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ROAD MAP FOR COORDINATION BETWEEN MEDICAL COLLEGES (MC'S) AND DISTRICT HEALTH SYSTEM (DHS)

G. V. Nagaraj¹

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ABSTRACT: The health indicators in the urban slum pockets are poor, or if not even worse than that of rural areas because of the poor accessibility of health services. The lucrative private sector exclusively for-profit has kept itself at bay, to provide even primary health care for the urban poor let apart essential / emergency services. It is perhaps best alternative, to make medical colleges more vibrant, functional and supportive to district health system, far, as of now, no public service health delivery system yet in functional mode, in urban areas particularly in bigger cities and towns. The Medical Colleges are functioning routinely in teaching and managing hospitals for teaching only. They are yet to spare more resources towards implementation of Government delivering health programmes.

KEYWORDS: National Health Mission (NHM), Health care, Intra-sectoral Coordination, Physical and Financial reports.

INTRODUCTION: The health care delivery system in India follows a national pattern since six decades starting from 1952, as per Sir Joseph Bhore Committee's recommendation in 1946.¹ The Health System comprises of District Health system providing 1) Primary Health Care (through Subcentres, Primary Health Centres) 2) Secondary Health Care (through Community Health Centres: First Referral Units: Taluk hospitals, District Hospitals) under 'Health Services' and 3) Tertiary Health Care being provided by hospitals attached to medical colleges and also specialized hospitals). These three as a chain of health care system should function in close coordination; then only it is possible to achieve the MDG goals² or ensuing 12th five year plan / NRHM Goals. While the Activated Social Health Activists (ASHAs), the Junior Health Assistants both male and female from health sector and Angan Wadi Workers (AWWs) from department of Women and Child Development are providing door to door health and health related services at village level, the medical officers and specialists posted at health institutions are responsible for providing comprehensive health care services(i.e. Preventive, promotive and curative services) nearly to the extent of 80% sickness load. The remaining 20% has to depend on tertiary care of specialist and super-specialist services.

Whatever the most ultra-level of clinical and surgical care available and / being provided in the country, the ultimate measure of quantity and quality of services have to be reflected in achieving higher levels in Human Development Index³ (Norway-1, Australia-2 as compared to India-135 in 2013) and more specifically in decline of infant mortality and maternal mortality. These indicators also reflect the socio-economic development of a region.

It is evident from the following statistics⁴, that there is still a gap compared to the goals to be achieved in the Infant Mortality and Maternal Mortality Rates in the State of Karnataka, one of the progressive States in southern India.

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Sl. No	Indicator	NHM Goals	2009	2010	2011	State Targets
1	Crude Birth Rate	-	19.5/1000 population	19.2/1000 population	18.8/1000 population	-
2	Crude Death Rate	-	7.2/1000 population	7.1/1000 population	7.1/1000 population	-
3	Maternal Mortality rate	< 100/ lakh live births	178/ lakh live births*	-	144/lakh live births	142/lakh births (2011-13)
4	Infant Mortality Rate	< 30/ 1000 live births	41/1000 live births	38/1000 Live births	32/1000 live births	26 /1000 live births (2011-13)
5	Total Fertility Rate	2.1	2.0	2.0	1.9	-

This gap, perhaps, also true for most of the States in India.

*SRS 2007-09

SOURCE: Sample Registration System, RGI, 2010, 2011, 2012.

It is said, that the performance especially in vital indicators does not commensurate with the efforts and resources being spent out of health budget. Because of adequate infrastructure, manpower, administration / management, the primary and secondary health care has progressed appreciably well in many aspects of programme delivery in respect of National, State and Externally Assisted Programmes through District Health System (DHS). Some of the 'evidence based' good examples are, high levels antenatal care and institutional deliveries, faster deceleration in infant mortality rate, moderate levels of achievement in immunization, promotion of small family norm, reduction, in diarrhea cases, in vaccine preventable diseases, in leprosy prevalence and eradication of Poliomyelitis.

