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**PEOPLE'S PARTICIPATION IN HEALTH CARE  
DELIVERY :  
AN APPRAISAL OF ACTION RESEARCH**

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## PEOPLE'S PARTICIPATION IN HEALTH CARE DELIVERY : AN APPRAISAL OF ACTION RESEARCH

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The aim of the present study conducted by the CMDR is to examine the effects of economic reforms on the health sector in India. The study has an action intervention component, which aims to strengthen the delivery of primary health care through the Primary Health Center (PHC) network.<sup>1</sup>

As India is a signatory to the Alma Ata declaration, we were required to achieve the goal of Health for All (HFA) by 2000 A.D. It is obvious that we have not been able to achieve this goal as enumerated in the health policy document for various indicators. In the wake of economic reforms, there seems to be a compression of budgetary resources in general, which has reduced the share of resources for the social sector in general and more so for the health sector. Shrinking resources have their impact on the health delivery system. Few research studies have documented this in the Indian context.

### **Methodology:**

As part of our ongoing study, we collected the household level information in the three

selected states of Maharashtra, Orissa and Karnataka through the help of structured questionnaire. We tried to elicit information regarding the socio-economic status of households, morbidity and nutritional profiles, utilization pattern and the risk factors affecting the health status of the population. Along with this we also tried to collect qualitative information on the perceived status of the community with regard to the health delivery system especially in the reforms period. The results from the data indicate that, the delivery of health services through public institutions have developed certain bottlenecks, which have resulted in lower levels of utilization by the community. Secondly, the aspirations of the community with regard to the public health care institutions are many and the present set-up is unable to meet the growing demand. Such a situation might have been created due to inadequacy with regard to manpower supplied as well as other inputs at the PHC level.

Our data also reveals that, private practitioners are exploiting the community under the nose of public health care institutions. Sometimes as public health

personnel are not available in the villages, the private practitioners (who are usually quacks) charge heavy fees from the patients. Poor people who do not have any options are forced to visit such private clinics. But at the same time we cannot afford to pass on the blame to the public system, which is trying honestly to cope up with the increased responsibilities on the one hand and declining budgetary support on the other.

### **Rationale for Intervention:**

Given this background we need to evolve new mechanisms of health care delivery which would strengthen the public health delivery system. Community involvement and participation in the provision of health care services is not a new idea altogether. We can note that there are innumerable experiences both within and outside India, which have demonstrated that community participation is an effective resource in the provision of health care services.

The need for such a participation in the present day context arises firstly due to inadequate manpower at the PHC level, which seems to be over burdened. The medical officer at the PHC is finding it hard to manage his time due to his involvement in 14 programmes / schemes. Thus, patients find it difficult to meet him whenever they visit the PHC. One may ask for additional doctor at the PHC, but in view of changing budgetary allocations, this may not be feasible.

Secondly, we also now observe that many state governments are willing to experiment using innovative methods to improve the situation with regard to the health delivery system. Recently the government of Karnataka has announced the introduction of Rogi Kalyan Samiti (RKS) based on the experiment of Madhya Pradesh. It needs to be noted here that RKS is quite a novel idea in managing the public health institutions. But the RKS of M.P. does not go below the level of Community Health Centers (CHCs), which means that it caters to referral rather than primary care. We need to experiment new methods of strengthening the public health delivery system at the primary health level also.

Based on the lessons of an experiment in Karnataka involving participation of Non Government Organisations (NGOs) in the delivery of health care services ( Report of Deccan Herald dated 4<sup>th</sup> May 14, 2002) the Central government has made changes in the health policy document 2002. The policy document clearly encourages NGO participation in the delivery of health services through public outlets.

