



NATIONAL RURAL HEALTH MISSION  
HEALTH AWARENESS & PROMOTION STRATEGY

# Report: Workshop on Health Sector Reforms: The Way Forward

Hotel International Tower, Kolkata

**Organised by Department of Health &  
Family Welfare, West Bengal**



12 January, 2008

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# Health Sector Reforms: The Way Forward

The workshop was organised on 12<sup>th</sup> January and the objectives of the workshop was to

- Facilitate common understanding of health sector reforms among personnel in State headquarters
- Pool in our knowledge and experience
- To improve service provision by HQ to the field formations

The workshop was attended by large number of senior level officials from the Department of Health and Family Welfare

## Session 1: Introduction and Overview

### ***Welcome and purpose of the Workshop-Deliberation by Mr Chandan Sinha, IAS, Mission Director, NRHM and Special Secretary DoHFW, GOWB***

**Mr Chandan Sinha, IAS** welcomed all and explained the purpose of the workshop. Mr Sinha gave a historical overview how reform process emerged and progress made since the turn of the century. He explained how health sector strategy guided reform process in the department. Health Sector Development Initiatives and the National Rural Health Mission have contributed in several areas and have brought in scope for innovations and change.

Health Awareness Promotion Strategy (HAPS) has been developed for awareness generation & capacity building among client groups and service providers to

- Improve User Access
- Improve Service Delivery
- Engrain Prevention Behaviour
- Empower Community
- State Headquarters should act as
  - Initiator of reforms
  - Implementer
  - Guide

He explained that reform means positive change but not all reforms mean positive changes. In this context even not all health system changes mean health sector reform. Reforms are **fundamental** changes intended to find **sustainable** solutions to those **problems** in the **existing** system which **limit** the achievement of these **objectives**

### ***Reforming systems- PPP for health service delivery by Mr A.K Das, IAS Commissioner Health and Family Welfare, Project Director HSDI and Special Secretary, DOHFW, GOWB***

**Mr A.K Das, IAS, emphasised** the need of private partners joining hands with the government. He reiterated that private participation in public health care delivery system can complement the enormous task of service delivery the health department has to meet at different levels. Already the MRI scanning at medical college hospitals, diagnostic services at rural hospitals, ambulance services at BPHCs are some examples of public private partnership that has happened in the state. Mr Das told that more such participation is solicited for overall improvement of health delivery as there is limitation of the government to address the large clientele and all complexities of situations.

### ***Health Sector Strategy and link to health system reforms by Mr Abdul Rahim, , the Deputy Team Leader, TAST***

**Mr Abdul Rahim, the Deputy Team Leader, TAST** explained the health sector strategy and its link to health systems reform. He elucidated that health sector strategy is a roadmap developed in achieving health outcomes through an equitable, sustainable, accessible and “for all” health service delivery mechanism

### ***The need for reforms-how we stand in comparison in to other states by Mr K.K Bagchi IAS Additional Chief Secretary, Department of Health & Family Welfare***

Dr K.K Bagchi, IAS shared his views on effectiveness of holding such workshops to bring about a uniform understanding of reforms actions that are pursued in the state. He expressed his ideas of making the workshop very participative. Dr K.K Bagchi shared his views regarding different health indicators of the state and did a comparative analysis of such indicators with other states. This was done through very colourful graphical presentation and this brought about surprises that West Bengal has advanced in many key indicators like fertility rate, birth rate, infant mortality rate etc. West Bengal has done moderately well in death rates also. But the area of concern lies in failure to reduce malnourishment among children and anaemia amongst women and children. Mean age at marriage still remains a concern area.

### ***Key note address by Dr Surjya Kanta Mishra, Minister in Charge, Department of Health & Family Welfare,***

Dr Surjya Kanta Mishra, Minister in Charge, Department of Health & Family Welfare, gave the key note address. He told that health development has not yet reached a matured level where health is conceived as complete physical, mental, and social well-being, not merely the absence of disease or infirmity, though the definition dates back half century ago .. The preventive and promotive health care is not given due importance and the emphasis on curative health care continues. Decentralisation of health system through proper devolution of power could be an option of improving health care delivery system. Community health in the hands of community is the best solution for health systems to function at an optimal level.

### ***Making Reforms Happen***

- ***Focused attention and rapid response –recent initiative in public health –Sanchita Bakshi***

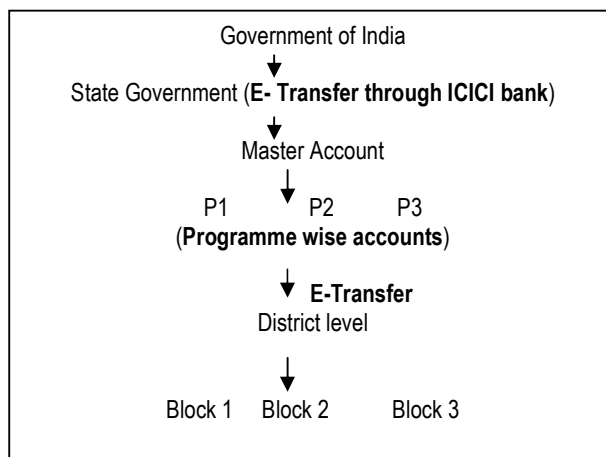
Dr Sanchita Bakshi explained that public health issues are largely led by national funds under CSS. However, available information is sketchy and uneven. Public health break outs often were detected late and limited actions could only be taken. It is also realized that MIS is not properly utilized and used.

Considering such a situation certain initiatives were taken up by the department. Those were

- (i) **adopting better targeting mechanism** by putting funds in the areas which need it the most Ex. Malaria in Jalpaiguri and also identify vulnerable blocks and focus attention.
- (ii) **Using information wisely by** identifying trends and detecting upcoming trends, further investigate causes of breakout / event and mitigate. Examples are *Infant death audit and profiling* and *age-wise analysis of diarrhoea deaths*
- (iii) **Rapid Response** by emergency response team for all outbreaks, daily reporting of malaria deaths from vulnerable blocks – detailed analysis of events, treatment and impact, Tracking of diarrhea deaths, measles cases, TB, Leprosy etc

- ***Improving district fund transfer through e-banking-Mr S.K.Sen, Special Secretary***

Previously Government of India sent advice of allotment and funds took some time to be credited to state account. Cheques were then issued to all districts, which took 2-3 months for clearing. If drafts were issued charges was also levied. Govt sent advice of allotment. Delays, inconvenience, unpredictability and errors in crediting were present in the previous system. With introduction of e-banking the process was simplified and money could be instantly transferred. Samities were instructed for maintaining their accounts in the same bank at district. Availability of all bank balance positions, online were available



This process yielded some positive results. Instantaneous transfers reduced time of transfer from 2 months to 1 day. Availability of bank balance on line has reduced the requirement of waiting for statements. Transparency of accounts has been established, state and districts know of the credit position. Convenience in reporting and accounting has been ensured.

• **Developing GPHQ SC as centres of decentralised health care Mr Ajay Bhattacharya**

Gram Panchayat Office is the Grass-root level office from where all the rural development activities are initiated. To ensure “Community’s health in Community’s hand” better integration of the primary health care services with the GPs is required; Sub centre is the very foundation of primary health care. Hence alignment of administrative boundaries needs to coincide with the health facilities.