While it is true that, there are more than the required inputs such as physical facilities, qualified manpower, drugs, modern and sophisticated gadgets available and affordable for elite urbanites, the same luxury are not accessible to the urban poor or those staying in slums / High Risk Areas. (Construction sites, Brick kilns, labor colonies, in and around industries)

These populations are forced to incur high Out of Pocket Expenditure (OPE) to come out from their ailments. It is because of the poor accessibility of health services, the health indicators in the urban slum pockets are poor, or if not even worse than that of rural areas. The lucrative private sector exclusively for-profit has kept itself at bay, to provide even primary health care let apart essential/emergency services for the poor. The National Health Mission (NHM) from 2013-14 onwards with its focus On 'Urban Health' is likely to take some more time to show results.

APPROACH: In the meanwhile, it is perhaps best alternative, to make medical colleges more vibrant, functional and supportive to district health system, far, as of now, no public service health delivery system yet in functional mode, in urban areas except in metropolitan cities e.g. Bengaluru, Mumbai, Chennai, Kolkatta & Delhi

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The medical colleges are functioning routinely in teaching and managing hospitals for teaching Purpose. They are yet to spare more resources towards implementation of Government delivering health programmes, many of which are supported with good funding meant for both BPL and APL families under continued NRHM⁵ schemes such as Janani SurakshaYojana (JSY), Janani Shishu Suraksha Karyakrama (JSSK), Madilu Kits (19 items), Arogya Bandhu, Prasoothi Araike, surgery for Cataract, Revised National Tuberculosis Control Programme (RNTCP), FP methods, School health programme and so on.... under NHM funds.

Further, in recent times, almost all the medical colleges coming under Government sector have been made autonomous with noble intentions, that the flexibility, decentralization in administration and management will pave way to better governance, functioning and yield better results in the implementation of the programmes and services. Unfortunately along with private managed medical colleges, the converted autonomous medical colleges (earlier Government) with attached hospitals are showing exactly the opposite phenomena. Medical colleges are yet to streamline themselves as 'Centers of excellence' for providing high order clinical and surgical services for the poor and also as skill transfer centers.

As regards, 'Health Data' in the form of 'Health management Information System'(HMIS), the collection, compilation, reporting of the data in prescribed IT enabled formats, has improved in general and remarkably good in certain areas as revealed from validation. This is particularly true under DHS covering primary health and secondary health care. However this data is not complete as it is not capturing the services being rendered by the medical colleges and hospitals covered by them in urban areas. Therefore the performance figures being sent to GoI under both physical and financial progress are either left out or incomplete because of not getting the reports at all or incomplete from the medical colleges, while compiling by DHS for consolidation of the reports. Whatever statistics we arrive seems to be not relevant to the population we are referring.

Further, the medical colleges started as centers of good learning is lagging behind in provision of essential clinical services, timely furnishing of reports, observance of 'Standard Treatment Guidelines', follow protocols, implementation of National Health Programmes, leadership in Governance /management, State-of-the-art in training, skill based training, proper documentation, monitoring and supportive supervision, Research, compilation of the reports and sending the same to district health system / directorate. There has been very less / no coordination in timely furnishing the details of the activities / progress figures.

Because of this lapse, of not including the performance figures of medical colleges in the quarterly reports (as reported by the 'District Health Mission' staff under NRHM), the overall performance is being pulled down particularly in the districts where medical colleges are functioning, and hence, the State overall performance is relatively registering low levels giving a grim picture. Even after nearing two decades of Integrated Diseases Surveillance Project implementation, it has not become possible to get an accurate, correct and complete and timely data for planning and implementing necessary interventions.

To facilitate intra-sectoral coordination between primary and secondary health care and medical colleges, the following strategic requisites have to be operationalized in the coming years as there can be a good budget support for each and every interventions under 'National Health Mission (NHM)' as the thrust in the coming years in on 'Urban Health'. These coordinated efforts will definitely improve the 'equity' in health accesses from all counts, not only for BPL families but also for

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those who like to seek the services. This will further give a big boost to the Public Delivery System in health care of the State, which is also a vision of present national Government.

