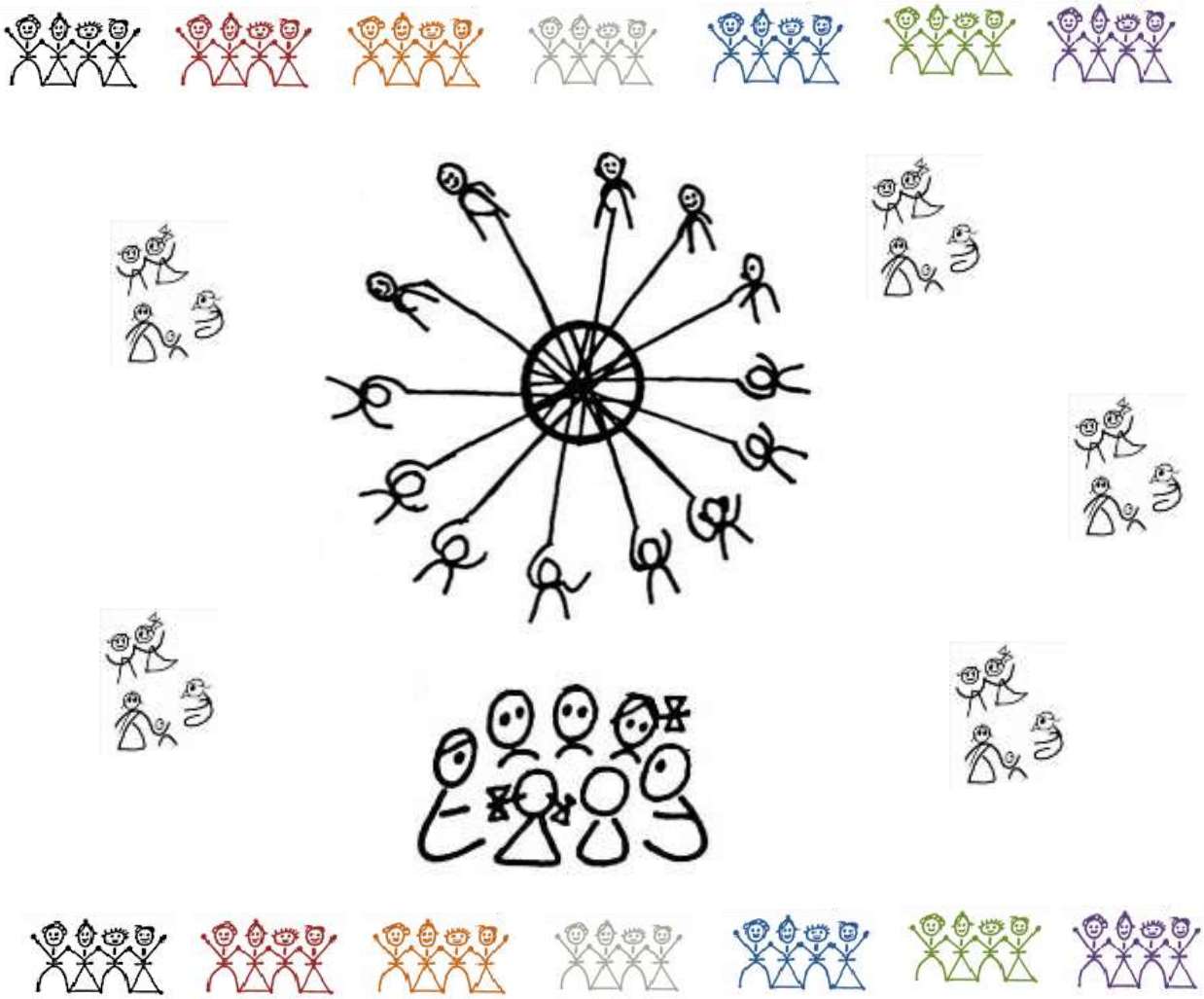
2022-23

Community Health Learning Programme

A Report on the Community Health Learning Experience

Karuna M.



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I would also like to thank the Chennai Sochara team including Ameer Khan and Suresh with whom I attended the district health assemblies and had many passionate discussions on how this can be made better.

Contents

Part A: Learnings from CHLP

Introduction

This report has three sections. Part A contains information about why I joined the fellowship, what my learning objectives were, what I learned from the course and what I plan to do in the near future

Part B is a report on a small project to strengthen the anganwadi system in a ward in Chennai.

Tamil Nadu has recently instituted a platform called 'Health Assemblies' to encourage people to voice their needs, grievances and collectively plan for what needs to be done to improve the health of the population. I attended some of the district meetings organised by Makkal Nalvazhvu Iyakkam to mobilize civil society organisations to participate in this initiative. Part C contains a brief report based on the few district health assemblies that I attended.

Why did I join the fellowship

I have been working in the development sector for some time; working on issues relating to right to food, employment and information. I have also been interested in health and have done some work earlier but have not done any health related course. Since I plan to spend more of my time on health issues, I wanted to get a deeper understanding of health and hence joined the fellowship.

What were my learning objectives and were they met?

My learning objectives were

1) To understand community health approach to addressing health issues
2) To understand 'Right to Health and Health Care'
3) To develop skills that enable community work including self-awareness, reflection, analysis, and communication

Yes, I have a better understanding of the community health approach and the right to health and health care and this would be useful in my work. I have become aware of the necessity to reflect more on what I read, listen and do and I also plan to reach out to more people through writing.

Learning from modules and how I applied the learning in my work

The key thing that I learnt from CHLP is the use of 'reflection' as a tool to learn. One does not become wise by just gathering more data and information. One has to interpret the facts based on personal experience and then consciously think about what it means. This is a skill I will take forward in my work.

While I do spend a lot of time reading articles, in future I have decided to consciously reflect on what I have read before moving to the next article. I also plan to write regularly (at least 300 words a day) on health and share it with others.

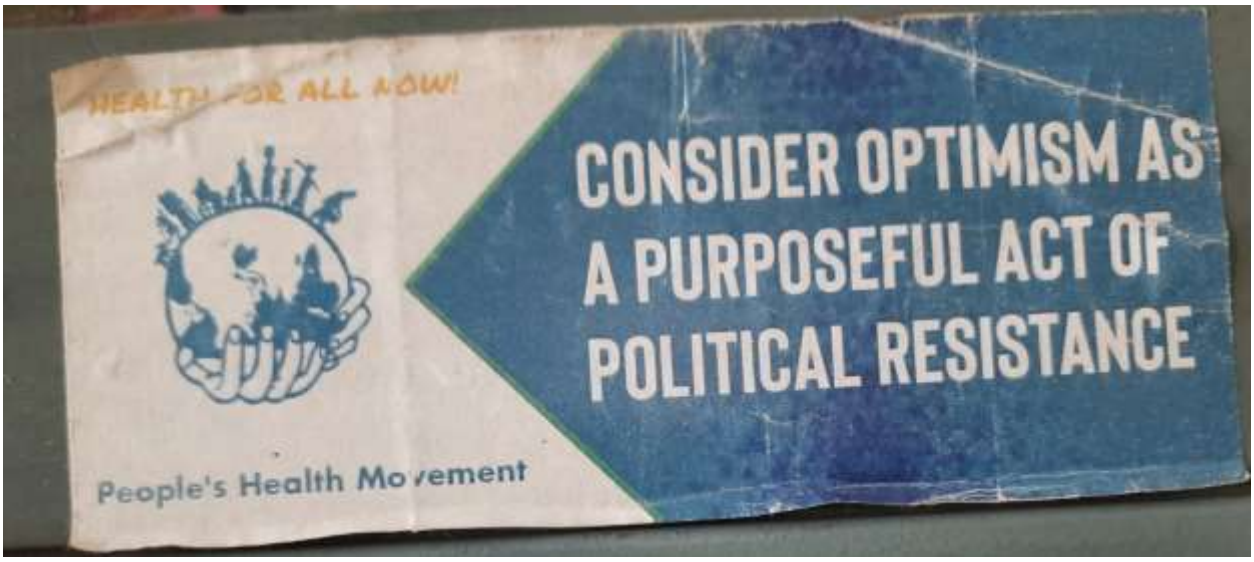
Reflections on the use of LMS, videos and participation in live online sessions

The Learning Management System was good but I did not use most of the features in it. I used it mostly as a website to look up the material that I needed to go through. For this purpose, actually an email with all the list of material (with links to files in drive and video links in vimeo) for each week would have also served the purpose. Video lectures were good in that it helped us prepare for the class ahead of time. The participation in the live online sessions could have been better. I did most of the individual

assignments but the group assignments was difficult to do. All the fellows were quite busy and found it difficult to meet for additional sessions in between the two classes every week.

Mentorship process and reflections

CHLP's idea of providing individual mentorship to each of the fellows is a good idea. I am happy to have been mentored by Dr. Thelma Narayan who not only has a lot of experience in community health but is also one of the architects of the CHLP programme. She was very gentle and encouraging and spent adequate time with me answering my questions and pointing me to other work that has been done before. From her, I have learnt to appreciate the small improvements/wins that we encounter and to be more optimistic and her enthusiasm was infectious. After she pointed out that my documentation of the health assemblies will be of help to others and help to advance community participation in other places, I began to be more interested in this process. As they say in CHLP, once you come in, you can never leave this network. Similarly, I hope to have a lifelong friendship with Thelma.



Project Learning Experience

The project was certainly the more difficult part of the course. It required meeting different people, gaining their trust and cooperation to do a joint activity. This is especially challenging when the community includes government employees as they are quite wary of working with other personnel or sharing information about deficiencies in the system.

Take away from CHLP and Looking ahead – Where do I go from here?

I feel that I was not able to give as much time to the course material as I would have liked. However, I plan to download all the material (there is some uncertainty over whether the course material would be available in the LMS itself after the completion of the course) and plan to systematically go through them especially the material that I found interesting and the material that will be useful for my work.

The project work was quite intense and I plan to follow up on that to see how to strengthen the anganwadis in ward 135 and more broadly in all anganwadis in Chennai. I will try to see if some form of

the score cards that I tried here could be institutionalized for all anganwadis in Tamil Nadu. My friends in Indus Action tell me that they have some funds to work on addressing malnutrition. I plan to work with them to develop a proposal that can be implemented maybe in Sittilingi (a rural tribal panchayat in Dharmapuri District which has many good people working on areas including health, livelihood and education, but they have not looked at the anganwadis. The current Panchayat President is a nurse from the Tribal Health Initiative and she is enthusiastic about this work).

Health Assembly - I think this has good potential to build a responsive and improved health system and I plan to work on participating and documenting this at all levels (village, block, district and state) in the next year.

Universal Health Care – A 'Right to Healthcare' Act would greatly help improve the access and quality of the healthcare to all in Tamil Nadu. While the government was initially enthusiastic, they have now gone back on the back foot saying 'We do not want to be under any obligation'. A sustained campaign for this is required and I plan to work on this.

Tamil Course – I would like to design a course similar to CHLP for health activists in Tamil Nadu. It will be for shorter time, will have simpler material (like the three page pamphlet on 'Preventing Suicide' prepared by the Illinois Department of Public Health) and the cost for running such a course should be low (can be done in an online manner and then have a confluence in the end for a couple of days).

Part B: Strengthening Anganwadis in a Chennai ward

Anganwadi Introduction

The Integrated Child Development Service (ICDS) was started in 1975 and is a centrally sponsored scheme. It caters to children in the age group 6 months – 6 years and pregnant women and lactating mothers. In Tamil Nadu, a total of 54,439 centers [1] are functional and the total annual budget is 2702 crores [2]. The six services that are provided to the beneficiaries are supplementary nutrition, immunization, health check-up, referral services, pre-school education and nutrition and health education.

Children from 3 to 6 are supposed to go to anganwadis, but in TN they take children from 2 years onwards. Since pre-kindergarten options are available in both public and private schools, most parents enroll their children in them once the children reach 3.5 to 4 years. Hence, in practice most children in the AWCs are in the age group of 2 – 4 years.

ICDS in Tamil Nadu is run fairly well compared to many other states [3]. In Tamil Nadu, in addition to supplementary nutrition and hot-cooked meal, children are provided 3 eggs a week, anganwadi workers are paid more than the amount recommended by the central government, the quality of services provided in the centers is high. However, there are significant issues which are listed in the next section.

Common Issues

There are many vacancies in the anganwadi centers. For instance, there are 22 vacant AWW positions (out of 99) and 26 vacant AWH positions (out of 99) in one block (Ashok Nagar in Chennai). In addition, there is corruption and delay in the appointment of anganwadi workers [4]. A recent research study supported by Government of Tamil Nadu suggests that adding an extra half-time worker to each anganwadi doubled the pre-school education time received by children and led to increase in math and language scores and also lower rates of stunting and malnutrition [5]. From this, one can infer that vacant positions will have a big negative impact on the key objectives of the programme.

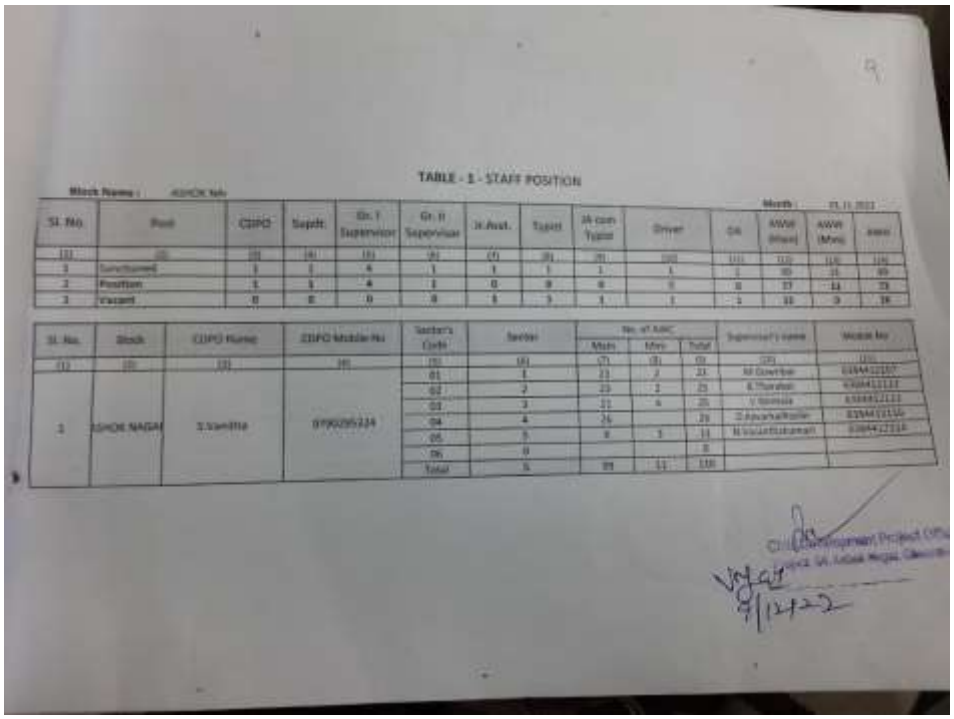


TABLE - 1 - STAFF POSITION

Block Name : ASHOK NAGAR

Month : 21.11.2022

Sl. No.	Post	CDPO	Supdt.	Gr. I Supervisor	Gr. II Supervisor	Jr.Asst.	Typist	Jr.com Typist	Driver	DA	AWW (Main)	AWW (Mini)	AWH
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
1	Sanctioned	1	1	4	1	1	1	1	1	1	95	21	95
2	Position	1	1	4	1	0	0	0	0	0	77	14	73
3	Vacant	0	0	0	0	1	1	1	1	1	18	7	22

Sl. No.	Block	CDPO Name	CDPO Mobile No	Sector's Code	Sector	No. of AWC			Supervisor's name	Mobile No
						Main	Mini	Total		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
1	ASHOK NAGAR	S.Vanitha	9790295224	01	1	23	2	25	M.Chandran	9384622207
				02	2	23	2	25	K.Thanalakshmi	9384611113
				03	3	21	4	25	T.Vanitha	9384611113
				04	4	24		24	[illegible]	9384611130
				05	5	8	3	11	[illegible]	9384622218
				06	0			0		
				Total	5	99	11	110		

Anganwadis are supposed to have an Anganwadi Level Monitoring and Support Committee (ALMSC) that will meet on a monthly basis. Guidelines on this have been issued by the center [6] and state [7]. However, this committee is not functional.