**Initiatives undertaken in the decentralisation process**

Boundaries of Sub-centres were re-aligned so that no sub-centre would covers more than one GPS .It was realised that there would be 3 to 4 sub centres attached to each GP. The sub centre located at the head quarter of the GP was brought to the GP office or to a close location. Health supervisors were posted at GPHQSCs, abolishing the “sector” system. It was decided that monthly meetings on 4<sup>th</sup> Saturdays would be held with Pradhans and all the members of the GP. The systems ensures better participation from the P& RD Department and the system would help in taking better control of the situation .Health Supervisors, ANMs and ICDS Supervisors attend these meetings;

Health Supervisors in their revised role are supposed to:

- Supervise the activities of all the ANMs / Sub Centres under GP;
- Supervise and guide Village Health & Sanitation Committees (GUSs);
- Supervise activities of ASHAs;
- Liaison with GP and PHC/ BPHC;

Construction of GPHQSC Buildings:

- 2073 GPHQSCs taken up ;
- Buildings have electricity, toilet and drinking water facilities;
- Provision of examination of women, labour Room, with accommodation of one ANM at the first floor of the building constructed

Status of construction as on 30.11.2007:

• Fully completed and functional	:	681 (32.85%)
• Completed but not functional	:	384 (18.52%)
• Construction between 71 - 99%	:	295 (14.23%)
• Construction between 31- 70%	:	153 (7.38%)
• Construction up to 30%	:	178 (8.58%)
• Construction work not yet started	:	382 (18.42%)

Other activities to strengthen

- Weekly Medical Camps with the Medical Officers of the PHC / BPHC held ;
  - Medical camps 3 days a week with doctors hired by the Gram Panchayats;
  - One Trained Birth Attendant (TBA), Community Health Guide (CHG) for promotion of public health activities;
  - Link workers for immunization programme are attached to GPHQSC;
  - 890 Homeopathy & Ayurvedic dispensaries functioning with doctors on contractual basis
  - One additional ANM on contractual basis;
  - One ASHA for 1000 population ;
  - Screening Camps for Blindness Control;
  - Disability Certification Camps;
  - Providing one Ambulance for quick referral services;
  - Opening of additional 185 Homoeopathy / Ayurvedic dispensaries with doctors on contractual basis
- **Free EMOC for all pregnant women by Dr Probhas Chowdhury**  
The state has decided to introduce free EmoC and CEmoC facilities. EmoC means services which can tackle obstetric complications without C.S. or blood transfusion. Comprehensive EmOC includes operative procedures, e.g., CS and blood transfusion along with basic services. The state has decided that signal function of Basic EmoC services includes *Parenteral Antibiotics, - Parenteral Oxytocic drugs, - Parenteral Anticonvulsants, - Manual removal of retained products, - Assisted Vaginal Delivery.* would be ensured

Signal function of CEmOC would ensure services by Skilled health personnel who can provide full basic EmOC plus :

- *Anaesthetic Services*
- *Surgical Services (Caesarean Section)*
- *Safe Blood transfusion*

In the districts of WB, there are have 59 institutions (MCH-3, DH-15,SD-38,SG-1 & RH-2) which offer CS & blood transfusion. There would be 7 more SDs, 18 SGs & 8 RH, and altogether 33 where CS without blood transfusion would be offered. Thirty four more institutions, mostly RHs are expected to be operational as CEmOC centres (FRUs) by the year 2008.

- **State Resource Centre as platform for supporting policy decision by Dr Prathistaha Sengupta**

SRC supports the Department of Health and Family Welfare and where appropriate other Health Institutions, with information and analysis necessary for better functioning of the health system. Precisely, State Resource Centre is: repository of knowledge base for the department.

The objectives of the State Resource Centre are

- Provide Knowledge & Information
- Act As a Repository of Institutional Knowledge
- Encourage Informed Policy Making and Practice

The personnel involved with SRC are one Health Sector Analyst , one Knowledge Manager and TAST Members

State Resource Centre has books, Data-Enumerating Volumes, plan documents, journals, government orders/notifications, Reports, Surveys on Health Policy, Media Watch and other miscellaneous relevant for the health department

The primary functions of SRC as of now are Procurement of Books, Journals & Reports, compilation of news Items on health system, analysis of demographic trends relevant to health policies, sharing the synopsis , articles with the programme Managers and monthly workshop on New Ideas on Health and process of integration on complimentary functioning with State Bureau of Health Intelligence, Deptt. of Health & Family Welfare.

## Session 2: Understanding the context of reform

### ***Could Rani have been saved? Why Health systems matter? Case Study and discussion by Mr Chandan Sinha***

The case study of a rural pregnant woman succumbing to death following inefficient health delivery mechanism and low awareness and other issues that affect lives adversely were discussed. (the case study is annexed for reference ) The participants were asked to discuss on the causes that led to her death and make sufficient ground for strengthening health system delivery.

- Lack of contraceptive choice
- Lack of appropriate information about abortion facilities
- No MTP facility at BPHC
- Lack of health education
- Unskilled providers (Dai)
- Family unable to perceive or assess risk, lack of care
- Community members were also not well informed
- Incomplete and inadequate ANC
- Did not consume IFA tablets
- No delivery facilities at PHC
- Lack of health facilities nearby
- No faith in the system
- Unavailability of transportation facilities causing delay
- Lack of responsibility of service providers – (BPHC Doctors) delay
- Too much of systemic procedures
- Lack of responsibility and delay in admission – DH
- No medicines available at DH

The discussion threw up questions on health awareness communication and service delivery and roles of service providers in the system

### ***Understanding inputs, throughputs, activities and outputs in health system by Mr Chandan Sinha***

#### ***What it requires to undertake reforms by Abdul Rahim***

Following a lively discussion on the case study the theoretical contexts of reform processes in health system was discussed. The importance of inputs, processes, activities and outputs

The state government has developed MTEF 06-11 and has adopted State Annual Plan & Budget. It has tried to align the state plan with national priorities and resources. The state government has also attempted to coalesce the district plans into State Plan

Development of district plans were important activity that was taken up in the 2007 and has been refined further in 2008. The district health plans have sufficiently addressed decentralisation and ground level issues and have collated GP level plans at the block level and subsequently the block plans at the district level. In the recent years state government has addressed gaps in policy and implementation by clearing scheme formulation, flexibility to districts, support through clarifications, support & supervision needed at all levels and regular course correction.

In the recent times monitoring and evaluation system has been strengthened. Regular review meetings are held with the Health Minister and ACS.

Mr Abdul Rahim clarified what it requires to carry forward the reform processes. He emphasised that often people look for resources or complains about lack of resources, but managers and others need to introspect into resourcefulness to implement reform processes.

It is important for all involved in the reform processes to take up leadership in whatever small way possible rather wait for directions

In taking such lead one must align with larger objectives of the state and national priorities. Since managers and senior officials are placed in a position of trust and responsibility, their actions need to be in accordance.

This has to be understood that no improvement is too small, even a small change or improvement is significant in reform process. On the other hand no change is too much in development process.

With time, managers need to evolve and they should be working together for change to happen.

### **Session 3: Group Work**

The participants were divided into 6 groups and they were asked to respond. They were asked to steer the discussion around the following issues under each subject.

