RUWSEC

Rural Women's Social Education Centre (RUWSEC) is a non-governmental women's organisation started in the year 1981 by a team of 13 women of whom 12 were dalit women from the local villages of Chengalpattu taluk near Madras (Chennai) in Tamil Nadu.

Achieving women's wellbeing through women's empowerment is our organisation's vision. Our focus has been on enabling women to gain greater control over their bodies and their lives and achieving wellbeing, through promotion of gender equality and sexual and reproductive rights.

Since its inception, RUWSEC was a grassroots organisation with community-based workers drawn from the local villages. Our approach was to motivate, educate and organise women from poor and marginalised communities to stand up for their rights and become agents of change. We wanted rural poor women to be able to analyse the socio-economic and political factors underlying their lack of good health and control over their sexuality and fertility and to have the knowledge and skills to alter their own situations.

Since 2004, the organisation has transformed into a research, training, advocacy and technical support organisation providing inputs to grassroots organisations in Tamil Nadu which are working on gender, reproductive, sexual health and rights. In addition, we have helped the formation of a group of grassroots organisations under the leadership of former RUWSEC workers, working on sexual and reproductive health and rights, and have been providing them with financial support and technical guidance for effective implementation.

The Executive Director
Rural women's Social Education Centre RUWSEC
Tamil Nadu, India.

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Patient Welfare Societies, Health Committees and Accountability to Citizens on Sexual and Reproductive Health: Lessons from Case Studies from Tamil Nadu

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Abbreviations

AIDS	-	Acquired Immune Deficiency Syndrome
ANM	-	Auxiliary Nurse Midwife
BEmOC	-	Basic Emergency and Obstetric Care
CEmOC	-	Comprehensive Emergency and Obstetric Care.
CHC	-	Community Health Centre
GG Pettai	-	Gnana Griswarar Pettai
G.O	-	Government Order
HIV	-	Human Immune-Deficiency Virus.
IEC	-	Information Education Communication
MCH	-	Maternal and Child Health
NGO	-	Non-Government Organisation
NRHM	-	National Rural Health Mission
PHC	-	Primary Health Centre
RCH	-	Reproductive and Child Health
RH	-	Reproductive Health
RTIs	-	Reproductive Tract Infections
RUWSEC	-	Rural Women's Social Education Centre
SC	-	Scheduled caste
SHG	-	Self Help Groups
SRH	-	Sexual and Reproductive Health
ST	-	Scheduled Tribes
STIs	-	Sexually Transmitted Infections
VHN	-	Village Health Nurse

Introduction

The National Rural Health Mission (NRHM) launched in 2005 advocates the establishment of patient welfare societies at district/taluk hospitals and at Primary Health Centre (PHC)/Community Health Centre (CHC) levels and village health, water and sanitation committees at the health sub-centre level. These societies and committees are supposed to 'not function as a government agency, but as an NGO as far as functioning is concerned' *(1)*. They are to comprise of elected people's representatives, community representatives, civil society organisations and government administrative/health officials *(1, 2)*. The patient welfare societies, in addition, could also include individuals/institutions who contributed donations of a fixed amount to the society *(1)*. The societies and committees are supposed to play several roles like responding to the problems faced by patients in accessing services; improving infrastructure and quality of clinical and non-clinical services; raising resources for the facility (including through levying user fees in the case of patient welfare society); promoting public-private partnerships for rendering services, and monitoring the implementation of national health programmes; and strengthening accountability to citizens *(1, 2)*.

In keeping with the national guidelines, between April 2006 and March 2007 the Tamil Nadu Health and Family Welfare Department issued orders on establishing patient welfare societies/village health, water and sanitation committees in each of the district and taluk/non-taluk hospitals, primary health centres, and health sub-centres *(3-6)*. Fortunately*, there was considerable opposition in Tamil Nadu to patient welfare societies being allowed to raise funds through levying user fees, leasing government health facility infrastructure to private parties and to include private parties who donated money on the committee *(8)*. Hence, the Health and Family Welfare Department issued new government orders which amended the original one and barred such powers of the society *(9-10)*. The opposition to indirect moves to privatise came from several quarters like Left leaning political parties, trade unions, a section of public health professionals and a section of providers (8). Non-Governmental Organisations (NGOs) do not seem to have been actively involved in these debatesari†.

**** For a discussion on detrimental impact of levying user fees on public health service utilization by poor in health and the world over see article by Ravindran. (7)***

† Discussion of the authors with the Director of Public Health and Preventive Medicine, Dr Padmanabhan in November , 2007

While this pro-poor modification of the national guidelines on patient welfare committees and health committees is indeed laudable, have these committees strengthened accountability to citizens on health services in general and sexual and reproductive health (SRH) services in particular? Have they strengthened availability, accessibility, affordability and quality of health services, and in specific sexual and reproductive health services? Are funds used in a transparent manner? What could the government and NGOs do to strengthen patient welfare societies and village health, water and sanitation committees in these directions? These are the questions that this paper explores through examining seven case studies on the functioning of patient welfare societies and village health, water and sanitation committees from Kancheepuram and Vellore districts of Tamil Nadu. Kancheepuram district is headed by a district health official who joined the service early and has risen up the ranks, while the Vellore district is headed by a health official with a Gandhian and non-governmental background who joined five years back. Both are from a public-health academic background. As the sample size is limited, the findings cannot be generalised to the whole of Tamil Nadu. Nevertheless, it is hoped that the case studies offer useful insights on the functioning of patient welfare societies and village health, water and sanitation committees, and areas for strengthening if they are to be accountable to citizens on sexual and reproductive health.

The paper is structured as follows. The first section elaborates on the concept of accountability and the concept of sexual and reproductive health. The second section sets the context within which the case studies are examined. It summarises the health administration in Tamil Nadu, the content of the Tamil Nadu government orders on patient welfare societies and village health, water and sanitation committees and how they differ from the ones of the central government. The third section documents seven case studies on the functioning of patient welfare societies and health committees from these two districts. Two case studies pertain to sub-centre health committees, two pertain to PHC committees, one to CHC committees (that is supposed to provide basic-emergency obstetric care (BEmOC) facilities), and two pertaining to district hospital committees. The fourth section pulls together the main findings on how far the seven patient welfare societies and health committees have promoted accountability to citizens with regard to SRH service availability, affordability, physical accessibility and quality. It also draws out lessons from the case studies on factors crucial to effective performance in this regard. The final section suggests possible directions for using health structures with community representation to strengthen accountability to citizens on SRH services.

1. Concepts

Accountability:

Goetz defines accountability as whether and how power holders answer for their actions and are sanctioned for their abuse. She considers there are two aspects of accountability: answerability and enforcement *(12)*. Caseley perceives that the concept of accountability is broader than, though linked to, these two aspects. In the context of public sector service delivery, Caseley sees engagement and responsiveness as two key elements of accountability *(13)*. Engagement refers to a reciprocal relationship between two actors whereby demands are articulated by one actor in a transparent manner to the other. Responsiveness refers to the extent to which the party on which demands are placed, acts on it. Responsiveness, in turn, is seen by Caseley as comprising one or more of the following three elements:

- Answerability (passing information and justifying decisions on the basis of demands placed),
- Enforcement (ensuring compliance with decisions) and
- Organisation change (changing the way the services are delivered).

Adapting elements of both these definitions, accountability to SRH services can be understood as the processes by which power holders in the health sector engage with and answer to those who make demands on it, and enforce actions in such a manner to strengthen availability, affordability, physical accessibility and quality of SRH services. Accountability to SRH can be explored from the following different angles *(14-18)*:

- Who is accountable?
- To whom?
- When?
- With regard to what?
- How are they held accountable?

Power holders in the health sector could range from health policy makers, health managers, health providers, to health workers. They could be from the public or private health sector. This paper will examine who within the health sector is held accountable and who is not. Accountability can be

'internal' in the sense to colleagues, to higher-ups within the health sector or to health professional bodies, or 'external' in the sense to citizens groups and/or to independent accreditation bodies. This paper is concerned with external accountability and in particular with accountability to citizens. Accountability can be before a health policy is formulated or a programme begins or during and after its implementation *(19, 15)*. Accountability can be operationalised through legal means, bureaucratic rules, public hearings and a variety of other means. One of the concerns of this paper is to examine whose accountability is promoted through the patient welfare societies and village health, water and sanitation committees, and to whom, when and how.

Sexual and reproductive health

Reproductive health refers to complete physical, mental and social well-being in all matters related to the reproductive system *(20)*. Sexual health refers to healthy sexual development, equitable and responsible sexual relationships, sexual fulfilment and freedom from illness, disease, disability, violence and other harmful practices related to sexuality *(21)*.

The 'full range' of (sexual* and) reproductive health care services under the Cairo International Conference on Population Development 1994, to be made available at the primary health care level as envisaged in the Programme of Action includes *(20)*:

- Family planning counselling, Information Education and Communication (IEC) and services,
- IEC and services for prenatal care, safe delivery and postnatal care,
- Prevention and appropriate treatment for infertility,
- Abortion, including prevention of abortion and the management of complications arising from abortions,
- Treatment of reproductive tract infections, sexually transmitted infections and other reproductive health conditions, and
- IEC and counselling as appropriate on human sexuality, reproductive health and responsible parenthood.

**** The Programme of Action, International Conference on Population and Development, 1994, does not use the term sexual health services through the full and comprehensive range of reproductive health services listed in the document refers to some elements of sexual health services. (20)***

In addition, comprehensive (sexual and) reproductive health services, to be available at the first referral level, includes complications arising out of the services listed above, and diagnosis and treatment of breast cancers, and cancers of the reproductive system. The first referral unit in the Indian context is the community health centre.

Sexual and reproductive health needs can be classified as the 'controversial' ones and 'non-controversial' ones (17*, 22). What is controversial and non-controversial may vary with contexts. Controversial health needs (due to stigma in society) in the Indian context include access of women to safe abortion, sexual and reproductive health services for unmarried adolescents, services to address sexually transmitted infections, and services for injury and trauma caused by gender-based violence. Accessing services for routine safe delivery, or reproductive cancer is, on the other hand, often non-controversial in India. However, not all non-controversial needs are of priority to the government based on the principle of cost effectiveness *(23)*. Services for diagnosing and treating reproductive cancers or mental depression are not a priority of the Indian government (though Tamil Nadu government has started focusing recently on reproductive cancers in selected districts under the World Bank supported Tamil Nadu Health Systems Project) when compared to female-focused contraceptive methods. This paper will examine what kinds of gender-specific health needs have been addressed through accountability processes and what kinds have not.

2. Context

Health administration in Tamil Nadu

The Health and Family Welfare Department, Tamil Nadu comprises of the Directorate of Medical Education, Directorate of Medical and Rural Health Services, Directorate of Public Health and Preventive Medicine, Directorate of Family Welfare, Directorate of Drugs Control, Commissionerate of Indian Medicine and Homeopathy and State Health Transport Department *(24)*.

**** Murthy et al have adapted this differentiation from Jacqueline Pitanguy; Pitanguy uses the term, 'heaven' and 'hell' SRH issues, which has been changed to controversial and not controversial ones by Murthy et al. (see 17, 22)***

The Directorate of Medical Education is in-charge of developing medical education curriculum, administration of medical education colleges and teaching hospitals and supervising selection of students. The Directorate of Drugs Control deals with enforcement of enactments relating to the manufacture, distribution and sale of drugs. The Commissionerate of Indian Medicine and Homeopathy deals with teaching as well as provision of health care in Ayurveda, Siddha, Unani, Homeopathy, Yoga and Naturopathy systems of medicine. The Tamil Nadu Health Transport Department aims at keeping the off-road vehicles of the Health and Family Welfare Department to the minimum *(24)*.

The Directorate of Medical and Rural Health Services is in-charge of planning and implementation of all medical services through the grid of district, taluk hospitals and non-taluk hospitals, dispensaries, mobile health units, women's and children's hospitals, tuberculosis hospitals and clinics, and leprosy hospitals. The Directorate of Medical and Rural Health Services also monitors the implementation of all health legislation. The Directorate of Public Health and Preventive Medicine is in-charge of providing primary health care services through a network of 1,417 PHC's and 8,683 sub-centres as of 2006 *(24)*.

