

## Health Strategy

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## Introduction

This document is Document 3 in a series of five documents; The Health Strategy is Document 1. This document is intended to give a brief overview of the major areas of activity within DHFW, noting where these are covered in more detail in Document 2: Background and Rationale for the Priorities in the Health Strategy. Individual sections within DHFW are invited to improve these descriptions.

Documents 2, and 4 are supporting documents to the Health Strategy.

Document 1: The Health Strategy.

Document 2: Background and Rationale for the Priorities in the Health Strategy.

Document 3: Overview of DHFW's present activities.

Document 4: The Integrated Financial and Economic Plan for the Health Strategy

Document 5a: Annexes 1 - 4:

Annex 1: The Honourable Minister's Budget Speech 2003.

Annex 2: Terms of Reference for the Strategic Planning bodies.

Annex 3: Draft Terms of Reference for HRD and Organisational Review.

Annex 4: Health Financing in West Bengal Study Report.

Document 5b: Annex 5:

Annex 5: Essential Service Package documents.

Document 5c: Annexes 6 – 8:

Annex 6: State HIV/AIDS Action Plan.

Annex 7: Review of Qualitative Studies.

Annex 8: DHFW staffing levels and Organogram

These documents in turn are supported by, and draw on, a range of other DHFW documents, including:

- The Honourable Minister's Budget Speech, 2003.
- The Honourable Minister's paper "On integration of functioning of PRIs with Health Systems and other recent initiatives in the Health Sector", 2003.
- Health Sector Reforms Edition 2.
- Other related Government Orders.



Abbreviations

a/c	Air conditioning
ACMOH	Assistant Chief Medical Officer of Health
AIDS	Acquired Immunodeficiency Syndrome
BCC	Behavioural Change Communication
BEmOC	Basic Emergency Obstetric Care
BHC	Block Health Committee
BMOH	Block Medical Officer of Health
BPHC	Block Primary Health Centre
CBO	Community-based Organisation
CBR	Crude Birth Rate
CCA	Convergent Community Action
CEmOC	Comprehensive Emergency Obstetric Care
CHC	Community Health Centre
CMOH	Chief Medical Officer of Health
CMR	Crude Mortality Rate
CPR	Contraceptive Prevalence Rate
CS	Civil societies
CSS	Centrally-sponsored Scheme
CT	Computerised Tomography
DALY	Disability-adjusted life years
DFID	Department for International Development (UK)
DFIDI	Department for International Development India
DH	District Hospital
DHC	District Health Committee
DHFW	Department of Health and Family Welfare
DHS	Director of Health Services
DOTS	Directly Observed Treatment (TB)
DP	Development Partner (Donor Agencies)
DSP	Director of Strategic Planning
DSRD	DFID Support to Rural Decentralisation
EC	European Commission
ESP	Essential Services Package
GO	Government Order
GDP	Gross Domestic Product
GoI	Government of India
GoWB	Government of West Bengal
GP	Gram Panchayat
GS	Gram Sansad
GTZ	Deutsche Gesellschaft für technische Zusammenarbeit
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRD	Human Resource Development
HS	Hospital Superintendent
HSDI	Health Sector Development Initiative
HSS	Health Sector Strategy
ICDS	Integrated Child Development Service
IDSP	Integrated Disease Surveillance Programme

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IEC	Information, Education, communication
IMR	Infant Mortality Rate
ISM	Indian Systems of Medicine
IT	Information Technology
KfW	Kreditanstalt für Wiederaufbau
LBW	Low birth weight
MCH	Maternal & Child Health
MDG	Millennium Development Goals
MDT	Multi-drug Therapy (Leprosy)
MMR	Maternal Mortality Ratio
MO	Medical Officer
MOH&FW	Ministry of Health & Family Welfare (Delhi)
MPW(F)	Multi-purpose Worker (female)
MTEF	Medium Term Expenditure Framework
MTP	Medical Termination of Pregnancy
NGO	Non-governmental Organisation
NLEP	National Leprosy Programme
NMR	Neo-natal Mortality Rate
OPD	Outpatients Department
ORS	Oral Rehydration Salts
PHCentre	Primary Health Centre
PHC	Primary Health Care
PMIS	Personnel Management Information System
PPP	Public-Private Partnership
PRA	Participatory Rapid Appraisal
PRDD	Panchayat & Rural Development Department
PRI	Panchayati Raj Institutions
PWD	Public Works Department
RCH	Reproductive and Child Health
RCH II	Reproductive and Child Health Programme II
RH	Rural Hospital
RNTCP	Revised National Tuberculosis Control Programme
Rs	Indian Rupees
RTI	Reproductive Tract Infection
SBHI	State Bureau of Health Intelligence
SC	Scheduled Castes
SCC	Secondary Care Committee
SDH	Sub-divisional Hospital
SF	Strategic Framework
SFWO	State Family Welfare Officer
SGH	State General Hospital
SIHFW	State Institute for Health & Family Welfare
SIP	Sector Investment Programme
SLCC	State-level Co-ordinating Committee
SPC	Strategic Planning Cell
SPSRC	Strategic Planning & Sector Reform Cell
ST	Scheduled Tribes
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection

Department of Health and Family Welfare, Government of West Bengal

TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TORs	Terms of Reference
TU	Tuberculosis Unit
UNFPA	United Nation Family Planning Agency
UNICEF	United Nations Children's Fund
VCTC	Voluntary Counselling & Testing Centre (HIV)
VHW	Voluntary Health Worker
WB	World Bank
WBHSDP	West Bengal Health Systems Development Project II
WBRCH	West Bengal Reproductive Health Project
WHO	World Health Organisation
ZP	Zilla Parishad

## 1. Health Systems

### 1.1. *Health Management and Information System (HMIS)*

**DHFW has selected HMIS as a phase 1 strategic priority, and it is covered in more detail in Document 2: Rationale for the Priorities in the Health Strategy.**

DHFW is committed to continuing to improve the HMIS. The various components of the HMIS will be further strengthened and linked together so as to be able to provide the demographic, epidemiological, geographical and administrative (assets, human resources and logistics) data necessary to monitor and plan health services at all levels in order to meet DHFW's vision.

HMIS data will inform future policy debate. The HMIS will produce sufficiently disaggregated data and be sensitive enough to allow analysis of geographical variation and the specific needs of vulnerable and marginalized groups. These data will be used to design specific local interventions to meet these needs.

### 1.2 *Human Resource Development*

**DHFW has identified HRD as a phase 1 strategic priority, and it is covered in more detail in Document 2: Rationale for the Priorities in the Health Strategy.**

Human Resource Development (HRD) is a vital and cross-cutting component in all DHFW strategic planning. DHFW recognises the fundamental importance of root and branch reform of Human Resource Development systems within the Department whilst also acknowledging the enormity of this task. DHFW has decided that the first step in tackling these issues will be a thorough review and analysis of HRD systems within all levels of the Department. As part of this process, DHFW has contracted an organisation to develop a Personnel Management Information database. When complete DHFW intends to use the database as the basis of future planning for its strategy to strengthen its HRD systems. DHFW has also secured funding from the EC through the SPSRC for its plans to undertake a review of HRD systems at State Level. The Terms of reference for this study are attached in Annex 3.

DHFW accepts that wholesale HRD reform is likely to raise many sensitive issues, and that it would be premature and ill-founded until these and other areas of analysis are complete. For this reason, such reorganisation does not feature as one DHFW's first phase priorities, whilst the continuing analysis does.

In future phases of implementation DHFW, supported by external HRD expertise, will seek to involve its technical and administrative staff in the process of producing technical job descriptions following technical job analyses. Key Functions will be identified, a hierarchy of Key Functions established and job descriptions for these will be produced. Following this process, personnel norms for Key functions will be developed and a revision of cadres undertaken so as to bifurcate technical and administrative Functions.

### *1.3 Asset management and logistics*

**DHFW has identified asset management and logistics as a phase 1 strategic priority, and it is covered in more detail in Document 2: Rationale for the Priorities in the Health Strategy.**

DHFW is committed to improving systems for the management of its infrastructure, equipment and logistics to ensure needs-based year-round supplies of essential drugs and consumables and cost effective preventive maintenance of its facilities.

