CHAPTER 3: COMMUNITY PARTICIPATION

3. Community involvement under the Mission

NRHM envisaged involving Panchayati Raj Institutions and the community in the management of primary health programmes and infrastructure, empowering the community to take leadership in health matters, put in place a pool of community workers and establishes institutional arrangement for community involvement in planning, management and monitoring of the Mission through setting up community based Planning and Monitoring Committees at State, district, block, PHC and village levels, Rogi Kalyan Samiti at District Hospitals, CHCs and PHCs and Village Health and Sanitation Committee in every village.

3.1 Community representation in planning and monitoring

As per the NRHM framework, every SHS was to constitute health planning and monitoring committees at village, PHC, block/CHC, district and State levels with representation from elected bodies of appropriate level, self-help groups/NGOs, user groups and government departments. 50 *per cent* of the community planning and monitoring set up was to be in place by the end of March 2007.

The Ministry constituted an Advisory Group for Community Action (AGCA) in August 2005 to develop the process of community planning and monitoring and build the capacity required. A detailed system of community planning and monitoring was started on a pilot basis in nine States viz. Tamil Nadu, Orissa, Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra and Rajasthan with the assistance of AGCA in a phase-wise manner[14].

The progress on community planning and monitoring so far made under the pilot project indicated that against the target of 1620 VHSCs, 324 PHC level committees, 108 block level committees and 36 district level committees envisaged to be operationalised in nine pilot States, only 1441 VHSCs (89 *per cent*), 173 PHCs (53 *per cent*), 34 blocks (31 *per cent*) and 12 district (33 *per cent*) level committees respectively had been set up. No committee was operational in Chhattisgarh. District and block level community monitoring committees had not been constituted in any of the selected districts and blocks in Assam, Jharkhand, Karnataka, Madhya Pradesh and Maharashtra (five States). In the absence of block level committee, other activities such as block providers' level workshop, media workshop and publishing of village report cards were also pending. Besides, Jan Sunwai at block and PHC level had not been conducted in any State, other than Maharashtra where Jan Sunwai was conducted in 13 out of 45 PHCs targeted under the pilots.

The progress on activities under community planning and monitoring made so far under the pilot project was not commensurate with targets. The target of setting up 50 *per cent* of various committees and activities by the end of March 2007 had not been achieved in any of the nine pilot States till July 2008. Review and revision of the

[14] National preparatory phase (March 2007 to May 2007), State preparatory phase (April 2007 to June 2007), Pilot implementation in the district (July 2007 to December 2007) and process documentation and review (July 2007 to January 2008)

State pilot projects was also not undertaken. Non-formation of community planning and monitoring committees at various levels adversely affected the monitoring of the programme by various stakeholders.

The Ministry stated that the process of community based monitoring and planning was by nature, a slow activity, which was acutely dependent upon capacity of the community to undertake organised and concerted action. The type of community empowerment, envisaged under NRHM, had never been attempted in any other department or programme. However, efforts were being made to accelerate the initiative so as to improve efficiency of the Mission.

However, the Ministry's correlation of delays in setting up community based planning and monitoring committees with the community's apparent inability to undertake organised and concerted action is not entirely correct. The AGCA delayed publishing manuals for (a) workshop, orientation and training of planning and monitoring committees, (b) monitoring framework and (c) management/ organisational responsibilities in respect of community monitoring until between December 2008 and March 2009. Thus the initial delays in outlining the manner of streamlining and encouraging community participation meant that no concerted effort towards this goal was made.

3.1.1 Complex design of community partnership

The framework of NRHM prescribes a multiplicity of committees at various levels details of which are as under:

Level	Name of the Committee	Membership structure
District	(i) District Health Mission	Chairman of Zilla Parishad, local MPs, MLAs, government officials and PRI and NGO representatives
	(ii) District Health Society	Governing body - District Collector, government officers and NGO representatives Executive committee - Civil Surgeon/CMO, government officials and NGO representatives
	(iii) District Health Planning and Monitoring Committee	PRIs, NGOs and government officials
	(iv) Rogi Kalyan Samiti (RKS) of District Hospital	PRIs, NGOs, CBOs and government officials Monitoring Committee under RKS - Composition not yet prescribed
Block	(i) Block Health Mission	Composition not yet prescribed
	(ii) Block Health Society	Composition not yet prescribed
	(iii) Block Health Planning and Monitoring Committee	PRIs, NGOs, CBOs and government officials
	(iv) Rogi Kalyan Samiti of the CHC	PRIs, NGOs, CBOs and government officials Monitoring Committee under RKS - Composition not yet prescribed
Village	(i) PHC Health Planning and Monitoring Committee	PRIs, NGOs, CBOs and government officials
	(ii) Rogi Kalyan Samiti of the PHC	PRIs, NGOs, CBOs and government officials Monitoring Committee under RKS - Composition not yet prescribed
	(iii) Village Health and Sanitation Committee (in each village with 1500 population)	PRIs, ANM and ASHA

