PERFORMANCE ANALYSIS OF PRIMARY HEALTH CENTRES; A CASE STUDY

MINOR RESEARCH PROJECT

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PROJECT INDEX

CHAPTER 1
INTRODUCTION

1.1 THE CONTEXT

Human Resource plays an important role in the economic development of a country. The quality of the same depends on the health condition of the human resource. The quality of the output in a nation is primarily depend on the human resource. India is a nation of large population. Indeed we have more than 50% of our population belongs to working age group and thus we have demographic dividend. Karnataka State is not an exception for all these trends in Demography.

Globally, governments are searching for ways to improve equity, efficiency, effectiveness and responsiveness of their health systems. At present, there is no agreement on optimum structures, content, and ways to deliver cost-effective services to achieve health gains for the population. However, in recent years there has been an acceptance of the important role of primary healthcare in helping to achieve these aims; providing cost-effective healthcare to the general population. Primary healthcare is essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals in the community through their full participation and at a cost the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

International studies show that the strength of a country's primary care system is associated with improved population health outcomes for all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from major respiratory and cardiovascular diseases. This relationship is significant after controlling for determinants of population health at the macro-level (GDP per capita, total physicians per one thousand population, percentage of

elderly) and micro-level (average number of ambulatory care visits, per capita income, alcohol and tobacco consumption).

In India, fertility, mortality and morbidity remain unacceptably high, both compared to countries in the region and those at similar income levels. Although poverty and low levels of education are the root causes, poor stewardship over the health system bears some responsibility. India's primary healthcare system is based on the Primary Health Centre (PHC), which is the cornerstone of rural health services – a first port of call to a qualified doctor

1.2 CONCEPT OF PHCs IN INDIA

The concept of Primary Health Centre (PHC) is not new to India. The Bhore Committee in 1946 gave the concept of a PHC as a basic health unit to provide as close to the people as possible, an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The health planners in India have visualized the PHC and its Sub-Centres (SCs) as the proper infrastructure to provide health services to the rural population. The Central Council of Health at its first meeting held in January 1953 had recommended the establishment of PHCs in community development blocks to provide comprehensive health care to the rural population. These centers were functioning as peripheral health service institutions with little or no community involvement. Increasingly, these centers came under criticism, as they were not able to provide adequate health coverage, partly, because they were poorly staffed and equipped and lacked basic amenities.

The 6th Five year Plan (1983-88) proposed reorganization of PHCs on the basis of one PHC for every 30,000 rural population in the plains and one PHC for every 20,000 population in hilly, tribal and backward areas for more effective coverage. Since then, 23,109 PHCs have been

established in the country (as of September 2004). PHCs are the cornerstone of rural health services- a first port of call to a qualified doctor

Primary Health Centres are the cornerstone of rural health services- a first port of call to a qualified doctor of the public sector in rural areas for the sick and those who directly report or referred from Sub-centres for curative, preventive and promotive health care. A typical Primary Health Centre covers a population of 20,000 in hilly, tribal, or difficult areas and 30,000 populations in plain areas with 4-6 indoor/observation beds. It acts as a referral unit for 6 sub-centers and refer out cases to CHC (30 bedded hospital) and higher order public hospitals located at sub-district and district level.

1.3 INDIAN PUBLIC HEALTH STANDARDS (IPHS) FOR PHCs

Organizations can be assessed against the set standards. The National Rural Health Mission (NRHM) has provided the opportunity to set Indian Public Health Standards (IPHS) for Health Centres functioning in rural areas. In order to provide optimal level of quality health care, a set of standards are being recommended for Primary Health Centre to be called Indian Public Health Standards (IPHS) for PHCs

The objectives of IPHS for PHCs are:

a) To provide comprehensive primary health care to the community through the Primary Health Centers. b) To achieve and maintain an acceptable standard of quality of care. c) To make the services more responsive and sensitive to the needs of the community.

Assured services cover all the essential elements of preventive, promotive, curative and rehabilitative primary health care. This implies a wide range of services that include:

Medical care:

OPD services: 4 hours in the morning and 2 hours in the afternoon / evening. Time schedule will vary from state to state. Minimum OPD attendance should be 40 patients per doctor per day.

24 hours emergency services: appropriate management of injuries and accident, First Aid, Stabilisation of the condition of the patient before referral, Dog bite/snake bite/scorpion bite cases, and other emergency conditions Referral services In-patient services (6 beds)

Maternal and Child Health Care including family planning:

a) Antenatal care:

i) Early registration of all pregnancies ideally in the first trimester (before 12th week of pregnancy). However, even if a woman comes late in her pregnancy for registration she should be registered and care given to her according to gestational age.

ii) Minimum 3 antenatal checkups and provision of complete package of services. First visit as soon as pregnancy is suspected/between 4th and 6th month (before 26 weeks), second visit at 8th month (around 32 weeks) and third visit at 9th month (around 36 weeks). Associated services like providing iron and folic acid tablets, injection Tetanus Toxoid etc (as per the "guidelines for ante-natal care and skilled attendance at birth by ANMs and LHVs)

iii) Minimum laboratory investigations like haemoglobin, urine albumin, and sugar, RPR test for syphilis iv) Nutrition and health counseling v) Identification of high-risk pregnancies/ appropriate management vi) Chemoprophylaxis for Malaria in high malaria endemic areas as per NVBDCP guidelines. vii) Referral to First Referral Units (FRUs)/other hospitals of high risk pregnancy beyond the capability of Medical Officer, PHC to manage. b) Intra-natal care: (24-hour delivery services both normal and assisted) i) Promotion of institutional deliveries ii) Conducting of normal deliveries iii) Assisted vaginal deliveries including forceps / vacuum delivery whenever required iv) Manual removal of placenta v) Appropriate and prompt referral for cases needing specialist care.vi) Management of Pregnancy Induced hypertension including referral vii) Pre-referral management (Obstetric first-aid) in Obstetric emergencies that need expert assistance (Training of staff for emergency management to be ensured) c) Postnatal Care: a) A minimum of 2 postpartum home visits, first within 48 hours of delivery, 2nd within 7 days through Sub-centre staff. b) Initiation of early breast-feeding within half-hour of birth c) Education on nutrition,

hygiene, contraception, essential new born care (As per Guidelines of GOI on Essential new-born care) d) Others: Provision of facilities under Janani Suraksha Yojana (JSY) d) New Born care:

i) Facilities and care for neonatal resuscitation ii) Management of neonatal hypothermia / jaundice

e) Care of the child: i) Emergency care of sick children including Integrated Management of Neonatal and Childhood Illness (IMNCI) ii) Care of routine childhood illness iii) Essential Newborn Care iv) Promotion of exclusive breast-feeding for 6 months. v) Full Immunization of all infants and children against vaccine preventable diseases as per guidelines of GOI. vi) Vitamin A prophylaxis to the children as per guidelines. vii) Prevention and control of childhood diseases, infections, etc. f) Family Planning: i. Education, Motivation and counseling to adopt appropriate Family planning methods. ii. Provision of contraceptives such as condoms, oral pills, emergency contraceptives, IUD insertions. iii. Permanent methods like Tubal ligation and vasectomy / NSV. iv. Follow up services to the eligible couples adopting permanent methods (Tubectomy/Vasectomy). v. Counseling and appropriate referral for safe abortion services (MTP) for those in need. vi. Counseling and appropriate referral for couples having infertility.

Management of Reproductive Tract Infections / Sexually Transmitted Infections:

a) Health education for prevention of RTI/ STIs

b) Treatment of RTI/ STIs

Nutrition Services (coordinated with ICDS)

a) Diagnosis of and nutrition advice to malnourished children, pregnant women and others. b) Diagnosis and management of anaemia, and vitamin A deficiency.

c) Coordination with ICDS.

National Health Programmes including Reproductive and Child Health Programme (RCH), HIV/AIDS control programme, Non communicable disease control programme - as relevant:

National Programme for Control of Blindness (NPCB):

(a) Basic services: Diagnosis and treatment of common eye diseases (b) Refraction Services

(c) Detection of cataract cases and referral for cataract surgery

National Vector Borne Disease Control Programme (NVBDCP):

(a) Diagnosis of Malaria cases, microscopic confirmation and treatment (b) Cases of suspected JE and Dengue to be provided symptomatic treatment, hospitalization and case management as per the protocols (c) Complete treatment to Kala-Azar cases in Kala-Azar endemic areas as per national Policy (d) Complete treatment of microfilaria positive cases with DEC and participation and arrangement of Mass Drug Administration (MDA) along with management of side reactions, if any. Morbidity management of Lymphoedema cases.

National AIDS Control Programme:

Referral Services: Appropriate and prompt referral of cases needed a) Stabilisation of patient b) Appropriate support for patient during transport c) Providing transport facilities either by PHC vehicle or other available referral transport

Training: (i) Health workers and traditional birth attendants ii) Initial and periodic Training of paramedics in treatment of minor ailments iii) Training of ASHAs iv) Periodic training of Doctors through Continuing Medical Education, conferences, skill development training, etc. on emergency obstetric care v) Training of ANM and LHV in antenatal care and skilled birth attendance

Basic Laboratory Services: Essential Laboratory services including: i. Routine urine, stool and blood tests ii. Bleeding time, clotting time, iii. Diagnosis of RTI/ STDs with wet mounting, Grams stain, etc. iv. Sputum testing for tuberculosis (if designated as a microscopy center under RNTCP) v. Blood smear examination for malarial parasite. vi. Rapid tests for pregnancy / malaria vii. RPR test for Syphilis/YAWS surveillance viii. Rapid diagnostic tests for Typhoid (Typhi Dot) ix. Rapid test kit for fecal contamination of water x. Estimation of chlorine level of water using ortho-toludine reagent

The PHCs would provide 24 hour delivery services and new born care, all seven days a week in order to increase the institutional deliveries which would help in reducing maternal mortality

Selected Surgical Procedures: The vasectomy, tubectomy (including laparoscopic tubectomy), MTP, hydrocelectomy and cataract surgeries as a camp/fixed day approach have to be carried out in a PHC.

1.4 PERFORMAMNCE INDICATORS

With this background, the present study focuses on the performance analysis of PHCs (in DK District, Karnataka State) by considering the major indicators of performances. The study considers the prime indicators such as

- Infrastructure of PHCs
- .General Medical/Clinical care in PHCs
- Maternal and Child health care services
- Work satisfaction under PHC set-up.