In this background CMDR has tried to evolve an intervention package to supplement and strengthen the public health delivery system. The broad objectives of this package are:

- Community should actively participate in the provision of health care services
- Delivery of health care services should be more community friendly
- Try to inject built in mechanisms in the package to make it sustainable, after the initial doses of supplements

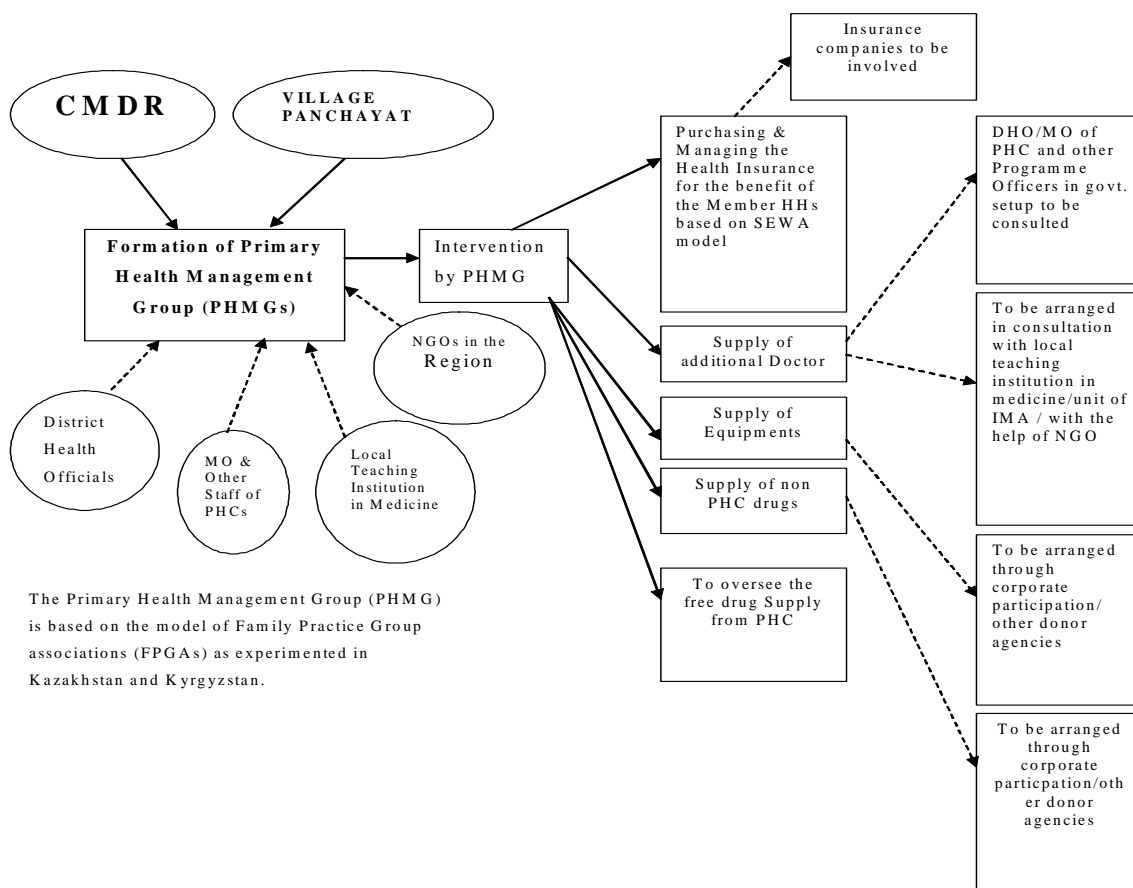
The envisaged intervention package is outlined as below.

- ❑ CMDR would create Primary Health

Management Group (PHMG) in the adopted village where a PHC is also located.

- ❑ Formation of PHMG would be through the active participation of District Health Officer (DHO) and other programme officers, village panchayat, CMDR and other NGOs and corporate bodies in the region
- ❑ PHMG would be registered as an NGO
- ❑ Initially CMDR would bear the salary costs of additional man power supplied

The following chart would depict the formation of PHMG and its responsibilities.