Each of the committees was designed to draw their membership from nearly similar sources and was to perform two sets of functions, viz. (i) planning and monitoring, and (ii) implementation, thus creating an overlap[15].

The Ministry stated that the institutional framework of NRHM as contained in framework for implementation was prepared after due consultations with experts and all stakeholders and had been approved by the competent authority.

It is not clear as to whether this complex structure would ultimately succeed in delivering the envisaged results, since it was noticed that the multiplicity of institutions and committees at district and sub-district levels resulted in delay in their constitution at different levels. Wherever formed, these functioned with varying degrees of effectiveness (discussed in succeeding paragraphs). This could affect expeditiously achieving the goal of effective community participation.

3.2 Village Health and Sanitation Committee

A Village Health and Sanitation Committee (VHSC) was to be formed in each village within the overall framework of the Gram Sabha. The VHSC was to be responsible for village level planning and monitoring. The Ministry had set the goal of constituting VHSC in 30 *per cent* of six lakh villages by 2007 and 100 *per cent* by 2008. Every village with a population of up to 1500 was to receive an annual untied grant of up to Rs. 10,000, after constitution and orientation of the VHSC. The untied grant was to be used for household surveys, health camps, sanitation drives, revolving fund etc. The Mission envisaged setting up of a revolving fund at village level by the VHSC for providing referral and transport facilities for emergency deliveries as well as immediate financial needs for hospitalization.

Success story

Against the target of formation of VHSCs in 30 per cent villages by 2007, VHSCs were formed in all villages of Andhra Pradesh, Sikkim, Manipur, Tamil Nadu and Puducherry.

The progress towards formation of the VHSC showed the scope of improvement in the Special Focus States. In nine States/UTs, the VHSC had not been formed in any village. In Rajasthan and Uttar Pradesh the Committee was formed in less than 30 per cent of the villages. In 14 States/UTs, VHSCs were formed in 30 to 96 per cent of the villages. The State wise status is at **Annex 3.1**.

During 2006-07, untied grants of Rs. 123.62 crore was approved/released to 19 States whereas VHSCs were formed only in two States resulting in non-utilisation of Rs. 119.28 crore released to the SHSs for the VHSCs. Similarly, during 2007-08, Rs. 282.52 crore was approved/released as untied grants to the health societies of 28 States/UTs. However, no VHSCs were formed in eight States/UTs.

[15] For instance, at the block level plans were to be prepared by the Block Health Society and approved by the Block Health Mission, the task of monitoring was entrusted to the Rogi Kalyan Samiti; while Block Planning and Monitoring Committee was also required to be set up for planning and monitoring purposes.

The revolving fund was not created with VHSCs in any State, (except Sikkim and Manipur) due to delayed setting up of VHSCs and consequent delays in release of grants to them.

The Ministry stated that they had issued detailed guidelines for VHSCs approximately two years back. However, the percolation of information and its implementation had taken time.

The delay in percolation of information to the grass roots, indicated that the goal of improving the healthcare delivery by setting up health societies at the State and district levels and orienting them to work in Mission mode met with limited success.

3.3 Monitoring/validation of data by the community

In terms of the NRHM framework, a desirable outcome of the Mission was to enable the community and community based organisations to become equal partners in the planning process. The community monitoring framework could be used for validating the data collected by the ANM, Anganwadi Worker (AWW) and other functionary of the public health system. The practice of validation of data collected by the ANM, AWW etc. or monitoring of data collection process by the local community/representatives of PRIs had not been initiated in any State/ UT except A & N Islands and only partially in Rajasthan (the data was validated by PRI in 13 out of 72 tested Sub Centres).

The Ministry stated that the data collected by ANM, AWW etc. is proposed to be triangulated (compared with each other) against the other sources of information including survey reports, community reports, findings of public hearings etc. and should not be viewed as a system of community validation of data.

The concept of triangulation of data is a commendable innovation. However, the Ministry needs to encourage the development of a system for sample verification of data as an internal control to improve data integrity.