1.5 OBJECTIVES OF THE STUDY

The broad objectives this Project are to

1. Review systematically the works on the studies on PHCs
2. Study the macro-status of Health and Health infrastructure
3. Analyze the performance of PHCs in the study region
4. Offer policy prescriptions

1.6 METHODOLOGY

Except the Bantwal Taluk the study was conducted in the Taluks of Dakshina Kannad District, Karnataka. To have a clear-cut picture it was decided to consider only those PHCs which are

supposed to render services for 24 hrs in all the days of a week (ie 24x7 PHCs). Three such PHCs from each Taluk was selected randomly for the study. Thus total number of PHCs selected was 12(around 50% of such PHCs in the District). In aggregate Ten patients (4 Men and 6 ever married women) from each selected PHCs were interviewed through structured questionnaire. Thus sample size of the patients from the District are 48 Men and 72 women, in aggregate 120. To understand the perceptions of the medical officers of the PHCs, all the doctors of selected PHCs (total 12 doctors) were interviewed. Analysis was done by considering the selected indicators of performance. Simple statistical tools and techniques were applied to find and present the results. Filed survey matrix is shown in table 1.1

1.1 ***FILED SURVEY MATRIX***

Taluks	**PHC selected (24X7)**	**Total Patients**	**Medical Officers**
Mangalore	3	30	3
Belthangady	3	30	3
Puttur	3	30	3
Sulliya	3	30	3
DK District	**12**	**120**	**12**

1.7 RATIONALE

In India Primary Health Centers (PHCs) are the cornerstone of rural health care; a first port of call for the sick and an effective referral system. It forms the first level of contact and link between individuals and the National Health System; bringing the health acre delivery as close as possible to where people live and work. In this context analyzing the quality of performance of PHCs assumes to be highly prominent

1.8 LIMITATIONS

The study is based on sample survey restricted to DK District. Due to the constraints of budget and time this study considers only 24X7 PHCs. The study considers only selected indicators of IPHS.

1.9 CHAPTER SCHEME

The Project has been divided in to Five chapters. ***First*** chapter deals with introductory aspects, objectives of the study, methodology applied in the study, rationale and limitations of the study. ***Second*** chapter is focused on the review of literature connected to the study of PHCs. Chapter ***Third*** deals with an macro perspective of health infrastructure in India, Karnataka and in the study region. Micro level evidences on the performance of PHCs are incorporated in the ***Fourth*** chapter. The ***Last*** chapter includes summary and discussions followed by suggestions and conclusions.

CHAPTER 2

REVIEW OF THEORETICAL AND EMPIRICAL EVIDENCES

2.1 INTRODUCTION

This particular chapter is focused on various issues related to Primary Health care issues that has been probed into from time to time by various researchers and theory buidlders at local ,National and International level. Gist of the various works has been gathered here in chronological order. Such review would certainly helps in bringing out the various research issues connected to Primary health care units including PHCs. The issues that have been summarized here can be utilized by the Research scholars for further study in this direction.

2.2 REVIEW OF LITERATURES

Gilson et al (1960), study is related to the structural quality is a key element in the quality of care provided at the primary level, which aims to offer health care interventions of proven efficacy. The assessment of the structural quality of Tanzanian Primary Health Services indicated serious weaknesses in the available physical infrastructure as well as supervision and other support both for government and non governmental services and for dispensary and first referral level services.

Ware and Snyder (1975) “Service quality refers to patients self reported experience of care. It is useful metric for evaluating health care quality (Ware and snyder 1975). The research of Davies and Ware (1988) and Ware (1992), focuses on the measurement of the quality from the perspective of the patient. Service quality is measured by asking patient about their experience on specific dimensions of care, such as perceived adequacy of communication, physical comfort etc.

Misra BD et al (1982) 'Medical Officers found to be mostly absent from their duties and when they are present, they merely involve in providing clinical services to the Patients. They lack managerial skills. The lack of role clarification and role consideration behaviours in the immediate supervisors results in a lack of job involvement of frontline health workers. The evaluation and monitoring system in the health organization is being weak, ineffective and not intact, results in the creation of a 'no work culture'.

The study of Joseph G, et al (1984), noted that prmary health care requires strong and continued political commitment at all levels of Government based upon the full understanding and support of the people. It recommends that government express their political will to attain health for all by making a continuing commitment to implement primary health care as an integral part of the national health system within overall socio-economic development.

Davies (1988), also describes the differences between technical and functional aspects of quality which is widely accepted within the medical literature, although different terminology is occasionally used. In the health care field , technical quality is referred to as clinical quality, which focuses on the technical accuracy of diagnosis and treatment. Functional quality refers to the manner or process by which health care is delivered.

Maine D (1991), addressing the weaknesses of PHC argues that many health centers and hospitals non functional or functions only few hours a day. Many a time staff does not stay at the head quarters, in difficult areas staff shortage is very common, equipment are inadequate and often out

of order, supply of drugs are irregular. Training is poor and lacks skill development, team building and motivational components.'

Parks (1991) on the study of PHC' It is the first level of contact of individuals. The family and community with the national health system where the primary health care is provided. As a level of care, it is close to the people , where most of their health problems can be solved.

Gupta RB et al (1992) 'The overall level of level of job knowledge of the health workers as well as their immediate supervisors has been found low as the training provided to them has been quiet inadequate'

Aldana JM, et al (2001), 'In India, Primary Health Centers (PHCs) is the keystone of tribal healthcare. PHCs play a vital role as the first level of contact and a connection between individuals and the health system, bringing healthcare delivery as close as possible to where people live and work. In addition, these PHCs are charged with providing promotive, preventive, curative and rehabilitative care in urban tribal and tribal areas. Even though there are numerous reasons for a meager performance of PHCs, almost all of them stem from weak stewardship of the sector, which produces a poor incentive framework. Primary healthcare is indispensable healthcare based on sensible, scientifically sound and socially suitable methods and technology made generally reachable to individuals in the community through their full involvement and at a cost the community and country can afford to sustain at every stage of their advancement in the spirit of self-reliance and self-determination'.

Srinivasa RG (2001) 'Opening of essential primary health centers (PHCs) in tribal dominant districts was an integral part of various tribal development programmes implemented since 1947.

The Bhore Committee Report recommended opening PHCs to cover only a population of 10000 and that each should have 6 specialist doctors, other required staff, and 75 beds. However, each PHC complex in the tribal blocks consists of 6 beds, 1 medical officer, 2 midwives and 1 ancillary person. Different governments have taken suitable measurements to upgrade the PHCs based upon various experts' committee reports. Recent national health policy has laid stress on a people-centered primary health care approach. Nevertheless, the ICMR report has exposed the fact that more than 80 percent of the population has no access to any form of health care. However, curative services, people's awareness about functioning of PHCs, preventive activities, and the attitude of the health staffs need to be properly evaluated through different research approaches. This current study examines the functioning of PHCs as viewed by the community in selected tribal blocks of south Karnataka.'

Manjundar et al (2004) "It is well known that Doctors are technically more resourceful than any other supporting Paramedical personnel. However, in rural India people are more dependent on the latter which play a dominant role. If we consider the elasticity coeffecients as a measure of productivity then in the rural health care system Paramedical staff are more productive than the Doctors"

Mavalankar D 2009, 'The Primary Health Centers (PHC) are not immune from issues such as the incapability to notice diseases early due to lack of multi-disciplinary medical expertise and a laboratory and other amenities and insufficient quantities of general medicines. Further, tribal patients usually do not visit PHCs in the early stages of their diseases. Therefore, healthcare providers (if at all present) are forced to focus only on seriously ill patients due to the heavy work load. Poverty and a low level of literacy are the basic causes for the poor health behavior among tribes. The absence of responsibility and accountability stems from the fact that there is no formal feedback mechanism and incentive to treat tribes as clients. Tribal Patients often find fault in the rude and abrupt behavior of health workers that discriminate against women and minorities from

scheduled castes or tribes. The lack of accountability leads to absentee doctors, as it is hard to get qualified doctors to tribal areas. Unresponsive ANMs, inconvenient opening times and little or no community participation are some of the other problems faced by the PHCs in tribal areas.'

Jones P et al (2009) 'Normally in India, a PHC covers a population of 20,000 in hilly, tribal, or difficult areas and a population of 30,000 in plains areas with 4-6 indoor/observation beds. It acts as a referral unit for 6 sub-centers and refers out cases to Community Health Centers (CHCs) (30 bed hospitals) and higher order public hospitals located at the sub-district and district level. Primary Health Centers (PHCs) form the backbone of the public health system in tribal India. The Mudaliar Committee (1955), Jungalwalla Committee (1965), Karthar Singh Committee(1973), the Shrivatsva Committee (1975), and the Bajaj committee (1986) have also highlighted the importance of up gradation of PHCs. Despite criticism they have faced concerning excellence of care and poor infrastructure, they continue to be the major primary care provider for the majority of India's population who reside in tribal areas"

Verma VM (2010) 'There is a strong need to remove the inadequacies in terms of buildings, manpower and provisions of drugs supplies and equipment constitutes major impediments to full operationalisation of rural primary health care system'

The Hindu Daily Nov (2011) 'The lack of basic skills undermines the confidence and inclination of Physician to successfully practice after graduation in settings primary care and secondary hospitals which are alien to them. And these precisely are the settings where India's health care system is most at fault. The basis of their road map for change is that the learning environment of future doctors should encompass all links in a model health care system extending beyond present teaching hospitals and PHCs. The setting of their training should convincingly demonstrate how all the levels of health work together to provide optimal care to the community . For this medical

colleges will need to develop formal and effective linkages with the local District hospitals, Taluk hospitals, and PHCs and also be responsible for the health of a defined population.'

Vartharajan et al 'While the PHC may be a crucial institution in the rural health sector, it is not possible for it to address the entire health care needs of the population, as indicated by our findings. A group of people not accessing PHCs for whatever reasons may remain untreated, may directly access higher-level government health care facilities (as there is no proper referral system in place), or may approach the non-government sector. Even those accessing PHCs may still use the nongovernment sector, as indicated by our finding that 30–50% of patients were referred to the non-government sector for purchase of drugs and supplies and performance of laboratory tests. While *panchayats* are concerned about the government health care sector (both modern and indigenous), the non-government sector is left outside their purview. Since this sector has a significant stake even in the rural health sector, and its actions influence the health status of the people, it is appropriate for *panchayats* to view the health system at a broader level rather than focus only on government care.

2.3 CONCLUSIONS

A review of various works on PHCs reveals that the service provided by PHCs are too weak. Further there is a serious lack of infrastructure. Medical Officers found to be mostly absent from their duties and when they are present, they merely involve in providing clinical services to the Patients. They lack managerial skills. Equipment are inadequate and often out of order, supply of drugs are irregular. Training is poor and lacks skill development, team building and motivational components.

CHAPTER 3

HEALTH AND HEALTH INFRASTRUCTURE; A MACRO PERSPECTIVE

3.1 INTRODUCTION

This chapter attempts to review the relevance of health in determining economic growth, to overview the status of health in India, Karnataka State and tryied to compare with Dakshina Kannada District. The chapter has also made to highlight the status of health infrastructure at various levels Viz; National, State and at District level.