I. NODAL CELL:

- One 'Health Programmes' nodal cell / Department shall be established in each of the medical colleges to streamline coordination between health services and medical colleges.
- The nodal cell will bring in convergence of all programme departments involved in 'NHM' and other non-health departments such as Women & Child Development, Education, Social welfare and others.
- One senior doctor preferably from the department of pediatrics shall be identified as 'Nodal Officer' to monitor the activities, and bring in coordination of all departments of the medical college.
- The nodal cell have one programme Assistant preferably with postgraduate qualification either Post Graduate in Health Management or Master of Public Health for data management and analysis.
- The nodal cell shall collect the reports from all the specialists particularly Ob & Gynecology, paediatrics, Ophthalmology, and National and State health programmes as per the standard formats prescribed by GOI and State Government and send it to DHS within the prescribed date.
- The nodal officer shall be supported by a faculty from Ob & gynaecology department and a faculty from Community Medicine department.
- All other departments will cooperate and coordinate in implementing the programmes and reporting of the progress every month to nodal cell.
- The nodal cell shall be provided a computer with internet facilities.
- The Programme Assistant shall be assisted by a Computer Assistant /operator.
- Shall keep Guidelines under different programmes, manuals and reference material and make available to the concerned programme officers from time to time so as to not only creating awareness on 'Health Mission' entitlements but also mobilize the vulnerable groups to utilize the NRHM entitlements.

II. Strengthening linkages with primary and secondary health care institutions, implementation of Health Programmes, Health management, Training, and health research, and studies.

A. LINKAGES:

- Since medical colleges are one of the categories of health care institutions, they too shall be responsible for comprehensive health care such as primary, secondary and more so tertiary health care.
- The medical colleges shall have formal linkages with district hospitals, Taluk hospitals, CHC's, FRU's and 24X7PHC's.
- The medical colleges shall support in extending clinical services and training.
- The medical college shall, along with Public delivery health system, jointly involve in enrichment of health services of a definite population (Area approach) showing low performance levels / underserved areas in the vicinity of the district. They can as well adopt one high risk population area.

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- The area can be shared, if there are more medical colleges in the district.
- A separate structure needs to be worked out to ensure sustainability.

B. HEALTH PROGRAMMES:

1. PREVENTIVE SERVICES:

i. Maternal Health (MH):

- Shall issue 'Thayi Cards', / Mother Child Protection cards/ Antenatal cards, provide necessary antenatal check-up, enter required information for first timers or not yet registered antenatal clients.
- Shall identify High Risk Pregnancy (HRP's) clients and provide them VIP treatment.
- Shall ensure immunization by Tetanus Toxoid and Iron and Folic Acid distribution.
- Shall promote safe Institutional Deliveries including of those referred from outside and make available 'Madilu kit (19 items) for SC, ST, and BPL category women.
- Shall opt only for elective Lower Segment Caesarean Section.
- Utilize the funds towards Diagnostics (Scanning) diet, drugs and consumables both for normal deliveries and Caesarean deliveries under Janani Shishu Suraksha Karyakrama (JSSK) both for BPL & APL families (Refer details).
- Promote hospital stay for at least two days in normal deliveries and at least 7 days in case of LSCS.
- Promote Baby Friendly Hospital Initiative and immediate breast feeding.
- Educate, motivate and cause to adopt small family norm.
- Take up Facility Based Maternal Death Review (FBMDR) along with DHS.
- Utilize the funds to provide the required services under 'Garbhakosha Chikitse Karyakrama (GCK) i.e., for treating 'Uterine diseases' free of cost.

ii. Child Health (CH):

- Shall ensure 'Birth registration' and 'Death registration' and arrange to get certificates accordingly through revenue authorities.
- Shall ensure recording of 'birth weight' of new born.
- Shall ensure measures to prevent asphyxia, hypothermia and Infection.
- Shall ensure immediate breast feeding.
- Shall ensure immunization for the infant before discharge.
- Shall hold regular sessions for immunization of children and ensure entry in the immunization card. Shall involve interneers and Nursing college students during immunization sessions particularly in slum areas, migrant populations and construction sites and in religious functions.
- Shall jointly prepare Micro- plan for Intensive Routine immunization (IRI) with DHS and also participate in the mass campaigns for e.g. Pulse Polio Immunization.
- Follow 'Open vial policy'.
- Monitor and provide supportive supervision for IRI and weekly immunization rounds.
- Shall jointly plan and involve in administration of Vit 'A' syrup particularly in Urban slums.