### *1.4 Managing quality*

#### *1.4.1 Links between Quality Management, decentralization, HMIS, HRD*

Implementation of a quality management framework is consistent with, and strengthens, other strategic plan priority areas. Examples of these linkages include:

- Supporting and encouraging decision making at multiple levels within the health sector is basic to quality management as well as to decentralization.
- Involvement of service users and other local bodies in the development of national or local service standards and clinical guidelines
- Involving service users, Gram Sansads, local NGOs, and Gram Panchayats in the monitoring and evaluation of health services against mutually agreed standards.
- Development of clinical guidelines for the most frequent conditions and diseases identified through the HMIS on Burden of Disease

Other areas of linkage that will need to be addressed are the linkages between the quality, legislative and funding frameworks. Identifying and addressing these linkages are essential to manage risks inherent in the current system and to enable whatever quality management methods and tools are put in place to bring about sustainable improvement.

DHFW has prioritised the assurance of quality at all levels of health and medical care as one of its four key objectives. Obstetric, neonatal and paediatric care have been identified as priority areas. In addition the ESP has made a significant start in determining those areas of priority for quality improvement within the District health services.

In order for the ESP and other improvements in specific conditions and diseases to bring about sustainable improvements they must be incorporated in an overall State-wide quality framework. The important first step is to agree on what principles are most important for sustainable quality improvement.

Many of these principles are evident in the current strategic framework. They include:

- Focus on the user and in particular the poor and disadvantaged.
- Decision-making based on data/information, including support of evidence-based medicine and practice in the areas of allopathic and Indian traditions of medicine.
- Leadership through a process of decentralization with an emphasis on shared decision-making and partnerships.
- Process and system improvement, including development of service standards and clinical guidelines.
- Focus on continuous quality improvement with an emphasis on supportive evaluation and monitoring.
- Capacity building with an emphasis on life-long learning.
- Multi-disciplinary team work and clear accountability and responsibility.

#### *1.4.2 Translating the Health Strategy priorities into action*

Now the priorities and direction of the Strategy have been agreed, the tools and methods needed to realize improvement must be put in place. This will include development and implementation of those tools and methods most congruent with the principles. For instance, for the above principles some of the activities would be:

- Agreement on service standards for all levels of the health services and developed in a process that would involve persons from various perspectives such as policy makers, health professionals, service users, and state and local bodies. For instance at the District level they would be based on the current ESP.

- Agreement on clinical guidelines for OB, gyn, neonatal, tuberculosis and other diseases and conditions identified as causing the greatest BOD, and again developed using a multi-disciplinary approach.
- Implementation of a supportive health service evaluation method such as accreditation.
- Mapping of current key processes such as admission and referral processes and redesign of these based on national and international best-practice information.

Many activities such as the ESP, the decentralization process and previous initiatives will support the implementation of the quality tools and methods. For instance, standards for health service facilities at the District Level could focus on the ESP and the groups developing the standards would involve the PRI alongside the professional groups, policy makers, local bodies, service users and others. The clinical guidelines could be used not only to guide clinical practice but as teaching and communication material. This development of standards and guidelines will build on the work of the Health Systems Development Project.

Quality Management means that the ultimate aim of all those providing care and services is the quality of that care and services. Providing a quality framework supported by specific, easily understood and agreed principles removes the mystic from quality improvement and provides all those working within the health sector with specific methods and tools to improve their efforts. This quality framework along with the understanding with the understanding of the cyclic process of improving quality will provide achievable and sustainable improvements within the health sector.

## 2. Social mobilisation for health

Social mobilisation brings a range of inter-sectoral partners and allies together to raise awareness, demand for action and influence public health policies. Centered on people's needs, it is a process of mobilizing action for better health services and policies. It builds on contributions of technical experts and strives to empower communities through active participation to identify health needs and responsibilities and promote healthy behaviour. Social mobilization has been used successfully in a number of areas such as vaccination programmes; particularly polio eradication, malaria control, HIV/AIDS and tuberculosis.

Key elements of social mobilization include:

**Advocacy:** Building political and popular support to effect policy change and to mobilise resources.

**Mobilising policy change:** Efforts to build a supportive policy environment for legislative reform through the use of declarations; parliamentary committees and other advocacy tools.

**Community mobilization:** The process of engaging communities in planning, advocating and implementing programmes.

**Building partnerships:** Mobilising alliances that may include local government, the private sector, non-governmental organisations and civil society.

**Mass media and social marketing:** Raising awareness, informing the general public and promoting behaviour change (eg. condom use).

**Strengthening co-operation:** between government and NGOs  
The success of social mobilization is influenced by political will and leadership; societal openness and determination to fight against stigma; multi-sectoral and multi level action; community based response; long term and sustained response; learning from experience and availability of adequate resources.

### 2.1 *Advocacy on determinants of health*

DHFW recognises the importance of advocacy for addressing the wider determinants of health within other GoWB departments (such as Education, PRI, Public Health Engineering, Public Works, Information and Social Welfare) and the wider political system.

## *2.2 Coordinated and comprehensive IEC/BCC*

DHFW recognises the necessity of stimulating informed demand for appropriate health services. This is particularly important if significant progress towards State, GoI and Millenium Development Goals are to be met in the reduction of maternal and neonatal mortality.

## *2.3 Promotion of reforms*

DHFW is justly proud of its reforms to date (summarised in Health Reforms, 2<sup>nd</sup> Edition, DHFW) and will promote them both within other departments of GoWB and (through the mass media) to communities so as to inform the people of West Bengal of their entitlements and how best to use their health services.

One of the recurring themes of the qualitative research described in Document 2: Background and Rationale for the Priorities in the Health Strategy is that many people, especially the difficult to reach, are not aware of even the broadest policy aims and changes that may affect them. DHFW recognises that mechanisms must be identified to more effectively promote its health reforms.

## *2.4 Disaster preparedness*

West Bengal is prone to floods, cyclones, landslides, epidemics and man-made disasters. Whist Nationally, Disaster preparedness is the responsibility of the Ministry of Agriculture, in West Bengal it is the function of the Relief Department to draw up pre-disaster, intra-disaster, post-disaster and rehabilitation plans, and co-ordinate the various GoWB line departments. District Magistrates can set plans rolling co-ordinating with Block Development Officers to enact the planned response and establish 24 hour response centres, lines of communication, daily and weekly reporting. A Government order is issued every March to ensure that contingency funds are available and can be released with other resources such as stocks of emergency medicines. Mapping ensures that supplies and responses are area-specific.

Functioning health facilities and systems are essential components of disaster preparedness. District and block linkages between District Magistrates, DHFW and PRIs will be built which will significantly improve communities' abilities to respond to disasters both in the immediate phase and the post-disaster phase. Previous experience shows that this is when epidemics commonly occur. Also, DHFW will explore the feasibility of mapping its more disaster prone facilities with a view to redesigning and rebuilding them to withstand future disasters emergencies.

### **3. Improving the quality of Primary Health Care and the health status of vulnerable groups**

DHFW will continue to refine and develop the Essential Service Package whilst implementing a subset of ESP activities designed to specifically and directly reduce maternal and neonatal mortality, in line with MDG goals, across the State.

#### *3.1 Essential Services Approach*

The Essential Services Approach is a strategy to ensure quality and cost-effectiveness in Primary Health Care. A DALY/Essential Services Approach has been adopted in several resource-poor countries (e.g. Bangladesh, Nepal, Cambodia) with variable degrees of success. This process typically takes several years and substantial technical assistance to develop. The services included in most essential packages, if comprehensively and equitably provided would be of great value, especially to the poor. However, such an approach has been criticised as:

- Paying insufficient attention to the (often considerable) systems, institutional and budget/financing changes necessary for implementation.
- Inconsistent with a responsive demand-led service.
- Tending to underestimate overall costs.

DHFW has decided to explore this approach, and has developed an Essential Drug list, an Essential Equipment list and a matrix that outlines the roles and responsibilities of various cadres of health worker at all PHC facilities (Annex 5). Work is underway to develop to State Drug Policy and standard treatment protocols. DHFW recognises the nature and extent of the systems changes necessary before it can implement a fully developed Essential Services Package (notably human resource development and asset and logistics management).

DHFW will continue to refine and develop its Essential Service Approach as a medium term goal. In the short term it will focus efforts on a prioritised subset of Essential Services designed to specifically and directly reduce Maternal and Neonatal Mortality across the State in line with MDG goals, this are presented in the Rationale Document. Simultaneously DHFW will review and address key systems and institutions weaknesses.