3.2 ROLE OF HEALTH IN ECONOMIC DEVELOPMENT

Manifestation for betterment of quality of health is an important objective of Economic development in many of the developing economies including India. To WHO, health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. Better health, education, equal and wider job opportunities to all, trustworthy and transparent peoples institution, sustainable and cleaner environment, dignity and self –esteem, life security are key manifestations of the quality of Economic growth.(WB 2000)

Health is a mulitimensional phenomenon. It is both an end and means of development strategy. The relationship between health and development are mutually reinforcing – while health contributes for economic development, economic development in turn, tends to improve the health status of population in a country. Health is also an important entitlement that enhances "Capabilities" of the poor people leading to increase in "commodities" and further improvement in health status (Dadibhavi and Bagalkoti 1994; Bloom et al 2004). As an investment on health increases the productive capacity of working population, and hence the level of income tends to increase and to the extent it contributes to a decline the incidence of poverty.(Reddy and selvaraju 1994). With rapid improvement in health, particularly of poor, 'vicious circle of poverty' can be converted in to 'virtuous circle of prosperity' Although there has been a two way relationship, strong casual link from adult health to economic growth is observed by many studies (Mayer

1999, Knowles and Owen 1997, Jaimson and Wang 1998). Furthe Knowels and Owen (1997) and Janison and wang (1998) find that life expectancy contributes to economic growth more than education. In addition to its direct impact on productivity, health has other affect on economic development and demographic transition. Good infant health and nutrition directly increases the benefits of education. (WB 1993; WHO 1999). Further Barro (1996), points out that by increasing longevity, health reduces the depreciation rate of human capital, making investment in education more attractive.

Health status is usually measured in terms of life expectancy at birth, infant mortality rate, fertility rate, crude birth rate and death rate.

It is well known fact that India is next only to China the second largest country in terms of population in the world. But health status of a great majority of people is far from satisfactory as compared to China and other developed countries. However over the last five decades or so, India has built up health infrastructure and manpower at primary, secondary and tertiary care in government , voluntary and private sectors and made considerable progress in improving the health of its population (Ray 2003). However India is one of the major countries where communicable diseases are still not under control. The incidence of new fatal diseases such as HIV/AIDS, hepatitis A is on the increase and tuberculosis and malaria still take a high toll. Chronic non communicable diseases such as heart disease , diabetes and cancer are also on rise.(Bhat and Babu 2004). Health risk due to high prevalence of alcohol and tobacco consumption is also increasing. India's dream of 'World Class' health care delivery system is difficult to achieve.

3.3 STATUS OF HEALTH IN INDIA

Crude birth rate , crude death rate, fertility rate, maternal mortality rate etc are the strong indicators of Health in a nation. As per the United Nations Development programmers (UNDP) Global Human Development Report (HDR) 2007, India ranks at 128 among the countries with

medium human development out of 177 countries of the world. In terms of Gender Development Index (GDI), India ranks 113 out of 157 countries. India's HDI rank reflects low relative achievement in the level of human development and it also indicative that the country has done better in terms of per capita income than in other components of human development. The condition of India's neighbours like China and even Sri Lanka with respect to health indicators including HDI values is far better than India (GOI, 2008). **Table 3.1Status of health in India**

Details	**1951**	**1981**	**1991**	**Current level**
Crude birth rate (per 1000 population)	40.8	33.9	29.5	23.5(2006)
Crude death rate(per 1000 population)	25.1	12.5	9.8	7.5(2006)
Total fertility rate(per 1000 women)	6.0	4.5	3.6	2.5(2005)
Maternal mortality rate (per 100,000 live births)	NA	NA	437(1992-93)	301(2001-03)
Infant mortality rate(per 1000 live births)	146(1951-61)	110	80	57(2006)
Child (0-4) mortality rate(per 1000 children)	57.3(1972)	41.2	26.5	17.3(2005)
Couple protection %	10.4(1971)	22.8	44.1	48.2(1998-99)

Source : GOI Economic Survey of India 2007-08

The table 3.1 reveals that crude birth rate in India is 23.5,total fertility rate is 2.5, life expectancy at birth in India is 63, infant mortality rate is 57 and maternal mortality rate is 301. From these figures we can understand the unhealthy condition of health status of our country. Again the serious matter of concern is that, even the improvement in health indicators since Independence is slow

3.4 PROGRESS OF HEALTH DETERMINANTS

Health status of country is usually measured by numerous factors such as per capita income, nutrition, housing, sanitation, safe drinking water, social infrastructure, health and me dical care services by the government, geographical climate, employment status, incidence of poverty, and the like. (Reddy and Selvaraju 1994; Dadibhavi and Bagalkoti 1994). In the next section an attempt is made to show the status of some of the Health Determinants in India

3.5 TRENDS IN CENTRAL AND STATE HEALTH EXPENDITURE

An important issue bothering the health care expenditure in India has been that the country has not only has a small proportion of government expenditure earmarked for healthcare but also has the disadvantage of experiencing a decline in its share in the total expenditure as well as that of the GDP. The data presented in table 3 on the share of health care expenditure in the GDP has declined from 1.32 percent in 1990-91 to 1.19 percent in 2003-04 and as a percent of total expenditure it declined from 4.8 percent to 4.27 percent during the period. However, a few years in between, i.e. from 1996-97 to 1998-99 experienced an increased share which remained relatively high unit 2001-02, this was largely the fifth pay commission effect. The decline in the share of healthcare expenditure can be largely attributed to the stabilization measures initiated by the country since 1991.

Public expenditure on health care in relation to GDP as well as in per capita terms is much higher in the developed countries. India compares very unfavorably with many other nations in its health

indicators. India's Rank in its Human Development Index has been very low and has not revealed much progress.

3.2 :*TRENDS IN CENTRAL AND STATE HEALTH*				
Year	Devt.Exp.	Revenue	Total Exp.	GDP
1990-91	10.13	6.10	4.80	1.32
1994-95	10.88	5.86	4.83	1.24
1996-97	11.21	5.70	4.92	1.18
1997-98	11.59	5.92	5.06	1.25
1998-99	11.95	5.92	5.06	1.31
1999-00	11.60	5.66	4.88	1.31
2000-01	11.51	5.60	4.88	1.30
2001-02	11.21	5.30	4.59	1.25
2002-03	10.82	5.03	4.40	1.19
2003-04	10.02	5.03	4.27	1.19
2004-05BE)	10.56	5.03	4.40	1.19
2005-06(BE)	10.92	5.80	4.86	1.48

Source: Computed from Indian public finance Statistics, Ministry of Fiancé, Government of India

3.6 RURAL HEALTH CARE STRUCTURE

3.3 : ***RURAL HEALTH SERVICE INFRASTRUCTURE 2000-01***

Service(per population)	Existing	Require
Primary Health Centers 1 per 20,000-30,000	22,842	24,717
Sub Center 1per 3,000-5,000	137,311	148,303
Community Health Centers 1 per 100,000	3,042	7,415

The National Health Policy (NHP) 1983 envisaged a three-tier structure of primary, secondary and tertiary healthcare facilities to bring the services within the reach of the rural population. In spite of the three-tier system of rural health infrastructure the condition of has been deplorable. A

Review of Rural Health Care Infrastructure Development by the Central Council of Health and family Welfare in April 1999 revealed not only gaps in the establishment of infrastructure but also in the amount of man power required.

Table 4 clearly shows the mismatch between the existing and required health infrastructure. for instance, if we Should have one CHC for every 100.000 rural population, we need atleast 7145 , CHCs, but we have less than half of what we should have.. In the 3,043 CHCs that we do have, only 440 have a pediatrician, only 704 have a physician only 780 have a gynecologist and 781 a surgeon.

3.7 HEALTH INDICATORS OF KARNATAKA

Total Fertility rate of the state is 2.1 Infant Mortality Rate is 47 and Maternal Mortality Ration is 213 (SRS 2004-06), which are the lower than the National average. The sex Ratio in the State is 965 (as compared to 933 for the country).

In the following table the Demographic, Socio-economic and Health Profile of Karnataka has been compared with Dakshina Kannada District.

3.4 *DEMOGRAPHIC , SOCIO-ECONOMIC AND HEALTH PROFILE OF KARNATAKA AND DK DISTRICT*

Description	KATNATAK	DK Dist.
Population in Million (2001)	52.85	1.898
Decadal Growth (2001)%	17.51	14.6
Crude Birth Ratio (SRS 2007)	19.9	
Crude Death Rate (SRS 2007)	7.3	
Total Fertility Rate (SRS 2007)	2.1	
Infant Mortality Rate (SRS 2007)	47	
Maternal Mortality (SRS 2004-2006)	213	
Population BPL %	20	
SC Population (in million)	8.56	6.9
ST Population (in million)	3.46	3.3
Female Literacy rate%	56	80.5 (DLHS-3)

3.5 *STATUS OF HEALTH INFRASTRUCTURE; KARNATAKA AND D.K DISTRICT*

Description	Required	In Position	Shortfall
Sub Centers	7369	8143	
PHC	1211	2195	
CHC	302	323	
Multipurpose	10338	8028	2310
Health worker (Male) at Sub	8143	3762	4381
Health Assistant Female /LHV	2195	1170	1025
Health Assistant (Male) at	2195	837	1358
Doctors at PHC	2195	2814	-----
Obstetricians and	323	215	108
Physicians at CHCs	323	192	131
Pediatricians at CHCs	323	116	207
Radiographers	323	30	293
Pharmacist	2518	1983	535
Laboratory Technicians	2518	1242	1276
Nurse/Midwife	4456	1647	2809

Source: (RHS Bulletin March 2008, M/O Health and F.W., GOI)

In the following table District wise number of PHC has shown. A separate Table has given to show the status of PHCs in the Dakshina Kannada District (Study Area)

Districtwise number of PHC's identified as 24 x 7 in Karnataka

S. No.	Name of District	No. of PHCs	No. of 24 x 7 PHC	% of 24 x 7 PHCs
1	Bagalokot	46	40	86.96
2	Bangalore (R)	31	17	54.84
3	Bangalore (U)	31	21	67.74
4	Belgaum	135	74	54.81
5	Bellary	54	35	64.81
6	Bidar	41	34	82.93
7	Bijapur	65	42	64.62
8	Chamarajanagar	57	40	70.18
9	Chikkaballapur	41	19	46.34
10	Chikkamagalur	51	28	54.90
11	Chitradurga	57	31	54.39
12	Dakshina Kannada	65	23	35.38
13	Davanagere	70	31	44.29
14	Dharwad	29	29	100.00
15	Gadag	29	20	68.97
16	Gulbarga	105	86	81.90
17	Hassan	81	37	45.68
18	Haveri	50	27	54.00
19	Kodagu	29	10	34.48
20	Kolar	45	45	100.00
21	Koppal	43	28	65.12
22	Mandya	71	32	45.07
23	Mysore	96	25	26.04
24	Ramanagar	42	14	33.33
25	Raichur	46	26	56.52
26	Shimoga	55	20	36.36
27	Tumkur	97	87	89.69
28	Udupi	63	23	36.51
29	Utara Kannada	61	30	49.18
	Total	**1686**	**974**	**57.77**