The Tamil Nadu Health Systems Project (2005-2010) is a World Bank funded project to improve the secondary health care system in the state, with a particular focus on reduction of maternal mortality and infant mortality, provision of universal cervical cancer screening, and prevention and treatment of coronary heart disease and hypertension. It works closely with the Directorate of Medical and Rural Health Services. The Tamil Nadu Reproductive and Child Health (RCH) project has been integrated with the State Rural Health Mission *(24)*.

The National and State Rural Health Missions

To implement the National Rural Health Mission in Tamil Nadu, State and District Rural Health Missions were launched in 2006 *(24)*. The objectives of the missions include reduction in infant and maternal mortality, promotion of universal access to public health services, prevention and control of communicable and non-communicable diseases, population

stabilisation, improving access to integrated comprehensive primary health care services, mainstreaming of local health traditions and Indian systems of medicine and promotion of healthy life style *(24)*.

To implement the National Rural Health Mission, State/District Health Societies have been formed in 2006. All the previously existing health societies (related to leprosy, blindness, tuberculosis and integrated disease control) other than the Tamil Nadu Acquired Immunodeficiency Syndrome (AIDS) Control Society have been merged into this society. All the national health programmes implemented in the state have been brought under one umbrella and are implemented through various sub-committees of the National Rural Health Mission including ones on RCH, maternal and child health and family welfare, communicable diseases, and Indian systems of medicine and homeopathy *(25)*. Under the missions, all PHC's and sub-centres are to be upgraded to Indian Public Health standards. The broader purpose is ostensibly to provide sustainable quality of care with accountability and people's participation along with total transparency *(24)*.

As the Government of India felt that such quality and accountability may not be possible unless a proper and participatory management structure was evolved, the idea of Rogi Kalyan Samiti or Patient Welfare Society was mooted. This structure was based on the successful experience of the Madhya Pradesh government (1). In keeping with the National Rural Health Mission directive on forming patient welfare societies, the Tamil Nadu Health Secretary passed Government Orders in 2006 on constituting patient welfare committees at district headquarters hospital levels, taluk/non-taluk hospital levels, and primary health care centre levels *(3-5)*. In March 2007, the Health Secretary of Tamil Nadu passed a government order, on constitution of village health, water and sanitation committees *(6)*, and in the same year amended the 2006 government orders allowing societies to levy user fees and allow private parties who donated funds to become members *(9-10)*. An important point to note is that the village health, water and sanitation committee and PHC and CHC patient welfare societies are overall supervised by the Deputy Director of Health Services at district level, while the district hospital patient welfare societies come under the Joint Director of Medical Services. The former is trained in public health, while the latter is not.

3. Functioning of health committees and patient welfare societies Village health, water and sanitation committee: Policy and reality

Envisaged objective and role

The envisaged objective of the village health and water and sanitation committee (village health committee in short) is to "improve the health status of the community by placing the responsibilities in their own hand through their empowerment" *(6)*. In particular the committees are to ensure convergence and utilisation of health, water, sanitation and other social services and promote community ownership of health and other development institutions. The committees are to work closely with the Development Committees of the gram panchayats*.

The specific roles of the village health committees fall under the category of health planning, outreach and implementation, and resource mobilisation and are listed below.

Health planning

- Assess, analyse, prioritise and develop area-specific health plans for each village and habitation.

Outreach and implementation

- Build awareness among community on health and determinants of health,
- Facilitate birth and death registration,
- Ensure the provision of safe drinking water,
- Facilitate the delivery of RCH outreach services, disease prevention activities and family welfare services (with special focus on non-scalpel vasectomy),
- Ensure emergency transportation of high-risk mothers and newborns and cater to other emergencies,
- Monitor referral complications of high risk mothers and the newborn,
- Facilitate growth monitoring and feeding of children in Integrated Child Development Service centres and ante-natal mothers,
- Monitor utilisation of basic services like immunisation, water chlorination, distribution of oral re-hydration packets, behavioural change communication meetings and weighing of newborn children,

**** The gram panchayat is the lowest level of self governance structure in rural areas of India since the 73rd Constitutional Amendment in 1993.***

- Monitor regular school attendance of children,
- Encourage the un-reached to avail basic services and raise demand for services among the general public,
- Surveillance for prevention of (male) sex-selection and infanticide and
- Facilitate the identification and distribution of cash benefits for eligible people under the Muthulakshmi Reddy Maternity Benefit Scheme*, Janani Suraksha Yojana† and female child protection scheme.

Resource mobilisation

- Mobilise resources from the community (does not specify the means) *(6)*.

On the whole, it appears that the village health committees were expected to play more of an 'implementation' role and little role in pressing for 'accountability' of the health sub-centre staff or health services that they offer. On the positive side, the village health committees have a broader mandate than health, water and sanitation, but also social issues like prevention of sex selection and infanticide, and promotion of girl children's education and nutrition.

Envisaged composition and activities

As per the Tamil Nadu Government Order, the village health committee is to comprise village panchayat president, village health nurse (VHN), Health Inspector, one woman representative from a self-help group (SHG) and one anganwadi‡ worker *(6)*. The village panchayat president is to act as the Chairperson and the VHN as the Member Secretary; with both of them being empowered to operate the bank account of the committee jointly. The panchayat president, the VHN and the Health Inspector will be

**** The Dr Muthulakshmi Reddy Maternity Assistance Scheme is a Tamil Nadu government supported scheme under which women are provided Rs 6000 per delivery in institutions at the rate of Rs 1000 per month for six months for two deliveries. (24,25)***

† Janani Suraskhi Yojana is a central government sponsored maternity benefit scheme for poor women. A cash assistance of Rs 700 is given for the first two births to rural women (Rs 600 for urban women) below the poverty line provided they deliver in public or private institutions. The assistance provided is more in the case of backward states (which excludes Tamil Nadu) and limits are not placed on the number of pregnancies. (26)

‡Anganwadi worker runs the Anganwadi/Integrated Child Development Scheme center which provides nutrition services to children in the 0-6 year age group and pregnant and lactating women. It also provides child care services for children in the 3-6 year age group

members of the committee as long as they hold their respective official posts (i.e. in ex-officio capacity), while the SHG representative and workers are to be rotated every year. This system of rotation of SHG representatives is because there are several SHGs and anganwadi workers in the area of operation of one gram panchayat. These members are to be selected by the panchayat president. Once the committee is formed, it is to be oriented and trained to carry out its activities. Under the NRHM, each committee gets Rs. 10,000 annually as untied grant to enable local action to address public health needs (e.g. cleanliness and sanitation), to raise awareness on health/social determinants of health, to prevent and control vector borne diseases, to meet costs of emergency transportation of poor patients, high risk pregnant women and newborns and to meet any other community activities that benefit more than one household. Every village is free to make additional contributions to the committee. The committee is to meet at-least once every month, with one-third attendance being the quorum. The committee is expected to maintain a register of funds received and expenditure, which should be monitored by the Sector Health Nurse, Community Health Nurse, PHC (in-charge) Medical Officer and the gram panchayat *(6)*.

A concern is that civil society members (elected representatives and SHG members) account for only 40% of membership of the village health committees; while 60% are government workers. How far this minority can hold the majority accountable is a moot question, especially when the member-secretary is the Village Health Nurse. Further, the quorum of one-third can be met without the participation of the SHG women representative or the Chair. The absence of a rule that minutes of the meeting have to be recorded is also a concern, as what gets and does not get discussed cannot be ascertained. Yet another concern is that unlike the development committee of the panchayat which performs oversight roles - that is inspect health sub-centres and health centres located in the panchayat area and submit its observations and suggestions to panchayat - the village, health, water and sanitation committee does not perform any oversight functions *(27)*. Discussions with panchayat leaders in visited villages revealed that with the constitution of the village health committee, they were not clear about the continuation of the panchayat development committees which performed other development roles like working towards prohibition of child labour, prohibition of liquor, prohibition of dowry, promotion of communal harmony, and eradication of untouchability *(27)*. Lastly, there are no procedures for public involvement in the newly constituted village health committees, or accountability of the committees to the community.

Actual functioning of village health, water and sanitation committees

Mayur village health, water and sanitation committees, Kancheepuram district

The Mayur health sub-centre was established in 1985, and is located in the Mayur village of Madurantagam Block of Kancheepuram district. It covers three gram panchayats, and five villages with a total population of 5,803 (and 1,466 households). The sub-centre is staffed by one (woman) VHN, one male Health Inspector and one traditional midwife. The VHN has appointed a ward assistant from untied funds to help her carry the immunisation box and expand outreach. The sub-centre also houses the residential quarters of the VHN, where she resides. The non-residential part of the sub-centre includes one room for seeing out-patients and one room for delivery (with one bed) with an attached bathroom (but without running water) for patients. There is no compound wall to the sub-centre cum quarters, which makes the nurse feel a bit insecure; in particular being from a dalit* Christian background. The outpatient room has a table and two chairs, and a fan for patients. The sub-centre has a blood-pressure reading apparatus, emergency light (in case the current goes off), gas stove (for sterilisation) and torch (for house-visits in the night). While the VHN† reported that the sub-centre was stocked with necessary medicines and essential supplies the SHG member of the committee (whom the research team met independently) mentioned that the public had to pay for needles for sutures. The VHN had been provided with a moped and a cell phone to help her carry out her work, and there was a display board outside the sub-centre mentioning the phone number of the VHN and where she was on that particular day. In fact, at the time of the visit by the research team a woman patient called her and enquired as to why she was late and not keeping her immunisation appointment! The Mayur sub-centre renders most of the services listed under the NRHM to be provided at sub-centre level, viz. maternal health services (Ante-natal care, post-natal care, institutional delivery and referral), child heath services, temporary methods of contraception (including emergency contraception), follow up services on sterilisation, adolescent health education (for both school and out-of-school children), monitoring of water

**** Dalit are socially and economically discriminated groups; considered untouchables and are also referred to as Scheduled Castes.***

† Discussion by two of the authors (Ranjani Murthy and Bhavani) with the VHN, Prascilla Mayur health sub center on 4th January, 2008.

quality, and basic curative services and recording of vital events. In addition, 'Varumun Kappom*' camps are held once a year at the village level and reproductive health camps are held in BEmOC centres during which cervical cancer screenings and breast examinations are carried out by doctors coming from PHCs and CHCs. The 'Accredited Social Health Activists' (ASHA) scheme is not operational in this district, as is the case in the rest of Tamil Nadu. However, tests to find out haemoglobin count, urine albumin and sugar are not done at the Mayur sub-centre as is supposed to be done *(26)*, but only at the Padalam PHC around 15 km away.

As the sub-centre covers three gram panchayats, three village health committees have been formed by the VHN in September, 2007. The VHN had received instruction during regular meetings from the PHC (in-charge) Medical Officer on how to form the committee, and no specific training was given to her before formation. Of these three committees, the Mayur village health committee was studied, which had according to the VHN met once after its formation (the research team visited in November, 2007). The committee composition strictly follows the guidelines of the Tamil Nadu government. Notably, four of the five members were from dalit background. However, the selection process was slightly different from what is mentioned in the guidelines. While the VHN claimed that the SHG leader was selected by the gram panchayat Chairperson, the Chairperson met by the research team pointed out that she was not involved in the selection. Apparently, the Chairperson wanted to change this SHG representative as the SHG representative had opposed her during the last local-government elections. None of the Mayur health, water and sanitation committee members had received training on the role and functions of the committee before or after its formation. The VHN mentioned that the village health committee members required training on the role and process of formation of the village health, water and sanitation committee, rules governing utilisation of funds, and maintenance of records.

The VHN and Health Inspector were clearly aware that they were members of the committee, while the other three - SHG leader, anganwadi worker and panchayat leader- were not aware as there were various committees in the village and the identity of different ones were blurred in their minds. Except the VHN, none reported having seen the government order on the

**** The Vaurumun Kappom scheme was initiated in 2006-2007 to facilitate early detection and treatment of illness. It is supposed to provide comprehensive health check up, treatment and health education to the people. (24- 25)***

role and functioning of the village health committee, or were aware of its content. Upon probing, three committee members (the VHN, the worker, and (woman) gram panchayat leader) expressed that the committee should improve sanitation and public hygiene in the village, assist VHN in strengthening outreach, improve sub-centre infrastructure and strengthen approach road to the sub-centre. The VHN also observed that the committee funds should meet emergency transportation expenses of pregnant women and claim the same from the women once they got paid Rs. 6,000 from the state government's maternity assistance scheme. It was the SHG woman member who had different notions of the role of the committee. She had been trained by the Rural Women's Social Education Centre (RUWSEC) which is a rights-based Non-Government Organisation (NGO). She expressed that the village health committee should in particular monitor whether the health sub-centre stocked medicines and provided services that it was supposed to render. She also held that it should look into issues of preventing domestic violence, and address issues of people with disability and single women. None of the committee members pointed to the role of the committee in developing a village specific health plan, monitoring access to health benefits under various schemes, ensuring that the poorest use health services, and preventing female infanticide or sex selection.

