

## **Rapid Assessment of functioning of Rogi Kalyan Samiti in Yavatmal District of Maharashtra State, India**

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### **Abstract**

Aim of the present research was 1. To study the structure and functioning of RKS, 2. To study the amount of funds available and revenue generated by the RKS and utilization of funds by RKS, 3. To assess the facilitating and inhibiting factors affecting the functioning of RKS. The study was conducted in Yavatmal District, Amaravati Division in Vidarbha region of Maharashtra State. Using multistage purposive sampling design, 2 SDH, 9 RH and 18 PHC'S were selected. The study subjects were RKS members (203 members), clients (5 IPD and 5 OPD patients) and beneficiaries (290 patients). A structured and pre-tested self administered questionnaire translated in local language was used for data collection from RKS members and beneficiaries. The third tool for study was onsite observations by the investigator. Data thus collected was analysed using Stata software version 12.1. RKS was constituted during 2005-2007 with governing body following issuance of government of India guidelines. Biological waste management was carried out at all 29 facilities in the study as per the guidelines from MPCB. All funds were received in time and work wise utilization was done as per the guidelines at all chosen health facilities. 41.9% at PHC's and 21.6% at SDH/RH, RKS members reported difficulties in utilization of funds, more difficulties were faced at PHC than at SDH/RH. (90.1%) RKS members are satisfied with overall functioning and activities conducted by the RKS. However, most of the community members and beneficiaries were satisfied with the provision of good quality of medicine, availability of specialist care, high referral rates and higher investigation.

**Keywords:** National Rural Health Mission, Rogi Kalyan Samitis, Maharashtra Pollution Control Board (MPCB), Public health facilities.

### **1. Introduction**

Health facilities in India were often criticized for poor management in ensuring health care needs of the community [1]. With the introduction of reform initiatives during 1991, local management of resources at health facilities, purchase of health services, drugs, and other social protection measures were reinforced [2]. Following the implementation of National Rural Health Mission (NRHM) in 2005, Rogi Kalyan Samiti [3] (RKS) or Patient Welfare Society (PWS) or Hospital Management Committee (HMC), were formed at all publicly funded facilities, for ensuring a degree of permanency and sustainability. This committee would be a registered society acts as a group of trustees for the health facilities to manage the affairs of the hospitals [4]. It consists of members from local Panchayati Raj Institutions (PRIs), NGOs, local elected representatives and officials from

government sectors who are responsible for proper functioning and management of the hospital/CHC/FRUs.

Formation of RKS model paved way to a new beginning for strengthening health system with involvement of local leaders, civil society to improve governance. The functioning is derived by availability of resources, capacity of committee members and the bureaucratic process. Revision in functioning of RKS model is essential towards self-sustainability and bridge between community-health systems. The functioning of RKS is through a formal registration of committee under the Society Registration Act of 1860 in the name of the respective health facilities [5]. Under the core activities, RKS has to address the needs of the patients at respective public health facilities and infrastructure needs of facility to ensure quality service to patients; ensure/monitor

cleanliness and maintenance of hospital building and premises. Opportunities are also available for engaging private providers available locally for clinical services (e.g. Anesthetic services), non-clinical services (e.g. Housekeeping services), and diagnostic services. Other activities would include resource generation through community donations, User Fees, fees for special services etc. The RKS is free to prescribe, generate and use the funds with it as per its best judgment, for smooth functioning and maintaining the quality of services. The RKS/HMS will function as a NGO, as far as functioning is concerned. It may utilize all government assets and services to impose user charges and shall be free to determine the quantum of charges on the basis of local circumstances. It may also raise funds additionally with donations and loans through various financial and donor agencies.

The Rapid Assessment of Health Interventions is a unique initiative for developing partnerships with different organizations working in the field of health and family welfare. Number of innovations has been supported by the states to improve access and enhance service quality. To know how well these innovations are performing so that in case of gaps corrective measures can be taken to achieve the stated objectives. There has been an increasing incremental improvement in the programmed delivery by undertaking quick and rapid health system research and engineering the feedback into the process [6].

The present study was undertaken with the overall objective to assess the functioning of RKS as well as to study the availability and utilization of funds by RKS.