3.7 Number of PHCs in Dakshina Kannada District (STUDY REGION)

	Name of the District Dakshina Kannada	
S. No.	Name of the 24x7 PHC	No. of 24 x 7 PHC
631	Suratkal	23
632	Kuppepadau	
633	Katipalla	
634	Ullala	
635	Shirthady	
636	Guttigaru	
637	Subramanya	
638	Kollamogaru	
639	Bellare	
640	Panja	
641	Ujjire	
642	Neriya	
643	Kokkada	
644	Naravi	
645	Koila	
646	Panaje	
647	Eshwaramangala	
648	Punjalkatte	
649	Mani	
650	Kurnadu	
651	Kadaba	
652	Venur	
653	Kaniyur	

3.8 CONCLUSIONS

Manifestation for betterment of quality of health is an important objective of Economic development in many of the developing economies including India.A glance over the major determinants of the health status reveals the ample scope for enhancing the magnitude and quality in infrastructure and health care. Rapid growth of population has undermined the outcome of economic growth and pushed the economy on low average standard of living. (Low PCI). Important issue bothering the health is that the expenditure in India on Health by the government is not only less but also has declining in its share in the total expenditure of GDP. There is also a

large gap between existing and required health service infrastructure like PHCs, sub-centers and community health centers. in rural areas. Despite 65 years of Independence nearly 30% of population do not have toilet facilities. More than 29% per cent of population is still illiterate to understand the basic health and health services. There is also problems of gender gaps. Rural roads are deprived the people to reach the health centers on time. Limited Insurance scheme under public sector made the poor to pay high cost for health services, else suffer with the problem.

The progress of Health indicators are much better in Dakshina Kannada District when compared with State as well as National average.

There is a need to review government expenditure over health sector. To ensure the availability, adequacy and functioning of health infrastructural facilities including the medical and para medical staff in PHC, there is a need to emphasis the systematic supervision , monitoring and reviewing the functions of PHCs. Provision of basic sanitation in both rural and urban areas is a need of the time. Strict enforcement of the compulsory education ACT is a serious duty of the related agencies. Strengthening the public Insurance Scheme protects the poor from high cost for health services. Finally, ensuring a better health of the public is the responsibility of multidimensional functioning of related organization

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CHAPTER 4

PERFORMANCE OF PRIMARY HEALTH CENTRES; MICRO LEVEL EMPIRICAL EVIDENCES

4.1 INTRODUCTION

In this Chapter the attempt has been made to present the empirical evidences from all the taluks of Dakshina Kannada District viz , Mangalore, Belthangady, Puttur and Suliya. Respondents include men and women,(Patients), Medical Officers of selected PHCs. Sample size and methodology has already discussed in the First chapter.

The Chapter has two broad Categories, I and II. The Category I highlights the average number of Patients treated per day in PHC – Taluk wise data. It also provides the data related to average number of deliveries in PHC- Taluk wise data

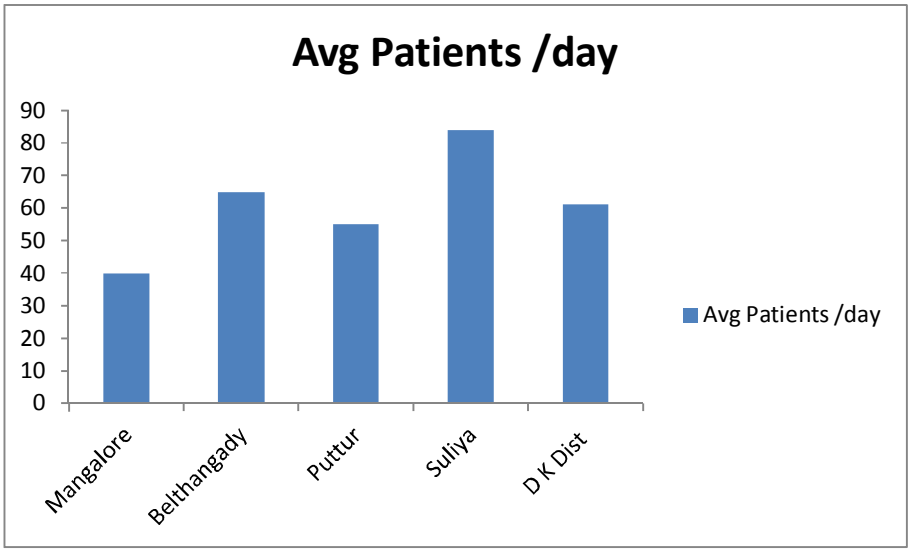
The Category II has Four different sections. **Section A deals with the availability of basic infrastructure and its quality for the PHCs.** It looks in to the basic laboratory services in a PHC, waiting and labor room, status of power supply and whether the PHC has approachable road. **Section B deals with General Clinical care under PHCs**. The section covers the issues like availability of general medicines in the PHC, how many times prescription to drug houses are given, presence of doctors in PHC, response of Paramedical Officer. **Section C deals with the role PHCs in ensuring Maternal and Child health care**. This section covers the related issues like whether any day has reserved for Maternal Check-up with provision for Registration, quality of Antenatal Drugs and Treatment , availability and quality of maternal equipment, kind of postnatal care and its quality. **Section D deals with Perceptions of the Medical officers regarding the work satisfaction in a PHC set-up.** This section has covered the issues like the quality of amenities provided to the Medical Officers, their working hours and patterns, some of the general problems faced by them and finally how Patients cop up with the doctors to meet their own needs.

Category I: Patients Treated And Delivery Cases

4.2 PATIENTS TREATED

The average number of Patients attending in the PHC in DK District is 61 per day. The evdinec has been collected from the Medical Officers of the respective PHCs and taken the average. The Taluk wise average has been shown in the following graph.(4.1) The average is highest in Suliya Taluk, 84 day, having above the District average and least in the Mangalore Taluk., 40 day.

Graph 4.1 ***PATIENTS TREATED***



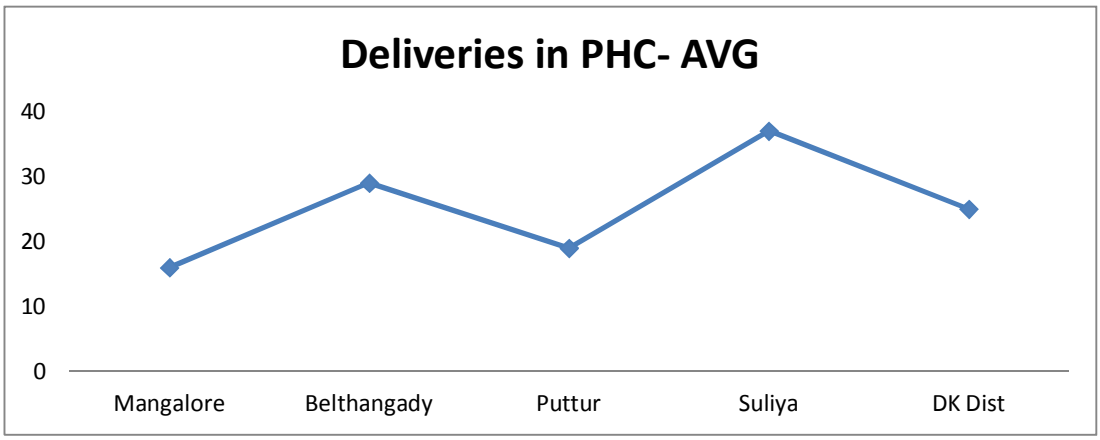
Source: Filed survey

One of the causes for this may be that in Mangalore taluk, the private practitioners are very high when compared to the rest of the taluks (PLP Report of Syndiacte bank)

4.3 DELIVERY CASES

One of the prime objectives of the PHC is to handle the Maternity cases. Reducing the Maternal Mortality is a prime objective National population policy 2000. In this context having a taluk wise delivery cases assumes to be relevant. Average number of delivery cases in the District has shown in the above Graph 4.2 It can be noted that highest has been recorded in suliya taluk, 35 per Month and least in 15 per Month in Puttur.

Graph 4.2 : ***DELIVERY CASES***



CATEGORY II INFRASTRUCTURE AND CLINLCAL CARE

SECTION A: BASIC INFRASTRUCTURE

Availability of infrastructure would certainly determine the quality of service is being provided to the Patients in any health-setup. And PHCs are having no exception as such. Indeed basic infrastructure like Laboratory facilities, a proper drug counter, well furnished wards, labor room, waiting room, power supply, water supply and a approachable roads are lot to do in ensuring quality treatment for the patients. Therefore some of the important related questions were asked to the respondents, and discussed the same in this section.

4. 4 LABORATORY SERVICE

In any PHCs basic laboratory services assumes to be highly crucial. Routine blood tests like TC DC, Test for Sugar, urine tests etc are required very often. Therefore working of 24X7 PHCs should have at least 10 hours of laboratory working time. The perception of the Patients regarding their satisfaction about the Laboratory service has shown below.

4.1 *LABORATORY SERVICE*

	Satisfactory	**Not Satisfactory**	**Not Applicable**	**Total**
Mangalore	9 (30)	15 (50)	6 (20)	30 (100)
Belthangady	14 (46)	8 (27)	8 (27)	30 (100)
Puttur	7 (23)	20 (66)	3 (11)	30 (100)
Suliya	11 (37)	15 (50)	4 (13)	30 (100)
Total	**41 (34)**	**58 (48)**	**21(8)**	**120(100)**

Source: Filed Survey. Number in the parenthesis shows percentage

Around 34 per cent of the patients responded that the laboratory service is satisfactory. 48 per cent have negatively replied for the question. (*Table 4.1*). Most of them were complained that the working hour of the Laboratory is not uniform/regular. Further, most of the times lab technicians were absent and even if they are present, they come late and are not so co-operative. Similar opinion was also given about the Pharmacists of PHCs. 8 percent of the respondent did not given proper answer, may be they are not very often visit PHC or because they did not avail such service form PHC. Relatively poor service of laboratory found in Puttur. And Belthangady Taluk found to be relatively much better and stood above the District average.

4.5 ROOM FOR CONSULTANCY

One of the important prerequisites for patients presentation is the availability of privacy. Therefore having a separate consultancy room with privacy is highly necessary. This would facilitate both for Patients as well as doctors. Therefore it was asked with the respondents whether or not PHC has a separate room for consultancy.

The *Table 4.2* below shows that 80 per cent of the respondents responded positively for the question. Only 20 per cent have some negative opinion. Puttur taluk has very positive response and stood above the District average.

