ACCOUNTABILITY INITIATIVE
research and innovation for governance accountability

Field Notes on Accountability

Rogi Kalyan Samitis: New Spaces of Participation

Field Notes on Accountability

The field notes in this series seek to document accountability mechanisms built into key government programs for service delivery. These include programs such as the National Rural Health Mission, Mahatma Gandhi National Rural Employment Scheme, Public Distribution System and others.

No.2

The current note examines the functioning of Rogi Kalyan Samitis under the National Rural Health Mission. It assesses the extent to which the RKS promotes people's participation in local hospital management.

Other Field Notes

No. 1: Incentivising Rural Sanitation – The Nirmal Gram Puraskar.

Background and Context

In 2005, the Government of India launched the National Rural Health Mission (NRHM) to provide affordable and accessible quality health care to the country's rural population. The Mission seeks to engineer an 'architectural correction' in the health care delivery system "to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country". One innovative feature of this correction was the decentralisation of hospital management to patient-welfare societies called Rogi Kalyan Samitis (RKS).

The push for greater decentralisation through the RKS comes against the backdrop of governmental efforts to enhance citizen participation in governance processes. Driving this trend is the idea that participation can make the state more responsive and accountable to citizens' needs. However new participatory spaces such as the RKS also raise some important questions. How do participatory institutions actually work in practice? What are the factors that facilitate or constrain participation? Does decentralised decision making translate into more accountability and better outcomes on the ground?

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CENTRE FOR POLICY RESEARCH

In an attempt to answer some of these questions, the *Accountability Initiative* undertook a process documentation of Rogi Kalyan Samitis in the district of Munger, Bihar. The specific objectives of the process documentation were to try and understand the structure and membership of the RKS, the nature of the decision making process and the interactions of the Samitis with the local health system. The report aims to promote further and more comprehensive research on the functionality and impact of Rogi Kalyan Samitis.

Rogi Kalyan Samitis

Under the NRHM, Rogi Kalyan Samitis are to be set up at all levels of district, sub-divisional hospitals, referral hospitals and primary health centers. According to official statistics, till date 29223 Rogi Kalyan Samitis have been set up across the country under the NRHM.[1] The Samitis are independent societies registered under the Societies Registration Act, 1860 and act as trustees for local hospitals. To encourage states to set up Rogi Kalyan Samitis, a support amount of Rs 5 Lakh per rural hospital and Rs 1 Lakh per Community Health Centre (CHC) per annum has been granted to these societies.

The Samitis have been given considerable autonomy in the utilisation of funds. In addition, they are free to use all government assets and services to decide user charges at the local level and can also raise additional funds through different means. The RKS has a diverse membership comprising of people's representatives (MLA/MP), health officials (Medical Superintendent/Chief Medical and Health Officer/Civil Surgeon), local district officials, community representatives, PRIs, NGOs and donors. The RKS is made up of a governing body, executive committee and a monitoring committee, each with defined roles and functions (see Box 1 for a detailed list of RKS functions).

[1] Ministry of Health and Family Welfare (2010) *The National Rural Health Mission: Meeting People's Health Needs in Partnership with States, 2005-2010*, Government of India, pp.8, http://mohfw.nic.in/NRHM/Documents/5_Years_NRHM_Final.pdf, accessed on 28 December 2010.

Box 1. Basic Functions of the RKS

The NRMH guidelines on the RKS specify that the society shall utilise its resources for the following activities:

- *Identifying problems faced by patients in the Community Health Centre/Public Health Centre;*
- *Acquiring equipment, furniture, ambulance for the hospital;*
- *Expanding the hospital building and making arrangements for maintenance of the hospital building, vehicles and equipment available with the hospital;*
- *Improving boarding/lodging arrangements for patients and their attendants;*
- *Entering into partnership arrangements with the private sector for the improvement of support services i.e. cleaning services, diagnostic facilities, ambulatory services etc;*
- *Developing/leasing out vacant land in the premises of the hospital commercial purposes with the view to improve the financial position of the society;*
- *Encouraging community participation in the maintenance and upkeep of the hospital;*
- *Promoting measures for resource conservation through adoption of wards by institutions or individuals and;*
- *Adopting sustainable and environmental friendly measures for day to day management of the hospital, e.g. scientific hospital waste disposal system, solar lighting systems, solar refrigeration systems, water harvesting and water recharging systems etc.*