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- Implement activities under Integrated Management of New born Childhood Illness (IMNCI).
- Operationalize Facility Based New born Care (FBNC).
- Operationalize Sick New Born Care Units (SNCU).
- Operationalize New Born Stabilization Units (NBSU).
- Promote Perinatal Intensive Care Units (PICU's).
- Promote Home Based New Born and Child Care (HBNCC).
- Utilise the funds fully towards maintenance and consumables.
- Utilise the funds for sick neonates up to 30 days under JSSK.
- Management of Diarrhoea and Pneumonia and Micronutrient Malnutrition.
- Take up Infant Death Audit (IDA) using FIR formats, VA formats and ID registers.

iii. Nutrition:

- Shall Promote Infant and Young Child Feeding (IYCF).
- Shall provide care for Sick Children and Severe Acute Malnutrition (SAM cases) at Nutrition Rehabilitation Centre (NRC) / Modified Nutrition Rehabilitation Centre (MNRC)/Child Development Nutrition Centre.
- Cooperate in screening of newborns for 'Retinopathy of Prematurity' (ROP).
- Shall conduct detailed and Regular Medical Examination of Severely Malnourished Children referred from the Taluks/Anganwadis.

iv. Family Planning:

- Shall cause to adopt small family norm such as spacing methods, minilap tubectomy, Laparoscopic sterilization, IUD (380-A) oral pills and Condoms.
- Shall counsel the client, motivate for adoption of Post-partum-IUCD before post-natal case is discharged.
- Shall ensure compensation for female sterilization clients.
- Shall undertake MTP's as deemed eligible.
- Shall promote No Scalpel Vasectomy.
- Shall strictly observe the standards and Quality Assurance of sterilization services.
- Shall facilitate early payment of ex-gratia amount for legal heirs in fatal cases.
- Shall get repairs of Laparoscopes.

v. PC & PNDT:

- Shall furnish details of Screening by Ultra sound
- Shall involve in public education
- Shall discourage sex selection tests
- Shall take up 'Decoy' drives to book the culprits

vi. Adolescent Reproductive Sexual health (ARSH):

- Shall fix up a convenient time on two days preferably Thursday and Saturdays and popularise the Adolescent Friendly Health Clinics (AFHC's), provide counselling and also required education and services for adolescents especially for addressing any physical, physiological, Psychological, emotional and behavioural deviations.

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- Shall provide education and Promote sales and usage of Sanitary pads for Menstrual hygiene.
- Implement Weekly Iron and Folic Acid Scheme (WIFS).

vii. School Health:

- Register the referred cases and provide the necessary specialist services including surgery if required under Suvarna Arogya Chaithanya Scheme or through Yeshaswini and facilitate payment of service charges.

2. COMMUNICABLE DISEASES:

i. National Vector Borne Disease Control Programme (NVBDCP):

- National Anti-malaria programme (NAMP): Active Surveillance- Collect Blood smear, Presumptive treatment, Smear examination within 24 hours, report to DHS and cause for radical treatment
- National Filaria Control Programme (NFCP): Collection of night blood smear, administration of Diethyl Carbamazine Citrate (DEC tablets) and report to DHS
- Take up curative and preventive measures against Chikungunya, dengue and Japanese-B-Encephalitis

ii. Revised National Tuberculosis Control Programme (RNTCP):

- Shall scrupulously follow guidelines under DOTS. Let, there not be any deviations and different mind sets for physicians and chest specialists in treating the tuberculosis other than RNTCP regimen.
- Notify the Tuberculosis disease to DHS.
- Shall arrange sensitization sessions to general practitioners to follow RNTCP guidelines while treating the TB cases.
- Involve professional bodies like IMA, IAP, IAGP, IAPH and others in all national health programmes in general and RNTCP in particular.
- Shall take care to break strong relationship between Tuberculosis and HIV/AIDS.
- Shall take care to break strong relationship between Tuberculosis and diabetes.

iii. HIV / AIDS:

- Shall involve in Counselling, diagnosis, Anti-Retroviral Treatment, Behaviour Change Communication, condom promotion, care and support services for PLWHA and services for PMTCT for HIV / AIDS control.
- Shall coordinate with NGO's and provide them logistic support.

iv. National Leprosy Eradication Programme (NLEP):

- Report the cases to DHS for treatment and follow up.
- Take up reconstructive surgery to reduce the disability.

