Executive Summary

A cross sectional observational study was carried out in three districts of the state of West Bengal by following observational , quantitative and qualitative methods. The study was carried out during the period from July to December 2006.The main objectives of the study was to find out the strengths, weaknesses & gaps as well as suggest recommendations.

Observation revealed that majority of the clients (25%) utilized government health facilities, followed by private practitioners (18.3%) and quacks or unqualified practitioners (19.64%). Free drug supply, round the clock availability of the services and low cost were the main reasons for utilizing the government health facilities. On the other hand good treatment was considered to be the main reason for utilizing the private health facilities (>60%). Qualitative survey report suggested that Private health facilities were used more for some specific diseases and their commitment for maintenance of confidentiality, privacy, *personal attention to the patients as well as the accompanying persons.* Proximity to the beneficiaries (43%) was the principle reason for availing services of quacks.

Opinion gathered from qualitative survey revealed some important aspects. According to one FGD group, people visited private doctor's chambers mostly for abortions and skin problems (this was linked with privacy & confidentiality). They also felt that people went to govt. facilities mostly for preventive services as well as for treatment of major illnesses and to private facilities for minor illnesses. Another group however opined that 'services most in demand' are the curative ones at the government health facilities. According to a CMOH-"30 beds are almost always occupied". One BMOH stated that 'very few cases are referred to higher centers'. Types of cases, which were referred, were "non progression of labor, complications of labor, *complications of New Born*, meningitis, *cerebro-vascular & cardio-vascular emergencies including* CVA, road traffic accidents and cases requiring major surgical *& orthopedic interventions &* blood transfusion. One BPHN stated that some referrals ended up in private doctors' chambers. A DM expressed that "basically people go to providers who are most accessible and available". Preventive services that were more utilized were immunization services and according to him immunization coverage was very satisfactory. This was supported by the findings of the

house to house survey data. DM also said, curative services were being utilized more after ensuring availability of life saving drugs at these centers along with medicines while *Promotive & Rehabilitative services appeared to be deficient.*

"Number of Nursing homes is an indicator of pattern of preference. I have seen in those areas where socio-economic status appeared to be better, nursing homes were flourishing. In this area, there is less number of nursing homes in this district- only 35 nursing homes– this means people are utilizing govt. services."- CMOH of one district commented.

Majority of the respondents felt that poverty was one of the major reasons for utilizing govt. facilities *where services* were provided free of cost. 'This was evident from the scene at the government hospitals' – the CMOH said. There were 4 patients admitted in 2 beds in the free ward whereas the paying beds were empty. Further to state that people prefer government health facilities due to certain weaknesses of private sectors as follows:

- Nursing homes only conduct deliveries. They could not attend critical cases & critical operations.
- Expensive
- Lack of skilled manpower, specially trained nurses

Expenses were pointed out as the major weakness of private health care

"Ekta D&C koratei tin-charsho taka lage (One DC costs Rs 300-400)" – BPHN

"Govt. *Services* ***lack glamour/outward show"*** – so people feel that services are mechanically delivered. It is opposite at private sector – (Ora mishti mukhe pocket kate i.e with sweet wards they take out money from the purse) Distance and poor communication is a constraint to utilization of existing govt. health facilities". -CMOH

Clients had expressed their satisfaction regarding the services provided by the Government health facilities. In-depth interview and focus group discussion carried out as part of study showed interest of community to use government health facilities more. However, it was noted that distance and time taken to reach the centre is a constraint for utilizing the *Government* health facilities. However the following measures have been suggested to improve its utilization.

- The problem of communication could be resolved to a large extent when roads and communication facilities would be improved upon with the help of PRI & PWD.
- PRI could also play some role by providing hired transport for emergency medical care & referral.
- An attempt should be made to motivate community more to use government health facilities by giving due consideration on face-lifting & maintenance of building, confidentiality, privacy, *more personal care to the patients & their accompanying persons.*

One of the major constraints was non-availability of a list of services provided by the government health facilities displayed at the appropriate location. This will help clients to know about the different types of health services that are available at different level of health care delivery systems (Informed choice) based on which they could choose . None of the BPHC and sub-centers displayed such list of services provided by them. Therefore, client gets confused about the services available there and sometimes unnecessarily been harassed. In such situation they opted for other health care providers or choose a wrong provider. The display of 'services available' will help them to have 'informed choices'. This was corroborated by one CMOH. The CMOH stated that the main problem was the lack of awareness in the community regarding the services available at the government facilities. This view was corroborated by the Swasthya Karmadhyaksha. One client went to a BPHC for abortion services but that BPHC was not performing this service (most BPHCs). As a result client went back home and did abortion by a quack and ultimately died due to sepsis. Display of list of services could have prevented such incident.

Around 30% respondents said free drug supply was one of the incentives for using govt. health facilities and quantitative survey showed that very few people had any complaints regarding the problem of getting drugs. But FGD with clients revealed a different picture. Clients stated – "hashpatale shuddhu nam bhorte asi, shab kintei hoy – khali saline-ta paoa jay" ***(we only go to hospitals to register ourselves. Most of the medicines were purchased from outside).***

The recommendations would be to supply essential drugs. ***Hospital should find out the morbidity pattern in their areas from OPD, Emergency and Indoor records and***

procure medicine as per requirement. The study also revealed that only few drugs in sufficient amount would solve their medicine demand as observed from both house to house and exit interview data. Presently the medicines were supplied arbitrarily based on a list of essential drugs. When the surveyors had gone through the list of medicines it was found out that most of the drugs were available at the BPHCs & Sub-centres. This meant that drugs needed and drugs available were not same. Therefore the need for drug supply should be assessed first from the *Field, Emergency,* Indoor and OPD records and then demand should be placed in a rational way.

"The long waiting hours are a major deterrent". The data from exit interview revealed that more than 56% had to wait for more than 30 minutes to 4 hrs to meet the doctor in addition to their travel time. 17% spent 1 to 4 hours to meet the doctors. Engaging two doctors and starting OPD in time could easily reduce this time. Further, if the health workers stay at Sub centers and are involved in treating minor illnesses, the OPD load will be much reduced while community will get treatment at an accessible health facilities run by the government. "Distance and poor communication is a constraint to utilization of existing govt. health facilities"-would also be solved.

Exit interview data showed that major causes for which patient attends the OPD were ANC, Fever, Cough & Cold, Diarrhea etc which could be managed at Sub- center level. Skill based capacity building program should be introduced in a continuous manner for providing quality of care at BPHC level. MOs should be given additional incentives for continuous skilled based training. ***Training at district level neither operationally feasible nor cost & time effective for health workers or paramedical staff.***

The cost of treatment is more or less same in all the facilities considered for seeking care as first choice. While in case of second choice facility the cost of treatment was much higher to the extent of around Rs. 300/-. Cost of curative treatment was excessive, even in government facilities as revealed from a FGD – "poyshakori nai, ki kosto kore aste hoy – gohona bandhok die meyeke bhorti korechi – ekta injectioner dam to 70/."

- Medical officer should understand this fact and should not prescribe any medicine unnecessarily. Prescription of antibiotic for No pneumonia, some dehydration in diarrhea was not needed. PRI should make the client understand about this. Frequent prescription audit study has been recommended for rational use of drug.

- Whenever any costly medicine or life saving drug is urgently required, PRI and Government Health facilities should work together to support clients with such essential medicine.

Client satisfaction in regard to services provided appeared to be more or less same at Government & private health facilities, as revealed from house to house survey. Exit interview also revealed more or less same findings. 29.75% of the clients were fully satisfied. According to clients in qualitative interview, 'the doctors did not have any time for giving instructions and the other workers tell us only about immunization and ORS'. "Haspatale je report thake ki hoyeche boley dey na (nobody explains what is there in the report)".

Therefore, Government *Sector* service providers should be oriented to provide care which satisfy the client and which would bring the clients more to government health facility. One could understand that simple explaining instructions either by doctor or SWO or pharmacist will resolve the issue. In this regard a module based training should be introduced at the time of ***Interne ship training as well as*** at the time of entry into the health services for all public health professionals and group D staff. They should be taught about the interpersonal relationship *& communication skills*. Such a module was developed earlier which contains the basic principles of communication along with case studies regarding the interpersonal relationship but it was never been used. It is expected that such training will help the public health professionals to deal with their *beneficiaries* in a more professional way, who will go back home, satisfied.

Internship program in the Medical Colleges should be oriented in such a way that they will be able to serve better in Health Services as basic doctors and work towards client satisfaction. Thus, their training should emphasize on:

- *Medical Ethics*
- *Medical Record Keeping & its Importance*
- *Health Information Management System*
- *Medical Data Analysis*
- *Health Economics & Health Budgeting*
- *Clinical Dietetics*

Basically, the decision of referral from the sub centre, primary health centre and BPHC was taken either by self or by family members (61%). The study highlighted that decision for such referral was taken for getting better treatment as well as when they were not cured in the first facility. Majority of the client went to another BPHC and a few to secondary and tertiary level facilities. Another BPHC provided more or less same type of care. They traveled a longer distance and spent more money, while many of them were yet to be cured as revealed from the data of House to House survey. Referral to another BPHC will involve cost and time only without much result. The decision to take their patient to another institution was made by the concerned patient or their family members even when it was, possibly, not needed from the medical point of view. People should be oriented that services at BPHCs are more or less same. More than half of the clients, referred to second health facility were satisfied with the services. *It should be looked upon to* improve their satisfaction further. Only 58% were cured. Appropriate referral by a health professional would have definitely improved the satisfaction level further & cure rate. This could be achieved through involvement of opinion leaders of community & appropriate BCC. It might be pertinent to mention that referral from the BMOH was negligible.

Unnecessary referral to another BPHCs (28.3%) and private practitioners (25.3%) should be minimized through development and use of appropriate referral protocol and circulating it to private practitioners through their professional bodies. Display of informed choices will also help to some extent.

*Greatest strength of govt. health facility is immunization services. Free supply of immunization and cordial approach of health workers in delivering immunization services were the main reasons for availing the immunization services by the community to the extent of 80%***.** Those who are not availing immunization services from government institution belonged mostly from the upper socio economic group. Inter personnel communication as well as frequent communication through electronic media will further improve the utilization of services.

It might be recalled that amount of expenditure spent for disseminating the message on HIV/AIDS was appeared to be high.

Some *more Funds* could also be utilized in the same way for whole gamut of RCH services. These should be disseminated either by print media or by electronic media & through interpersonal communication. The fund should be available for these activities or else HIV/AIDS fund might be linked or integrated with RCH services as both are intimately associated. The evaluation mechanism should be existed with the involvement of experts from apex institution or with the involvement of professional bodies like IPHA. They should examine the correctness of the content and methods for dissemination The key messages for RCH services like:

- Immunization,
- Antenatal care,
- Institutional delivery,
- Post natal care including new born care,
- Breast feeding
- Family planning
- *Adolescent health*
- *Infertility management-where available*
- *Prevention & Management of STIs & RTIs*
- *The messages which helps clients to have Informed choices*

Sub centre and BPHC *were* mostly chosen by the beneficiaries for antenatal care. However, it was sad to note that one third of the clients were not utilizing the antenatal care services for at least 3 times or more. Utilization of antenatal services was shown an marginal increase in comparison to other studies (IJPH, NFHS 2). A joint training on RCH with the help of health, ICDS and panchayat functionaries will further improve the utilization of Antenatal care services. Health worker females should be trained time to time, especially on their Skill.

Post natal care was provided through sub centre and BPHC mainly. The quality of care was appeared to be poor. No postnatal care was provided to 22.31% of the clients. The care provided was mainly advised on breast feeding. Advice on positioning and attachment was not included at all during message disseminations. Until and unless breast feeding advice contains such information along with exclusive breast feeding & timely complementary feeding, advice will not be complete. Advice on Care of stitch and

perinatal toileting was hardly given. However, the advice on immunization was given to the extent of more than 90%. Post natal care appeared to be a neglected issue. The public health professionals did not take it seriously as it did not have immediate impact. Experience suggested that this area was also neglected even at the time of RCH training and it was felt that emphasis on post natal care should be given due emphasis in view of reduction Neonatal and Maternal morbidity & mortality.

Family planning services are provided by government sectors without any cost involvements of clients. Around 69% utilized family planning methods & mostly sterilization. ***The effort to improve condom use through IEC, appeared to us, has yielded very little results (only 6.8% were using condoms).*** Further some court order had made the doctors apprehensive of taking up sterilization operation for family planning as mentioned by some. These must be seriously looked into, otherwise; sterilization operation will be reduced with further reduction in the couple protection rate.