## 2. Materials and Methods

This rapid appraisal study carry out in Yavatmal District of Maharashtra State during the period of April 2011 to October 2012, after approval from the Ethical Committee. The study was of 1.6 years duration. The study population comprises of Chairman, Member Secretary, Members of Rogi Kalyan Samiti (Governing Council and Executive Committee) and beneficiaries (Patients) who seeks health services at the health facilities. Those RKS members willing to participate and those beneficiaries willing to participate after consent were included in the study. Those RKS members and beneficiaries not willing to participate after consent and seriously ill patients were excluded. The multistage purposive sampling method was adopted for the study. In the selected region, there are total 3 sub district hospitals (SDH), 14 rural hospitals (RH) and 63 primaries health centres (PHC's) are available in the district. Among these 2 SDH, 9 RH and 18 PHC's were selected. So the total 29

health facilities have been selected for the study. Government medical college and hospital was excluded from the study as RKS is not applicable to them. The study subjects were 50% (203 members) of Rogi Kalyan Samiti members, randomly selected from the chosen health facilities of study population. 5 indoor patients and 5 outdoor patients and 290 beneficiaries interviewed at 29 facilities. Three study tools were used for data collection - A structured and pre-tested self administered questionnaire translated in local language for RKS members and for beneficiaries. The third tool for study was onsite observations by the investigator.

Preparation of detailed programme schedule day and date wise was done. Meeting days of Medical Officers at District, Block and Holidays were considered while preparing the schedule, programme schedule was conveyed to Member secretary so that maximum number of members should be present on the day of data collection. On the day of data collection RKS members were oriented about the purpose of the study and if they have any doubts were clarified. Verbal consent obtained from them before administering the Questionnaire. Chairman, Member secretary and Member of the RKS (Governing council and Executive committee), were given self administered, structured and pretested questionnaire to respond. It is translated to local language in Marathi; Hindi speaking peoples also speak and understand the Marathi language very well. Hence translation was done in Marathi only. Before administering the questionnaire it was discussed and anybody had any doubts were clarified by the investigator on spot. For beneficiaries interview health facilities were visited during OPD hours, and Outdoor Patients (beneficiaries), were randomly selected. At the same time Indoor Patients admitted were randomly chosen and interviewed. Before interviewing the beneficiaries they were made to sit in a group and Questionnaire was explain to them in Marathi. If they had any doubts were clarified by the investigator, following that each beneficiaries interviewed by using structured pretested, questionnaire, translated in local language (Marathi). Hindi speaking people know the Marathi language very well hence only Marathi translation was done. Each interview took 15 to 20 minutes.

### 2.1 Data Analysis

The data of 203 RKS respondents and 290 beneficiaries was collected, compiled and then entered in MS Excel 2007 worksheet. It was analysed using *Stata software version 12.1*. Qualitative data analysis- a) Pearson's Chi-square test is applied to test the relationship of categorized Independent and dependent variables. b) If expected number in the cell was below 5 in a table, Fisher's Exact Test (Exact Two sided) was used.

### 3. Observation and Result

#### 3.1 Facilities available and conducted at SDH, RH and PHCs

Various parameters have been checked for the availability at SDH, RH and PHCs such as outreach camps conducted at the facility, outreach immunization sessions, essential medicine, safe drinking water and cleanliness,

maintenance of equipment, waiting area for OPD. Total 203 respondents were undertaken for the study, out of these 74 were from SDH and RH, and 129 were from PHCs. The results obtained by these studies were depicted in table 1. The non significant results were obtained by applying Pearson chi 2(1) and Fisher’s exact test.

**Table: 1 Facilities available and conducted at SDH, RH and PHC**

Health facility	Outreach camps conducted at the facility		Outreach immunization sessions conducted		Essential Medicine		Safe water & Cleanliness		Maintenance of equipment		Availability of waiting area for OPD		Total
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
SDH & RH	46 (62.2)	28 (37.8)	32 (43.2)	42 (56.8)	70 (94.6)	4 (5.4)	72 (97.3)	2 (2.7)	71 (96)	3 (4)	73 (98.7)	1 (1.3)	74
PHC	72 (55.8)	57 (44.2)	63 (48.8)	66 (51.2)	126 (97.7)	3 (2.3)	127 (98.4)	2 (1.6)	120 (93)	9 (7)	125 (96.9)	4 (3.1)	129
Total	118 (58.1)	85 (41.9)	95 (46.8)	108 (53.2)	196 (96.5)	7 (3.5)	199 (98)	4 (2)	191 (94.1)	12 (5.9)	198 (97.5)	5 (2.5)	203 (100)
Statistics	Pearson chi 2(1)=0.7786, (p=0.378 Not significant)		Pearson chi 2(1)=0.5910, (p=0.442 Not significant)		Fisher’s exact, (p=0.26, Not significant)		Fisher’s exact, (p=0.623, not significant)		Fisher’s exact test (p=0.542, not significant))		Fisher’s exact, (p=0.655, Not significant)		