#### **Issues for Group Discussion**

1. Enhancing transport access for timely maternal care
  - a. Current concerns on availability, accessibility and affordability of transport
  - b. Working through PPP model for ambulance provision – improvements possible
  - c. Enhancing access and reach of ambulances
2. Increasing drug availability at the Primary Health Centers
  - a. Making drug supply predictable, timely and quality controlled
  - b. Drug prescription issues
  - c. Planning and utilization of additional funds for primary sector drugs
3. Towards more effective Rogi Kalyan Samities
  - a. Issues which affect their capacity to perform
  - b. Evolution of RKS as effective units of decentralized planning and management
  - c. Encouraging improved use of funds with RKS
4. Improving service delivery through better hospital administration
  - a. Issues pertaining to current hospital performance and quality
  - b. Capacity building for better management
  - c. Issues in information availability, computerization and HMIS

5. Reducing financial time-cycle and improving financial reporting
  - a. Issues in current system of funds release, transfer and communication
  - b. Issues in reporting on SoE and UCs – delays in replenishment of funds
  - c. Towards faster and more efficient financial reporting systems
6. Reaching the unreached
  - a. Addressing issues of service availability in remote areas
  - b. Involving Panchayats, WCD and other related departments for increased access
  - c. Using NGO partners/PPP models for supplementing public health sector

#### ***Group 1: How can we improve access to transport for timely maternal care?***

- Awareness about the ambulance service in the community –how to access, whom to contact
- Such communication made specifically by ANMs during Ante natal visits
- Transport need to be available from doorstep of the mothers
- Panchayats to take actions in making provisions of transport from the village to the nearby health facilities
- Availability of such transports ensured 24x7
- Referral transport relooked and provisions made for better service delivery, including financial revision of distant villages

#### ***Group2: How can we increase availability of quality drugs to patients in primary health centres?***

- District wise budget for procurement
- Rational costing of drugs to be done by the department
- Supplier to be selected by zone to reduce delay in supply time
- Decentralised procurement to ensure direct supply to the BPHCs
- Three pharmacy institutions (Burdwan ,Jalpaiguri & Kalyani ) could be utilised for quality testing and use them for manufacturing the drugs
- Drug supply should be done by the pharmacist
- Emergency fund to be made available for emergency drug supply
- Lead time to be minimised
- Need for a standard treatment protocol for prescribing drugs
- Monitoring mechanism for prescription to be in place (prescription audit)
- Prescription should be in Bengali /local language

#### ***Group3: How can we make Rogi Kalyan Samities more effective and proactive?***

- Institution wise listing of needs –this enlistment is very important
- Prioritisation of needs –emergency, immediate /prospective
- Delegation of powers at the level of supervisor / BMOH-financial & administrative to be laid down
- Specific persons for accounts needed
- Conducting regular meetings
- The state should formats for deciding the agenda
  - Patient welfare
  - Services to be provided
  - Gaps and lacunae
  - Administrative matters
  - Expenditure
- Awareness generation
- Capacity building of RKS of personnel

#### ***Group4: How can we improve health service through better hospital management?***

- Restructuring of the directorate to include hospital services annual plans
- Increase of maternity beds & improvements of support service
- Segregation of emergency and cold cases
- Setting up of standards –accreditation
  - Reorganisation of OPDs
  - OT services
- Diagnostic tie ups-24 hours service and wide publicity made of such services

- Popularisation of pay clinics
- Competent trained personnel
  - Finance
  - Records section –appointment of analyst
  - HR
  - Support services
- May I help you booth!

### **Group 5: How can we improve system and reduce delays in fund release utilisation and reporting**

- Fund Release & transfer (State level)
  - Programme wise funds to be released
  - Co-ordination and compilation to be improved at the state level
  - Release of fund based on justified demand
  - Half yearly financial time cycle suggested
  - A decision whether to follow DHP or departmental plans without any reference to DHP
- Fund release and transfer (district level)
  - Transfer of all funds to Block Health Samities by e-banking
  - Suggested that BHP is followed and requisite actions taken to make it functional?
  - There is delay in getting approval and it is suggested that standing approval may be sanctioned by the district samity
- Reporting on Statement of Expenditure & Utilisation Certificate
  - Lack of accounting concept in block and district level
  - Time lag from block to district and from district to state to be minimised
  - Rewarding /punishment for timely/late submission of SOE/UC
  - To Introduce Samity's operating manual both at block and district level
- Efficient Financial Reporting
  - Increase in manpower
  - Setting up of financial management group within District Management Unit-the group need to be headed by a an accounts officer/treasurer of samity
  - Introduce on line financial reporting
  -

### **Group 6 How can we ensure that the most poor and need are reached?**

- Better targeting to reach unreached
  - Mapping of unreached uncovered population
  - Mapping of poor performance area
  - Mapping of in accessible areas
  - Special focus on tribal minorities
- Situational assessment
  - Ethnicity
  - Gaps in Service delivery
  - Communication
  - Identification low income group
  - Disease incidence /prevalence mapping
- Improving service Delivery
  - Village level team formulation with support of ANM
  - Need based transportation
    - Mechanised boats
    - Dolis
  - Plan for outreach clinics, GP Mahila health camps with services
  - Identifying existing poor functional facilities-Upgrading or strengthening them
  - Improving fund flow for logistic support /drugs
  - Using PPP models to broaden service delivery
  - Social Mobilisation-PRI, SHG NGOs
  - Involvement of AWW, TBA, SHGs ASHA to communicate information
- Behaviour Change Communication

- Better awareness about schemes among service providers
- Better IEC & IPC with stake holders
- Capacity Building
- Monitoring
  - Generating quality data and analysing data
  - Using data for planning & review
  - Feeding back
  - Fund Utilisation
- Intersectoral collaboration
  - Between PRI, Education, ICDS, PWD(Road) & PHE

The workshop ended with Vote of Thanks from Mr Chandan Sinha, thanking all the participants his senior colleagues and TAST members. He reiterated the need for more such workshops and expressed willingness to conduct workshops in different thematic areas.

## Annexure:

## Annexure 1: Programme

**NATIONAL RURAL HEALTH MISSION  
HEALTH AWARENESS & PROMOTION STRATEGY (HAPS)  
Workshop  
Health Sector Reforms: The Way Forward  
Hotel International Tower, Kolkata  
12 January 2008**

Time	DETAILS	SPEAKER
9.45 – 10.15 am	<b>REGISTRATION</b>	
	Session 1: Introduction and Overview	
10.15 – 10.25 am	Welcome and purpose of the workshop	<b>Mr. Chandan Sinha, IAS</b> Mission Director, NRHM and Special Secretary, DoHFW, GoWB
10.25 – 10.35 am	Reforming systems – PPPs for health service delivery	<b>Mr. A K Das, IAS</b> Commissioner, Family Welfare, Project Director HSDI, and Special Secretary, DoHFW, GoWB
10.35 – 10.45 am	Health Sector Strategy and link to health system reforms	<b>Mr. Abdul Rahim</b> Deputy Team Leader, TAST
10.45 – 11.00 am	The need for reforms – how we stand in comparison to other states	<b>Dr. K K Bagchi, IAS</b> Additional Chief Secretary, Department of Health & Family Welfare, GoWB
11.00 – 11.20 am	Keynote Address	<b>Dr. Suriya Kanta Mishra</b> Minister in Charge, Department of Health & Family Welfare, GoWB
11.20 – 11.45 am  (5 mins each)	<u><i>Making reforms happen</i></u> Ex. 1: Focused attention and rapid response – recent initiatives in public health Ex. 2: Improving district fund transfer through e-banking Ex. 3: Developing GP HQ SC as centres of decentralized healthcare Ex. 4: Free EmOC for all pregnant women Ex. 5: State Resource Centre as platform for supporting policy decisions	<b>Dr. Sanchita Bakshi</b> Director of Health Services, GoWB  <b>Mr. S K Sen</b> Special Secretary, DoHFW, GoWB <b>Mr. Ajay Bhattacharya</b> Joint Secretary (NRHM), DHFW <b>Dr. Probhas Chowdhury</b> ADHS(MCH), DoHFW <b>Dr. Pratishta Sengupta</b> Health Sector Analyst, SRC, DoHFW
11.45 – 12.00 n	<b>TEA BREAK</b>	