Some other suggestions, which came out, were included as follows

- *Adolescent Health should be taken into account.*
- *Components of RCH should be taken with importance.*
- *Planning & Programming on Life Style Diseases & Non Communicable Diseases having high morbidity & mortality (like Cerebro & Cardio-vascular Diseases, Diabetes, Neuropsychiatric Diesaes, Anemia related disorder, Cancers, Asthma etc)*
- *Local level Health Planning should be done on the basis of Data-Based approach.*
- *Community Need Assessment Approach*

Action points identified

Environmental :

1. Waiting space in Sub-centres and CHCs to be increased. Especially in the SCs people felt there is lack of adequate waiting space.
2. General cleanliness should be improved and maintained.
3. Waste disposal system to be made functioning. Logistics and capacity building of manpower are to be taken care of.
4. Screens are to be provided and used for privacy and examination of patients in both SCs and CHCs.
5. Toilets are in dismal state and need improvement. Though latrines were present they were either devoid of water supply or functioning outlets as well as full of stain and bad odor.
6. Though majority of BPHCs & SC had electric connection yet all government health facilities should be provided with electricity & generator.
7. About half of the staff quarters needed repair or painting.
8. Provision of potable water to be present in all facilities.

In short repair, painting, availability of drinking water, adequate waiting space, clean environment with usable toilets, privacy and ***face-lifting*** will definitely attract client to utilize services provided by the government more

Service delivery:

1. Flexibility is needed in the delivery of antenatal care through SCs. Usually its weekly and timings are fixed. Timings should be as per the discretion of clients & this would be possible, if HW(F) is residential
2. Antenatal services at BPHCs showed varied picture, ranging from once weekly to once in 4 weeks. This need to be regularized. There should be monitoring why it is so?
3. Delivery services were not available in SCs usually (only one SC has recently started this service) in the study area. It needs to be introduced slowly. A close look in the quality of services and the problems in the service delivery are warranted.

4. Post natal care services are in a precarious state. The home visits are almost non-existent and it's mostly linked with 1st.visit for immunization of the child. Postnatal services at the grass-root level should be planned, which should be operationally feasible. RCH training should addressed this issue and provide need based training for providing Postnatal care. Some activities could be done by the mother that should be instructed at the time of ANC
5. There was no scope for Emergency Obstetric care services at the BPHC. In addition to logistics, the skilled and specialist manpower was also lacking. Blood transfusion facility, anesthetic equipments are urgent needed. One baby resuscitation cot was kept under lock and key as there was no pediatrician to mange this. So proper planning and placement of staff is mandatory, wherever such a facility was given.
6. From the sub centers complicated pregnancies were referred to the BPHCs. But unfortunately it often helps in increasing the delay in management only as the BPHCs are not equipped to manage such cases. The information should be given through PRI & ICDS functionaries as well as through display of services provided by the specific BPHC as per IPHS standard
7. Most of the BPHCs did not have facilities for sterilization or MTP at present.
8. Prescription should be dispensed with quickly so that patient should not wait more.

Managerial/administrative issues:

1. Time spent for explaining management was quite short and not acceptable to the patient. 2 doctors should be posted; they should attend duties at OPD in time as well as one paramedical worker should be there to explain the instruction one by one.
2. Behavior of all categories of staff health care delivery personnel should improve. Behavior of the nursing staff at indoor appeared to be an important determinant for level of satisfaction of patients.
3. Referral instruction to the patients was almost non-existing and this often puts them in a confused state. They wanted some guidance and clarification for the

referral, but most of the time did not get it. Social Scientist or Paramedical Worker could help.

4. ECCR maintenance and updating was a sensitive issue. Increasing population, absence of health assistants' especially male, volume of information, time constraint as well as less priority to ECCR than other services, was the prime reasons for poor maintenance of ECCR. This area needs attention. Importance of ECCR should be explained to all categories of staff through sensitization meeting. Training of staff about its maintenance, availability of ECCR register and involvement of ICDS as well as PRI in updating ECCR through CNA approach and sharing the records of each others may solve the problem.
5. Supervising the maintenance of ECCR by BPHC staff was unsatisfactory. Lack of motivated staff, poor coordination between health and other relevant sectors, increasing population were few suggested hurdles for proper supervision. Present level of supervision on ECCR appeared to be poor and needed improvement.
6. Further research is necessary to identify specific, feasible remedial measures to alleviate these problems of updating and maintenance of ECCR. Novel, innovative ways from block and village level workers should be appreciated and evaluated for wider use in future.
7. A prescription audit is necessary as a good number (44.63%) of patients did not receive drugs according to prescription from the designated pharmacy as revealed from qualitative data. With adequate information back-up necessary change in the inventory list could be initiated.
8. Anti snake venom and anti rabies vaccine seems to be in short supply in all the BPHCs.
9. Training and retraining of staff is necessary. Mostly they are trained in RNTCP, NLEP, RCH and dai training. Training to develop managerial skills seems to be lacking. All training should be conducted at BPHC level and fund should be allotted for such training at BPHC.
10. Too frequent meeting and calling of Health staff from the periphery causes disruption of their routine services. Mobile phone should be given to all health

workers at the periphery to carry out instruction, providing feedback and facing emergency in a pragmatic way.

Policy-level :

Governmental health facility was utilized almost by the same proportion of people as private practitioners. On the other hand lots of people consulted quacks and a considerable proportion remained unattended by any health care providers.

1) Further research is necessary to identify causes and feasible solutions of poor health care seeking behavior.
2) Quacks or traditional healers need to be sensitized regarding the national health programme with special reference to treatment of minor illnesses, IEC in national health programs as relevant and referral. Their influence and proximity to the rural mass can aid in percolation of knowledge and health awareness in the community. After such sensitization they will not perform such activities which were wrong. This will be as part of Private Public Partnership while not allowing them to replace doctors.
3) An umbrella forum e.g. NRHM- Rogi Kalyan Samiti, could be initiated and made functioning with the help of PRI, Health department and private providers to improve the overall health situation of areas. They would act as a bridge between the community and health care providers. They should not be allowed to instruct professionals in regard to management of patients and health actions.
4) Training of ASHA should be state specific as educational level of ASHA will not be same throughout the country. Female literacy being more here ASHA in West Bengal could take up better activities
5) Involvement of Professional Body in planning, supervision & implementation
6) Doctors should not be interfered in professional matter. Their duties should be arranged in such a way that they should have to perform minimum duty hours allotted to them.

Summarization of the suggestions on action points

A. Infrastructure

1. Construction of SC building with adequate space for waiting. Sheds may be constructed as temporary measure.
2. Upgradation of BPHCs to CHC along the lines of IPHS
3. Piped water supply, if not possible then handpumps installed in all SCs and other institutions
4. Provision of toilets in SCs and their regular maintenance
5. Supply of necessary logistics for waste management; capacity building
6. Repair and renovation work for the staff quarters
7. screens for patient examination
8. Inter-sectorial co-ordination - The problem of communication will be resolved to a large extent when roads and communication facilities will be improved upon with the help of PRI & PWD

B. Manpower:

1. Sanction & recruitment of specialists in G&O, Pediatrics & anesthesia in BPHCs
2. Recruitment of 2nd ANMs, nursing staff & lab technicians
3. Contracting the above manpower, as short term measure
4. Skill development of GDMOs in the above disciplines, particularly anesthesia as well as of Health workers in conduction of deliveries, injection, IUD insertion, dressing, initial management of dog bite, animal bites, snake bites, some emergency management & referral

C. Drugs & Equipments

1. Supply of drugs according to the essential drug list, including AVS & ARV..
2. Procurement of equipments according to the essential equipment list and RCH guidelines. Maintenance of such equipments like BP instruments, weight machine,

D. Service Delivery

1. Popularizing & Regularization of antenatal services in BPHCs through mothers meeting with the involvement of PRI, posters.
2. Revamping postnatal care services at BPHC, PHC & SC, reorienting it along with home visits of ANM. At the time of capacity building on RCH due emphasis on Postnatal care should be given, which appeared to be neglected now
3. Operationalisation of FRU services: EmOC, neonatal stabilization & support units, blood transfusion facility. Newborn care at sub centre and home level should be given due consideration including referral

4. Provision of full range of RCH services in the BPHCs, including MTP & sterilization

E. Capacity building needs:

1. Management skills: hospital administration, leadership, stress taking, motivation building
2. Communication skills: communication with clients and colleagues in the direction of client satisfaction
3. Monitoring & Supportive Supervision,
4. Frontline work: serving clients, maintaining records
5. Rogi Kalyan Samiti: rights & responsibilities & sharing with other categories of health personnel
6. Good inventory management
7. Hospital based IEC activities to improve client satisfaction
8. Capacity Building seminar , workshops and training should be organized at BPHC level by MO under monitoring & supervision of district level officer of health. MOs may be trained at district or Medical College level

F. Research Issues:

1. Background reasons and possible solution to improve care seeking among the community
2. Orientation of quacks or traditional healers, utilizing them as community level links as a part of Public Private Partnership
3. Data generation by frontline workers: how to improve
4. Prescription audit and comparison with drug supply or EDL
5. Morbidity Pattern as well as changing trend in morbidity
6. The Professional Bodies, who has expertise of such research or Medical Colleges can undertake such research projects
7. The study of Morbidity Pattern at BPHC level

Background

IOM Definition of Quality: In 1996, the Institute of Medicine (IOM) launched a concerted, ongoing effort focused on assessing and improving the nation's quality of care

"The degree to which health services for individuals and population increase the likelihood of desired health outcomes and are consistent with current professional knowledge"(iomwww@nas.edu)

Quality of Care: Quality of Care Refers to the way in which individuals and couples are treated by Health care system providing services

Quality of Services is the service or care one wants to receive or would want one's spouse, children or parents to receive

Quality means it will meet the client's needs and allowing staff to work more efficiently

Quality Improvement requires on-going attention- it is not attended by a one time meeting or training event, but should become part of what staff is always doing

(Reproductive and child health module for medical officer MO (PHC), National Institute of Health & Family Welfare, Munirka, New Delhi, November 2002. P 135-152.

It is often argued that increase in price of health care (by means of introduction of or increase in user fees, cost recovery system for diagnostic tests) in government facilities would not have significant adverse impact on the utilization of health care by the poor, if the quality of health care could be improved.

(Abel-Smith, B. and P. Rawal (1992): 'Can the Poor Afford Free Health Services? A Case Study of Tanzania', Health Policy and Planning, 7(4): 329-41).

It indirectly implies that an increase in price of health care will not have any negative impact on the already existing large poor-rich difference in the utilization of health care, provided quality is also improved along with hike in price.

In many developing countries, the oft-stated objective of seeking additional resources for the health sector, especially under health sector reforms, is to improve the quality of health care. The call for improved quality is also a favorite of health sector policy. *(How Important are Quality and Price in Choice of Health Care? Understanding the Health Care Seeking Behaviour of 'Poor' and 'Rich' in Urban West Bengal , Subrata Mukherjee. This is the html version of the file*

http://www.igidr.ac.in/whatsnew/csh/subrata-paper.doc).

When an individual falls sick, other members of the household (apart from the sick) may need to spend time for seeking health care for the sick. It may, therefore, be more meaningful to consider the time spent by the household as a whole rather than time spent by the ill individual for seeking health care. In such a situation, it would be more appropriate to use information about a household's occupational nature (instead of considering the occupational nature of the ill individual) to get some idea about the opportunity cost of time. *(Arrow, K. .J. (1963): 'Uncertainty and the Welfare Economics of Medical Care, The American Economic Review, 53(5): 941-73)*

For example, if there are two households – one *regular wage or salaried* and the other *self- employed* – with same economic status (measured in terms of per capita consumption expenditure), it is reasonable to assume that opportunity cost per unit of time would be higher for the *self- employed* household compared to the *regular wage or salaried* household. We assume that opportunity cost per unit of time is highest for the *labor* household (which shows the lowest average economic status) and lowest for *regular wage or salaried* (which shows the highest average economic status). *http://www.igidr.ac.in/whatsnew/csh/subrata-paper.doc).*

Although, it is difficult to say definitely that opportunity cost per unit of time is lower for the *self-employed* households compared to *labor* households (since the former is a highly heterogeneous group ranging from very poor to very rich), we assume that the opportunity cost per unit of time is higher for the *labor* households compared to *self-employed* households since the latter are expecting to have more flexibility in allocating their working hours. However, this assumption is subject to empirical verification. *http://www.igidr.ac.in/whatsnew/csh/subrata-paper.doc).*

Introduction

On the basis of the recommendation of Bhore Committee the primary health centre has been started functioning since 1952 in community development block. It proposes to provide comprehensive health care facilities (preventive, promotive and curative) in the rural areas. Subsequently the sub-centres were established for 5000 population to provide mostly preventive care like MCH, Immunization etc. as well as for treatment of minor illness (Park JE 2007). In 1983 the national health policy came into existence which was subsequently modified in 2002 (Taneja DK). Functions of the primary health centres were evaluated and to make health care delivery system accessible to the community, primary health centre for 30,000 populations and community health centre for community development block was envisaged (Park JE 2007). Around 1981 Ray SK at al evaluated the utilization of primary health centre and found out that utilization was not to the extent of satisfactory level. It might be because of the many factors like non-availability of medicine, equipment, non-cordial behavior of the staffs as well as poor availability of manpower. Therefore, a study is needed to understand many of the issues of utilization of services that has a link to human development issues. The objective of the study will be as follows.