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v. Others:

- Shall immediately report any high fever, rash, jaundice, seizures, unconsciousness, and cases of cough to DHS.
- Shall report any large number of illness cases of similar nature and initiate preventive measures and immediately report to DHS.

3. Non-Communicable diseases:

i. National Programme for Control of Blindness (NPCB):

- Shall undertake cataract surgery for the referred as well as self-presenting cases
- Shall conduct health education activities
- Shall involve NGO's for publicity of the camps and provide service
- Shall report, performance of cataract surgeries to DHS

ii. National Programme for Cancer, Diabetes, Cardio-Vascular Diseases and Stroke (NPCDCS):

- Shall fix up specific days, popularize the clinics.
- Screen the clients to diagnose, investigate, register, provide treatment and follow up of cases of cancer, Diabetes, etc.
- Provide Palliative care for NCD's including Cancer.

iii. National Programme for the Health Care of Elderly (NPHCE):

- Shall fix up specific days, popularize the geriatric clinics,
- Reserve few beds and admit if necessary, provide Care, Support, treatment and follow up of clients.

iv. Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH) Systems:

- Shall work through Directorate of AYUSH to involve practitioners of AYUSH for making them aware of areas of cooperation in allopathic institutions such as planning and monitoring of NHM programmes, management of health institutions, supportive supervision.
- Shall arrange interactive sessions between allopathic and AYUSH practitioners to get sensitized by allopathic doctors about Life Style Management, home remedies for mothers and children, stress management and prevention of cataract.

4. Integrated Disease Surveillance project (IDSP):

- Shall incur expenditure towards consumables for up-scaling Laboratory services.
- Shall send the progress figures in Form P and L.
- Cause Network with all clinical establishments and get the data as per the Karnataka Private Medical Establishment bill.

5. Super-specialty services for Catastrophic Illnesses:

- Shall get empanelled under 'Vajpayee Arogya Shree'/Rajiv Gandhi Arogya Shree' scheme to provide super-specialist services, be it Cardiology, Nephrology, Neurology, etc.

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- Shall arrange for accommodating Blood Storage Centres within the hospital campus.
- In view of these services, the financial benefits to the college will be quite substantial.

6. Mental Health Services:

- Mental illnesses are on the increase in recent times. Medical colleges are yet to establish mental health care units to provide the required services. The proposals for required manpower, space and drugs have to be worked out and shall appraise and move the Government to immediately get these inputs sanctioned.
- This will reduce high of Out-of-Pocket expenditure towards travelling long distance in seeking of, required investigation and treatment.

7. Drugs and Drug Wear houses:

- Shall preferably promote generic drugs which are not only cheaper but also appropriate to reduce the cost of drugs and bring down Out of Pocket expenditure.
- Shall work with Drug Wear House officers in improving drug logistics and supply chain management.

8. Environmental Sanitation:

- This is one area for which very less attention is given by health sector. To begin with, Medical College through their internees shall collect water samples from various sources and get it tested to find out the portability of water.
- The internees shall provide health education to urban and semi-urban areas to get toilets constructed and use the same which reduces the contamination of human waste with water sources. This will also avoid fly nuisance.
- Shall guide, help and also supervise the hospitals and health institutions in strictly implementing the guidelines spelt out under 'Biomedical Waste Management' rules.

C. Health management:

- Shall help and guide the DHS in Needs Assessment, strategic planning, Preparation of Programme Implementation Plan (PIP), Organizing outreach camps, disease detection and service camps (for cataract, Cancer, Diabetes, and FP).
- The guideline for NHM- PIP-2015-16 has reached the state. It is a right time that the medical colleges shall also be involved in the PIP preparation. This will bring in ownership in the planning, implementation of the programmes.