A common issue noted by many is that the anganwadi workers have too many registers to maintain [3]. The issue has become much worse now. Not only do they have to maintain the registers, but they also have to enter data in 'Monthly Progress Report' maintained by the WCD Ministry, enter data in the POSHAN Tracker [8] and also enter data in another application 'TN-ICDS' created by the state ICDS department. Common problems faced by the workers include bugs in the application, application downtime, poor connectivity, calls from project office to correct data etc. In addition to this, the department has stopped giving registers and the workers have to buy books on their own. These issues hugely detract from the core work they have to do.

Because of shortage of workers, some of the workers have been given additional charge of another anganwadi which means that they have to enter two sets of data which doubles their work.

Anganwadi workers are also routinely given other works. Currently, each anganwadi worker has to collect aadhar numbers of all the voters in her area as the government wants to link each voter's aadhar number with their voter ID. Some of workers are also asked to login to another app and enter this data.

Flexi fund of Rs 1000 per anganwadi was given to each anganwadi to meet out small expenses but that has been stopped since 2017. An annual maintenance grant of Rs 3000 is given, but only to 80% of the anganwadis.

Starting a new anganwadi can be done only in locations which have been constructed with all the requisite permissions. To get around this, the MLA from Virugambakkam is actually paying rent from his funds for two anganwadis which are running in a building without the requisite permissions. Such solutions should be found for other places or relaxation should be given for the criterion.

Data discrepancy

According to NFHS-5, a quarter of children are stunted and 22% of are underweight. Most children who come to anganwadis are from poor family backgrounds and it is expected that the percentage of underweight and stunted children among this group will be higher. However, according to the department data, the number of underweight or stunted children is much less.

Data Source	Stunted (%)	Underweight (%)
ICDS Nov 22 MPR for Ashok Nagar Project	1	2
POSHAN Tracker [2]	22	12
NFHS-5 (2019-21)	25	22
NFHS-4 (2016)	27	24
Performance Budget Note	-	5

Many of the weighing machines are not working and it is not clear that actual weight readings are taken every month.

The infrastructure is in poor condition in most places but this is also not reflected in the official documents. For instance, the monthly progress report for Ashok Nagar project says that all anganwadis have water and toilet facilities even though most do not actually have it.

Issues in anganwadis in ward 135

There are sixteen centers, but in practice there are only twelve physical places. Four of the centers have two anganwadis running in the same place. In two of the centers, there are two teachers handling two classes in the same room, while in the other two centers, it is one teacher who is handling the two centers. Not having a separate place for the anganwadi adversely affects all aspects of the functioning of the centers.

As per the register, the number of children who come to all the twelve anganwadis is only 149. In practice, the daily attendance is much lower. There are many reasons why the attendance is poor.

Some of the anganwadis are not close to the areas they serve. For example, the people in Bajanai Koil Street have to cross a very busy road to come to their anganwadi in Pudur. Two anganwadis were functioning in Kanniyappa Nagar School which is close to the area they serve. These anganwadis were merged with others due to construction work in the school. Now, the work is over, but the school is not giving the previous space. Ambedkar Colony (next to Udhayam Nagar) is too far away from its anganwadi # 401. The anganwadi helper takes an auto every day to bring children from the colony to the center.

The status of infrastructure of the anganwadis (water, drinking water, toilet facility, building status, cleanliness of the surrounding area etc.) is very poor. Parents do not have confidence that their children will be safe and be taken care of well in such an environment.

The Chennai Corporation public schools and private schools are running kindergarten schools and many parents think that they quality of education they receive there is better and are sending their children there.

Toilets in the ICDS Project Office

There were four anganwadis functioning in a complex at the intersection of 16th Avenue & 77th Street. Two of the rooms were taken for the office of the CDPO. Now, four anganwadis are functioning in two rooms. The toilets are not functional in these centers and children have to go outside. There was one toilet in the CDPO's office that was functioning but even that has backflow now and the staff in the CDPO's office have asked the Anganwadi workers and Anganwadi helpers to not use this. So, they have to use the security person's toilet in neighbouring buildings but are now facing resistance from the apartment owners.

This problem has been going on for nearly three years and in spite of multiple complaints and follow up, the problem has not been addressed yet.

Anganwadis in Ward 135, Chennai

There are two hundred wards in Chennai and ward 135 (comprising Ashok Nagar) is one of them. After a gap of ten years, elections were held in the local bodies of Tamil Nadu and new councillors were elected for each ward in Chennai. Out of 200 wards, seats for women were reserved in 100 wards. The councillor for 135 ward is Ms. Yazhini who belongs to the Viduthalai Siruthaigal Katchi. Being a mother and aware of the importance of anganwadis to the nutritional well-being of young children, she has submitted proposals for the improvement of many anganwadis in the zonal council (Chennai has fifteen zones and

each zone has a council comprising of all elected ward councillors in that zone). However, she has not received approval for any of the projects from the Chennai Corporation due to lack of funds.

Theory of Change

Even though anganwadis have been functioning since 1975, the % of malnourished children in India and Tamil Nadu is quite high.

In 2018-19 [9], ISO grading and accreditation of 128 anganwadis in 32 districts (4 in each) was done and an amount of Rs 32.80 lakh was spent. To do this for all anganwadis will take a long time. It is not how clear much was spent on the certification cost and how much was to make the anganwadi ready for certification. Also, it looks like this was abandoned after one year.

If the community is aware of the services that should be provided to them and are involved in actively monitoring the functioning of the system, then it is likely that this will improve the performance.

Social audit of ICDS centers has been done very sporadically even though it has been shown to have a significant improvement in the functioning of the system. To do social audit would require support from the department and that is usually not given readily though all policy documents say that social audit should be done.

What we have done instead is to use the ALMSC mechanism that is already available (though with significant limitations such as the composition of the committee, lack of training, funds etc.) to see if that can be used to identify and address some of the issues in the functioning of the anganwadi system.

Objective of work

To document current status of anganwadis in ward 135

To give voice to the anganwadi workers & visibility to their issues; this could lead to some of the issues they face being addressed and improved functioning of the anganwadis

Score Cards

In Kerala, the Women and Child Development department devised a system to rate all the anganwadis in the state based on 26 factors including basic infrastructure, cleanliness, maintenance of registers, quality of pre-school education, community participation etc [10]. Using this system, they rated all the 33115 anganwadis in the state – 56 % received A grade, 39% received B grade, 5 % received C grade and 0.2 % received D grade. Apart from giving the status of all anganwadis in the state, this system enables anyone to understand the current status of a particular anganwadi and what needs to be done to improve it.

We decided to try a similar grading exercise in the anganwadis in ward 135 with some modifications. Two score cards were designed (Support Score Card and Monitoring Score Card – included in the appendix) and instead of the supervisor doing the grading as in Kerala, the anganwadi level monitoring and support committee did the grading. The 'Support Score Card' had eleven parameters each of which was to be graded according to whether the parameter is good (Green), needs improvement (Orange) or Poor (Red). Allocation of marks was done as follows – Green: 2 marks, orange: 1 mark and red: 0 mark. The marks for all the 11 parameters were added and then the overall grades for both the support and monitoring score cards were determined as given in the table below

Marks	**Grade**
>= 80	A
>= 60 and < 80	B
>= 40 and < 60	C
< 40	D

Process followed

It was decided that instead of having individual ALMS Committees for each anganwadi, there will be one committee for a cluster of anganwadis. Accordingly, 5 clusters were formed.

Initially, it was thought that the Councillor will nominate self-help group members from among the active self-help groups that she was aware of. An orientation session was held for 15 of these members but there were many issues with this approach. The houses of these members were far from most of the anganwadis, they would require some training and they also had questions about what is in this for them. Hence it was decided that the anganwadi workers would themselves decide who the committee members would be (as was the practice before). The anganwadi workers were requested to decide on a day which would be convenient for them for the first meeting. The meetings were held on the following dates.

Date	**Location**	**List of anganwadis**
19 Dec 2022	402	401, 402, 403, 404
20 Dec 2022	421	407, 408, 409, 421
22 Dec 2022	222	221, 222, 223, 224
26 Dec 2022	320	320, 319
28 Dec 2022	423	422, 423, 424

ALMSC Meeting

After a round of self-introduction, a short introduction on the committee and its mandate was shared. The two score cards (with explanation on how to use it) was given to all the committee members. Each of the parameters was discussed. The anganwadi worker filled the support grade card with the input of the other committee members.

The committee members are selected by the anganwadi worker herself and many of them are people who have a friendly disposition to the anganwadi worker. These people have difficulty in monitoring the performance of the anganwadi and being critical about its performance. A few people did mention that the anganwadis are not clean, that they open late and there are toilet and water issues. Parents with young children cannot spend too much time at the meeting. Hence while we went through the questions in the monitoring score card, it was difficult to actually do the grading for each of the parameters. A better approach would be to have an animator interact with individual beneficiaries filling a 'Citizen Report Card' and/or have a focus group discussion with the beneficiaries (easier to do this in a rural area) and then present the results in the ALMSC meeting for discussion. This was not done.

Flexi Fund

GoI has sanctioned Rs 1000 / year for each AWC [11]. Tamil Nadu government has been issuing this but for some reason this was stopped after 2016-17 [12]. To find out whether this amount is required and how it will be used, we did a small experiment – we gave 1000 Rs to each of the centers and asked them to buy whatever is required. Many of them made purchases which address some of the small issues they have had for some time. Based on this, it is recommended that the GoTN allocate the flexi fund to each AWC every year.

Results

In the table below, we give information for the Support Score Card for each anganwadi - total marks obtained (maximum of 100), the grade (A, B, C or D) along with the main issues. It can be see out of 12 anganwadi centers, only one is in the B grade. eight have received C grade and three have received D grade, the lowest possible. Clearly, the situation of the anganwadis is quite poor and lot of work needs to be done to improve them.

Support Score Card Marks, Grade and Main Issues

Anganwadi Number	Marks	Grade	Main Issues
221 & 224 (mini)	45	C	Water, Weighing Machine, Building repair, wall painting, floor and kitchen repair, drinking water
222 & 223 (other ward)	50	C	Floor repair, Water, Toilet repair, Open window, Wall painting
319	36	D	Water, unclean surroundings, fence required, garbage needs to be removed every month, electricity connection, weighing machine, FAN, black board
320	41	C	Motor repair, fence, steps in the entrance, water dripping in the middle of the anganwadi when it rains, weighing machine
401 & 404	23	D	Toilet not working, full reimbursement of cylinder cost, UHN visit, unclean surroundings, expenses reimbursement on time, weighing machine, build floor outside, need additional center
402 & 403	27	D	Toilet not working, weighing machine, UHN visit, build floor outside, full reimbursement of cylinder cost, periodic cleaning, need additional center
408	68	B	Water & Drinking water, bureau, wash basin, wall painting, unclean surroundings, weighing machine
409	45	C	Toilet pipe broken, kitchen repair, bent light pole in the front needs to be removed, stove, cooker, floor is broken, rat menace, bureau doors, water leak, water stagnation in floor
407 & 421	55	C	Water (motor repair), water seepage in kitchen, bureau for storing items
422	41	C	Roof repair, toilet repair, drinking water, weighing machine, play material for children
423	41	C	Roof is in bad shape and rain water seeps in, need stairs in the entrance, block in sewage pipe, block in sewage pipe, need wall paintings, need to add soil outside to raise height
424	41	C	Roof is in bad shape and rain water seeps in, window, door, & bureau doors are broken, Rat menace, block in sewage pipe, need stairs in the entrance

In the table below, for each parameter, we give the number of anganwadis that have received green orange and red and this table is sorted by values in the red column.

Some of the issues can be fixed with less cost (like cleanliness, bore well motor repair) but some of the others like building condition will require funds to fix. But, surely the corporation should be able to find funds to fix these issues. It is clearly unacceptable for young children from disadvantaged background in Chennai to not have access to a safe and clean anganwadi with drinking water and a functional toilet.

Parameter wise scoring

S No	Parameter	Green	Orange	Red
1	Surrounding Cleanliness	1	1	10
2	Building Condition	0	3	9
3	Safety aspects (floor, fence, stairs)	2	2	8
4	Toilet	0	6	6
5	Doors, windows, floors, cooking shelf, bureau	1	5	6
6	Drinking Water	2	5	5
7	Separate Center	7	0	5
8	Water	6	2	4
9	Cooking utensils, plates, tumblers, buckets, weighing machine, pre-school educational material and toys	0	8	4
10	Cooperation from health department	10	0	2
11	Cooperation from CDPO office	11	1	0

The sad part is that some of the buildings were constructed only about 10-15 years ago and their condition has become so bad. This shows that they were not built properly in the first place.

Related Issues

In two of the centers (4 anganwadis actually – 401,402,403,404), the anganwadi workers said that it's been more than a year since the Urban Health Nurse visited. We visited the PHC to find out the reasons The PHC doctor herself was quite supportive pointing out the issues she faces – lack of staff, water leakage in monsoon time, lack of scan machine etc. While doing a TB detection camp, she said that the sewage blockages are causing many serious health problems and they need to be addressed immediately. We wrote a letter (included in Annexure 2) to be given to the Chennai Corporation Commissioner.