Objectives

1. To assess the strength of the health care delivery system at the community development block.
2. To find out the weaknesses of the existing health care delivery system.
3. To find out the gap between the existing and desired heralth care facilities.
4. To understand the health care seeking behavior of the community
5. To suggest measures to improve health care delivery system at the community level.

Methodology

Study type: A cross sectional observational study was carried out in three districts of the state of West Bengal by following observational, quantitative and qualitative methods as well as specific feedback from BMOH.

Study Design

Study Period**:** The study was carried out during the period from July to December 2006. During this period the instruments were developed and shared with public health professionals of different parts of the country. Based on their feedback the tools were modified and again shared with experts and funding agency. Based on their views tools were reviewed and re-modified. The tools were further modified after pre-testing in Diamond Harbor rural areas. The finalized tools were shared with the surveyors. The Principal Investigator conducted training on hose to house survey & exit interview followed by hands on training for 4 days on FGD and In-depth interview for qualitative survey. MOs were also trained in technique of facility survey. The survey teams then went to three districts more or less simultaneously. Each team consisted of a Faculty member & Paramedical staff/PGT

Observation: To observe facilities available i.e. BPHC and Sub-centre, situational analysis of facilities as well as observation of behavior of staff etc was carried out.

Quantitative methods included the followings:

i. House to house survey in sampled households of the district to find out the extent of utilization of services provided by public & private sectors, reasons for utilization & non utilization etc.
ii. Exit interview of the patients to understand about client satisfaction, distance traveled etc.

Qualitative methods:

In-depth interview: To understand the feelings of the health care providers & CDPO, strength and weakness of direct or indirect service providers. In-depth interview at different level included the following.

At district level:

i. District Magistrate/Additional District Magistrate looking after Health
ii. Chief Medical Officer of Health in the district
iii. Sabhadhipati / Swasthya Karmadhakhya of district

Block level

i. Block Medical Officer of Health
ii. Block Public Health Nurse
iii. Chief District Project Officer

Focus Group Discussion (FGD)

To understand the strength and weakness from the client, Panchyat Raj Institution representatives and Health workers the FGDs were conducted in all the three districts. In each one of the districts one BPHC was selected randomly for conducting FGDs among Clients, one for PRI & one for Health workers.

Sample size:

For house-to-house survey sample size was determined by standard technique with the help of statistician.

Three districts were selected by purposive sampling method from three geographical area (stratification). From each district three block P.H.Cs was selected by Simple Random

Sample Size:

Sample size for each district was calculated, taking 71.05% utilization of Health care with 10% allowable error and with design effect (Ray SK et al, 1981).

Considering 71.05% utilization of health care we calculated sample size for each district with design effect and 10% allowable error and 95% confidence interval.

Sample Size = 161 X 2 = 322

Sample size was approximately 330 (322 rounded off) for each district.

From each block and block PHC a village was selected .The other two villages were selected from a distance of 5 Km and another at a distance of >5 Km. Thus 330 population was distributed into above mentioned 3 villages i.e 110 population from each one of the above three villages.

For exit interview

Sample size is determined by purposive sampling technique based on operational feasibility. Average attendance at OPD in West Bengal BPHC is 130/day and 15% sample of 130 (=19.5)~20. This meant that at every BPHC 20 persons was interviewed randomly, i.e. every 6^{th}.person attending the OPD was interviewed. Five clients were interviewed from indoor patients. This was based on the data that on an average a BPHC has 30 general beds. Considering all beds were full on the day of the visit 15% of that comes to 5 (~4.5). So, five patients were interviewed from the inpatient department.

Sample size was purposive for Qualitative survey which was based on operational feasibility, fund and time constraints. Sample was decided as follows.

District level:

In-depth interview at the district level with District Magistrate/Additional District Magistrate looking after Health, Chief Medical Officer of Health in the district and Sabhadhipati / Swasthya Karmadhakhya was carried out. At north Dinajpur district interview with District Magistrate and Sabhadhipati / Swasthya Karmadhakhya could not be carried out due to operational reasons.

Out of three Block Primary Health Centers chosen in the districts, one each Block Primary Health Centers in the district was selected randomly for interview of Block Medical officer of health, CDPO & BPHN.

FGD:

It was carried out at the block level for clients, PRI and HWs. Similarly, out of three Block Primary Health Centers chosen in the districts, one each Block Primary Health Centers in the district was selected randomly for FGD of Clients, Health workers and PRI members

Sampling frame and place of study:

Mainly two stage sampling (stage 1- District level and stage 2 - Block level) was done.

Stage 1: Considering the fund and time constraints, three districts from the state of West Bengal were chosen after discussion with the members of IPHA and funding agency. One district each was chosen from Presidency, North Bengal and Burdwan division as follows:

Presidency division: Uttar Dinajpur

North Bengal: Puruliya

Burdwan: Murshidabad.

Additional reason for selecting Puruliya was due to the fact that it has predominant tribal population.

Stage 2: To have a wide coverage at the district level three blocks were chosen randomly from each district i.e. a total of nine blocks were covered in three districts.

At each block for conducting house to house survey, based on the total sample size of 330, it was decided as follows :

110 households were covered at one BPHC village. If 110 house holds could not be obtained in that village & adjacent village was covered.

110 households were covered in a village which was situated 5 km. away from BPHC

110 households were covered in a village which was 5-10 km. away from third BPHC.

The selection of BPHCs was done on a random basis. The direction to move for number 2 & 3 villages was done also randomly.

Place of study:

District	BPHC
Puruliya	Bundwan, Jhalda and Banda
Murshidabad	Jiagunj, Raghunathgunj I (Teghori) and Jalangi
Uttar Dinajpur	Itahar, Kaliagunj and Karandighi

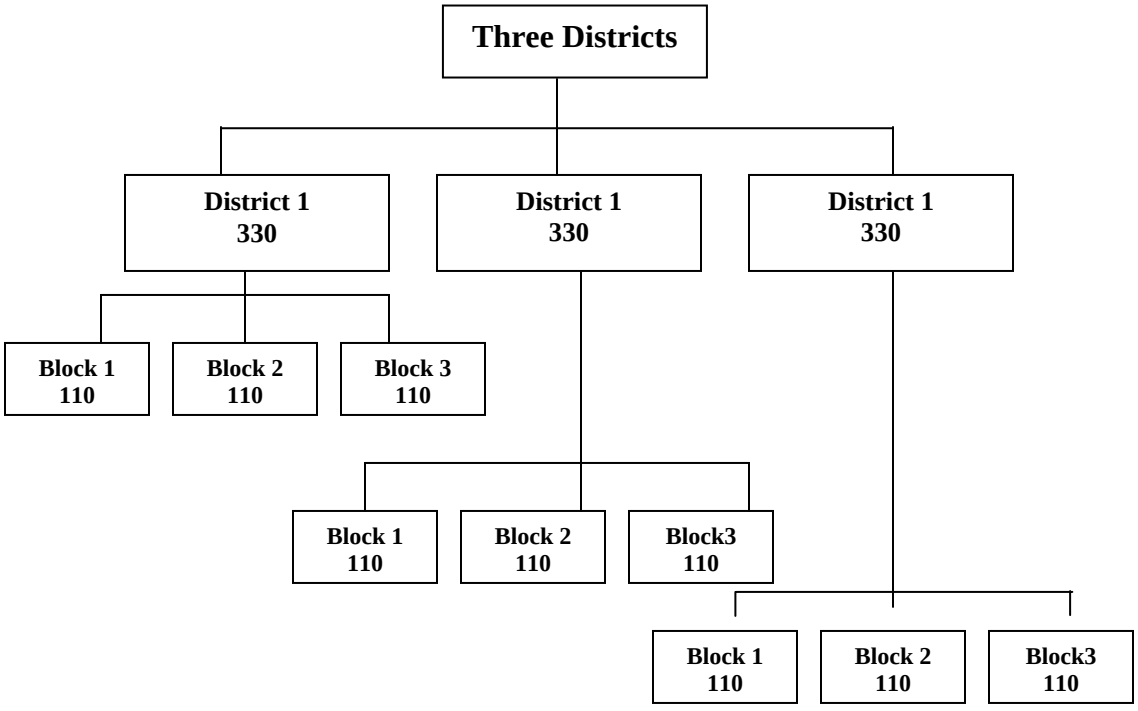
Medical Officer Questionnaire

Five BMOH who were either transferred to MES or left jobs or transferred from the posts recently, were interviewed to find out further some of the strength & weaknesses issues in an unbiased way.

How it was conducted:

In-depth interview of the senior administrative officers was conducted by principal investigators and senior experts. At the block level in depth interview was done by faculty members trained for the purpose. Paramedical professionals, post graduate trainee conducted house to house survey and exit interview. Faculty members or doctors conducted observation at PHC and sub-centres.

Schematic diagram of sampling design



Findings of Quantitative Survey

Three districts (One each from each division) were chosen for the purpose of study. These districts were Uttar Dinajpur, Mursidabad & Purulia. Total households covered during the survey were 997 in the three districts with a minimum target of 330 per district. Among the respondents 404 & 593 were male and females respectively. Religion-wise distribution showed 793, 178 & 26 respondents were Hindu, Muslim & christen respectively. General Caste was 555 while Schedule caste and Scheduled tribe were 314 & 128 respectively. Majority (734) belonged to Nuclear family and rest 263 was from joint family.

There was occurrence of 672 episodes amongst the 496 respondents during past three months i.e. 1.35 episodes per family with. Regarding loans taken for treatment, the study revealed that in 25.72% of these episodes loan was received. In 6.2% of episodes they denied that the loan was not taken confidently. It was interesting to note that in 68.07% episodes respondents bypassed the questions. It was felt that many did not like to comment. It might be due to the fact that the respondents were reluctant to comment about the loan to an unknown person or they might not have felt comfortable to express any thing about the loan taken for their personal reasons.

Average distance from sub centre, PHC, BPHC and secondary hospital was 2.49 km, 5.98 km, 6.02 km and 33.5 km respectively (**Table 1)**.

It was decided to take past three months' recall to find out episodes of morbidity/ morbidities. Out of 997 respondents covered in the study, 496 (49.75%) respondents reported that they suffered from one or more episodes in the past three months. It was observed from the study that there was occurrence of 672 episodes of different types of morbidities amongst the 496 respondents i.e. 1.35 episodes per family with past three months recall. Amongst the 672 episodes 451 episodes reported to health facilities (67.11%) and rest 221 (32.89%) did not go for any treatment in any health facilities.

Report of Utilization of Health Care Services and Medical Care

The findings revealed that 13.85%, 21.62% and 42.92% utilized government health facilities for treatment of episodes at Purulia, Murshidabad & N. Dinajpur respectively with an overall percentage of 25.89%. Utilization of Pvt. Practitioners was observed to be

highest at Mursidabad (27.48%) followed by North Dinajpur (19.63%) and Purulia (8.23%) with an overall utilization rate of Pvt. Practitioner was being 19.2%. Utilization of quack practitioners was highest in North Dinajpur (30.29%) followed by Murshidabd (27.93%). Quack utilization was lowest in Purulia (1.29%) while overall utilization of quack was 19.64%. Utilization of Ayush was less than 6% of the total episodes. At Purulia district respondents did not go for any treatment for 76.19% episodes while it was only 18.92% in Murshidabad and very less in (1.37%) in North Dinajpur. Over all rate of utilization of not being treated by any system was 32.89% **(Table – 2)** at Purulia, which was a tribal district. Majority of the tribal from a particular block did not take any treatment for their illness, even after motivation which was noticed during the study. Further, tribal has their own way of treatment based on their culture. This might be existed in that specific block. Over all utilization of public sector was higher in comparison to private sector. The highest utilization of public sector (42.92%) was observed in North Dinajpur. The reason for higher use of government health facilities followed by quack might be due to the facts that studied government health facilities were situated at an accessible distance. Further utilization of private Practitioners was comparatively less, which might be due to their less availability at N Dinajpur. It may be concluded that government sector played an important role in providing services to the community, while the role of private sectors could not be ignored. They were also playing an important role for curative services to the community next to government facilities. Better utilization of government health facilities might be due to Good treatment (27.5%) provided as well as Free supply of drug (29.6%). These were the two main reasons for availing government Health facilities. Good treatment was the main Reason for availing the Private facilities (61.8%). Other reasons were more or less similar both in the private & government sectors. Utilization of services by quack was due to their proximate to community as well as they were available even at night or on holidays **(Table3)**.

It was observed that majority of the health facilities which were utilized were situated within 5 kms. Quack was closest (84.5%) followed by government health facilities (77.3%) and private facilities (64.5%) **(Table-4)**.