Note: Figures in brackets indicate percentages

#### 3.2 Public Private Partnership by the health facilities

At SDH and RH out of 74, 33(44.6%), RKS members feel that private public private partnership was working good at the health facilities and 41(55.4%), RKS members feel that public private partnership was poorly working at the health facilities. At PHC’s out of 129, 55(42.6%), RKS members feel that public private partnership was working well at the health facilities and 74(57.4%), RKS members feel that the public private partnership was poorly working at the health facilities, Pearson chi 2(1) test was applied ( $X^2= 0.073$ ,  $p=0.789$ ) and the difference was found to be not significant.

#### 3.3 Disposal of hospital waste at SDH/RH and PHC’s

As per the Maharashtra Pollution Control Board’s (MPCB), directive it is compulsory and mandatory to all health facility irrespective of their status, Government, private, corporate or trust, run, has to follow the scientific disposal of hospital waste. It is noted at every health facility visited by the investigator and found that at each health facility strict biological waste disposal management was carried out as per the standard guidelines issued by the MPCB [7].

#### 3.4 Training status of doctors and paramedical staff

When respondents opinion on skilled based training status of doctors and paramedical staff was taken out of 203, 188(92.6%), respondents told that the doctors and paramedical staff are adequately trained and 15(7.4%) respondents told that the doctors and paramedical staff are not adequately trained. From the observation we can say that training status of doctors and paramedical staff was adequate at all health facilities. Skill based trainings like Basic Emergency Obstetric Care (BEmOC), Emergency

Obstetric Care (EmOC), Comprehensive Emergency Obstetric Care (CEmOC), Medical Termination of Pregnancy (MTP) with Manual Vacuum Aspiration (MVA), Mini laprotomy, No Scalpel Vasectomy (NSV), CuT380A, Life saving skills in Anaesthesia, Biomedical waste management, trainings are must for the doctors working at health facilities and trainings like Skilled Birth Attendant (SBA), CuT380A, are important for the nursing staff for the skill development.

#### 3.5 Availability of lodging and boarding for the patient and accompanying person at health facility

At SDH & RH out of 74, 40 (54%), respondents told that the lodging and boarding facility for the patients and accompanying person is available at the health facilities, 34 (46%), respondents told that the non availability of lodging and boarding facility for the patients and accompanying person at the health facilities. At PHC’s out of 129, 73(56.6%), respondents told that the availability of lodging and boarding facility for the patients and accompanying person is available at the health facilities. 56(43.4%), respondents told that the lodging and boarding facility for the patients and accompanying person is not available at the, health facilities. Pearson chi 2(1), test was applied, ( $X^2 =0.1225$ ,  $p= 0.726$ ), and the difference was found to be not significant.

#### 3.6 Availability of suggestion box at the health facility

At SDH & RH out of 74, 49 (66.2%), respondents said that suggestion box is available at the health facilities and, 25(33.8%), respondents said it is not available. At PHC’s out of 129, 91(70.5%), respondents told that the suggestion box is available and 38 (29.5%), respondents

told that the suggestion box is not available. The evaluation study, Common Review Mission conducted annually to look at the progress made at the health facilities. As per the report in Maharashtra state suggestion box is available at the health facilities [8].

**3.7 Availability of Funds**

**3.7.1 RKS fund, untied fund and annual maintenance grant**

Out of 203, 194(95.6%) members said that RKS fund, untied fund and annual maintenance grants are received in time and 9(4.4%), said fund is not received in time at the health facility. At health facility three funds are available under NRHM. At SDH/RH, Rupees 50,000 untied fund and Rupees 50,000 annual maintenance grant is annually available, Rupees 1 lac is annual RKS fund. At PHC Rupees 25000, untied fund, Rupees 50000, annual maintenance grant is annually available and Rupees 1 lac is annual RKS fund.