While interacting with SHG women about ALMSC, they mentioned many of their other problems – the service in one of the PDS shops is poor and that people do not get their full entitlements, that water and sewage stagnation is a big problem and that no action is being taken on this in spite of repeated complaints.

We met an anganwadi helper whose daughter has TB in her neck and got treated in a private hospital. The insurance card given to anganwadi workers did not work and she had to borrow 1 lakh Rs (at 84% interest rate) for the treatment. The helper does not have confidence in the treatment provided at the private hospitals based on her experience with her father and sister both of whom passed away. We informed the PHC doctor who asked the RNTCP nurse to follow up. But since the treatment is nearly complete now, the helper was not interested in taking the RNTCP's help.

Learning and Reflection

The objective of the project changed from when it was initially planned. Initially, more focus was to be on monitoring the performance of the anganwadi through the ALMSC, to find out whether there are people in uncovered areas (each anganwadi has been allocated specific areas but all areas of the ward are not covered), whether there are people in the covered areas who have been left out because they are not aware. However, this was a difficult task for different reasons. The quantum of work required for this is high and would require a lot more time. This might have been possible for a single anganwadi, but there was value to treating the ward as a unit and looking at all anganwadis in the ward rather than a single one.

Monitoring through the ALMSC would involve careful selection of committee members which was difficult. In New Delhi, the government issued an advertisement in newspaper and social media seeking volunteers for the ALMSC [13]. More than 6000 people responded. We reached out to Mobile Creche in Delhi to find out more about this initiative but did not hear back.

We reached out multiple times to 'Hand In Hand' a big NGO working across Tamil Nadu in many different areas. But, they were busy and did not respond. They actually run mobile clinics in one area 'Rani Anna Nagar' from which many children attend 3 of the anganwadis. One of the

ALMSC itself as designed today cannot do the monitoring. To really monitor the performance of an anganwadi would require a paid facilitator who will do all the background work (check with beneficiaries whether they are receiving their entitlements, whether the anganwadi is open on all days, whether they have any suggestions for improvement etc.) and then present the findings in an ALMSC meeting.

In the 'Support Score Card', the parameter relating to cooperation from CDPO office can be removed as almost all of them said it is good. It's partly because they do not have major complaints but they also recognize that there is a staff shortage in the CDPO itself.

Anganwadi workers do not have voice. They are paid low wages. Their issues are not addressed. There is a huge cost to the push towards digitalization that is not considered.

Recommendations to the councillor

Since the cleanliness of the anganwadi has been flagged as a major issue by 10 of the 11 anganwadis, request the sanitation wing to clean the surroundings of each Anganwadi at least once a month as was the practice before.

For infrastructure issues, request the engineer to look at the anganwadis and prepare the required budget for repair and maintenance. Major issues include

1) borewell motor repair
2) water leaks from roof
3) non-functional toilets
4) door, window and floor repair
5) rat menace

Take steps to address the longstanding toilet issue in the 16th Avenue and 77th Street anganwadi complex.

Find out why work has not started in anganwadi number 421 for which administrative sanction was given last year.

Look for rental spaces to run anganwadi centers in underserved areas such as Bajanai Koil Street

Talk to the school in Kaniappan Nagar and request them to give back the rooms where anganwadis were functional before.

Ensure that none of the anganwadis are merged in the ward. The CDPO had said they have already sent requests for this. This would mean that there will be only one anganwadi instead of two.

Explore creating a mechanism for collecting complaints regularly from the anganwadi centers. Maybe the AWW or the ALMSC member can call '104' (Chennai corporation complaint number) and register a complaint?

Follow up work

After writing up this report, I went and visited the councillor and talked to some of the anganwadi workers. I came to know that four anganwadis in the ward had been closed (they refer to it as merge). A cycle of poor infrastructure, poor quality will lead to people losing interest and dropping out. It is a vicious cycle that needs to be broken.

I talked to the councillor and she immediately called the Urbaser (the company in charge of waste management in Chennai) supervisor and requested him to send someone to clean the external surroundings of all anganwadis at least once a month.

When she asked the corporation officials regarding the proposals she had submitted earlier this year, they said they do not have any funds for anganwadis and that she can use her ward development funds to address the issues. She has a budget of 35 lakhs/year for building infrastructure and 10 lakhs/year for maintenance but that she has run out of the funds this year. She said she will use the funds for the next year to address all the issues. She called the contractor and requested him to visit all the anganwadis and prepare a budget for the work that will be required.

She also agreed to go meet the Chennai Commissioner and ICDS Commissioner to talk about these issues. She was also open to talking to the press about the issues and highlighting the effort that we did here which we plan to do.

I have also received calls from the CDPO asking about the follow up work and I plan to meet all of them shortly and take this forward in some meaningful way.

Recommendations to the Social Welfare Department

The performance budget document which is hosted in the TN government website should list the total sanctioned posts, filled posts and vacant posts for all levels. It should also list the actual number of physical centers that are operational (Currently, it says there are 54,439 centers, but since many of these have to share space with another center, the total number of physical centers is less)

All vacancies should be filled immediately in a transparent and fair process. Corruption in this has to be addressed.

As recommended by the research supported by Tamil Nadu Government [5], additional part-time workers should be placed in all anganwadis.

The school education department in Tamil Nadu has made a big push towards ensuring people's participation by reviving the School Management Committee, training all members and ensuring that the meetings happen every month. They have also collected information about the support required in each school and calculated the amount (Rs. 68 thousand crores) that would be required to fulfil this. A similar effort is required for the anganwadis also. ALMSC should be formed in all anganwadis. The government should support this – select good volunteers, supply registers to record minutes, sanction an amount for the tea/coffee.

Social Audit of anganwadis should be done at least in a certain % of anganwadis to identify common issues as it has been shown to improve the performance in rigorous studies.

Steps should be taken to increase the involvement of elected representatives. For this a website should be created listing all anganwadis in each area along with staff position, requirements etc. This information should also be printed and distributed widely.

A card (like a bank account passbook or MGNREGS Job Card or ration card) which has space for recording the entitlements given by the provider (AWW or AWH) should be given to all beneficiaries. The AWW should also record the weight and height of the child along with plotting the values in a height-weight chart so that the parent knows where their child is.

Flexi fund of Rs 1000 / month should be given to all AWWs.

The amount for repair and maintenance needs to be increased and should be given to all anganwadis.

Positions with significant slum population and rural areas where an AWC is not present should be identified and AWCs should be created.

Monthly or fortnightly entitlements should be specified rather than the current practice of specifying daily entitlement. Thus, instead of 165 gm/day (works out to 4.125 kgs/25 days – the amount distributed in a month), the amount / month should be specified. It could be either 4 kgs or 4.2 kgs or even 4.125 kgs. This should be distributed in two equal bags which is easier for people to understand and help them to demand their entitlement.

Steps should be taken to reduce the amount of work that the anganwadi workers. In particular, work time studies should be done to see how much time they have to spend on data entry in different applications and see how this can be reduced.

The Anganwadi workers should be reimbursed the full cost of the cylinders. Currently, they are plaid only Rs 400 (but they actually buy the cylinder for Rs 1100). On average, most centers buy four cylinders in a year.

Annexures

Annexure 1: Score Cards

Introduction to score cards

ALMSC has two key words in it – monitoring and support. Both of these are two different functions and we have designed two separate cards for these - Support Score Card and Monitoring Score Card.

The support score card contains parameters which evaluate the support that the AWW and AWH require from others including the Supervisor, CDPO, local administration, health department etc.

Monitoring Card contains parameters to monitor the functioning of the Anganwadi services and the AWW or the Supervisor should not be involved in filling this. One or more of the ALMSC members should have talked to few parents, pregnant and lactating women before the meeting. They should also go through some of the registers and ask any clarify any questions they have with the anganwadi worker.

After filling this card, there should be a conversation between the AWW, Supervisor and the others in the ALMSC team about what can be done to improve the situation.

For questions requiring a yes or no as an answer, only Green (yes) and Red (no) should be used. For other questions, Green, Orange or Red should be used. In terms of points, Green shall be worth 2 points, Orange shall be worth 1 point and Red shall be worth 0 points. The score for both sheets should be converted to 100 and graded as below

Score is greater than 80	A grade
Score is greater than 60 and less than or equal to 80	B grade
Score is greater than 40 and less than or equal to 60	C grade
Score is less than or equal to 40	D grade

Centre Data

Date	
Centre Number	
AWW Status	Present / On Leave Full time / Additional responsibility
AWH Name	Present / On Leave Full time / Additional responsibility
AWW Name	
AWH Name	
Supervisor Name	

Important issues / Suggestions

Support Score Card

Total Marks	Total Marks out of 100	Support Score Card

Monitoring Score Card

Total Marks	Total Marks out of 100	Support Score Card

Guide for filling Support Score Card

S No	Indicator	How to Grade?
1	Does Anganwadi have a separate center that is not shared?	Green – Yes Red - No
2	Overall Building Condition (whether any water leaks, whether there are any structural issues, any wall painting required)?	Green – Good state; no changes required Orange – Minor repairs are required Red – Major repairs are required
3	Status of doors, windows, floors, shelves, kitchen counter, wash basin	Green – Good state; no changes required Orange – Minor repairs are required Red – Major repairs are required
4	Does anganwadi have bureau for storing material? Does it have adequate kitchen utensils, plates, tumblers, buckets, weighing scales, adequate learning & educational material and toys?	Green – Good Orange – Satisfactory Red - Poor
5	Water	Green – piped water supply to kitchen, toilet Orange - water source close by Red – difficult to get water
6	Drinking Water	Green – water filter is available Orange – water source close by Red – difficult to get good quality drinking water
7	Toilets	Green – child-friendly toilet, in working condition, with piped water supply Orange – functional but improvement needed Red – non-functional toilet
8	Safety aspects (steps, floor, fence etc)	Green – safe Orange – minor changes required Red – not safe
9	Cleanliness of surrounding area, fence, gate, steps etc.	Green – good Orange – satisfactory Red – poor
10	Cooperation from the health department (UHN attends VHND, provide list of pregnant women, good response to referrals)	Green – good Orange – satisfactory Red – Poor
11	Support from CDPO (salary on time, leave sanction, reimbursement of bills etc.)	Green – good Orange – satisfactory Red – Poor

Guide for filling Monitoring Score Card

S No	Indicator	How to grade
1	Anganwadi Timings	Green – Centre starts on time and closes on time Orange – Centre starts late and/or closes early often Red – Starts late and/or closes early regularly
2	Anganwadi Regularity	Green – Centre is open six days a week Orange – Centre was not open on few days Red – Centre is closed often
3	Height and weight measurement of children who come to Anganwadi	Green – Done for all children Orange – Not done for few children Red – Not done for most children
4	Height and weight measurement of children who do not come to anganwadi	Green – Done for all children Orange – Not done for few children Red – Not done for most children
5	Distribution of take home rations & eggs	Green – All eligible people received it Orange – Few people did not receive it Red – Many eligible people did not receive it
6	Quality and quantity of food in the anganwadi	Green – Good Orange – Satisfactory Red - Poor
7	Cleanliness of the anganwadi & safety	Green – Good Orange – Satisfactory Red - Poor
8	Quality of pre-school education	Green – Good Orange – Satisfactory Red - Poor
9	Availability and use of toys and play material	Green – Good Orange – Satisfactory Red - Poor
10	Community events (VHND & other events)	Green – events were conducted and well attended Orange – events were conducted but poor attendance Red – no community events were conducted

Annexure 2: Letter to Commissioner about PHC vacancies

Date: 20 Nov 2022

From,
Mrs Yazhini
135 Ward Councillor
Ashok Nagar, Chennai Corporation
Phone Number: 98844 08024

To,
Shri Gagandeep Singh Bedi
Commissioner, Chennai Corporation

To,
Dr. G. Shanthakumari,
Chairman Standing Committee (Public Health)

Subject: Ward 135 UPHC – staff shortage and other requests

Dear Sir/Madam,

Greetings. Based on the feedback from people in my ward, especially people from marginalized community who are dependent on the public health care system, I request you to kindly fulfil the following requests in the 'Ashok Nagar UPHC, 34, 35th Street, Chennai – 83'

A medical officer has been appointed, but she comes to work only one or two days in a week. Rest of the time, she has been asked to report to the EOC in Saidapet. A medical college intern is deputed to come to the UPHC, but she is not yet a full doctor and does not inspire confidence among the patients. I request you to ensure that the medical officer posted in this PHC comes here on all the six days of the week. In case, she has to be deputed to another institution, please appoint another full-time medical officer for the UPHC.

There are five sectors associated with the PHC, but there are only 2 Urban Health Nurses and 1 ANM. I request you to appoint 2 UHNs so that all the sectors can be covered. Currently, there are many anganwadis in the ward which have not been visited by any UHN for more than nine months. This adversely affects all health education and immunization services provided in the anganwadi.

There is a senior health nurse to manage the urban health nurses and the ANM but she has been on long leave for quite some time now. I request you to post a senior health nurse.

2 NCD staff are required to be present but there is only one NCD staff who joined recently and she is also managing the OP Assistant's work.

There is a lab technician but she also gets posted to Koyambedu and other places often.

One of the staff mentioned that they need a male security officer because it is an all women PHC and sometimes when people come and find out the doctor is not there, they get upset and shout and the staff feel threatened.

The PHC is functioning with almost half the sanctioned strength which severely hampers the performance.

Post Name	**Sanctioned**	**Present**	**Vacant**
Doctor	1	1 (only 1 or 2 days a week)	0
Lab Technician	1	1 (but gets posted to other places often)	0
Pharmacist	1	1	0
NCD Nurse	2	1	1
UHN	3	2	1
ANM	2	1	1
SHN	1	0	1
OP Assistant	1	0	1
Security Assistant	1	0	1
Total	**13**	**7**	**6**

To provide ante-natal scans, there was a scan machine, but that has now been taken away to another centre. There are nearly 30 women every month who register for ante-natal care in this UPHC and they find it very inconvenient to go to some other place for the scan.

The doctor mentioned that there is a shortage of drugs especially b-complex and multivitamin tablets. Also, the amount allocated for general drugs (Rs 1 lakh for 6 months) is not sufficient and this needs to be increased.

The lab technician also mentioned that sometimes the store in Chintadripet gives less lab supplies than what is required.

The compound wall of the UPHC is broken and there is a leakage of rain water from the roof in the laboratory. I request you to sanction sufficient funds to fix these issues.

The patient welfare society has not met in a long time. It would be good to reconstitute this society and ensure that it meets every month.

