination and social exclusion. These include:

- **Adequate representation:** It is crucial to make sure that there is adequate representation of the marginalized and vulnerable groups on the committee (especially at the district level). These should not only include caste groups, and women, but also representative of sexual minorities, religious minorities, persons with disabilities etc. All necessary steps should be taken to ensure that these members are able to engage adequately with the proceedings.
- **NGOs working with marginalized/discriminated groups:** It may be useful to make sure to include the representation from NGOs working in the district who work with marginalized groups and development. These groups will bring with their membership a lot of resources which will strengthen the capacity of the RKS to ensure equity and social inclusion.
- **Regular agenda point:** One way of ensuring that the issue of equity and social inclusion is discussed and given space is to ensure that it remains a fixed agenda point in every monthly meeting, EC meeting as well as in the annual action plan of the RKS.

## 6.4 ENSURING ACCOUNTABILITY AND TRANSPARENCY IN THE UTILIZATION OF RKS FUNDS

While you will be trained in understanding the issue of transparency and accountability of health service delivery, it is also important to maintain transparency and accountability in RKS funds utilization. As you are a publicly funded committee, you are accountable for auditing. Participatory social auditing tool, which is used in many other areas will be used for RKS funds auditing. As opposed to financial audit, which is expert oriented, social audit includes community participation. Such an exercise followed by planning will help in efficient utilization of RKS funds. There will be active participation of stakeholders such as elected members, RKS members, Health care providers and Civil Society Organizations in this process. Accounts of RKS expenditure should be public and it is the member's responsibility to maintain transparency and accountability.

In Maharashtra, such 'Participatory Audit and Planning process' was conducted in FY 2014-15, as a part of community based monitoring and planning process. Steps followed by the auditing group in Maharashtra are adapted for use in all RKS.

### Table 6.1: Steps of Social Auditing process*

| | |
|---|---|
| 1. Preparatory stage | ◗ Collecting the expenditure information of previous year.<br>◗ Analysing the heads which had maximum spending.<br>◗ Displaying this information in health facility premises. E.g. in the form of poster. |
| 2. Conducting social audit | ◗ Joint meeting between RKS members and other stakeholders in the premises of health facility.<br>◗ Examination of financial documents and records related to RKS expenditure and minutes of RKS meetings.<br>◗ Tour to health facility by participants, for cross checking between verified financial records and physical availability of purchase items through RKS funds. |
| 3. Dialogue between participants | ◗ Discussing issues and needs identified during examination of financial records and physical verification.<br>◗ Planning next year's RKS funds expenditure. |
| 4. Follow up of decisions taken during the participatory social audit event | ◗ At PHC/CHC level, issues will be discussed and resolved in RKS meeting.<br>◗ Unresolved issues will be raised in public hearing.<br>◗ At District level, report of social audit will be shared with district and state officials for further action. |

** (Adapted from Participatory Audit and Planning of Rogi Kalyan Samiti (RKS) funds, A tool for monitoring and ensuring 'Decentralized planning' in the utilization of RKS Committee funds in Maharashtra, India, February 2017.)*

CHAPTER 7

# ROGI KALYAN SAMITI FUNDS AND UTILIZATION

## 7.1 WHAT ARE THE SOURCES OF FUNDS FOR RKS?

1. Each RKS will be provided with untied funds under NHM by State Health Society/District Health Society based on the level of facility, its case load, fund utilization capacity and availability of previous year funds.
2. User fees* as determined by RKS for hospital services E.g. X-ray, Ultrasound scanning, laboratory services, private wards etc. Levying of user charges will depend on local circumstances and decided by the GB, and implemented by the EC.
3. Funds can also be raised from donations, grants from government and loans from financial institutions (with permission of State Government).
4. Leasing or Renting the walls, open space, hospital premises for activities like Canteen, long distance telephone booths, parking stands, rest house and tea shops which could be done without compromising on health facility set up and equity in service provision. Private laboratories or chemist shops should not be allowed in the premises. Suggestive steps for using hospital premises are at **Annexure VIII.**
5. Income on account of service provision under insurance/insurance like scheme/reward on account of quality certification etc.

*Levying of user charges will depend on local circumstances by RKS. User charges contribute to the overall corpus of the RKS which is the untied fund at the disposal of the facility for carrying out urgent patient –welfare activities. Funds received are deposited with the RKS and not in the government exchequer. This provides flexi-money for cross-subsidizing the poor/disadvantaged patients.

User Charges are to be kept minimum for the economically weaker sections of the society decided as per norm of government like persons/family below the poverty line would be exempted from the levy. A Minimum User fees can be successful in improving efficiency in the use of resources, quality of care and promoting participation and accountability of the users. When fees are introduced, a significant decline in service utilization can result in part due to a shift in user preferences and also due to the fee being a financial barrier to low income groups. Fee exemptions for certain groups may reduce the problem of user fees becoming barriers to access to services. Exemptions need clear criteria as they can be difficult to administer.

## 7.2 WHAT IS THE PROCESS FOR UTILIZATION OF RKS FUNDS?

- Tasks of RKS are to facilitate hospital management such as the patient satisfaction surveys; mechanisms of grievance redressal, monitoring of health facilities and to provide inputs on possible activities for utilizing the financial resources of the RKS. The decision of prioritizing these activities is finally undertaken by the Executive Committee. The Executive committee has to pass a resolution to spend money on the activities as decided by the committee.
- Chairperson, member Secretary or MO in-charge of the health facility, etc. may also decide to spend RKS funds for patient welfare activity up to the authorized limit.
- RKS funds may also be utilized for the interim period till government budget is released which can be reimbursed/adjusted after receiving budget from the Government.
- Suggested areas where such untied grants can be used is at **Annexure IX**.

**Table 7.1: Office bearers can sanction the amount mentioned in table below: In case of exigency/ emergency (Illustrative):**

| Office Bearer of Executive Committee | Type of expenditure | Block PHC/ CHC/AH & PHC (N) | Sub Divisional Hospital | District Hospital |
|---|---|---|---|---|
| Chairperson | Non-recurring expenditure | 50,000 | 100,000 | 200,000 |
| | Recurring expenditure | 25,000 | 50,000 | 100,000 |
| Member Secretary | Non-recurring expenditure | 25,000 | 50,000 | 100,000 |
| | Recurring expenditure | 10,000 | 25,000 | 50,000 |

*Note: The state governments can amend the powers of office bearers.*

## 7.3 CONTRACTING OUT BY RKS

By now it must be clear that on occasions RKS will need to contract in the services such as: services of specialists, Medical/Para medical staff, professional counsellors. You must remember that all these contracts would be approved by the EC and reviewed periodically (say one year) and renewed if appropriate.

RKS would outsource certain services, such as those for cleanliness, security, laundry and other supportive services. It may contract-in services of individuals for supportive service functions on a short term basis only and decide the remuneration of the maintenance and other support staff engaged out of RKS funds.

In all these kinds of contract, contract is to be done in name of Member Secretary of the Executive Committee of RKS. The indicative list of services that can be outsourced to increase efficiency and service quality:

a. Food and catering services.
b. Facility sweeping and cleaning.
c. Management information system.
d. Security
e. Maintenance of equipments.
f. Landscaping
g. Patient billing and collection services.
h. Pharmacy
i. Diagnostic imaging and Lab services.
j. Bio-medical waste disposal.

### 7.3.1 Principles of Contracting out/Contracting in Services

1. The member- Secretary on behalf of RKS shall have the power to enter into contract with any agency, firm or individual subject to the delegated Financial Power guideline as specified in the schedule IV.
2. All contracts and other instruments for and on behalf of the Society shall be subject to the provisions of the Societies Registration Act, 1860, be expressed to be made in the name of the Society and shall be executed by the persons authorized by the Governing Body.
3. 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.
4. All contracts and other instruments for and on behalf of the RKS shall be subject to the provisions of the rules & regulations of the parent society, and to be made in the name of the RKS and shall be executed by the persons authorized by the RKS.
5. Unless approved by the Department or the State Nodal Officer to do so, the RKS shall not select or engage any manpower even on daily wage basis or enter into contract with any agency, firm or individual for outsourcing of manpower. No post-facto approval shall be given.