4.2 ***TABLE ROOM FOR CONSULTANCY***

	Yes	**No**	**Total**
Mangalore	25 (83)	05 (17)	30(100)
Belthangady	19 (63)	11(37)	30 (100)
Puttur	28 (93)	02(07)	30 (100)
Suliya	24 (80)	06 (20)	30 (100)
Total	**96 (80)**	**24(20)**	**120(100)**

Source: Filed Survey. Number in the parenthesis shows percentage

4.6 ROAD FOR PHC

Approachable road is one of the basic infrastructure for any PHC. Therefore some of the related questions were asked to the respondent, whose perceptions are discussed below.

4.3 ROAD FOR PHC

	Yes	**No**	**Total**
Mangalore	24 (83)	06(17)	30(100)
Belthangady	22 (63)	08 (37)	30 (100)
Puttur	24 (93)	06(07)	30 (100)
Suliya	21 (80)	09 (20)	30 (100)
Total	**91 (76)**	**29 (24)**	**120(100)**

Source: Filed Survey. Number in the parenthesis shows percentage

About 76 per cent of the respondents *(Table 4.3)* were positively replied that roads of PHC is approachable. Only 24 per cent of the respondent were not happy with the roads. Puttur taluk is found to be much better and stood above the district average.

4.4 ***CLEANLINESS IN PHC***

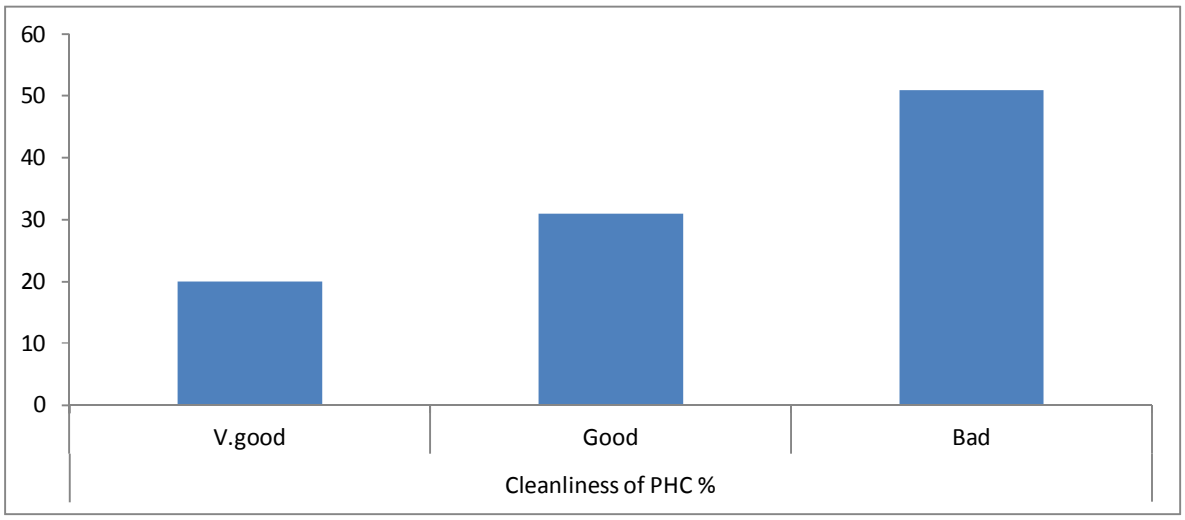
	V. Good	**Good**	**Bad**	**Total**
Mangalore	7(29)	6 (16)	17 (57)	30 (100)
Belthangady	6 (25)	11(30)	13 (43)	30 (100)
Puttur	5 (21)	8 (21)	13 (43)	30 (100)
Suliya	6 (25)	12 (33)	18(60)	30 (100)
Total	**24 (20)**	**37(31)**	**61 (51)**	**120(100)**

Cleanliness in a health-set up is mandatory. It prevents possible secondary infections. Therefore keeping the entire PHC is highly necessary as such. So perceptions of the respondents were collected to assess the extent of cleanliness. *(Table 4.4)* Respondents were asked to rate the cleanliness of their PHCs as 'Very good', 'Good' and 'Bad'. Only 20 per cent of the respondents in the District were replied that the quality of cleanliness as 'Very good', 61 per cent of the respondents as 'Good' and more than 51 per cent of the respondents as 'Bad'. Thus overall response is highly unsatisfactory. A taluk wise glance tells that response is very negative in Suliya Taluk, followed by Mangalore taluk.

When we asked with Medical officers about reasons for poor the cleanliness, the major causes reveled are problem of local laborers, absence of laborers without intimation and also government has not been appointed any such labor on permanent basis.

Cleanliness of PHC appears to be one of the great challenges to ensure the credibility of public sector unit like PHC. If PHCs are maintained in such conditions there is a possibility of deviation of the patients in course of time.

GRAPH 4.3 CLEANLINESS IN PHCS



Source: Table 4.4

SECTION B GENERAL MEDICAL / CLINICAL CARE

One of the important objectives of PHC is to provide Primary general health care services to the population of its area of operation. Therefore it was decided to have the perceptions of the beneficiaries on availability of General medicines, availability of doctors and response of the personnel in the PHC

4.8 AVAILABILITY OF GENERAL MEDICINES IN THE PHC

Availability of General Medicines in the PHC on time is crucial aspect in ensuring the general health care of the population. It is known from the Medical officer that fever, Gastritis, Blood pressure, Menus irregularities, Diabetes are the common health problems in the study area.

Table 4.5 : *AVAILABILITY OF GENERAL MEDICINES IN THE PHC*

	Always	Occasionally	Not available	Total
Mangalore	15(50)	2(7)	13(43)	30 (100)
Belthangady	18 (60)	4 (13)	8 (27)	30 (100)
Puttur	25 (83)	3 (10)	2 (7)	30 (100)
Suliya	26 (86)	3 (10)	1(4)	30 (100)
Total	84(70)	12(10)	24(20)	120(100)

Source: Filed Survey. Number in the parenthesis shows percentage

An attempt has made to catch the perceptions of the beneficiaries regarding the availability of regular drugs in the center. About 70 per cent of the patients in the District had the opinion that general drugs are available regularly, thus having an positive response to the question. 10% percent responded that drugs are available Occasionally and 20% of the respondents said that drugs are not available regularly. Suliya Taluk shows relatively better supply of drugs and Belthangady Taluk relatively poor.

4.9 PRESCRIPTION TO THE DRUG HOUSES

In order to have the clear picture regarding the availability of necessary drugs in the PHCs, respondents were asked how many times they have been prescribed to take medicines from the drug houses Table 4.6 shows the same

4.6 ***PRESCRIPTION TO DRUG HOUSES***

	Always	**Occasionally**	**Never**	**Total**
Mangalore	10 (33)	17 (56)	03 (11)	30(100)
Belthangady	06 (20)	22 (73)	02 (7)	30 (100)
Puttur	05(16)	23 (77)	02 (7)	30 (100)
Suliya	03 (11)	24 (78)	03 (11)	30 (100)
Total	**24 (20)**	**86 (71)**	**10 (9)**	**120(100)**

Source: Filed Survey. Number in the parenthesis shows percentage

Table 4.6 shows the number of times that a patient have been prescribed to the drug houses. It is evident from the above table that in the District 20 per cent of the patients said that they have been always prescribed to drug houses. Such cases are found to be highest in Mangalore Taluk and least in the Suliya. Interestingly, 9 percent of the respondents said that they have never been prescribed to the drug houses.

All the respondents reported that medicines are given freely. The Drugs liker higher Antibiotics, Drugs related to pregnancy, Iron and Calcium tablets are the most common kind of drugs for which prescriptions were given by the Doctors. Few of the respondents have told that even the very general drugs have also been prescribed. Further it is also been complained that in most of the PHCs there are no Pharmacists and therefore there is danger of mismatching of drugs with what doctors are being told.

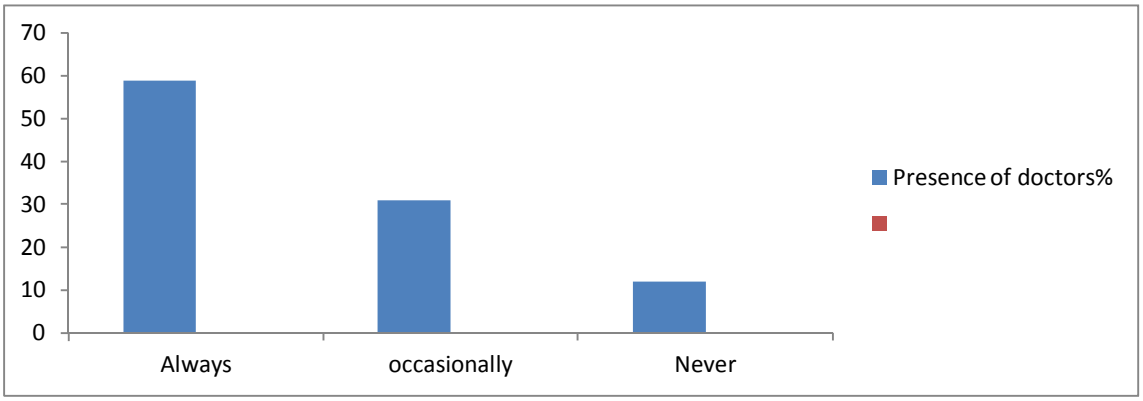
4.10 PRESENCE OF DOCTORS

Regular attendance of the Doctors (medical officers) is one of the important indicators of the quality of service is being provided in a PHCs. Besides it would also shows the attention towards the general health care services. Regular presence of the doctors in PHC would also decides the number of Patients that would visit and rely the local PHCs. Therefore an attempt is made to know the presence of the doctors in the PHCs.