## COMPOSITION OF PHMG

- All households in the village
  - Panchayat members
  - District Health Officer (DHO) and other programme officers were included when CMDR actually tried to operationalize PHMG. However, it was not possible to include DHO and his staff due to their non-co-operation for the whole experiment.
  - School teachers of the village
  - Youth associations of the village
  - Women's Associations of the village
  - Corporate bodies in the region
  - CMDR
- Providing M.B.B.S. Doctor to the PHMG clinic
  - Providing health cards to the Households (HHs) to retain the medical history of the members
  - Providing telephone facility and logistical support to the members to avail referral care
  - Inviting specialized doctors to the village for the benefit of the villagers
  - Organizing eye check up and treatment camps with the help of donors
  - Educating the members about preventive health care
  - Working out the feasibility of providing health insurance to the members to avail referral care
  - Collaborating with charitable hospitals to avail referral care

- Collecting user fees from the patients and managing the PHMG clinic on a sustainable basis

During the course of intervention, we had to hold series of meetings and Focus Group Discussions (FGDs) in different villages of the district. Same useful lessons were learnt from the village where we first attempted to establish a PHMG. We conducted a baseline survey to gather information about the socio-economic condition, morbidity profile, care seeking behavior and the cost of treatment. We also tried to gauge the willingness of the community to pay for the services to be provided by the proposed clinic. Though initially some young members of the community evinced interest in the whole affair, gradually the euphoria subsided. When we started holding FGDs with various sections of the community, we started realizing the ground realities. The elders in the village had no interest to promote such experiment wherein they were required to pay for the health services. One issue that came to the forefront in this village is that, it was quite near to the urban center. The people in the village had an easy and quick access to the health care institutions in the urban center, which probably acted as a demotivating factor in arousing the interest of the community to participate in such an experiment.

By this time, we had also initiated the process of bringing the District Health

Officer into the experiment. Initial discussions were held with DHO and other programme officers of the district connected with various schemes of the health sector. The interest shown by the DHO and his team was really encouraging. He very much supported the idea of making the community responsible for the primary health care services on their own. The prototype of action intervention was explained to him and his team. He also suggested that, since health happens to be a Panchayat subject it would be better to involve the Zilla Panchayat in the whole experiment. Such a move would facilitate the involvement of Panchayati Raj Institutions (PRIs) in overseeing the effective delivery of health care services. With this idea in mind, we arranged a much bigger meeting involving Chief Executive Officer of the District Panchayat and Officials of Health Department. The meeting focused on the modalities of community involvement, user charges to be levied by the PHMG clinic and partnership between PHMG and PHC in the village. Partnership envisaged in this context was to depute additional doctor and nurse to the PHC through the institution of PHMG. These professionals would be based in the premises of PHC. The community would get the benefit of this additional manpower by paying user fees. One issue which came up for discussion during the meeting was that, if a patient gets treated by the Government doctor in the PHC and not by the PHMG doctor, whether he or she is required to pay the user fees or not. If this were so, no-body would opt for the PHMG

doctor for the simple reason of paying the user fees. Hence it was decided in the meeting to collect the user fees from all patients who would visit the PHC irrespective of the doctor that they consult. Thus user fee turned out to be an entry fee into the PHC. The District Health Officer gave his approval for this in the meeting. Chief Executive Officer of the ZP also endorsed this. He was of the opinion that, since PRIs are also involved in the experiment, there should not be any problem in collecting the user fees.

When the action intervention started taking some definite shape with these developments, we intensified the efforts to choose a village where such an experiment would take place. In this context, we started listing those villages in the district where PHCs are located and also such PHCs where either one Doctor or no doctor is functioning. In Uppin Betageri, there was only one doctor at the PHC and the community in that village as well as other villages covered by that PHC felt that there is a need of one more Doctor. Though, two posts of Doctors were sanctioned, only one Doctor was functioning. With this clue, we thought of choosing this village for the intervention. We approached the Panchayat and conducted the FGD. In the focus group discussion the members of the village showed interest and were keen to participate in the action intervention. However, forces operating behind the scene were really indicative of the nature of support from

government officials. The District Health Officer was quietly recruiting new doctors to the PHC of this particular village. Initially one doctor was appointed and gradually even the third doctor was installed in the PHC though there was no provision for the third doctor. These developments saw the mood of the villagers change very fast as they thought it futile to participate in an experiment wherein they themselves would shoulder the responsibility of running the clinic after the intervention support is over. They were very happy to have three doctors in the PHC but our efforts to enthuse them did not yield the desired results. The DHO who perceived our experiment as a threat professionally, was successful in foiling our experiment in this particular village. The fact that came out from this experience was that, though the public health officials were appreciating the kind of intervention that CMDR was trying to introduce, in actual practice they were not very keen to support it. They were not ready to accept the fact that public health delivery system is not effective in providing health services to the people.