#### *3.2 Prioritising the reduction of maternal and neonatal mortality*

The Consultative Group responsible for PHC has prioritised those elements of the ESP that will directly contribute to reducing maternal and neonatal mortality.

**The rationale and evidence base for these decisions is presented in Document 2: Rationale for the Priorities in the Health Strategy.**

DHFW will design and implement the following interventions, ensuring that there will be complete synergy with the RCH II programme which is presently being designed. Some of these will be phase 1 priorities, others longer-term goals.

DHFW plans to upgrade all BPHCs to Rural Hospitals, unless there is already a rural hospital in the Block. One third of all PHCs will be made bedded, and staff relocated to these facilities from the remaining two thirds of PHCs which will be made available for NGO or private sector contractors to manage.

### **Reducing Neonatal Mortality**

**At community level** (mothers, households, peripheral government staff from health and other sectors, opinion leaders, religious leaders, sub centres):

- Qualitative studies to identify key neonatal care issues in the home (these will not be uniform across the State).
- Identify appropriate Behaviour Change Communication (BCC) messages, co-ordinate and target locally.
- Develop dissemination plan for messages: decide who communicates messages to whom, equip them to deliver messages (materials, training, supervision), identify means to disseminate (village meetings, mass media etc).
- Engage PRI partners, NGOs, private sector, quacks etc in BCC activities.
- Advocate for PRIs to be able to raise, hold and use funds from NGOs and private sector for use in promoting BCC activities.
- Build the capacity of PRI partners to engage in the registration of all births, stillbirths, deaths and early pregnancies.

### **At PHC (bedded and unbedded) and BPHC level:**

- Development of facility and cadre-specific neonatal care treatment (based on the care of the normal newborn) and referral protocols (based on birth weight and danger signs).
- Hands-on, team training to improve the quality of neonatal care.
- Establish system whereby the quality of care can be supervised.
- Establish a locally appropriate 24hr referral system (with access to community-managed emergency funds).

### **At RH, FRU, SDH, and DH level:**

- Establish level II neonatal care.

### **At State Level:**

- Establish a State Centre of Excellence for neonatal care to provide level III neonatal care, co-ordinate training, update treatment protocols, appraise facilities quality of performance, outreach and research.

### **At Policy Level**

- Introduce independent practitioner status for midwives and nurses. Pilot and closely supervise evidence-based extensions of the roles of key health workers (nurses, midwives and grassroots workers) to permit them to provide key elements of neonatal care. Removal legislative barriers to the State-wide adoption of successful pilots.
  - Establish neonatology as an independent speciality.
  - Establish a State-level Neonatal, Perinatal and Safe Motherhood Advisory Committee to support and facilitate Policy formulation.
  - Establish a State-level Breast Feeding Committee to extend and monitor Mother and Baby-friendly health facility status and promote and monitor strict adherence to International, National and State policies on the promotion of breast feeding substitutes, especially in State health facilities.
- Strengthen adolescent health policy to prevent anaemia and Low Birth Weight.

### **Reducing Maternal Mortality**

**At community level** (mothers, households, peripheral government staff from health and other sectors, opinion leaders, religious leaders, sub centres):

- Qualitative studies to identify key maternal care issues in the home, focusing on awareness of danger signs and barriers to seeking help (these will not be uniform across the State) and including adolescent girls as a key group to be reached.
- Identify appropriate Behaviour Change Communication (BCC) messages, primarily to promote birth preparedness, skilled attendance at birth (from public and private sectors, NOT including TBAs) encourage recognition of danger signs and promotion of prompt referral. These will need to be co-ordinated and targeted locally.
- Develop dissemination plan for messages: decide who communicates messages to whom, equip them to deliver messages (materials, training, supervision), identify means to disseminate (meetings, mass media)
- Engage PRI partners, NGOs, private sector, quacks etc in BCC activities to promote prompt and appropriate referral.
- Advocate for PRIs to be able to raise, hold and use funds from NGOs and private sector for use in promoting BCC activities.
- Build the capacity of PRI partners to engage in the registration of all births, stillbirths, deaths and early pregnancies.

### **At PHC (bedded and unbedded) and BPHC level:**

- Team training for health workers to improve Safe Motherhood skills to provide the quality of ante, intra and post natal, cadre and facility-appropriate, routine services. There will be a strong emphasis on emergency obstetric services and strengthening decision-making in obstetric first aid, pre-referral stabilisation skills, Basic and Comprehensive Emergency Obstetric Care services, including facility-appropriate anaesthesia.

- Develop facility and cadre-specific (obstetric first aid, basic emergency obstetric care, referral and stabilisation before referral) protocols.
- Establish system whereby the quality of care can be supervised, sequentially introducing maternal “success”, “near miss” (and eventually) mortality audits and audits of case fatality rates.
- Establish a locally appropriate 24hr referral system (with access to community-managed emergency funds).
- Expansion of quality MTP facilities at all BPHCs.
- Strengthen PHC staff ability to interpret PRI early pregnancy registration data and interpret in the light of the rate of institutional deliveries, outcomes etc.

**At RH, FRU, SDH, DH level:**

- Focusing primarily on FRUs, and DHs, establish and improve the highest level of emergency obstetric care and appropriate referral possible, identifying and removing barriers to providing more comprehensive levels of emergency obstetric care (e.g. the availability of anaesthesia, blood, equipment, training etc) and carefully mapping and monitoring what services are available so as to accurately stimulate demand side BCC messages.

**At Policy Level**

- Establish, promote and support a cadre of private midwives with strong links to government health services.
- Increase the availability of anaesthetic services by promoting short course obstetric anaesthesia courses for doctors, following up and supporting these trained doctors and contracting anaesthetic services from the private sector where necessary.
- Increase the availability of safe blood transfusion services.

*3.2 Strengthening decentralised management of PH services*

*3.2.1 Overview*

A wide range of changes have already been agreed in the health sector in West Bengal and are now in the process of being implemented at district level and below. The changes include significantly increased delegated financial and administrative powers to the primary care management in the districts, increased user fees and the creation of District Health Samities which are jointly staffed by Health, PRI and District Administration officials. The Department of Health and Family Welfare (DHFV) has also committed itself to developing a:

*“State level Strategic Framework for Health ... (which would) provide an opportunity to address policy*

*formulation, systems development and decentralisation issues”.*

The constitutional amendment and the GoWB's policy are committed to decentralisation of the health sector. However the form and process of decentralisation are issues yet to be settled. This is a complex problem and needs to be addressed through proper design, field trials, documentation of capacity building and problem solving process and then expanding in a phased manner. The Institutional Development Capacity and Organisational Development within the PRI system need to be reviewed and reorganised before passing over health management responsibilities.

Although India is committed to decentralisation and though the various policy papers and the National Health Policy promote decentralisation, there is still no consensus at the national level as to how the publicly funded health service delivery system will be decentralised. For example, is the future health service going to be provided by autonomous bodies or is it going to be deconcentrated to allow facilities to manage their own services? Is it going to be devolved to the locally elected bodies, and, if so, to what level – the district or block? What will be the future role of the centre and the State level – planning, monitoring, setting of output indicators, purchasers of services? Although States are mandated to develop their own decentralisation policies, it would be helpful if the Centre were to develop clearer guidelines in this area.

### *3.2.3 Dilemma of Decentralisation in the Health Sector in West Bengal*

The process of decentralisation in West Bengal so far as the Health Sector is concerned, is seen to unfold in a manner which is at once complex and contradictory. There are two scenarios emerging.

The first scenario is at the normative level under which in terms of the 73<sup>rd</sup> and the 74<sup>th</sup> Amendments to the Constitution of India (1992), the subjects covered under the Eleventh Schedule and the Twelfth Schedule of the Constitution are required to be transferred from the State Administration to the Panchayats and Municipalities. The State Government has acknowledged this in bold terms through the actual practice of issuing orders and notifications concerning the same. The process of transfer of functions, finances and functionaries would be supervised by the highest political body: a Cabinet subcommittee on Decentralisation, headed by the Chief Minister.