Majority reached the health facilities on foot (47.45%) followed by Van rickshaw (28.6%) and by bus (10.86%)**(Table-5)**. There was not much difference between average time to reach the government (22.78 minutes) and private facility (23.5 minutes) as well as between sub centre (14.10 min) and quack (17.58 minutes). However from the range it was observed that private practitioners (1-300 minutes) were situated at a greater distance followed by BPHC (1-120 minutes). **(Table-6).**

Expenditure incurred for reaching Govt., private and quack was around less than Rs 50/- in case of more than 95% of the first care seeking in illness episodes. In case of referral above Rs. 300 was spent in case of 41.1% episodes. **(Table-7).**

Overall, in case of majority of the episodes no problems were faced during treatment. Only in case of 13.6%, 9.8% and 9.3% episodes, some problems were faced with providers in case of quack, private practitioners and government health facilities **(Table-8).**

No improvement following treatment was the main problem reported by the quack, followed by government and private facilities **(Table-9).** Due to smaller sample size nothing could be commented.

Amongst some common episodes of illness ARI ranks first (13.1%) followed by Diarrhea and dysentery (5.8%) and fever (4.8%) **(Table-10).**

Out of 451 episodes, when respondents sought treatment from any of the facilities, 271 (60.09%) were satisfied while 13.97% were not satisfied while 30.38% did not like to comment. Highest client satisfaction was observed in case of government health facility (35.42%) followed by quack (31.36%) and Private Practitioners (27.54%) during their exposure to different episodes **(Table-11).** This finding was contrary to the popular belief that private sector provided better client satisfaction than government health facilities.

Amongst 451 episodes that attended health facilities, 67 (14.86%) were referred to another health facility. Some episodes (28.3%) were referred to BPHC/CHC. This was followed by referral to Private Practitioner (25.3%) and secondary hospital (14.93%). Referral to Medical College and Ayush was only 2.9% each. **(Table-12)**

The decision to refer the case to other health facilities was taken by self (34.3%) and family members (26.7%) mostly. Medical officer referred in 15% episodes, while quack in 7.5% episodes. **(Table-13).** The main reason for referral to other facilities was for

"better treatment" (46.3%), followed by, "not cured in that facility" (31.3%) as perceived by the respondents **(Table-14).** Both these responses were of similar in nature. To bring down the load at the referral centers direct individual referrals to higher facilities should not be encouraged. Awareness of the community as a whole and appropriate training of Health personnel is a key issue to bring down the referral load of peripheral centers and provide better quality of care. The average distance of referred facilities was 26.54 kms including the medical colleges **(Table-15).** Mode of transport used was mainly bus (34.3%), followed by Rickshaw van (19.4%) and foot (17.9%) **(Table-16)**. In comparison to mode of transport to reach first choice facility (Table 5) the movement by bus was much higher for referrals. This was due to the fact that referral institution may be in another block PHC (28.3), private practitioner at distant place (25.3), secondary hospital (14.3) and even medical colleges (Table 12).

Average time to reach the referred health facilities was 75.20 minutes with an average of 20-800 minutes **(Table-17)**. Average time to reach first choice facility was around 26 minutes (Table-6). Similarly average amount of money spent to reach the referred facilities for these episodes were Rs. 127/- in comparison to Rs. 55/- for reaching first choice facility **(Table-18).**

Only 19.4% said that they did face some problems after referral **(Table-19).** The problems were high cost (38.46%), long waiting time (30.77%), non-availability of medicines and in adequate services (23.08% each) **(Table-20).** However sample size was small and there were multiple responses hence it would not be appropriate to make a comment based on this.

It was observed that out of 67 referred episodes 55.22% were satisfied. Rest was either not satisfied (13.44%) or did not like to comment (31.34%) **(Table-21).**

It was noted that out of total episodes referred to other health facilities, 58.2% episodes were cured while 7.5% were improving. 13.4% said that nothing much to comment at that stage and 7.5% also commented that their patients were not improving **(Table-22).**

Episodes were referred to other facilities (Table 23) for better treatment (46.3%) and for not being cured at first level facility (16.4%). Attempts for improvement in treatment at the first level facility might bring down the referral rate.

Immunization:

Out of 997 respondents **(Table-24)** under five children was present in 409 respondents' families (41.02%).

Majority of the respondents (73.11%) preferred sub centre for immunization followed by BHPC/CHC (24.69%). No body went to private practitioners for immunization while 1.22% preferred private hospital **(Table-25).** Preference for government facilities, by the community, in connection with immunization of children is one of the greatest strength of government for provision of primary prevention. This occurred due to sustainable BCC efforts of government for more than 20 years in a planned manner using different methods of health education. This experience should be tried in improving delivery of other preventive services. Another reason might be, supply of free vaccine to the beneficiaries (80.2%). Some considered it to be the main reason for choosing the government health facility for immunization. Other important reasons **(Table-26)** might be proximity of the government health facility to their home (31.78%) and good behavior of staff (15.89%)**.**

Antenatal care :

There were 121 child births in the families in the surveyed areas in past 12 month period as reported by respondents **(Table-27)**. They were interviewed regarding Antenatal services as per CES (National Immunization Programme, Government of India, 1990) protocol (Govt. of India). 58.68% preferred sub centre for antenatal care followed by BPHC/CHC (47.11%). Utilization of government hospital for antenatal care was 7.44%. Private practitioners provides only 8.26% antenatal care while local dai and private hospital each provided this services to the extent of 2.48%. Another 2.48% women did not receive any care **(Table-28).**

Reasons for preference of government health facility for antenatal care were due to free vaccine supply (61.98%), proximity to beneficiaries' home (47.11%), good treatment (28.93%) and good behavior to the extent of 17.36% **(Table-29)**. Preference for other facilities was not analyzed due to small number.

The study revealed that only 59.50% of pregnant women received antenatal care on three or more occasions **(Table-30)**. It was disheartening to note that even after 10 years of RCH programme we are not able to reach the goal of 100% of antenatal care to all

pregnant women. This is one of the main components of services for pregnant women to reduce both maternal morbidity and mortality. A strong, all out effort should be made to improve coverage with pregnant women with quality of care-the goal RCH Program. However, it was also good to note that out of 121 women only 2.48% did not receive any antenatal care. Therefore an all out effort along with panchayat and ICDS functionaries with the leadership of health worker (F) should be undertaken to emphasize the importance of three antenatal checkups, physical examination like BP and weight recording and advocacy for institutional deliveries. Self-help groups may also be involved in such approach as partner.

Postnatal Care:

One third of the respondent reported that they had not received any postnatal care. Sub centre and block primary health centre / CHC provided postnatal care for 52.07% and 56.2% respectively. The role of other facilities in providing postnatal care was negligible **(Table-31).** It might also be mentioned that the so called postnatal visits, as reported, might be a mere a visit where no physical examination was done as per stipulated norms based on RCH guidelines (RCH Module, Government of India, 2002).

22.31% respondents reported no postnatal care provided to either mothers or new born or young infant. Care of the children was provided in case of 25.62% respondents, perinatal toileting was given to 5.78% respondents, care of stitch was given to 0.83%. Advise on immunization and breast feeding was reported by 90.91% and 49.59% respondents respectively. However, the meaning of postnatal care was not understood by the respondents properly and appeared to be very poor as reported by the interviewer and their supervisor. The advice on breast-feeding and immunization falls under the IEC activities of post natal care. The clinical part and history for postnatal care was missing as it was addressed neither by medical officers nor in any RCH training programme. They emphasized mainly on iron folic acid tablet and partly on breastfeeding **(Table-32).**

Family planning:

It was revealed from the study that there were 679 (68.1%) married female (15-45 years age group) living with their husbands at the time of study **(Table-33).** Findings further revealed that 69.37% eligible couples were adopting any family planning methods currently. Sterilization operation (mainly tubectomy) was done amongst 27.98% cases

followed by OCP (18.41%), safe period (11.49%). 6.8% respondent eligible couples used the condom. Insertion of IUD was low (1.33). If we do not include safe period (11.49%) & Indigenous method (3.68) couples protection rate as per the present table will be 54.2%. However, it appeared that coverage of family planning methods was improving in comparison to earlier reports. Such efforts should be sustained **(Table-34)**. BPHC was the most preferred place for getting family planning services (42.04%) followed by sub-centre (21.02%). In case of rest of the facilities the coverage was very poor around 1-7% **(Table-35)**. The main cause for selection of the specific health facility **(Table-36)** was due to the reason that family planning services were provided free of cost (46.5%) and close to home (21.23%)

Table 1.

Average distance of the government health facilities as reported by Respondents

positive responses

Nearest government health fac(Distance in km)	Secondary hospitals n=629	BPHC n=994	PHC n=842	SC n=629
Mean	33.5 km	6.02	5.98	2.49
Range	6-65 km	1-15 km	1-11 km	0.25 -20 km

N B: "n" was based on the responses given by the respondents. Rest of the respondents remained silent over these questions

Table 2

Utilization of health facilities as the first preference by respondents for various episodes of illnesses.

Health facilities utilized for episodes	Total episodes							
	Overall N=672 (100)		Purulia N=231		Murshidabad N=222		N. Dinajpur N=219	
	No	%	No	%	No	%	No	%
iii. Sub Centre	30	4.46	5	2.16	11	4.95	14	6.39
iv. PHC	25	3.72	8	3.46	2	0.9	15	6.85
v. BPHC/CHC	119	17.71	19	8.23	35	15.77	65	29.68
Sub total (govt. facilities)	***174***	***25.89***	***32***	***13.85***	***48***	***21.62***	***94***	***42.92***
• Pvt. Practitioners	123	18.30	19	8.23	61	27.48	43	19.63
• Quack	132	19.64	3	1.29	62	27.93	67	30.29
• Ayush	20	2.98	0	0	8	3.60	12	5.48
• Traditional Healers	02	0.29	1	0.43	1	0.45	0	0
Sub total (non –govt.)	**277**	**41.22**	**23**	**9.96**	**132**	**59.46**	**122**	**55.71**
No Treatment	**221**	**32.89**	**176**	**76.19**	**42**	**18.92**	**3**	**1.37**

Figure - 1
Utilization of health facilities as the first preference by respondents for various episodes of illnesses (N=672)

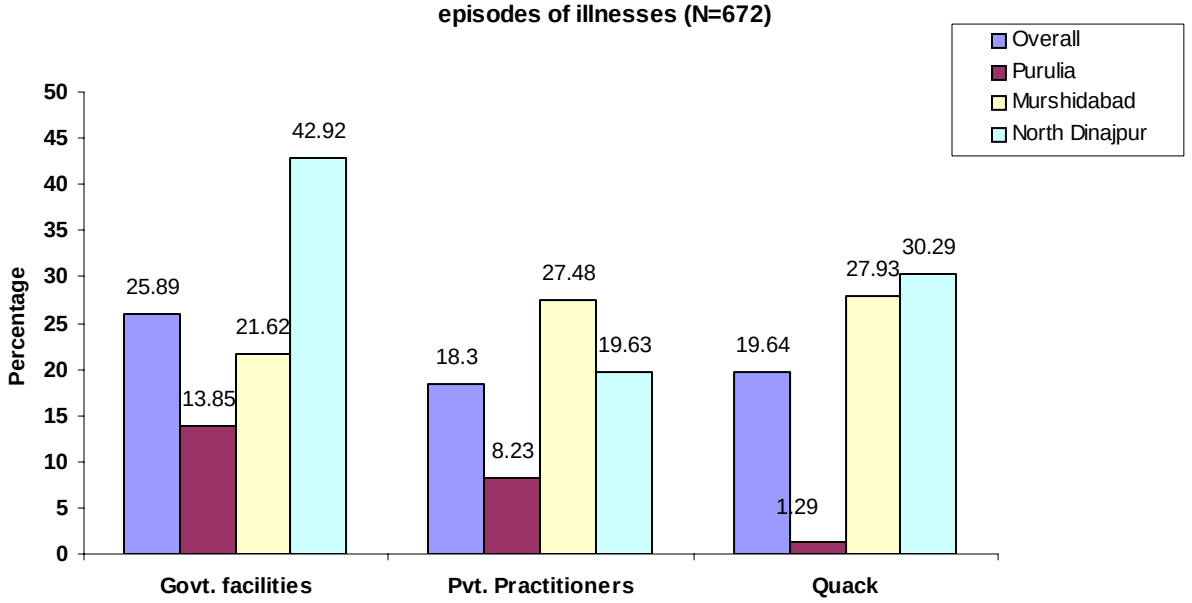


Figure - 2
Utilization of health facilities as the first preference by respondents for various episodes of illnesses (N=672)