Source: *Rogi Kalyan Samitis, Government of India, National Rural Health Mission, Official Website, http://mohfw.nic.in/NRHM/RKS.htm, accessed on 28 December 2010.*

To understand how the RKS functions in practice, documenters observed and studied 4 Rogi Kalyan Samitis in Munger district, Bihar. In Munger, the district hospital and Public Health Centres (PHCs) in each block have Rogi Kalyan Samitis. Specifically, documenters studied the RKS in the district hospital of Munger (Sadar hospital) and the RKS in the PHCs of Kharakpur, Bariarpur and Jamalpur.[2] In addition to studying the RKS, documenters also conducted focus group discussions in two panchayats in each block.

[2] In each hospital, interviews were conducted with RKS members including members of the governing body, the Civil Surgeon (CS)/ Medical Officer In-charge (M.O.I.C), the accountant, the Deputy Secretary/ Second Medical officers (M.Os.). Documenters also attended one RKS meeting at the district level in Munger to observe the functioning of RKS in practice.

Rogi Kalyan Samitis in Practice[3]

1. Structure of the RKS

Membership: On average the RKS has between 8 and 9 members. The RKS in Sadar Hospital, Munger and the RKS in Bariarpur had 9 members; while the RKS in Kharakpur and Jamalpur had 8 members. Members are nominated by the Civil Surgeon (CS) at the district level and the Medical Officer in Charge (M.O.I.C.) at the block level. The membership of the RKS in Sadar Hospital was quite diverse. Members included representatives from the Dalit community, AYUSH doctors, local health officials, the Indian Medical Association, panchayat/ward members, NGOs and the local community. In terms of gender representation, it was observed that only the RKS at Sadar hospital in Munger and the RKS in Bariarpur hospital had women members.

A number of RKS members in Munger District hold important positions in agencies and offices other than the hospital. In contrast, the RKS members of the PHCs were relatively less active in public life suggesting a difference in the perceived importance of the RKS in the district and the PHCs. Membership of the RKS is voluntary and members do not receive any payment for their services.

Tenure

The NRHM guidelines require a change in RKS membership every three years; however, it was observed that there has been no change in RKS membership since the societies were set up. However, it was reported by the District Program Manager (DPM) that the District Health Society (DHS) has submitted a request requiring all Rogi Kalyan Samitis in the state to implement the three year member rotation clause.

[3] The Self Employed Women's Association (SEWA), one of the most active NGOs working in Munger, facilitated this research. SEWA has been working on various issues in the region including health care. They have developed a strong network with local health officials and were able to provide data and arrange interviews with RKS members. Notably, SEWA is also a civil society representative in the RKS.

Roles and Responsibilities

The CS of Munger district is the head of the RKS in the district. The local M.O.I.C. is the head of the RKS governing body in the PHC at the block level. The CS and the M.O.I.C appear to be the key decision makers of the RKS on a day to day basis. All decisions regarding the functions and finances of the RKS at the block level are first approved by the M.O.I.C before being sent to the CS's office. Members have not been assigned specific roles and responsibilities within the RKS but rather assist hospital staff in the day to day functioning of the hospital. For example, during a polio drive in June 2010, RKS members were tasked with controlling crowds of patients outside the hospital.

Interviews revealed that members had no clarity about their roles and responsibilities. One important reason for this is the lack of training and formal instruction of members on the functions of the RKS. Members broadly described the activities of the RKS to include identifying patient problems in the hospital/PHC, overseeing equipment, hospital and ambulance maintenance; hospital expansion, encouraging community participation, promoting resource conservation; improving lodging arrangements for patients, adopting sustainable and environmental friendly measures for day-day hospital management and reviewing services on a daily/weekly/and monthly basis.

2. RKS Meetings

RKS meetings are chaired by the CS in the district hospital and the M.O.I.C. in the PHC. RKS members meet once a month to map out a monthly agenda, following which a monthly budget of expenditures is approved. There are no fixed dates for the meeting and the Secretary of the RKS is responsible for arranging a date that is convenient for all members.