The doctor posted here is on an NUHM contract and she does not have any financial powers. The financial powers and administration of the UPHC is with a permanent doctor who is in another

PHC. This arrangement is sub-optimal. **Please take steps to fill all positions in the PHC with permanent staff rather than on contract.**

Fixing the above issues will help with better UPHC utilization and patient satisfaction. It will also help in getting the NQAS certification.

I also request you to arrange a one day orientation session for all the ward members on the public health system and how we can work to strengthen it.

Thanking you.

Yours Sincerely

Mrs. Yazhini

cc: Zonal Chairman, Zone 10

Photographs


START


AMC

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Part C: Tamil Nadu Health Assemblies

Introduction

The declaration of the International Conference on Right to Health Care held in Alma Ata in 1978 says 'The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.'

In India, the National Health Mission has introduced many initiatives to enable community participation including Village Health, Nutrition and Sanitation Committee, Jan Arogya Samiti, Rogi Kalyan Samiti, Community Action for health and ASHA workers.

In Tamil Nadu, the community based monitoring and planning was implemented in 446 Gram Panchayats in 6 Health Unit Districts (HUDs) from 2009-2012 and then till 2015, efforts were made to strengthen the VHNSCs in these panchayats. However, this project was not continued after 2015 for different reasons.

Currently, Tamil Nadu is implementing a health system reform program supported by the World Bank. One of the eight indicators of the program is *'increased transparency and accountability through citizen engagement (voice, agency and social accountability)'*. As part of this Tamil Nadu is committed to holding health assemblies at the village, block, district and state levels. Last year, health assemblies were conducted in fourteen districts followed by the state health assembly and this financial year, health assemblies are being conducted in sixteen districts.

In the state assembly held in the last financial year, 272 resolutions were passed and 20 Government Orders (GOs) sanctioning 23.5 crores have been issued and there are 13 more GOs in the pipeline. Approved proposals include a snake bite center in Kalakadu and a post mortem center in Yercaud.

Based on attending four health assemblies, some recommendations to improve them are given below. Individual district health assembly reports for Madurai, Krishnagiri and Dindigul districts are also given below.

Recommendations

1) As specified in the health assembly guidelines, VHNSC meetings should be held at the village level before the block health assembly. Animators could be appointed at the block level (say one per block) to facilitate this process. A Checklist such as the one enclosed below may be given to the VHNSC to get key resolutions from them.
2) Resolutions passed by the VHNSC meeting should be presented at the block health assemblies.
3) District health assemblies should take stock of the current health status, respond to the resolutions made at the village and block levels and plan for the next year.
4) The current structure of the health assembly (village and block health assemblies) is more suited for the rural areas. There is no equivalent meetings in the urban areas. A structure for the urban areas should also be designed. Maybe the Patient welfare societies in DMS & DME hospitals could hold a public meeting once in a year and then the resolutions from these meetings can be brought to the District Health Assembly.
5) Issues should be categorized into different types such as insufficient human resources, infrastructure, equipment, maintenance & repair, denial of service, personal grievance etc. and

data on the number of different types of issues could be presented. Also, it could be said that example issues from all categories should be presented in each of the health assemblies.

6) A neutral person (such as from a civil society organisation) or an official from another department should moderate the session.
7) A website should be created containing all details about the health assembly – guidelines, GOs, circulars, calendar of district and block health assemblies, copies of presentations made in the health assemblies, scheduled meetings, meeting minutes etc. to ensure greater participation of the public in the process.
8) An MIS should be created to keep track of all resolutions at the village, block and district levels. Appropriate action should be taken on these resolutions and/or an explanation should be given as to why it is not possible to take action on the resolution. Both the resolutions and the action taken report should be publicly available. There is no such information in the public domain for the health assemblies conducted last year.
9) An application should be created to track requests by health staff to other line departments such as Tamil Nadu Water Supply and Drainage Board, Electricity Department, Local administration, Revenue Department, TNMSC etc. There are many requests to these departments but the response from the corresponding department is lacking.
10) Just as the state government has taken good efforts to bring people's participation in the school management committees and is working to identify and address issues at the field level, similar effort should be taken by the health department. It should bring people's participation in the health system – VHNSCs should be revived, patient welfare societies should be strengthened, public meetings should be held at different facility levels followed by the district health assembly.
11) The health department rather than TNSRTP should own the health assembly process so that it is not ended after the completion of the current World Bank supported program. Also, currently, the resolutions of the assembly are aimed at gaining support for specific needs from the TNSRTP program. The objective of the assembly has to be much broader than this.
12) A two page pamphlet with the status of health, public messages, summary of key resolutions from village and block, number resolved etc. should be distributed to all attendees
13) The department should prepare a presentation on all the norms and the recent policy decisions and the circulate it ahead of time (some points that were made by the independent observer in the meetings: current thinking is not to purchase vehicles but to hire on a need basis; that it has become increasingly difficult to get permission from Atomic Energy Regulatory Board to set up X-ray units, that focus should be on toilets for differently abled persons, that staff quarters are often not used, that one needs to be considerate of cost while proposing a request; norms for when to set up a NICU, SNCU, X-ray unit, CT scan, MRI, sub-center, PHC etc. If such norms do not exist, they should be fixed and communicated to all so that there is some uniformity and then people can know what is possible). This will ensure equity and all locations receive at least the minimum standards.

Madurai District Health Assembly, 27 Dec 2022

Precursor to DHA

The District Collector nominated Dhan Founndation and Voice Trust to be the civil society representatives. Other NGOs including Saathi and Rotary club also participated in the process.

Block Working Groups (BMO, BDO, CDPO, local Panchayat/Town Panchayat President, Block staff) were formed in all blocks. Block Health Assemblies were held in all the thirteen blocks. Either the deputy director of DPH or the second line staff from the district participated in it. The Block Health Assemblies (BHAs) were conducted in a public place for 4 – 5 hours, 10 am – 2 pm and in some places till 4 pm. Minutes were recorded. Block Medical Officers were requested to give lesser importance to human resources issues and civil infrastructure issues while making resolutions. The urban PHCs were attached to one rural block but the involvement from them was less. Stalls for NCD, MTM, Family Welfare and Nutritious food were put up at the BHA venue.

Some requests from people were not possible. For instance, people asked for a new PHC but the population was only 15000. People were informed about the population norms for a new PHC. A total of 241 resolutions were approved by the BHAs.

Separate meetings were held with the JD of DMS, Dean of MMC and City Health Officer of Madurai Corporation to collect their requirements.

A District Working Group (DWG) with around 60-70 members was constituted. Its members included DDHS, PD of DRDA, DD of TB, BMOs, Corporation City Healty Officer, GH CMOs, Social Welfare Department officers etc. The Additional Collector chaired it. An officer from the state also attended. The main role of the DWG was to look at the 241 resolutions received from the BHAs, classify them as minor or major and select key resolutions to be discussed in the DHA (58 were selected for presentation – 32 from DPH, 25 from DMS and 1 from DME). This meeting was held on 27th Oct and was also attended by a state representative.

On November 15, the District Organising Committee (DOC) met. The DOC included District Collector (Chair), Dean of Medical College, JD, DD, APM and NGO representatives (a total of 9 persons). They reviewed the filtered resolutions, decided on the DHA date and discussed the arrangements for the meeting.

Proceedings of the DHA

The DHA was conducted in the Collectorate campus itself. It was inaugurated by the Mayor of Madurai Corporation. It was attended by the District Collector, Madurai Member of Parliament, Usilampatti MLA, Madurai Commissioner, RDO, JDHS, DDHS, State Observer (SO) and other officials. Five people from each block had come (BMO, Nurses, pharmacist and one elected representative).

Issues pointed out by elected representatives

1) Member of Parliament requested that the existing Madurai HUD district should be split into two as has been done in few other districts.
2) Usilampatti MLA said that the hospital services are mostly good and flagged a few issues
    a. In Usilampatti GH, pregnancy ward, OP and emergency ward all share the same entrance. It would be good to have a separate building for the pregnancy ward (there is sufficient land close by)
    b. There is a shortage of quality medicines. For diabetes, if patients buy drugs from outside their sugar level is even but when taking medicines from the government facility, there is variation in the sugar level
    c. Insulin is not available
3) Dog menance seems to be a big issue. Data relating the number of dog bites was quite alarming. A local representative pointed out that PHCs are refusing to give vaccines for dog bite victims saying that the vial they have contains vaccine for 10 people and that if they break it for one person, then the rest of the doses will go waste. He said after arguing and putting pressure, the doctor finally gave the vaccine.

4) Poor service in the Sholavandan non-taluk hospital. Even for small issues, people are referred to the tertiary hospital (The Medical officer said that though 6 positions are sanctioned, there are only 3 doctors at present)
5) The mortuary room does not even have a light in Sholavandan and people have to use their cell phone light to do work in there. This has not been fixed even after multiple complaints
6) Melur Municipal Chairperson wanted underground drainage facility
7) Alanganallur President said while they are working on sterilizing dogs, this does not seem to reduce the number of dog bites.

Issues raised by Dean, MMC

The Dean raised the key important issues faced by the tertiary hospital. MMC is situated in one of the smallest land areas among medical colleges in Tamil Nadu. He said that the situation is so bad that pregnant women have to sit on the floor in the CeMONC center. He requested the district administration to provide around 4-5 acres of additional land.

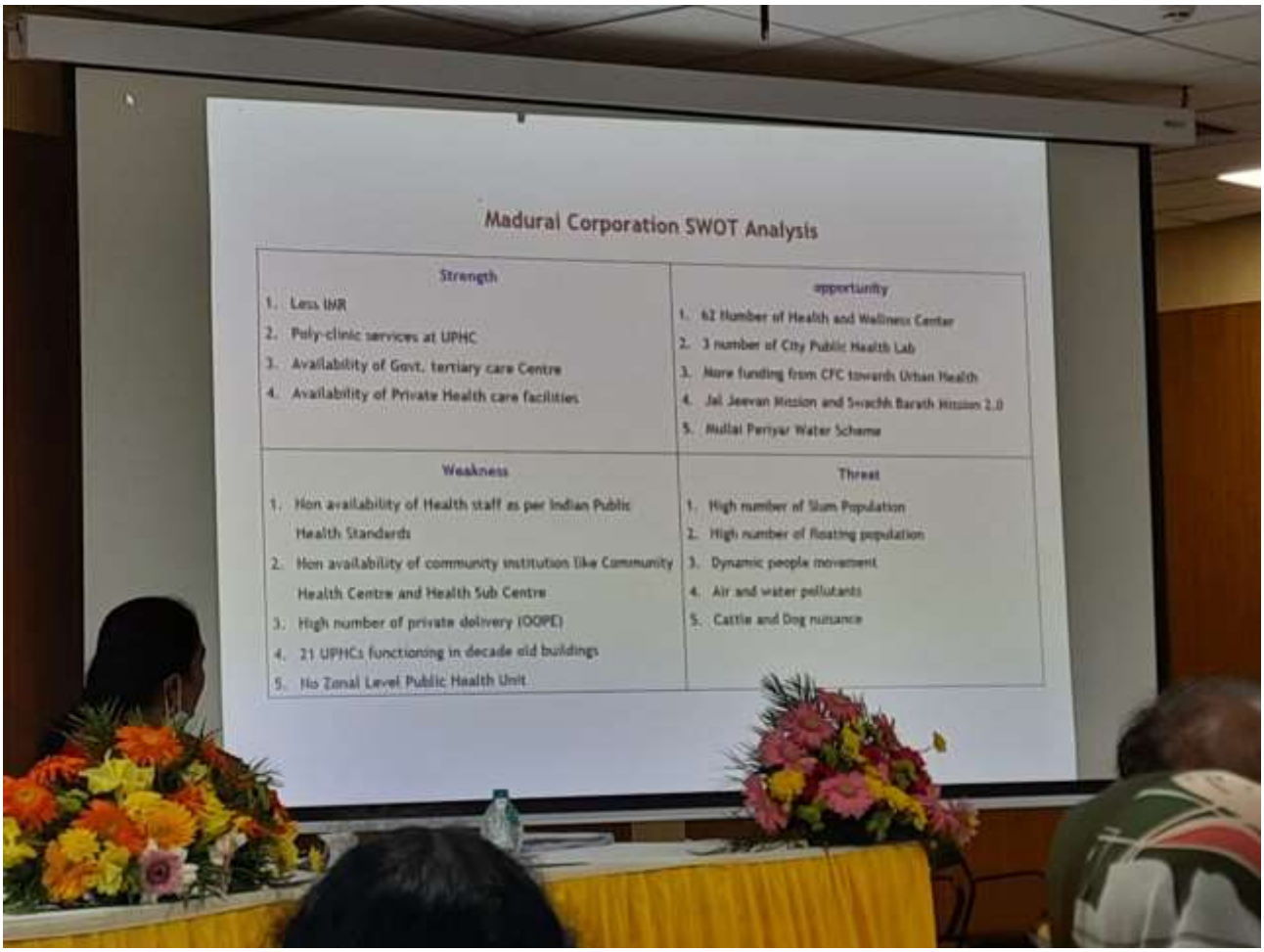
Around ten thousand people visit the hospital every day and there is a shortage of water. There is a problem with sewage backflow also. The auditorium is in a really bad shape and NMC has pointed this out multiple times. The medical college campus has many dirt roads that need to be upgraded to tar roads.

He wanted an Extracorporeal Shock Wave Lithotripsy (ESWL) machine as the existing one is broken and it will cost more than 70% to replace it. They have a letter from Tamil Nadu Medical Service Corporation (TNMSC) which asked them to get a new machine. The MMC is the main tertiary hospital for seven districts and they need this machine. Thoppur peripheral center needs to be strengthened and a CT scan machine is required here. There is a problem of sewage mixing with water in Balakrishnapuram hospital.

He said that compared to the RGGH in Chennai, they get very less funds. If he is provided as much funds as the RGGH, he can beat the performance of the Delhi AIIMS in Delhi in one year (In a recent report, the Coimbatore Dean had also said their staff strength is poor but the performance is good)

Issues raised by Madurai Commissioner and City Health Officer

The Madurai Commissioner presented a SWOT analysis of the health system in the Madurai Corporation and mentioned that a main weakness is the non-availability of medical staff as per Indian Public Health Standards. The City Health Officer gave a more detailed presentation specifying the current situation, health priorities and their demands. The demands included an additional MO in all UPHCs, to create zones as in Chennai, and nursing vacancies to be filled.