While the VHN reported that all the members of the committee had attended the meeting to discuss 'utilisation of funds of the committee', discussions with the anganwadi worker, gram panchayat leader, SHG leader, and the Health Inspector revealed that none had attended the meeting. The anganwadi worker and the SHG leader reported they were not well on that day, and the gram panchayat leader was busy with another meeting. The Health Inspector was busy with some other work. According to the VHN, issues of stagnant water in Mayur village, breeding of mosquitoes, meeting emergency transport expense for delivery incurred by her for one pregnant woman from Mayur, repairing damage to approach road to sub-centre, building compound wall for the sub-centre and cleaning water tank of the sub-centre were discussed. Of these issues, a decision was taken to address only the Mayur village-specific health, water and sanitation issues. The VHN expressed that as the sub-centre catered to three gram panchayats, the issue of building compound wall and cleaning water tank of the sub-centre was a common concern, for addressing which all the three committees had to meet and there was no protocol for the same.

The Rs. 10,000 allocated to the committee for the year 2007-08 had been used for filling stagnant water collection points in the village with mud,

purchasing bleaching powder for the wells, repairing the approach road to the centre, purchasing blood-pressure recording apparatus and weighing machine for the Integrated Child Development Services Centres and paying the ward member to carry the immunisation box and help in outreach. The additional untied funds of Rs. 10,000 per sub-centre (managed independently by the Health Inspector and the VHN) for the year 2007-08 was used for purchasing bed sheets, towels, gas cylinder, and toilet pans for the sub-centre; repairing of common septic tank for sub-centre and quarters and reimbursing expenses for delivery for one patient. The VHN and the Health Inspector expressed that they preferred the 'untied fund' to 'committee' funds, as they had greater powers to determine its use; while they had to involve other committee members on the use of committee funds. In particular, the Health Inspector reported that the gram panchayat president of that village wanted the committee funds to be diverted for other purposes. He also expressed that unlike the untied funds and the committee funds could not be used for repair of building or windows.

According to the VHN, the improvements brought about through the funds of village health committee and untied funds together had reduced water borne diseases, improved physical access to sub-centre health services, access of pregnant women to transportation in case of emergencies, and made their visit to the sub-centre more comfortable. Improvements in sub-centre facilities were also noted also by seven citizens met by the author from Sampthivannalur and Ambedkar Nagar hamlets attached to Mayur village, namely three male youth, another woman SHG leader (30 years) and two middle aged women. However, none were aware of the existence of the new village health committee. Three of the seven citizens however mentioned that they had attended eight months back a large public meeting organised by RUWSEC, during which the functioning of the sub-centre and the VHN was monitored. Issues of non-availability of supplies (e.g. needles for sutures) and drugs (for scorpion and snake bites) in the sub-centre were discussed, as well as the fact that the VHN charged at that time for delivery services that were meant to be free. Following enquiry by higher officials during which none of the community members expressed the complaint, the VHN stopped charging for delivery services. After meeting district officials, the representatives of this larger forum concluded that the non-availability of supplies was not a lapse on the VHN's part but the larger issue of distribution of drugs and supplies. They were also informed that the medicines for scorpion and snake bites were to be available only at the PHC level. The relationship between the VHN and members of the community subsequently improved.

Reports from the VHN, suggest that though the infrastructure at the sub-centre had improved, there was no increase in delivery at the sub-centre level. The number of deliveries in the sub-centre between April 2006 and March, 2007 stood at 12; while the number of deliveries between April to December, 2007 was 8 (only slightly lower). In fact, the VHN reported that of late the district health officials encourage her to send pregnant women to PHCs for delivery, as they were better equipped to handle emergencies.

Manguppam village health, water and sanitation committee, Vellore district

The Manguppam health sub-centre was established in 1967, and is located in Manguppam village of Arcot Block of Vellore district. It covers one gram panchayat, and four villages with a total population of 8,031 (and 1,502 households). The sub-centre is staffed by one (woman) Village Health Nurse, one male Health Inspector and one traditional midwife. The traditional midwife is paid Rs. 100 per month through the untied funds of the health committee. Like Mayur, the Manguappam sub-centre also houses the residential quarters of the VHN. However, she does not reside in the village as the roof of her quarter leaks. The non-residential part of the sub-centre is similar to that of Mayur. Again, water for the patient toilet has to be fetched from outside. A positive aspect is that the sub-centre has a secure compound wall. The out-patient room has a table and two chairs, and a fan for patients. The sub-centre has an apparatus for recording blood-pressure an emergency light, gas stove (for sterilisation) and torch. The gas stove, according to the VHN, is kept in the unoccupied residential quarters to 'save on space'. The sub-centre is stocked with necessary medicines and accessories. Like the VHN in Mayur, the Manguppam VHN has been provided with moped and a cell phone. The services rendered by the Manugappam health sub-centre are similar to that of Mayur health sub-centre. The NRHM scheme of appointing Accredited Social Health Activists (ASHA) was again not operational here. Again, tests to determine haemoglobin count, urine albumin, and sugar levels are not done at the Manguppam health sub-centre as is supposed to be done, but only at the nearest PHC five kilometres away.

The Manguppam VHN formed the village health, water and sanitation committee in April, 2007 with the guidance of the PHC (in-charge) Medical Officer, and as of November, 2007 two meetings had been held. Like in the case of Mayur, no public meeting was held to aid selection of committee members. A positive aspect, however, was that the VHN, Health Inspector

and panchayat leader had received a day's training before formation of the committee from the Deputy Director of Health Services, Vellore district. The training covered the role, functioning, funds and records of the committee, and was also attended by the PHC (in-charge) Medical Officer. During the training, the participants were given a manual in Tamil (the local language) covering the role of the committee, its composition, its resources and procedure for operating its bank account. The manual also contains information on water-protection measures, hygienic toilet construction, prevention of communicable diseases, maternal and child health promotion, immunisation schedule for pregnant women and children, the health services that should be available at the PHC and the sub-centre level (in the eyes of district officials) and cell phone numbers of PHC doctors and VHNs in the district.

The Manguppam VHN, under the guidance of the PHC doctor, appears to have slightly adapted the Tamil Nadu government guidelines on formation of the committee. The Manguappam village health committee consists of the panchayat president (male), panchayat vice-president (female), two representatives from SHGs (females), one youth group representative (male), the VHN (female), the Health Inspector (male), and anganwadi worker (female). The SHG and youth representatives were selected by the VHN, and their dynamism and leadership qualities were the criteria for choice. Non-government representatives in the committee outnumbered those from the government in this sub committee.

The research team could meet three of the eight committee members, namely the VHN, the Vice-President and one SHG leader. All of them were aware that they were on the committee, but only the VHN was aware of the existence and content of the Government Order pertaining to the committee. The VHN claimed that the gram panchayat president had attended the training with her and knew about the Government Order as well, but this could not be ascertained. All three members expressed that the committee was meant to serve the public (with regard to health, water and sanitation), clean drainage, strengthen sanitation, and eradicate mosquitoes in the village. The VHN mentioned that the committee was also to facilitate better nutrition of pregnant women and improve their access to emergency transport. The Manguppam SHG leader was not as dynamic as the leader from Mayur, and did not see any role for the committee in facilitating the addressing of gender-specific health issues like (reducing) domestic violence. Like the case of Mayur committee members, none of the Manguppam committee members pointed to the role of the committee in

developing a village-specific health plan, monitoring access to health benefits under various schemes, ensuring that the poorest use health services, and prevention of (male) sex-selection and infanticide. Discussions with seven citizens*, from Manguppam (4 females and 3 males, all from Backward Castes† working as wage labourers, with varying levels of education) reveal that only two knew about the existence of the village health committee. Both were daily labourers in factories (one male and female), with high school or graduate levels of education. They were informed about its existence by the VHN. However, they were not clear about the role of the committee.

The VHN reported that most of the members of the committee had attended the two meetings of the committee held since inception. Discussions with the Vice-President, and SHG leader confirmed that they had indeed attended the meetings. The SHG leader met observed that she represented 11 SHGs in the village, and that she reported back whatever was discussed in the village health committee meetings to the SHG leaders from all the eleven groups when they met once a month. The main issue discussed during the village health committee meetings was how to use the Rs. 10,000 allocated to the committee. The entire amount was utilised towards the following: 'Expected date of delivery' campaigns, purchase of chlorine tablets, purchase of a chloroscope to measure the level of chlorine in water, and for advancing money to pregnant women for emergency transport during delivery. The 'Expected date of delivery' campaigns are innovative events operating in Vellore district wherein pregnant women and their families were informed about the possible date of the women's deliveries, the improved and free delivery facilities available at PHCs, and the referral services that the PHC can arrange in case of an emergency. The pregnant women were also given nutritious food. The district had chosen to give chlorine tablets over bleaching period, as they were easier to store and did not get damaged. The VHN mentioned that in future the committee planned to implement a garbage management system and mosquito eradication system using the funds. She also held that if more funds than Rs. 10,000 per annum were available with the committee, it could be used for providing iron injections to anaemic pregnant women at the cost of Rs. 270 per woman for 40 women a year. However, the present allotment was not adequate for this. The untied fund of Rs. 10,000 (managed by the VHN and the Health Inspector) was used for white washing the sub-centre,

**** Interviewed by one of the authors Bhavani on 29th November, 2007***
† Backward castes are castes considered socially and economically disadvantaged by the Indian government.

repairing the door to the sub-centre, purchasing a gas cylinder, purchasing needle cutter, purchasing phenol for the centre, and cell phone card of Rs. 100 every month.

According to the health committee members, the improvements brought about through funds of health committee and untied funds together had improved access to emergency transport for pregnancy women, enhanced proportion of delivery in public facilities, reduced costs of delivery for pregnant women and their families and improved maternal nutrition. In the period April 2006 to March 2007, 43% of the deliveries in the village were in private nursing homes, while in the period April to October 2007; the proportion had declined to 34% *(28)*. Within public health facilities, there was a decline in deliveries in the health sub-centres and district hospitals, and marked increase in deliveries in PHC facilities *(28)*. No such improvement in contraceptive or abortion services was reported as a result of health committees and untied funds *(28)*.

PHC patient welfare societies: Policy and reality

Objectives

The Tamil Nadu Health and Family Welfare Department Government Order of 2006 on the PHC patient welfare societies notes the objectives listed below *(5)*:

Improve implementation

- Organise outreach services/health camps at the facilities under its jurisdiction,
- Participate in the running of the health facility,

Strengthen infrastructure

- Undertake construction and expansion in the facility building,
- Ensure optimal use of health facility land,
- Ensure proper use, timely maintenance and repair of health facility building, equipment and machinery,

Improving quality

- Ensure compliance of minimal standards for facility and for health care services,
- Upgrade and modernise the health services provided by the health facility,

- Ensure proper training of doctors and staff,
- Ensure supply of subsidised food, medicines, drinking water and cleanliness to the patients and their attendants,
- Ensure scientific disposal of waste generated by the facility,

Generate additional resources

- Generate resources locally through donations, user fees and other means,
- Enter collaboration with private institutions to upgrade services,

Strengthen accountability and transparency

- Ensure accountability of the public health providers to the community,
- Introduce transparency with regard to management of funds,
- Display a citizens' charter in the health facility and ensure its compliance through operationalisation of a grievance redress mechanism, and

Strengthen monitoring:

- Supervise the implementation of national health programmes at the particular facility and other facilities that come under its jurisdiction

Envisaged composition

The first members of the Governing Body of the PHC patient welfare society is supposed to include the following 12 persons, namely the Block Development Officer, in-charge Medical Officer, Child Development Project Officer, Community Health Nurse or Sector Health Nurse, Block Health Supervisor, Block Extension Educator, PHC level Health Inspector, Staff Nurse or Auxiliary Nurse Midwife, Pharmacist, Lab Assistant and a VHN. The Block Development Officer and the PHC (in-charge) Medical Officer are to act as the Chairperson and Member Secretary respectively, while the others are members. As per the 2006 Government Order, later several (minimum 27) additional members are to be added to the Governing Body: Member of Parliament, Member of Legislative Assembly, town panchayat/village panchayat president of the area, two panchayat members (one woman) of the PHC area, two Scheduled Caste

(SC)*/Scheduled Tribe (ST)† representatives, two patients randomly selected on the day of the meeting, Assistant Elementary Education Officer, Assistant Executive Engineer, Assistant Engineer Public Works Department, Indian System Medical Officer, other medical officers, two representatives from industries/corporate sector, two representatives from the local NGO, two eminent persons, three leaders of self-help groups, District Maternal and Child Health Officer/Assistant Director or District Entomologist, special invitees, institutional members who contribute Rs. 100,000 or more, associate members who contribute Rs. 25,000 or more and additional members (professional associations). The provision of allowing institutional and private contributors to join the committee was later repealed by the Tamil Nadu government; following protests from several quarters *(11)*. The quorum for the Governing Body is supposed to be a minimum of one-third of official members.