We chose another village which was willing to participate in our action experiment. We had discussions with the members of the Grama panchayat of this village. They were happy about the fact that the PHC in their village would get an additional doctor and a nurse. The Chief Executive Officer (CEO) of the Zilla Panchayat (ZP) was prepared to extend his help for the experiment and he even directed

DHO to actively support it. As a matter of caution, we had similar discussions in another village also so that we had an alternative option if again our attempt was aborted here too. Another reason for doing so was to see whether we could undertake such an experiment in the second village without involving the PHC. The joint meeting of ZP, District Health Officials, members of respective villages and CMDR team was held to discuss the modalities of intervention. The people of both villages welcomed the idea of joining hands with PHC and to have additional staff in the premises of PHC. They were willing to pay for obtaining services from the PHC. During the course of the meeting the District Health Officer openly stated that he would permit the additional doctor and nurse to use the premises of the PHC and the new doctor would be required to function as per the existing government framework. But very soon, in almost a week's time we learnt that the DHO had a different story to narrate. He said, he would require the permission from his higher-ups in Bangalore and only if he gets the approval from them, he would be in a position to handover a portion of the PHC to the new staff recruited under the experiment. This was breaking news for the team of CMDR as well for the village that was ready to participate in the experiment. The villagers were not very happy over this development. They at the same time were not very keen on undertaking such an exercise without involving the PHC. The office bearers of the Gram Panchayat opined that, the villagers

lacked the necessary mental make-up and the capacity to participate in such an experiment in which public set up is not participating. One member felt that the drugs and other supplies to be supplied for the peoples' clinic would be misused by certain sections of the society and people may start suspecting any transaction by the office bearers of the PHMG. Thus, the fate of the first of the two selected villages was sealed.

In the stand by village, which we had selected as a matter of caution, we tried to experiment our prototype of action intervention. One advantage of this particular village was that, it had a good background of community participation in the drinking water supply scheme. The government of Netherlands had initiated a rural drinking water and sanitation scheme in the state of Karnataka, which tried to create the infrastructure for the drinking water supply with about 15 percent of the cost of the project to be borne by the community. After the expiry of the project phase, the created infrastructure would be handed over to the community itself for maintaining and operating the services on sustainable basis. This village named Morab, was managing the scheme of water supply successfully. It had the facility to treat the water before supplying and couple of water tanks were constructed to store the water to be supplied to the community. If a household wished to own a tap in their own home, it had to pay higher user fee than the household, which got water through community tap. In any

case community had to pay for the drinking water. The scheme was handed over to the Grama Panchayat and it has been running the show successfully for past seven to eight years. We considered this as the best positive factor in favor of enthusing the community to shoulder the responsibility of providing health care services also along with the water supply and sanitation facilities. At the outset we informed the villagers that, we are trying our best to get the nod from the higher-ups of the health department in Bangalore to initiate the experiment in this village with the effective participation of PHC set up. But if we fail to get the permission, the community has to be ready to experiment on their own. As expected the government machinery did not respond at all to our various requests to have discussions with them regarding the modalities of our proposed action intervention. More than a month was just wasted in waiting for the official response. We felt that nothing would move forward in this regard. **Finally we made up our mind to go ahead without joining hands with the PHC set up.**

The village people got convinced about the non-cooperation of the government machinery and they also expressed the desire to experiment the action intervention. When we decided to move forward, we actually planned the details of the experiment with the Grama Sabha members as well as other prominent members of the community. The suggestion which came out during such meetings, was



that, there is a need to place the details of the experiment before the general public of the village in a open meeting which is known as Grama Sabha or Village Meet. The CMDR team attended such a meeting in the village and the details of the action intervention were explained to the people. To our surprise the health related matters were taken up at the outset of the meeting and people expressed a desire to have a doctor at the PHC. They made this request because the post of doctor had remained vacant for many years. There had been many ad-hoc arrangements, which never fulfilled the requirements of the PHC. Incidentally, the District Health Officer made one more adhoc posting for the vacancy of doctor, and the concerned doctor had come on the day of meeting to convince the people that government has done something for their village by sending the doctor. When the doctor informed the people that he had taken the charge of Medical Officer of PHC for the past one month or so, the people could not believe it. They asked the office bearers of the panchayat and other people as to whether they noticed the presence of this doctor at the PHC at any time. It meant that the doctor had taken charge only on paper and had no time to visit the PHC to deliver the services. This event actually benefited us to a great extent. We explained the details of the experiment. The idea of formation of PHMG and establishing a clinic by it in the village appealed to the people. There was a unanimous agreement for this idea. When we also explained about the introduction of