CHAPTER 8

# FINANCIAL MANAGEMENT AND ACCOUNTING

## 8.1 FINANCIAL RESOURCE

The funds of the Society shall consist of the following:

a. Grant in aid/corpus from the State Government and/or State level Societies in the health Sector and/or District Health Society.
b. Grants and donations from individuals, industry and trade.
c. Receipts from user fees.
d. Receipts from insurance or insurance like agencies.
e. Receipts from rentals, disposal of assets.
f. Miscellaneous eg. auction of RKS assets like old computers, equipment etc.

## 8.2 TRANSACTIONS

A separate account in the name of RKS is to be opened in a bank approved by the EC which is named after the facility. All funds shall be paid into the account of the Society with the appointed bank and shall not be withdrawn except by a Cheque, bill note of other negotiable instruments signed by the Member Secretary and such one more person from amongst the EC members as may be decided by the EC. Cheque book and counter foil must be kept with Member Secretary. Due stock entry certificate may be obtained before payments.

## 8.3 PETTY CASH

Member Secretary/appointed person of RKS at DH may keep maximum cash up to Rs.20,000 while Member Secretary/appointed person of RKS at CHC/SDH and Member Secretary/appointed person of RKS at PHC may keep Rs. 10,000 and Rs. 2500/- respectively to meet exigencies.

## 8.4 BOOKS OF ACCOUNT

The corresponding RKS Bank account should have a single cash book but a separate ledger account should be maintained for funds received from different Programmes so that fund position under

different heads can easily be monitored. All vouchers relating to expenditure should be kept in the facility along with proceedings of meetings of EC and GB of RKS.

## 8.5 RECORD MAINTENANCE

The following records and registers shall be maintained by the Society:

1. Journal (for transactions which do not involve any movement of funds).
2. Cash book (for transactions where there is movement of funds) should be balanced and closed every day and should be signed by the designated officer of the hospital.
3. All bank transactions should be entered in a pass book which shall remain in the custody of designated officer. The pass book shall be sent to the bank periodically for having it updated.
4. Ledger (account head-wise summary of expenditure).
5. Register of Bank reconciliation.
6. Petty cash book shall be balanced periodically.
7. Stock register for consumables.
8. A Statement showing the schedule of fixed assets (Register for fixed assets) held by the society at the end of each financial year should be sent to state govt. the value of assets to be shown at the original cost in the accounts. The society shall maintain an upto- date stock position of all items purchased indicating Description of items, Specific Identification (e.g. serial number), Date of purchase, Supply order no., Original value, Location/User and Person responsible for it. Separate stock registers shall be maintained for fixed assets, consumables and non-consumables.
9. Dead stock register.
10. Record of audit and settlement of audit objections.
11. Utilization Certificate: UC should be sent to Chief Medical and Health officer in case of District hospital and sub-district hospital and to Block Medical Officer in case of CHC and PHC on quarterly basis as per the prescribed format. It is mandatory to present the detailed half yearly expenditure to the GB of RKS.
12. Income and Expenditure account and Statement of Expenditure.
13. For all payments received (Receipts) by the Society in form of user charges, donations, etc, shall be acknowledged by a receipt given in the name of RKS. Serial numbered receipt books with counter foils shall be procured for the same.
14. 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 as finally approved by the Governing Body shall be forwarded within six months of the closure of a financial year to all members of the society. Suggested formats are at **Annexure X**.

## 8.6 AUDIT OF ACCOUNTS

The accounts of the Society shall be audited annually by a Chartered Accountant included in the panel of Chartered Accountants drawn by the designated authority of the State Government and the audit report shall be submitted to District Health Society. It will be submitted to the State Government in case of RKS of district hospitals. The report and action taken report of such audit shall be communicated by the auditor to the GB of the Society. Any expenditure incurred in connection with such audit shall be payable by the Society.

## 8.7 DONATIONS RECEIVED

All funds received by way of grants, gifts, donations, benefactions, transfers and in any other manner, any source other than Government, the RKS should obtain necessary approval from the income tax authorities for tax benefits to the donors.

## 8.8 AUTHENTICATION OF ORDERS AND DECISION

Signature of the Chairperson or any other member authorized by the Governing Body shall authenticate all orders and decisions of the society.

## 8.9 PROCUREMENT

The procedure for procurement as applicable in the State Government should be followed. For this purpose, the Executive Committee should form a purchase committee (as mentioned in functions of EC) to purchase material, equipment, and drugs etc. The purchase committee should have at least one member/person from technical background/expertise.

# INDIAN PUBLIC HEALTH STANDARDS (IPHS) GUIDELINES

***Reference:*** *Indian Public Health Standards (IPHS) Guidelines, 2012.*

### Table I (a) - Service Details of Primary Health Centres

| | Service Variable | Norms for PHC |
|---|---|---|
| **1.** | **Population coverage** | 20,000 in hilly, tribal, or difficult areas and 30,000 populations in plain areas. |
| **2.** | **Bed Strength** | 6 indoor/observation beds. |
| **3.** | **Criteria to function as 24*7 PHC** | CHC/FRU is over one hour of journey time away. |
| **4.** | **Types of PHC** | Type-A : Delivery load of less than 20 deliveries/month.<br>Type-B: Delivery load of equal to or more than 20 deliveries/month. |
| **5.** | **Manpower** | |
| a. | Doctors | One MBBS, for Type B two will needed.<br>AYUSH Medical Officer - Desirable. |
| b. | Paramedics | - 3 Staff Nurses.<br>- One: Female Health Worker, male and female Health Assistant, Lady Health Visitor, Lab-Technician, Pharmacist.<br>- Additional one person in each of these categories will be needed for Type B. Also required will be a Health Educator. |
| c. | Administrative staff | Accountant cum data entry operator. |
| d. | Other support staff | Two: Multi skilled Group D Worker (additional two for Type B).<br>One Sanitary worker (additional for Type B) can be deleted. |
| **6.** | **Essential (Minimum Assured Services)** | |
| a. | OPD | - A total of 6 hours of OPD services out of which 4 hours in the morning and 2 hours in the afternoon for six days in a week. |
| b. | 24 hours emergency services | Appropriate management of injuries and accident, First Aid, stitching of wounds, incision and drainage of abscess, stabilisation of the condition of the patient before referral, Dog bite/snake bite/scorpion bite cases, and other emergency conditions. |
| c. | Referral/Transport Services | Patient stabilization, transport with PHC ambulance or 108/EMRI, care during transport, drop-back of mother and infants under JSSK. |
| d. | In-Patient Services | 6-Bedded |

| | Service Variable | Norms for PHC |
|---|---|---|
| **7.** | **Services under National Health Programmes** | |
| a. | Reproductive and Child Health (RCH) | |
| i. | Maternal Health | Complete Antenatal Care (ANC), Postnatal Care (PNC), Normal-Assisted Delivery using partograph, management of pregnancy induced hypertension, pre-referral management of obstetric complications, 48 hours stay, provision of benefits under JSY and JSSK. |
| ii. | New born care | Essential Newborn care with facilities of New born care corner, early initiation of breastfeeding, provision of Kangaroo mother care, immunization at birth, identification of sick newborn and immediate referral. |
| iii. | Child Health | Treatment of Childhood Diseases as per Integrated Management of Neonatal and Childhood Illnesses (IMNCI) protocols, identification of sick newborn and immediate referral, full immunization, growth assessment of under 5 children management of malnutrition, diagnosis of and nutrition advice to malnourished children, nutritional counselling, vitamin supplementation. |
| iv. | Family Welfare | Education, motivation, counselling for adoption of contraceptive methods. Distribution of condoms, oral pills, emergency contraceptives and Intra Uterine Contraceptive Device (IUCD) insertion. Provision of No Scalpel Vasectomy (NSV)/Tubectomy wherever services available or undertake referral and follow up. Counselling and referral for infertility. |
| v. | Safe abortion | First Trimester Medical Termination of Pregnancy (MTP) –Manual Vacuum Aspiration (MVA) only where trained personnel exists. Referral for 2nd trimester MTP. |
| b. | School Health Programme | (a team of 2 workers) visit the schools (one school every week) for screening, treatment of minor ailments and referral. Based on screening reports PHC doctor visits one school/week. |
| c. | Adolescent Health Care | Adolescent friendly clinic for 2 hours once a week on a fixed day. Adolescent and Reproductive Health: Information, counselling and services related to sexual concerns, pregnancy, contraception, abortion, menstrual problems. Reproductive Tract Infection (RTI)/Sexually Transmitted Infection (STI) management, referral Services for Voluntary Counselling and Testing Center (VCTC) and Prevention of Parent to Child Transmission (PPTCT) services. |
| d. | Revised National Tuberculosis Control Program (RNTCP) | Functions as Directly Observed Treatment- Short course (DOTS) Centres, provide Treatment as per guidelines, Collection and transport of sputum samples. |
| e. | National Leprosy Eradication Program (NLEP) | Health education, Diagnosis and management of Leprosy and its complications including reactions, training for self-care for ulcers, counselling for treatment completion. |
| f. | Integrated Disease Surveillance Project (IDSP) | Weekly reporting of epidemic prone diseases in S, P & L forms and SOS reporting of any cluster of Cases. Collect and analyse data from Sub-Centre. First level action in out-break situations. Lab-services for diagnosis of Malaria, Tuberculosis, and tests for detection of faecal.<br>Contamination of water (Rapid test kit) and chlorination level. |
| g. | National Program for Control of Blindness (NPCB) | Early detection of visual impairment, referral.<br>Detection of cataract cases, referral for cataract surgery. Basic treatment for common eye diseases. Awareness generation for prevention of eye problems. |