As the Governing Body is huge, it is envisaged that a smaller Executive Committee from among the Governing Body members will be set up which meets every month to implement decisions of the Governing Body. The Executive Committee is to consist of a minimum of 14 members, with 7 being from the PHC itself, with the in-charge medical officer of the PHC heading it‡. Four of the 14 members are from the civil society namely two SHG leaders or two Panchayati Raj Institution members and the others are the Block Health Supervisor, Engineer from the Public Works Department and any institutional member. The Governing Body may in addition constitute a monitoring committee§ to visit PHC wards and collect patient feedback. This monitoring committee, which has more civil society and local government (elected) representatives than health officials, is to report to the Executive Committee. However, while the monitoring committee is to be chaired by an eminent person, it is to be convened by the in-charge medical officer.

**** The castes listed under the Indian Constitution (Scheduled Castes) Order, 1950 (C.O.19). Scheduled castes are also referred to as dalits .***

† The tribes listed under the Indian Constitution (Scheduled Tribes) Order, 1950 (C.O.12). Scheduled castes are also referred to as Adivasis.

‡Namely, the PHC in-charge Medical Officer (Chairperson), Pharmacist (Member Secretary), senior most Staff Nurse, senior most Lab-technician, Community Health Nurse/Sector Health Nurse and PHC level Health Inspector.

§The monitoring committee is to be headed by an eminent person in the governing body, with the Medical Officer being the Convener. The other members of the monitoring committee are the Member of Parliament, Member of Legislative Assembly, two panchayat members, one SC/ST representative, one NGO representative, institutional representatives and members who are willing to work voluntarily.

Resources:

The funds of the Society were to initially include cash assistance from the Government of India or state government. In addition, it could mobilise donations from trade, industry, institutions and individuals; raise funds through sale of assets; and through any fees or charges levied by the Society. The PHC patient welfare societies were to get Rs. 1,00,000 per annum (this is in addition to Rs. 50,000 which the PHC received as annual maintenance and Rs. 25,000 (additional PHC) and 50,000 (24-hour PHC) as untied funds under the NRHM).

A concern is that the envisaged representation of civil society (NGO, SHGs, and citizens) actors is only 28% in the Governing Body of the patient welfare societies of PHC's, and it is even lower at 14% in the Executive Committee. Further, how far the Monitoring Committees can press for accountability to citizens when they are either convened by the in-charge Medical Officer remains a moot question. The Executive Committee again is convened by the Medical Officer (5)

Actual functioning of PHC patient welfare committees

Gnana Griswarar Petttai PHC patient welfare committee, Kancheepuram district

The Gnana Griswarar (GG) Pettai additional PHC was established in 1988, and is located in Madurantagam Block of Kancheepuram district, Tamil Nadu. It covers 10 gram panchayats and one town panchayat, with a total population of 37,450 spread over 42 villages. The PHC is staffed by one in-charge medical officer (a man), two Health Inspectors, seven village health nurses, one Sector Health Nurse one Auxiliary Nurse Midwife (ANM), and one sweeper. The posts of one additional medical officer, three additional Health Inspectors, a male nursing assistant and a Pharmacist are vacant. Except the vacant post of Health Inspectors (for whom there is a state wide shortage), the others are diverted from other neighbouring PHCs.

The GG Pettai PHC looked newly painted, and had one waiting room for out-patients, two rooms for medical officers, one labour ward with three beds (against a stipulation of six under the NRHM) with an attached operational toilet, one injection room, one Pharmacist room and one room for storing files. The labour room had a huge television (reportedly functioning), but was unoccupied at the time of visit. It was reported by the medical doctor that one woman had just left after her delivery. The PHC had a foetal monitor, standing blood-pressure recording apparatus and standing lamp to aid assessment of foetal position during delivery. The

PHC had recently acquired an inverter, but the battery had to be recharged; and hence it was not operational. Because of the construction of a sump recently (through town panchayat funds), water is available in the PHC. The GG Pettai PHC renders morning and evening out-patient care, ante-natal care and post-natal care, routine institutional delivery (but not forceps and vacuum delivery), temporary contraception services (including emergency contraception), adolescent (in school and out of school) health camps, and school health camps. The Lab Technician comes from Jammen Endathur 24-hour PHC (BEmOC Centre, located 25 km away from GG Pettai) during which urine and albumin tests are carried out for pregnant women. On the day when the RCH camp is conducted (as part of Varumun Kappom) in GG Pettai higher secondary school, the Lab Technician also conducts Reproductive Tract Infection (RTI)/Sexual Tract Infection (STI) testing, as part of which Visual Inspection with Acetic Acid tests are carried out and breasts are examined manually by doctors for screening for cervical and breast cancer respectively. The PHC had an information board outside stating that free delivery was conducted in the facility, and listed the mobile phone numbers of the medical officer and VHNs. In-side the PHC, boards on the maternity assistance scheme, the scheme of allowing birth companions, and strategies to prevent communicable diseases were displaced. However, detailed information on services available under the NRHM or the existence/functioning of the PHC patient welfare society was not available. Further, unlike the stipulation under the NRHM, the PHC is not open 24 hours. Abortion services using manual aspiration is also not available. Permanent contraceptive procedures like tubal litigation and vasectomy are not carried out in the GG Pettai PHC like stipulated under the NRHM. The GG Pettai PHC did not report stocking Haemoceel (for replacing blood loss) or Anti-D Immunoglobin (for countering the adverse effect of Rh negative blood of either parent on infant). These are emergency medicines to be available at the PHC level. Voluntary testing for Human Immunodeficiency Virus (HIV)/ Acquired Immunodeficiency Syndrome (AIDS) is also not available as required under the NRHM *(27)*.

The GG Pettai Patient Welfare Society was formed on the 27th December, 2006 by the in-charge medical officer, but started functioning only in April 2007. Three meetings were reported by the medical officer to have been held between April and November, 2007; once every two months. No public meeting was held to aid the selection of society members. The medical officer in-charge was given instruction by the Deputy Director of Health Services in a routine meeting on how to form the society, and its role. No specific training was organised, and the medical officer and Health

Inspector in particular wanted training on financial audit procedures. The Governing Body of the patient welfare society initially comprised 12 government officials: namely the Block Development Officer (as Chairperson), Medical Officer (as Secretary), Child Development Project Officer, Pharmacist (as Treasurer), Auxiliary Nurse Midwife, Sector Health Nurses, three Health Inspectors, and three Village Health Nurses. The two male Councillors were added upon the advice of the Deputy Director of Health Services. An Executive Committee was formed from among the Governing Body members, consisting of the Block Development Officer, Medical Officer, the Pharmacist, and the Sector Health Nurse. No monitoring committee had been formed as of November, 2007. The Governing Body and Committee have no representation of civil society representatives.

A majority of members of the Governing Body were from the backward castes, but above the poverty line. Five of the 14 Governing Body members were women. The senior most Health Inspector was chosen by the medical officer. The ANM from the same village as the PHC was selected by the medical officer. The two panchayat leaders were chosen for their commitment, ascertained by the medical officer in consultation with the Health Inspector in the committee. Unlike the provisions in the guidelines on forming PHC-level patient welfare committees, there were no representatives of women SHGs, women elected representatives, local NGOs, Scheduled Caste/Scheduled Tribe members or patients in the Governing Body of the Society.

The research team could interview five of the 14 Governing Body members - the medical officer, the Health Inspector, two Councillors, and the ANM. One Councillor was not aware that he was in the Governing Body of the society, while the others knew that they were members. Both Councillors had not attended the three meetings reported to have been held since inception (till November, 2007). That is the meetings were attended only by the government administrative and health professionals. Except the Medical Officer, none were aware of the existence of the Government Order pertaining to the Society or its content. The four members, who were aware that they were in the Governing Body, expressed the view that the Society was meant to improve infrastructure, services and amenities available at the PHC. The Medical Officer in addition expressed the view that it was there also to improve services. The four members met did not mention the Society's role in strengthening accountability of the PHC to citizens, promoting transparency in utilisation of funds, in monitoring implementation of the NRHM or finding out and addressing grievances of

patients. No complaint box or register was maintained by the PHC. However, the Councillor in the Society complained to the 24-hour PHC doctor nearby that to access health benefits under the Muthulakshmi Reddy Scheme and Jananai Suraksha Yojana, patients from GG Pettai PHC area had to go to the 24-hour PHC located 25 km away. The doctor attached to the GG Pettai PHC was subsequently empowered to disburse cheques to eligible beneficiaries.

Discussions with the PHC (in-charge) Medical Officer and the Health Inspector suggest that the meetings were used mainly as a forum to decide how to spend the funds allocated to the PHC. The patient welfare society had received Rs. 50,000 in the year 2006-2007 and Rs. 50,000 for the year 2007-2008. The PHC (in-charge) Medical Officer and the (diverted) Pharmacist operated this account, and reported that they spent it for purposes decided by the Governing Body. In addition, the PHC had received Rs. 50,000 each in the two financial years as annual maintenance fund and Rs. 25,000 each as untied fund. Positively, the patient welfare society took decisions on utilisation of all the three amounts. The amount of Rs. 125,000 for 2006-2007, received in March 2007, had been spent, while the amount of Rs. 125,000 received for the year 2007-2008 in April, 2007 was yet to be spent as of November, 2007. The patient welfare society does not levy any charges, and neither has it accepted any donations.

The funds of the patient welfare society had been used to purchase a foetal monitor, standing blood-pressure recording apparatus, standing lamp to aid delivery, glucometer, a x-ray viewer, a DTH mike, benches for patients to sit and a drinking water purifier. The annual infrastructure maintenance grant had been used for painting of the building, repair of electricity cables, repairing water leakage through windows of the building, construction of sun-shade and purchase of motor for pumping water (into a sump constructed through town panchayat funds). The untied funds have been used for purchase of bins for disposal of waste, linen, buying episiotomy sutures and purchasing haemoglobin meter. Some needs of the PHC were felt to fall outside the mandate of all the three funds and have hence been shelved. These include construction of a compound wall for the PHC premises, hiring of watchman on contract on daily wages, drilling a bore well for water (at present dependent on water supply to sump by town panchayat), constructing a ramp, replacing wiring, purchase of second-hand van for emergencies, and purchase of specific drugs and supplies which were in short supply. According to the in-charge Medical Officer, new civil constructions and new electrical works were not allowed, and neither could the funds be used for purchase of

drugs. That is, though the guidelines permitted new constructions, the medical officers were not aware about it.

An interview by the research team with ten citizens (50% dalits, 60% females with varying levels of education) working mainly as agriculture labourers from GG Pettai village and three other villages serviced by the PHC, revealed that none were aware of the existence of the GG Pettai patient welfare society; leave alone its activities. However, they were aware that improvements had taken place in the PHC* and were more inclined to visit the facility in case of illness or delivery (women) than earlier.