4.7: *PRESENCES OF DOCTORS*

	Always	**Occasionally**	**Never**	**Total**
Mangalore	12 (40)	10 (33)	08(27)	30(100)
Belthangady	22 (73)	7(24)	01(3)	30 (100)
Puttur	19 (63)	11 (37)	0 (07)	30 (100)
Suliya	18 (60)	9 (30)	03(10)	30 (100)
Total	**71(59)**	**37(31)**	**12 (10)**	**120(100)**

Source: Filed Survey. Number in the parenthesis shows percentage



About 59 per cent of the respondents (*Table 4.7),* felt that Doctors are present 24x7 in all the days of their visit. And 37 per cent of the respondents felt that Doctors are present Occasionally in the Center. A small proportion of the patients said that the Doctors are never present in the Centre. The response of the patients in this context would certainly shows the irregular presence of the Doctors. Taluk wise data shows that the presence of Doctors is relatively better in Blethangady Taluk (73%) and poor (40%) in Mangalore Taluk. Irregularities of the Doctors would effect negatively for overall quality of general health care in the system. Puutur and Suliya Taluks are moderate in terms of the availability of the doctors

The lack of role clarification and role consideration behaviors in the immediate supervisors results in a lack of job involvement of frontline health workers. The evaluation and monitoring system in the health organization is being weak, ineffective and not intact, results in the creation of a ‘no work

culture'. (Misra et al 1982, Misra B.D., Ali Ashraf, B. Simmons and J. Simmons 1982,) in the 'Organisation. The prevailing slackness in supervision and management control, many a time permits the grassroots level workers take decision of not visiting the sub centers

4.11 RESPONSE OF PARAMEDICAL OFFICERS

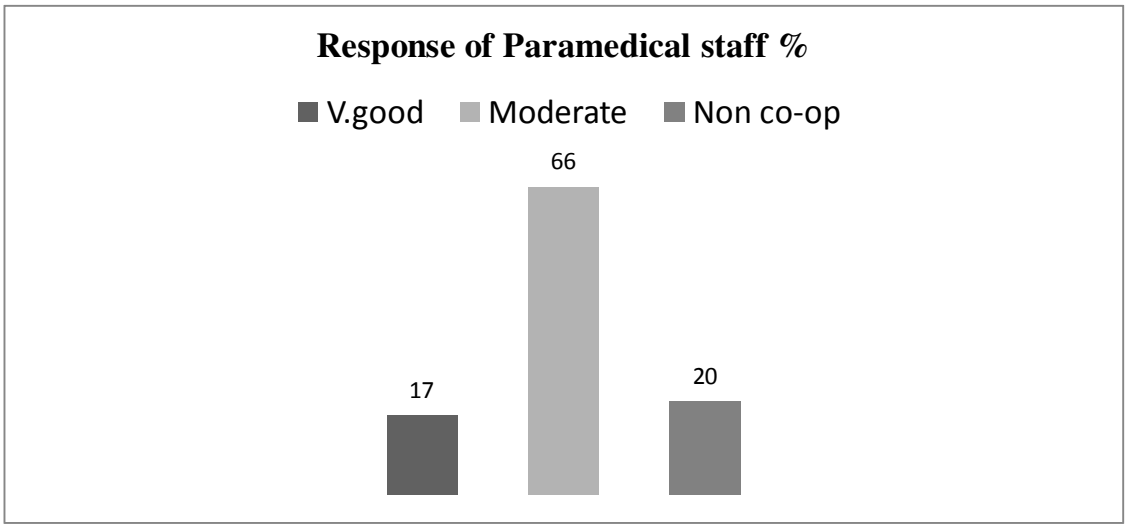
Para medical officers are like an executive wing in PHC, who are suppose to provide most of the health care services directly to the patients. Therefore, it is equally important that the response/ co-operation of paramedical staff too having impact on the overall service of PHC for quality general health care. Therefore it is tried to have perceptions the respondents regarding the response /co-operation of paramedical staff

4.8 : ***RESPONSE OF PARAMEDICAL OFFICERS***

	V.Good	**Moderate**	**Non-cooperative**	**Total**
Mangalore	2 (7)	22 (83)	06 (20)	30(100)
Belthangady	10 (33)	16(53)	04 (14)	30 (100)
Puttur	7 (23)	19 (63)	04 (14)	30 (100)
Suliya	2 (7)	18 (60)	10 (33)	30 (100)
Total	**21(17)**	**75 (66)**	**24 (20)**	**120(100)**

Source: Filed Survey. Number in the parenthesis shows percentage

The response of the patients are not very positive regarding the co-operation of the para medical off icers. About 24 per cent of the of the respondents felt that staff in the PHCs are not at all cop-operative.(*Table 4.8*) Again, 78 per cent of the respondents felt that the response of the staff is moderate. Only 21 per cent of the patients in the District felt that staff are very co-opertive. Non-cooperation as per the perception of the respondents includes, poor response, absence, late-coming of the staff etc. Such attitude of the staff found highest in the Mangalore and suliya Taluk, and service of the staff found to be very good in Belthangady taluk, the data stood above the District average.



Non-cooperation of the staff in the PHC would certainly have long lasting negative impact on the number of patients rely on the PHCs.

Poor Monitoring, low attendance of the medical officer in the PHC, low salary structure, lack of proper training and poor attitude of the people are some of the major causes for the non-cooperation of the staff.

SECTION C. MATERNAL AND CHILD HEALTH CARE.

Maternal and child health care is one of the important objectives of any PHC to ensure family and child Welfare. It includes Antenatal care, Post –natal care like related injections, proper ward with beds and cradle for baby, child immunization facilities.

To catch the clear-cut data, the questions were asked only to the ever married woman of 18-49 Years of age group. 72 such women were interviewed.(Details given under Methodology)

Under this section an attempt has also made to have an interview of the Medical Officers of all the PHCs about the medical tools and other facilities available for delivery in the PHCs

4. 12 SCHEDULE FOR MATERNAL CHECK-UP

The first question that has thrown to the respondents that, whether any particular day has reserved in a week for maternal check-up and whether there is any provision for registering the antenatal check-up.

4.9: DAY HAS RESERVED FOR MATERNAL CHECK-UP

	Yes	**No**	**NA**	**Total**
Mangalore	14 (77)	4 (23)	0 (0)	18(100)
Belthangady	13 (72)	3 (16)	2 (12)	18 (100)
Puttur	15 (83)	2 (11)	1(6)	18 (100)
Suliya	7 (94)	1 (6)	0 (0)	18 (100)
Total	**59 (82)**	**10 (14)**	**03 (4)**	**72 (100)**

Source: Filed Survey. Number in the parenthesis shows percentage

Table 4.9 shows that 82 per cent of the respondents said that*)* there is a particular day that has been reserved for Maternal check-up. Among the Taluks Suliya appears to be the best. Further majority out of such sample said that PHCs have keeping the system of Registering the Antenatal visits. Negligible portion of the respondent have said 'No' for the same question. Further 3 per cent of the respondent belongs to Not Applicable (NA) category, because of the reasons that they are never carried a baby, never had a vist to PHC for Antenatal check-up , not remembering the events, refused to respond etc.

Above response appears to be very positive as for as Antenatal initial care is concerned. Because the first pregnancy confirmation in the villages certainly takes place in PHCs. Besides care in the initial stages of Pregnancy is very crucial from her own health and overall welfare of the family too.

4. 13 ANTENATAL DRUGS AND TREATMENT

An attempt has made to understand the quality of medical care is being provided for the Pregnant woman under the PHCs. Therefore questions were asked to the respondent regarding the Antenatal

injections and tablets were given as per the schedule. 78 Per cent of the respondents *(Table 4.10)* were given positive reply for the same. 9 per cent were given negative answers saying that some important tablets like iron and calcium are not available in PHCs. And therefore they had been prescribed to the nearby drug houses. And 13 per cent were belonging to NA Category.

4.10: ***ANTENATAL DRUGS***

	Yes	**No**	**NA**	**Total**
Mangalore	15 (82)	1(06)	2 (12)	18(100)
Belthangady	14 (77)	2 (11)	2 (12)	18 (100)
Puttur	11 (61)	3 (17)	4 (22)	18 (100)
Suliya	16 (88)	0 (0)	2 (12)	18 (100)
Total	**56 (78)**	**06 (09)**	**10 (13)**	**72 (100)**

Source: Filed Survey. Number in the parenthesis shows percentage

The respondents were complained that the Laboratory for blood test very often remains closed in PHCs because the Technician either not appointed in the center/ if appointed not present in the center. The same complaint was also lodged against the Drug counter of PHCs.

4. 14 MATERNAL EQUIPMENT/ FACILITIES

Any medical treatments or surgeries are hard to do without suitable tools as such. Therefore to have a clear-cut idea on the tools available for handling Maternity cases are required to assess. In this regard some of the questions were asked with the Medical officers. Only 17 per cent of the

4.11: ***MATERNAL EQUIPMENT/FACILITIES***

Taluks	**Satisfactory**	**Not Satisfactory**	**Total**
Mangalore	1 (33)	2 (67)	3 (100)
Belthangady	0 (0)	3 (100)	3 (100)
Puttur	0 (0)	3 (100)	3 (100)
Suliya	1 (33)	2 (67)	3 (100)
District	**2 (17)**	**10 (83)**	**12 (100)**

Source: Filed Survey. Number in the parenthesis shows percentage

Medical officers were positively responded (*Table 4.11)* on the quality of the equipments that are therein the PHC. About 83 per cent of the doctors were not satisfied with the available facilities to have safe deliveries in PHCs. The Problem of emergency Oxygen, quality glows, problem of nearby blood bank, scarcity of trained nurses/staff, uninterrupted power supply etc are the very general constraints. In addition to this there is also lack of HIV Kit to facilitate the doctors to handle the delivery cases safely. Further HIV Counselors are also required for PHCs to handle such cases. Besides some of the doctors also shown dissatisfaction about working hours of PHC. They felt that a doctor can hardly work 24 hrs a day. Under such circumstances doctors are not ready to accept even if a small complication arises in delivery cases. They try to avoid such cases and may refer to the Private hospitals or Govt. District hospitals.

4.15 POSTNATAL CARE

One of the most important event in any PHC is Postnatal Care. Merely Maternal care will not ensure the family welfare. After the child birth the care of new-born baby and care of mother are most important to ensure the health of both. Therefore utmost care has to be taken by every PHC. Some of the questions were asked to the respondents who ever gone through the process.

4. 12: ***POSTNATAL CARE***

	Satisfactory	**Not Satisfactory**	**NA**	**Total**
Mangalore	7 (39)	9 (50)	2 (11)	18(100)
Belthangady	4 (22)	13 (72)	1 (06)	18 (100)
Puttur	3 (17)	15 (83)	0 (0)	18 (100)
Suliya	8 (44)	7 (39)	3 (17)	18 (100)
Total	**22 (30)**	**44 (61)**	**6 (09)**	**72 (100)**

Source: Filed Survey. Number in the parenthesis shows percentage

Only 30 per cent of the respondents (*Table 4. 12)* in the District said that they are satisfied with the Post-natal care of PHCs. And 61 per cent were not at satisfied and 6 per cent cases found Not Applicable. Mangalore Taluk stood comparatively better for better service of post natal care. Very poor response found in Puttur Taluk where 83 per cent of the respondent said that they are not satisfied with Post-natal care of PHCs

Lack of quality Beds, absence of Doctors, poor follow-up by the doctors, non availability of injections/tablets lack of cradles/poor quality of cradles, poor quality of nursing care etc, are the most general complaints.

Such poor service would naturally prevents the patients to go to the PHCs for delivery cases.

SECTION D WORK SATISFACTION OF MEDICAL OFFICERS UNDER PHCs

To deliver a quality service by the employees in any organization work satisfaction is highly necessary. Therefore it was decided to ask the same with Medical officers that how is the quality of amenities provided to them, their perceptions on the working hours etc.