DMS issues presented by JD, Madurai HUD

There is one district HQ hospital in Usilampatti and 5 taluk hospitals and one non-taluk hospital in Sholavandan. He requested the following:

1) STP to treat liquid waste as per Biomedical waste Act 2016 for Usilampatti, Thirumangalam and Peraiyur hospitals
2) Blood storage unit for Vadipatti and Thiparunkundram, Sholavandan and blood component separator for Usilampatti
3) Usilampatti - Patient waiting hall, patient calling system, modular kitchen, office building for superintendent, central sterile supply department, maintenance funds for generator and PSA plant. lift for CEmONC Center
4) T. Vadipatti - Maintenance and repair work, ultrasound scan machine, vertical autoclave
5) UPS battery for Peraiyur, will cost around 25K (SO asked why it cannot be purchased from CMCHIS or CSR funds)

6) Melur – Solar panel, solar water heater, silent generator, furniture, kitchen utensils and storage pallets
7) An approaching road and compound wall was required for Peraiyur hospital (SO mentioned that it will be expensive to do compound wall if the area is huge. Maybe a living fence with plants can be grown with the help of the forest department)

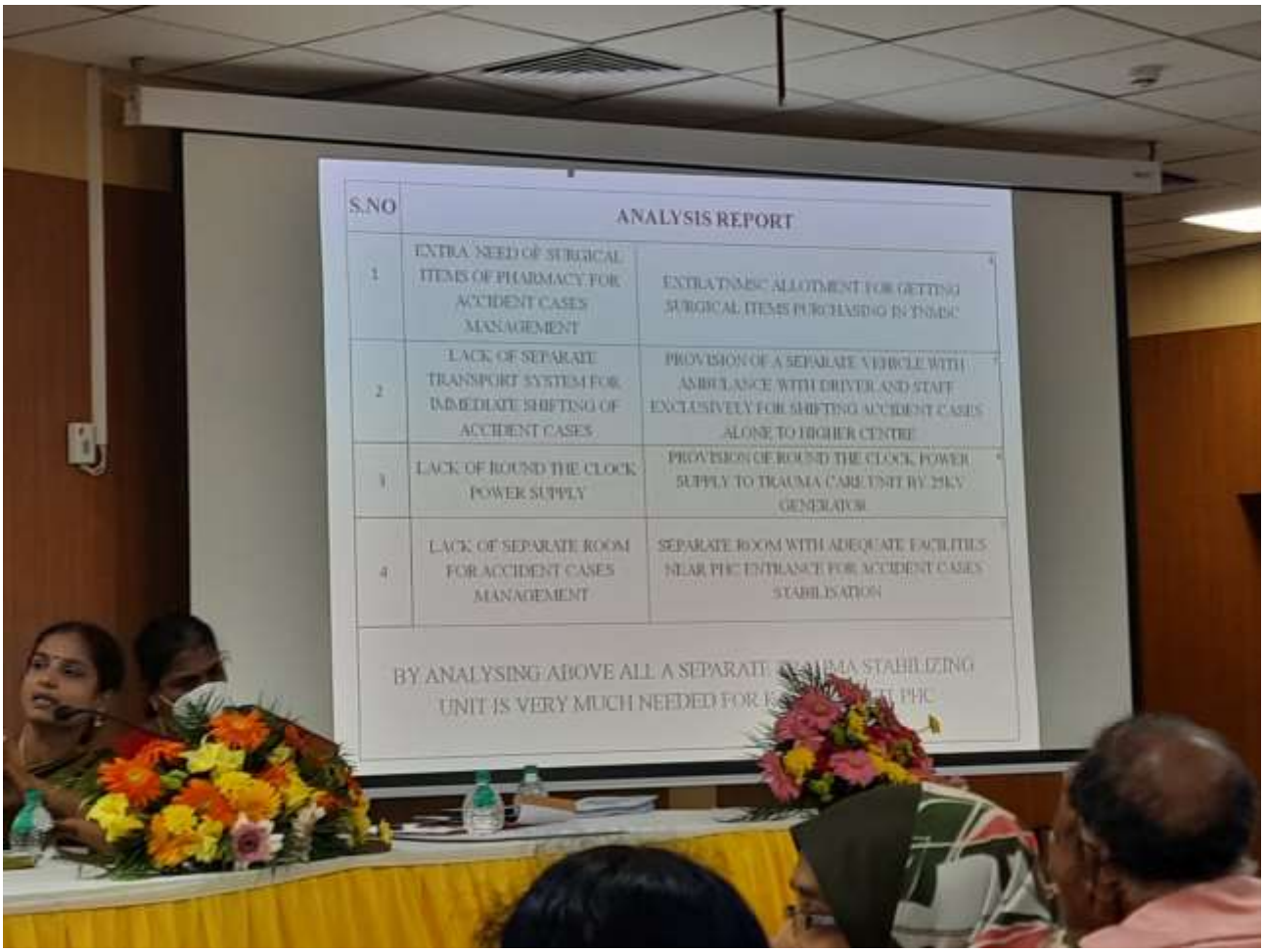
The TB DD said that he has 90+ centers but binoculars to detect TB are there in only 21 centers. SO said that this issue should be taken up with his superior in the DMS office and if that request is included in this health assembly, duplicate orders might be issued. He said he has been making requests for the last three years without any response. Usilampatti Commissioner requested a special medical check-up for sanitary workers. AD, Town Panchayat also requested for this. SO made a request to the PWD EE and TWAD EE to give priority to hospitals.

Issues presented by Block Medical Offifcers (BMOs):

The BMOs from the thirteen different blocks presented the key resolutions from their block health assemblies. A key common issue was the need for autoclaves, help with managing trauma/poison cases, staff vacancies and compound walls.

There is a pressing need for urgent medical care (accidents, poison victims, complications during child birth for both mother and children), but the 108 ambulance is not up to the mark. Their response time is low, they can take only one person at a time, there are vacancies which cause them to work only one shift etc. Melur BMO mentioned that it takes nearly an hour for the ambulance to come and then another hour to take the person to the tertiary hospital.

Medical Officer from Karukalakudi PHC gave details about the number of accident victims seen over the 1st 6 months of this year (83 major issues which were referred to the higher center and 647 minor issues). He mentioned shortage of hospital staff, lack of equipment, lack of training, lack of surgical pharmacy items and lack of 24 hours power supply. He requested a separate trauma stabilizing unit to be established there.



Some of the issues presented are listed below:

1) Accident, Emergency management unit is required in 5 blocks (Kottampatti, Thirumangalam, Sedapatti, T. Vadipatti and Thiruparankundram)
2) Autoclave machines are needed in 5 blocks (Chellampatti, T. Kallupatti, Kottampatti, Chellampatti and Thirumangalam)
3) NBSU is required in 4 blocks (Thirumangalam, Thiruparankundram, Madurai East, Madurai West, Alanganallur) and NICU in Usilampatti (SO said that this is very expensive and adequate paediatricians are not there for this)
4) Blood storage unit is required in 4 blocks (Sedapatti, Melur, T. Vadipatti and Kaligudi)
5) A counselling center to prevent teenage pregnancy and higher order births is required in 4 blocks (Chellampatti, Sedapatti, Madurai East and Usilampatti)
6) Thiruparunkundram has a 30 bedded hospital but no operation theatre equipment for more than a year.

7) Many PHCs including those in Grathanoor and Nagamalai Pudukottai are in a dilapidated condition
8) T Vadipatty does not have round-the-clock power supply
9) T Kallupatti needs dental unit, x-ray machine and counselling unit
10) Sedappati Block – a panchayat president mentioned that 3 sub-centres are in a bad situation, ambulance delay in Sathur PHC and compound wall for Sathur GH
11) Melur BMO said that their BHA was conducted very well and many issues including sanction of new anganwadi centers got resolved in the BHA itself. He also requested for a deaddiction center.
12) In the block health assemblies, there were many maintenance and repair issues such as for chlorination and water tank leakages. These are to be sorted out by BDOs

Some observations

Positive Points

1) The DD and his staff had put in a lot of effort to ensure that this process is implemented well. The DHA itself was well attended.
2) This is probably the first time that such a health assembly has been held – where health personnel, staff from different departments, elected representatives, general public got together to discuss about health care and broader issues affecting health.
3) Important issues facing the health system are discussed in an open forum and this could lead to public pressure to address some of the pending issues.
4) Block health assemblies were held in all 13 blocks. Rather than hold the meeting in the Block PHC (which was done in many districts), the block health assemblies were held in kalyana mandapams (marriage halls) which would be more open to the public. However, the district health assembly was held in the Collector's office.
5) District administration had appointed two NGOs (Dhan Foundation and Voice Trust). Representatives of these NGOs and another Saathi (who helped a lot during Covid period) participated in the block health assemblies.

Areas that could be improved

1) Village meetings are mandated by the guidelines but these were not held.
2) The focus seems to have been on the equipment to be bought and infrastructure issues but issues faced by common people were not discussed much and are not part of the resolutions. One way to address this is to have the village level meetings.
3) The participation of public and elected representatives was lesser than mandated by the guidelines
4) While it was said there were 241 resolutions in the BHAs, these were not presented in the DHA; at least the resolutions could have been grouped and summaries presented
5) Participants were asked not to focus on staff vacancies or physical infrastructure such as new buildings. However, staff vacancies is a key limiting factor in providing quality health care to all and hence should be discussed

6) Transparency – There was no public notice about the district health assembly, the block health resolutions are not available in a public website nor were they displayed in the venue.
7) The meeting did not have any media representatives; having them will ensure that people are aware of the proceedings, will help increase participation in future meetings and might lead to quicker and better solutions for some issues
8) It seemed that the focus of the DHA was to short list resolutions for the state health assembly and not for addressing some of the serious frontline issues.
9) Health Assembly was conducted like an internal departmental review meeting. Some people were scolded, some voices were dismissed.
10) There was no discussion on the functioning or grievances related to the private health care sector. DMS could have presented data on the status of clinical establishments act.

Health assembly should give space for public to talk, it should not be a review meeting.

The meeting was like a review meeting by the state observer. BMOs were put down – one of the BMOs who wanted a counselling center to prevent teenage pregnancies and early marriages was told that she first needs counselling on how to make a presentation in a health assembly. When a nurse mentioned that their buildings are in a dilapitated state, she was told by the DD 'Do not waste our time'. This behaviour creates a hostile atmosphere that prevents others from freely expressing their requests or grievances.

The state observer at one point said why you are asking this here. It is your district administration that should provide it. She seemed to be under the impression that the district health assembly is being conducted just so people can make requests to the state.

Melur GH wanted solar panel, solar water heater, silent generator and furniture, kitchen utensils including covered plates (SO asked why the 53 lakhs that was given for NQAS certification 50K/bed for 100 beds was not used for all these minor requests and said that she is ashamed that the MO is making such requests and requested BMOs to present more serious issues.

When a Medical Officer asked for an autoclave she berated him as to how he is managing currently and then asks whether some NGO can provide this, then she asks other BMOs who have received funds for NQAS certification whether they can give money for this.

The medical Officer from Karukalakudi PHC (who sees a major accident victim every other day and 10 minor victims every day) said that they do not have adequate surgical pharmacy items. The SO said such issues should not be brought up and that they can get this from the TNMSC. Obviously, there is no interest to note down issues and see how they can be addressed.

It would be best if the session is moderated by a neutral person such as an NGO representative or an official from some other department. The 'state observer' should just play the observer role. The DHA is not meant to be a review of the different resolutions by senior officials from the state. It should also not be used to select resolutions to be presented in the state.

Krishnagiri District Health Assembly, 04 Jan 2023

The meeting was held in the auditorium of the Medical College Auditorium with more than 400 people attending. Planning Commission Members Dr Amalorpavanathan and Prof R Srinivasan attended it. It started promptly at 10 and was attended by District Collector, state observer and other officials.

The Collector said though there are many industries, there are also serious health issues also. There are remote villages without roads where people have to be carried in stretchers for long distances when they fall sick. He said in addition to making demands from the government for different needs, the public should also make resolutions relating to child marriages and including healthy food to avoid malnutrition.

Krishnagiri had organized village level meetings, followed by block health assemblies in the ten blocks. Many block health resolutions were resolved and were not brought to the assembly (examples include requests for large nebulizer, wheel chair, stretcher, toilet repair, RO system).

Some of the village level resolutions include requests for sub-centers, anganwadis, vacancies etc.

Thally Block chairman said that the size of Thally is as big as Kanyakumari and there is a big floating population as well. He said that people in Kodagarai are allotted to Anchetti PHC which is very far. There is a closer PHC in Kelamangalam but they refuse to treat people. He said that 8 sub-centers are in very bad shape and he has been raising this for more than 2 years but no action has been taken. He asked the PWD to either build new ones or give permission to the local bodies so that they can do it by themselves.

A TB champion from Uthangarai requested for CP-NAAT machine. Another public representative said that there is only one nurse in MC palli PHC at night, the doctor is irregular, anganwadi buildings have been demolished two years ago but are yet to be constructed,

There were infrastructure requests for new sub-centers, PHCs, and anganwadis, toilets in health centers and schools, noon-meal centers, compound walls. Equipment requests were for X ray machine, Generator etc.

A local representative was upset with the PWD since neither are they doing any work nor are they giving permission for the local bodies to do work.