Time	DETAILS	SPEAKER
<b>12.00 – 1.45 pm</b>	Session 2: Understanding the context of reforms (Interactive session)	
12.00 – 12.15 pm	Health Systems – how other states and countries are doing	<b>Mr. Abdul Rahim</b>
12.15 – 1.15 pm	Case study – could Rani have been saved? <i>Why health systems matter – Case study and discussion</i>	<b>Mr. Chandan Sinha, IAS</b>
1.15 – 1.30 pm	<i>Understanding inputs, throughputs, activities and outputs in health system</i>	<b>Mr. Chandan Sinha, IAS</b>
	<b>What it requires to undertake reforms</b>	<b>Mr. Abdul Rahim</b>
<b>1.45 - 2.30 pm</b>	LUNCH	
<b>2.30 – 3.30 pm</b>	<b>Session 3: Group Work</b>	
	<u>Group 1</u> How can we improve access to transport for timely maternal care?	<b>Facilitator:</b> <i>Dr. Sebanti Ghosh, TAST</i>
	<u>Group 2</u> How can we increase availability of quality drugs to patients in Primary Health Centres?	<b>Facilitator:</b> <i>Mr. Ranjan Roy, TAST</i>
	<u>Group 3</u> How can we make Rogi Kalyan Samities more effective and pro-active?	<b>Facilitator:</b> <i>Ms. Baisakhi Banerjee, TAST</i>
	<u>Group 4</u> How can we improve health service through better hospital management?	<b>Facilitator:</b> <i>Dr. Aniruddha Mukherjee, DHFW</i>
	<u>Group 5</u> How can we improve system and reduce delays in fund release, utilization and reporting?	<b>Facilitator:</b> <i>Mr. P K Mohanty, DHFW</i>
	<u>Group 6</u> How can we ensure that the most poor and needy are reached?	<b>Facilitator:</b> <i>Ms. Anindita Roy, TAST</i>
<b>3.30 – 3.45 pm</b>	TEA BREAK	
3.45 – 4.45 pm	<i>Presentations by the groups, and reactions</i>	<i>Senior functionaries of the Department</i>
4.45 – 5.00 pm	Vote of Thanks	<b>Mr. Chandan Sinha, IAS</b> Special Secretary, DoHFW, GoWB

**Annexure 2: List of Participants**

		<b>S</b>	
<b>Sl. No.</b>	<b>Name</b>		<b>Designation</b>
1	Dr. R.S. Shukla, IAS		Project Director, WBSAPCS & e.o. Secretary
2	Dr. J. Mitra Ghosh		Director of Medical Education & e.o. Secretary
3	Dr. S. Bakshi		Director of Health Services & e.o. Secretary
4	Mr. Chandan Sinha, IAS		Project Director, NRHM & e.o. Special Secretary
5	Dr. S.N. Bannerjee		Director, Institute of H&FW
6	Mr. S.K. Sen		Programme Director, BHP & e.o. Special Secretary
7	Mr. P.K. Guha Roy		Executive Director, WBSHFWS
8	Dr. S.K. Ojha		Addl. DHS (Admin)
9	Mr. P.K. Mohanty		DDHS (AA&V)
10	Mr. S.N. Roy Chowdhury		Addl. DHS (AA&V)
11	Dr. Aniruddha Kar		Addl. Dir (TB, STO)
12	Mr. Ajay Bhattacharya		Jt. Secy, NRHM
13			Jt. Secy, MERT
14			Jt. Secy, MS
15			Jt. Secy, ISM&H
16			Jt. Secy, TDE
17			Jt. Secy, P&B
18			Jt. Secy, PHP
19	Dr. Subir Basu		Jt. DHS, TB
20	Dr. Sekharesh Ghosal		Jt. Director, SAP&CS
21	Dr. A.C. Debnath		Jt. DHS, P&D
22	Mr. N.K. Roy		Dy. Director, SPSRC
23	Dr. Swapan Chakraborty		DDHS (Admin)
24	Dr. Nila Mukherjee		SFWO
25	Dr. D.D. Basak		DDHS, Malaria
26	Mr. S. Kanjilal		SMEIO
27	Dr. S.P. Basak		Director, SBHI
28	Dr. Samir Sengupta		Deputy Secretary, MA
29	Dr. Aditi Aikat		Asstt. Director, SPSRC
30	Dr. Subhra Basu		Asstt. Director, SPSRC
31	Mr. Manas Chakraborty		CF&AO
32	Dr. Probhas Chowdhury		ADHS, MCH
33	Dr. S. Tudu		ADHS, School Health
34	Dr. P.S. Chowdhury		ADHS, EPI
35	Dr. Aniruddha Mukherjee		Technical Officer, SPSRC
36	Dr. Tapas Sen		Technical Officer, SPSRC
37	Ms. Shraboni Majumder		State NGO Coordinator
38	Mr. P.N. Dasgupta		Consultant, SPSRC
39	Mr. Manas Chakraborty		Consultant, HMIS
40	Dr. Chandan Sen		DDHS (E&S)
41	Dr. N. Deb		Jt. Director, SAP&CS
42	Dr. Bhaskar Bhattacharya		DD (Blood safety)
43	Dr. Anjan Debnath		Addl. Director (SAP&CS)
44	Dr. Som Subhra		Jt. Director, Nutrition
45	Dr. R.C. Sahoo		Director, CCL

46	Dr. Tapas Kr. Bannerjee	Jt. DHS-Admin
47	Dr. Satyendranath Dutta	Jt. DHS - PH&CD
48	Dr. Shibprasad Bannerjee	Jt. DHS-Leprosy & SLO
49	Dr. Achyut Bannerjee	DDHS -Admin
50	Dr. J. Chaki	DDHS-Family Welfare
51	Dr. Achyut Bramha	DDHS-PH
52	Dr. B.R. Satpathy	ADHS-Planning
53	Dr. Ashoke Bannerjee	ADHS-School Health
54	Dr. Ratan Lal Gangopadhyay	ADHS-IUD & Trng.
55	Dr. Ramendra Nath Maity	ADHS-Dental
56	Dr. Sikha Adhikary	DADHS-MCH
57	Dr. Asit Kr. Biswas	DADHS-PH
58	Dr. Satyajit Chakraborty	DADHS-Admin
59	Dr. Asutosh Kr. Mondal	DADHS-P&E
60	Dr. Adhir Kr. Saha	DADHS-P&D
61	Dr. Santosh Kr. Sarangi	ADHS-P&E
62	Dr. Bikash Sindhu Dutta	ADHS-P&D
63	Dr. Pradip Kr. Mandal	ADHS-P&I
64	Dr. Anup Kr. Mandal	ADHS-Civil Defence
65	Dr. Chandra Sekhar Roy	ADHS-EC&C
66	Dr. Bijon Mandal	ADHS-NCD
67	Dr. Ashesh Mukherji	ADHS-Mental health
68	Dr. Bimalendu Roy	ADHS-Filaria
69	Dr. Suphol Chandra Mukherji	ADHS-Oncology
70	Dr. Pradyut Saha	ADHS-TB
71	Dr. Aditi Kishore Sarkar	ADHS-Epidemiology
72	Dr. Sankar Saha	ADHS-Cadre
73	Dr. Braja Kishore Saha	ADHS-Ophthalmology
74	Dr. Mrinal Kanti Ghosh	ADHS-MPHW
75	Dr. H.S. Pradhan	Asst. Malreiolegist
76	Dr. R.K. Mohanty	ADHS-IBD
77	Dr. R. Maity	ADHS-Dental