| | Service Variable | Norms for PHC |
|---|---|---|
| h. | National Vector Borne Diseases Control Program (NVBDCP) | Diagnosis, confirmation of malaria, Symptomatic treatment of JE, Dengue and hospitalization as per protocols, Complete treatment to Kala-azar cases in endemic areas, Complete treatment of microfilaria positive cases, with DEC and participation for Mass Drug Administration (MDA). |
| i. | National AIDS control Programme | Help and guide patients with HIV/AIDS receiving ART with focus on adherence, IEC activities, school health education, preventive measures about STIs and HIV/AIDS, Prevention of Parents to Child Transmission (PPTCT) services. |
| j. | National Program on Prevention and Control of Deafness (NPPCD) | Early detection of cases of hearing impairment and deafness and referral. Basic Diagnosis and treatment services for common ear diseases like wax in ear, external ear infections, ear discharge etc. |
| k. | National Mental Health Programme | Diagnosis and treatment of common mental disorders such as psychosis, depression, anxiety disorders and epilepsy and referral). IEC activities for prevention, stigma removal. |
| l. | National Programme for Prevention and Control of Cancer, Diabetes, CVD and Stroke (NPCDCS) | Early detection of cancer with warning signals, referral of suspected cases for early diagnosis. Early detection, management and referral of Diabetes, Hypertension and other Cardiovascular diseases and Stroke through simple measures like history, measuring blood pressure, checking for blood, urine sugar and ECG. Health promotion and prevention through counselling for diet modification, stress management and other risk factors. |
| m. | Other programmes such as - National Tobacco Control Programme (NTCP), National Programme for Health Care of Elderly, National Programme for Prevention and Control of Fluorosis (NPPCF) (In affected (Endemic Districts) | Case detection, Health promotion, IEC activities related to each of these. |
| **8.** | **Diagnostic Services** | Routine urine, stool and blood tests (Hb%, platelets count, total RBC, WBC, bleeding and clotting time). Tests for RTI/STDs Sputum testing for TB as per guidelines of RNTCP, Blood smear examination for Malaria, Blood grouping and Rh typing, RDK for Pf malaria in endemic districts. Rapid tests for pregnancy, test for Syphilis/ YAWS surveillance (endemic districts), Rapid test kit for faecal contamination of water, Estimation of chlorine level of water and Blood Sugar. |
| **9.** | **Essential Drugs** | Each PHC has to maintain supplies and undertake distribution of drugs as per the Essential Drug List for specified for PHC by the state. The EDL has been prepared based on the types of services to be delivered by PHC. Efforts should be to ensure a minimum three months of buffer stock for different categories of drugs. |
| **10.** | **Other auxiliary services** | Laundry services for hospital linens, diet for patients and waste management as per "Guidelines for Health Care Workers for Waste Management and Infection Control in Primary Health Centres". |
| **11.** | **Other Functions** | Training Programmes for clinical, paramedic staff, ASHAs, Distribution of ASHA incentives, payment to beneficiaries, Reporting of vital events, provision/linkages for issuance of birth and death certificates. |

## Table I (b) Service Details of a CHC

| | Service Variable | Norms for CHC |
|---|---|---|
| **1.** | **Population coverage** | 80,000 in hilly, tribal, or difficult areas and 1,20,000 populations in plain areas. |
| **2.** | **Bed Strength** | 30 indoor/observation beds. |
| **3.** | **Manpower** | |
| | Personnel in the Block Public Health Unit | One: Block Medical officer/Medical Superintendent, Public Health Specialist, Public Health Nurse. |
| a. | Speciality Doctors | One: General Surgeon, Physician, Obstetrician & Gynaecologist, Paediatrician, and Anaesthetist. |
| b. | Other Doctors | Two MBBS, One Dental Surgeon, and one AYUSH Medical Officer. |
| c. | Paramedics | -10 Staff Nurses, -One: Pharmacist, Pharmacist AYUSH, Lab-Technician.<br>In addition, other paramedics such as Radiographer, Assistants for OT, dental, ophthalmic, Cold Chain & Vaccine Logistic OT Rehabilitation services and Counsellor, Dietician. |
| d. | Administrative staff | Two: Registration Clerk, Statistical Assistant/Data Entry Operator, One: Account Assistant, Administrative Assistant. |
| e. | Other support staff | Five: Ward Boys/Nursing Orderly, one: Dresser (certified by Red Cross/ Johns Ambulance), Driver*. |
| **4.** | **Service Delivery in CHCs** | |
| i | OPD and IPD Services: CHC provide specialist services for General, Medicine, Surgery, Obstetrics & Gynecology, Pediatrics, Dental and AYUSH services. Eye Specialist services (at one for every 5 CHCs), a higher level of Emergency Services than PHC, Diagnostic services and secondary care services for National Health Programmes as specified in the guidelines. | |
| ii | Care of Routine and Emergency Cases in Surgery | All basic emergency care provided at PHC + surgical care for Hernia, Hydrocele, Appendicitis, Hemorrhoids and Fistula, Intestinal Obstruction, Hemorrhage, etc. Other management including nasal packing, tracheotomy, foreign body removal fracture reduction, putting splints/plaster cast is also undertaken. |
| iii | Care of Routine and Emergency Cases in Medicine | All basic emergency care provided at PHC + handling of emergencies like Dengue Hemorrhagic Fever, Cerebral Malaria, Congestive Heart Failure, Left Ventricular Failure, Pneumonias, meningoencephalitis, acute respiratory conditions, status epilepticus, Burns, Shock, acute dehydration etc. and services specified under National Health Programmes, guidelines. |
| iv | Maternal Health | All basic care provided at PHC + proficiency in identification and management of all complications including PPH, Eclampsia, Sepsis etc, Essential and Emergency Obstetric Care including surgical interventions like Caesarean Sections and other medical interventions. |
| v | New born care and Child Health | All basic care provided at PHC +New born Stabilization unit and other facilities for Stabilisation of complications and referral Care of LBW newbornsλ>1800 gm Referral services for newborns. |
| vi | Child health | All services of PHC including prevention and management of routine childhood diseases, infections and anaemia etc. and management of Malnutrition cases. |
| vii | Family Welfare | All services of PHC+ Services of Laproscopic Sterilization. |
| viii | Safe Abortion | All services as specified for PHC + MVA up to 8 weeks as per MTP guidelines, Post abortion contraceptive counselling, Referral linkages with higher centre for cases beyond 8 weeks of pregnancy up to 20 weeks. |
| ix | School Health Programme | All services as specified for PHC+ secondary level management of diseases, detailed check-up, referral cards for priority services at SDH/DH. |
| x | Adolescent Health Programme | All services specified at the level of PHC +additional services. |