3.4 Rogi Kalyan Samities (RKS)

3.4.1 Setting up of RKS

As per the NRHM guidelines, the RKS were to be constituted and registered under the Societies Registration Act, 1860 for efficient community management of healthcare centres up to the PHC level under the Panchayati Raj framework by 2007-08. A grant of Rs. 1 lakh per PHC/CHC and Rs. 5 lakh per District Hospital was to be given to the States for PHCs/CHCs/District Hospitals, wherein RKS had actually been constituted. RKS had been authorized to retain the user fee at the institutional level for its everyday needs.

Case study: RKS in Punjab

The health centres were under the control of the Punjab Health Systems Corporation (PHSC) since October 1996. The SHS transferred Rs. 2.44 crore to PHSC (April, 2007) for further release to the RKS. However, no RKS was constituted by the PHSC on the ground that hospitals were under their control and management which was already an autonomous body constituted through a special Act. The PHSC issued instructions that amount released as corpus grant at the rate of Rs. one lakh to each CHC may be utilised by the Medical Officers in consultation with the Civil Surgeon by involving the representatives of local MLAs and Deputy Commissioners. The reply of PHSC that NRHM guidelines were merely guidelines not instructions was incorrect. Further the SHS released Rs. 3.63 crore to 484 PHCs @ Rs.75000/- each PHC with the instructions to constitute an alternate committee at PHC level i.e. PHC Management Committee headed by Senior Medical Officer/Medical Officer in-charge PHC till the RKS was constituted. The release of Rs. 2.44 crore for RKS at District Hospitals, Sub Divisional Hospitals/CHC level and Rs. 3.63 crore to 484 PHC level RKS without constitution/registration of RKS was incorrect.

The RKS was formed at every health centre in Chandigarh, Gujarat, Jammu & Kashmir, Kerala, Manipur, Mizoram, Rajasthan, Sikkim, Tamil Nadu and West Bengal. However, in Delhi and Punjab, no RKS was formed. In the remaining 21 States/UTs, the RKS was formed at 420 District Hospitals and was not formed at 29 District Hospitals of seven States/UTs. At CHC level, the Samiti was formed at 2069 CHCs and was not formed at 166 CHCs involving 10 States/UTs. The shortfall was more striking at the PHC level. While the Samiti was formed at 8514 PHCs, it was not formed at 6023 PHCs of 20 States/UTs. The State wise status of shortfall in formation of the RKS is highlighted in **Annex 3.2.**

During 2006-07, the Ministry released Rs. 92.76 crore to 15 States as grants for the RKS. However, in 11 States, Rs. 41 crore was released in excess of the requirements, which were calculated on the basis of details about the number of RKS formed and registered by the end of the financial year (details in **Annex 3.2**). This resulted in an unspent balance of Rs. 41 crore with 11 States as of August 2007.

3.4.2 Proceedings of the RKS bodies

The Governing Body and the Executive Body of the RKS were required to hold meetings on a quarterly basis and monthly basis respectively for reviewing the functioning of healthcare facilities. The RKS was to submit a monthly report to the DHS and give recommendations for improvement of the healthcare system.

Positive development

In Andhra Pradesh 6 District Hospitals, 10 CHCs and 21 PHCs made recommendations to the District Health Society (DHS). The DHS took immediate action on sanitation matters. The feedback on action taken by the DHS was communicated to the RKS in all test-checked cases.

The meetings of the RKS bodies did not take place at the prescribed/regular intervals in any State. In Assam, Puducherry (9 PHCs), Rajasthan (6 CHCs and 13 PHCs) and Karnataka (two District Hospitals), records of meetings of the RKS were not maintained. No meeting of the RKS was held in Haryana, Karnataka (one District Hospital), Lakshadweep and Manipur[16] (3

[16] At one CHC meeting was held regularly

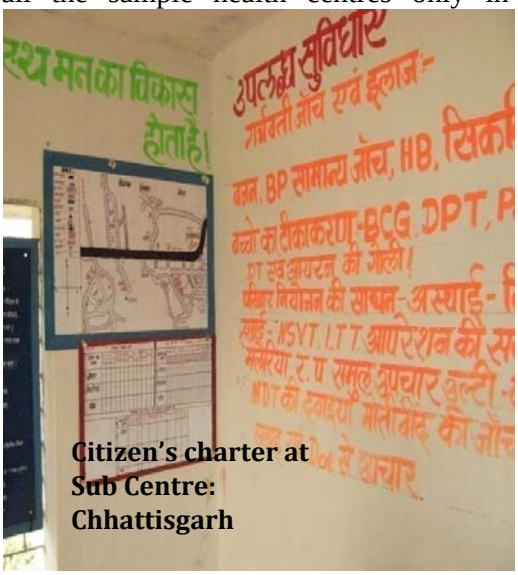
District Hospitals, 5 CHCs, 14 PHCs). In Jammu & Kashmir, Jharkhand, Kerala (RKS not registered) and Tamil Nadu, the governing body and executive body were not formed separately under the RKS.

