ORGANIZATIONAL AND ADMINISTRATIVE SET UP OF HEALTH SYSTEM IN INDIA AT STATE AND DISTRICT LEVEL

INTRODUCTION

States are largely independent in matters relating to the delivery of health care to the people. Each state has developed its own system of health care delivery, independent of the Central Government. The Central Government responsibility consists mainly of policy making, planning, guiding, assisting, evaluating and coordinating the work of the State Health Ministries. The organization at state level is under the State Department of Health and Family Welfare in each state headed by Minister and with Secretariat under the charge of Secretary/ commissioner (Health and Family Welfare) belonging to the cadre of Indian Administrative Service (IAS).

AT THE STATE LEVEL

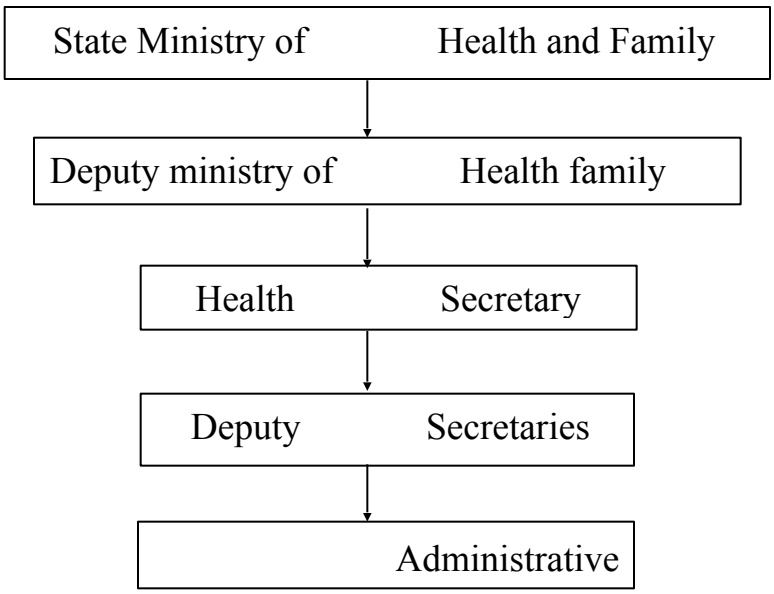
The health subjects are divided into three groups: Federal, Concurrent and State. The state subjects are the responsibility of the state, including provision of medical care, preventive health services and pilgrimage within the state.

STATE HEALTH ADMINISTRATION

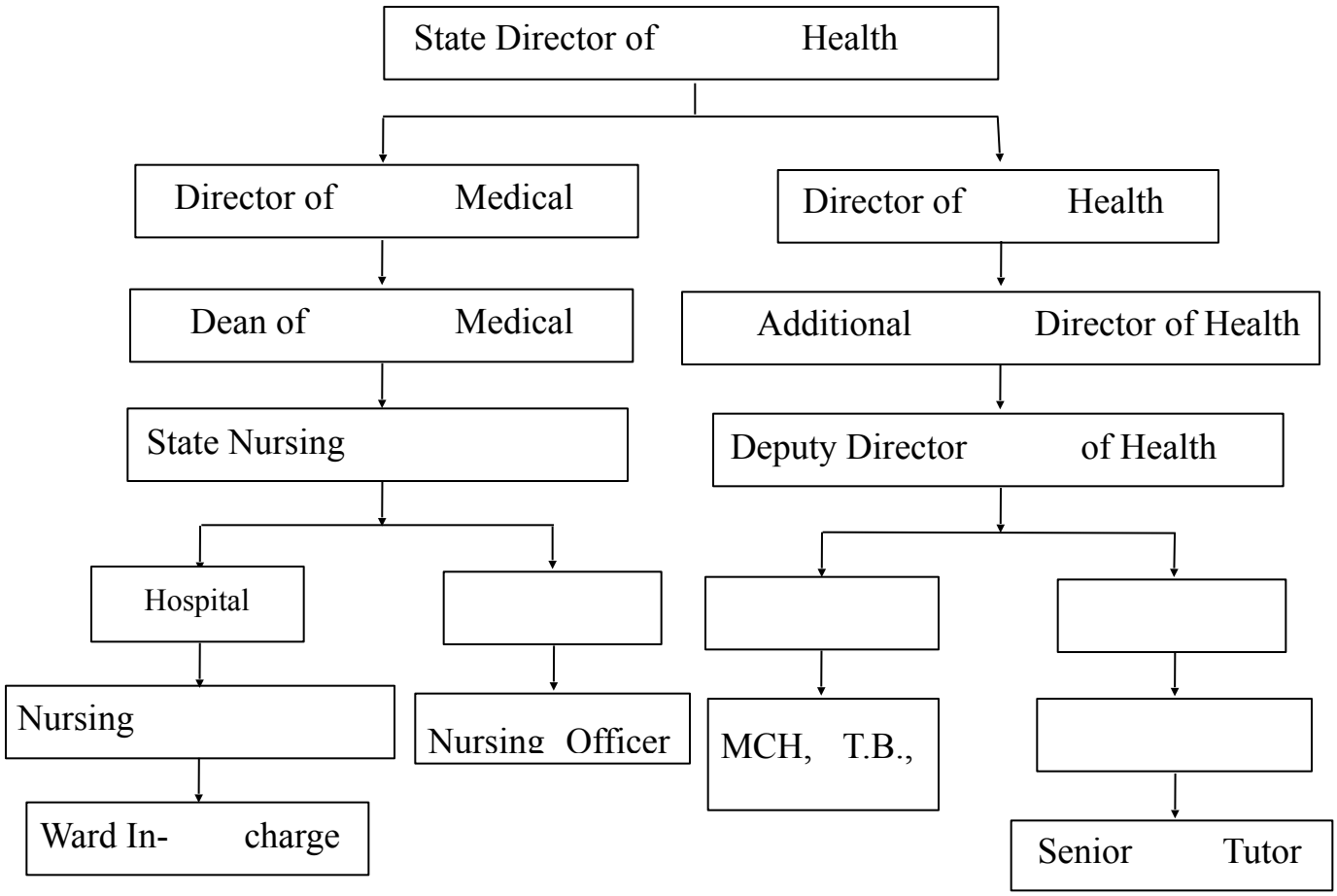
At present there are 29 states in India, each state having its own health administration.