**3.7.2 Active involvement of RKS members in the preparation of Project Implementation Plan (PIP)**

At SDH and RH, out of 74, 42 (56.8%), respondents told that the RKS members are involved in the

preparation of PIP and 32(43.2%), respondents told that they are not involved in the preparation of PIP. At PHC out of 129, 96(74.4%), respondents said that RKS members are involved in the preparation of PIP, and 33(25.6%), respondents told RKS members are not involved. Pearson chi 2(1) test, was applied, ( $X^2= 6.7390$ ,  $p=0.009$ ) and the difference was found to be highly significant.

**3.8 Utilization of funds**

**3.8.1 Utilization of funds as per guidelines at the health facility**

Utilization of funds as per guidelines was reported by, (Table 2) 198 (97.5%) members and only 5(2.5%), reported funds are not utilized as per the guidelines. It was seen that 195 (96%), RKS members said there was work wise utilization of funds as per the guidelines and only 8(4%), members said there was no work wise utilization of funds at the health facilities [9]. However statistically significant difference was not seen in work wise utilization of funds at SDH/RH ( $p=0.118$ ).

**Table 2: Utilization of funds as per guidelines at health facility**

Health facility	Utilization of funds as per guidelines		Work wise utilization of funds		Difficulties in utilization of funds		Total
	Yes	No	Yes	No	Yes	No	
<b>SDH &amp; RH</b>	71 (96)	3 (4)	69 (93.2)	5 (6.8)	16 (21.6)	58 (78.4)	74
<b>PHC</b>	127 (98.4)	2 (1.6)	126 (97.7)	3 (2.3)	54 (41.9)	75(58.1)	129
<b>Total</b>	198 (97.5)	5(2.5)	195 (96)	8(4)	70 (34.5)	133(65.5)	203 (100)
<b>Statistics</b>	Fisher’s exact test, $p=0.357$ (Not significant)		Fisher’s exact test, ( $p=0.118$ , Not significant)		Pearson chi 2(1) test =8.5259, $p=0.004$ (Highly significant)		

Note: Figures in brackets indicate percentages

It is expected and mandatory to utilize the funds received judiciously under the head of allocation, any diversion from it leads to complications and difficulty may arise in settling the account [9].

At SDH, RH and PHCs 34% RKS members told that the difficulties are faced in utilization of funds while 65.5% RKS members told that the difficulties are not faced in utilization of funds. Pearson chi 2(1) test, was applied ( $X^2=8.5259$ ,  $p=0.004$ ) and the difference in observation was statistically highly significant.

**3.8.2 Submission of statement of expenditure and utilization certificate**

RKS members’ awareness was asked about regular submission of statement expenditure and utilization certificate (SOE/UC). 198(97.5%), RKS members said that the SOE/UC are regularly submitted and 5(2.5%), RKS members said that the SOE/UC not submitted regularly. Statement of Expenditure/Utilization Certificate (SOE/UC), has to be submitted quarterly to the authority with regularity and demands for further grants can be made thereafter, authorities may block or suspend the grants if timely and regularly SOE/UC not submitted

[9]. As per the CRM reports, it was observed that in various states like, Arunachal Pradesh, Maharashtra, Gujarat, Kerala, Tamil Nadu, Punjab, all facilities submitting the SOE/UC regularly [50,51]. In states like Haryana, Chhattisgarh, Bihar, Orissa, UP, MP, WB, Jharkhand, Uttarakhand, SOE/UC not regularly submitted by the health facilities [10].

**3.8.3 Audit and audit report for discussion**

Question were asked to RKS members about audit being done regularly at the health facility, out of 203, 194 (95.6%), said that audit is done regularly and only 9(4.4%), said audit is not done regularly. But by and large almost at all facilities it was done as it is mandatory and compulsory for them to audit their account as per Government guidelines [3,11].

As per the CRM report findings in states like Haryana, Chhattisgarh, Andhra Pradesh, UP, Maharashtra, Gujarat, MP, Kerala, Tamil Nadu, West Bengal and Punjab where audit done regularly as per Government guidelines [8,12]. Audit report is kept in the RKS meeting for discussion at the chosen health facilities, out of 203,185 (91.1%), members said that it was kept in the

meeting for discussion and rest said it was not kept in the meeting, that means at almost all the chosen facilities audit report was discussed in the meeting. Audit report should be discussed in the meetings, so that the financial decisions taken are as per the Government guidelines or not and can be assessed. It shows the transparent functioning of the health facilities [9].