Further, monthly reports, and hence recommendations for improvement of the healthcare system, were not sent by the RKS in most States (except Andhra Pradesh, Chhattisgarh and Rajasthan).

3.4.3 Efficacy of monitoring by RKS

The RKS was to develop and display a charter of citizens' health rights at each level of health facilities so as to make healthcare users aware of their health rights and facilities available. Compliance with the citizens' charter was to be ensured through operationalisation of a grievance redressal mechanism. A monitoring committee was to be constituted by the RKS to visit hospital wards and collect patient feedback for remedial action.

The citizens' charter was displayed at all the sample health centres only in Puducherry, Punjab, Delhi and Manipur. In Andaman & Nicobar Islands, Haryana, Himachal Pradesh, Bihar, Jharkhand, Lakshadweep, Orissa, Mizoram, Tamil Nadu, and West Bengal, the charter was not displayed in any of the audited health centres and other than in Andaman & Nicobar Islands and Tamil Nadu, the SHS had also not issued any instructions/ guidelines for the display of citizens' charter at health centres. In the remaining States/UTs, the citizens' charter was displayed at some health centres and not displayed at others. At 66 District Hospitals of 13 States/UTs, the charter was displayed but was not displayed at five District Hospitals of three States. At the CHCs, the charter was displayed at 123 centres of 15 States, while at 77 CHCs of 15 States/UTs it was missing. At the PHCs, the shortfall was quite considerable, while the charter was displayed at 178 centres of 14 States/UTs; it was not displayed at 221 PHCs of 16 States/UTs.



Citizen's charter at Sub Centre: Chhattisgarh

In Arunachal Pradesh, Sikkim and Manipur, the citizens' charter was not displayed in the local language. In Andhra Pradesh, Assam, Gujarat, Kerala, Karnataka, Jammu & Kashmir, Maharashtra, Punjab, Rajasthan, Uttar Pradesh and Uttarakhand, the citizens' charter was displayed in the local language.

Barring a few exceptions, a mechanism for redressal of the grievances of individuals and the community regarding demand/need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel at service points, denial of care and negligence was not institutionalised, nor was the reference to a grievance redressal mechanism found in the citizens' charter displayed at sample health centres in any State.

The monitoring committee was not constituted in most of the test checked Health centres where the RKS had been set up. The monitoring committee under the RKS, where formed, had neither collected feedback from the patients on presence and conduct of health care personnel nor sent any report to any authority and hence was mostly dysfunctional.

3.4.4 Levying of user charges by the RKS

The RKS was to prescribe user charges for non-BPL patients for various types of services rendered by the healthcare centres. The only condition for release of central grants to the States for the RKS was that the Samiti would levy the charges and retain the money received on account of those charges for using them as per local needs.

In Andaman & Nicobar Islands, Andhra Pradesh, Jammu & Kashmir, Puducherry, Punjab, Sikkim, Arunachal Pradesh, Tamil Nadu and Jharkhand, no user charges were collected from non-BPL patients. In Gujarat and Karnataka, the RKS of PHCs did not levy any user charges. At 6 CHCs and 19 PHCs in Rajasthan, 14 CHCs and 30 PHCs in West Bengal and 2 CHCs and 17 PHCs in Tripura, user charges were not levied.

The Samitis were authorised to retain only 50 *per cent* of the amount of user charges in Uttar Pradesh. In West Bengal, the RKS could retain 40 *per cent* of the collection of user charges in 2005-06 and 80 *per cent* of all additions to the 2005-06 level subsequently. In Lakshadweep, user charges were deposited into government account. In Bihar, all the CHCs were levying users charges at the rate of Rs one per patient instead of Rs 2 per patient as prescribed by the government.

The Ministry stated that money was provided to RKS to operationalise a transparent management structure with public participation.

However, release of the funds to States not levying user charges was not in accordance with the Framework for Implementation of the NRHM.