In her presentation, Dean stressed the importance of providing a U-turn facility in the highway so that ambulances coming from Hosur direction do not need to travel an extra 10 kms. She requested ninety items costing about 1.5 crore Rs. She said MRI, CT, digital x-ray have not been shifted and that the campus does not have adequate water,

Positives

1) Village level assemblies were conducted and resolutions obtained

2) Many block health assembly resolutions were resolved using other funds such as the District Mineral Fund, CSR fund and untied funds.
3) Summary of resolutions were presented which was easier to understand
4) Cost to procure / construct requested line items was presented which will make it easier to estimate total demand, prioritize items
5) Performance metrics were presented
6) Very good IEC stalls were set up outside the venue

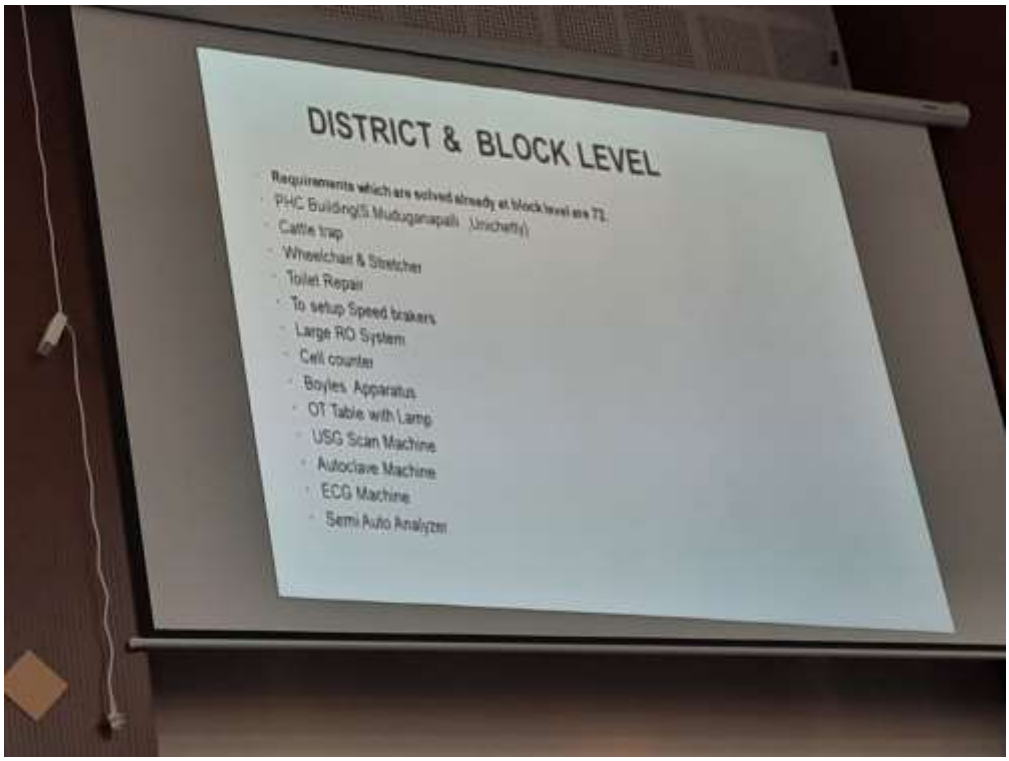
Areas for improvement

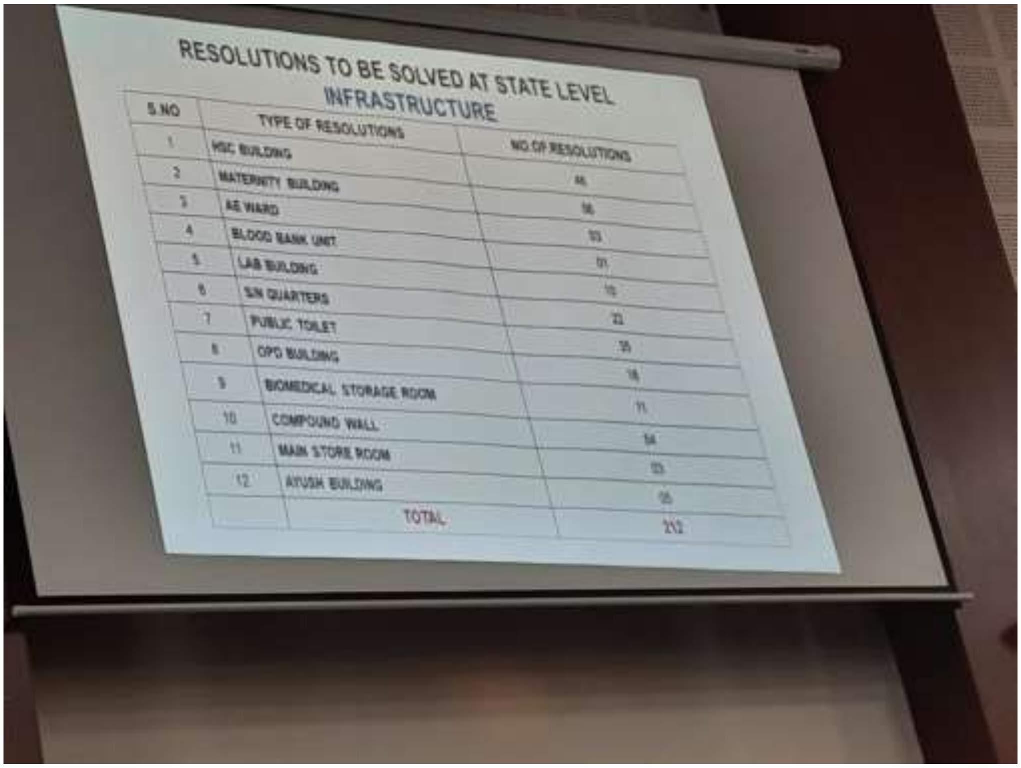
1) Time management of the event could have been better. All BMOs were presenting very similar requirements and there was not much to distinguish them. Not enough time was given for the general people to speak which is the key idea behind the assembly. A suggested schedule has been given above
2) Wide publicity needs to be given for the event which was not done
3) State observer insisted that there are no HR vacancies and that there should be no resolutions on HR. This is being insisted in all the other health assemblies conducted so far. This is an unacceptable stand. The number of health personnel (sanctioned, appointed and deputed for all categories) should be presented
4) No status information about resolutions relating to other departments such as ICDS.
5) It would be useful to give a total cost estimate of all the requirements for the different resolutions. That would be the amount that would be required from the state.
6) Cost of different line items (such as for napkin incinerator and cost to construct a sub-center) could have been shared with all the presenters ahead of time so that all presenters use a uniform value.
7) Very few social issues were discussed. A checklist of different issues to be discussed distributed in the village assembly (such as alcoholism, drug abuse, violence against women, child marriage etc) could have helped to get resolutions from the bottom
8) PWD should present details about list of all buildings under their control, how much have been condemned, the status of other buildings, how many proposals they have sent, how much money they have received for repair and maintenance and how much they have used etc.
9) All presentations, Block & District Health Assembly resolutions and ATRs should be uploaded in the Krishnagiri website
10) State observer's role should be to observe and not do a review or question or confront the presenter. For instance, in response to a question, the observer asked a public person about abortion data and told another person to find out whether a particular road is part of the state highway or forest road or local body body and then come back with his request! Most people were presenting to the observer instead of to the assembly and it became like an internal departmental review meeting.
11) The district collector became impatient in the end due to time pressure and cut people off quite abruptly. He could have just said that the senior administration will consider the

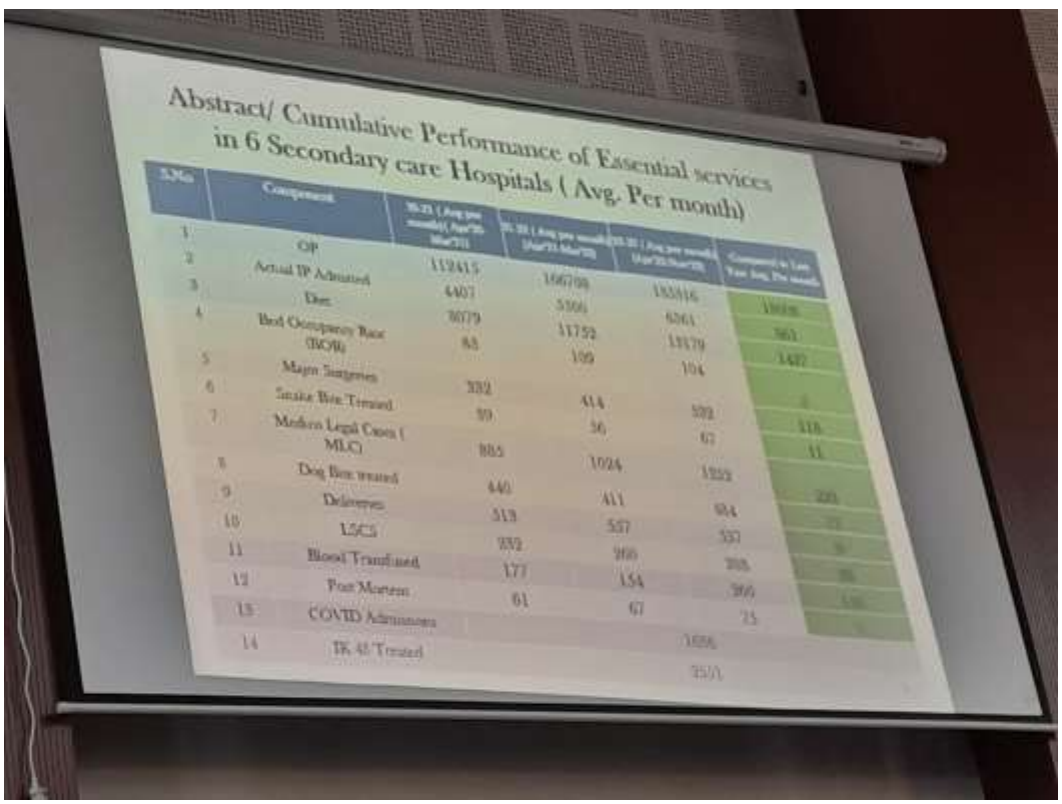
trade-offs and then decide on difficult issues such as installing a u-turn facility in the highway opposite to the medical college or about providing services as before at the district hospital now that there is medical college just 7 kms from there.

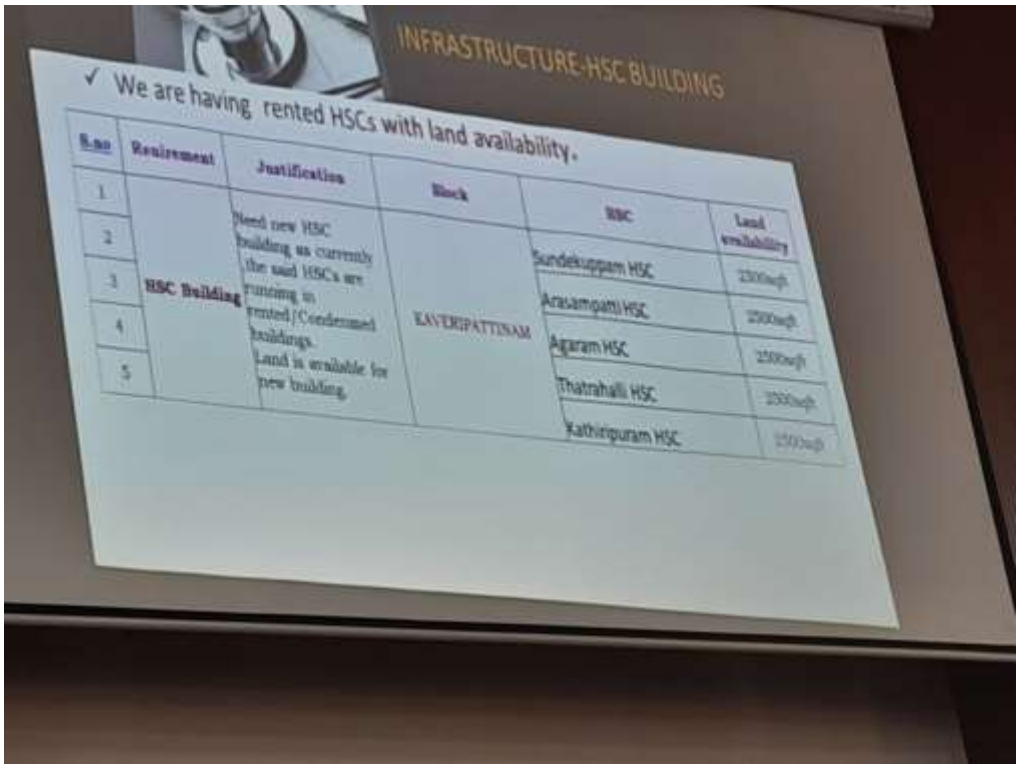
Photos

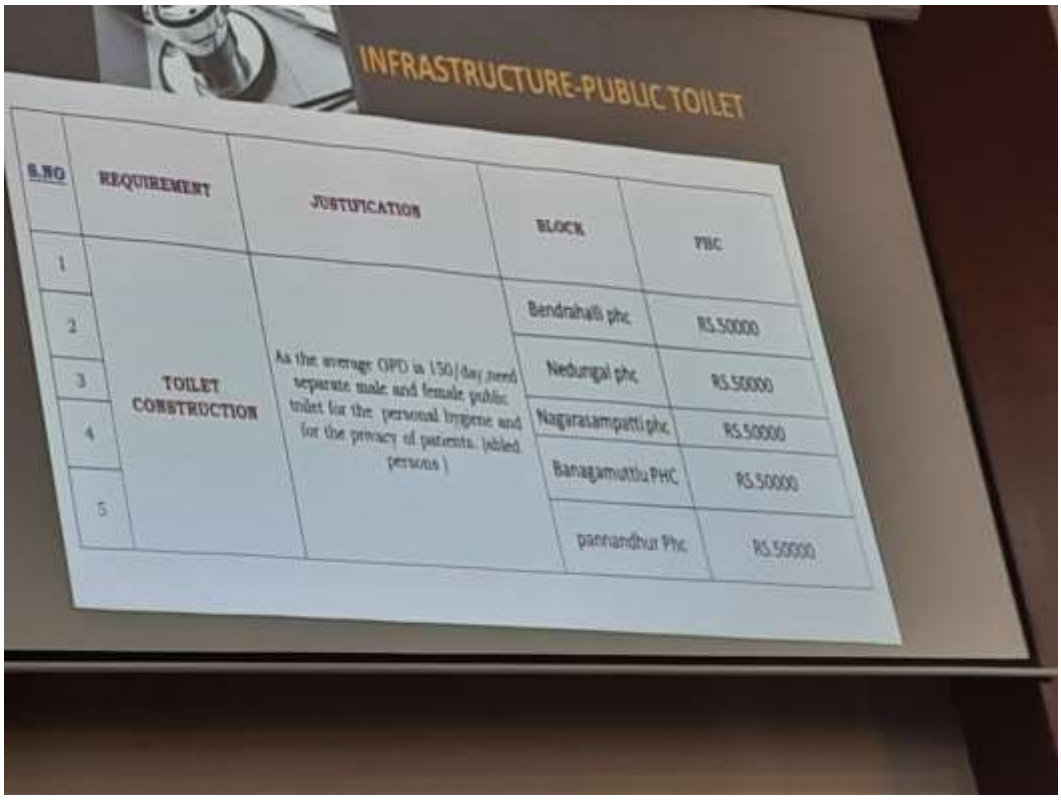

மாவட்ட சுகாதாரப் பேரவை
திருவ்ணகிரி மாவட்டம்
DISTRICT HEALTH ASSEMBLY
KRISHNAGIRI DISTRICT


DISTRICT & BLOCK LEVEL
Requirements which are solved already at block level are 72.
PHC Building(S.Muduganapalli Unicheth)
Cattle trap
Wheelchair & Stretcher
Toilet Repair
To setup Speed brakers
Large RO System
Cell counter
Boyles Apparatus
OT Table with Lamp
USG Scan Machine
Autoclave Machine
ECG Machine
Semi Auto Analyzer


RESOLUTIONS TO BE SOLVED AT STATE LEVEL
INFRASTRUCTURE
S.NO
TYPE OF RESOLUTIONS
NO.OF RESOLUTIONS
HSC BUILDING
MATERNITY BUILDING
AE WARD
BLOOD BANK UNIT
LAB BUILDING
S/N QUARTERS
PUBLIC TOILET
OPD BUILDING
BIOMEDICAL STORAGE ROOM
COMPOUND WALL
MAIN STORE ROOM
AYUSH BUILDING
TOTAL


Abstract/ Cumulative Performance of Essential services in 6 Secondary care Hospitals (Avg. Per month)
S.No
Component
OP
Actual IP Admitted
Bed Occupancy Rate (BOR)
Major Surgeries
Snake Bite Treated
Medico Legal Cases (MLC)
Dog Bite treated
Deliveries
LSCS
Blood Transfused
Post Mortem
COVID Admissions


INFRASTRUCTURE-HSC BUILDING
✓ We are having rented HSCs with land availability.
S.no
Requirement
Justification
Block
HSC
Land availability
1
2
3
4
5
HSC Building
Need new HSC building as currently the said HSCs are running in rented/Condemned buildings. Land is available for new building.
KAVERIPATTINAM
Sundekuppam HSC
2300sqft
Arasampatti HSC
2500sqft
Agaram HSC
2500sqft
Thatrahalli HSC
2500sqft
Kathirpuram HSC
2500sqft


INFRASTRUCTURE-PUBLIC TOILET
S.NO
REQUIREMENT
JUSTIFICATION
BLOCK
PHC
1
2
3
4
5
TOILET CONSTRUCTION
As the average OPD is 150/day need separate male and female public toilet for the personal hygiene and for the privacy of patients. (abled persons)
Bendrahalli phc
RS.50000
Nedungal phc
RS.50000
Nagarasampatti phc
RS.50000
Banagamuttlu PHC
RS.50000
pannandhur Phc
RS.50000

Dindigul DHA, 24 Jan 2023

Introduction

The meeting started quite late (at 11.30 am instead of at 10 am – maybe because there was a bus accident in Sirumalai and the collector had gone there to supervise relief work?). It was held in the conference hall in the collectorate and was well attended (more than 300 people) by elected representatives including Palani MLA, Vedasandur MLA, Dindigul Mayor, Dindigul district chairman, block representatives, panchayat presidents and general public.