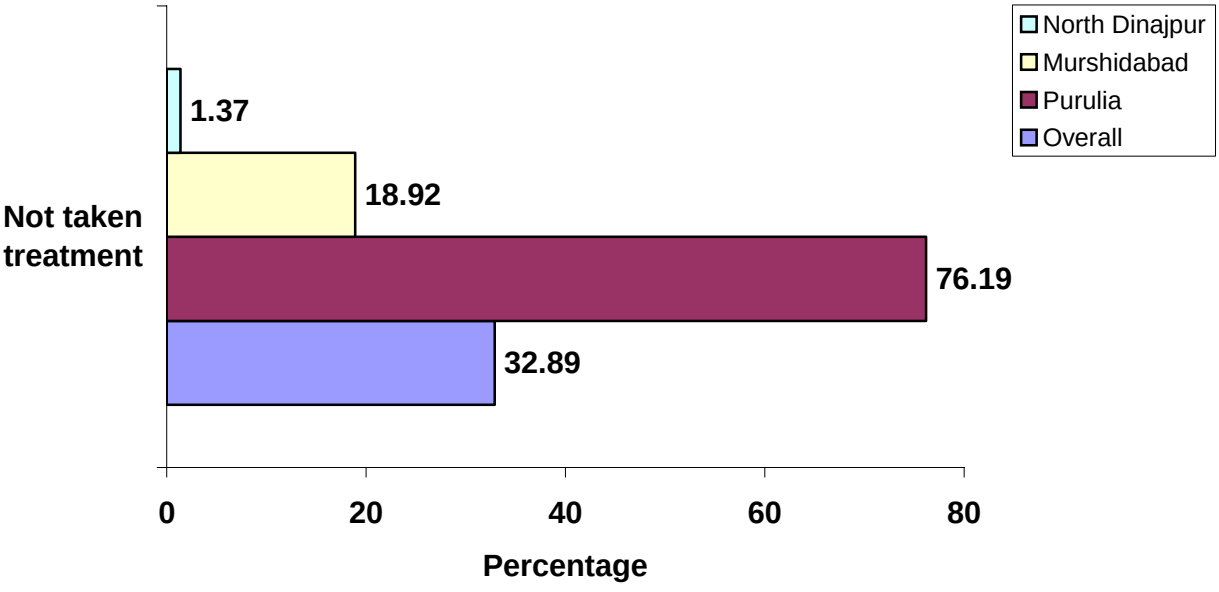


Table 3

Reasons for preference to specific health facilities for episodes of illnesses

Reasons*	**Total episodes N=672(no treatment=221) n = 451**						
	SC n=30	**PHC n=25**	**BPHC n=119**	***Sub Total n=174***	**Pvt Pract n=123**	**Quack n=132**	**Others n=22**
1. Round the clock availability of doctor	2(8.7)		14(13.6)	***16(10.5)***	9(7.3)	53(43.1)	1(5.3)
2. Low cost		2(8)	20(19.2)	***22(14.5)***	11(8.9)	29(23.6)	7(36.8)
3. Good behavior	----	----	----	***----***	14(11.4)	----	-----
4. Close to home	8(34.8)	6(24)	14(13.6)	***28(18.4)***	6(4.9)	24()19.5	2(10.5)
5. Good treatment	2(8.7)	15(60)	24(23.1)	***41(27.0)***	76(61.8)	8(6.5)	6(31.6)
6. Free Drugs available	11(47.8)	2(8)	32(30.8)	***45(29.6)***	1(0.8)	1(0.8)	0
7. No alternative			4(3.8)	***4(2.6)***	4(3.3)	0	
8.Suitable timing				***0***	8(6.6)	7(5.7)	
9. Any other, specify				***0***	2(1.7)	1(0.8)	1(5.3)
No response	**7**	**0**	**11**	***18***	**0**	**9**	**3**

*Multiple responses
NB. Non responses were not included for calculation pf percentage

Table 4

Distance of different Health Facilities utilized as first preference in various episodes of illnesses.

Distance (Km)	Total episodes N=672 (no treatment=221)						
	SC	PHC	BPHC	*Sub Total*	Pvt Pract	Quack	Others
1 to 4	11(100)	6(100)	34(69.4)	***51(77.3)***	40(64.5)	33(84.6)	4(50)
5 to 10			12(24.5)	***12(18.2)***	17(27.4)	-------	4(50)
11to 15			2(4.1)	***2(3.0)***	0	2(5.1)	----
16 to 20			1(2.0)	***1(1.5)***	1(1.6)	--------	
21 to 30						1(2.6)	
31 to 50							
51 & above					4(6.5)	3(7.7)	
NR	19	19	70	***108***	61	93	14
Total	30	25	119	***174***	123	132	22

NB: Non response (NR) was not considered for calculation of percentage.

Table 5

Mode of transport to reach the health facilities

Type of transport	Total episodes N=672 no treatment=221 n=451	
	Number	Percentage (%)
On foot	214	47.45
R+ R Van	129	28.60
Bus	49	10.86
Cycle	21	4.66
Tempo, tracker & trolley	6	1.33
Taxi	6	1.33
Train	3	0.67
No response	23	5.10
Total	451	100.00

Table 6

Average time to reach the specific health facilities

Time	**Specific health facilities**						
	SC n=30	**PHC n=25**	**BPHC n=119**	***Sub Total (govt.) n=174***	**Pvt Pract n=123**	**Quack n=132**	**Others n=22**
Total time (Minute)	283	250	1586	***2119***	1928	1213	265
No. of respondents	20	12	61	***93***	82	69	10
Average time(Minute)	14.10	20.83	26	***22.78***	23.5	17.58	26.5
Range(Minute)	2-40	10-30	10-120	***2-120***	1-300	1-60	10-60
No. of no-response	10	13	58	***81***	41	63	12

Table 7

Distribution of respondents according to cost of treatment during first & second choice health facilities

Cost (Rs)	Episodes choosing first choice health facilities				Episodes choosing second choice health facilities (referral)
	All episodes n=451	Govt facilities n=174	Pvt Pract n=123	Quack n=132	All referred n = 67
	No %	No %	No %	No %	No %
Less than 50	437 (96.9)	166 (95.4)	121 (98.4)	129 (97.7)	6 (9.0)
50 – 99	3 (0.7)	-	1 (0.8)	2 (1.5)	6 (9.0)
100-149	4 (0.9)	2 (1.1)	-	1 (0.8)	6 (9.0)
150-199	-	-	-	-	6 (9.0)
200-249	-	-	-	-	9 (13.4)
250-299	1 (0.2)	1 (0.6)	-	-	3 (4.4)
Above 300	6 (1.3)	5 (2.9)	-	-	28 (41.8)
Above 20,000	-	-	1 (0.8)	-	3 (4.4)
Total	451 (100)	174 (100)	123 (100)	132 (100)	67 (100)

N.B: Out 672 episodes treatment was sought in case 451 episodes while 67 episodes were referred

Table 8
Problems faced, if any, in specific health facilities

Problem faced	Specific health facilities						
	SC	PHC	BPHC	*Sub Total (govt.)*	Pvt pract.	Quack	Others
Yes	3(10.0)	4(16.0)	9(7.6)	***16(9.2)***	12(9.8)	18(13.6)	2(9.1)
No	22(73.3)	19(76.0)	80(67.2)	***121(69.5)***	93(75.6)	106(80.3)	17(77.2)
No Response	5(16.7)	2(8.0)	30(25.2)	***37(21.3)***	18(14.6)	8(6.1)	5(22.7)
Total	30(100)	25(100)	119(100)	***174(100)***	123(100)	132(100)	22(100)

Table 9
Types of problems faced, if any, in specific health facilities

Problem faced*	Specific health facilities						
	SC n=3	PHC n=4	BPHC n=9	*Sub Total (Govt.) n=16*	Pvt Pract n=12	Quack n=18	Others n=2
Non-availability of doctor	NA	-----	1(10)	*1(3.4)*	1(9.1)	2(14.3)	------
Unavailability of drugs	2(13.3)	1(25)	2(20)	*5(17.2)*	2(18.1)	------	------
Far from home	-----	-----	4(40)	*4(13.8)*	---------	------	-----
No transport available	------	------	-------	----	4(36.4)	------	-------
Long waiting time	--------	--------	1(10)	*1(3.4)*	1(9.1)	--------	2(100)
No Improvement	13(86.7)	1(25)	2(20)	*16(55.2)*	3(27.3)	8(57.1)	-----
NR	------	2(50)	----	*2(6.9)*	------	4(28.6)	----
Total	15(100)	4(100)	10(100)	*29(100)*	11(100)	14(100)	2(100)

*Multiple responses possible

Table 10

Some Common Episodes of illnesses in Past 3 Months

Disease episodes in past 3 months	N=672	Percentage
ARI	88	13.1%
Fever	30	4.5%
Dysentery & Diarrhea	39	5.8%
Dyspepsia & Acidity	8	1.2%
Pain Abdomen	21	3.1%
Malaria	18	2.7%
Headache	10	1.5%
Body ache & Backache	19	2.8%
Asthma	14	2.1%
Tuberculosis	6	0.9%
Hypertension	2	0.3%
Skin Disease	4	0.6%
Ear Pain	2	0.3%
Paralysis	3	0.4%
Piles	1	0.1%
Chest Pain	1	0.1%
Total	266	39.6%

Table 11

Client Satisfaction in regard to services provided by the facilities

Health facilities utilized for episodes	**Satisfaction N=451(100)**					
	Yes N=271		**No n=63**		**Can't Say N=117**	
	No	**%**	**No**	**%**	**No**	**%**
• Sub Centre (30)	18	6.64	4	6.35	8	6.84
• PHC (25)	15	5.53	4	6.35	6	5.13
• BPHC/CHC (119)	63	23.24	18	28.57	38	32.48
Sub total (govt. facilities) (174)	***96***	***35.42***	***26***	***41.27***	***52***	***44.44***
• Pvt. Practitioners (123)	76	27.54	13	20.63	34	29.06
• Quack (132)	85	31.36	21	33.33	26	22.22
• Ayush (20)	14	5.17	2	3.17	4	3.42
• Traditional Healers (2)	0	0	1	1.59	1	0.85
Sub total (non –govt.) n=277	**175**	**64.58**	**37**	**58.73**	**65**	**55.56**

Table 12

Distribution of respondents regarding their choice for second (referred) health facility

Health facilities utilized for second (referred) episodes	N = 67	
	No.	%
BPHC / CHC	19	28.3
Secondary Hospital	10	14.93
MC, Kolkata	02	2.9
Pvt. Practitioners	17	25.3
Quack	1	1.4
Ayush	2	2.9
Not recorded	16	23.8

Table 13

Decision maker for referral to other facilities

Decision makers of referral	N = 67	
	No.	%
BMOH	1	1.5
BPHN	1	1.5
Custom to referral for some ailments like complication of pregnancy	1	1.5
Medical Officer / Doctor	10	15
Neighbour	6	9
HW	1	1.5
Quack	5	7.5
Relative	1	1.5
Self	23	34.3
Family members	18	26.7

Table 14

Cusses of referral to other health facilities

Causes	N = 67	
	No.	%
Referred for better treatment	31	46.3
Not cured	21	31.3
Family members not coming to attend	1	1.5
High cost	2	3
Quack	1	1.5
Referred due to worsening of condition	3	4.5
Referred for spectacle	1	1.5
Not recorded	7	10.4
Total	**67**	**100**

Table 15

Distance of Health Facilities utilized as second choice in various episodes of illnesses.

Distance of second choice health facility	(Distance in km)
Mean	26.54 km.
Range	0.5 to 180 km.

N B: "n" was based on the 63 responses given by the respondents. Rest of the 3 respondents remained silent over these questions
Total distance 1672/63 = 26.54 km.

Table 16

Mode of transport to reach the second choice health facilities

Type of transport	Total episodes N=67	
	Number	Percentage (%)
Bus	23	34.3
Rickshaw & Van	13	19.4
Foot	12	17.9
Car	5	7.4
Cycle	3	4.4
Train	3	4.4
Ambulance	1	1.4
Taxi	1	1.4
No response	6	8.9

Table 17

Average time to reach the referred health facilities

Average time to reach referred health facility	(Time in minutes)
Mean	75.20
Range	02-300

N B: "n" was based on the 61 responses out of 67 respondents. Rest of the 6 respondents remained silent over these questions
Total time 4567/61 = 75.20 minutes

Table 18
Average expenditure to reach the referred health facilities

Average expenditure to reach referred health facility	(Amount in Rs.)
Mean	127.02
Range	08-1000

N B: "n" was based on the 49 responses out of 67 respondents. Rest of the 18 respondents did not respond.
Total expenditure 5843/46 = 127.02
3 respondents said there is no cost incurred in reaching the referred facilities

Table 19

Problem faced in Referred facilities

Problem faced	n= 67	
	No	%
Yes	13	19.4
No	45	67.16
Can't say	09	13.43

Table 20

Types of the problems in Referred facilities

Problems* n= 13	**No**	**%**
High cost	5	38.46
Inadequate Services	3	23.08
Far from home	1	7.69
Long waiting time	4	3077
Non availability of Medicine	3	23.08
Can't get cured	1	7.69

*Multiple responses from 13 respondents who told that they did face some problem after referral.