user fees at the clinic there was no opposition to such an idea, in fact people were in favor of this, because getting a M.B.B.S. doctor for their village involves certain expenditure was the message from their discussion. The village meet finally gave an unanimous YES for our experiment. After this meet, we intensified our efforts towards the formation of PHMG. A series of meetings were held with Grama Panchayat members and other village leaders, social activists, women organizations and youth associations. Our intention was to involve the panchayat set up in the organization of PHMG on an official basis. This would help the process of decentralization in the provision and management of health care services. But the opinion of the office bearers of the panchayat was that, the decentralized set-up has been reeling under the effects of "Red Tape" and hence it would not be proper to bring PHMG also under a system which suffered on account of many socio-political factors. We considered their argument and finally decided to keep PHMG out of the decentralized set up, but we inducted some of the panchayat members as the members of PHMG also.

Thus the formation of PHMG took place in the village. The members of PHMG included, Panchayat members, school teachers, representatives of women organizations, other prominent members of the community and of course CMDR was also a member of this group. The doctor and nurse were appointed for the clinic. We were

able to search an experienced M.B.B.S. doctor, who had several years of practice in rural areas. We had a series of meetings to complete the modalities of opening the clinic in the village. A bank account was opened in the village in the name of PHMG and three people were authorized to operate the account. The doctor of the clinic, the president of the PHMG and the president of the Gram Panchayat were to manage the financial matters of the PHMG. In any case, CMDR had taken the responsibility of shouldering the doctor's and nurse's salary, supply of medicines and 50 percent of the rent for the premises of the clinic. The CMDR had intimated to the PHMG members that such financial support from CMDR would be for a period of six months only. After the expiry of such period, the PHMG will have to take over the responsibility of running the PHMG clinic on its own. A suitable place in the village was chosen to start the clinic. The members of PHMG named the clinic as Samudaya Arogya Kendra (SAK) which means Community Health Center. Before the inauguration of the clinic, CMDR supplied the minimum of equipments and other small requirements of the SAK. The following table shows the kind of materials supplied and their value.

The clinic was opened on the 19<sup>th</sup> of September 2002. The PHMG had agreed to collect the user fees from the patients visiting the clinic. The fee structure consisted of two slabs. An examination along with supply of minimum tablets and medicine would cost the patient Rs 5/- whereas the fee would be Rs 10/- if the patient received an injection. From day one the patients showed interest to visit the clinic. The mood on the opening day in the village was quite euphoric with villages and members of the PHMG feeling contented as they were instrumental in bringing a M.B.B.S. doctor to the village. They had put up a small board for the clinic with the working hours of the clinic mentioned on it. The clinic was to function from 9 a.m. to 5 p.m.

The clinic started functioning, and the staff of CMDR used to visit the village to give publicity to the clinic. They also used the occasion to elicit the views of the patients regarding services offered by the PHMG clinic as well as the PHC situated in the village. The following table shows the month-wise income and expenditure of the PHMG clinic.

**Table 1: Assets given to the SAK**

Type of assets	Amount (Rs)
Medical Instruments	8825.5
Furniture	4242
Other materials	1055
<b>Total</b>	<b>14122.5</b>

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regarding services offered by the PHMG clinic as well as the PHC situated in the village. The following table shows the month-wise income and expenditure of the PHMG clinic.