**3.9 Factors affecting the functioning of RKS**

**3.9.1 Active participation and coordination of members in achievement of RKS objectives**

It was observed that (Table: 3), out of 203,177(87.2%), members are serious about achieving the

RKS objective and actively participates in the RKS meeting. Only 26(12.8%), members are not serious about RKS objectives and do not participates in the RKS activities. In SDH, RH and PHC total 62.1% members were not avoiding the meeting while rest of the RKS members avoided the meetings. Pearson chi 2(1), was applied, ( $X^2 = 0.0783$ ,  $p = 0.780$ ) and the difference was statistically not significant. However 81.8%, members said that no lack of coordination among the members. Pearson chi 2(1), was applied, ( $X^2 = 6.0510$ ,  $p = 0.014$ ) and the difference was found to be significant.

**Table 3: Active participation and coordination of members in achievement of RKS objectives**

Health facility	Members active participation the meetings		Members avoiding the meetings		Lack of confrontation and coordination among members		Total
	Yes	No	Yes	No	Yes	No	
SDH & RH	62(83.8)	12 (16.2)	29 (39.2)	45 (60.8)	20 (27)	54 (73)	74
PHC	115 (89.1)	14 (10.9)	48 (37.2)	81 (62.8)	17 (13.2)	112(86.8)	129
Total	177 (87.2)	26(12.8)	77 (37.9)	126(62.1)	37 (18.2)	166(81.8)	203 (100)
Statistics	Pearson chi 2(1) $X^2 = 1.2113$ , $p = 0.271$ , Not significant)		Pearson chi 2(1) ( $X^2 = 0.0783$ , $p = 0.780$ , Not significant)		Pearson chi 2(1) ( $X^2 = 6.0510$ , $p = 0.014$ , significant)		

Note: Figures in brackets indicate percentages

**3.9.2 Meetings conducted one sided**

RKS members were asked about, how the meetings are conducted. Most of the members from all facilities replied that the meetings are conducted in a democratic manner and all the members opinion is taken while taking any crucial decisions. At few places dominant, Zilla Parishad members, Panchayat samiti members take the decisions without consensus of other members; this fact was told by some members during their interaction with the investigator.

**3.9.3 Consensus on purchase process**

RKS members were asked about the consensus on purchases among the members. Most of the members from all facilities replied that there is always consensus on purchases, because decisions of purchases were taken in the RKS meetings and all members opinion is taken while decisions taken. At few places dominant, Zilla Parishad members, Panchayat Samiti members take the decisions without consensus of other members about purchases; this fact was told by some members during their interaction with investigator.

**3.9.4 Timely implementation of decisions taken in the meetings**

At SDH and RH out of 74, 60(81.1%), members said that the decisions taken in the meetings are implemented on time and 14(18.9%), members said decisions taken in the meetings are not implemented on time. At PHC's out of 129, 116 (89.9%), members said that the decisions taken in the meetings are implemented on time, and 13 (10.1%), members said decisions taken in the meetings are not implemented on time. Pearson chi

2(1) was applied ( $X^2 = 3.1877$ ,  $p = 0.074$ ) and the difference was found to be not significant.

**3.9.5 Members knowledge about the functions and funds of RKS**

At SDH and RH out of 74, 52(70.3%), members responded that they had adequate knowledge about the functions and funds, and 22(29.7%), members did not have adequately knowledge about the functions and funds. At PHC's out of 129, 98 (76%), RKS members had adequate knowledge about the functions and funds, and 31(24%), members were not adequately knowledgeable about the functions and funds, Pearson chi 2(1), was applied ( $X^2 = 0.7916$ ,  $p = 0.374$ ), and the difference was found to be not significant. Though it is not statistically significant, but 29.7% members at SDH/RH and 24% members at PHC's are did not have the adequate knowledge about the functions and funds of RKS. These members should be identified and reoriented once again about the functions and funds of RKS.