Table 21

Satisfaction about the services in Referred facilities

Satisfaction of services n=67	**No**	**%**
Yes	37	55.22
No	09	13.44
Do not like to comment	21	31.34

Table 22

The result of the treatment at the referred facilities

Result of Treatment	n=67	
	No.	%
Cured	39	58.2
Improving	05	7.5
Nothing much to comment at this state	09	13.4
Not improving	05	7.5
No Comments	09	13.4

Table 23

Causes of referral to other health facility

Causes for referral	n=67	
	No.	%
Better treatment	31	46.3
High cost	2	3
Lack of family member	1	3
Not cured	11	16.4
Quack	1	1.5
Referred due bad condition	3	4.5
for spectacle	1	1.5
Not recorded	17	25.3

Table 24
No of respondents having under five children

Under five children n=997	No	%
Yes	409	41.02
No	568	56.97
Not recorded	20	2.01

N B: "n"is based on total attended

Table - 25

Choice of health facilities for immunization

Health facilities utilized for immunization n = 409	No	%
• Sub Centre	299	73.82
• PHC	4	0.99
• BPHC/CHC	101	24.94
• Govt hosp	1	0.25
Sub total (govt. facilities)	***405***	***100***
• Pvt. Practitioners	0	--
• Pvt. Hospital	5	1.22
• Not immunized	3	.73

NB: Multiple responses were recorded

Table – 26
Reasons for preference of Government health facility for immunization

Causes for preference to specific health facility n=409	**No**	**%**
• Free vaccines available	328	80.20
• Low cost	12	2.93
• Good behavior	65	15.89
• Close to home	130	31.78
• Good treatment	***45***	***11.01***
• No alternative	17	4.16
• Suitable timing	6	1.47
• Others	1	0 .24
• Not immunized	3	0.73

NB: Multiple answers were recorded

Table - 27
Child birth in the families in past twelve months

Under twelve month old children n=997	No	%
Yes	121	12.13
No	816	81.85
Not recorded	60	6.02

Table - 28
Choice of health facilities for Antenatal care

Health facilities utilized for Antenatal care (n=121)	No	%
• Sub Centre	71	58.68
• PHC	3	2.48
• BPHC/CHC	57	47.11
• Govt hosp	9	7.44
• Pvt. Practitioners	10	8.26
• Pvt. Hospital	3	2.48
• Local dai	3	2.48
• No care	3	2.48

NB :Multiple answers were recorded

Table - 29
Reasons for preference to government health facility for antenatal care

Causes for preference to specific health facility n=121	**No**	**%**
• Free vaccines available	75	61.98
• Low cost	42	3.71
• Good behavior	21	17.36
• Close to home	57	47.11
Good treatment	***35***	***28.93***
• No alternative	08	6.61
• Suitable timing	02	1.65
• Others	02	1.65

NB: Multiple answers were recorded

Table – 30
Number of Antenatal Visits

Antenatal visits to specific health facility n=121	No	%
Less than 3 care	40	33.06
3-5 care	68	56.19
More than 5	04	3.31
Not recorded	09	7.44

Figure - 3
Number of Antenatal Visits

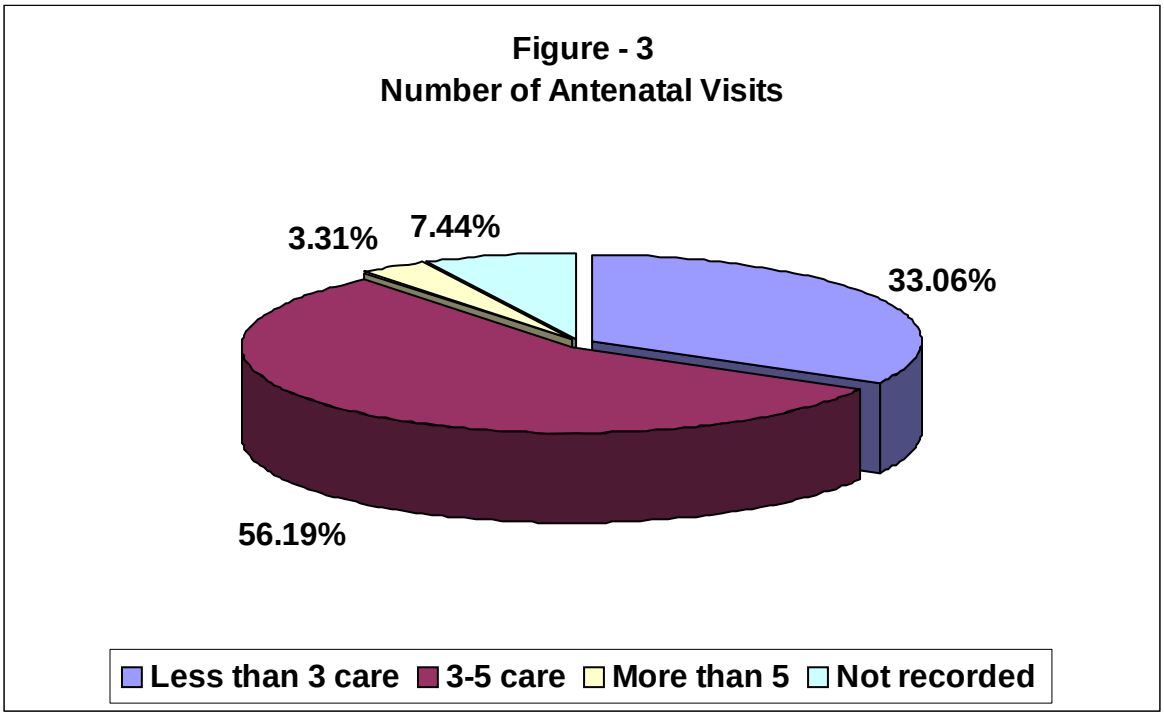


Table 31
Choice of facilities for postnatal care

Postnatal care to specific health facility N=121	**No**	**%**
SC	63	52.07
PHC	08	6.6
BPHC	68	56.2
Govt. hospital	***04***	***3.3***
Pvt.Practitioner	10	8.26
Pvt hospital	01	0.83
Indigenous practitioners	-	-
Local dai	03	2.48
Nowhere	38	31.4

NB: Multiple answers were recorded

Table 32
Post natal care provided

Care & information on health provided to care givers N=121	**No**	**%**
No care	27	22.31
Care on children	31	25.62
Adv on breastfeeding	60	49.59
Perinetal toileting	07	5.78
Care stitch if any	***01***	***0.83***
Adv on immunization	110	90.91
Others	-	-

N.B: those who were not given any postnatal care after delivery information on immunization , breast feeding etc was provided

Table – 33
Married Female aged (15-45) living with her husband at the time of study

Women (15-45 yrs.) n=997	**No**	**%**
Yes	679	68.1
No	270	27.08
Not recorded	48	4.82

Table – 34

Family planning method practiced by couples currently

Family planning methods **N=**679	**No**	**%**
OCP	125	18.41
Condom	44	6.80
Safe period	78	11.49
IUD	09	1.33
Sterilization	190	27.98
Other than approved method like indigenous methods	25	3.68
Sub total	***471***	***69.37***
Not using any methods	208	30.63

Figure - 4
Family planning method practiced by couples currently

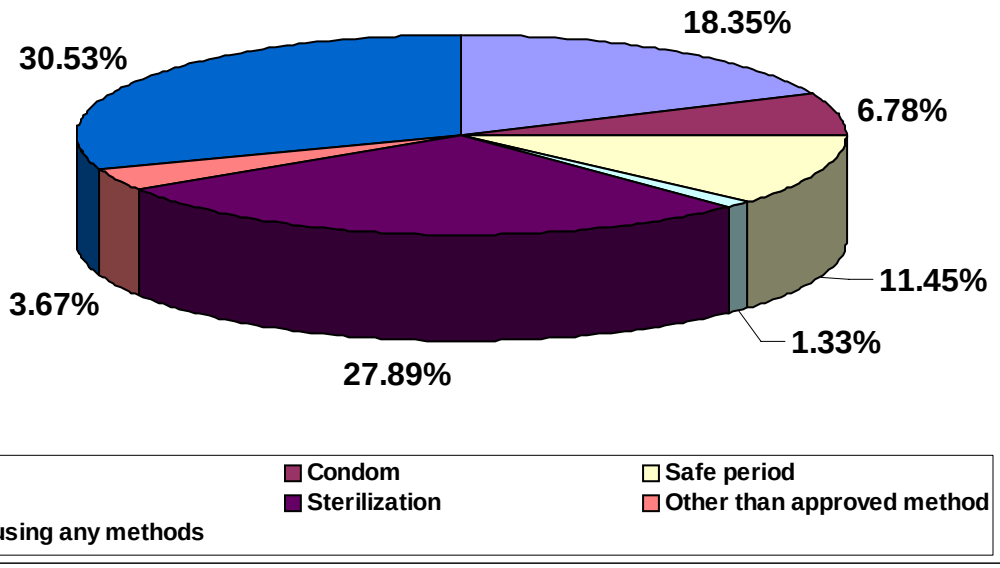


Table – 35

Places from where F. P. service were advised

Places **N=**471	**No**	**%**
SC	99	21.02
PHC	09	1.01
BPHC	198	42.04
PP	19	4.03
Quack	***05***	***1.06***
Ayush	10	2.12
Pvt Pract /Others	36	7.64
Not recorded	105	22.29

Table – 36

Causes of selection of centre for FP services

Causes **n=**471	**No**	**%**
Free service	219	46.50
Low cost	33	7.01
Good behavior	33	7.01
Close to home	100	21.23
Doctor present	***29***	***6.16***
No alternative	09	1.91
Suitable timing	12	2.54
Others	02	0.42
NR	34	7.22

NB: Multiple answers were recorded

Findings of Exit Interview

Total number of respondents in the exit interview was 242. Male respondents were 117 (48.3%) and female were (51.7%). Amongst the respondents 53.3% were Hindu by religion and 42.6% were Muslim and rest 4.1% were Christian. Out of 129 Hindu respondents schedule caste were 41 (31.78%), followed by schedule tribe and OBC 25 (20.33%), and 63 (48.83%) were others category. Majority of the respondents **(Table-37)** were housewives (45.50%) by occupation followed by farmer (16.50%)**.** Main reasons for attending the health facility was fever (24.8%) followed by pain abdomen (9.1%), cough and cold (8.20%), low back pain (8.20%) and for antenatal checkup (8.20%) **(Table-38)**. Out of 242 clients who attended the health facilities 88 (36.4%) were referred. They were referred mainly by MBBS doctor (34.10%) and Quack (28.4%) as well as by the community (22.8%) **(Table-39)**. Time taken to reach the nearest BPHC was within 30 minutes for 45.45% clients followed by 30 minutes to one hour for 37.6% clients and rest of the clients took between one hour to four hour **(Table-40).**

At the BPHC, 43.8% respondents had to wait approximately half an hour and 38.03% had to wait around 1 hour to meet doctor **(Table 41).** Around 16% had to wait further. An attempt to bring down the waiting time will be feasible, if planning is done properly.

Cordial behavior of doctor were reported to be highest (76.86%) followed by Pharmacist (69.42%) & Nursing staff (56.19%) **(Table 42).** However, “did not like to comment” appeared to be very high for “nursing staff group” (30.99%) followed by Pharmacist. Cordial and non-cordial behavior was a spontaneous reply while “do not like to comment” usually goes more in favor of “not a cordial behavior”, as many clients/respondents were apprehensive to comment on the behavior of a staff as long as they were close to the facilities. Behavior is an important component for providing services to beneficiaries who expected both dignity and respect. The nursing personnel should improve their behavior. A similar finding was also noted down, when the beneficiaries were asked to comment whether the doctors treated them with dignity and respect or not. Majority (78.93%) opined affirmatively **(Table 43).** Only 55.37% beneficiaries said they received medicine as per prescription **(Table 44).** Time to taken to

get medicine was within half an hour as reported by 42.97% respondents. Rest of them took more than half an hour time to get medicine **(Table 45)**

64.05% clients opined that waiting space was inadequate **(Table-46).** Usable toilets were reported by only 5.78% clients **(Table-47)**. Availability of drinking water was mentioned by 55.37% only rest said quality was poor (14.04%). 3.3% clients reported that water was not available. Some also commented (15.7%) that they have not used water and can't give their comments **(Table-48)**.

Full treatment satisfaction was mentioned by 29.75% clients while part satisfaction was mentioned by (44.67%), while not like to comment (14.16%) and not satisfied (9.5%) was also mentioned at the time of interview **(Table 49)**.

Comment on over all satisfaction was made by 55.37%, while 15.29% were not satisfied and 29.34% did not like to comment **(Table 50)**.