The receipts of the clinic for the period September 2002 to March 2003 shows that, a total of 3,280 patients visited the clinic, generating an income of Rs. 26,300. Certainly this amounts to a significant sum for the PHMG of Morab. But at the same time, we also need to look at the expenditure. The CMDR was paying Rs. 10,000 as salary plus Rs. 3,000 as allowances to the doctor. The nurse used to get Rs. 5,000 as salary and Rs. 680 by way of allowances. Apart from this CMDR had

Month	No.of patients @ Rs. 5	Amount	No.of patients @ Rs. 10	Amount	Total No.of patients	Amount
2-Sep	28	140	96	960	124	1100
2-Oct	140	700	439	4390	579	5090
2-Nov	145	725	431	4310	576	5035
2-Dec	79	395	355	3550	434	3945
3-Jan	135	675	380	3800	515	4475
3-Feb	179	895	299	2990	478	3885
3-Mar	554	2770	0 *	0 *	554	2770
<b>Total</b>	<b>1260</b>	<b>6300</b>	<b>2000</b>	<b>20000</b>	<b>3260</b>	<b>26300</b>

\* Note: In view of the non-availability of break up of patients, we have included all under Rs.5 category.

The clinic started functioning, and the staff of CMDR used to visit the village to give publicity to the clinic. They also used the occasion to elicit the views of the patients

also spent on non-recurring items like, equipments and furniture for the clinic and recurring expenditure on medicines. This is shown in the table below.

**Table 3: Recurring Expenses of the Clinic (Rs.)**

Month	Salary		Medicines	Total
	Doctor	Nurse		
2-Sep	5200	5676	6943	17819
2-Oct	13000	5676	1390	20066
2-Nov	13000	5676		18676
2-Dec	13000	5676	2783	21459
3-Jan	13000	5702		18702
3-Feb	8000	5624		13624
3-Mar	13000	5676		18676
Total	78200	39706	11116	129022

The average income and expenditure per patient would give us the overall scenario of the finances of the clinic. It would also indicate the gap that exists with the present

user fee structure as well as compensation structure for the staff employed. The following table gives us the average income and expenditure per patient.

**Table 4: Per Patient Income & Expenditure**

Months	Income / Patient	Expenditure / Patient	Difference
2-Oct	8.8	34.7	-25.9
2-Nov	8.7	32.4	-23.7
2-Dec	9.1	49.4	-40.4
3-Jan	8.7	36.3	-27.6
3-Feb	8.1	28.5	-20.4
3-Mar	5	33.7	-28.7
Total	8.1	39.6	-31.5

The average income per patient varies between Rs. 5 to about Rs. 8 whereas the average expenditure is between Rs. 28 to Rs 40. This only means that the cost of providing medical care services is quite burdensome and if the community is made to shoulder this responsibility, it may not be feasible for it to do so. What could be the alternatives before us to deal with a situation like this? If one considers increasing the user fees, the community may not support it. Even if some segment of the community supports it, it may severely affect the equity aspects of the services rendered by the clinic, leaving out the poorer sections in the cold. In such a situation, the best thing would be to reduce the operating costs of the clinic by reducing the salary of the doctor and by a reduction of other manpower support. In this particular experiment it was found that, as the clinic was catering to the needs of the community with regard to the treatment of common diseases and injuries, the services of the nurse was not considered to be very essential. The clinic had no facilities to provide the MCH services, which also made the nurse less useful for the clinic. The premise of the clinic was rented at the rate of Rs 600 per month. There was scope to shift the clinic to cheaper premises to save on the costs. The various permutations and combinations of the viability aspects of the clinic showed that, at least 35 to 40 patients must visit the clinic and it must generate an income of Rs. 7,000 to 7,500 per month. The clinic must then find a doctor who is willing to serve for Rs. 5,000 per month.

Rest of the amount could be utilized for the purchase of medicines and payment of rent and salary of the helper, with of course some minimum savings for the PHMG. Under such circumstances the take over of the clinic by the PHMG would be quite smooth and sustainable, after CMDR's withdrawal from the intervention.

#### **Views of the Community About the Clinic:**

When the clinic started functioning in the village, the news started spreading slowly within the village as well as to the neighboring villages. Thanks to the efforts of the CMDR field team which was instrumental in canvassing the opening up of the clinic as well as services rendered by it for the benefit of the community. The doctor of the clinic was also effective in rendering the services as required by the community and his interpersonal skills helped in gaining the confidence of the community. As promoters of the clinic, CMDR was keen to know how the community viewed the clinic vis-à-vis the PHC that was also functioning in the village. Exit interviews, discussions with the people and patients were conducted at regular intervals to elicit the information.