In the Memorandum dated 24<sup>th</sup> May, 1999 of the Government of West Bengal, (Development and Planning Department), it is clearly stated that 'in pursuance of the 73<sup>rd</sup> and the 74<sup>th</sup> Amendments to the Constitution, the State Government has already started formalising the process of preparation of plans towards strengthening and extending participatory decentralised planning through the elected Panchayats in the rural areas and the elected Municipalities in the urban

areas'. Note the message of the Memorandum regarding transfer of personnel: 'the services of Line Department officials will be made available to the respective tiers of the Panchayat bodies/Municipalities. The concerned District level officers and officers having functional jurisdiction extending over more than one Panchayat Samity/Block in the district may be given suitable ex-officio designation signifying their association with the Zilla Parishad and similarly the Block level officers with the Panchayat Samiti'.

In a similar vein, the Notification order dated 18<sup>th</sup> August, 1999 mentions that 'the Governor is pleased to order that the powers and functions be transferred to such tier of Panchayat bodies/Municipalities within the districts...' and modus operandi to be worked out to transfer 'district sector schemes of state departments to the Panchayats and Municipalities along with the placement of services of the concerned officials and staff. Further, the Notification dated 28.8.2001. states that 'the post of Health Assistants (Male) and (Female) be re-designated as Health Assistant and Ex-Officio Gram Panchayat Health Assistant. The aforesaid officials alongwith community Health Guides and Trained Dais attached to a sub-centre will be working under the supervision of the Gram Panchayat'. This is, as it should be, in conformity with the constitutionally mandated course of action, as formally accepted by the State government.

The second story, however, takes a different route. What constitutes the second story is the unabashed departure from the normative constitutional path. Also, it marks a covert departure from the state's formally declared will to decentralise at the level of local self-government.

The second scenario ps demonstrated by Memo No. HF/O/PHP/322/O-23/98 dated 20/05/2002 gives a twist to the decentralisation story. Instead of devolving functions and responsibilities to panchayats and other urban local bodies in accordance with the Constitutional mandate, the emphasis has shifted to the need for 'an integrated approach to the communicable diseases control programmes'. This has resulted in the formation of a district level Samiti which is an amalgamation of the existing disease-specific health societies. The District Samiti has a governing body headed by the Sabhadipati of Zilla Parishad as the President but the District Magistrate as its Executive Vice-President looks after the management of the Samiti. Chief Medical Officer of Health (CMOH) is the Secretary who continues to remain the kingpin, which means 'business as usual'.

There are the other Project Officers in charge of various health programmes and all the Superintendents of the district, sub-divisional and state general hospitals. The membership of the Samiti is heterogeneous, symbolic of taking everybody along including local government, NGOs and government functionaries.

There are several actors here:

- A1- Central government who originally recommended the formation of Disease-specific societies which are centrally funded;

- A2- State Government introduced single Samity
- A3- PRIs/Municipalities;
- A4- Health Professionals (Doctors/Paramedics).

The formation of the Samiti hints at the fact that A2 and A4 have joined hands in order to serve their respective interests. The doctors could well avoid the village members and the Panchayat leaders who, they feel, would be pointing fingers at them for negligence of duty. The accountability continues to flow along traditional vertical lines. Accountability to the local elected leadership is carefully fudged and transparency in operations is thus unlikely to be significantly improved. Thus a compromise formula is crafted which heavily tilts towards state control and professional autonomy. Decentralisation is only a 'front'. The 'backstage' is a different story. Here the state carries out its agenda of deconcentration and not devolution. As a result, A3 are deprived of their constitutional right.

### *3.2.3 Developing a Decentralised Health Service in West Bengal*

In the existing situation further progress and development of a decentralised health service is unclear. The need to improve the quality and coverage of the primary care services is recognised and it is felt that decentralisation would significantly improve the system. However the design of such a system and the balance of responsibility between the line Department (DHFV) and the PRIs but still need to be decided and agreed. The role of development partners in the process is also being discussed in the State; a useful discussion on all these aspects of decentralisation is given in a paper written by Prof. Dutta who is a member of the State planning Board and the Chairman of the Subject Committee for Health and Family Welfare, GoWB<sup>1</sup>.

The Panchayat and Rural Development Department and DFID are developing a programme to support rural decentralisation<sup>2</sup> which emphasises the need for the all the line departments working in the districts to work with the PRIs at district and sub-district level. The mechanisms for this are discussed in outline but the programme itself would define the relationships and responsibilities for planning, implementing and monitoring activities and programmes.

In response to this situation, SPSRC has developed a proposal to design and implement decentralisation in the health sector in a way that works closely with the PRIs, is co-ordinated with the rural decentralisation programme and is owned and controlled by GoWB and its agencies.

### *3.3 Control of communicable diseases*

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<sup>1</sup> Prof. G. P. Dutta, Health Care Development through the Panchayati Raj Institution

<sup>2</sup> DFID Support to Rural Decentralisation, Draft Programme Memorandum, August 2003

DHFW recognises the importance of the centrally-sponsored communicable disease control programmes. Valuable work will continue in these programmes. The development of an integrated Disease Surveillance System will be an essential part of the process of improving disease control. Whilst DHFW supports further integration of these vertical programmes, this will remain a long term goal which will follow central Govt policy to pursue such integration. The RCH II programme is presently being designed.

### *3.3.1 Revised National Tuberculosis Control Programme (RNTCP)*

The RNTCP service is available in all the districts of West Bengal except Darjeeling. It will start in this District in 2003. The remaining 39 of the planned 819 designated microscopy centres for carrying out quality sputum microscopy will be operationalised, allowing Direct Observed Treatment (DOTS) to be delivered from 8126 Government centres and monitored every day by health workers, community volunteers, local clubs, NGOs. Private practitioners and NGOs will be encouraged to participate further with the more than 1381 Government and Municipal health facilities that are providing diagnostic and curative services.

Drug supply even at the PHC level has been ensured and will be maintained through the establishment of a network of drug centres at the Tuberculosis Unit (TU) level. The quality of diagnosis even at the peripheral health institutions will be further improved by increasing the availability of sputum microscopy.

DHFW will ensure that the encouraging reductions in rates of default (to present levels of 5-10%) will continue, and that case detection will improve from 45 new sputum positive cases per lakh population per year towards the expected case load of 50 new sputum positive cases per lakh population per annum.

Cure rates for sputum positive cases will be improved from the present 84% towards the benchmark of 85% in the 14 Districts where this is not yet the case. Sputum conversion rates of at least 90% in the 10 Districts that have not achieved this benchmark yet.

DHFW will support the proposed increase in inter-sectoral collaboration by involving the Employees State Insurance in 8 centres, Medical Colleges, NGOs and private practitioners.

### *3.3.2 National AIDS Control Programme and Blood Safety*

There is State HIV/AIDS Action Plan (Annex 6) which describes the State's response to the growing epidemic in more detail.

The State is a low prevalence state in terms of prevalence of HIV, but the recent sentinel surveillance figures show a sharp rise in the seropositivity figures in

some centres. DHFW recognises the need for increasing the coverage of all vulnerable populations such as the commercial sex workers, injecting drug users and males having sex with males.

DHFW is concerned that awareness levels among the general population especially among the women are very low and special attention will be paid to increasing the awareness of the general population through focused IEC activities.

VCTCs play a vital role in making the testing facility easily accessible for those who feel the need to take a test. The network of Voluntary Counselling and Testing Centres (VCTCs) will be expanded from the present 18 sites in medical colleges and district and sub-divisional hospitals. Telecounselling services such as “Jiggasha” will be expanded. DHFW recognises the particular importance of this service for adolescents who need to understand the psychological and physiological changes occurring in their bodies and obtain accurate information rather than base their opinions on myths and misconceptions.

DHFW will intensify efforts to increase the coverage of vulnerable groups. A comprehensive IEC strategy is being designed after which a number of campaigns would be taken up to sensitize people about the threat of HIV. STD control will remain an important component and is being implemented through the 30 STD clinics in the medical colleges and district hospitals in the State. Outreach campaigns will be expanded to provide an opportunity for all to get treatment for STDs especially women and prison inmates.

Advocacy programmes will be expanded to reduce stigma and discrimination towards people living with HIV/AIDS. Training of the health care providers will expand to include rural private practitioners who constitute the first line of treatment for STDs. Diagnostic facilities will be increased to expand the availability of CD4 and viral load estimation services. Services for the treatment of opportunistic infections will remain a key component and health workers personnel of the health institutions would be sensitised.