D. Training:

- Shall intensively involve in skill based/competence development training. Some of the trainings which will strengthen the DHS are LSCS, SBNC, MTP, Laparoscopic sterilization, NSV, LSAS, AEFI, CEMoC, Cataract surgery, reconstructive surgery for leprosy cases, and application of Partograph. Functioning of special 'work stations' such as 'Resuscitation', 'Thermal regulation ' and 'Breast feeding' 'prevention of Hospital infections' etc. in paediatric wards. The earlier approach of 'canters of excellence' should be revived.

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- In fact, imparting such types of Hands-on training will not only improve the availability of skill oriented specialists in the medical colleges but also doctors of DHS. Availability of required skilled personnel will further gear up the progress many folds. As a result, the credibility of the institution will also be enhanced.
- Shall work in close cooperation with State Institute of Health and Family Welfare to draw up a training calendar of training programmes for entire year to be taken up for the faculty of medical college and also doctors of DHS.

E. Health Services Research and Studies:

- UGC will provide funds medical colleges for research purposes every year. These funds could be utilized for taking up community project studies on local health issues e.g. water quality, Total Sanitation Campaigns, Non-communicable disease problems and so on.... Few Theory sessions could be spared and certain field based studies shall be taken up by the departments involving students, post graduates and junior faculty. This will be more useful if it is conducted during 6th or 7th term. The State Health Resource Centre (SHRC) under NHM, help can be sought to take up Health Systems Research.

F. Health Education / IEC/ BCC:

- Students (UG's and PG') and nursing students shall be involved in providing health education to patients in the wards and interneers during their clinical postings. In fact 'Health talks' can be taken up in the slums for mother groups, link workers, SHG's, adolescents and school children.
- Usually the walls in the hospital wards will appear empty and grim quite often demotivating the patients. Hence action shall be initiated to display good looking posters of child, mother, parenting, immunization pictures including photos of national leaders and celebrities. If funds are available, TV/ Video facilities shall be provided in Corridors / waiting halls and play telecast clippings of health programmes and other messages.
- Shall plan along with DHS to organize a 'Health Exhibition' or 'Health Mela' to attract large number of people from surrounding villages and towns for 'Awareness Creation and Social Mobilization'.
- Shall utilize mass media such as TV, AIR, Song and Drama division of DAVP, MoI & BC, New-Delhi for publicizing the mega camps, specialist services and programmes being provided by the local medical colleges / district hospitals under the control of medical college authorities.
- Further, Simple Hand outs, flip books in local language shall get it printed or get from DHS and make available to all the medical students, interneers, nursing students to be used in the wards and during field visits.
- Shall arrange 'Dissemination meetings' to share the achievements, experiences, challenges and constraints.

G. Operational Research:

- As of now, there have been fewer efforts so far to carry out any research activities about the services rendered by various departments of the medical college hospitals. Rarely, well written articles are entering into reputed journals such as Journal of Indian Medical

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Association (IJMA), Indian Journal of Public Health (IJPH), Indian Journal of Community Medicine (IJCM) and Indian Journal of Pediatrics. There will be lot of scope to carryout operational research studies by various departments, given more than the required position of HR as prescribed by MCI and good qualification of the teaching faculty.

- The DHS support can also be sought in identification of needed domains in operational Research.

H. Evaluation of Health Programmes:

- In view of good number of well qualified and experienced teachers working in medical colleges, there will be ample opportunities to take up evaluation studies of various programmes being implemented. Well-designed proposals shall be formulated jointly involving DHS and team of faculty drawn from few departments and request NHM authorities for approval, sanction orders and funding. Medical colleges can discuss with NHM authorities for initiation of proposals. In fact each faculty should be assigned a field study regularly every year and this should be a bench mark for his/her promotion.

I. Monitoring and Supportive supervision:

- Shall take up monitoring cum supervisory visits once or twice per month and cover entire district as a team consisting of District Surgeon/ Civil Surgeon along with District Health Office programme officer, specialist of district hospital with finance personnel.
- The supervisory visit will keep checks and balance of the financial aspects. Also improve the quality of services and skills of the doctors.
- The supervisory team shall be provided with funds for mobility as required.