The improvements in the PHC through the three funds appear to have led to an increase in the number of out-patients, improvements in PHC delivery, and improvement in PHC staff morale. As per the PHC records, the year April 2006 to March 2007 had seen only 8 deliveries taking place, and this increased to 62 for the period April 2007 to December 2007. According to the PHC Medical Doctor, the better rooms, clean sheets, toilets, water, facilities and medical equipments had contributed to the increase in off-take of services, along with the birth companion scheme† and Muthulakhsmi Reddy scheme. The number of out-patients visiting the PHC was 2,167 in the month of April, 2007 before the improvements happened, and increased to 3,584 in the month of October, 2007. However, no such improvements were reported by the Medical Officer with regard to other services like abortion and contraception etc.

Kaveripakkam additional PHC patient welfare society, Vellore district

The Kaveripakkam additional PHC was established over 20 years back and is located in Kaveripakkam Block of Vellore district. It covers ten gram panchayats with a total population of 28,514. Since June 2007, it has started functioning 24 hours, and it is soon expected that it will be officially recognised as a 24-hour PHC. The PHC has more staff than the GG Pettai PHC. It has a female medical officer, in addition to the PHC in-charge Medical Officer (a male). Three Staff Nurses were posted in June 2007 to meet increase in demand for delivery, with one of them being in the PHC round-the-clock in rotation. It has a full time Pharmacist, Lab-technician and sanitary worker. However, it has only one Health Inspector

**** Namely KK Pudhur, Malaiyapalayam and Erivakkam.***

† Under which one birth companion was allowed to stay with the pregnant women during and after delivery.

(one post being vacant). The Kaveripakkam PHC looked newly painted, and was housed in a compound with a nice garden. A shed for patients to sit was under construction. The number and use of rooms was similar to that of GG Pettai, except that the labour ward had six beds instead of three; with three being occupied when the team visited. The Television Set was kept in the outpatient area, and screened health messages on HIV/AIDS, maternal health, and nutrition (through a Digital Versatile Disk) when the research team visited. The out-patient area was over-crowded, with people standing outside the building in a queue to see the doctor. Boards containing information on services under the NRHM, patient welfare committee, and birth companion scheme were put up in the out-patient area. An open box containing condoms was kept outside the PHC. There were also two illuminated boards explaining that free delivery was conducted in the PHC- one at the entrance of the approach road and another at the entrance of the PHC.

Like GG Pettai PHC, the PHC at Kaveripakkam also had a foetal monitor and standing lamp in the delivery room. In addition, it had an emergency tray containing Haemoceel, Anti-D Immunoglobin, Misoprostol (to reduce excessive bleeding), and injection for snake bites. The PHC was equipped with an advanced albumin test kit and a needle destroyer. Services offered by the Kaveripakkam PHC were similar to that of GG Pettai, except that it was better equipped to handle emergencies, had more beds in the labour room, and had a full time laboratory; and that these services are available round the clock. However, like GG Pettai, abortion services using manual aspiration was not available. The PHC is as yet not equipped with facilities (e.g. operation theatre) or staff to operate as Basic Emergency Obstetric Care Unit*, though the NRHM proposes that each PHC should be able to provide basic emergency obstetric care. Voluntary testing services for HIV/AIDS is also not available, as well as services to deliver using forceps and vacuum aspiration. An innovative procedure however is that in case of any emergency during delivery which cannot be handled by the PHC, a woman staff accompanies the patient to the nearest (preferably government) referral point and ensures that she is treated.

The Executive Committee of the Kaveripakkam Patient Welfare Society was constituted on 6th, March, 2007. The Medical officer of the PHC reported that there is no larger Governing Body or smaller Monitoring Committee. Since inception, seven meetings were reported by the medical

**** BEmOC centers includes in addition to the GG Pettai staff a non medical Superintendent, community health nurse, Ophthalmologist Assistant and Block Health Supervisor.***

officer to have been held; once every month. The Executive Committee consists of nine members, with all the nine being government officials. Other than the Block Development Officer who was also the Chairperson, the others were from the PHC or the block PHC; namely the Block Health Supervisor, Senior Medical officer, Kaveripakkam PHC in-charge medial officer (secretary), Pharmacist, Lab-technician , VHN and PHC Health Inspector. Sensibly, the VHN residing in the same village as the PHC was chosen rather than the senior most (which was advised in the guidelines). However, there was no SHG representative or elected representative represented in the Executive Committee as stipulated by the Tamil Nadu Government *(5)*. Hence, how far the patient welfare society promotes accountability to citizens is a moot question.

The research team could meet two of the nine committee members - the PHC in-charge Medical officer and the Health Inspector. Both of them mentioned that they were aware that they were in the committee, aware of the Government Order pertaining to the Society and mentioned having seen it. However, they seemed to recall only that the committee was to serve the patients and improve infrastructure, services and amenities available at the PHC. Like the case of GG Pettai doctor and Health Inspector, the two members did not mention the Society's role in strengthening accountability of the PHC to citizens, promoting transparency in utilisation of funds, in monitoring implementation of NRHM or finding out and addressing grievances of patients. The medical officer nevertheless mentioned that a complaint register was maintained in the PHC; which was reviewed during staff meetings. The concerns expressed by the patients included the waiting time, the fact that only one medical officer was present (with the woman doctor going to the villages for camps), the absence of adequate benches to sit on, absence of public phone to inform relatives about deliveries and absence of food for women who had delivered.

The PHC in-charge Medical Officer reported that most of the members of the Executive Committee of the Society had attended the seven meetings of the committee. However, it was not possible to verify this due to time constraints. Discussions with the Medical officer and Health Inspector suggest that the meetings were used as a forum to decide how to spend the funds allocated to the patient welfare society, as well as the annual maintenance grant and untied funds of the PHC. It was also used to ratify any emergency expenses incurred in between meetings. The allotments to this PHC were similar to that of GG Pettai; only this committee had used Rs. 74,000 of the second instalment of Rs 125,000 as well as the first

instalment. The funds of the patient welfare society had been used to repair electrical wires, construct a patient waiting shed (in progress), and purchase an inverter, focus-lamp, water filter, needle cutter, nebuliser and educational video-compact discs. The annual maintenance grant has been used for purchase of motor for pumping of water, construction of sump, purchase of syntex tank, flooring of waiting room, purchase of fire extinguisher, purchase of foetal monitor and a television stand. The untied funds have been used for reimbursing transport costs to take two pregnant women to hospitals and repair of bathrooms of the PHC. Unlike the GG Pettai PHC, the Kaveripakkam PHC had invested in new civil constructions like a shed for patients. The Medical Officer mentioned that the Deputy Director of Health Services had approved this decision. The Medical Officer nevertheless expressed that if the PHC had more funds it would purchase a scanning unit which would help in detecting complications during delivery.

Like the case of GG Pettai PHC, the improvements in the Kaveripakkam PHC through the three funds appear to have led to an increase in the number of out-patients, ante-natal care/post-natal care check ups, improvements in PHC delivery, and improvement in PHC staff morale. In addition, it has led to saving of a pregnant woman and an adolescent girl's lives. The number of women who came for ante-natal care check ups was 38 in January, 07 (before the improvements began) and rose to 184 in the month of October 2007. PHC deliveries increased during the same period from 4 to 36. According to the medical officer, the education through the 'Expected Date of Delivery' campaigns, presence of foetal monitor, emergency medicines, and the procedure of one PHC staff accompanying any pregnant woman to government hospitals in case of delivery complications made a difference. The referred patient got better treatment when a PHC staff accompanied them. More than anything else there was a spread effect, with women who were happy with the delivery services informing others. Interview with three women in the labour ward confirmed that they were happy with the delivery services and cleanliness/facilities at the PHC. Two additional benefits were seen by the women of improved facilities at PHC level: saving of expenditure and access to greater respect when compared to district government hospital or private providers. The patient saved Rs. 1,000 for a routine delivery when compared to District Hospital (under the pocket payment, transport) and Rs. 2,000 in the case of private hospital (service charge, medicines and transport). However, none of the three women met in the labour ward were aware of the patient welfare society. Similarly, of the eight out-patients met by the researchers (three women and five men; all labourers; from four

villages), one male person knew about the existence of patient welfare society as he had seen a board on it in the outpatient area of the PHC. However, he was not aware of its role or functioning.
Similar improvements were not reported in abortion services, tracking scanning centres for abetting sex selection or contraceptive services. Two innovative uses of government funds (but not patient welfare society funds) cited by the PHC (in-charge) Medical Officer, was the case of an unmarried poor pregnant adolescent girl who developed complications, and was taken to a private hospital for delivery, which asked for Rs. 20,000 before conducting caesarean operation. The relatives abandoned her in the hospital and informed the VHN, who used Rs. 500 for fuel from the (nearest) block PHC fund and transported her to the Vellore Medical College, wherein an operation was conducted free of cost and she safely delivered. In another case, a pregnant woman from the PHC area whose foetus had died was refused admission in the Kancheepuram Government Hospital as the doctors felt that the case was too complicated. The relatives contacted the PHC who then used the Block PHC fund to transport her to a private hospital in Vellore; where she delivered with the aid of forceps. The cost of delivery was met by the family, as they were grateful that her life had been saved!

CHC patient welfare committee, Banavaram, Vellore district

The Banavaram CHC, established in 1974 serves as a Basic Emergency Obstetric Care Centre (BEmOC), and was reported* to be one of the three BEmOC centres that carry out Caesarean operations in the country. The BEmOC centre has a family welfare operation theatre, and recently a caesarean operation theatre, supported by a labour ward, a family welfare ward and a male ward with toilets. Except one, all the toilets for patients were operational. The CHC has blood collection facilities and has recently established a blood storage facility. It has a functioning laboratory, where RTI/STI diagnosis takes place, including testing for HIV/AIDS. The CHC has an ophthalmic, paediatric, STI/RTI, Voluntary Counselling and Testing Centres and diabetic clinic within its premises. However, as yet it does not carry out laparoscopy, vasectomy, or abortion services (staffs have just received training on vacuum aspiration method). Surgeries for treating fistula, hydrocele, hernia, appendicitis and haemorrhoids are also not carried out. These additional services are to be provided at the CHC level as per the guidelines of the NRHM *(27)*.

The Bananvaram patient welfare society was established in January, 2007 and between January and November, 2007 11 meetings were reported to

have been conducted. The membership of the patient welfare society strictly adheres to the guidelines on the initial composition at the time of registration. However, the membership was not expanded to include representatives of SHGs, elected representatives, patients or NGOs. The in-charge Medical Officer was not aware of the distinction between Governing Body, Executive Committee and Monitoring Committee. Five society members met by the research team* mentioned that they were aware of their membership and had attended 2 to 3 meetings. They expressed that they had not seen the Government Order pertaining to the functioning of patient welfare societies. Only one of the society members - Health Inspector - was aware of the role of the patient welfare society. He expressed that initially meetings were not convened properly, and he was asked to sign and endorse expenses already undertaken. Upon protesting, this practice has changed. The Health Inspector as well as the VHN and Sector Health Nurse in the committee mentioned that only the Health Inspector participated on an equal footing with the doctor in the meeting. They also expressed that all departments of the CHC should be represented, and not just a few as is the case now.

The patient welfare committee funds of Rs. 50,000 allocated for the year 2007 has been used for purchase of foetal monitor, needle destroyer, drugs for which stock is not there (e.g. Anti D), transport of patients in cases of emergencies, painting of cots and provision of security boxes next to cots, repair of leaking roof-tiles, construction of a shed for patients, and purchase of a fire extinguisher. The annual maintenance fund of Rs. 50,000 had been used for whitewashing of premises, repair of toilets†, painting of doors, electrical repairs, plumbing, and strengthening of water supply. The routine government funds as well as patient welfare funds (when the former is not enough) had been used for hiring anaesthetist (Rs. 1,000 per day) and obstetrician (Rs. 800 per day) for elective Caesarean operation, as the CHC does not have full time staff of such expertise. The PHC in-charge Medical Officer mentioned that due to the establishing of the Caesarean operation theatre (direct support form the department) and the improvements in the CHC due to the three funds, the number of Caesarean sections in the CHC has increased from 2 in July, 2007 to 32 in October, 2007. Normal deliveries in CHC increased from 9 in December

**** By the Deputy Director Health Services to the research team. The other two centers were reported by him to be in the same district.***

† Health Inspector (Vijayagobi), Village Health Nurse (Shanthi), Sector Health Nurse (prema), Community health Nurse (Rajakumari) and Child Development Project Officer (Pushpa).