Blood Safety will remain a central component of the State’s overall AIDS control strategy. West Bengal leads India in terms of the percentage of voluntary blood donation (over 78% in 2002). Regulation, monitoring and quality assurance of blood collection has been extended to cover all private blood banks, ensuring a standard operating protocol for all blood banks. DHFW supports the accreditation of all blood banks.

Blood component separation units will be established at medical colleges so as to reduce the requirement for whole blood. Specialist training programmes for MOs and specialists in the rational use of blood will be initiated and extended to cover all relevant health care providers in Government hospitals.

### *3.3.3 National Anti Malaria Programme*

Surveillance data shows that there has been increase of 27% in malaria cases detected and 35% in malignant malaria cases, but due to prompt diagnosis and treatment, deaths from malaria fell from 191 in 2001 to 152 in 2002.

DHFW will improve the annual blood examination rate from 4.5 towards the objective of 10. The use of insecticide spray, residual spray, bio-larvicides and other measures for the prevention and control of malaria will be supported and more accurately targeted. Jalpaiguri District will continue to merit special attention.

DHFW supports community mobilisation and IEC activities to promote the eradication of environmental conditions favourable to the breeding of mosquitos. Community participation and the involvement of PRIs, ICDS workers and NGOs will facilitate the establishment of drug distribution centres and fever treatment depots in those areas of the State where malaria remains a significant problem.

### *3.3.4 Diarrhoeal and Enteric Disease Control*

DHFW supports efforts to reduce the case fatality of diarrhoeal disease further. Due to improved surveillance of diarrhoeal diseases through the HMIS in the districts and various other measures the case fatality ratio has remained within a near static state. An expert committee of doctors from the State level or the regional level are deputed for inspection and control of the disease. DHFW supports efforts to improve the awareness of the prevention and treatment of diarrhoeal disease among people most at risk in the State. DHFW strongly endorses IEC and BCC activities that promote the use of home made fluids, ORS, improvement in personal hygiene and referral of severe and complicated cases to appropriate facilities. Community participation and the involvement of PRIs, ICDS workers and NGOs will be central to this activity.

### *3.3.5 National Programme for the Control of Blindness*

The State has achieved remarkable progress in the control of blindness, with a reduction in prevalence to less than 1%. Equity of access to cataract surgery is improved as of fifty thousand IOL operations in 2001, 70% were free of cost. West Bengal has been a pioneer in banning the operation of flying eye camps whilst encouraging sustainability by supporting NGOs to perform cataract operations and provide other services through DHFW PHCs and BPHCs as bases. The village wise blindness register will be maintained in all Districts.

Tertiary level equipment will be installing in the medical college hospitals and in District and sub-divisional hospitals. A cadre of surgeons will be trained in specialist ophthalmic techniques and the cadre of trained paramedical ophthalmic assistants will be expanded. Bedded eye wards at selected hospital will be established and the Central Eye Bank at the Regional Institute of Ophthalmology, Kolkata will continue to play a central role.

DHFW recognises the School Eye Screening programme as a very important preventive programme, coordinating the distribution of vitamin A and free spectacles. The Regional Institute of Ophthalmology will be developed to be a centre of excellence, a provider of continuing medical education and a training centre, including a community ophthalmology training centre.

### *3.3.6 National Leprosy Elimination Programme*

The goal of the National leprosy programme (NLEP) is the elimination of leprosy in the State (less than 1 affected person per 10,000) by 2004-05. Six Districts have either achieved this goal or are close to achieving it. DHFW supports efforts to achieve this goal in the remaining Districts. Multi-drug Therapy (MDT) was first introduced in 1982 and has been available in all Districts since 1996 and the prevalence has been falling

DHFW recognises the difficulties in implementing the programme and targeting the vulnerable such as the poor, urban slum dwellers and migrants from highly endemic states such as Bihar, Jharkhand and Orissa. Partnerships with expert NGOs such as Ramakrishna Mission and Bharat Sevashram to improve awareness in the community through IEC/BCC activities will be central to eradicating leprosy in the State. DHFW notes that due to the decrease in caseload a large vertical health infrastructure to provide MDT is now less necessary and it will be integrated with the general health care system.

In partnership with experienced NGOs, specialist services will be provided free of charge to all leprosy patients, such as the surgical correction of deformities provided by the Leprosy Mission and the provision of protective footwear by the German Leprosy Relief Association which will.

### *3.3.7 State Arsenicosis Control Programme*

DHFW will establish two new programmes to address public health problems that are specific to West Bengal. In partnership with UNICEF, a pilot Arsenicosis Control Programme will be introduced in the worst affected areas, focusing on identifying and removing sources of contaminated water. This programme will run for 3 years and its components include a prevalence study, a case-finding door-to-door campaign by the paramedical and health workers to identify sufferers and an IEC campaign to raise awareness and improve self-referral to health centres.

Work is underway to standardise case definitions and diagnostic criteria. Diagnosis will be available in all PHCs, BPHCs and SDHs in the target Districts.

### *3.3.8 State Thalassaemia Control Programme*

DHFW will continue to implement and monitor the State Thalasemia Control Programme on a pilot basis. West Bengal has one of the highest prevalences of thalassaemia is one of the highest in the country. Three Districts will be targeted in the first phase with activities extended to a further three in phase 2. A baseline survey will be conducted to ascertain the perception of the problem in the community and identify what messages need to be communicated to improve awareness, especially among the youths and adults approaching marriage. This group will be targeted by working with schools and colleges in partnership with local opinion leaders, PRIs, religious leaders, civil society and NGOs.

Counselling and testing will be made available at nominal cost. Those who are found be carriers will be offered further genetic counselling along with their relatives.

### *3.4 Reproductive and Child Health Programme II (RCH II)*

MoHFW is developing the second reproductive and child health intervention for implementation across India. The main tenets of this programme are:

- RCH is to be viewed as a programme
- Evolving effective partnership with the private sector and NGOs
- Built on the lessons learnt from RCH I
- Achieving the MDGs.
- A decentralised programme formulation.
- Sharing of best practices.
- Special strategy for urban areas.
- Resource mapping for optimum utilisation.

A “Road Map” has been developed by the West Bengal to guide the development of its own Plan of Action.

1. Health outcomes have been defined.
2. Formulation of the State Project Design Team (Nov. 2003).
3. Agency to evaluate RCH 1 (Nov 2003).
4. Formulation of District Plans including an essential package and special interventions (March 2004).
5. Budgetary exercise including planning process, resource requirements & key indicators (March 2004).
6. Sharing and adoption of best practices (Jan. 2004).
7. Involvement of PRIs and Municipal bodies in project design (March 2004).

8. Building administrative structures and processes to ensure community involvement through Gram Sonsads and other PRIs and Municipal bodies (ongoing).
9. Build administrative mechanisms to ensure “joined up” Government.
10. Resource mapping from government and non-government sources (Jan. 2004).
11. Training needs assessment and State Training Design Team (March 2004).
12. Development of BCC programme.
13. Convergence of Public Health and Family Welfare activities for training, BBC and human resources deployment.
14. Neo-natal facilities strengthened at district hospitals.
15. Specialised training in Neo-natal care.
16. Development of an apex Neo-natal Unit for HRD and research.
17. Specific strategies for urban areas to be designed.

The aims of RCH II and the targets defined in the Strategy are fully compatible. DHFW has identified reducing MMR and NMR as being of the highest priority in the State. Preliminary designs of a strategy to reduce morbidity and mortality have been outlined in Section 3.2 above.

DHFW will continue to review and adapt the RCH II programme to fit in with its own special interventions to ensure that there are significant and sustained falls in MMR and NMR.

#### *3.4 Detection and treatment of non-communicable diseases*

As socio economic and health indicators improve and life expectancy increases the pattern of the burden of disease changes and significant new health problems emerge. Health systems in West Bengal must be able to detect such trends and predict changes in health needs through a high quality HMIS and plan to meet them.

Through the Essential Services Approach, DHFW will further develop its Primary Health Care systems to be able to prevent, screen for, detect, treat, follow up and where necessary refer non-communicable diseases of public health importance such as cardiovascular diseases, diabetes mellitus, cancer (primarily cervical, breast and oral cancers), mental illness and dental problems.