ORGANIZATIONAL PATTERN

1) Organizational pattern headed by State Ministry of Health and Family Welfare



2) Organizational pattern headed by State Director of Health



DIRECTORATE OF HEALTH SERVICES

The Directorate of Health Services is fully committed in the total health care of its people in the spirit of health. The priority attention of the department is to provide the optimum health need of the people in general and particularly to those living in rural and tribal areas as well as other peripheral remote areas of the state.

It also looks after the promotion & curative aspect of Health and Family Welfare Department from State Hospitals to Sub-divisional Hospitals

The Directorate of Health Services is concerned with the planning, implementation, supervision and monitoring of prevention, pro- motive and curative services for all the population of the state. It is also working as nodal agency for implementation of The Central Births and Deaths Registration Act 1969 and Prevention of Food Adulteration Act, 1954.

FUNCTIONS OF STATE HEALTH DIRECTOR

1. Studies in depth the health problem and needs in the state and plans scheme to solve them.
2. Providing curative and preventive services.
3. Prevention of any outbreak of communicable diseases.
4. Provision for control of milk and food sanitation.
5. Promotion of Health Education.
6. Promotion of health programmes such as school health, family planning and occupational health.
7. Supervision of Primary Health Centre.
8. Establishing training for health personnel.
9. Co- ordination of all health services with other minister of state such as minister of education, central health and voluntary group.

AT THE DISTRICT LEVEL

There are 640 (2011 census) districts in India. Most of the district in India are divided into two or more sub-divisions, each in-charge of an assistant collectors or sub collector. Each division is again divided in taluks, in-charge of a Thasildhar. A taluk usually comprises between 200 to 600 villages. The community block comprises of approximately 100 villages and about 80,000 to 1,20,000 population, in-charge of a Block development officer. There are the village panchayats, which are instructors of rural local self government. The urban areas of a district are organized into Town Area Committee (i.e. in areas with population ranging between 5,000 to 10,000), Municipal Board (i.e. in area with population ranging between 10,000 and 20,000) and Corporation (i.e. with population above 2,00,000). The town area committees are like panchayats. They provide sanitary services. The Municipal Boards are headed by Chaiman/ President, elected by members.

The functions of Municipal Board are as follows:

1. Construction and maintenance of roads.
2. Sanitation and drainage.
3. Street lighting.
4. Water supply.
5. Maintenance of hospital and dispensaries.
6. Education.
7. Registration of birth and death etc.

8. The corporation is headed by Mayors, elected by councilors, who are elected from different wards of the city. The executive agency includes the commissioner, the secretary, the engineers and the health officer.

The activities are similar to those of municipalities on a much wider scale.

Within each districts, there are 6 types of administrative area. They are:

1. Sub- division.
2. Tehsil (Taluks).
3. Community development blocks.
4. Municipalities and Corporation.
5. Villages and
6. Panchayats

Panchayat Raj:

The panchayat raj is a 3-tier structure of rural local self-government in India linking the village to the district. It includes:

1. Panchayat (at the village level)
2. Panchayat Samiti (at the block level)
3. Zila Parishad (at the district level)

Panchayat (at the village level):

The Panchayat Raj at the village level consists of

1. The Gram Sabha
2. The Gram Panchayat

The Gram Sabha:

It is the assembly of all the adults of the village, which meets at least twice a year. The gram sabha considers proposals for taxation, and elect members of the Gram Panchayat.

The Gram Panchayat:

It is the executive organ of the gram sabha and an agency for planning and development at the village level. The population covered varies from5000 to 15000 or more. The members of panchayat hold offices for a period of 3to4 years. Every panchayat has an elected president (Sarpanch or Sabhapati or Mukhia), a vice president and panchayat secretary. It covers the civic administration including sanitation and public health and work for the social and economic development of the village.