2006 to 34 in October, 2007. Tubectomy operations increased from 4 in December 2006 to 42 in October, 2007. Out-patients increased little from 4,624 in Oct, 2006 to 5,820 in Oct, 2007. None of the five women patients (three in post-operative (caesarean) ward and six (in family welfare room) were aware of the existence of the patient welfare society*. Of the three (male) outpatients met, one had read the board displayed on the existence of patient welfare society but was not aware of its functions (this was not mentioned in the board). However, all observed that services had improved in the CHC over the last six months. In particular, they appreciated functioning toilets with water, clean wards, and availability of caesarean operations and permanent sterilisation at CHC level. All the three mentioned that the first delivery of their wives was normal, and they had incurred between Rs. 1,000 (Government Hospital) to Rs. 2,500 as expense (private). All three reported not having spent any money (including under the table payments) on the caesarean operation for the second delivery. According to them, caesarean operation in a private hospital would cost a minimum of Rs. 6,000. Two of the three women who went through a caesarean section reported being picked up by a government ambulance, while one came along with the VHN. Similarly, the cost of sterilisation was lesser in CHC than in the government hospital. One of the women who underwent sterilisation operation mentioned that her mother had spent Rs. 400 (informal payments) on her operation in the Wallajapet district hospital (in addition to transport costs), while she did not incur any costs other than transport.

District hospital level patient welfare committee

Objectives

The objectives of the District Hospital Patient Welfare Societies are similar to that of the PHC patient welfare societies and cover similar issues of improving service outreach, quality, implementation, monitoring and infrastructure, accountability to citizens.

Envisaged composition

The first members of the Governing Body of the district patient welfare society is supposed to include the following 10 persons: the District Collector, the Joint Director of Health Services, the Medical Superintendent of the Hospital, the Municipal Commissioner, the Executive Engineer (Public Works Department), the Deputy Director of

Mainly wage laborers in the age group of 22 to 42 years.

Health Services, the Deputy Director of Medical and Rural Health Services (Family Welfare), the Deputy of Director of Medical and Rural Health Services (Tuberculosis) and the District Siddha Medical Officer and District the Maternal and Child Health (MCH) Officer. The Collector and the Joint Director of Health Services are supposed to act as the Chairperson and Vice-Chairperson respectively of the society, with the Medical Superintendent acting as the Secretary and Convener of the patient welfare society *(3)*. All the members are appointed on an ex-officio basis.

Later on, several (minimum 38) additional members from civil society, government, elected representatives, and private sector are to be added to constitute a minimum of 48-member Governing Body. The civil society members to be added include the patients from below poverty line, members of Scheduled Castes and Tribes, eminent citizens, members of media and consumer associations and a district Red Cross Society member. The elected representatives to be added later include the Member of Parliament representing that area, the Member of Legislative Assembly representing that area, the Corporation Mayor, and members and leaders of village, block, district and town panchayats. The government representatives to be added later into the Governing Body are surgeons, Indian System of Medicine doctors, nurses, Pharmacists, and Lab Technicians *(3)*. Two representatives from the industrial sector were also to be recruited as members. In addition to these compulsory members, the Executive Committee was empowered to call officers from other government department and private sector or civil society members as special invitees. The 2006 Tamil Nadu Government Order on district patient welfare societies envisaged that any institution which contributed Rs. 200,000 or more could become an institutional member and any individual who contributed Rs. 50,000 or more could become an associate member *(3)*. This provision was removed in 2007 to prevent vested interests from entering the welfare society *(9)*.

The Governing Body meetings are to be held once every quarter and the quorum for the Governing Body is supposed to be with a minimum of one-third of official members *(3)*. As the Governing Body is huge, it is envisaged that a smaller Executive Committee from among the Body members will be set up and meet every month to implement decisions of the Governing Body. The Executive Committee is to consist of a minimum of 11 members, with 6 being from the hospital itself, with the senior most medical officer

being the Convener (nominated by the Medical Superintendent). None of the Executive Committee members are to be from civil society *(3)*. The hospital patient welfare society Governing Body may in addition constitute a 10-member monitoring committee to visit hospital wards and collect patient's feedback. This committee, which has to have more local government and civil society representatives (selected from gram panchcyats, NGOs and eminent citizens) than health officials, is to be chaired by an eminent civil society person, and managed by the Medical Superintendent *(3)*.

Funds:

It was initially envisaged that the funds of the Society were to include cash assistance from the Government of India or State Government; donations from trade, industry, institutions and individuals; funds through sale of assets; and through any fees or charges levied by the Society *(3)*. The proposal of permitting hospital patient welfare society to charge user fees was removed subsequently through a Government Order *(9)*. The Government of India provides Rs. 500,000 per annum to each district hospital patient welfare society under the National Rural Health Mission *(3)*.

A concern is that the representation of civil society actors is only 35% in the Governing Body of the patient welfare societies of district hospitals, 30% in the monitoring committee and none in the Executive Committee. Further, how far the Executive Committee and Monitoring Committee can press for accountability to citizens when they are either managed (Secretary) by the Medical Superintendent or in-charge Medical Officer (Monitoring Committee) is a moot question *(3)*.

Actual functioning of hospital patient welfare societies

Kancheepuram district hospital patient welfare society

The Kancheepuram district hospital was established in 1965 and is located in the town of Kancheepuram. As of November 2007, it covers 396 gram panchayats, eight town panchayats and 2 municipalities, with a total population of 1,221,548 spread over 994 villages. The hospital is staffed by 26 doctors, 6 gynaecologists, two anaesthetists and 40 staff nurses. The requirement for doctors is estimated at 60, gynaecologists at 11 and anaesthetists at 7.

Unlike the PHC's visited, the Kancheepuram district hospital looked fairly dilapidated. It had 409 beds, but 500 in-patients; with some sleeping on the floor. Of the 409 beds, 43 are obstetrics and gynaecology beds and 40 are family planning beds. The hospital had 12 departments namely the medical, surgical, anaesthetic, theatre, orthopaedic, electro-cardio gram, paediatric, X-ray, dental, general physicians, and gynaecology departments.

The Kancheepuram district hospital is a BEmOC centre. It provides ante-natal care and post-natal care, routine institutional delivery (forceps and vacuum), caesarean operations, temporary and permanent contraceptive services (emergency, laparoscopy, vasectomy) and abortions services. HIV/AIDS testing is provided, but treatment is offered only for pregnant women to prevent mother to child transmission. All other HIV positive patients are referred to the Tambaram Government hospital located 45 km away for treatment. Other STIs (as well as RTIs) are diagnosed and treated in the hospital. Pap-smear is carried out to deduct cervical cancer, but treatment is not available. Patients with cervical cancer are sent to Kancheepuram cancer hospital for treatment. Facilities to carry out mammography are not available, as well as for infertility diagnosis or treatment. In addition to SRH services, the hospital handles cardiac emergencies and offers first aid for head injury.

The Kancheepuram hospital patient welfare society was formed on 1st April, 2007 by the Resident Medical Officer as per instructions given to her by the then acting Joint Director of Health Services*. As of November, 2007 only the Executive Committee of the patient welfare society has been formed. The Monitoring Committee or larger Governing Body was not reported to exist. The Executive Committee comprises eight members, namely the Resident Medical Officer, the Hospital Superintendent, the Member of Legislative Assembly from the district, representatives of two other political parties, the Municipal Commissioner, the chief of the Orthopaedic Department and one representative from the NGO (called Nadu- meaning country) which also provides counselling services to patients (directing them to appropriate facilities). No patients were represented in the Executive Committee. No public meeting was held to aid the selection of the Executive Committee members, and no training was

**** This was reported by the Resident Medical Officer. The Hospital Superintendent however informed Ranjani Murthy and Bhavani that the society members were selected by the Collector.***

provided for the Executive Committee members on the role and functioning of the patient welfare society, including its citizens' on accountability role.

The research team met two of the 10 Executive Committee members - the Resident Medical Officer and the Health Superintendent. Both of them were aware that they were in the committee, were aware of the Government Order pertaining to the Society and its content; and had a copy of the same. They expressed that the Committee was to serve the patients and improve infrastructure, services and amenities available at the hospital. The two Executive Committee members met did not mention the Society's role in strengthening accountability of the hospital to citizens, promoting transparency in utilisation of funds, in improving quality of services, or in finding out and addressing grievances of patients. No complaint box or register was reported to be maintained by the hospital.

None of the six patients in different wards and in outpatient met by the research team were aware of the existence of patient welfare society. A female nursing assistant in the labour ward was however aware of its existence, as her supervising doctor had informed her about its existence. She however did not know detailed information about its role or functioning. A concern is that there was no public display board on the patient welfare society in the hospital premises.

As of November, 2007 the Executive Committee had met only once. According to the Resident Medical Officer, majority of members had attended the same. However, this could not be ascertained by the research team. Discussions with the Resident Medical Officer and Health Superintendent who are in the Executive Committee suggests that the meetings were used mainly as a forum to decide how to spend the funds allocated to the patient welfare society. The patient welfare society had received Rs. 2,00,000 in the March 2007 for the year 2005-2006 and Rs. 2,00,000 in May as the first instalment for the year 2006-2007. The patient welfare society had not levied any charges or accepted donations. The Executive Committee decided to use the first instalment of funds for electrical repairs and fitting, for paying daily wages for labourers, for purchasing equipments and for purchasing accessory materials for patients. Several electrical repair works have been undertaken like repair of fridge and air conditioner in the blood bank, four air-conditions & FOTs in the operation theatre, 25 fans and 25 tube lights in different wards, and grinder in the kitchen. In addition new tube lights and five new fans had been purchased. Daily wage labourers had been used for putting up

fences, washing bed-sheets and linen, cleaning the compound and repairing drainage blocks to make the toilets functional. Patient accessories like wheel chairs had been repaired, and new stretchers had been purchased. Boyls apparatus (anaesthetic machines) and suction apparatus are two new medical equipments purchased through the patient welfare society funds. The patient welfare society proposes to use the second instalment for constructing a waiting shed with four pillars for pregnant women coming for ante-natal care check up as well as elderly out-patients to wait, and to construct a shed for the canteen for cooking. As the Committee members were told by the acting Joint Director of Medical Services that new civil constructions were not allowed, the idea of putting waiting sheds with brick walls was ruled out. The two committee members who were met by the authors expressed that if they had another Rs. 200,000 and were allowed to do new electrical fittings, they would like to rewire the building.

The improvements in the district hospital through the patient welfare society funds were reported by the resident medical officer and health superintendent to have led to more in-patients. In particular functioning fans, clean bed-sheets and functioning toilets were appreciated by the patients. The number of in-patients was reported to have increased slightly. The number of surgeries per day was reported to be the same, but waiting time for patients was reported to have decreased as more operations could be done at the same time due to more operation tables. Hard facts from the Gynaecology and Obstetrics departments of the hospital do not support the perception of increase in patients. The average number of deliveries conducted per month has in fact came down from 468 in 2004 to 401 in 2007 which means about 800 fewer deliveries were conducted in 2007 than in 2004. This could be due to improvement of delivery services at PHC levels. Emergency caesarean-sections as a proportion of all deliveries have increased from 23% in 2004 to 30% in 2007 and of all Caesarean-sections (elective included) from 27% to 34% *(29)*. Similarly, post partum sterilisation rates have declined from 258 per month to 158 per month, probably because of sterilisations being conducted regularly in PHC's *(29)*.

Wallajapet district headquarters hospital patient welfare society, Vellore district

Vellore district comprises 753 gram panchayat, 9 municipal towns, and 4827 villages *(http://www.tnenvis.nic.in/DtProfiles/vellore.pdf).* The Wallajapet district hospital was established in 1967, and caters to the Vellore district of Tamil Nadu. The hospital is staffed by 8 doctors (against

a need for 11), four Staff Nurses, one nursing superintendent, one radiographer, two anaesthetics (one attached to Comprehensive Emergency Obstetric Care centre (CEmOC) centre).

On the day of the visit, the Wallajapet district hospital was looking clean, as a higher official had come on an inspection visit the previous day. The hospital was smaller than the Kancheepuram district hospital and was allocated only 84 beds, of which 4 were in the delivery room, 10 in the labour ward, 20 in the family welfare ward, 20 in the men's ward, 8 in the women's ward, 12 in the communicable disease ward, and 10 in the accident and emergency ward *(30)*. That is, the number allocated to family welfare was more than for institutional delivery. The hospital has a foetal monitor, forceps for forceps delivery (which it has started discouraging, and prefers Caesarean) and stocks Haemoceel, Misoprostol and Anti D Immunoglobin.