## Annexure 3: Study Materials

### What is a Health System?

Health systems, like other socioeconomic systems, evolve in unique historic, cultural and political contexts. Nonetheless, every system is structured by state actions or non-actions to serve certain social purposes. The system exists and evolves to serve societal needs. Simply put, **a health system is a means to an end.**

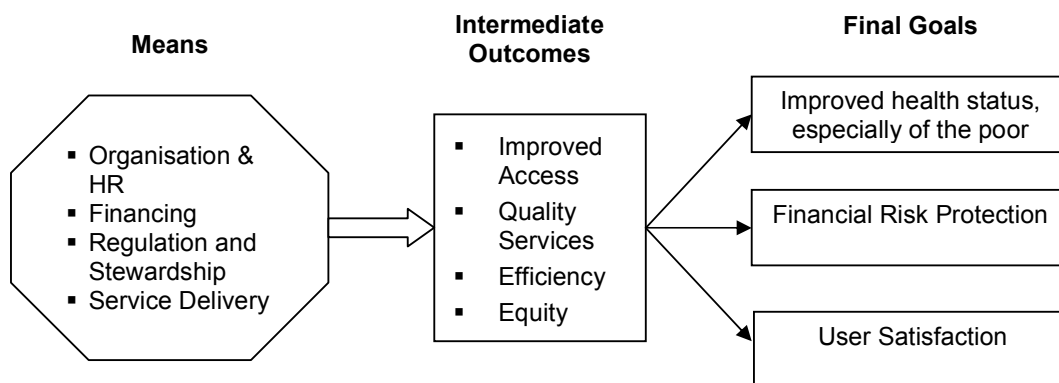
The WHO describes the boundary of the health system as “*all the activities whose primary purpose is to promote, restore, or maintain health.*”

A health system can also be seen as a set of relationships in which the primary variables are causally associated and linked with the outcomes. Using this set of criteria, Hsaio (2003) proposes a new definition.

**“A health system is defined by those principal casual components that can explain the system’s outcomes. These components can be utilized as policy instruments to alter the outcomes.”**

The objective of government then is to make policy choices in such a way that they maximise the intermediate outputs and help in achieving the ultimate outcomes of the programme. The relation of these policy decisions (which will act as means) is brought out in the figure below:

### Means, Intermediate Outcomes and Final Goals



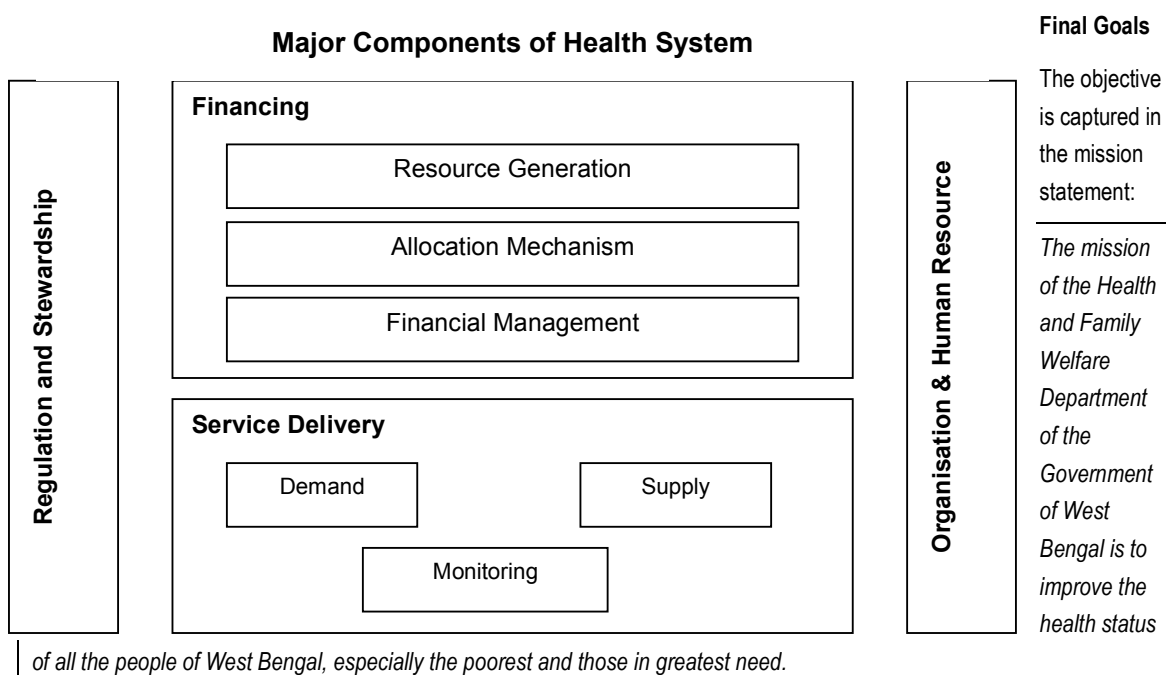
### Means – the Control Knobs

The causal levers or means for health outcomes may be divided into the following four components:

1. Organisational and HR systems;
2. Healthcare Financing;
3. Service Delivery aspects; and
4. Stewardship and Regulatory functions

Each control knob can use various instruments with optional settings. These choices constitute the policy options for the state.

This is brought out in the following figure:



The strategy further identifies four overall objectives for the GoWB:

- To improve the access of poor and unreached groups to curative, preventive, promotive and rehabilitative health services.
- To reduce maternal and child mortality, and the burden of communicable, non-communicable and nutrition-related diseases and disorders.
- To ensure quality at all levels of health and medical care services.
- To maintain excellence in education and research in medicine and all allied professions (including management).

The strategic goals within the framework are:

- Reducing neonatal and maternal mortality
- Strengthening and developing HMIS
- Strengthening decentralisation and community participation
- Reviewing and restructuring HRD systems
- Improving health financing and effectiveness of budget spend
- Strengthening and broadening the strategic planning process

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*Adapted from 'What is a Health System? Why Should We Care?' (2003) Author: William C. Hsiao, Harvard School of Public Health*

## ***What is health sector reform?***

### **reform (noun)**

A change to a system to make it better.

**Example:** This reform will help us to give a better service to children in care.

**Reform means positive change.** But health sector reform implies more than just any improvement in health or health care. In 1995 Data for Decision Making Project (DDM) advanced a definition of health sector reform as **“sustained, purposeful and fundamental change”** – “sustained” in the sense that it is not a “one shot” temporary effort that will not have enduring impacts; “purposeful” in the sense of emerging from a rational, planned and evidence-based process; and “fundamental” in the sense of addressing significant, strategic dimensions of health systems (Berman, 1995).

Health sector reform is not a concept that demands a single global definition, nor should we try to be too specific in splitting hairs about what is and what is not reform (Cassels and Janovsky, 1996). Still, the emerging critique of the concept suggests that we should be more explicit about what was sought and what is now open to criticism. We need to be clearer about what qualifies as health sector reform in order to evaluate its effectiveness.