Another important and growing element of the burden of disease is trauma, (principally road traffic and industrial accidents). The Essential Services Approach will include strengthening systems to treat, stabilise and refer trauma victims. DHFW notes that a network of facilities that are providing Basic Essential Obstetric Care (BEOC), stabilisation and emergency transport to Comprehensive Essential Obstetric Care (CEOC) can provide almost all the necessary systems

(resuscitation skills and equipment, safe blood transfusion, anaesthesia, laboratory services and basic surgical skills) to function as basic trauma treatment systems. DHFW will develop this function further through the Essential Services Approach.

### *3.4.1 National CANCER Control Programme*

West Bengal with population of 8.20 Million (2001 census) will have approx 63,200 new cases of Cancer (estimated) per year based on the yardstick of 800 new cases per million per annum. Under the National Cancer Control Programme in the State of West Bengal and through Tobacco Control Programme an approach has been taken to reach the population which is not aware or is not able to get adequate diagnostic or treatment facilities. This consists of:

1. Primary prevention, i.e Health Education/ School Health Education by and through NGOs, PMA, PRI, Female Literacy Programme, V.H.W (F), ISM practitioners, private practitioners and unqualified practitioners.
2. Secondary prevention, i.e early detection of suspected cases referred from Sub Centre, PHC, BPHC, CHC.
3. Tertiary prevention, adequate treatment facilities.

Primary prevention will take place at the level of Sub Centre/PHC/BPHC/RH. PRIs will be encouraged and enabled to work with NGOs to increase the awareness of cancer and its causes through IEC/BCC activities. Such awareness is important if cancer is to be detected early especially for the age group between 35 to 60 years of age. Health workers and women in both rural and urban areas will be sensitised to the early symptoms of cervical cancer. Unqualified practitioners, practitioners of ISM services and all PH staff attached to primary health care system will be trained by MO of PHC/BPHC/RH to recognise the symptoms of early cancer and refer suspected cases to secondary prevention centres.

Treating referred cases at secondary level will be improved. Cervical cytology tests will be introduced, initially for all post partum women at Family Welfare Clinic. Positive smears will be recorded and referred to District level secondary hospital. In each District, a cancer detection centre will be established headed by a District Cancer Specialist. A multidisciplinary team comprising a pathologist, a gynaecologist, a surgeon, an anaesthetist and specialist nurses will assist the District Cancer Specialist. The District Cancer Specialist will examine all referred cases (suspected plus new cancer cases and patients referred back from tertiary level teaching hospitals for the administration of chemotherapy and follow up). Designated inpatient facilities will be expanded for both treatment and palliative care. Cancer detection centres will be established and run by the District Cancer Specialist and cervical cytology services will be developed at all District Hospitals

Tertiary care will be developed and extended at all Medical Colleges. A centre of excellence will be established linked to a State network of tertiary radiotherapy centres. Partnerships with the private sector and NGOs will be encouraged and new centres will be established with financial assistance from the Government of India.

CNCI will be the nodal centre for guidance and will act as advisor to the State Cancer Control Authority.

#### *3.4.2 National Mental Health Programme*

DHFW will continue to support inpatient services at specialist psychiatric hospitals and medical colleges and expand inpatient and outpatient services to all District Hospitals where they do not presently exist. Specialist psychiatric drugs will continue to be supplied to these OPDs and specialist medication will be made available at BPHC/RH/SGH level for patients who have been discharged for follow up treatment in the community. NGOs with particular experience in this field will be encouraged to participate in establishing psychiatry OPD services at sub-divisional hospitals and to counsel school children regarding mental health problems.

Centres for the treatment of drug addiction will be established in each District and sub-divisional hospital.

DHFW supports the rehabilitation of longterm residents in psychiatric facilities. One pilot project of the District mental health programme, with assistance of the Govt. of India, in Bankura District has demonstrated that nearly a third (110 of 337) long stay patients can be rehabilitated and return to the community and their families supported by NGOs, despite the considerable stigma attached to mental health problems.

#### *3.5 Integrated Primary Health Services for the urban poor*

The urban population will continue to grow. DHFW recognises the unique health needs of this group, especially the urban poor. Urban health remains the responsibility of the Municipal authorities. A network of clinics for preventive services and dispensaries for simple curative care exists. In some dispensaries, specialist outpatient services are available.

There is no functioning referral system. Urban PHC facilities are routinely bypassed either by patients inappropriately seeking care at higher levels or private practitioners inappropriately referring them to Tertiary facilities. This puts a great burden on Tertiary facilities.

Closer links will be built between Municipal and DHFW services to provide integrated urban PHC services with equitable and appropriate referral to secondary and Tertiary level services so as to relieve some of the pressure at this level.

The usefulness of Honorary Health Workers, initially established under the IPP8 programme, has been variable across India. However in KPMD areas an evaluation found them to be successful. In order to replicate this success, this scheme has been extended to several non KPMD municipalities with assistance from DFID.

## **4. Indian Systems of medicine**

### *4.1 Availability*

DHFW supports the concept of widening the availability of practitioners of Indian Systems of Medicine and their supply both in the public and private sectors.

#### *4.1.1 Ayurveda*

The State Ayurvedic Drug Testing Laboratory is under construction. It is the first of its kind in the State. It is being constructed with the assistance of the Central Government. DHFW will build stronger links with this State-run institution as it expands with Central Assistance to produce Ayurvedic medicines which will be made available to patients free of cost from at Ayurvedic Dispensaries.

Ayurvedic services have been split with effect from August 1<sup>st</sup> 2002 (by enactment of the West Bengal State Ayurvedic Health Service Act). This created the West Bengal Ayurvedic Education Service and the West Bengal Ayurvedic Health Service.

The State Medicinal Plants Board is working to increase the cultivation of Herbal and Medicinal Plants throughout the State. It seeks to market, preserve and export (either in raw or processed form).

#### *4.1.2 Homeopathy*

Homeopathy services have also been split with effect from August 1<sup>st</sup> 2002 (by enactment of the West Bengal State Homeopathic Health Service Act ). This created the West Bengal Ayurvedic Education Service and the West Bengal Ayurvedic Health Service. This created the West Bengal Homoeopathic Education Service and the West Bengal Homoeopathic Health Service.

#### *4.1.3 Unani*

There are three State Unani dispensaries, with plans to establish a third.

#### *4.1.3 Acupuncture*

Dr. B. K. Basu Memorial Research and Training Institute of Acupuncture is a State-run institution and has been running three acupuncture clinics in Kolkata. There are also State acupuncture clinics in Purulia, Bankura, Burdwan, Suri, Chunchura and Medinipur Sadar and at Zilla Parishad Dispensary of Onda in the district of Bankura. of the register. It is expected that one Acupuncture clinic in each of the District Head Quarters, in ten Sub-divisional Hospitals and in all the

25 BPHCs of the newly created Purba Medinipur District will be established in the ensuing financial year.

#### *4.2 Strengthening the links with PHC*

DHFW is committed to building closer links with Indian Systems of Medicine, harnessing this system to support outreach and extension activities. DHFW will not encourage extending the role of ISM practitioners to using allopathic medicines. DHFW will explore the feasibility of including ISM practitioners in disaster preparedness plans and as depot holder for health related commodities.

#### *4.3 Supporting private ISM practitioners*

DHFW approves of supplying of ISM practitioners with appropriate IEC/BCC materials and ISM medicines.

#### *4.4 Improving regulation*

DHFW is committed to improving the regulation of practitioners of ISM so as to reduce the overlap between genuine ISM practitioners and untrained allopathic practitioners and increase the quality of the ISM services offered. ISM will be discouraged from using allopathic drugs which are beyond the scope of their training and may be harmful.

## **5. Secondary level health services**

Since 1996 there has been very significant investment (approx Rs.700 crore) in Secondary Health Care through the World Bank loan assisted Health Systems Development Project. The Main components of this project were:

- Improving the institutional framework for policy development.
- Strengthening management and implementation.
- Developing disease surveillance capacity.
- Renovating and extending District, Sub Divisional and Regional Hospitals.
- Upgrading clinical and support services and service quality in hospitals.
- Improving the referral system.
- Upgrading PHC in the Sunderbans.

This project is due to come to an end in 2004. There has not yet been an external evaluation (one is planned for early 2004). Project reports suggests the following achievements.