| | Service Variable | Norms for CHC |
|---|---|---|
| **5.** | **Revised National Tuberculosis Control Program** | All services of PHC + Slightly advanced diagnostic services through the microscopy centres and treatment services as per the Technical and Operational Guidelines for Tuberculosis Control. |
| **6.** | **HIV/AIDS control Programme** | Services of PHC+ Integrated Counselling and Testing Centre, Blood Storage Centre, Sexually Transmitted Infection clinic, PPTCT. |
| **7.** | **National Vector Borne Diseases Control Program** | Provides diagnostic/linkages to diagnosis and treatment facilities for routine and complicated cases of Malaria, Filaria, Dengue, Japanese Encephalitis and Kala-azar in the respective endemic zones. |
| **8.** | **National Leprosy Eradication Program** | Diagnosis and treatment of cases and management of complications including reactions of leprosy along with counselling of patients on prevention of deformity and cases of uncomplicated ulcers. |
| **9.** | **National Program for Control of Blindness** | All services of PHC+ one ophthalmologist catering to 5 CHCs. Undertakes Vision Testing with Vision drum/Vision Charts. Refraction errors, early detection of visual impairment and their referral. |
| **10.** | **Integrated Disease Surveillance Project (IDSP)** | Functions as peripheral surveillance unit and collate, analyse and report information to District Surveillance Unit on selected epidemic prone diseases. |
| **11.** | **National Programme for Prevention and Control of Deafness (NPPCD), National Mental Health Programme (NMHP), National Programme for Prevention and Control of Fluorosis (NPPCF), National Tobacco Control Programme (NTCP), National Iodine Deficiency Disorders Control Programme (NIDDCP).** | Early identification, diagnosis and treatment of illnesses under each of these health programmes with Health promotion, IEC activities. |
| **12.** | **National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)** | Facilities for early detection and referral of suspected cancer cases, screening for Cervical, Breast & Oral Cancers. Education about Breast Self Examination and Oral Self Examination. PAP smear for Cancer Cervix. Treatment & Timely Referral for (Complicated cases) of Diabetes Mellitus, Hypertension, Ischemic Heart Disease, Congestive Heart Failure etc. Assured investigations for follow up on disease progression. Health Promotion and Prevention activities related to each of the specified illnesses as per the guidelines. |
| **13.** | **National Programme for Health Care of Elderly** | Medical rehabilitation services. Compilation of elderly data from PHC & forwarding the same to district nodal officers. Visits to the Homes of disabled/bed ridden persons by rehabilitation worker on receiving information from PHC/Sub-centre. Geriatric Clinic: twice a week. |
| **14.** | **Physical Medicine and Rehabilitation (PMR)** | Primary prevention of Disabilities. Screening, early identification and detection Counselling. Issue of Disability Certificate for obvious Disabilities by CHC doctors. Community based Rehabilitation Services. |
| **15.** | **Oral Health** | Dental care and Dental Health education services as well as root canal treatment and filling/extraction of routine and emergency cases. Oral Health education in collaboration with other activities e.g. Nutritional education, school health and adolescent health. |
| **16.** | **Other Services** | Blood Storage Facility, Referral (transport) Services, Maternal Death Review (MDR). |
| **17.** | **Diagnostic Services** | Basic Lab services+ facilities for essential lab investigations-serology, urine/stool examination, pathology, biochemistry, ECG, Refraction errors, Retinoscopy, ophthalmoscopy, X ray for Chest, Skull, Spine, Abdomen, bones, Dental X ray Ultra- Sonography is (Desirable). |

| | Service Variable | Norms for CHC |
|---|---|---|
| **18.** | **Essential Drugs** | As per EDL- Emergency Obstetric Care Drugs-71,<br>Drug Kit for Sick Newborn& Child Care - 25, Other Essential Drugs - 80, drugs under various National Health Programmes and Vaccines as under Immunization Programme are. |
| **19.** | **Other auxiliary services** | Laundry services for hospital linens, diet for patients and waste management as per "Guidelines for Health Care Workers for Waste Management and Infection Control in Community Health Centres". |

### Table I (c)- Service Details of Sub-Divisional Hospital

| | Service Variable | Norms for TLGH |
|---|---|---|
| | **Population coverage** | 5-6 Lakh Populations in plain areas. |
| **1.** | **Bed Strength** | Either 31-50 or 51-100 beds. |
| **2.** | **Manpower** | |
| a. | Doctors | Specialists-General Medicine, Obstetric/Gynaecology, Surgery, skin, Paediatrics, Anaesthesia, ENT, Ophthalmology, Orthopaedic, Radiology, Dental, Pathology.<br>Additional one specialist for Medicine, Surgery, Obstetric/Gynaecology, Paediatrics and Anaesthesia will be needed for SDH which are more than 50 beds.<br>-Seven Casualty Doctors/General Duty Doctors (at least three female lady MOs > 50 bedded require nine casualty doctors (at least four female allopathic doctors). |
| b. | Others | -One: Hospital Superintendent, Public Health Manager, AYUSH Physician. |
| c . | Paramedics | -30 Staff Nurses, -11 General Duty Attendant, four Pharmacist, three Laboratory technician, two Radiographer and Multi Rehabilitation worker.<br>In addition, other paramedical staff such as –Opthalmic Assistant/ Refractionist, ECG Technician, Audiometrician, Dental Assistant/Dental Technician/Dental Hygienist, Physiotherapist/occupational therapist/ Rehabilitation therapist, Counselor, etc.<br>Additional numbers of staff nurses, pharmacists, lab technicians and other technical attendants are in place for SDH>50 beds and above. |
| d. | Administrative staff | One: Junior Administrative Officer/Office Superintendent<br>Two: Accountant,<br>6 Computer Operator |
| e. | Other support staff | Two: Driver, Peon, Security Staff. |
| **3.** | **Operation Theatre, Blood Storage Unit, Post Partum Unit (Desirable) with Man Power and resources much greater than CHC.** | |
| **4.** | **Service Delivery in Sub-Divisional Hospital** | |
| | **SDH provide a mix of services under medical and surgical specialities.**<br>**Services include OPD, indoor and Emergency services and diagnostic services for a Secondary level health care facility.** | General Medicine, General Surgery Accidents and emergency services including poisoning and Trauma Care, General Orthopaedic, Obstetrics & Gynaecology, all FP services.<br>Paediatrics including Neonatalogy, Anaesthesia, Ophthalmology, ENT, Radiology including Imaging services, Dental care, DOTS centre, Designated Microscopy centre, AYUSH, Public Health Management, Integrated Counseling and Testing Centre, Disability Certification, Services provided under other National Health, Programmes including lifestyle disorders,<br>Diagnostic and other Para clinical services: Laboratory services, X-ray, Ultrasound, ECG, Blood transfusion and storage.<br>Desirable: Psychiatry Geriatric Services Tobacco Cessation Services Physical Medicine and Rehabilitation services Critical care/Intensive Care (ICU) [if bed strength is more than 50 beds] Dermatology & Venerology including RTI/STI. |

| | Service Variable | Norms for TLGH |
|---|---|---|
| **5.** | **Essential Drugs** | Wide Range and large number of Essential Drugs under twenty broad categories such as- pain killers, antibiotics, anti diabetic, anti –hypertensives, emergency drugs, paediatric newborn drugs, anti diarrhoeal, infusion fluids, eye and ENT drugs, anaesthetics etc should be kept in stock. |