Following our initial definition, it is useful to specify what we mean by **“fundamental” change**. William Hsiao (2000) specifies a set of **“control knobs”** that determine the major processes and outcomes of health care systems. Hsiao’s framework implies that the major focus of health sector reform efforts is to establish, set, or adjust these control knobs of financing, payment, organization, regulation, and consumer behavior.

Making explicit such mechanisms of health system action can help us to characterize health sector reform more carefully. **It may be useful to distinguish more strategic and fundamental programs of system change from those that are more limited, partial, or incremental.** The former might be called “big R” reforms and the latter “little R” reforms. We propose that “big R” reforms are those that involve at least two or more of Hsiao’s control knobs in programs that affect a substantial part of the health care system. “Little R” reforms are those that address only one control knob with a more limited scope of change.

For example, establishing a new or greatly expanded system of national health insurance should properly involve substantial changes in financing, regulation, and delivery. Depending on how these are structured, they would significantly affect the organization of health care delivery as well. This would qualify as a “big R” reform. In contrast, “small R” reforms would include the introduction of user charges in public clinics or granting of autonomy to the national teaching hospital. Such efforts can have important benefits, to be sure, but in isolation they are not of the same scope or degree of difficulty as the “big R” changes. While a “big R” reform may involve the implementation of many “small R” activities, it is the broad systemic package that makes a “big R” implementation more than the sum of its “small R” parts.

Secondly, the reform should be “purposeful.” This means that the elements and components of the reform need to have been developed in a rational manner: identifying clearly the problems of the health systems—evidence-

based—and linking the mechanisms of system change to solving those problems. A clearly articulated policy of health reform is required so that major actors responsible for implementing the change can specify goals and objectives, acknowledge the relationship of their activities to achieving the goals of reform, and the purposeful linkage among different components of system change.

Third, the reform should be “sustainable.” Most fundamental changes will be sustained because they involve significant transformation of systems and the creation of actors who will defend their new interests in the political process. However, reforms that are passed by legislation and not implemented would not qualify; nor would failed reform efforts that are later reversed. For instance, the ambitious “managed competition” reforms of the Netherlands were not sustainable—they were never fully implemented and the reform laws were amended to remove most of the anticipated system changes.

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*Extract from ‘A Decade of Health Sector Reform in Developing Countries:What Have We Learned?’ Authors: Peter A. Berman, Ph.D., Thomas J. Bossert, Ph.D., Harvard School of Public Health, 2000*

## Issues for Group Discussion

### Enhancing transport access for timely maternal care-Group 1

#### Background Note

One of the major objectives outlined in Health Sector Strategy is “to reduce maternal mortality”. The state goal for RCH II is to reduce maternal mortality ratio to 100 per 100000 live births by the year 2010.

**It is widely recognized that one of the 3 Delays, which contribute to maternal deaths is Delay in reaching health facility.** Delay in reaching health facility is mostly due to financial constraint to meet transportation cost, non-availability of transport, non-availability of accompanying person, use of slow moving vehicle etc.

#### Current initiatives in state

In an effort towards encouraging institutional deliveries and improving access of pregnant women the **referral transport scheme** under RCH II provides financial support to BPL and SC/ST pregnant women attending institutions, which can be used to hire transport for reaching the health institution.

An **Ambulance Scheme on a PPP model** involving reputed NGOs/CBOs/Trusts etc. as partners has been initiated to meet the demand for emergency transportation services in rural areas, especially the remote ones. In the first phase, the scheme was introduced in 8 districts of Bankura, Birbhum, Coochbehar, Darjeeling, Jalpaiguri, Paschim Medinipur Purba Medinipur and Purulia whereby 133 ambulances were handed over to the NGOs for running them at the BPHC levels. This has been further up-scaled to cover all the BPHCs in the State. Accordingly, 201 ambulances were further procured and handed over to NGOs under HSDI in 2006-'07.

Recently DoHFW has launched a **voucher scheme** on pilot basis in Bankura district to encourage institutional delivery and ensure adequate safety net for the poor and vulnerable rural women (holding JSY card) for transportation to institutions for delivery through ambulance operators under the block through PPP.

#### Some emerging issues:-

Delay in reaching the health facility mainly due to lack of financial resources to pay for transport or for health care & non-availability of transport & **more than 2/3rd of the families had to borrow or sell property to meet transport cost** (Ref: Interim Report – Maternal Death Investigation in Purulia District, West Bengal supported by UNICEF, 2006).

JSY review indicates that 57% of the women interviewed used car/jeeps for traveling, which was arranged by family members. **On an average, Rs 251.70/- was spent for transport related costs** to reach ultimate place of delivery. **53% of the women took loan to meet such expenses** and only **15% women were reimbursed/received money through government scheme.**

**17% women shifted from institutional delivery to home delivery (during second pregnancy) due to lack of time and non-availability of transport** (JSY review report,07

**The ambulance under PPP scheme has been mostly used for referral from BPHC to higher level of institution and not from residence to BPHC.**

**Of the ambulance non-users interviewed, 27% were women needing transport for delivery or having pregnancy related complications and majority use private cars to reach the facility (Assessment report - GOPA EPOS07).**

#### Issues for group discussion & probe

- Current concerns on availability, accessibility and affordability of transport
  - Suggest reasons why well-intended schemes to reduce transport barriers may fail to fully achieve their objectives. (design, management, monitoring, communication, partnership, contracting, community participation, accountability, institutional arrangements etc
- Suggest how the current schemes could be made more effective and give alternative ideas for reducing the 3<sup>rd</sup> delay, especially for poor women.
  - Working through PPP model for ambulance provision –improvements possible
  - Enhancing access and reach for ambulances – Role of community based emergency transport services
  - Discuss what should be the role and responsibilities of government in schemes to reduce transport barriers.

## **Increasing drug availability at the Primary Health Centres-Group 2**

The state provides free services (including drugs) in the primary healthcare facilities from sub-centre to rural hospitals. In secondary and tertiary facilities, drugs are provided free to poor and underprivileged patients. The current system of drug supply consists of a decentralised structure with only the drug list and rates being determined through central tender. All orders are placed from the district offices and supplies received directly at District Reserve Stores (DRS). Thereafter issues are made, based on indents, to various facilities in the district.

In order to strengthen the primary healthcare system and reduce the load on next levels of care, the state has identified availability of drugs as a focus area of improvement. Accordingly, the funds allotment for drugs has been considerably enhanced in 2005-06 and 2006-07. However, the state realises that increased funding alone is not sufficient.