There have been important improvements in infrastructure, and significant strengthening of HMIS and Disease Surveillance systems. There has been a rationalisation of Human Resources, with some ancillary services being contracted to the private sector. Others staff such as MOs and nursing staff have been contracted by District authorities to fill key staffing gaps.

There has been significant training activity for doctors both in induction of newly appointed MOs and specialist training for more senior doctors. Nurses have received general and specialised training in psychiatry and dentists, physiotherapists, pharmacists, and other paramedical staff have also received training. Specific attention was paid to training in hospital management for a broad range of key hospital staff.

Referral systems have been strengthened; a referral manual has been produced and transport and communications established. IEC materials have been developed and used to promote rational referral as part of an integrated communication strategy, and the HMIS system has been strengthened to monitor and record referral patterns. There is reported to have been a significant increase in referral activity.

An extensive set of facility performance and client satisfaction quality indicators has been identified and systems established to record and disseminate them. Between 1997 and 2003 there have been reported improvements at DH, SDH/SGH and RHs in overall admission rates, overall outpatients attendance, bed occupancy and turnover rates, emergency admission rates and lab/imaging investigation rates.

Health Care Waste Management systems have been established. There are reported to have been significant improvements in providers' and attenders' opinions of overall facility cleanliness.

### *5.1 Strengthening referral systems*

DHFW recognises that secondary level health services have a vital role to play in the reduction of maternal and neonatal mortality through the provision of Comprehensive Essential Obstetric Care and grade III neonatal care. DHFW will ensure appropriate systems of emergency referral to these centres. This necessitates reliable communication and transport between primary and secondary (and to a lesser extent between secondary and tertiary) facilities. In rural areas, novel systems of community referral linking motor and non-motor transport, will be developed as those currently being piloted by DHFW in several districts as part of its Essential Services Approach.

Strong communication systems will be developed both for both "up" (i.e. patient details, diagnosis, immediate treatment undertaken, estimated time of arrival) and "down" (outcome, final diagnosis, prognosis, follow up, appropriateness of referral) sides. In this way, each referral will become an opportunity for continuing medical education and will form the basis of "success", "near-miss" and maternal and neonatal death audits as powerful tools for health systems audit in the future.

### *5.2 HMIS at secondary level*

Secondary level HMIS will be further strengthened and more closely linked with PHC and Tertiary Care HMIS. Key indicators such as rates of emergency obstetric interventions, case fatality rates, maternal and neonatal deaths and "near misses", appropriateness of PHC facility referral and self-referral will be regularly analysed. An important constraint to improving the quality of the secondary level care is the detection and management of inappropriate self-referral.

Demand side activities will be further developed to improve the appropriate use of local health services and systems will be designed to triage "primary level" attenders to appropriate services at or near the secondary facility so as to protect and enhance its genuine secondary function.

### *5.3 Ensuring sustainability through strengthening systems*

DHFW recognises the importance of developing key secondary health care systems to ensure quality and sustainability. Systems which will be strengthened

include; overall asset management, repair and preventative maintenance, logistics, supplies and quality monitoring.

DHFW will continue to extend its reforms to improve the quality and sustainability of secondary care facilities through introducing user fees with equitable exemptions for the poor, afternoon pay clinics, private beds, public-private initiatives and affordable pharmacy outlets.

#### *5.4 Exit strategy for WB project staff*

DHFW will develop an exit strategy and HRD plan for the staff remaining with the PMU for the World Bank funded HSSP II project.

#### *5.5 Building links with urban health facilities*

As noted above, urban areas have specific problems. In urban settings, social barriers to equity of access can be as real as geographical barriers in rural areas. Closer links will be established between Municipal and DHFW secondary facilities. Systems will be established to triage attenders so that referrals from Municipal facilities are given priority.

## **6. Tertiary level health services**

### *6.1 DHFW and stakeholders to review tertiary care*

DHFW recognises that tertiary care is a key part of the State health system. It is traditionally not generally a high priority area for GoI or development partner funding. DHFW recognises that tertiary services are disproportionately used by the better off. Tertiary care has a high public, media and political profile; its centres of excellence provide undergraduate and postgraduate training for vital cadres of staff (such as obstetricians, neonatologists, anaesthetists, cardiologists, ophthalmologists, specialist physicians, specialist surgeons and oncologists). It has many powerful advocates among professional bodies, the private sector, politicians and civil society

DHFW will engage these stakeholders in a comprehensive review and planning process to reorganise tertiary care from the combined perspectives of technical and systems development so as to meet its objective. Such an exercise will necessarily examine options for financing tertiary care and will address public-private partnerships, autonomy, appropriate referral, triage of attenders, equity of access for vulnerable groups, user fees and exemption systems, afternoon pay clinics, elective day surgery etc.

### *6.2 Strengthening referral systems*

Several prestigious tertiary institutions are presently almost overwhelmed by the level of unregulated referral. This may come from other public facilities (where staff may feel apprehensive about providing appropriate care due to hostile press coverage), the private sector, or self-referral. A large proportion of such referral is inappropriate and hinders the ability of the tertiary institutions to provide quality specialist care, undergraduate and postgraduate training which is their remit.

DHFW recognises the need for effective and appropriate referral systems from primary and secondary facilities. This may require strengthening and enabling these facilities where necessary, both public and private. Where necessary, communications systems may need to be developed. Demand side activities to promote appropriate health seeking behaviour and on-site triage and management of inappropriate self-referral will also be necessary to improve the quality of efficiency of tertiary hospital services.

### 6.3 *HMIS at tertiary level*

HMIS will be strengthened so that tertiary care services can be most efficiently and equitably planned. Although Tertiary Care represents only a small proportion of service delivery effort in terms of numbers of staff employed and patients treated, it is very important that it is integrated into the State HMIS for the following reasons:

- It consumes 39% of the whole health budget, and so data to ensure cost-effectiveness is essential as economies in this sector can release significant funds.
- There is a whole category of diseases treated and procedures undertaken that only, or predominantly occur at tertiary level (e.g. dialysis, CT scanning, radiotherapy, cardiac surgery etc).
- If future private-public partnerships are to be developed in the tertiary sector, private for profit partners are unlikely to be enthusiastic unless there is reliable data on which to base their business plans.

### 6.4 *Ensuring sustainability through strengthening systems*

DHFW will further engage the private sector in discussions about redesigning tertiary care so that it can be sustainable.

#### *Hospital Autonomy*

The DHFW plans to upgrade the essential tertiary health care facilities like cardiology, nephrology and urology. These would become integral parts of teaching institutions. As a next step, the Centres of Excellence in medical institutions could be made autonomous<sup>3</sup>.

DHFW is considering granting larger hospitals as well as Centres of Excellence autonomy. The type and extent of autonomy and the appropriate HRD and financial systems are being considered.

### 6.5 *Building links with urban health facilities*

As noted above, urban areas have specific problems. In urban settings, social barriers to equity of access can be as real as geographical barriers in rural areas. Closer links will be established between Municipal and DHFW secondary facilities.

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<sup>3</sup> DHFW Health Sector Reforms, 2<sup>nd</sup> Edition, 2002

## **7. Public Private Partnerships**

DHFW have already entered into a number of agreements with the private sector and with NGOs to provide specific services to improve the quality of health care being given in the State.

### *7.1 Tertiary and Secondary hospitals*

To meet the ever-growing need for quality health and medical care services, GoWB has decided to enter into partnerships with the Private Sectors and Non Government Organisations. DHFW (vide its memo no. HF/ 0/ MERT/ 637/W-64/2001 dated 06.08.2001) partially modified its earlier memo (no. HF/ 0/ MERT/ 500/W-64/2001 dated 20.06.2001) and accorded approval towards installation of three C.T. Scanning Machines at B.S. Medical College, Bankura, N.R.S. Medical College, Kolkata and Calcutta Medical College, Kolkata by private agencies under a Joint Venture Project.

The terms and conditions of this partnership impose certain obligations on the private sector to provide free services to at least 35 poor patients per hospital and at approved Government rates to not more than 615 cases per month. The private partner would bear all operational and maintenance costs for running these facilities. Further, these facilities should be in operational condition for 95% of available time. The entire capital cost would be borne by the partner, the Government providing rent-free accommodation. Furthermore, the entire system commissioned by the private agency shall be accessible for teaching and training purposes for undergraduates and post-graduate students. The Government would be entitled 25% commission from the charges charged to the general public.