A close reading of the RKS meeting minutes provides an insight into the formal structure of the meetings and their proceedings. In Sadar hospital, Munger district, the meetings are formally called into session by the Secretary and chaired by the CS. The minutes and agenda fixed at the previous meeting are reviewed and discussed as is the status of work. The income and expense reports of the RKS are also discussed. Thereafter, members put forth their ideas and these are put to vote before other members. The meetings end with the CS and Secretary signing the meeting minutes and closing the proceedings.

When documenters attended RKS meetings in Munger, they found that the meetings at the district level were much more formal than those held at the block level. In interviews, members indicated that they used the meetings to chalk out a course of action for the RKS. Discussions in meetings are open and all members have the opportunity to participate and discuss their views.

RKS Meetings in Munger

During the meetings, members identify major health problems affecting the local community. A review of the RKS meeting minutes indicates that once an issue has been identified, members discuss how the RKS can address the problem or assist other health agencies in doing so. Within the last year some of the projects that had been commissioned and completed by the RKS at the district level include: building structures for safe water storage, undertaking infrastructure maintenance and purchasing X-ray and ultrasound machines. In the next fiscal year, RKS members intend to undertake the construction of labour rooms, increase the number of hospital beds, construct registration windows, open a blood bank and expand the operation theatre. Similarly, at the block level some of the projects approved by RKS members include cleaning and repairing broken beds, taking measures to control Malaria outbreaks through net distribution, DDT spraying and increasing the availability of medicines. Moreover, in the forthcoming financial year, members intend to use RKS funds to improve PHC infrastructure, install fans and new beds, white-wash outer walls, and remove fees for X-rays, etc. At the end of the meetings, the discussions and agenda are recorded and a monthly report is sent to the District

Magistrate's (DM) office at the district level. However, it came to light in interviews that the district had not received any of the RKS meeting minutes from the respective blocks.

Overall the RKS meetings are fairly participatory with all members being given the opportunity to speak and voice their opinions. However it is worth noting that when it comes to actually backing decisions with funds, the ultimate authority rests with the CS/M.O.I.C. This raises important questions about the ability of RKS members to influence the allocation and utilisation of RKS funds. As we will see in the following sections, the concentration of financial power in the hands of the CS and M.O.I.C has to an extent disempowered other RKS members.

3. RKS Funds

All members stated that the district hospital in Munger received 5 Lakh from the State Health Society (SHS) and the block PHCs received 1 Lakh each from the CS's office as part of an annual RKS funding package. Members stated that the RKS also raised funds through fees levied on patients (Rs 2 each at the district level and Rs 1 each at the block level). In addition, funds were appropriated from ambulance services provided by the hospital or PHC. Furthermore, members reported that the Indian Tobacco Company had in the past provided funds to finance infrastructure development of the hospital and PHC. Once collected, the funds are placed in a bank account to which only the M.O.I.C and the second M.O. have access.

During the interviews it became evident that members were unclear about the sources of RKS funds. Members confessed that much of their knowledge of RKS' funding was based on hearsay and that they did not receive information about when funds were received and from what sources. The members added that they focused their attention on utilizing funds rather than inquiring where funds were coming from.

Fund Utilisation

The RKS constitutes a small portion of the hospital and PHC annual budget such that hospital accountants do not maintain independent financial records of the RKS. The accountants of RKS Bariarpur, Jamalpur and Munger district stated that the RKS funds were incorporated within the NRHM section of hospital/PHC income report. How are RKS funds spent? In interviews members revealed that since the volume of RKS funds is small and RKS membership is voluntary not a lot of attention is paid to

how RKS funds are actually spent. In fact there is no annual agenda mapping out the proposed expenditure of the RKS. In practice, RKS funds are spent as and when needed.

The small size of the RKS budget has meant that even district officials do not pay sufficient attention to RKS fund flows and utilisation. This view was expressed by the accountants as well as the M.O.I.C. of both Kharakpur and Bariarpur. In interviews members expressed their concerns about the lack of information about RKS funds and the need for greater financial transparency and accountability.