J. Exchange and Interactive Programmes:

- The DHS and medical colleges are running parallel since decades. Even after commencing of Health Universities, there have been no initiatives to interface the programme officers of health services and teaching faculty of medical colleges and hold exchange sessions of state of the art in recent programmes e.g. NRHM/NHM, IDSP, NVBDCP, NPCDCS, ROP, Pentavalent vaccine and many others.
- It is a paradoxical situation that on many occasions, the specialists / programme officers of DHS are aware of providing very recent and approved interventions under the programmes than the teaching faculty of medical colleges.
- Further, in many of the MCI approved text books for medical course, the contents are old and remain to be corrected / updated. In addition, some of the programmes being implemented in recent years do not find a place in recent edition paediatric and preventive and social medicine books. For e.g. Retinopathy of prematurity (ROP), NRHM, Immunization schedule with two doses of measles vaccine, Sick new born care, Home based new born care, perinatal intensive care unit, advantage of PP-IUCD, new generation IUD-380A, NPCDCS, new born care guidelines, JSY, JSSK, Nutrition rehabilitation canters functioning, ARSH, School health programmes, Mobile Health clinics functioning, PP Partnership, ASHA Diary, Mentoring, Infant Death audit, Maternal Death Review, Mother Child Tracking System, 108-Ambulance services, AEFI, Village

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Health and Nutrition Days, V H & SC's functioning, BEmOC, and EmOC, SBA, IMNCI, NSV, IYCF, Drug Ware House and many others. Because of this, medical graduates coming out from medical colleges are not aware of important national and state health programmes. It is true that there will be a gap of 2-3 years between theory (medical colleges) and practice (by DHS). Coordination efforts will minimize this gap and in the process bring in higher benefits to patients.

- Workshops, Seminars and training programme are worth taking to stream line the medical education for primary and secondary health care in the coming years. 'Visionary' / 'Horizon' lecture session shall be arranged every month regularly and an expert shall be invited to speak to all the faculty and students.
- Candidates undergoing postgraduate studies in community medicine, paediatrics, Ob & Gynecology, Ophthalmology shall get mentored by the senior programme officers working at state level or by DPMO, DPM and DAM at district level.

K. '108' Emergency Services (EMRI):

- Clients being referred / coming in 108 ambulances may be requiring critical emergency obstetric services, medico-legal cases, and trauma cases or poisoning cases. Such cases shall be provided immediate required services.

L. Best practices:

- Medical colleges would have confronted with various problems / difficulties because of various inherent constraints in not only administration but also in discharging technical / professional work. At the same time, they would have found out the right approach / answers which can be replicated any time elsewhere. There can be certain best practices too. Such examples shall be documented and bring to the notice of DHS or state health directorate authorities to incorporate in the PIP of NHM as new initiatives.
- The best practice could be of any domain administrative, financial or technical or it could be entirely new initiatives which are unique but yielding better and faster solutions.

M. Community mobilization:

- Communitization has been one of the very important components of NRHM. The nodal point for this is Panchayati Raj Institutions in the form of Zilla Panchayats, Taluk panchayats and Gram panchayats.
- At every stage of planning, implementation, coordination, and social mobilization medical colleges shall seek necessary support from these local bodies and provide the required health intervention in the form of field studies, awareness drives, mass camps.
- Many Philanthropists and Corporate houses are willing to come forward to help in resource mobilization as their Corporate Social Responsibility provided the seekers are trust worthy. Here medical colleges can play an important role in roping these agencies and utilize their inputs fully to provide the required health care service through 'Camp approach' / Specialist clinics in urban slums.

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- Medical Colleges can identify NGO's having good track of records and use them as 'change agents' and 'service providers'. Credible NGO's can also be negotiated to enter into Public Private Partnership in selected pockets in urban areas for providing cheaper health care through special cadre of 'link workers'.
- Medical Colleges shall work in close coordination with Corporations / Municipalities in mapping out urban poor pockets and delivering primary health care services, utilizing trained health workers / link workers on the basis of monthly honorarium.
- What works better whether local body health management system, involvement of medical colleges, or PPP model should be explored by medical colleges and implemented in close cooperation with the Government.
- Medical colleges shall involve medical students, interneers and nursing students to Work with Village Health and Sanitation Committees (VH & ND's), Self Help Groups (SHG's), AnganWadi Workers in reaching the adopted semi-urban pockets in providing various health interventions.