4.16 WELL-FURNISHED HOUSE

It was asked with the Medical Officers that what the quality of quarters/houses given to them. Whether they are well furnished or not.

*4.***13:** ***QUALITY OF HOUSE***

Taluks	**Satisfactory**	**Not Satisfactory**	**Total**
Mangalore	0 (0)	3 (100)	3 (100)
Belthangady	1 (33)	2 (67)	3 (100)
Puttur	0 (0)	3 (100)	3 (100)
Suliya	2 (67)	1 (33)	3 (100)
District	3 (25)	9 (75)	12 (100)

Source: Filed Survey. Number in the parenthesis shows percentage

The conditions of the houses/quarters given to the doctors by the government found to be very poor. About 75 per cent of the doctors (*Table 13)* were not happy. They complained that houses are half furnished/ not fit to live with, during rainy seasons. Some of the doctors also complained that the house given to them are not nearby the PHC. However around 90 per cent of the doctors said that they have the land line telephone connections and regular water supply.

4.17 ELECTRICITY BACKUP

The questions regarding the power back-up was also being asked. Around 67 per cent of the doctors (*Table 14)* said that they are having the power-back-up. In Puttur and sulliya taluks such amenity found to be quiet low.

4.14*: ELECTRICITY BACKUP*

Taluks	**Satisfactory**	**Not Satisfactory**	**Total**
Mangalore	0 (0)	3 (100)	3 (100)
Belthangady	1 (33)	2 (67)	3 (100)
Puttur	0 (0)	3 (100)	3 (100)
Suliya	2 (67)	1 (33)	3 (100)
District	**3 (25)**	**9 (75)**	**12 (100)**

Source: Filed Survey. Number in the parenthesis shows percentage

Lack of power-backup would certainly reduces the quality of service provided by the Medical officers. Some times they are required to attend the patients during mid-night, especially the delivery cases. Therefore power backup too assumes to be highly crucial for quality service.

4. 18 PERCEPTIONS ON THE WORKING HOURS AND PTTERNS

4.15: WORKING HOURS/PATTERN

Taluks	**Satisfactory**	**Not Satisfactory**	**Total**
Mangalore	0 (0)	3 (100)	3 (100)
Belthangady	0 (0)	3 (100)	3 (100)
Puttur	1 (33)	2 (67)	3 (100)
Suliya	1(33)	2 (67)	3 (100)
District	2 (17)	10 (83)	12 (100)

Source: Filed Survey. Number in the parenthesis shows percentage

Working pattern in the PHC is one of the major problem complained by the doctors. To them the present working hours and working pattern is highly illogical. About 83 per cent (*Table 4.15)* of the doctors shown dissatisfaction regarding this. They felt that, there should be two medical officers per PHC to work in a shift. One doctor in a PHC can hardly provide justice for 24 hrs a day according to their perception. Besides most of the doctors were complained that much of their times are being

wasted in attending monthly taluk meetings, many visits to Grama Sabha, unnecessary training programmes etc. Moreover it is been complained by them that they got very less number of holidays in a year.

Apart from above compulsory commitments some of the doctors have also shown dissatisfaction regarding the involvement of local political parties in the day to day function of PHCs.

Because of all these problems involved in the day do day working PHCs doctors have expressed the possibility of deviation of patients towards the private health care system.

4.19 TREATMENT FOLLOW-UP

One of the most important constraints in the successful treatment at village level PHC is lack of proper follow-up by the patients. About 67 per cent of the doctors interviewed (*Table 4.16)* have told that Patients were not following the instructions properly and they do not follow-up the treatment.

4.16: TREATMENT FOLLOW-UP

Taluks	**Yes**	**Do not Follow**	**Total**
Mangalore	1(33)	2 (67)	3 (100)
Belthangady	2 (67)	1(33)	3 (100)
Puttur	0 (0)	3 (100)	3 (100)
Suliya	1(33)	2 (67)	3 (100)
District	**4 (33)**	**8 (67)**	**12 (100)**

Source: Filed Survey. Number in the parenthesis shows percentage

According to the doctors in most of the cases a pregnant suspected woman registers her name in the PHC only after 2-3 Months. Despite repeated instructions and warning they do not follow the treatment lines.

Such cases are reported more in Puttur taluk and such cases are relatively less in Belthangady taluk.

Besides most of the times Patients do not complete the Antibiotic courses as per the doctors advice. Poor literacy rate in some of the remote villages, ignorance, distance to PHC from their residence, some times non availability of certain kinds costly of drugs etc are all the major causes for poor follow-up by the patients.

4. 19 CONCLUSIONS

The average number of Patients attending in the PHC in DK District is 61 per day. Around one third of the patients responded that the laboratory service is satisfactory. About Fifty per cent have negatively replied for the question. Regarding whether the PHC has approachable road, about 76 per cent of the respondents were positively replied that roads of PHC is approachable. Only 20 per cent of the respondents in the District were replied that the quality of cleanliness as 'Very good',. About 70 per cent of the patients in the District had the opinion that general drugs are available regularly. In the District 20 per cent of the patients said that they have been always prescribed to drug houses. About 59 per cent of the respondents felt that Doctors are present 24x7 in all the days of their visit. The response of the patients are not very positive regarding the co-operation of the para medical off icers. 82 per cent of the respondents said that there is a particular day that has been reserved for Maternal check-up. About 83 per cent of the doctors were not satisfied with the available facilities to have safe deliveries in PHCs. The conditions of the houses/quarters given to the doctors by the government found to be very poor. Working pattern in the PHC is one of the major problem complained by the doctors. About 67 per cent of the doctors interviewed have told that Patients were not following the instructions properly and they do not follow-up the treatment.

CHAPTER 5

SUMMARY AND SUGGESTIONS

In this Chapter the findings are summarized systematically. On the basis findings suggestions are given

PATIENTS AND DELIVERIES

The average number of Patients attending in the PHC in DK District is 61 per day. The average is highest in Suliya Taluk, 84 day, having above the District average and least in the Mangalore Taluk., 40. Delivery cases highest has been recorded in suliya taluk, 35 per Month and least in 15 per Month in Puttur

SECTION A BASIC INFRASTRUCTURE AND ITS QUALITY FOR THE PHCS.

LABORATORY SERVICE

Around 34 per cent of the patients responded that the laboratory service is satisfactory. 48 per cent have negatively replied for the question. Most of them were complained that the working hour of the Laboratory is not uniform/regular. Further, most of the times lab technicians were absent and even if they are present, they come late and are not so co-operative. Similar opinion was also given about the Pharmacists of PHCs. 8 percent of the respondent did not given proper answer, may be they are not very often visit PHC or because they did not avail such service form PHC. Relatively poor service of laboratory found in Puttur. But Belthangady Taluk found to be relatively much better and stood above the District average.

ROOM FOR CONSULTANCY

Regarding the existence of separate room for consultancy, 80 per cent of the respondents responded positively for the question. Only 20 per cent have some negative opinion. Puttur taluk has very positive response and stood above the District average

ROAD FOR PHC

Regarding the PHC has approachable road, about 76 per cent of the respondents were positively replied that roads of PHC is approachable. Only 24 per cent of the respondent were not happy with the roads. Puttur taluk is found to be much better and stood above the district average.

CLEANLINESS IN PHC

Only 20 per cent of the respondents in the District were replied that the quality of cleanliness as 'Very good', 61 per cent of the respondents as 'Good' and more than 51 per cent of the respondents as 'Bad'. Thus overall response is highly unsatisfactory. A taluk wise glance tells that response is very negative in Suliya Taluk, followed by Mangalore taluk.

SECTION B GENERAL CLINICAL CARE UNDER PHCs

AVAILABILITY OF GENERAL MEDICINES IN THE PHC

An attempt has made to catch the perceptions of the beneficiaries regarding the availability of regular drugs in the center. About 70 per cent of the patients in the District had the opinion that general drugs are available regularly, thus having an positive response to the question. 10% percent responded that drugs are available Occasionally and 20% of the respondents said that drugs are not available regularly. Suliya Taluk shows relatively better supply of drugs and Belthangady Taluk relatively poor.

PRESCRIPTION TO THE DRUG HOUSES

In the District 20 per cent of the patients said that they have been always prescribed to drug houses. Such cases are found to be highest in Mangalore Taluk and least in the Suliya. Interestingly, 9 percent of the respondents said that they have never been prescribed to the drug houses.

All the respondents reported that medicines are given freely. The Drugs liker higher Antibiotics, Drugs related to pregnancy, Iron and Calcium tablets are the most common kind of drugs for which prescriptions were given by the Doctors

PRESENCE OF DOCTORS

About 59 per cent of the respondents(Table 3), felt that Doctors are present 24x7 in all the days of their visit. And 37 per cent of the respondents felt that Doctors are present Occasionally in the Center. A small proportion of the patients said that the Doctors are never present in the Centre. The response of the patients in this context would certainly shows the irregular presence of the Doctors. Taluk wise data shows that the presence of Doctors is relatively better in Blethangady Taluk (73%) and poor (40%) in Mangalore Taluk. Irregularities of the Doctors would effect negatively for overall quality of general health care in the system. Puutur and Suliya Taluks are moderate in terms of the availability of the doctors

RESPONSE OF PARAMEDICAL OFFICERS

The response of the patients are not very positive regarding the co-operation of the para medical off icers. About 24 per cent of the of the respondents felt that staff in the PHCs are not at all cop-operative. Again, 78 per cent of the respondents felt that the response of the staff is moderate. Only 21 per cent of the patients in the District felt that staff are very co-opertive. Non-cooperation as per the perception of the respondents includes, poor response, absence, late-coming of the staff etc. Thus staff commitment and feeling of ownership is lacking Such attitude of the staff found highest in the Mangalore and suliya Taluk, and service of the staff found to be very good in Belthangady taluk, the data stood above the District average.

SECTION C: MATERNAL AND CHILD HEALTH CARE.

SCHEDULE FOR MATERNAL CHECK-UP

82 per cent of the respondents said that there is a particular day that has been reserved for Maternal check-up. Among the Taluks Suliya appears to be the best. Further majority out of such sample said that PHCs have keeping the system of Registering the Antenatal visits. Negligible portion of the respondent have said 'No' for the same question. Further 3 per cent of the respondent belongs to Not Applicable (NA) category, because of the reasons that they are never carried a baby, never had a vist to PHC for Antenatal check-up , not remembering the events, refused for response etc

ANTENATAL DRUGS AND TREATMENT

78 Per cent of the respondents were given positive reply for the same. 9 per cent were given negative answers saying that some important tablets like iron and calcium are not available in PHCs. And therefore they had been prescribed to the nearby drug houses. And 13 per cent were belonging to NA Category. The respondents were complained that the Laboratory for blood test very often remains closed in PHCs because the Technician either not appointed in the center/ if appointed not present in the center. The same complaint was also lodged against the Drug counter of PHCs.