The Wallajapet district hospital is supposed to be a CEmOC centre, but is not fully equipped for the same in terms of staff. It provides ante-natal care and post-natal care, routine institutional delivery, Caesarean operations, temporary and permanent female contraceptive services (but not laparoscopy or vasectomy) and abortions services. Like in the case of the Kancheepuram hospital, HIV/AIDS testing services are provided, but treatment is offered only for pregnant women to prevent mother to child transmission. All other HIV positive patients are referred to the Tambaram Government hospital, around 120 km away, for treatment. Other STIs (as well as RTIs) are diagnosed and treated in the hospital. Pap smear is carried out to deduct cervical cancer, but for treatment they are sent to Kancheepuram cancer hospital. Facilities for mammography or infertility diagnosis or treatment are not available. In addition to SRH services, the hospital handles tuberculosis cases. A blood bank with collection and storage facilities is available, and a 24-hour ambulance service is supposed to be provided for pregnant women.

The Governing Body of the Wallajapet Hospital Patient Welfare Society was formally constituted only on the 19th, October, 2007 by the District Collector, though the process of discussion on its formation began in June, 2006. As of November, 2007 the Executive and Monitoring Committees had not been formed, and only the Governing Body functions. The Governing Body comprises 62 members, including government hospital and health officials, officials from other relevant government departments (Engineering, Electrical, Police and Women's Development

Corporation), Members of Legislative Assembly and Parliament from that area, local elected bodies, President of Indian Medical Association, industrial houses, NGOs, citizens who are SC/STs and patients who are below poverty line *(30)*. No public meeting was held to aid selection of these society members. The panchayat representatives, SC/ST citizens, NGOs and patients are selected by the District Collector. The others are selected on an ex-officio basis. The Governing Body is chaired by the Collector, with the Medical Superintendent of the hospital acting as the Member Secretary and the Convener *(30)*. No specific training had been organised for the Governing Body members on the role and functioning of the patient welfare society; though they were given information on the same during the first meeting. The secretary of the Governing Body mentioned the need for training on methods of raising awareness among the public about the existence of patient welfare society, audit rules and management of accounts.

The research team could meet three of the Executive Committee members - the Resident Medical Superintendent, Senior Medical Officer and a senior Staff Nurse. All were aware that they were members of the committee. The first two had a copy of the letter from the Health Secretary to the Collector on its formation, but no detailed guideline beyond that. All the members expressed that the committee was to serve the patients and improve infrastructure, services and amenities available at the hospital. The society members who were met by the authors did not mention the society's role in strengthening accountability of the hospital to citizens, promoting transparency in utilisation of funds, in improving quality of services, or finding out and addressing grievances of patients. A complaint box was maintained by the hospital but the nature of complaints received (need for waiting shed, and drinking water for patients and rudeness of a few staff members) was not mentioned to be an agenda of discussion of the patient welfare society.

As of November, 2007, the Governing Body had met twice, with 2/3rds of the 62 members attending the meetings. Discussions with the Resident Medical Superintendent suggest that the meetings were used as a forum to mainly decide how to spend the funds allocated to the patient welfare society. However, in addition a few issues (not involving funds of patient welfare society) facing the hospital were discussed. Notably, the Governing Body decided that the patient welfare society would request the government to fill vacancies in the hospital. A letter to this effect had gone from the patient welfare society to the Director of Medial and Rural Health

Services, but as yet no action has been taken. The Society had received Rs. 100,000 in the March 2007 and Rs. 292,000 in June, 2007. The Wallajapet Patient Welfare Society, has not levied any charges, or accepted donations. Of this amount, the Wallajapet Patient Welfare Society had spent only 64,152 as of November, 2007, and work for an additional Rs. 57,700 was just about to commence. A balance amount of Rs. 268,658 was still left in the bank account of the Wallajapet Patient Welfare Society *(30)*.

Based on the decision of the Governing Body, the Rs. 64,152 was spent towards electrical repairs, repair of X-ray machines, cleaning the hospital, cleaning of septic tank and pipe lines (for toilets), purchase of cord clamps, and purchase of kitchen utensils for patient canteen. Nearly half the amount had been spent towards electrical repairs *(30)*. The patient welfare society proposes to use another Rs. 57,700 towards painting and repairing cots and repairing other pipelines for which three quotations have been received. However, decisions of the Walljapet Patient Welfare Society's Governing Body like constructions of common toilet for outpatients, patient waiting hall, ambulance shed and purchase of cupboards, purchase of water heaters for wards and uninterrupted power supply equipments for operation theatre and labour ward were yet to be implemented. The decision to set a canteen was yet to be implemented. According to the Secretary of the Governing Body an important constraint in spending was the difficulty in convening a meeting of 62 people to examine three quotations for approval (a government procedure). The absence of an Executive Committee to take quick decisions was an issue. Several of the local carpenters and electricians - who do small repair work - are not able to adhere to the norms of producing quotations. Some decisions like equipping operation theatres with uninterrupted power supply equipments were rethought of in the light of experience from other hospitals; and it was decided to stick to the present practice of using a generator.

As the patient welfare society started functioning only in October, 2007, no visible impact on service availability or utilisation was reported by the Secretary. It is interesting that the report provided by the hospital records an increase in condom service users between April, 2006 and March 2007 (910 per month to 1940 per month), but a decrease in routine institutional delivery, caesareans, medical termination of pregnancies, female sterilisation and intra-uterine devise insertions between April, 2006 and

March 2007. Specifically, institutional deliveries had decreased from 94 to 78, Caesareans from 10 to 4, medical termination of pregnancies from 21 to 6, intra-uterine devise insertions from 224 to 124 and female sterilisation from 108 to 82 *(30)*. This is attributed by the Medical Superintendent to strengthening of these services at PHC level (other than medical termination of pregnancies which are not done at PHC level). The better availability of contraception at PHC level may, according to her, has reduced abortion. However, she complained that the delivery cases that they now dealt with were more complicated cases than earlier.

Seven patients (three men and four women) were met by the research team from the general ward and four (women) from the labour ward. Of the eleven, only one woman patient in the general ward knew about the existence of the patient welfare society. She had noticed that the light and fans had been changed, and had enquired with the Staff Nurse in charge of the ward, who informed her about the society and its funds. Though most patients met were not aware of the existence of the patient welfare society, they used to leave as soon as possible if hospitalised, as there were no fans, clean sheets or functioning toilets, now they did not mind staying the necessary days!

4. Findings on village health committees, patient welfare societies, and accountability to citizens on SRH

Have public health services improved?

The case-studies on the seven village health, water and sanitation committees, PHC/CHC patient welfare societies, and hospital level patient welfare societies suggest that these have, together with the annual maintenance grant (PHC/CHC/hospitals) and untied funds (all facilities), improved the infrastructure, equipments and pre-existing health services at sub-centre, PHC, CHC and district hospital levels. The physical accessibility (e.g. through better roads), quality (e.g. through better equipments) and affordability (as for basic services they do not have to go to higher levels of care) have improved. Rarely have new health services been added through the activities. It was also difficult to say which improvements in health service delivery were due to the patient welfare society/village health committee funds, which were due to the annual maintenance fund, and which were due to untied funds; as all three acted in unison.

The improvements were more noticeable in the facilities managed by the Directorate of Public Health (sub-centres, PHCs and CHCs, including BEmOC centres) than the facilities managed by the Directorate of Medical services (taluk and district hospitals); and more noticeable in Vellore district *(31)* than Kancheepuram district. The leadership was more committed in the former. Certain innovations in maternal health services seen in Vellore district were not reported in Kancheepuram district, like the 'Expected Date of Delivery' campaign with pregnant women and their families, monthly provision of nutritious food for pregnant women, stocking of medicines to replace and arrest blood loss during delivery, stocking of Anti-D Immunoglobin, accompaniment by PHC/sub-centre staff of pregnant women to hospitals in case of emergencies, conversion of sub-centres to PHCs where needed, and availability of elective caesarean facilities in CHCs.

Have SRH services improved?

To the extent that pre-existing services have included maternal health services, contraceptive services, reproductive health (RH) camps with RTI/STI screening, HIV/AIDS testing, and adolescent IEC on health the availability, affordability and quality of these SRH services have improved; with improvements being particularly marked with regard to maternal health services; and delivery in PHC's and CHCs within that. In Vellore district, access to BEmOC (Vellore district) facilities had improved. No improvements were seen in the availability of abortion services, infertility services, or availability of anti-retroviral therapy for HIV positive patients in stipulated facilities under the NRHM. Health services for dealing with gender-based violence were also not available. Further, while improvements were seen in access to institutional delivery (both district) and access to BEmOC (in Vellore district), forceps and vacuum delivery were not available at PHC level as should be under the NRHM guidelines. Similarly, while utilisation of contraceptive services had improved, vasectomy services were not available in CHCs (as stipulated under NRHM) or district hospitals; leaving women to face the burden of contraception. Less invasive laparoscopy method of female sterilisation was also not available at CHC or hospital levels. While cervical cancer screening services and manual breast examination services (not mammography) are available through RH camps in BEmOC centres, access to treatment for cancer is limited to selected hospitals. Both the district hospitals visited did not offer these services. *On the whole availability, affordability and quality of controversial services (e.g. abortion, male sterilisation and treatment for violence), expensive services*

(e.g. anti-retroviral therapy, cancer treatment and, infertility treatment) and low priority services (e.g. laparoscopy) had not improved (at the respective levels they are supposed to be available). With few exceptions, SRH services seem to have improved for married women more than single women/adolescent girls.

Has accountability to citizens been strengthened? With regard to policy or implementation?

The findings from the 7 case studies suggest that the village health committees and PHC, CHC and hospital level patient welfare societies have strengthened accountability of doctors and providers to 'higher ups'. As the Deputy Director of Health Services of Kancheepuram district put it, "With the availability of patient welfare society funds, annual maintenance grant and untied funds, doctors cannot make excuses to me like non-availability of water, electricity, and basic equipments for non-conducting of deliveries in PHCs"*. This accountability has been with regard to implementation and not policy-making; and ex-ante and not ex-post. None of the village health committees or patient welfare societies held providers to account in case of any lapses.

The village health committees and patient welfare societies have not really promoted accountability to citizens or external actors. Of the fourteen citizens who were met by the team in the villages covered the two sub-centres, only two (14%) were aware of the existence of the village health committees, leave alone being involved in its constitution or expressing their demands to it. They were however not clear about its role. Of the 52 patients met in PHCs, CHC and district hospitals, only three (6%) were aware of the existence of patient welfare societies. Awareness among patients about the existence of patient welfare societies, though low, was slightly higher in Vellore district than Kancheepuram district. This was because of the information board in each facility on the existence of patient welfare societies. However, even in Vellore those (literate members) who were aware that a patient welfare society existed did not know about its functions or how the funds were used. Neither were they involved in the selection of civil society members, if any.

The seven village health committees and patient welfare societies (Governing Body or/and Executive Committee) were dominated by the government officials (in particular health officials and service providers).

**** Discussion with Dr Devaparthasarathy, Deputy Director of Health Services, Kancheepuram District, on 28th November, 2007***

The extent of civil society representation was none in the PHC and CHC patient welfare societies visited, less than 10% in the hospital patient welfare society level and around 20% in village, health, water and sanitation committee level. In all the seven committees and societies the secretaries or Conveners were health personnel; though the background of the Chairperson varied. Monitoring committees, which are supposed to be chaired by an eminent person and have a higher representation of civil society organisations, were yet to be established in all the patient welfare societies studied. Given this composition and leadership, it is a moot question as to how far such a government and health provider/manager dominated structure can 'monitor' the functioning of the facility or 'promote accountability' to citizens. Similarly, the extent of representation of elected government representatives in PHC/CHC/hospital patient welfare societies was minimal (other than in the case of GG Pettai PHC and Wallajapet district hospital), and this seems important if the facilities are to mobilise additional resources from local government (see the GG Pettai PHC example of constructing sump using local government funds) Interviews with a few committee and society members whom the research team met suggest that the awareness that they were there in the committee or PHC/CHC society was higher in Vellore district than Kancheepuram district. Barring one person, the village health committee and society members met did not articulate the 'public accountability' or 'monitoring' role; but felt that the committee was there to strengthen 'implementation' of programmes and services. Specifically, the committee and society members felt the role of the committees and societies was to improve infrastructure, maintenance, amenities and services at respective facilities. The village health committee members in addition expressed the view that their role was to improve the sanitation and hygiene in the village, outreach of services, and improve access to emergency transport for pregnant women. The committee and society members by and large did not see their role as promoting 'accountability' to citizens, 'monitoring' the work of providers, arranging for 'training' of providers, advocating filling up vacancies*, preventing sex selection, or monitoring accessing to health benefits. The lone person who articulated such roles was a SHG leader in the village health committee trained by RUWSEC. *In short the health committees and patient welfare societies visited were not vehicles for enforcing accountability of health providers or workers to citizens, leave alone of public health policy makers. The committees and societies visited do not promote managerial or policy accountability to citizens, ex-post or ex-ante.*

**** Barring Wallajapet District Hospital Patient Welfare Society which had taken up this issue, but with no success as of November, 2007.***

As accountability to citizens to health services in general was not promoted, accountability to citizens on SRH was still a far away.