The collector welcomed the people and said that people can not only say words of appreciation but they can also criticize in the health assembly. He said he has been there for 1.5 years and the healthcare staff performed very well during the COVID period but there is potential for improvement. He said commitment is more important than brilliance and requested people's representatives to speak first.

DD presented an overview of the health assembly process and a summary of the resolutions. There were 288 resolutions from all the block health assemblies. The resolutions were categorized and separated based on the level at which they will be addressed.

Resolution Type	Block	District	State
Infrastructure	14	98	107
Equipment	6	18	29
Vehicle			4
Policy	1		1
Services	1	7	
Facility	1		
Total	**23**	**123**	**141**

Overall, many elected representatives appreciated the work done by the doctors and nurses during the COVID period. They said that when the private hospitals had closed their doors, it was only the government hospitals that were functioning.

There were many requests relating to poor performance of 108 service, new buildings for condemned sub centers, new sub centers and PHCs, reallocation of areas to closer PHCs and toilets in schools & anganwadis.

Positive Points

1) The meeting was well attended
2) There were stalls outside on many public health topics
3) DD shared public health messages including about what people need to do to reduce MMR
4) Information about upcoming cancer screening camps was given
5) More time was given to the public rather than to the health staff to speak
6) The compere had a list of elected representatives scheduled to talk and called them by name one by one to the podium (though this limited the spontaneity and reduced the time given to the non-elected public)

Questions / Reflections / Suggestions

It is not clear that village level meetings were held. There was no information about the number of meetings held at the village level or resolutions from the villages. This should be done the next time.

All resolutions were healthcare related only and classified into few categories including infrastructure, equipment and vehicle. This shows that the assembly did not take note of other health issues.

Minimum standards should be specified for each sub center, PHC, HWC. For instance, one could say that every center should have water, electricity, toilets, drinking water, usable building (not condemned by PWD) etc. Similarly, other standards should be specified for personnel, diagnostic facilities, medicines etc. and it should be guaranteed that all centers adhere to this (This could be part of the 'Right to Health' act that the government agreed to initially but has now gone back on). Right now, while many of these basic facilities are not available in all places, there is a policy to start a medical college in every district. This entails huge expenditure that in turn removes the funds available for primary care facilities. Is there a standard on how much of the state budget should be spent on primary health care?

Standards are very important to ensure that quality is maintained – effort should be made to get NQAS (National Quality Assurance Standards) certification for all health centers. If this is difficult, at least a

grading system should be established for each sub-center / primary health center so that when resource allocation happens, the poorer centers receive the resources first.

The most common request in many health assemblies seems to be requests for new sub-centers and PHCs but these are denied based on pre-existing GoI norms (5000 for sub center, 30000 for PHC in plains and 20000 for PHC in hilly areas). The RD department publishes population distribution of gram panchayats like this

S No	Population	No of Village Panchayats
1	< 500	66
2	501 – 1000	1177
3	1001 – 3000	7241
4	3001 – 5000	2571
5	5001 – 10000	1379
6	Above 10000	186
	Total	12620

The health department should also publish data like this for sub centers and PHCs (for both plains and hill areas). That will help identify health centers which serve a higher population.

In a previous health assembly, the state observer said that the Tamil Nadu Government is using the 2011 population. Instead of this, projected 2023 population should be used. Also, Tamil Nadu can relax the NHM norms and sanction new centers in places based on the accessibility (in terms of distance, time required to reach, availability of public transportation, disease burden, floating population etc). Maybe if not a full-fledged PHC, the new HWC should be started in places where there is a real need.

While some classification of resolutions was given, it could have been more detailed. What sort of infrastructure is required – how many sub centers have been condemned, how many need to be repaired. What resolutions have to be done immediately, what are good to have but not urgent etc? Additionally, what would be the total cost that will be required for all the resolutions that have to be done immediately? This could lead to increased budget allocation for health and ensure equality – allocation is done for the most essential infrastructure / equipment in all places before budget is allocated for other items. Such input could also lead to a participatory budgeting exercise in the future.

While the DD made a summary of the resolutions made in the BHA, there was no summary of the issues raised during the day and whether these have been converted into resolutions.

While the elected representatives were appreciative of the health staff, they did not bring up any service issues. More opportunities to speak should be given to non-elected public and representatives of organisations working on people's rights.

When the JD was presenting about the issues they have and their needs, one of the attendees questioned him as to why he is saying all this in the assembly and that he can make his requests to higher authorities

or in internal meetings. The attendee said they need to listen to the people first since the purpose of the assembly was to listen to people's voices. While there is some validity to this, it is also important for people to know about the issues in the healthcare system which could lead to greater pressure on the system to respond. Maybe more time needs to be given to the general public to speak and maybe this can be done first.

When a councillor was talking about public health menace due to pigs and dogs in his town panchayat, the Palani MLA asked why he is bringing it to the health assembly and that it should be handled by the local body. All people should be informed that this is a health assembly, not healthcare assembly and that issues including water, sanitation, and nutrition can be brought up and they need to be noted and addressed.

At one point in response to an elected representative requesting for specific equipment in PHCs, they were asked who told them to make these requests; they said that the doctors gave them these requests. The elected representative were then asked to talk about health issues that are affecting them rather than request for specific equipment. An orientation session to all elected representatives will be helpful so that they can raise health needs of the community rather than just the requests from the doctor.

Proceedings

The notes below do not cover all the points that were made in the health assembly. It is also likely to have some wrong information especially with respect to the names of people who spoke and their locations. Ideally, as specified in the guidelines, the department should publish the meeting minutes, a copy of all the presentations made, a copy of all the resolutions along with those that will be/has been addressed at the village level, block level and district level and those that have been forwarded to the state. But none of the districts are doing this. In this scenario, such a note is helpful to get a gist of what happened in the health assembly.

Vedasandur MLA said he has met the Health Minister and given a long list of requirements that are required for his constituency. The total amount required for this is Rs fifty crores and he said that the minister asked him to imagine what would happen if each MLA were to give such a huge requirement list.

Vedasandur MLA requested post-operative ward, new in-patient building and a new post-mortem building both of which are in poor condition for the Vedasandur GH. He said that he has been asking for 3 additional PHCs for two years now. These are not sanctioned easily but he is hoping they will get one this year. He wanted the Guziliamparai PHC to be upgraded to taluk HQ hospital. He said he has made this request in the 'Ungal thohuthiyil Muthalvar Thittam' (Chief Minister in your constituency scheme). He appreciated the Dean who responds even when he calls her at odd hours. Last week, he had called her at 12 am regarding a snake bite victim; the person was given proper treatment and saved.

Palani MLA spoke about the increased pace of work in Dindigul Medical College and about many of the positive schemes like 'Makkalai Thedi Maruthuvam' (Healthcare at doorsteps). He said that Boolathur PHC has 28K people, but only one PHC. He said it will take 90 minutes to travel from Pachalur to Boolathur. There is only one VHN for many villages and it is difficult for her to cover all the areas. He said some relaxation should be given for hill areas and requested the assembly to pass a resolution on this.

A resident from Guziliamparai requested the PHC to be upgraded to a GH. He said new PHCs are required in Kootunatham and Pudukottai. He said the quality of sub-centers is poor and appreciated the conduct of this assembly which has not been done before.

An MNI activist listed the following issues

1) Garbage is being burned, it needs to be separated into compostable and non-compostable
2) A yoga center was converted to corona center but is not used now
3) Regulation of quacks has to be done
4) Taluk hospitals are not responding quickly to emergencies; most people die before they reach Madurai
5) Sewage lorries let out the sewage into tanks
6) Private hospitals overcharge for pregnancies. For normal deliveries, people pay 45K and for caesarian section deliveries, they have to pay 1.5 lakh. Government should fix an amount for this.
7) Pan parag is widespread and available close to schools
8) To regulate consumption of tobacco, a committee should be formed
9) The surroundings of many sub centers is not clean and full of under-growth
10) In Goa, PHCs are better than private hospitals and PHCs in TN should also become like that

Ganesan, Vadamadurai town panchayat councillor requested that the Vadamadurai PHC be upgraded to a GH and the Ayyalur PHC be changed to an upgraded PHC. There are many accidents near Vadamadurai and hence a critical care center needs to be added there. To prevent accidents, an overpass has to be constructed (Vedasandur MLA says that he has met Minister Velu thrice and have given this request). He said that people in the town panchayat and other nearby villages have to go Kannapadi PHC which is very far and requested that the area allocation for PHCs be redone so that people can go to a nearer PHC (MLA said that he drew a sketch and had given it about a year back but no action has been taken so far. ICDS CDPO from Vadamadurai also seconded the request to reallocate areas so that people do not have to travel for long). He said there are only 10 mazdoors for the town panchayat while the requirement is for 20 or at least 15. He said that pigs and dogs are a big issue.

Dean presented the requirements for the medical college. The total amount required for this is Rs 75 crores. Palani MLA responded by saying that he will talk to the additional collector and ensure that the work to lay the access road is taken up soon. The Vedasandur MLA says that he has already given many of these requirements to the Health Minister.

Pandi from Kannapadi reiterated the need to change the area allocation in Vadamadurai and an ambulance in Kannapadi.

Kongaipatty panchayat president Rajarathnam said that his GP has 5813 people but there is no sub center yet. He also requests an ambulance to be stationed in the Pilathu PHC.

Karadikattu panchayat president Rajmohan says that they need a sub center and e-cart for clearing garbage. He said they have set up 6 common toilets and that these really help to improve health.

Syed from Indian Red Cross Society said that the MM Kovilur PHC needs to be upgraded, an ambulance should be stationed in Sirugudi PHC, and Sithirai PHC does not have access road (only 2 wheelers can go now).

Sirumalai panchayat secretary said there are 12000 people and 9 villages in the hills. There are 2 sub centers but for any small problem, they have to come to Dindigul GH which is nearly 40 kms away. He said there is sufficient land and requested for a PHC to be set up.

Dindigul 37th ward councillor said that a new PHC building was constructed 8 years ago, but till today it is locked.

Vedasandur Kovilur panchayat president said that there is no drainage or soak pits in her panchayat and that the gram panchayat needs to be converted to a town panchayat. She also said the PHC building is poor and there are no compound walls for the anganwadis.

Pappampatty panchayat president Rathi Devi said their PHC needs 24 hour electricity supply and there is a shortage of doctors and nurses.

Corporation ward councillor Manoranjitham listed many of the UPHC requirements. For Kamala Nehru hospital, the following are required: generator, semi auto analyzer, mosquito net, bio-medical wastage room, feeding room, toilets, RO system, heater, washing machine, computer system etc.

An activist from Ponnimandurai mentioned that skin diseases and cancer incidence is high due to pollution from leather factories.

A resident from K. Pudukottai pointed out the issues in the PHC there which serves 60 villages. There is only one doctor. There is shortage of nurses. There is no pharmacist, cleaning staff or watchman. The lab technician comes only once a week from Kannivadi and for even small issues, they have to go to Dindigul GH. The 108 ambulance takes a long time to come and the PHC does not have a compound wall (snakes from the neighbouring tank often come there).

Palaniappan from Natham pointed out the difficulties that people from Kuttupatty area face. There are more than 3000 people in 5 villages and they have to come 12 kms by walk to a sub-center and from there the nearby PHCs are more than 10 kms away. He requested that the sub-center should be converted to a PHC and that this request has been given to multiple people over the years.

Thoppampatty union chairperson Sathyabhavani requested that out of 22 sub centers in the block, 15 are in a bad shape. She said there are lots of accidents in Kallimandayam and there is a need for TAEI center there. Keeranur PHC needs compound wall. There is a need for neurosurgery ward & MRI in Palani as all critical patients have to be referred to Madurai.

Oddanchatram union chairperson Ayyammal said there are 23 sub centers in the block, but only 6 are active and 17 are in bad condition. She also requested RO systems for anganwadis.

Periyakottai GP president said that the main issue is the poor sex ratio. She said more than 30-40 men in the village are unable to get married because there are not enough women. She says that many private

hospitals are responsible for this and the sex ratio at birth in the different private hospitals need to be monitored to see which ones are worse.

Idayakottai panchayat president requested toilets for school, drinking water for anganwadis and schools and more vehicles (kuppai vandis) for garbage disposal.

Paneerselvam from a GP in Oddanchatram says that the sub-center is in bad condition and the nurse does not stay there. He says they can give land for construction of new sub-center.

Latha, Manalur panchayat president says that they need 24 hour doctor presence in the Perumbarai PHC. Staff nurses also do not stay there since there is no staff quarters.

Mehurinassa from Manidham Arakkatalai said that drainage and pig menace is a big issue in Dindigul. She said their NGO is willing to work together to create awareness among the public if they get communication from the district health department.