Table-37

Distribution of respondents according to occupation

Occupation	Respondents	%
Housewife	110	45.50
Farmer	40	16.50
Labourer	24	9.90
Business	35	14.50
Student	5	2.10
Rickshaw puller	5	2.10
Bidi binder	20	8.20
Bamboo craftsman	3	1.20
Total	**242**	**100**

Table-38
Distribution of according to problems for attending health facility

Problems	Respondents	%
Fever	60	24.80
Antenatal checkup	20	8.20
Cough & cold	20	8.20
Diarrhoea	4	1.70
ENT problem	5	2.10
Skin problem	4	1.70
Low back pain	20	8.30
Leprosy	1	0.40
Tuberculosis	2	0.80
Jaundice	5	2.10
Pain in lower limb	10	4.10
Gastritis	10	4.10
Injury	8	3.30
Hypertension	12	5
Pain in abdomen	22	9.10
Not mentioned	39	16.10
Total	**242**	**100**

Figure - 5
Distribution according to major morbidities for attending health facility

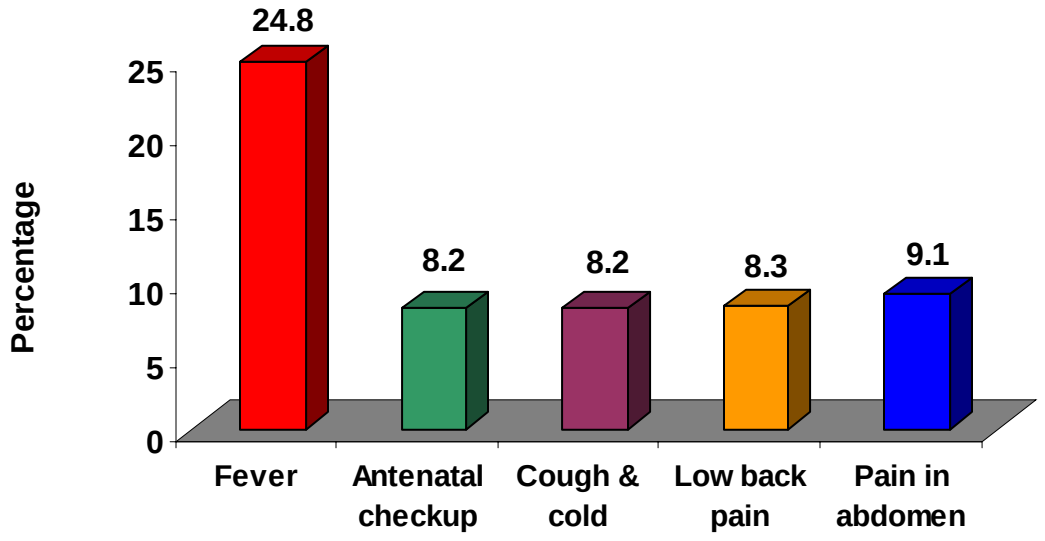


Table-39

Distribution of respondents according to health professional who referred

Referred by	**Number**	**%**
M.B.B.S	30	34.10
Ayush	4	4.50
Quack	25	28.40
Community	20	22.80
Others	9	10.20
Total	**88**	**100**

Table-40

Distribution of clients as per traveling time to reach the BPHC

Time	Number	Percentage
< ½ hour	110	45.45
½ - 1 hour	91	37.60
1 – 2 hour	37	15.29
2 – 4 hour	3	1.25
> 4 hours	1	0.41
Total	**242**	**100**

Figure - 6
Distribution of clients as per traveling time to reach the BPHC

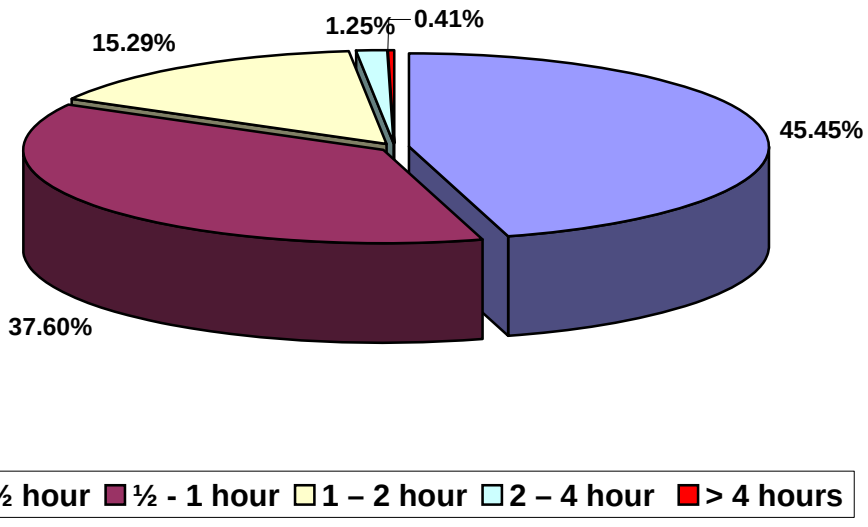


Table 41
Distribution of clients according to the waiting time to meet doctors

Time	Number	Percentage
< ½ hour	106	43.80
½ - 1 hour	92	38.03
1 – 2 hour	38	15.70
2 – 4 hour	4	1.65
> 4 hours	2	0.82
Total	**242**	**100**

Figure - 7
Distribution of clients according to the waiting time to meet doctors

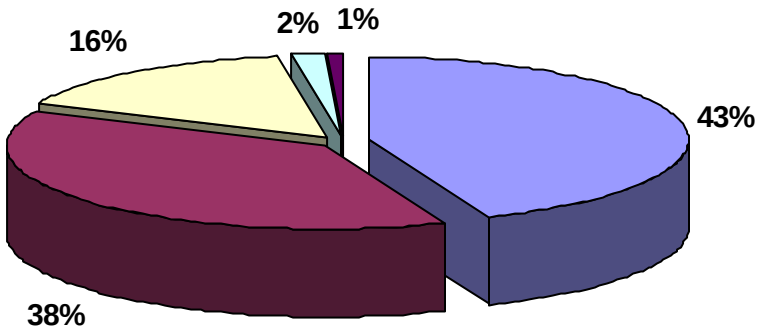


Table 42
Distribution of clients according to their comments on behaviour of health care providers

Type of behaviour	Care providers							
	Doctors		Nurse		Pharmacist		Others	
	No.	%	No.	%	No.	%	No.	%
Cordial	186	76.86	136	56.19	168	69.42	171	70.66
Non cordial	24	9.92	21	8.68	15	6.19	11	4.54
Did not like to comment	26	10.74	75	30.99	42	17.37	55	22.73
Not recorded	6	2.48	10	4.14	17	7.02	5	2.07
Total	**242**	**100**	**242**	**100**	**242**	**100**	**242**	**100**

Figure - 8
Distribution of clients according to their comments on behaviour of health care providers

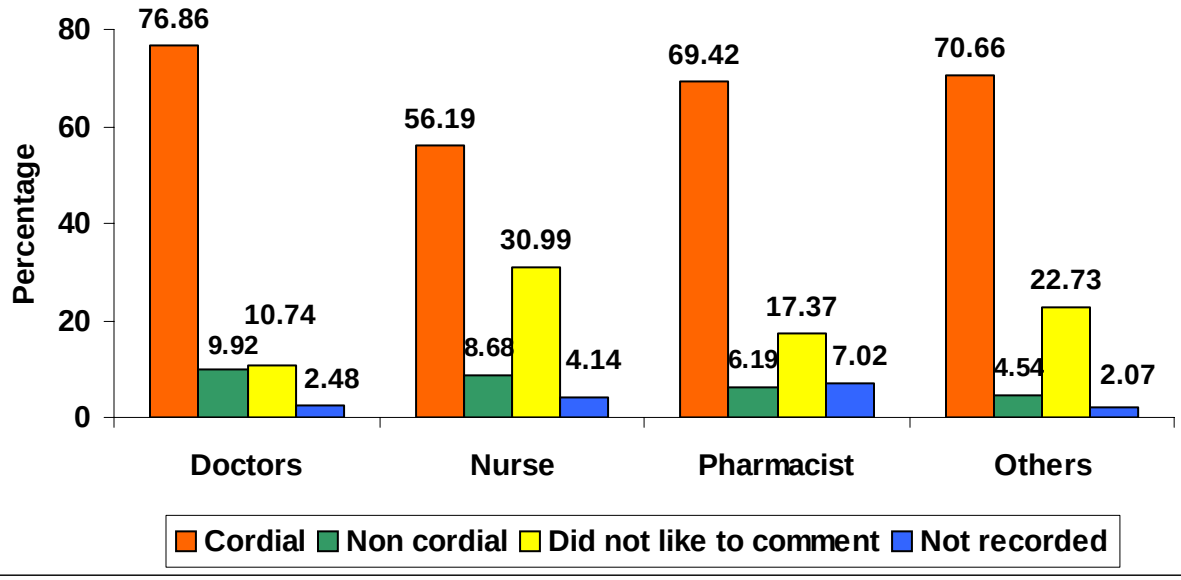


Table 43
Distribution of clients according to care of the patients by respect and dignity

Opinion	Number	Percentage
Treated with respect	191	78.93
No respect	13	5.37
Not like to comment	38	15.70
Total	**242**	**100**

Table 44
Distribution of clients according to receipt of prescribed medicine

Opinion	Number	Percentage
Yes	134	55.37
No	64	26.45
Do not know	38	15.70
Not received	6	2.48
Total	**242**	**100**

Table 45
Distribution of clients according to the time taken to receive medicine

Time	Number	Percentage
< ½ hour	104	42.97
½ - 1 hour	90	37.19
>1 hour	48	19.83
Total	**242**	**100**

Table 46
Distribution of respondents according to their comments on adequacy of waiting space

Waiting space	Respondents	%
Adequate	87	35.95
Inadequate	155	64.05
Total	**242**	**100**

Table 47
Distribution of respondents according to their comments on toilets

Toilets	Respondents	%
Toilets usable	14	5.78
Toilets not usable	66	27.20
Dirty & needs cleaning	56	23.12
Can't say as not used	65	26.86
No functional toilet	9	3.72
NR	32	13.32
Total	**242**	**100**

Figure - 9
Distribution of respondents according to their comments on toilets

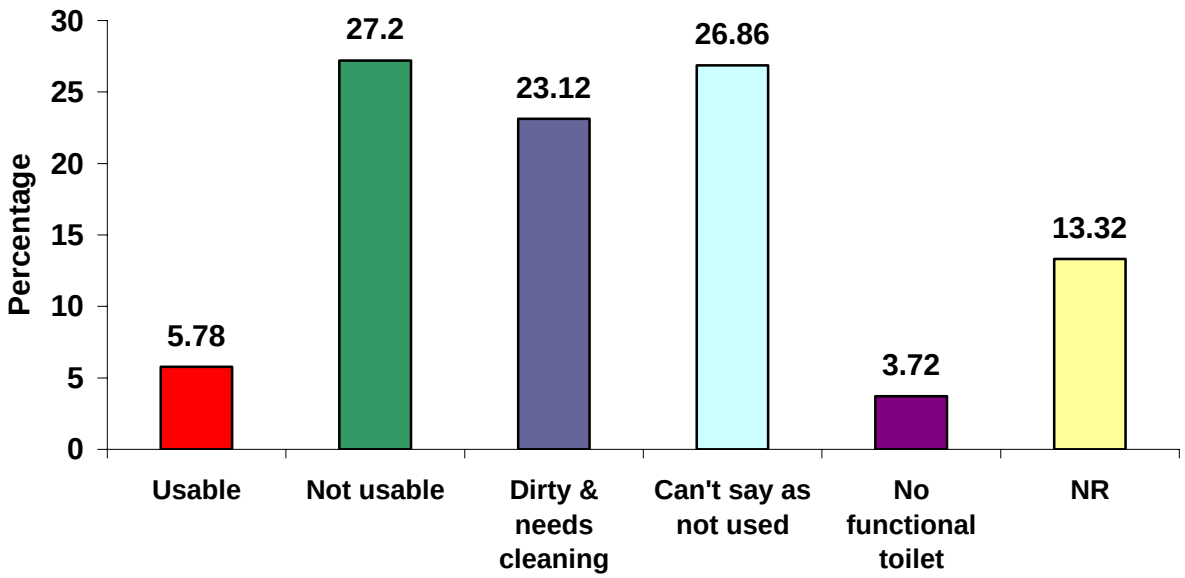


Table 48
Distribution of respondents according to their comments on availability of drinking water

Drinking water availability	Respondents	%
Available	134	55.37
Not available	8	3.30
Poor quality	34	14.06
Not used, can't say	38	15.70
NR	28	11.57
Total	**242**	**100**

Table 49
Distribution of respondents according to their comments on satisfaction after treatment at facility