Investment in building capacities of village health committee members and medical officers on the role and responsibilities of village health committees was higher in Vellore district when compared to Kancheepuram. During the one day training given to gram panchayat leaders, VHNs, medical officers, and SHG leaders in Vellore district, a manual in Tamil was given which spelt out the role of the village health committees (but not PHC/CHC patient welfare society). This manual was indeed appreciated by the participants. However, like in the case of the Government Order, it does not place much emphasis on the accountability role of the health committee. Of the 21 responsibilities of the committee spelt out, only one pertains to the 'monitoring and evaluation' role of the committee. Though two of the roles mentioned pertained to preventing female infanticide and gender-based violence, as well as helping pregnant women and girl children access health benefits, these were not mentioned by the committee members who had attended the training. Further, it was not distributed by the government to committee members who were not included in the training as well as PHC/CHC patient welfare society members. The manual produced in Vellore district was not used in Kancheepuram district.

5. Lessons on health committees, patient welfare societies, and accountability to citizens on SRH

Flowing from the findings on how far health committees and patient welfare societies have strengthened accountability to citizens on SRH are three sets of lessons: the first is on accountability to citizens on any development services, the second is on accountability to citizens on health services, and the third on accountability to citizens on SRH services.

Lessons on accountability to citizens on development services

Structures pertaining to social services (health, education, water and sanitation, rations etc) cannot promote accountability to citizens if the public is not aware of and mobilised around these structures, if civil society representatives in the structure are a minority, the roles of these structures are multiple (and one small part pertains to accountability), if they are formed by government agencies, if they are headed by the service providers/health managers themselves, and capacities are not built towards a monitoring and accountability role. The patient welfare

societies and village health committees while strengthening infrastructure, services and amenities at the service points, as yet had not strengthened accountability to citizens as the formation and functioning of these committees were precisely shaped by such adverse features. Further, systems for such structures to engage with citizens, respond to their needs and make providers answerable to citizens have to be put in place. Such systems were lacking in the committees and patient welfare societies studies. Another lesson is that to press for accountability (in the enforcement sense) citizens need to know what development services they are entitled to. In Vellore district, gram panchayat chairpersons were more aware of services to be available at PHC and sub-centre level, though as yet their influence was little at PHC level as they were not represented in these patient welfare societies visited. Structures and systems with the necessary pre-conditions discussed above need to be put in place at all levels; otherwise there is a danger that accountability of only those government personnel at middle and lower rungs will be promoted; and not those at policy level.

Lessons on accountability to citizens on health services

All the above lessons on what conditions structures involving citizens can promote accountability to them on development services apply to health services. In addition, there are some lessons that are specific to the health sector. The first is that unlike services such as water and sanitation, there is a huge hierarchy in knowledge between providers and citizens on the technical field of health *(18)*. It is hence very difficult for citizens to press for accountability with regard to availability (they may not know what services are required for their health problems) or quality of health care services (they may not know what health service is of good quality). They may however be able to press for affordable services; and in particular stopping of informal payments for services meant to be free (see Mayur example, through NGO initiated processes). Further, unless enough budgets are allocated to health, it is difficult to address needs emerging through demands from citizens. For example, citizens met in Banavaram CHC wanted a paediatrician, full time anaesthetist and ophthalmologist. There was no budget for the same. Even when there was allotment and budget, health professionals did not want to serve in locations far away from their home and so on. Another lesson flowing from the better performance of committees/societies at sub-centre/PHC/CHC levels than hospital level is that the 'public health' expertise of Directorate of Public Health staff helps in efficiency of these structures.

Lessons on accountability to citizens on SRH services

Accountability to citizens on SRH services poses a distinct set of challenges, especially with regard to services which are of low priority or are controversial in nature. Firstly, the hierarchies in knowledge between providers and citizens are particularly high with regard to SRH needs and services between providers and patients (other than on routine delivery). Citizens may rarely articulate low priority needs like services for cancer screening or controversial ones like services for abortion or vasectomy. This is particularly so when men in positions of power are represented in the health committees and patient welfare societies. Even women may not be aware of strategic health interests (services for health complications due to violence against women)v unless they have been mobilised and organised over time, and exposed to thinking on such issues continuously. The lone woman SHG member of the Mayur village health committee who articulated such strategic roles of the committee was part of groups organised by an activist NGO RUWSEC in Kancheepuram. One training mentioning strategic or accountability role of committees and societies is not enough. Further, even when citizens articulate such needs, providers have to be trained to provide such services. Doctors in Banavaram CHC were not equipped to do vasectomy and only one was trained to do manual vacuum abortion and that too recently. Further, attitudes of providers also come into play in whether they deem a particular service as appropriate.

6. Recommendations

The preceding analysis has suggested that the village health committees and PHC, CHC and hospital patient welfare societies (along with other provisions under NRHM) have improved health services in public health facilities in the two districts visited, and more so at the sub centre, PHC and CHC levels than at the hospital level. The improvements have largely been due to the funds at the disposal of these village health committees and societies as well as other funds with the facilities, than other activities of the committees and societies. The improvements were more marked in Vellore than Kancheepuram district; the former being headed by a dynamic Deputy Director of Health Services. Among different SRH service needs, the improvements were more marked with regard to maternal health services (in particular referral services at sub centre level, institutional delivery at PHC level and Basic Emergency Obstetric Care at CHC level), followed by female sterilisation. The availability, affordability,

physical accessibility and quality of these services had improved in the facilities visited. No improvements were seen with regard to availability of services (at appropriate levels) towards abortion, health complications due to violence, vasectomy, laparoscopy, infertility, cancer treatment, and HIV treatment. That is controversial, low priority or expensive health services were less prioritised.

While the improvements in maternal health services are indeed laudable in the context of stagnant maternal mortality ratio in Tamil Nadu in the 1990s, it is a concern that these village health committees and patient welfare societies have not substantially strengthened accountability to citizens (in general) on health, leave alone to women citizens and on SRH services. This could be one of the reasons for health facilities not addressing some of the non-maternal SRH services listed earlier. To ensure that the patient welfare societies and village health committees strengthen accountability to citizens on SRH services the recommendations listed in the next pages are made

Create civil-society exclusive structures (representing marginalised) to promote 'accountability to citizens'.

While the present structures of patient welfare societies and village health committees may be retained for strengthening health service and infrastructure 'implementation' and 'management', for promoting accountability to citizens a new structure headed and composed solely by non-government organisations, sensitive elected representatives, women SHG leaders, general members of the public, and (non-government and non profit) private midwives and doctors may be promoted through a Government Order. Fifty per cent of this new structure may be women, 33% from dalit community and at least one person who is differently-abled. A committed and competent civil society organisation working in the same district may be entrusted with the responsibility for formation of these committees, as well as building their capacity to carry out its 'accountability to citizens' functions. The responsibilities of the health committee may include articulating health needs to government policy makers and providers, monitoring that public health infrastructure, staffing, services and amenities adhere to guidelines (in terms of availability, affordability, and quality), and putting pressure on government to take remedial or disciplinary action in case of shortfalls. The accountability structures may perform its monitoring and advocacy function once in three months, as part of which it should hold a public meeting to find out feedback and grievances. The watchdog committees

may submit one copy of its report to the Deputy Director of Medical or Health Service (as appropriate) with a copy to the District Collector; and be empowered by the government to receive a response in one month. The accountability structures must be empowered with funds to perform their monitoring and advocacy functions as well as to strengthen their own capacity to perform such roles.

Earmark funds of committees and societies to address needs expressed by the 'citizen exclusive' accountability structures.

It is recommended that at least 50% of funds of the existing village health committees and patient welfare societies, as well as annual maintenance fund and untied funds, be earmarked for priorities expressed by the accountability committee attached to that level. These could be related to improvements in infrastructure, equipments, amenities, drugs, existing services, offering of new services (including SRH services, as appropriate to that level of health care), staff training or hiring of temporary staff or contractual staff. Needs such as iron injections for treating anaemia for pregnant women, health complications due to violence, and abortion services have been articulated by the women met. However, it is unlikely that all the health/SRH service needs of the citizens can be met through these three funds.

Reduce power imbalances between public medical professionals/health workers and citizens

It is recommended that power imbalances between public medical professionals/health workers and citizens be reduced through entrusting responsibility of training Governing Body and Executive Committee of existing patient welfare societies and village health committees to the same civil society organisation responsible for formation of accountability structures so that the government officials, health providers, elected representatives and health workers in these forums are more aware of their role in promoting accountability to citizens; and the civil society and elected representatives in these committees and societies are aware of the NRHM and state government programmes to be available at the respective facilities. The government must be encouraged to amend Government Orders so that the civil society actors in Governing Body and Executive Committee are at least 33%, and in Monitoring Committees at least 50%. As at present this is not the case, this may be an opportunity for rights-based NGOs and community-based organisations they have promoted to enter these structures. Manuals may be evolved in Tamil (the local

language in Tamil Nadu) strengthening what has been attempted in Vellore district on these structures. SHG leaders and elected representatives in the committees and societies must be encouraged to hold public meetings before and after the official meetings, to take forward demands and disseminate decisions to/of these forums (see Manguppam health sub-centre example)

Strengthen accountability to citizens on SRH services

Strengthen accountability to citizens on SRH services through broadening the emphasis of the NRHM beyond maternal health services to include services towards safe abortion, SRH complications due to violence, uterine prolapse, widening contraceptive choice, promotion of vasectomy, treatment for reproductive cancers, anti-retroviral therapy for HIV positive patients, and treatment for infertility (at appropriate levels of care). As of now while several of these services are mentioned under the NRHM (at CHC level) and Tamil Nadu Health Systems Project (at hospital level), they are either not prioritised through funding, staff training, equipments, and monitoring (e.g. abortion services) or the envisaged service is restricted to diagnosis and not treatment (e.g. reproductive cancer and HIV/AIDS screening). It is hence important that training is provided to doctors to provide these SRH services along with the funds for upgrading infrastructure and equipments and providing not just diagnosis services but also treatment (at appropriate levels of health care). To strengthen demand for SRH services beyond maternal health services - and that these services are articulated and monitored by citizens in the village health committees and patient welfare societies - it is important to empower citizens (women in particular) to break the silence and sense of shame regarding such health needs. There is also a need to document and disseminate innovations in this direction by existing committees and societies and suggested citizen-led accountability structures; so that they are replicated.

Strengthen the capacities of committees and societies to address social determinants of women's SRH

It is recommended that the government strengths capacities of patient welfare societies and village health committees to address the social determinations of women's SRH like gender discrimination, gender-based violence and girls' education through highlighting these roles in training of

members. These roles are already mentioned under the roles and functions of patient welfare society and village health committees, but have not been internalised. The government and accountability structures may monitor whether such issues are discussed in the patient welfare society and health committee meetings. Further, progress on these fronts may be part of the indicators used by the government for monitoring the functioning of these societies and committees. Similarly, the role of village health committees and patient welfare societies in ensuring that clients access health benefits under the NRHM and state government health/social schemes may be highlighted in trainings for members and achievement in this aspect also needs to be closely monitored by the health committees and patient welfare societies.

The first two recommendations are applicable to strengthen accountability of any public service (education, health, public distribution system) to citizens. The second recommendation pertains to any effort to promote accountability to citizens on health, while the third and fourth sets of recommendations pertain to accountability to SRH services.

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