Panchayat Samiti (at the block level):

The block consists of about 100 villages and a population of about 80,000 to 1,20,000. The panchayat samiti consists of Sarpanch, MLAs, and MPs residing in block area, representative of women, SC, ST and cooperative societies. The primary function of The Panchayat Samiti is to execute the community development programme in the block. The Block development Officer and his staff give technical assistance and guidance in development work.

Zila Parishad (at the district level):

The Zila Parishad is the agency of rural local self government at the district level. The members of Zila parishad include all heads of panchayat samiti in the district, MPs, MLAs, representative of SC, ST and

women and 2 persons of experience in administration, public life or rural development. Its functions and powers vary from state to state.

HEALTH CARE SYSTEM

Health care system can be categorized into the following manners.

1. At village level.
2. At sub center level.
3. At Primary Health Centre (PHC) level.
4. At Community Health Centre (CHC) level.

At village level:

At the village level, elementary services are rendered by (a) Village health guides (b) Local dais (c) Anganwadi workers and (d) Accredited Social Health Activist **(**ASHA)

Village health guides:

Village health guide is a person with an aptitude for social service and is not full time government functionary. Village health guides scheme was introduced on 2nd October, 1977.

Guidelines for their selection:

1. They should be permanent resident of the local community, preferably women.
2. They should be able to read and write, having minimum formal education at least up to the VI standard.
3. They should be acceptable to all sections of community.
4. They should be able to spare at least 2 to 3 hours every day for community health work. After selection the health guide undergo a short training in primary health care. The training is arranged in the nearest PHC, sub-center or other

suitable place for the duration of 200 hours, spread over a period of 3 months. During the training period they receive a stipend of Rs.200 per month.

Functions of Village health guides:

1. Provide treatment for common minor ailments.
2. First aid during accidents and emergency.
1. Maternal and Child Health (MCH) care.
3. Family planning.
4. Health education.

Local dais:

Most deliveries in rural areas are handled by untrained dais. The training for dais is given for 30 working days. Each dais is paid stipend of Rs. 300 during the training period. The training is given at Primary Health Centre (PHC), sub-centers or Maternal and Child Health (MCH) care center for 2 days in a week and on the remaining four days of the week they accompany the health worker (female) to the village. During her training each dais is required to conduct at least 2 deliveries under the supervision and guidance of health worker (female), ANM, health assistant (female).

Functions of dais:

1. Maternal and Child Health (MCH) care
2. Family planning.
3. Immunization.
4. Education about health.
5. Referral services.
6. Safe water and basic sanitation.
7. Nutrition.

Anganwadi worker:

Under the ICDS scheme there is an anganwadi worker for a population of 1000.There are about100 such workers in each ICDS project. The anganwadi worker is selected from the community and she undergoes training in various aspect of health, nutrition and child development for 4 months. She is a part time worker and paid an honorarium of Rs.200-250per month for the services.

Functions of anganwadi worker:

1. Maternal and Child Health (MCH) care.
2. Family planning.
3. Immunization.
4. Education about health.
5. Referral services.
6. Safe water and basic sanitation.
7. Supplementary nutrition.
8. Non-formal education of children.

Accredited Social Health Activist (ASHA):

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist – 'ASHA' or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system. Following are the key components of ASHA.

SELECTION OF ASHA:

In general, the norm for appointing ASHA will be 'One ASHA per 1000 population'. But in tribal inhibited area, hilly area or the desert areas, the norm

could be relaxed to one ASHA per habitation depends upon workload etc. The States is also responsible to work out the district and block-wise coverage/phasing for selection of ASHAs. It is envisaged that the selection and training process of ASHA will be given due attention by the concerned State to ensure that at least 40 percent of the ASHA in the State are selected and given induction training in the first year as per the norms given in the guidelines. Rest of the ASHAs can subsequently be selected and trained during second and third year.

Criteria for Selection:

1. ASHA must be primarily a woman resident of the village 'Married/Widow/ Divorced' and preferably in the age group of 25 to 45 years.
2. ASHA should have effective communication skills, leadership qualities and be able to reach out to the community. She should be a literate woman with formal education up to Eighth Class.

Roles and responsibilities of ASHA:

1. Provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living.
2. She will counsel women on birth preparedness, importance of safe delivery, breast-feeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/ Sexually Transmitted Infection (RTIs/STIs) and care of the young child.
3. ASHA will mobilize the community and facilitate them in accessing health and health related services available at the village/sub-center/primary health

centers, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government.

4. ASHA will provide primary medical care for minor ailments such as diarrhea, fevers, and first aid for minor injuries.

5. She will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy(ORS), Iron Folic Acid Tablet(IFA), chloroquine, Disposable Delivery Kits(DDK), Oral Pills & Condoms, etc. She will inform about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-Centers/Primary Health Centre.

6. She will promote construction of house hold toilets under Total Sanitation Campaign.

CONCLUSION

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