3.4.5 Flow of funds to the RKS

RKS at a district hospital was to receive a corpus grant of Rs. 5 lakh per year. At CHCs and PHCs, the Samiti was to receive annual corpus grant of Rs. 1 lakh each, annual untied grant of Rs. 50,000 and Rs. 25,000 respectively and annual maintenance grant of Rs. 1 lakh and Rs. 50,000 respectively as Central grants. Besides, the RKS were to receive grants from State Governments and were supposed to generate their own resources through levying user charges, receiving philanthropic donations etc. From 2007-08 onwards, the funds at RKS from three sources, viz. internal, State and Centre, were to maintain a ratio of 1:1:3.

The RKS did not receive all the three central grants every year after their constitution in any State. Further, the State/UT Governments of A & N Islands, Andhra Pradesh, Arunachal Pradesh, Haryana, Jammu & Kashmir, Maharashtra, Mizoram, Punjab, Jharkhand, Orissa, Tamil Nadu, Lakshadweep and Sikkim had neither made their contribution nor had the RKS been able to generate resources to maintain the prescribed ratio of sources of RKS funds.

In the remaining States, while the RKS had generated internal resources, chiefly through collection of user charges[17], the State government had not made any contribution to the RKSs in any State/UT other than Gujarat and Bihar. Further, there was no mechanism at the SHS to verify that the prescribed ratio of funds at RKS was adhered to.

In Bihar, the State Government released an amount of Rs 10.12 crore in December 2007 for annual grant of RKS for 84 Referral Hospitals (RH equivalent to CHC) and 470 PHCs[18] disregarding the fact that the RKS had been formed only at 44 RHs and 311 PHCs in the State as of March 2008. Further, the RKSs concerned could not receive this grant as the funds remained in the bank account of the civil surgeon and subsequently lapsed. In addition, the central fund of the RKS at the rate of Rs 1.5 lakh per PHC and Rs 2 lakh per RH (CHC) was provided to Medical Officer in-charge of three PHCs and one RH in Bihar having no RKS.

In Uttar Pradesh, Rs. 36.60 crore was released for all PHCs (3660) as corpus grants as against the eligible PHCs (only 560) in which RKS had been formed. Thus, Rs. 31 crore released to 3100 PHCs was in contravention of both the norms of financial discipline and the framework of the NRHM.

3.4.6 Utilisation of funds by the RKS

Considerable funds were with the Rogi Kalyan Samitis for their use as per local requirements. The utilisation of funds available with the RKS was, however, very low. In 16 States/UTs, 31 to 98 per cent of the funds available with the RKS remained unspent. The details are as follows:

Table 3.1: Funds utilisation by RKS in sample districts during 2005-08

(Rs. in crore)

State/UT	No. of RKS	Funds with RKS	Expenditure incurred	Unspent amount	Unspent amount as per cent of total funds
Bihar	52	1.57	0.03	1.54	**98.25**
A & N Islands	19	0.21	0.01	0.20	**97.56**
Manipur	38	0.66	0.12	0.54	**81.95**
Jharkhand	78	0.85	0.15	0.69	**81.78**
Meghalaya	98	1.98	0.55	1.43	**72.08**
D & N Haveli	1	0.20	0.09	0.11	**53.36**
Uttar Pradesh	78	2.88	1.22	1.67	**57.79**
Orissa	269	1.87	0.80	1.06	**57.05**
Jammu & Kashmir	136	1.53	0.67	0.85	**55.80**
Chhattisgarh	22	0.68	0.34	0.34	**50.17**
West Bengal	305	5.58	2.85	2.73	**48.98**
Gujarat	30	15.13	7.91	7.22	**47.73**
Maharashtra	525	6.69	4.15	2.54	**38.02**
Assam	230	6.12	3.80	2.32	**37.94**
Himachal Pradesh	14	1.96	1.29	0.67	**34.28**
Karnataka	59	9.41	6.50	2.91	**30.91**
Total	**1954**	**57.31**	**30.48**	**26.83**	**46.82**

(Source: Information provided by SHSs/DHSs/health centres)

[17] Only one RKS of Lakhimpur District in Assam has generated resources through philanthropic donations from ONGC for Rs.2.00 lakh.

[18] Only 70 RH and 398 PHCs existed in the State

Further, in Assam, Chhattisgarh, Jammu & Kashmir, Madhya Pradesh[19], Uttar Pradesh, Uttarakhand and Jharkhand the books of accounts and subsidiary records like cash book, vouchers, ledgers etc., were either not maintained or not maintained as per government accounting rules of the States. Discrepancies in expenditure by the RKS were also noticed in 13 States/UT as detailed in **Annex 3.3**.