MATERNAL EQUIPMENT/ FACILITIES

About 83 per cent of the doctors were not satisfied with the available facilities to have safe deliveries in PHCs. The Problem of emergency Oxygen, quality glows, problem of nearby blood bank, scarcity of trained nurses/staff, uninterrupted power supply etc are the very general constraints. In addition to this there is also lack of HIV Kit to facilitate the doctors to handle the delivery cases safely. Further HIV Counselors are also required for PHCs to handle such cases. Besides some of the doctors also shown dissatisfaction about working hours of PHC. They felt that a doctor can hardly work 24 hrs a day. Under such circumstances doctors are not ready to accept even if a small complication arises in delivery cases. They try to avoid such cases and may refer to the Private hospitals or Govt. District hospitals.

Only 30 per cent of the respondents in the District said that they are satisfied with the Post-natal care of PHCs. And 61 per cent were not at satisfied and 6 per cent cases found Not Applicable. Mangalore Taluk stood comparatively better for better service of post natal care. Very poor response found in Puttur Taluk where 83 per cent of the respondent said that they are not satisfied with Post-natal care of PHCs

SECTION D : WORK SATISFACTION OF MEDICAL OFFICERS UNDER PHCS

WELL-FURNISHED HOUSE

The conditions of the houses/quarters given to the doctors by the government found to be very poor. About 75 per cent of the doctors Table 9 were not happy. They complained that houses are half furnished/ not fit to live with, during rainy seasons. Some of the doctors also complained that the house given to them are not nearby the PHC. However around 90 per cent of the doctors said that they have the land line telephone connections and regular water supply.

ELECTRICITY BACKUP

Around 67 per cent of the doctors said that they are having the power-back-up. In Puttur and sulliya taluks such amenity found to be quiet low.

PERCEPTIONS ON THE WORKING HOURS AND PTTERNS

Working pattern in the PHC is one of the major problem complained by the doctors. To them the present working hours and working pattern is highly illogical. About 83 per cent of the doctors shown dissatisfaction regarding this. They felt that, there should be two medical officers per PHC to work in a shift. One doctor in a PHC can hardly provide justice for 24 hrs a day according to their perception. Besides most of the doctors were complained that much of their times are being wasted in attending monthly taluk meetings, many visits to Grama Sabha, unnecessary training programmes etc. Moreover it is been complained by them that they got very less number of holidays in a year. Apart from above compulsory commitments some of the doctors have also shown dissatisfaction regarding the involvement of local political parties in the day to day function of PHCs. Because of

all these problems involved in the day do day working PHCs doctors have expressed the possibility of deviation of patients towards the private health care system.

TREATMENT FOLLOW-UP

About 67 per cent of the doctors interviewed (Table 12) have told that Patients were not following the instructions properly and they do not follow-up the treatment. According to the doctors in most of the cases a pregnant suspected woman registers her name in the PHC only after 2-3 Months. Despite repeated instructions and warning they do not follow the treatment lines. Such cases are reported more in Puttur taluk and such cases are relatively less in Belthangady taluk. Besides most of the times Patients do not complete the Antibiotic courses as per the doctors advice. Poor literacy rate in some of the remote villages, ignorance, distance to PHC from their residence, some times non availability of certain kinds costly of drugs etc are all the major causes for poor follow-up by the patients.

SUGGETIONS

* The urgent need of the PHCs is to appoint the suitable personnel where it is lacking. Most of the PHC are found to be paralyzed due to the lack of para medical staff, especially Lab technicians. If there is any delay to make permanent appointments for this post, state shall provide autonomy to the concerned PHC to appoint the staff on temporary basis, but with a handsome salary. For this it should create a separate fund for quick disbursement.

* Proper attention shall be provided towards the cleanliness and waste management of the Centers. Otherwise these centers may be become of the disease spreading centers. Local laborers may be hired for cleanliness by paying an attractive wage.(After analyzing cost-benefit aspects)

* There is also a need to provide adequate facilities and equipment for the existing PHCs. Each PHC should consist of a preliminary screening room with a computer, an separate examination room for the doctor, a laboratory for medical tests and toilets. Many PHCs lack even such a basic element of

infrastructure. The State should consider providing either solar panels or diesel generators (based on cost-benefit analysis) connected to batteries for uninterrupted electric power for computer

* The quality service in most of the PHCs found to be very poor. Recognition of good work is absent and punishment for not working also absent. Therefore is a need to provide incentive for staff to perform. Besides, promotions/ salary hike should be linked to the performance. State should think in this direction and shall have a mapping for the same by consultation with the private players in the connected field.

* One of the important reason for the under utilization of government facilities is the poor staff attitude. Therefore is a requirement of training and supervision systems efforts that would change the negative staff attitude towards the patients. Training shall include all those techniques that build human skills, staff patients relationship and counseling, building proper attitude towards work, conducive work culture, creation of commitment to the organization, and develop pride in job.

* There is a requirement to review the kind of routine health problems in a given region. Accordingly drugs shall be supplied. Proper appointment of pharmacist shall also be made and the task of requirement of drugs and keeping the track of its availability should be made by the pharmacists. Medical Officer shall make the supervision of the same at least once in a week. Thus all these work shall be done with proper coordination of both Pharmacists and Medical Officer.

* The present working pattern of doctors are required to change. State should think more practically in this regard. The frequency of meetings that Medical officers suppose to attended should be curtailed. Otherwise most of the time likely to waste without any meaningful results. Further local authorities should be restricted strictly in involving the medical affairs of PHCs.

* To ensure the regular availability of the doctors for rural PHCs ,government should make rural service as compulsory but with proper amenities on the part of the medical officers. Proper

electrification with power back-up, telephone service, regular water supplies should be the basic requirements. Dignity of work should be ensured by the sate.

* To ensure quality medical service government shall think about the appointment of one more Graduate doctor for 24X7 PHCs to work in shift system. Indeed it practically hard to serve a medical officer for 24 hrs a day. This is very much needed specially for rendering Maternity services. In this case gender balance can also be ensured in the appointment of doctors for PHCs. Such approach certainly helpful both for men and women to share any health issues with the doctors

* There is a requirement on the part of the state to think over the drugs available for Maternal care. It should review the entire issue and shall take steps to provide the drugs related to iron and calcium., which are very much necessary both for mother and child. Besides the quality equipments related to delivery cases too shall be provided.

* Special training should be given to the paramedical officers regarding post-natal care. It shall include how to prepare the mother for breast feeding, cleaning the mother, handling and cleaning the baby too.

CONCLUSIONS

The average number of Patients attending in the PHC in DK District is 61 per day. Most of the respondents per cent have negatively replied for Laboratory services. Only 20 per cent of the respondents in the District were replied that the quality of cleanliness as 'Very good',. About 70 per cent of the patients in the District had the opinion that general drugs are available regularly. About 59 per cent of the respondents felt that. About 83 per cent of the doctors were not satisfied with the available facilities to have safe deliveries in PHCs. The conditions of the houses/quarters given to the doctors by the government found to be very poor. Working pattern in the PHC is one of the major problem complained by the doctors. The urgent need of the PHCs is to appoint the suitable personnel where it is lacking. Proper attention shall be provided towards the cleanliness and waste management

of the Centers. There is also a need to provide adequate facilities and equipment for the existing PHCs. Therefore is a need to provide incentive for staff to perform. Promotions/ salary hike should be linked to the performance. Therefore is a requirement of training and supervision systems efforts that would change the negative staff attitude towards the patients. There is a requirement to review the kind of routine health problems in a given region. The present working pattern of doctors are required to change. To ensure the regular availability of the doctors for rural PHCs ,government se as compulsory but with proper amenities on the part of the medical officers. To ensure quality medical service government shall think about the appointment of one more Graduate doctor for 24X7 PHCs to work in shift system. There is urgent requirement on the part of the state to think over the drugs available for Maternal care. Special training should be given to the paramedical officers regarding post-natal care.

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PEROFMANCE ANALYSIS OF PHCs – A CASE STUDY

Minor Research Project Sponsored by UGC

Interview Schedule for Patients

Appendix 1 A

A. General Medical/Clinical Care YES Always, Occasionally No

1. Whether General Medicines are available in PHC always ? ☐ ☐ ☐
2. Have You ever referred to Medical Shop for Medicines ☐ ☐ ☐
3. Does Doctor present all times? ☐ ☐ ☐
4. Does Nurses/other personnel present all times ? ☐ ☐ ☐
5. The response of the personnel in PHC is V.Good Moderate Non-co-op

B. Maternal and Child Health Care

6. Does any day has reserved in a week for Maternal health check-up ? YES ☐ NO ☐

*** Is there any system for Registration ?

7. Does Antenatal injections are available all times in PHC YES always ☐ Occasionally ☐ ☐

NO

8. Does PHC has infant care facilities ? YES ☐ NO ☐
9. Does Post-Natal cares are satisfactory ? YES ☐ No ☐
10. Does PHC has ever conducted health care awareness camp ? YES ☐ No ☐
11 Does doctor ever counseled you about contraceptive use ? Yes ☐ NO ☐
12. Does doctor counseled you about Nutrition care during pregnancy ? Yes , No

C**. Basic Infrastructure and service.** **Yes** **No**

13. Does Laboratory open all times ? ☐ ☐

**Does Lab technician present all times during working hours ?

14. Have you ever refereed out-side for blood test ? ☐ ☐

15 Does your PHC has approachable road ? ☐ ☐

16. Does PHC has power-supply all times ? ☐ ☐

17. How do you grade the cleanliness of PHC V.good Good Bad

18 Does PHC has YES NO

a. Spacious labour room ☐ ☐

☐ ☐

Waiting room

b. Spacious wards ☐ ☐

c. Posters related to health care ☐ ☐

d. Separate room for consultation ☐ ☐

e. Separate room for examinations ☐ ☐

19. Are you satisfied with overall service of PHC ? If no what you suggest ? Explain

PEROFMANCE ANALYSIS OF PHCs – A CASE STUDY

Minor Research Project Sponsored by UGC

Interview Schedule for Medical Officer ***Appendix 1 B***

Place----------

Taluk----------

		YES	NO
1	Does your PHC has regular supply of regular drugs?	☐	☐
2	Does your PHC has proper lab-facility?	☐	☐
3	Does your PHC has all Maternity equipment?	☐	☐
4	Do you feel that patients follow-up the treatment line properly?	☐	☐
5	What are the current challenges of PHCs ?	☐	☐
6	Does your house has		
	a. Well furnished ?	☐	☐
	b. Adequate water supply ?	☐	☐
	c. Telephone ?	☐	☐
	d. Electricity with back-up ?	☐	☐

7.What you suggest to improve the working of PHC ?----------Medical Officer

8. What you suggest to improve the working of PHC ? --------Para-medical officer