**4. Discussion**

Outreach health camps and immunization sessions organized at poorly- served, inaccessible, difficult, tribal and unreachable areas, so the peoples living in these areas should gets benefitted. At SDH/RH and PHC's health camps are organized as per norms and services provided to under privileged, poor people residing in those areas. In Maharashtra outreach health camps are organized regularly at almost all health facilities [8]. Compared with other states health facilities it was observed that, in Haryana, Gujarat, Madhya Pradesh health

camp are organized as per the need regularly at most of the health facilities [10,12]. Outreach health camps are organized infrequently and irregularly in the states of Uttar Pradesh, West Bengal, Arunachal Pradesh [10,13].

As responded by the RKS members, it was observed that, at about more than 95% of health facilities had adequate supply of essential medicines, safe drinking water, equipment maintenance and waiting room for OPD. When this observation was compared with other districts of Maharashtra it shows that adequate supply of essential medicine was not available at Satara and Gondia district, which was different observation than our study [8]. When compared to other states it was observed that at Tamil Nadu (95%) Madhya Pradesh adequate supply of medicines (83%) is available at the health facilities [8,14]. At Jharkhand and Assam, only 60% and at Jammu and Kashmir (50%) PHC's inadequate supply of medicine was found [9,19]. Regarding the availability of adequate and safe drinking water it was seen that, (100%) in Tamil Nadu, (80%), in Assam, (70%), in J&K, (67%), in MP, (65%), in Jharkhand and (58%) in UP [15,16].

In Maharashtra state equipments were well maintained at most of the facilities [8]. When compared to other states it was found that in Assam, Bihar, Orissa, UP, states where maintenance of equipments is done through untied fund and annual maintenance grant at the health facilities [14,17]. In Chhattisgarh and Jharkhand states where equipments were not well maintained at most of the health facilities, as most of untied fund and annual maintenance grant was observed unspent [10]. In Maharashtra adequate space and sitting arrangement for patients was available at the OPD of health facilities [8,18]. In Andhra Pradesh, Gujarat, Kerala, Tamil Nadu, Punjab, states adequate space with proper sitting arrangement was observed at most of the facilities [8,10].

Lodging and boarding facility was equally available at SDH/RH and PHC's 54% and 56% respectively. In Maharashtra, at most of the health facilities lodging and boarding facilities are available for indoor patients [8]. In Gujarat and Tamil Nadu states where at most of the health facilities lodging and boarding facilities for indoor patients are available [10,14]. Comparing this fact with other health facilities of other states it was observed that in states like Haryana, Assam and Andhra Pradesh, where lodging and boarding facility was not available at many facilities [8,10].

Under NRHM health facilities through RKS can take the help or tie up with the private functionaries to provide certain services otherwise not present at the facility. In the chosen district of study for public private partnership memorandum of understanding (MOU) has been signed with multispecialty hospital for providing services of Gynaecologist and Paediatrician to the

beneficiaries of one block in rural area. Services like ANC, PNC and Neonatal care are included even surgical procedures like Emergency caesarean sections are carried out by the hospital and high risk patients are referred to this hospital. It is functioning well in the study district since 2008. Doctors and paramedical staff were adequately trained in skilled based trainings at most of the health facilities in Maharashtra state [8]. Other states training status shows that satisfactory training of doctors and paramedical staff was observed in Kerala, Tamil Nadu, Andhra Pradesh [8,14]. In states like Assam, Bihar, Chhattisgarh, Jharkhand, where adequate trainings (skilled based) are not completed at most of the facilities [10,17].

Project implementation Plan (PIP) is a comprehensive plan of all the activities that to be carried out at health facility for whole year, if more RKS members are actively involved in preparation process then better inputs from the RKS members regarding welfare of patients can be made. These important inputs then incorporated in the plan and better services provided to the beneficiaries who are based on the community need [19]. The present study suggested that, as compared to SDH and RH, at PHCs more RKS members are actively involved in preparation process. According to internal evaluation reports available from planning commission of India, in different states there was no active involvement of RKS members in preparation of PIP was found [19]. In the states like, Rajasthan, Uttar Pradesh, Orissa, Jharkhand, UttaraKhand, Bihar, Chhattisgarh, Haryana, Punjab where RKS members are not involved in the PIP preparation [8,18,19].