### Table I (d)- Service Details of District Hospital

| | Service Variable | Norms for District Hospital |
|---|---|---|
| | **Population coverage** | Every District One district hospital. |
| **1.** | **Bed Strength** | 101 - 500 beds. |
| **2.** | **Manpower** | |
| a. | Doctors Specialist | - **Two specialists for:** Medicine, Surgery, Obstetric & Gynaecology, Paediatrics, Anaesthesia and one for Ophthalmology, orthopaedic, Radiology, Pathology, ENT, Dental, Psychiatry and AYUSH Doctors. -11 Medical officers<br>- **Desirable:** Dermatology, Microbiology, Forensic Specialist. |
| b. | Paramedics | - 45 Staff Nurses, - 6 Lab Tech, - 5 Pharmacist, -4 O.T. technician, -Two: Radiographer, Social Worker, Darkroom Asstt.<br>- **One:** Storekeeper, ECG Tech/Eco, Opthalmic Assistant, Dietician, Physiotherapist, CSSD Asstt, Counsellor, Dental Technician, Rehabilitation Therapist, Biomedical Engineer, Audiometric an, EEG Tech, Dermatology Technician, Cyto-Technician, PFT Technician. |
| c. | Administrative staff | One Hospital Administrator, Housekeeper/manager, Medical Records officer, Medical Record Asstt., Admn. Officer, and others |
| | Other support staff | Numbers much higher than those for TLGH |
| **3.** | Operation Theatre, Blood Bank/Storage Unit, Post Partum Unit (Desirable) with extra manpower. | |
| **4.** | **Service Delivery in District Hospital** | |
| a. | Services that a District Hospital is expected to provide include all kinds of tertiary care services for OPD, indoor and Emergency Services and diagnostic care | General Specialties: General Medicine General Surgery Obstetrics & Gynaecology Services including all kinds tertiary care for the related cases, All Family Planning services including all types of surgical methods, Paediatrics including Neonatology through SNCU, Emergency (Accident & other emergency) Critical care/Intensive Care (ICU) Anaesthesia Ophthalmology. Dermatology and Venerology (Skin & VD) Radiotherapy Allergy, De-addiction centre, Physical Medicine and Rehabilitation services Tobacco Cessation Services Dialysis Services, Otorhinolaryngology (ENT), Orthopaedics Radiology including Imaging, Psychiatry Geriatric Services (10 bedded ward), Health promotion and Counseling Services, Dental care, District Public Health Unit, DOT centre, AYUSH Integrated Counseling and Testing Centre; STI Clinic; ART Centre, Blood Bank, Disability Certification Services, Diagnostic and other Para clinical services, Ancillary and support services, Post Partum Unit3, Super Specialties (May be provided depending upon the availability of manpower in State/UT). |
| b. | DRUGS | Wide Range and large number of Essential Drugs under twenty broad categories such as- pain killers, antibiotics, anti diabetic, anti –hypertensives, emergency drugs, paediatric newborn drugs, anti diarrhoeal, infusion fluids, eye and ENT drugs, anaesthetics etc should be kept in stock. |

# DRAFT CHARTER OF PATIENTS' RIGHTS

The definition of rights in this charter implies that both citizens and health care stakeholders assume their own responsibilities. Rights are correlated with both duties and responsibilities. All hospitals should adopt such a Standard Charter of Patient's Rights, display it in the local language in a prominent location in the Hospital, make copies available on demand, ensure its observance and orient their staff for the same.

## 1. RIGHT OF ACCESS TO HEALTH CARE

All patients have a right to access health care appropriate to the level of the hospital. This care should be provided without any discrimination on the basis of sex, religion, caste/ethnicity, social background, language etc.

## 2. RIGHT TO INFORMATION

All patients have the right to be adequately informed about the state of their health, including medical data, proposed medical procedure, risks and advantages of various alternative procedures and treatment options and the possible effects of the non use of medical treatment, and any likely costs involved. Only in exceptional circumstances shall information not be revealed to the patient, namely when there is sound reason to believe that such information could cause more harm rather than benefit to the patient. This includes the right to reports and records, wherein the patient shall have the right to get all relevant investigation reports, written reports on the diagnosis, any procedures performed, the medical treatment and the state of his/her health on discharge from hospital.

## 3. RIGHT TO INFORMED CONSENT BEING SOUGHT

Health care providers and professionals should give the patient basic information related to a treatment or an operation to be undergone. In case of major procedures, this information must be given with enough advance time (barring exceptions where not feasible due to medical urgency) to enable the patient to actively participate in the therapeutic choices regarding his or her state of health and in a language the patient can understand.

In the case of a minor, the consent of a parent or guardian should be taken only in cases where a patient lacks the capacity to give or withhold consent, and where a qualified medical doctor determines that treatment is urgently necessary in order to prevent immediate or imminent harm, may procedures be performed without informed consent.

## 4. RIGHT TO PARTICIPATE IN DECISION MAKING

Patients have the right to participate in decision making regarding the course of their treatment. Patients have the right to be appropriately referred, or to seek a second opinion on request, from a health provider of one's choice.

Patients have the right to accept or refuse to take part in clinical trials or research concerning the use of new drugs, procedures or medical devices. Clinical trials and experimental treatment should never be carried out without informed written consent of the patient.

## 5. RIGHT TO RESPECT AND DIGNITY

Each patient has the right to receive respectful care and communication at all times and under all circumstances, as recognition of his/her personal dignity.

## 6. RIGHT TO PRIVACY AND CONFIDENTIALITY

All the data and information related to an individual's state of health, and to the medical/surgical treatments to which he or she is subjected, must be stored and used in such a manner as appropriate/ prescribed. Confidential information shall be disclosed to any person designated by the patient only if the patient gives his/her consent.

Personal privacy must be respected in the course of various procedures (diagnostic exams, specialist visits, medications, etc.), which must take place in an appropriate environment and/or in the presence of only those who need to be there (unless the patient has explicitly given consent or made a request).

## 7. RIGHT TO SAFETY AND HEALTHY HOSPITAL ENVIRONMENT

Each patient has the right to a clean and healthy environment in the hospital, which minimizes the risk of hospital-related infections**.**

## 8. RIGHT TO MAKE COMPLAINTS AND TO SEEK REDRESSAL

Patients have the right to complain about any aspect of hospital service, and to have the complaint investigated by an appropriate authority. A complaint must be followed up by requisite response by the Hospital authorities within a fixed period. Complaints of serious lapses, negligence or infringement of patients' rights, if substantiated by enquiry, must be followed up with appropriate action.

Every hospital should publicize prominently at major locations in the hospital the information about the complaint procedure along with the name, address and telephone number of persons to be contacted.

***Source:*** *Guidelines for Rogi Kalyan Samities in Public Health Facilities, National Health Mission, June-2015.*

# PURCHASE COMMITTEE

A purchase Committee thus may be set up to undertake all such activities:

**Constitution of a Purchase Committee:**

Few members of executive committee and Specialist/MOs will be members of the standing local purchase committee. This Committee shall have all the purchasing powers from the RKS funds.

**Illustrative purchasing authority and modes:**

**a. Local purchase of consumables and other items:**

Local purchase of consumables and other items upto Rs. 5,000 for District RKS can be done on direct purchase by single quotation by concerned Member Secretary or as per State norms.

**b. Procurement Modes:**

i. Rate contracts, if fixed by any Government agencies may be utilized. However it is not obligatory to operate a rate contract if it is not so mandated by the State government.

ii. Local shopping can be undertaken by the Purchase Committee. If any Govt outlet or public sector outlet exists, they should be preferred over other agencies. Quotations should be invited for any single purchase of more than Rs. 5,000 in District RKS after specifying the quality and quantity of the items required. There should be, however, no compromise on the quality even if it means that the lowest quotation is not accepted. However, the Purchase Committee should justify the decisions in such situations.

**c. Service Contracts:**

The Purchase committee will have full powers to repair and service the instruments, equipment and vehicles directly through manufactures or authorized dealers. In other cases, quotations should be invited.

**d. Civil Works:**

Civil works including addition/alteration will be carried out through States agencies like PWD or through competitive quotations from local agencies.

All bills of purchase should be certified by the person handling the stores stating "item" received in good condition and entered in stock register No……, page no……, entry no……,and countersigned by Member Secretary. A physical verification of stores should be done once in a year, preferably in April every year by a committee consisting of three members constituted by the Member Secretary.