Some of the persisting problems in the area are

- Drugs ordering process, identifying issues in their planning, ordering and receipt at the CMOH / DRS. The facilities exaggerate the indents and the DRS or the issuing body deducts the same resulting in huge gap between requirement and receipts.
- Drug quality testing is an issue. Late receipt of drug quality testing report from the CMS and Drug Control Authority at the facilities after the drugs is distributed and consumed by the patient.
- Drug distribution mechanism identifying delays. Some drugs remain "Not available" at the DRS for considerable time period.
- Availability of drugs at the facilities with reference to their timeliness, quality and quantity. No monitoring of stocks done at the facility.
- The drug expenditure is yet another issue. On one hand, drugs are supplied to the facility in lesser quantity than the indent, but there are no tracks of drug distribution to the patients particularly in wards.
- Many drugs particularly anti-biotic drugs are scantily available at the facilities and hence the patients have to purchase drugs from outside the facility.
- The status of drugs storage is another area of concern. At the primary health care level particularly, drug losses do occur due to damping, stores are infested with pests.
- Medical practitioners in the department often prescribe branded drugs instead of generic drugs without sufficient justification. This problem area needs to be addressed effectively.
- Additional fund for drug procurement has been put in for increased use in the primary health sector but a system is yet to emerge for better planning and utilisation of fund

### **Issues for Group discussion and Probe**

- Making drugs supply predictable, timely and quality controlled
- Drug prescription issues
- Planning and utilisation of additional funds for primary sector drugs

## **Towards More Effective Rogi Kalyan Samities-Group 3**

Rogi Kalyan Samities were constituted in West Bengal by GO No: HSL (MISC)-307/05 in the year 2005. Through this directive it was envisaged that management structure formed would be responsible for proper functioning and management of the hospital /Community Health Centre/FRUs. The group of trustees thus formed was empowered **to prescribe, generate and use the funds with it as per the best judgement for smooth functioning and maintaining the quality of services.** The RKS guideline published through NRHM clearly stated that RKS would not function as a Government agency, but as an NGO. The objective was also to activate participation from local staff, along with representatives of local population and administration to improve accountability and keep pace

with service requirements and patient welfare. Their responsibility was to ensure services to the poorest of the poor seeking services in the hospital. The society was to plan, design and implement the management of the institutions to aim at the aforesaid goal. The society was provided with much sought after decentralised management structure. However, the expected convergence of general administration, health administration and hospital administration as envisaged through RKS has not taken place.

- At the operational level, lacuna exist in **identifying needs, translate needs into demands for funds, decision making process and specific knowledge about how to spend the fund.**
- The RKS is supposed to monitor and supervise certain activities. The expenditure should supposedly stem from such activities that RKS has to look after. Expenditure is intrinsically linked to the efficient functioning of RKS.
- RKS is independent without any direct accountability to the state. The responsibility of implementation, functioning and supervision related to patients' welfare lie on the hospital authorities, endorsement of the decisions depend on the samity consisting of members from different areas and the authority of expenditure jointly lies with CMOH, DM and Superintendent. All these systems are sometimes conflicting. Some rationalisation on accountability also needs to be built in, retaining the spirit of decentralisation and transparency expected from RKS.
- Low expenditure of RKS is a manifestation of inefficient management of the hospital by RKS. Corrective measures in running the hospital should precede the efforts towards fund management.
- A need is felt to strengthen the working of the RK Societies in terms of **overall management, planning, financial management, procurement, contracting, resource mobilization and provision of medical services as per the needs of the populations they serve. This will also lead to greater autonomy and functioning while remaining within the broad framework of the public health system in the State.**

Stronger RKS will lead to improved services at affordable costs to patients, which in turn will lead to better utilization of hospital services, higher income and reduced government subsidies for patients who can afford to pay resulting in better targeting of subsidized medical care for the poor.

#### **Issues for Group discussion and Probe**

- Issues which affect their capacity to perform
- Evolution of RKS as effective units of decentralised planning and management
- Encouraging improved use of funds with RKS

#### **Improving service delivery through better hospital administration-Group -4**

Hospitals are a key component of the health care system and are central to the process of health system reform, but as institutions they have received remarkably low attention from policy makers and researchers. They have been regarded as black box whose workings are impenetrable

Some of the problems are as follows:

##### **Quality**

- No set standards for the services to be delivered to the clients
- No Standard Operating Procedures (SOPs) and Standard Treatment Protocols (STPs) available at hospitals

##### **Performance**

- Shortage of anesthetists
- Lack of ward space for maternity cases  
(In a major hospital, 30% to 40% maternity cases are admitted all the time although only 5-10% beds are allotted for the same)
- Emergency cases and cold cases put up in the same space
- Bio Medical Waste generated by emergency patients much more as compared to cold cases leading to dirty wards
- Lack of proper treatment of both emergency and cold cases by hospital authorities
- Delay in communicating pathological reports from pathology unit to respective wards

- Negligence in timely transport of emergency patients from one facility to another
- Irregular cleaning and scavenging in most hospitals

#### ***Issues for better management***

- Key positions in hospitals lack core management skills
- The support sectors for hospitals like Drug and Equipment Store have received very few/no trainings on store and drug management
- Other areas related to hospital management like space management, management of assets etc. are not addressed

#### ***Information availability, computerization and HMIS***

- Patient related data although generated at the hospitals (at the OPDs and wards) but are not well managed
- Lack of data on key factors like seasonality of diseases, nature of patients admitted in hospital etc.
- Operationalisation of installed softwares at hospitals remains a critical issue
- Information gathering remains a weak area with computer data entry being done mostly by Group D staff lacking requisite training
- No analysis of collated information
- Data collected only from the OPDs and Emergency Wards
- No records on medico-legal cases

#### ***Issues for Group discussion and Probe***

- Issues in current hospital performance and quality
- Capacity building for better management
- Issues in information availability, computerisation and HMIS

## **Reducing financial time-cycle and improving financial reporting-Group 5**

Financial time cycle varies from different sources of fund and in some cases it takes longer time than expected. There are also gaps in the financial reporting. Some of the problems are discussed below.

### **Fund release and transfer:**

The current problems pertaining to parallel funding to Samities and Govt. account is the compilation. The multiple sources of funds and multiple receiving points are adding problems to correct transfer of funds.

Yet another problem is overlapping of allotments.

Moreover proper demand of funds (indent/budget) is not justifiably prepared.

Financial time cycle for various fund sources are different thus creating gaps in reporting.

### **Issues in reporting on SoE and UCs**

The major problems regarding reporting of SOE & UCs is timely submission. The collection is neither done in proper time. Hence the compilation is also delayed.

There are lack of proper understanding of the accounting documents and their importance.

### **Financial reporting system**

Existing government accounts reporting not yet streamlined with samity reporting. Till date both reporting system is treated in a different manner. Moreover, separate person are responsible for maintaining the reports. Both categories of person do not have any convergence so far as communication and compilation is concerned.

### **Issues for Group discussion and Probe**

Issues in current system of funds release, transfer and communication

Issues in reporting on SOE and UCs-delays in replenishment of fund

Towards faster and more efficient financial reporting systems

## **Reaching the un-reached-Group 6**

### **Service availability in remote areas**

- Reducing health inequities (policy level) setting goals and systems to meet health needs of the poorest and the marginalised
- Effective targeting at GP level – mapping of un-reached zones, identifying poor performing pockets,
- Barriers to access
- Awareness
- Knowledge
- Distance - transportation cost, escort
- Cost of medication
- Poor previous experience
- Indigenous care providers – accessible, available and affordable
- Vulnerability of population-groups:
- Socio-ethnic (Caste, Class, SC / ST, Minorities Etc)
- Gender (Social position of women, decision-making abilities)
- Geographic (distance from health facilities)
- Economic (income-poor, who controls resources)
- Disabilities and disease related
- Work-place related (tea gardens, collieries etc)
- Facility-linked (unavailability of staff, services)

### **Improved service delivery**

- Planning, data use, review
- Poor involvement of other sectors to increase access

- Community mobilization – involving CBOs, (SHGs), Youth clubs,ASHA and others who brings information to the service providers
- Convergence with other sectors (ICDS, PRI) – Sharing and cross-checking information base, using AWWs as depot holders, Sub-centre level consultations with PRIs and ICDS
- Use of PPP models for supplementing public health sector
- There had been some limited efforts in integrating private partners to supplement services rendered through public health sector.
- Low involvement of NGOS in community mobilization, identifying gaps in service delivery
- The need for further expansion & strengthening of existing schemes to broaden service delivery mechanism (eg Ayushmati, Ambulance etc.) –
- Private Nursing Homes
- Private practitioners (including homeopathy)
- Private diagnostic facilities

**Issues for Group discussion and Probe**

- Addressing issues of service availability in remote areas
- Involving Panchayats, WCD and other related departments for increased access
- Using NGO partners / PPP models for supplementing public health sector

## **Could Rani Have Been Saved? Why Health Systems Matter-A case Study**

Rani's husband is a migrant labourer. Being a migrant labourer, he stays away from the family for most of the time in a year. The responsibility of running the household singlehandedly lies with Rani. The family lived in a village without any accessible health or education institutes close by. The daily provisions could be bought only once in a week from the local market "hat".