Raja from Sriramapuram said there are too many accidents especially after conversion of the 2 lane Madurai highway to 4 lane. The 108 ambulance takes at least an hour to respond. The PHC needs to be upgraded; it does not have a compound wall, there is no safety for nurses after dusk. In a medical camp conducted last month, 67 women were checked and among them 10 had cervical cancer. Need more awareness about this.

Valarmathi, panchayat president from a village in Kodaikanal said there are 8000 people in her village and they have to go 17 kms from Kookal to Mannavanur PHC. The sub center is yet to be completed. In the 8th and 9th ward, there are about 500 families living in 2 acres and there is no space for constructing individual toilets. Hence, she requested 30 common toilets to be constructed. Mannavanur PHC requires a compound wall. It also requires quarters for doctors and nurses. They need an electric crematorium because the one in Kodaikanal is 45 kms away and the one they have is right next to the village.

Vadakavunji vice president said that their sub center is functioning in a rented building as the contractors refused to build the sanctioned one as the amount allocated was less.

Raj from Abdul Kalam foundation, Mannavanur presented issues faced by tribal people in the hills. Three years back, they did a survey and found that there are many malnourished children. He says that such children in Chennai were treated with a special package and the same needs to be done in his area also. Anemia is also quite common. Child marriages are common and they need to strengthen volunteers from among the tribal community to address this. Pregnant women need scans in 3rd, 5th, 7th and 9th month and doctors are asking for this but women find it difficult to travel to get this done. They require a scan center in Pannaikadu GH. Tribal patients are usually referred to either the Theni or Dindigul GH but they find it difficult to navigate. There should be a guide/friend in these hospitals to help them. In Pannaikadu area, the toilets in schools are very bad. They are working with SUN foundation and are cleaning toilets in a few schools. Government should take this model and implement it in all places. A PHC is required in KC Patty.

Nagendran, Pullapatti panchayat president, Nilakottai Union said they need a Primary Health Center. Kottanuthu Panchayat President also asked for a PHC.

Subramanian, YNEW coordinator said that pregnant women do not have a place to sit in both Kosavapatty and Gopalapatty. Pharmacists are quite rude and do not explain when giving the tablets. In Gopalpatty, they do not have a female Medical Officer. There are many hill villages around where teenage pregnancies are quite common and children are anemic. More sub centers are required in these villages.

DD asks all BMOs to send their requirements to the DD office since there is not enough time for presentation.

Kodaikanal municipality health officer says that the area is 21.45 sq km and that norms for health centers should be based on area covered rather than the population basis as is the current practice. For urban area, only one HWC has been sanctioned but two are required. There is only one Medical Officer. If there are two, then one person can do the field work. In addition to the resident population, there is at least 20k floating population which can be 1 to 3 lakh in the summer. These should be considered while deciding on the health facilities that are required. There is bison man confict and trauma related facilities would help save lives. When conducting block health assemblies, urban representatives should also be invited. Unlike rural areas, there are only sectors in urban areas (ie) there are no sub centers. Nurses have to come to PHC and go to the area which can be quite far. It will be good to have sub centers in Kodaikanal also. In hilly areas, cost of construction is 40% higher. If this amount is not sanctioned, then the contractors leave with half-constructed buildings.

Dindigul CHO said the population is 249K and around 30% of households live in slums. They have 4 UPHCs. There are 20 HSCs, 8 have become HWC, 5 are being built now and 7 need to be constructed. Compound walls with cattle traps are required for all UPHCs. Palani Road UPHC was constructed only in 2019, but now major plastering work is required. Similarly, another UPHC constructed in 2019 requires major tile work. All 4 UPHCs need generators, anti-shock garments for mothers, RO system, labour cots, computer with printer & scanner, biomedical waste room and feeding room, toilet facilities for differently abled persons and separate toilets outside for all. Semi auto analyzer is required for Kamala Nagar UPHC.

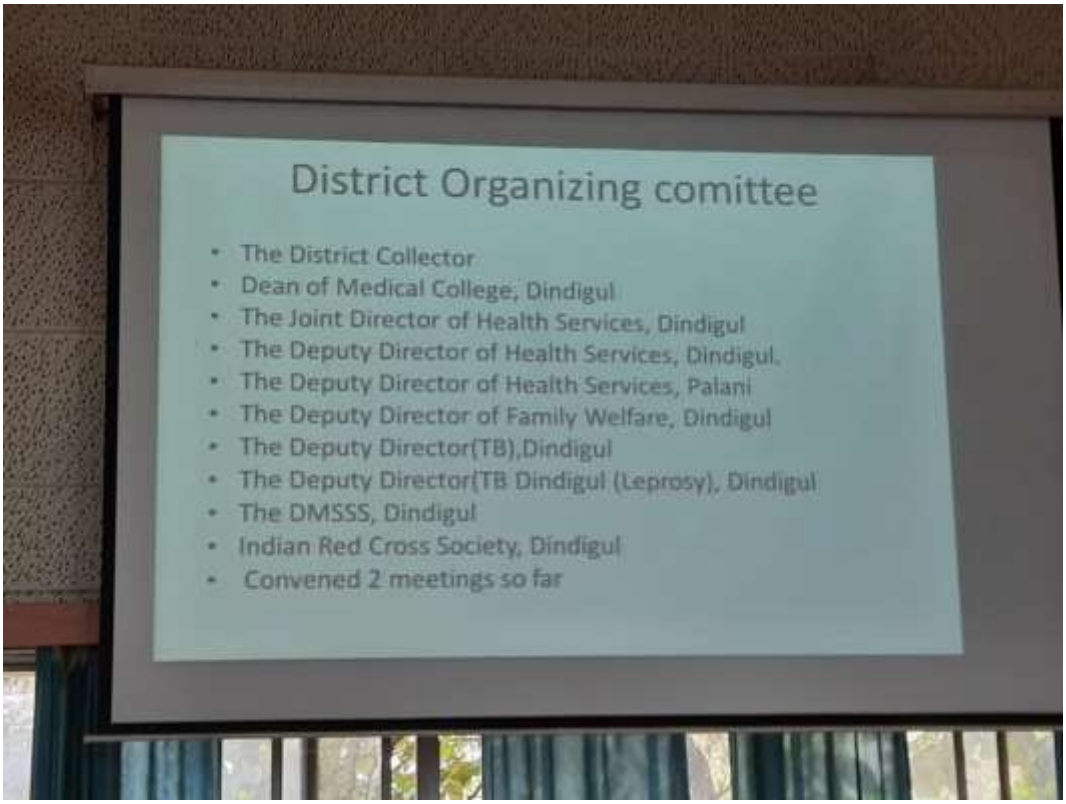
DMS doctors made the following requests

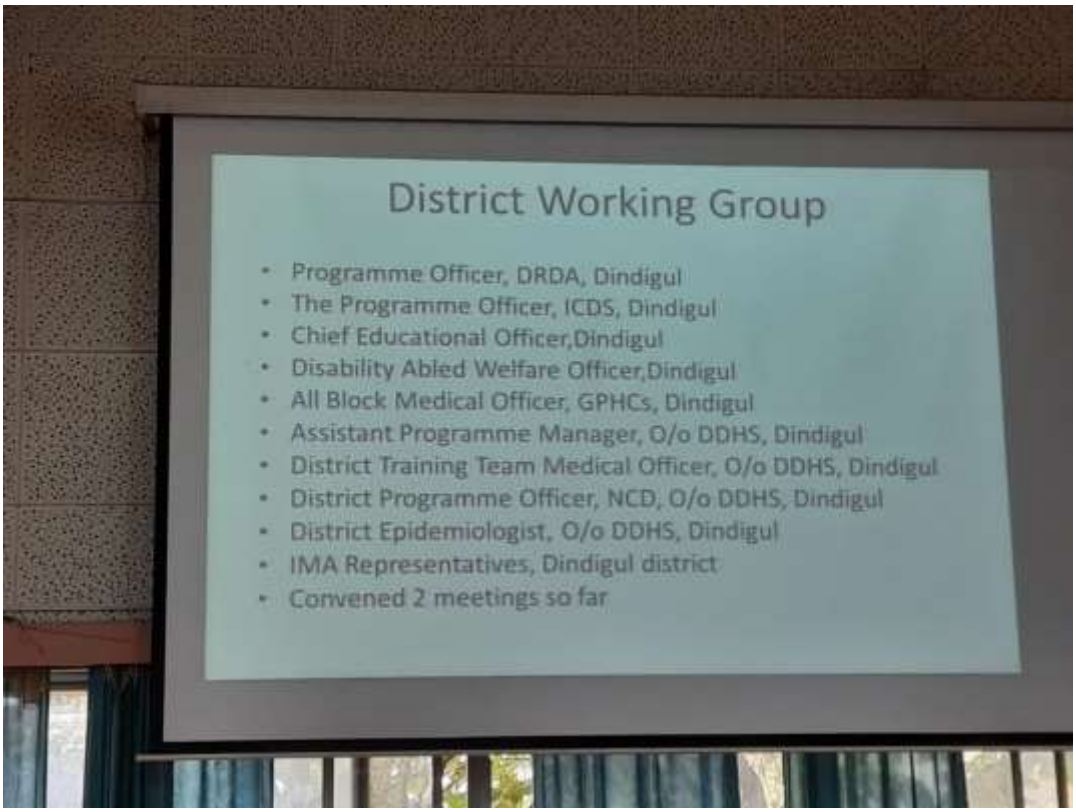
1) Palani GH
    a. Sewage treatment plant
    b. Head injury treatment center
    c. Digital x-ray unit
    d. New CT scan machine
    e. Orthopedic surgery equipment
    f. RO plant
2) Kodaikanal GH
    a. Compound wall to prevent dogs, bison from coming in
    b. Every month there are 2-3 unidentified bodies, need NQAS certified mortuary
3) Ayyakudi GH
    a. New OP and IP blocks
    b. Two 40 KVA generator set
4) Pannaikudi GH – all the buildings are more than 50 years old and PWD have condemned them

5) Thandikudi GH
    a. Staff quarters
    b. Scan machine
6) Natham & Vedasandur GHs need digital x-ray unit
7) Athur GH needs generator

JD said that though many people are asking for the PHC to be upgraded to a GH, it need not lead to improved performance. For instance, in Chinnalapatti PHC, there are currently 5 doctors, but if it is made into a GH, they will remove all equipment including table, chair and it will take more than two years for it to be functional and most likely it will have only 2 doctors. He said that though GHs are there in Pannaikadu and Thandikudi, the functionality there is quite less.

JD said that all requests will be noted and sent to state and they will see which can be done with World Bank funds, which can be done NHM funds and which can be done with state funds.


District Organizing comittee
The District Collector
Dean of Medical College, Dindigul
The Joint Director of Health Services, Dindigul
The Deputy Director of Health Services, Dindigul.
The Deputy Director of Health Services, Palani
The Deputy Director of Family Welfare, Dindigul
The Deputy Director(TB),Dindigul
The Deputy Director(TB Dindigul (Leprosy), Dindigul
The DMSSS, Dindigul
Indian Red Cross Society, Dindigul
Convened 2 meetings so far


District Working Group
Programme Officer, DRDA, Dindigul
The Programme Officer, ICDS, Dindigul
Chief Educational Officer,Dindigul
Disability Abled Welfare Officer,Dindigul
All Block Medical Officer, GPHCs, Dindigul
Assistant Programme Manager, O/o DDHS, Dindigul
District Training Team Medical Officer, O/o DDHS, Dindigul
District Programme Officer, NCD, O/o DDHS, Dindigul
District Epidemiologist, O/o DDHS, Dindigul
IMA Representatives, Dindigul district
Convened 2 meetings so far

Annexures

Annexure 1: Draft VHNSC Checklist

(VHNSC should fill and send to the BMO for discussion at the Block Health Assembly)

Category	Question / Parameter	Answer / Plan to address issue
Personnel	Is there any personnel vacancy in health centres (doctors, nurses, pharmacist, VHN, ASHA)?	
	Is there any vacancy in anganwadis?	
Access and Quality	Are the health facilities open at the specific times?	
	Are the health facilities easily accessible?	
	Are adequate testing facilities available in the health centres?	
	Are adequate medicines available?	
	Is the quality of care provided at the health centre satisfactory?	
	Are there any difficulties in getting benefit under the maternity benefit scheme?	
	Are there any difficulties in getting access to emergency ambulance?	
Public Health Issues	Does everyone in the village have access to adequate drinking water?	
	Are there issues related to snake / dog bites?	
	Is tobacco use a widespread issue?	
	Is alcohol abuse a widespread issue?	
	Is drug abuse an issue?	
	Is violence against women prevalent?	
	Is poor sanitation an issue?	
	Are mosquito control measures adequate?	
	Is open-defecation an issue?	
Infrastructure	Is there any requirement for new buildings / roads / drains / waste management facility?	
	Is there any requirement for repair of buildings / roads / drains / waste management facility?	
	Is there any requirement for water in public facilities such as schools, health centres & anganwadis?	
	Are there households which do not have access to water?	
	Is there any requirement for soak pits?	

	Is there any requirement for building toilets?	
	Are toilets in schools and anganwadis functional and clean?	
	Does the village have adequate waste management facilities?	
	Are there any issues with electricity access?	
	Are there sufficient street lights?	

VHNSC resolutions to be considered by the Block Health Assembly

Annexure 2: Suggested schedule

S No	Topic	Time
1	Inauguration	20 minutes
2	Introduction of the health assembly, process followed in the state, key statistics including number & type of resolutions, number & type resolved, number to be presented in the DHA, total budget required etc.	20 minutes
3	Overall presentation – including health facilities in the district, HR position, new initiatives, public health messages	20 minutes
4	Time for elected representatives and general public from any place to talk; each person to talk for a maximum of 2 minutes and opportunity to people who have not talked before (as done in Villupuram)	90 minutes
5	Opportunity for workers from different health cadre (ASHA workers, nurses, doctors, pharmacists, lab technicians) to present – 30 minutes	30 minutes
	Lunch Break	
6	DDHS presenting a summary of all the requirements	10 minutes
7	BMOs wanting to stress any particular points and/or show a few photos	20 minutes
8	City Health Officer	10 minutes
9	JDHS presenting a summary of all requirements	10 minutes
10	CMOs wanting to stress any particular points and/or show a few photos	10 minutes
11	Dean of Medical College presenting a summary of requirements	10 minutes
12	Open time for anyone to talk for a maximum of 2 minutes	30 minutes
13	Project Officer, ICDS	10 minutes
14	Project Officer, DRDA	10 minutes
15	EE, TWAD; EE, PWD; and other officers	10 minutes
16	Summary of discussion, new resolutions that have been added and response from senior person	25 minutes
17	Closing session	5 minutes