***Source:*** *Guidelines for Rogi Kalyan Samities in Public Health Facilities, National Health Mission, June-2015.*

Annexure IV

# PATIENT SATISFACTION FORM: INPATIENT FEEDBACK

**Dear Friend,**

You have spent your valuable time in the hospital in connection with your/relative's/friend's treatment. It will help us in our endeavor to improve the quality of service, if you share your opinion on the service attributes of this hospital enumerated in the table below .

| S. No. | Attributes | Poor | Fair | Good | Very Good | Excellent | No comments |
|---|---|---|---|---|---|---|---|
| 1. | Availability of sufficient information at Registration/Admission counter | | | | | | |
| 2. | Waiting time at the Registration/Admission counter | more than 30 mins | 10-30 mins | 5-10 mins | Within 5 mins | Immediate | |
| 3. | Behaviour and attitude of staff at the registration/admission counter | | | | | | |
| 4. | Your feedback on discharge process | | | | | | |
| 5. | Cleanliness of the ward | | | | | | |
| 6. | Cleanliness of Bathrooms & toilets | | | | | | |
| 7. | Cleanliness of Bed sheets/pillow covers etc. | | | | | | |
| 8. | Cleanliness of surroundings and campus drains | | | | | | |
| 9. | Regularity of Doctor's attention | | | | | | |
| 10. | Attitude & communication of Doctors | | | | | | |
| 11. | Time spent for examination of patient and counselling | | | | | | |
| 12. | Promptness in response by Nurses in the ward | | | | | | |
| 13. | Round the clock availability of Nurses in the ward hospital | | | | | | |
| 14. | Attitude and communication of Nurses | | | | | | |
| 15. | Availability, attitude & promptness of Ward boys/girls | | | | | | |

| S. No. | Attributes | Poor | Fair | Good | Very Good | Excellent | No comments |
|---|---|---|---|---|---|---|---|
| 16. | All prescribed drugs were made available to you free of cost. | | | | | | |
| 17. | Your Perception of Doctor's knowledge | | | | | | |
| 18. | Diagnostics Services were provided with in the hospital | | | | | | |
| 19. | Timeliness of supply of diet | | | | | | |
| 20. | Your overall satisfaction during the treatment as in patient | | | | | | |

Please tick the appropriate box and drop the questionnaire in the Suggestion box:

| Your valuable suggestions ( if any ) |
|---|
| |

Date _____ IPD Ticket no_____._____

Ward_____

Name _____ _____

***Source:*** *Guidelines for Rogi Kalyan Samities in Public Health Facilities, National Health Mission, June-2015.*

Annexure V

# OPD PATIENT FEEDBACK

**Dear Friend,**

You have spent your valuable time in the hospital in connection with your/relative's/friend's treatment. You are requested to share your opinion about the service attributes of this hospital which will be used for improving the services

| S. No. | Attributes | Poor | Fair | Good | Very Good | Excellent | No comments |
|---|---|---|---|---|---|---|---|
| 1. | Availability of sufficient information at registration counter | | | | | | |
| 2. | Waiting time at the registration counter | more than 30 mins | 10-30 mins | 5-10 mins | Within 5 mins | Immediate | |
| 3. | Behaviour and attitude of staff at the registration counter | | | | | | |
| 4. | Cleanliness of the OPD, Bathrooms & toilets | | | | | | |
| 5. | Attitude and communication of Doctors | | | | | | |
| 6. | Time spent for examination and counseling | | | | | | |
| 7. | Availability of Lab and radiology tests. | | | | | | |
| 8. | Promptness at Medicine distribution counter | | | | | | |
| 9. | Availability of drugs at the hospital dispensary | | | | | | |
| 10 | Your overall satisfaction during the visit to the hospital | | | | | | |

Please tick the appropriate box and drop the questionnaire in the Suggestion box:

| Your valuable suggestions (if any) |
| --- |
| |

Date _____ IPD Ticket no_____._____

Ward_____

Name _____ _____

***Source:*** *Guidelines for Rogi Kalyan Samities in Public Health Facilities, National Health Mission, June-2015.*

# KEY PERFORMANCE INDICATORS

**Table (a): Key Performance Indicators for District Hospital**

| Name of the Facility | | | District | |
|---|---|---|---|---|
| Period (Quarter) | | | | |
| Last Internal Assessment | | | | |
| **A. Gap Closure Status** | | | | |
| No of Gaps | | Closed | In Process | Not Initiated |
| A1 | Facility Level | | | |
| A2 | District Level | | | |
| A3 | State Level | | | |
| A4 | Total | | | |
| | | 1 | | |
| | Brief Description of | 2 | | |
| A5 | Resources required | 3 | | |
| | | 4 | | |
| | | | | |
| | | 5 | | |
| **B. Departmental Score Cards** | | | | |
| | Department | Baseline | Previous Quarter | Current Quarter |
| B1 | Accident & Emergency | | | |
| B2 | Outdoor Department | | | |
| B3 | Labour Room | | | |
| B4 | Maternity ward | | | |
| B5 | Paediatric ward | | | |
| B6 | General ward | | | |
| B7 | Sick New born care Unit | | | |
| B8 | Intensive Care Unit | | | |
| B9 | Operation Theatre | | | |
| B10 | Post Partum Unit | | | |
| B11 | Blood Bank | | | |

| | Department | Baseline | Previous Quarter | Current Quarter |
|---|---|---|---|---|
| B12 | Laboratory | | | |
| B13 | Radiology | | | |
| B14 | Pharmacy | | | |
| B15 | Auxiliary Services | | | |
| B 16 | General Administration | | | |
| B17 | Nutritional Rehabilitation | | | |
| | Centres | | | |
| B18 | Mortuary | | | |
| B19 | Please add | | | |
| B20 | Please add | | | |
| | Overall Score | | | |

**C. Thematic Score cards**

| | Area of Concern | Baseline | | Previous Quarter | | Current Quarter | |
|---|---|---|---|---|---|---|---|
| C 1 | Service Provision | | | | | | |
| C2 | Patient Right | | | | | | |
| C3 | Inputs | | | | | | |
| C4 | Support Services | | | | | | |
| C5 | Clinical Services | | | | | | |
| C6 | Infection Control | | | | | | |
| C7 | Quality Management | | | | | | |
| C8 | Outcome | | | | | | |
| | Overall Score | | | | | | |

**D. Key Performance Indicators**

| | Indicator | Unit | Previous Quarter | Current Quarter | | Previous Year's (Average) |
|---|---|---|---|---|---|---|
| | ***Productivity*** | | | | | |
| D1 | Bed Occupancy Rate | | | | | |
| D2 | Lab test done per thousand Patients (indoor & OPD) | | | | | |
| D3 | Percentage of cases of high risk pregnancy/obstetric complications out of total registered pregnancies at the Facility | | | | | |
| D4 | Percentage of surgeries done at night out of total surgeries | | | | | |
| D5 | Percentage of surgeries done during day out of total Surgeries | | | | | |
| D6 | Percentage of C- Section out of Total deliveries | | | | | |
| | ***Efficiency*** | | | | | |
| D7 | No of Deaths in Emergency/Total no of emergency attended | | | | | |
| D8 | Percentage of out referrals out of Total Admission | | | | | |
| D9 | No of major surgeries per Surgeon | | | | | |
| D10 | OPD per Doctor (Average per day) | | | | | |

| | Indicator | Unit | Previous Quarter | Current Quarter | | Previous Year's (Average) |
|---|---|---|---|---|---|---|
| D11 | External Quality score for lab tests (Median value) | | | | | |
| D12 | Percentage of Stock outs of Vital drugs (list of essential commodities under RMNCH+A) | | | | | |
| | ***Clinical Care/Safety*** | | | | | |
| D13 | No of Maternal Deaths out of total admission during ANC, INC, PNC | | | | | |
| D14 | No of Neonatal Deaths out of total live births and neonatal Admission | | | | | |
| D15 | Percentage of cases for which Maternal Death Review done | | | | | |
| D16 | Average Length of Stay | | | | | |
| D17 | Percentage of Mortality out of total SNCU admissions | | | | | |
| D18 | Number of Sterilization Failures cases | | | | | |
| D19 | Number of Sterilization Complications | | | | | |
| D20 | No. of Deaths after Sterilization | | | | | |
| D21 | No of unit issued on replacement X 100/Total no of unit issued | | | | | |
| D22 | Percentage of delivery having partograph recorded | | | | | |
| | ***Service Quality*** | | | | | |
| D23 | Percentage of LAMA out of Total Admission | | | | | |
| D24 | Patient Satisfaction Score for IPD | | | | | |
| D25 | Patient Satisfaction Score for OPD | | | | | |
| D26 | Registration to Drug Time (average) | | | | | |
| D27 | Percentage of JSY payments done before discharge | | | | | |
| D28 | Percentage of women provided drop-back facility after delivery | | | | | |