The Rogi Kalyan Samiti, which was designed as a pro-active intervention under the Mission to ensure the goal of reliable and accountable health delivery through community ownership of the health centres was not functioning as prescribed under the NRHM framework. There were delays in setting up of the Samities and in most of the States, particularly in Special Focus States, the RKS was yet to be constituted at each health centre. Wherever established, the failure to hold prescribed number of meetings of the governing and the executive bodies affected the regular management and monitoring of the activities of the health centres by the RKS. The general performance of the health centres was not reviewed by the Samities, as the Samities did not send the reports and suggestions to higher levels for improvement of facilities and services available at health centres. The accountability structure under the RKS framework was further weakened by the non-institutionalisation of grievance redressal mechanism, non-display of citizen charters at the majority of tested health centres and non-formation of monitoring committees under the RKS.

The Ministry released RKS funds to the State Health Societies for all health centres without confirming the constitution of RKS at the health centre and authenticating the fulfilment of the condition of levy and retention of user charges by the RKS.

The Rogi Kalyan Samitis were not receiving the prescribed grants from all the sources, specially from the State Government nor were they able to generate their internal resources, other than the user charges which had been prescribed mostly by the State Government. Thus the nature of funding affected the viability of the long term goal of community ownership of the health centres through the RKS. Funds available with the RKS, mostly remained unutilised due to lack of generation of capacity within the Samiti to incur expenditure.

In response to the observations on the functioning of RKS, the Ministry stated that it had issued detailed guidelines for RKS approximately two years back. The percolation of information and its implementation had taken time. The functioning of the RKS was under the overall supervision of the State Government through the Mission Director, NRHM. It added that the Ministry conducted regular surveys to review progress and take appropriate remedial actions.

However, the Ministry's contention that the inadequacies in the functioning of the RKS was due to the inability of the State Governments to implement the Mission, needs to be seen in perspective. RKS is an innovation to encourage quality health services through community participation. The RKS was functioning within the ambit of autonomous health societies in the States and districts, receiving funds and directions from the Ministry directly, and so the Ministry had a guiding role to play.

[19] at three PHCs

3.5 Interaction with the community

Community action was to be catalysed through conducting public hearings (Jan Sunwai) or Public dialogues (Jan Samvad) which were required to be conducted at PHC, block and district levels once or twice in a year. Health camps were also to be organized to bring a range of health services to the community and make them aware of their entitlements.

Jan Sunvai/Jan Samvad was not conducted at PHC, block and district levels in most States. Only in Chhattisgarh, Gujarat, Rajasthan and Tripura were these conducted and that too not on a regular basis at each centre at every level.

Further, no health camps were organised at any level in Bihar, D & N Haveli, Daman Diu, Haryana, Himachal Pradesh, Jharkhand and Jammu & Kashmir. In Assam, Chhattisgarh, Maharashtra, Madhya Pradesh, Puducherry, Punjab, Rajasthan, Sikkim, Uttarakhand, Kerala, Lakshadweep, Manipur, Tamil Nadu, Tripura and West Bengal health camps under various disease control programmes, especially Reproductive and Child Health were organised. However, in A & N Islands, Chhattisgarh, Madhya Pradesh, Punjab, Rajasthan, Tamil Nadu and Tripura health camps were not organised regularly at the prescribed frequency at all the health centres. In Orissa and Uttar Pradesh, records relating to data on total number of camps were not maintained.

The Ministry stated that the community monitoring process had been internalised by various States and that community interactions were increasing at various levels.

However, the achievements regarding the indicators of community participation did not match the targets prescribed for these under the NRHM Framework.

Recommendations

- ***The process of community monitoring needs to be accelerated to help develop community based planning and monitoring system of health delivery/services.***
- ***The VHSC may be formed in every village as prescribed in the guidelines and funds to support the VHSCs may be released to the SHS only after receiving information on setting up of the committees.***
- ***The prescribed revolving fund may be set up with the VHSCs from the untied grants of the Sub Centre and expenditure from the same may be monitored by the ANM on a regular basis.***
- ***The RKS may be constituted with broad-based representation and registered at all the remaining health centres, so as to constructively participate in the functioning of the health centres as envisaged under the NRHM framework.***
- ***Management capacity under the RKS may be generated to ensure timely utilisation of funds available. The Ministry noted this recommendation for consideration.***