Rani had three children one four year old boy, a 2 year old girl and a nine month old daughter. She also had ailing parents in law to look after. In this situation, she got pregnant again. Rani was not on regular contraception as her husband was not around for most of the time.

She wanted to abort the child but did not know where to go for abortion. A neighbour informed that only person who could come to help was the PHC doctor who conducts abortion at his residence privately in lieu of fees amounting to around Rs 400. It was difficult for her to collect the amount of money immediately. However, after selling off the goat she was rearing, she managed to get the money for abortion. One day after doing all the household work, she somehow managed to go to the doctor along with her neighbour but to her dismay she found the chamber closed. She made two more futile attempts to reach the doctor. Finally the day she met the doctor, she was advised not to undergo abortion as she was more than 6 months pregnant.

During pregnancy she never intended to go for any antenatal care. Usually health workers never came to her village as the village was quite inaccessible from the nearest sub centre. On insistence from a neighbour she only went once to the sub centre from where she received a TT injection and was given 200 IFA tablets as she was detected with anaemia and was advised the therapeutic dose. She was told about JSY benefits and asked to come for 2 more ANC checkups. Apart from these she was not given any advice. It was not possible for her to go for any more ANC checkups. She kept the IFA tablets and never bothered to consume them.

Rani realised she was not all that fit but could not do much about it. Once she thought she must visit the local quack, Ramapada but could not find time to go. She continued with her daily chores and one day she felt extremely weak and was unable to get up early as it was usual for her. She had dizziness and was feeling nauseated. She also started feeling labour pain feebly. In the evening, the local quack, Ramapada was called. He advised her to go to the BPHC as there was no indoor facility in the PHC, which was closer to her home. Rani could have gone to the PHC by a rickshaw van but getting a transport to the BPHC was difficult in the evening. They decided to go the next day early morning by hiring a taxi. Moreover others advised that since her labour pain had started she could deliver at night. If she delivered she need not be taken to the hospital. They informed the local TBA, Kajaler Ma for any emergency that might arise in the night.

She was extremely unwell during the night. Her neighbours accompanied her to the BPHC the next day early morning when she was complaining of severe headache and blurring of vision. However, she had not lost her consciousness and repeatedly told how difficult it was for her to leave behind two children at home with the two elderly people.

The BPHC was running with minimal staffs as it was year-end and everyone was busy exhausting the accumulated casual leaves. Moreover she was in critical condition and was advised by the lone doctor to go to the district hospital which was another 65 kms from the BPHC. Moreover the young doctor was not sufficiently trained in gynaecology and obstetrics and was not confident of handling the case. When she reached the hospital she was unconscious and was having respiratory distress. It was a usual busy day for the district hospital at the peak hour. It took quite some time for registration, a stretcher could be found but it was difficult to get a GDA to take her to Gynaecology & Obstetric ward. In the mean time, two persons stealthily came to them and asked that it was advisable to go to nursing home than get admitted in hospital where she would not get any care. They also cited the lack of care they have meted with so far. The accompanying persons were indecisive as no close relative had come. They preferred to wait for service at the hospital.

Her neighbours waited outside as they were told that the patient was in critical state. They never knew what transpired inside the ward but were informed after an hour that Rani has expired.

**Invisible eye in the ward of the hospital says:** Out of 4 gynaecologists in the DH hospital, one was on leave, other was in the OT, one could not be traced and the 4<sup>th</sup> one was on call. Intimation was sent to the on call doctor and a vehicle was sent to his residence. He was not available at the moment. The nurses on duty tried to resuscitate and the machine was not working properly. One of the emergency drugs was not available and a person was sent quickly to fetch the drug from the store. The nurses frantically called the doctors on their mobile phones, and one could be reached. By the time the nurses received instruction Rani breathed her last.

**Issue of discussion : What would have been the right chain of events that could have saved Rani's life?**

**Strengthening health system, solution to reduction of maternal mortality**

## Annexure 4: Feedback

### Post Workshop Feedback

1	Your overall assessment of the workshop:		Excellent	Good	Satisfactory	Poor	Very poor
		Contents	50%	50%	-	-	-
Structure	16.67 %	66.67%	16.67%	-	-		
Methodology	16.67%	83.33%	-	-	-		
Facilitation / Presentation	33.33%	50%	-	-	-		
2	Your specific assessment of the facilities at the workshop:		Excellent	Good	Satisfactory	Poor	Very poor
		Venue	-	16.67%	66.67%	16.67%	-
Food	16.67%	50%	33.33%	-	-		
Sitting arrangement	-	16.67%	33.33%	33.33%	-		
Other facilities	16.67%	16.67%	66.67%	-	-		
3	Your assessment of the utility of this workshop:		Very Useful	Somewhat Useful	Not very useful	A waste of time	
		Workshop utility	33.33%	66.67%	-	-	
5	What were your three key learnings from the workshop:	<ol style="list-style-type: none"> <li>1. Interactive confidence building i. e. "we can also become one of the best performing states"</li> <li>2. "Communities health is safe only in communities" by Hon'ble Minister-in-charge</li> <li>3. How each step of health care delivery system is important.</li> <li>4. Overall knowledge of the programmes</li> <li>5. Current scenario of health sector</li> <li>6. Future planning overview</li> <li>7. Broad overview of the reform process</li> <li>8. Exchange ideas in open discussion</li> <li>9. Better planning before execution</li> <li>10. Quality sustainable monitoring</li> <li>11. Intersectoral Coordination and necessity of working together</li> <li>12. Regular update of activities in different programmes</li> <li>13. Active cooperation is essential</li> </ol>					
6	Should more such workshops be held in future?  If yes, do you have any suggestions for further participants?	Yes: 100%      No: 0%  Further participants suggested:  NGOs, Panchayat functionaries, JS (family welfare), DME, Districts,					
7	Which part of the workshop did you like best ?  Why?	<ol style="list-style-type: none"> <li>1. Interactive session( for find out the solution by discussion) 33%</li> <li>2. Presentation by ACS (Interacting and animating) 40%</li> <li>3. Interactive presentation on BR, IMR, MMR (Because it could raise self-confidence) 15%</li> <li>4. Group working (fro exchange of views)3%</li> <li>5. Presentaion by A. Rahim 3%</li> <li>6. Others 6%</li> </ol>					
8	Please provide your suggestion for improvement in future workshops	<ol style="list-style-type: none"> <li>1. Group discussion 50%</li> <li>2. More interactive discussion 34%</li> <li>3. Introductory notes to the participants 5%</li> <li>4. Better selection of key topics for discussion 3%</li> <li>5. Group work presentation 2%</li> <li>6. Discussion on current situation 2%</li> <li>7. Others 4%</li> </ol>					