### Table (b): Key Performance Indicators for CHC

| Name of the Facility | | | District | |
|---|---|---|---|---|
| Period (Quarter) | | | | |
| Last Internal Assessment | | | | |
| **A. Gap Closure Status** | | | | |
| | No of Gaps | Closed | In Process | Not Initiated |
| A1 | Facility Level | | | |
| A2 | District Level | | | |
| A3 | State Level | | | |
| A4 | Total | | | |
| A5 | Brief Description of Resources required | 1 | | |
| | | 2 | | |
| | | 3 | | |
| | | 4 | | |
| | | 5 | | |
| **B Departmental Score Cards** | | | | |
| | Department | Baseline | Previous Quarter | Current Quarter |
| B1 | Accident & Emergency | | | |
| B2 | Outdoor Department | | | |
| B3 | Labour Room | | | |
| B4 | Ward (IPD) | | | |
| B5 | NBSU | | | |
| B6 | Blood Storage Centre | | | |
| B7 | Operation Theatre | | | |
| B8 | Laboratory | | | |
| B9 | Radiology | | | |
| B10 | Pharmacy & Stores | | | |
| B11 | General Administration | | | |
| B12 | Auxiliary Services | | | |
| B13 | Radiology | | | |
| B14 | Please add | | | |
| B15 | Please add | | | |
| | Overall Score | | | |
| **C. Thematic Score Cards** | | | | |
| | Area of Concern | Baseline | Previous Quarter | Current Quarter |
| C 1 | Service Provision | | | |
| C2 | Patient Right | | | |
| C3 | Inputs | | | |
| C4 | Support Services | | | |
| C5 | Clinical Services | | | |
| C6 | Infection Control | | | |
| C7 | Quality Management | | | |
| C8 | Outcome | | | |
| | Overall Score | | | |

| D. Key Performance Indicators (KPI) | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Indicator | Unit | Previous Quarter | Current Quarter | | | Previous Year's (Average) |
| | **Productivity** | | | | | | |
| D1 | Bed Occupancy Rate | | | | | | |
| D2 | Lab test done per thousand Patients (indoor & OPD) | | | | | | |
| D3 | Percentage of cases of high risk pregnancy/obstetric complications out of total registered pregnancies at the Facility | | | | | | |
| D4 | Percentage of C-Section out of Total Deliveries | | | | | | |
| D5 | Percentage of LSCS surgeries done in night (8PM to 8 AM) | | | | | | |
| D6 | Percentage of Newborn admitted to NBSU out of Total live birth at Facility | | | | | | |
| | **Efficiency** | | | | | | |
| D7 | Percentage of referral of admitted patients out of total admissions. | | | | | | |
| D8 | Critical Emergencies (Snake Bite, Poisoning, Trauma, CVA) attended out of total emergency patients Registered | | | | | | |
| D9 | Emergency call attended per specialist per month | | | | | | |
| D10 | Percentage of Stock outs of Vital drugs (list of essential commodities under RMNCH+A) | | | | | | |
| | **Clinical Care/Safety** | | | | | | |
| D11 | Average Length of Stay | | | | | | |
| D12 | Number of Maternal deaths at the Facility | | | | | | |
| D13 | Percentages of DOT cases completed successfully | | | | | | |
| D14 | Percentage of AEFI cases reported | | | | | | |
| | **Service Quality** | | | | | | |
| D15 | Percentage of LAMA out of Total Admission | | | | | | |
| D16 | Average Patient Satisfaction Score for IPD | | | | | | |
| D17 | Average Patient Satisfaction Score for OPD | | | | | | |
| D18 | Percentage of women provided drop-back facility after delivery | | | | | | |

## Table (c): Key Performance Indicators for PHC

| | | | |
|---|---|---|---|
| Name of the Facility | | District | |
| Period (Quarter) | | | |
| Last Internal Assessment | | | |

**A. Gap Closure Status**

| | No of Gaps | Closed | In Process | Not Initiated |
|---|---|---|---|---|
| A1 | Facility Level | | | |
| A2 | District Level | | | |
| A3 | State Level | | | |
| A4 | Total | | | |
| A5 | Brief Description of Resources required | 1 | | |
| | | 2 | | |
| | | 3 | | |
| | | 4 | | |
| | | 5 | | |

**B. Departmental Score Cards B Departmental Score Cards**

| | Department | Baseline | Previous Quarter | Current Quarter |
|---|---|---|---|---|
| B1 | Out Patient Dept. | | | |
| B2 | Indoor Department | | | |
| B3 | Labour Room | | | |
| B4 | Laboratory | | | |
| B5 | National Health Prog. | | | |
| B6 | General Administration | | | |
| B7 | (Please add) | | | |
| B8 | (Please add) | | | |
| | Overall Score | | | |

**C. Thematic Score Cards**

| | Area of Concern | Baseline | | Previous quarter | | Current Quarter | |
|---|---|---|---|---|---|---|---|
| C 1 | Service Provision | | | | | | |
| C2 | Patient Right | | | | | | |
| C3 | Inputs | | | | | | |
| C4 | Support Services | | | | | | |
| C5 | Clinical Services | | | | | | |
| C6 | Infection Control | | | | | | |
| C7 | Quality Management | | | | | | |
| C8 | Outcome | | | | | | |
| | Overall Score | | | | | | |

**D. Key Performance Indicators (KPI)**

| | Indicator | Unit | Previous Quarter | Current Quarter | Previous Year's (Average) |
|---|---|---|---|---|---|
| | **Productivity** | | | | |
| D1 | OPD per Month | | | | |
| D2 | Percentage Deliveries conducted out of expected | | | | |
| D3 | Percentage of Deliveries conduced in the night | | | | |

| | Indicator | Unit | Previous Quarter | Current Quarter | | Previous Year's (Average) |
|---|---|---|---|---|---|---|
| D4 | Percentage of MTP Conducted | | | | | |
| | **Efficiency** | | | | | |
| D5 | Percentage of stock out of vital drugs (RMNCHA) | | | | | |
| D6 | Percentage of High Risk Pregnancy/Obstetric cases referred to FRU | | | | | |
| D7 | Percentage of client accepting limiting or long term contraception methods of contraception | | | | | |
| D8 | Dropout rate of DPT Vaccination | | | | | |
| | **Clinical Care/Safety** | | | | | |
| D9 | Percentage of high risk pregnancies detected | | | | | |
| D10 | Percentage of women stayed for 48 hrs after normal Deliveries | | | | | |
| D11 | Percentage of Anaemia cases treated successfully | | | | | |
| D12 | Percentage of AEFI cases Reported | | | | | |
| D13 | Percentages of DOT cases completed successfully | | | | | |
| D14 | Percentage of Children with diarrhoea treated with ORS | | | | | |
| | **Service Quality** | | | | | |
| D15 | Percentage of LAMA out of Total Admission | | | | | |
| D16 | Patient Satisfaction Score for IPD | | | | | |
| D17 | Patient Satisfaction Score for OPD | | | | | |
| D18 | Percentage of women provided drop-back facility after delivery | | | | | |

Annexure VII

# INCENTIVISATION FOR QUALITY ASSURANCE PROGRAMME

A provision has been made in the proposed QA programme to recognize efforts of those facilities, who have met the quality standards and got certified. A norm of incentive of Rs. 5,000 per functional bed has been planned on attainment of the national certification and every year on maintaining it. In addition, the states are also eligible to receive Incentivisation on the states' health facilities attaining the State level QA certification.