Young and old, male and female rich and poor patients visited the PHMG clinic. Usually more patients visited the clinic in the morning hours (between 10 a.m. to 1.30 p.m.) and in the evenings i.e.

around 5 p.m. or at the time of closure of the working hours. The community response to the services provided by the clinic was quite positive which was mainly due to the absence of a M.B.B.S. doctor in the village, for the past several years. Most of the quacks who did function in the village were not very impressive. The doctor at the PHC who was a M.B.B.S. was not available for most of the time.

People said that the clinic was located in a convenient place, in the center of the village. Space within the clinic was quite sufficient, both for the patients to wait in queue and for the doctor to examine the patients. The doctor of the clinic, according to the patients, was receptive and humane in his approach. The views of the patients about the clinic are summarized below:

- Need for the doctor to stay in the clinic during night time also
- Patients felt that the user fee of Rs. 10 and Rs. 5 was affordable for the members of the community
- Quality of the services rendered was found satisfactory by the patients
- Patients preferred the services of PHMG clinic due to poor quality of services provided by the PHC
- People expressed the need to include maternity services in the clinic
- The poor expressed a desire to get free services from the clinic
- Need was also expressed to have special health check-up camps
- It was also brought out from our survey that more publicity for the clinic needs to be provided in some areas of the village as well as the surrounding villages

The clinic started by the PHMG had a positive impact on the functioning of the PHC located in the village. As the PHMG clinic started providing good service on a regular basis, the sleeping governmental set-up woke up and started responding in a reactive way to the initiatives of the peoples' clinic. The DHO came out of his routine style of functioning and tried to match the '**Patient Friendly**' services of the peoples' clinic. Where there was no doctor for years in the PHC, we could see a doctor visiting the PHC daily. Even holidays saw a doctor at the PHC, which was a rare scene in the village. The PHC geared up its activities by visiting households in the village and providing services at their doorsteps. This change in attitude put the villagers in confusion who slowly started thinking that, there was no need to continue with the PHMG clinic as things are quite satisfactory at the PHC. Fortunately, this view was held by a small group of people. The villagers were ultimately convinced that things at the PHC improved only because of the CMDR experiment, and once the experiment is over and the PHMG clinic is closed, there is every possibility that the PHC would revert back to its old status. So people were cautious enough to safeguard the interest of the community by continuing to support CMDR led action intervention.

The views of the community and the support extended by the villagers really enthused us because we had sensed the urge in the community to carry on with the experiment even after the withdrawal of

CMDR. As mentioned earlier, we were busy identifying a less expensive doctor to be posted in the clinic, so that the finances of the clinic would be managed within the limits of the PHMG. When we finally found a doctor who was ready to work for Rs. 5,000 per month, CMDR handed over the clinic to the PHMG by withdrawing the staff recruited earlier. Thus, from the seventh month of its inception, the peoples' clinic started functioning in the village as peoples' own initiative.

The experiment has highlighted the fact that there is a potential in the community to participate in experiments which calls for their participation. In matters related to health, the need for community participation is still more crucial and villagers are looking for outside help for initial doses

of supplements. Even the working hours of the PHC are not in tune with the requirements of the people. A clinic of their own is certainly a boon to them. Our experiment supported the community clinic for just six months. The community felt that it needs to be extended by about a year or so, in order to encourage the community to shoulder the responsibility of running the clinic. The people were also not able to contribute seed money on account of drought situation for the past couple of years. Capacity building in the community and getting a clear vision of sustaining such experiments on long-term basis are time-consuming factors. A long-term experiment would certainly be more beneficial to evaluate the sustainability aspect. Nevertheless the community has now taken change of the clinic and the health services are reaching the people in a smooth manner.

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#### End Notes:

**1** \* CEO – Chief Executive Officer

CHC – Community Health Center

DHO – District Health Officer

FGD – Focus Group Discussion

HFA – Health For All

PHC – Primary Health Center

PHMG – Primary Health Management Group

PRI – Panchayati Raj Institutions

RKS – Rogi Kalyan Samiti

ZP – Zilla Panchayat