The accounts and details of RKS expenditure were not readily available. Through observation and interviews, documenters were able to piece together details of expenditure incurred by the RKS. At the PHC level, upwards of 80% of RKS' annual funds were used for infrastructure maintenance. Projects such as, painting the inner and outer walls of the health facility, installing ceiling fans, and improving plumbing were the most common projects funded by the RKS. The other 20% of funds were used for purchasing decontamination solvents to control malaria outbreaks, building safe water tanks and subsidized ambulance services. The RKS in Sadar hospital, Munger district had in the past year used portions of the RKS funds to purchase X-ray and ultrasound machines. Additionally, using RKS funds, the PHC in Jamalpur had installed sophisticated drinking water filters and air-conditioners for staff and patient halls. RKS funds are also often diverted to finance non-RKS projects.

Interviews with RKS members did not reveal any instances corruption. However RKS members in Kharakpur and Munger did reveal that the accounts of the RKS had not been audited perhaps because the district administration does not give the RKS much importance. Consequently, there was no means of ascertaining how much money had been spent, on what items and how much had been lost due to leakages. Despite protests from members, the governing body has refused any audits of the RKS accounts.

4. Observations

The purpose of studying the RKS in Munger was to understand how these new participatory committees function in practice. Specifically, documenters set out to understand how RKS members perceive their roles and functions, how they participate in the management of local hospitals/PHCs and how decisions regarding

fund utilisation and projects are taken. Interviews with RKS members in Sadar hospital in Munger and the PHCs in Kharakpur, Bariapur and Jamalpur brought out some interesting findings:

- *Diverse Membership*: In its membership, the RKS is fairly representative of different segments of society in Munger at the district and PHC level. However the membership process is not democratic with members being appointed for an indefinite term. In the long run this is likely to affect and undermine the participatory nature of the society.

- *Lack of training and capacity building*: The RKS members interviewed had not received any training on their roles and responsibilities. This was reflected in the lack of clarity about the basic objectives and functions of the RKS and the limited understanding of RKS funds and their utilisation. Thus while the structure of the RKS has been put in place, the ability of members to participate effectively has been limited by the lack of training and capacity building. The disconnect between hospital officials and other RKS members is also a reflection of the fact that hospital officials have not been sensitized and trained on how to effectively engage community representatives in the day to day functioning and management of the RKS.

- *Limited Participation in Decision Making:* The RKS has certain inbuilt structural features that in fact make meaningful participation near impossible. For one thing the RKS rules require that the CS and M.O.I.C retain all financial control as they have signatory authority to sanction funds for specific projects. De facto this has meant that the CS and M.O.I.C have the power to override decisions made by the RKS. This coupled with the fact that RKS members have received no training and have no information on financial matters has meant that RKS members are disempowered. So despite the decentralisation of hospital management to local communities, decision making in the end remains an official privilege.

  A second structural feature that has further disempowered RKS members is the absence of a grievance redressal system. In this particular instance, members' requests for audits of society accounts and the minutes of RKS meetings were not addressed. Members did not have any means of expressing their discontent. This appears to have affected the participation of

members in the RKS and has meant that the hospital officials continue to run the RKS as they see fit.

To conclude, the RKS is an interesting experiment in decentralised health management. The RKS grants functional autonomy to public hospitals to improve the efficiency, quality and performance of hospital services while simultaneously engaging local communities in the decision making process. In theory the RKS has the potential to bring about significant changes in the way hospitals and PHCs function at the district and block levels. However our documentation of the day to day functioning of the RKS in Munger indicates that the ability of individuals to participate effectively in the RKS has been compromised by the unequal division of power between officials and members, the lack of information and training and capacity building of members. The story of the RKS in Munger is becoming increasingly familiar across the landscape of decentralised and participatory spaces in India. Whether it is Village Education Committees, School Management Committees or Village Water and Sanitation Committees – participatory spaces have been created but efforts have not been made to effectively engage local communities in the decentralisation process. Without systematic efforts to build the capacities and nurture these participatory committees, there is a danger of the status quo persisting.

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