***Reference:*** *Operational Guidelines for Quality Assurance in Public Health Facilities, 2013, National Health Mission, Ministry of Health & family Welfare, Government of India.*

Annexure VIII

# SUGGESTIVE STEPS FOR DEVELOPMENT OF HOSPITAL PREMISES BY RKS FOR RESOURCE GENERATION THROUGH COMMERCIAL USAGE

1. RKS may formulate a master plan with 15-20 year projections & expansion especially for District Hospital, CHC & Civil Hospital. The master plan needs to spell out: a) Roadmap for development b) Relocation into new site, if required and c) In the existing facilities in-situ, the prioritization of spaces, would be for water/Sanitation and waiting area for patients and attendants.
2. The free space in the hospital premise could be used by RKS for developing commercial complex for fund raising without compromising the efficiency of the hospital operations. The land will be leased out on fixed term contract (as determined by the respective RKS) and under no circumstances, will the ownership of the land be transferred to private party.
3. All requisite clearances as prescribed by the Government of the State will be obtained before commencing the construction work, for e.g. (No Objection Certificate from Municipality, Town Planning Board et al).
4. The shops will not undertake vertical or horizontal expansion without permission and they will only be allowed to conduct business in the sector that the lease agreement mentions.
5. The income/resources generated from these activities would be used for strengthening the health care facility in keeping with objectives of RKS.
6. Every RKS needs to develop a complete holistic plan for the respective hospital before undertaking any commercial lease. These plans need to allocate space for hospital expansion, residential facility, attendants lodging & boarding facility, public toilet, parking lot, land-scaping on priority before allocating space for commercial purposes.
7. Care needs to be taken that the allocation of land for commercial purpose should not be for purposes which are contrary to health care and has possibility of noise/atmospheric pollution and promotes unlawful activities.
8. Every commercial proposal needs to have prior approval from Executive Committee and General Body.
9. New constructions should be in accordance with funds of RKS and technical due diligence.

***Source:*** *Guidelines for Rogi Kalyan Samities in Public Health Facilities, National Health Mission, June-2015.*

Annexure IX

# SUGGESTED AREAS WHERE UNTIED FUNDS MAY BE USED

1. Cleaning up of the facility especially in labour room and post- partum space, cleaning and maintenance of the campus to ensure a pleasing appearance.
2. Outsourcing/contracting in of clinical/non-clinical services.
3. Transport of emergencies to referral centres/Referral Transport.
4. Transport of laboratory samples during epidemics.
5. Provision of safe drinking water to patients.
6. Minor Repairs of building and furniture.
7. Building/repairing Septic tanks/toilets.
8. Improved signage in the facility.
9. Arrangement of stay for poor patients and their attendants.
10. Setting up of Rogi Sahayta Kendra/help desk.
11. Providing for Medicines and diagnostics for needy people.
12. Arrangement for hygienic environment for washrooms and toilets.
13. Making arrangement for proper disposal of wastage etc.
14. Repair/Maintenance of Government owned vehicles.
15. Purchase of medical equipment.
16. Providing security at hospital premises for safety/security of patients through outsourcing.

***Source:*** *Guidelines for Rogi Kalyan Samities in Public Health Facilities, National Health Mission, June-2015.*

Annexure X

# SUGGESTED FORMATS FOR MAINTAINING RECORDS

## *A. Format for Cash Book*

| | Receipts | | | | | Payments | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Date | Particulars | Ledger Head | Ledger Folio | Cash Rs. | Bank Rs. | Date | Particulars | Ledger Head | Ledger Folio | Cash Rs. | Bank Rs. |
| | | | | | | | | | | | |

## *B. Format for Standard Ledger*

*(Illustrative and not exhaustive)*

**Receipts**

1. Grants from State/Central Govt
2. Receipts from User charges
3. Receipt from other agencies
4. Interest on bank account
5. Miscellaneous receipts

**Payments**

1. Medical and diagnostic consumable
2. Equipment
3. Drugs
4. Furniture
5. Linen
6. Maintenance contracts and repairs
7. Outsourcing

8. Rented Vehicle and POL, maintenance
9. Printing
10. Training, IEC
11. Contingencies
12. Miscellaneous

### *C. Format for Petty Cash Book*

**Name of RKS:**

| Date | Particulars | Ledger Head | Ledger Head | Ledger Head | Ledger Head |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| Total | | | | | |

### *D. Format for Balance Sheet*

**Name of RKS** _____

**Balance Sheet for the Year Ending 31-3-200….**

| | Liabilities | | Assets | | |
|---|---|---|---|---|---|
| **Particulars** | **Amount Rs.** | **Amount Rs.** | **Particulars** | **Amount Rs.** | **Amount Rs.** |
| Opening Balance<br>Add: Excess of Income over expenditure | | | Fixed Assets<br>Advance to peripheries/agencies<br>Outstanding Receipts Interest accrued and due from bank | | |
| Other Liabilities<br>Expenses outstanding<br>Other Fixed Assets Reserve Account | | | Current Assets<br>Loans/advances<br>Cash in hand<br>Cash in bank | | |
| Total | | | Total | | |
| *RKS B/S will be prepared in the same manner as NHM financial statements are prepared*<br>Name of the RKS_____ | | | | | |

## G GFR 19-A

[See Rule 212 (1)]

## Form of Utilization Certificate

| Sl. No. | Letter No. & Date | Amount |
|---|---|---|
| | Total | |
| | | |
| | | |
| | | |

Certified that out of ……. of grant-in-aid sanctioned during the financial year …….in favour of……. under this Ministry/Department Letter No. given above and ……. on account of un-spent balance of the previous year, a sum of ` ……. has been utilized for the purpose of ……. for which it was sanctioned and that the balance of ……. remaining unutilized at the end of the year has been surrendered to Government (vide No. ……., dated……..) / will be adjusted towards the grant-in-aid payable during the next year ……

2. Certified that I have satisfied myself that the conditions on which the grants-in-aid was sanctioned have been duly fulfilled / are being fulfilled and that I have exercised the following checks to see that the money was actually utilized for the purpose for which it was sanctioned.

**Kinds of checks exercised**

1.

2.

3.

4.

Signature of the RKS Member Secretary

Signature of Superintendent/MO in Charge

Signature of Accountant

### *E. Format for Income and Expenditure Account*

| Expenditure | | Income | |
|---|---|---|---|
| **Particulars** | **Amount Rs.** | **Particulars** | **Amount Rs.** |
| Salary for contractual staff | | Receipt from Govt. | |
| Consumables | | Receipt from User Charges | |
| Drugs | | Receipt from Rentals etc | |
| Equipments | | Receipt from other agencies | |
| Linen | | Miscellaneous | |
| Contingencies | | | |
| Training | | | |
| Maintenance & Repairs | | Excess of Expenditure over in- come c/f to balance sheet | |
| Civil works | | | |
| Printing | | | |
| Miscellaneous | | | |
| | | | |
| | | | |
| Total | | Total | |

## *F. Format for Statement of Expenditure*

| **Activity** | **A** | **B** | **C** | **D=(B+C)** | **E** | **F** | **G=(E+F)** | H= (A+D)-G<br>Unspent Balance |
|---|---|---|---|---|---|---|---|---|
| | Opening Balance (Beginning of the year) | Amt Received (In current FY) Till the previous Month | Amt Received During the Month | Total Amt Received (In current FY) Till date | Exp. (In current FY) Till the previous Month | Exp. During the Month | Total Exp. (In current FY) Till Date | |
| | | | | | | | | |

## *G. Format for Receipts and Payments*

Receipts and Payment Account For The Period 1-4-20… to 31-3-20..

| Receipt | | | Payment | | |
|---|---|---|---|---|---|
| **Particulars** | **Amount Rs.** | **Amount Rs.** | **Particulars** | **Amount Rs.** | **Amount Rs.** |
| Opening Balance | | | Outsourced Activity | | |
| Cash in hand | | | Consumables | | |
| Cash in bank | | | Drugs | | |
| Receipt from Govt | | | Equipment | | |
| Receipt from user charges | | | Furniture | | |
| Receipt from rentals etc | | | Linen | | |
| Receipt from other agencies | | | Contingencies | | |
| Interest on bank account | | | Training | | |
| Miscellaneous | | | Maintenance & repairs | | |
| | | | Civil works | | |
| | | | Printing | | |
| | | | | | |
| | | | | | |
| | | | Closing balance<br>Cash in hand<br>Cash in bank | | |
| **Total** | | | **Total** | | |

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GOVERNMENT OF INDIA