DHFW is looking to collaborate with teaching and research institutions of Government of India, viz.; IIT Kharagpur, ICMR and other reputed private institutions/NGOs to develop Centres of Excellence in the disciplines of Neuroscience, Nephrology and Urology, Gastro-enterology, Cardiology and Cardio-thoracic Surgery, Paediatric Medicine and Neonatology and Haematology.

DHFW has decided to set up a National Institute of Medical Science and Technology in collaboration with IIT, Kharagpur. The purpose of this Institute is to promote research in high-end and frontier areas of Medical Science and Technology with special reference to the problems related to Mass Health Care of citizens.

DHFW is looking into the possibilities of outsourcing a number of "hotel" functions in the hospital including cleaning services, laundry and food. For instance: to

improve the quality of diets in hospitals, the DHFW is introducing 50% cost of diets to patients occupying paying beds. Only patients belonging to BPL category would be provided diet free of cost. The present manpower engaged for cooking food would be gradually redeployed against vacant posts and contracts will be made with cooperatives, particularly women's cooperatives or women's Self Help Groups, to supply cooked food in the future.

## 7.2 *Primary Care Level*

Innovations and pilots using public-private partnerships are also being undertaken to improve services at district level and below.

Discussions are being held with private and practitioners to assess their potential to enter into service agreements to take over the management of Primary Care Centres in the rural areas. This has already been successful in one PHC. This policy is an attempt to increase the availability of quality primary care services to as many parts of the State as possible. Incentives to encourage providers to run PHCs in under-served and remote areas are being discussed with potential partners.

Three PPP-pilots are being carried out with the support of the KfW-supported Basic Health Project:

- To improve ambulance services at PHC/BPHC level by providing vehicles to NGOs who are then responsible for providing the service and maintaining the vehicles.
- To provide laboratory services in BPHCs and PHCs through service agreements with private providers.
- To make drugs available at fair prices through service agreements with private providers to place "Fair price drug stores" within BPHCs and PHCs.

All these initiatives are being closely monitored by DHFW and by the PRIs to assess their effectiveness (measured by their ability to improve services) and to assess whether they should be rolled out across the State.

A range of other options for co-operating with the private sector and NGOs continue to be assessed so that services to the population continue to be improved.

## **8. Medical, nursing and paramedical education**

**DHFW has identified HRD and medical and paramedical education as a phase 1 strategic priority, and it is covered in more detail in Document 2: Rationale for the Priorities in the Health Strategy.**

### *8.1 Coordinating all pre service medical, nursing and paramedical education*

Policy formed and actions undertaken already:

- GoWB has set up a University of Medical Science to develop medical education and research by bringing all medical and nursing institutions under a single umbrella.
- Actions have been initiated to develop medical institutions of the State into Centres of Excellence in medical education and research. These are to be given autonomous status.
- DHFW proposes to collaborate with teaching and research institutions of Government of India, viz., IIT Kharagpur, ICMR and other reputed private institutions and NGOs to develop Centres of Excellence in various medical disciplines.
- DHFW has decided to set up a National Institute of Medical Science and Technology in collaboration with IIT, Kharagpur. The purpose of this Institute is to promote research in high-end and frontier areas of Medical Science and Technology.
- DHFW is in the process of reviewing nurses' training and education and paramedical schools (lab technicians, etc.) in the State.

## **9. Working with, developing and regulating NGOs and CBOs**

### *9.1 Harnessing potential through partnership*

DHFW recognises the potential of the rapidly growing NGO and CBO sector. As part of the organisational reform of the DHFW at State level, DHFW will design and system whereby NGOs and CBOs wishing to work in partnership with DHFW will be registered and monitored to ensure they adhere to agreed DHFW strategic priorities and quality standards. DHFW will establish a focal point for NGO and CBO liaison at State level. DHFW has appointed several prominent NGO members to sit on the Strategic Planning Committee.

Civil society is usually understood as the social arena that exists between the state and the individual or household. It lacks the coercive or regulatory power of the state and the economic power of the market but provides the social power or influence of ordinary people.

Within this social domain, individuals and groups organize themselves into civil society organizations (CSOs) to pursue their collective interests and engage in activities of public importance. CSOs are broadly understood to be non-state, not-for-profit, voluntary organizations. The term as it is used here indicates a wide range of civil society actors, including NGOs.

CSOs have been contributing to public health since several decades. In more recent years however they have grown in scale and influence and are known to have considerable impact on health.

With a shift towards a more rights based approach to development, CSOs have acquired a more prominent role in raising, advancing and claiming the entitlements of different social groups. They have the potential to act as participants, legitimisers and watchdogs of policy as well as collaborators in development. They bring human resources, technical expertise and new knowledge to health and provide additional pressure for the recognition of public interests within the health sector.

**Table 9.1: Health Systems and Civil Society Roles**

<b>Health System Function</b>	<b>Examples Of potential Civil Society Roles</b>
Health services	<ul style="list-style-type: none"> <li>- Service provision</li> <li>- Facilitating community interaction with services</li> <li>- Distributing health resources such as condoms, bed nets, or cement for toilets</li> <li>- Building health worker morale and support</li> </ul>
Health promotion and information exchange	<ul style="list-style-type: none"> <li>- Obtaining and disseminating health information</li> <li>- Building informed public choice on health</li> <li>- Implementing and using health research</li> <li>- Helping to shift social attitudes</li> <li>- Mobilising and organizing for health</li> </ul>
Policy setting	<ul style="list-style-type: none"> <li>- Representing public and community interests in policy</li> <li>- Promoting equity and pro-poor policies</li> <li>- Negotiating public health standards and approaches</li> <li>- Building policy consensus, disseminating policy positions</li> <li>- Enhancing public support for policies</li> </ul>
Resource mobilisation	<ul style="list-style-type: none"> <li>- Financing health services</li> <li>- Raising community preferences in resource allocation</li> <li>- Mobilising and organizing community co-financing of services</li> <li>- Promoting pro-poor and equity concerns in resource allocation</li> <li>- Building public accountability and transparency in raising, allocating and managing resources</li> <li>-</li> </ul>
Monitoring quality of care and responsiveness	<ul style="list-style-type: none"> <li>- Monitoring responsiveness and quality of health services</li> <li>- Giving voice to marginalized groups, promoting equity</li> <li>- Representing patient rights in quality of care issues</li> <li>- Channelling and negotiating patient complaints and claims</li> </ul>

Community based organizations and civil society stakeholders are known to be effective in consulting with users on their needs and priorities, managing services and monitoring the performance of service providers. Their engagement can serve to increase effectiveness, service quality and equity of access.

While there are benefits for the state, the interaction with CSOs is not without some risks that would need to be managed. In working with CSOs it would be important to assess their representativeness, levels of accountability to the communities they speak for, authenticity, interests and capacities. CSOs clearly do not speak in one voice leading to diversity in views that can be difficult to manage. Their views on issues such as human rights, consumer protection or ethical issues may generate tension with the government. Implicitly it would be necessary to be selective.

West Bengal has chosen to include CSOs in the membership of District Health Samities and it is likely that CSOs will also be represented in Block Health Samities as and when these entities come into existence. An investment in building CSOs capacity to act as partners at different levels in the health sector could pay rich dividends.

### *9.2 Clinical Establishment Act*

The Clinical Establishment Act (CEA) was passed in 1968 and detailed rules were ratified in 1992. It is patchily enforced, particularly in the private sector.

DHFW recognises the importance of bringing the CEA up to date to ensure appropriate cover of NGOs, CBOs, and the private sector, particularly in the areas of:

- The appropriateness of staff training.
- The appropriateness of the premises and equipment.
- Quality of reporting (a particular weakness at present).

## **10. Financing health care**

**DHFW has identified Financing Health care as a phase 1 strategic priority, and it is covered in more detail in**

- **Document 4: Integrated Financial and Economic Plan.**
- **Document 2: Rationale for the Priorities in the Health Strategy.**
- **Document 5a: Annex 4: Health Financing in West Bengal**

These documents include discussion of budget and planning systems, equity issues, health insurance, user fees, donor partner contributions and projected contributions, central scheme contributions and projected contributions and past and projected State budget allocations.