Through untied funds and annual maintenance grant, maintenance and repair work is undertaken and in emergency untied fund can be utilized for any purpose. RKS fund is utilized for the welfare of the patients and improved facilities at the health facilities [3,11]. In Maharashtra state all these grants (untied fund, annual maintenance grant and RKS fund) are received in time at health facilities from the state health authority as observed in evaluation study conducted in the state [8]. In the states of Kerala, Tamil Nadu, Andhra Pradesh and Haryana where grants from the state authorities received in time at the health facilities [10,14]. It was found that at PHC's Panchayat Raj Members (PRI) members like Zilla Parishad (ZP) members, Panchayat Samiti (PS) members are actively involved and interferes with utilization process and not considering the actual need of the community, most financial decisions taken one sided without taking all the members into confidence.

Member's attitude was judged by asking their seriousness towards achievements of objective of RKS. Investigator while discussing functioning of RKS with the members noted that only few members aware about the

activities conducted at health facilities under RKS, like construction and expansion of hospital, disposal of biomedical waste, provision of essential medicines, safe drinking water and cleanliness, maintenance and repair of equipments, instruments and availability of suggestion box, availability of waiting hall for OPD patients, referral transport etc. However activities like outreach services, health camps, lodging and boarding facilities for the indoor patients and relatives, were not done at any facilities. Major reason for poor attention towards these activities was lack of knowledge of the RKS members. The members had a tendency to avoid meetings or made excuses not to attend meetings, frequent confrontation amongst members during meetings act as a barrier for smooth functioning, these barriers hamper the decision making process as a result decisions are not made or not implemented.

As per the Primary Evaluation of services under NRHM, Midterm Evaluation of the NRHM, conducted by Ministry of Health and Family Welfare, New Delhi and present status of reviewed through Common Review Mission, the findings of which are as follows. In Maharashtra state RKS members are participating but not aware of the RKS objectives. Needs to be reoriented [8,12]. In Haryana, Assam, Andhra Pradesh, Tamil Nadu states where members are actively participating in the meetings and are serious about the objectives of the RKS [18,19]. RKS members are not participating actively in the meetings and are not serious about the RKS objectives observed in states like, Bihar, Arunachal Pradesh and Uttar Pradesh [8,12].

CRM report shows that RKS meetings conducted in states like, Haryana, Assam, Andhra Pradesh, UP, MP, WB, TN, Kerala, Punjab are not one sided [8,18]. Sometimes at few places one sided meetings does observed in states like Gujarat, Maharashtra, Bihar, Chhattisgarh [12,18]. In states like Orissa, Arunachal Pradesh, Rajasthan, Uttarakhand, meetings are not attended by most of the members hence the decisions taken and meetings are one sided [10,20]. As per CRM report consensus on purchases was seen in the states like, Haryana, Chhattisgarh, Maharashtra, Gujarat, UP, MP, WB, TN, Kerala, Punjab [8,18]. No consensus on purchases observed in states like Assam, Bihar, Orissa, Arunachal Pradesh, Rajasthan, Uttarakhand [10,12,20]. As per the report of common review mission and evaluation study conducted at different states reveals that in the state like Maharashtra and Gujarat where delay occur in implementation of decisions taken in the meetings [8,18]. In states like Haryana, Assam, Chhattisgarh, Bihar, Arunachal Pradesh, Madhya Pradesh, West Bengal, Uttar Pradesh, Punjab, decisions taken in the meetings are not implemented in time due to shortage of manpower

[8,10,20]. No significant decisions are taken in the meeting and decisions taken not implemented in time in Rajasthan, Uttarakhand, Jharkhand states [12,18].

On comparing RKS members knowledge about the functions and funds with Haryana, Chhattisgarh, Andhra Pradesh, Kerala, Madhya Pradesh, Tamil Nadu, states, where RKS members, were adequately knowledgeable, as per the observations made by the Common review missions [8,18]. In the states of Assam, Bihar, Orissa, Arunachal Pradesh, Uttar Pradesh, Maharashtra, Gujarat, West Bengal, Punjab, UttaraKhand, Rajasthan and JharKhand members who were not adequately knowledgeable, as per the observations made by the Common review missions [10,12,20].

## 5. Conclusion

The present study concluded that, various facilities were available at SDH, RH and PHCs such as adequate supply of essential medicines, safe drinking water, equipment maintenance, suggestion box and waiting room for OPD in the selected region. Funds also have been utilized as per the guidelines at health facility and audit being done regularly as per Government guidelines. It has been seen that there was active participation and coordination of members in achievement of RKS objectives. The results of the present study reflect the satisfactory working of RKS as per government regulations and norms.

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