N. Statistics, Charts and Diagrams:

- This is one area which is useful in Health Sector institutions. Although, there is a Medical Record Department in medical college hospitals, the case sheets are piled up. There has been no / very less usage of the case sheets on a regular basis. Most of the times, we don't get the data of patients attending the hospitals such as year wise, month wise, new, old, male, female, children, sickness wise data (morbidity), OP's, IP's, specialist wise, drugs distributed, patients cured, dead, infant deaths, mother deaths, major surgeries conducted, minor surgeries conducted, total deliveries, total caesareans (%), total referred in specialist wise, blood transfusions and so on.....Medical Record Section shall be made User friendly by using IT gadgets..
- It is experienced time and again that whenever any information or data required, it is invariably with the assistants kept in the lockers or no information available if he/she is not available.
- There is an urgent need to analyse the data and provide feedback to DHS for any strategic planning purpose.
- Further, such type of data could be put up as charts and diagrams in the concerned departments which help to the planners and researchers.
- In addition, the labour rooms shall be displayed with important charts prescribed by the Government under NRHM /NHM. The medical colleges shall get these important charts from DHS and display in the labor rooms.

O. Budget and expenditure:

- Funds will be provided through DHS under Hospital Strengthening, Untied funds (UTF), Annual Maintenance Grants (AMG) and Arogya Rakhsa Samitis (ARS).
- Guidelines have been communicated regarding the pattern of expenditure and unit cost. The budget is towards requirements to upscale the hospital to IPHS and in future NABH standards. This will enhance availability, accessibility, quality and coverage in services as per NRHM /NHM programmes policy.

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- The Medical colleges and attached hospitals shall incur the budget fully and report to DHS from time to time.

P. Registers, Records and Reports:

- Shall strictly follow the guidelines for incurring expenditure under the line items.
- Shall follow 'Transparency in Public Procurement Act' if enacted, while procuring any items.
- Shall keep every details of materials received, entering into stock book along with details such as number, date, unit cost etc.
- Shall keep expenditure details along with vouchers filing them in well secured files.
- Shall maintain all required details properly in the registers.
- Shall furnish Statement Of Expenditure (SOE's) to the concerned.
- Shall also submit physical and financial progress as per line item with Financial Management Report (FMR) Code.

III. Way Forward:

- Sooner the better, all the above activities shall be initiated by Medical Council of India, send strict guidelines to all the Health Universities, medical, nursing, dental and AYUSH colleges to fall in line with the guidelines and start the programmes. Further, The MCI should make mandatory, provide 'Credit points' and grade them based on 'Management of all Health programmes both State and centre' during their annual inspections
- As a curtain raiser, a State level workshop shall be held involving Department of Health and Family Welfare services and Medical education along with concerned Hon'ble Ministers. Also Vice-Chancellor, University of health Sciences and Directors of Government and Private medical colleges
- Later on, Regional workshops shall be held involving principals and faculty of medical colleges
- Kits containing background material of NRHM/NHM and PIP-2015-2016 guidelines /formats shall be distributed to all the participants
- A simple manual on NRHM and / NHM schemes shall be prepared jointly for all the concerned faculty and all NGO's along with programme guidelines and make available to all the undergraduates, postgraduates, all the faculty and also to nursing college and faculty.
- If all the above said things does not happen in the very near future on an urgent basis, it may not be a surprise that one of wise citizens of our country may approach Supreme Court with a 'PIL' questioning about the role of medical colleges in health care for our poor urban population and ultimately judiciary will have to set right things.

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ORIGINAL ARTICLE

AUTHORS:

1. G. V. Nagaraj

PARTICULARS OF CONTRIBUTORS:

1. Associate Professor, Department of Community Medicine, MVJ Medical College and Research Hospital, NH-4, Hoskote, Bengaluru Rural.

NAME ADDRESS EMAIL ID OF THE CORRESPONDING AUTHOR:

Dr. G. V. Nagaraj,
19, 34th Main,
7th Cross, TMCS layout,
Sarakki, J. P. Nagar,
1st Phase, Bengaluru-560078.
Email: gubbinagaraj@gmail.com

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