Satisfaction after treatment	Respondents	%
Fully	72	29.75
Partly	108	44.67
Not satisfied	23	9.50
Not like to comment	35	14.43
NR	4	1.65
Total	**242**	**100**

Table 50
Distribution of respondents according to their comments on overall satisfaction

Overall satisfaction	Respondents	%
Yes	134	55.37
Not satisfied	37	15.29
Not like to comment	25	10.34
NR	46	19
Total	**242**	**100**

Findings of Facility Assessment - Report of Observation BPHC and Sub-centre

Items	Sub-centre (9)	Block Primary Health care
Population served	6500+8537+6319+7905+6500 +7000+11375(madanpur-absent)+5764	123000+100000+249500 +205000+370000+195000+ 218000+104096+90182
a. Standard space present: Yes/No	Y : 5	Y : 8
b. Waiting space: Yes/No	Y : 5	Y : 7
c. Cleanliness:		
❑ Spitting stains present: Yes/No	Y : 1	Y : 4
❑ Waste papers present: Yes/No	Y : 3	Y : 5
❑ Dust bins present: Yes/No	Y : 5	Y : 3
❑ Mopping of floors (observation): Yes/No	Y : 5	Y :7
d. Screen available: Yes/yes & used/No	Yes: 3 yes & used: 2 No:4	Yes
e. Toilets		
• Present: Yes/No	Y: 3	Y: 8
• Usable: Yes/No • If no, blocked/no door/no window	Y: 2 N:7	Y: 5 Blocked: 2 no door:2
Comment on • Cleanliness: Clean/unclean If unclean, stains/soiled with fecal matter/broken window /door/ cobwebs	Clean:4 Unclean: 5	Cleam:3 Uncleean:6 Stain: 6 Soiled:3: Broken window:2 Broken door: 2 cobwebs:1
• Water for toilet cleaning: present/Absent	Y: 2 N:7	Y: 7

• Running water in toilet: present/Absent	Y: 1 N:8	Y: 6 N:3
i. Drinking water- source: Tube well/ Tap/ others specify	Tw:7 Tap:1 None:1	Tw: 7 tap:3
j. Electricity: Yes/No	Y: 7 N:2	Y:9 N:0
k. Quarters for staff Needs repair: Yes/No	Y: 4, N:1, None:3, NA-1	Y: 9
l. Condition of hospital building Needs repair/Needs painting/others (specify)	Needs repair: 4 Needs painting:2	Needs repair: 7 Needs painting3
m. Rented/owned	R: 2 O:7	…….
SERVICES		
a. Antenatal Care provided: weekly/ biweekly/ daily	W 7 Twice weekly 2	Weekly 4 Twice weekly 2 Thrice weekly 1 Daily 2
b. Delivery conducted: Y/N	N 9	Y 9
If yes, how many per month (observe record, if available or mention non-availability)		Avg 75 / m Range 50 - 125
c. Post natal care: Y/N	Y 7	Y 8
If yes, how many PNC per month (observe record, if available or mention non-availability)	33 / 6	Avg 97 / m Range 30 - 225
d. Scope for Emergency Obstetric services: Present/Absent	NA	Present 1 Absent 8
If absent, what scope/s are absent: OBG/Anesthetist/Blood transfusion fac./Equipment/others specify	……..	OG 8 Anaes, 8 Blood T 8 Eqip 4
e. FP services Provided: Yes/No	Y 9	Yes 9

If yes: condom/copper T/ oral-pill /tubectomy/vasectomy/MTP/other Remarks, if any	Cond 9 CuT 8 OCP 9 Tubectomy 2? Vasectomy 1? MTP 1?	Cond 9 CuT 9 OCP 9 Tubectomy 2 Vasectomy 1 MTP 3
f. Routine Immunization Provided:	Weekly 8 Biweekly 1	Weekly 7 Biweekly 1
g. Treatment of common Ailments Provided: Yes/No	Y 8 N 1	Yes 9 No 0
h. Disease control programme? Specific actions narrated by health personal	Malaria Filaria ADD IEC	Kzar Tb L F M
I. Outbreak response (narrate what is done)	Disinfection of tubewells, ORS distribution, IEC, reporting	• Disinfection of water sources • Mass & contact survey • Health/ mobile camp
j. Environmental sanitation (narrate what is done)		Disinfection with bleaching powder Insecticide spray
k. Indoor services -Minor surgical procedure performed: Yes/No	N-9	Y 9
If yes, name few commonly done in last 6 months		Hydrocele, abscess, FB extraction, small tumors
-Major surgical procedure: Yes/No	N-9	N 9
if yes, name few commonly done in last 6 months	…….	NA
Indoor facility: Autoclave used sterilizer used Waste disposal-colour coded bags used	---------- N-9 N-9	 Y 4 / N 5 Y 7 / N 2 Y 2 / N 7

j. Availability of Lab facilities Yes/No	……	Y 9 / N 0
If yes, name few commonly done in last 6 months	……..	Malaria, sputum for AFB, aldehyde test
k. Referral services provided Yes/No If yes, name few common events for which patients were referred in last 6 months	Y-9 Pneumonia, Risk Pregnancy PHC,BPHC	Y 9 / N 0 MI CVA Eclampsia Complicated labour Intest, obstruction Accident, head injury, poisoning **Secondary**
l. Training last 12mths Yes/No	N-8, Y-1	Y 9 / N 0
If yes, name few commonly conducted in last 12 months	Dai training	Malaria, RNTCP, Leprosy, pulse polio
m. Civil registration system Yes/No	Y	Y 9 / N 0
If yes, name few commonly done in last 6 months		Death, birth
n. ECCR done in block/Sub-centre: Yes/No	Y 9	Y
If yes, has it been updated in last 6 months: Yes/No	Y 9	
if yes, verify Observe presently maintained: yes/no If yes, name what was done in last 6 months.		
	Records-available	Records-available
Any problems in maintaining: yes/no	Y 3 N 6	

If yes, name few commonly faced problems in maintaining ECCR	Population increasing No helper High workload Too many information Time consuming	Yes/No
	Previous records not available Work load more No HA posted	
n. **Behavior (observe randomly 5)** At the registration ❑ Cordial	Y 24 N 6	Y 29 N 6
o. **Time (approx. in minutes)** ❑ For registration ❑ Cordial At the time of exam & treatment Cordial At the time of getting medicine ❑ ❑ ❑ Cordial (Y/N) Explaining management to patient Cordial Referral instruction if any	Avg. 7.6 min Range 5 – 10 min Y 24 N 6 Avg. 13.7 min Range 5 – 20 min Y 24 N 6 Avg. 9.4 min Range 2 – 20 min Y 23 N 7 Avg. 3.2 min Range 1 – 5 min Y 24 N 6	Avg. 16.3 min Range 5 – 60 min Y 29 N 6 Avg. 14.3 min Range 1 – 75 min Y 32 N 3 Avg. 6.7 min Range 1 – 35 min Y 31 N 4 Avg. 2.4 min Range 1 – 18 min Y 34 N 1

	All NA	All NA

Items	Sub-centre	Block Primary Health care
a. Sanctioned Medical Paramedical Gr C (clerical) Gr D	18	6+2+4+7+2+nk 6+3+5+20+9+nk 3+2+2+3+2+nk 16+8+8+27+6+nk
b. Present Medical Paramedical Gr C (clerical) Gr D	17	4+2+3+7+2+15 4+3+2+16+9+24 2+1+1+2+2+67 13+8+9+13+8+52

Availability of drugs:

Drugs	Sub-centre(8)	BPHC(9)
Albendazole	Full-3,Partial-3,No-3	Full-9
Mebendazole	Full-2,No-7	Full-3,Partial-1,No-5
• Atropine	No-5,not relevant-4	Full-8,No-1
• Anti snake venom	No-5,Not relevant-4	Full-7,Partial-2
Antacid	Full-4,Partial-4,No-1	Full-9
Chloroquin	Full-9	Full-9
Chlorpheniramine	Full-1,Partial-3,No-5	Full-7,Partial-1,No-1
Metronidazole	Full-8,Partial-1	Full-9
Metochlorpromide	Full-1,No-8	Full-4,Partial-2,No-3
• Adrenaline	No-6,Not relevant-3	Partial-1,No-8
• Intra venous fluid (IVF)	No-5,Not relevant-4	Full-9
Oral rehydration salt (ORS)	Full-9	Full-9
Paracetamol	Full-8, Partial-1	Full-8,Partial-1
Cotrimoxazole	Full-9	Full-8,Partial-1
Salbutamol	Full-1,Partial-3 No supply-5	Full-9
Tetanus toxoid	Full-9	Full-9
BCG	Full-9	Full-9
DPT	Full-9	Full-9
OPV	Full-9	Full-9
Measles	Full-9	Full-9
B copmplex	Full-3,Partial-2,No-4	Full-9

• Crystalline penicillin	No-7,Not relevant-2	Full-1,No-7, Not relevant-1
RCH kit	Full-1,Partial-3 No-5	Full-2,Partial-1 No-5

Strength and Weakness

Points for strength

- Standard space present in 5 out of 8 sub centre and 8 out of 9 CHC or BPHC
- Waiting space was present in 5 sub center and 7 BPHC/CHC
- Mopping of floors was done in 7 out of 9 BPHC/CHC & in 5 out of 8 SC while waste papers were only found in 2 sub centre & spitting stains in 1 sub centre. The later could be due to less patent load in sub centre Latrine was present almost in all the BPHC/CHCs (8 out of 9). Out of them 5 was usable Water for toilets were present 7 and running water at toilets were present in 6.
- Drinking water through Tube-well/tap was present in all the studied health facilities except one SC
- Quarters for staff was present in all BPHCs. Majority of sub centers were government's own building
- Antenatal care was provided by all BPHCs an Sub centers aand deliveries were conducted by all BPHCs on an average 75 per month with a range of 50-125.
- In 6 out of 8 SCs and in all 9 BPHCs post natal care was given. The average is 33 per month for and 97 per month for BPHCs with arrange 50-225. Family planning services were provided in all the studied facilities. Condom, Oral pill and Copper T in the facilities except one Sub centre where Copper T was not available
- Treatment of minor illnesses was done in all the facilities except in one sub centre.
- In connection with the disease control programme, specific actions were narrated by health personnel. At sub centre level malaria, filaria & ac diarrhea disease was reported. Kalaazar, TB, Leprosy, filaria and malaria etc. outbreak response in case of these disease includes Disinfection of water sources, Mass & contact survey & Health/ mobile camp
- Environmental sanitation activity includes Disinfection with bleaching powder & insecticide spray
- All BPHCs are performing minor operations. Some of these are performing operations like Hydrocele, abscess, FB extraction, small tumors.
- In all BPHCs except 2 sterilizers were used while autoclaves were available in 4.Laboratory facilities were available for Malaria, sputum for AFB, aldehyde test

- Referral services was provided for few common events like MI, CVA, Eclampsia, complicated labor, Intestinal obstruction, Accident, head injury, poisoning from BPHCs. From sub centre Pneumonia & risk pregnancy were referred to BPHC
- In past 12 months training was conducted mainly at subcentre for malaria, RNTCP, Leprosy & IPPI
- In last 6 months births & deaths were recorded at BPHC mainly.
- All sub centers had ECCR & all updated in last 6 months as told by them records although verification at field level could not be done. 3 out 8 mentioned few problems in maintaining it like Population increasing, No helper, High workload, Too many information, Time consuming,, Previous records not available, Work load more, No HA(M) posted.
- BPHC usually supervises ECCR updating and maintenance Records could not give us information whether updating the ECCR records was done or not. Around 3 of them mentioned problems like Lack of motivated staff as well as lack of joint participation of HWs and ICDS functionaries in updating data, increase in population etc.
- Out of 25 patients followed at the OPD at sub center level, cordial behavior was observed in 75% patients. At BPHC level out of 35 observations it was noted in 82.86 % cases. Average time taken for registration was 7.6 and 16. 3 minute with a range of 5-10 minutes and 5-60 minutes at Sub centre and BPHC respectively. Average time to examine a patient at sub centre and BPHC was 13.7 minute with a range of 5-20 minutes and 3.37 minutes with a range of 0.25 minute to 10 minutes respectively. At the time of giving the prescribed medicine also average time was more in Sub centre (9.4 minutes with a range of 2-20 minutes) tan in BPHC (average 6.7 minute with a range of 1-35 minute). More time given at the sub centre level might be due to less number of patients there. .
- Albendazol, Antacid, Cloroquin,, Metronidazol, Co-trimaxazol, ORS, Paracetamol,Salbutamol, TT & all vaccines under UIP, B complex tablets were available in all the BPHCs. In all te subcentres Cloroquin,, Metronidazol, Co-trimaxazol ORS, Paracetamol, TT & all vaccines under UIP,

Weaknesses

- Waste papers were seen in 5 BPHC/CHCand spitting stain 4. Dust bins were seen only in 4 sub centre 3 BPHCs. It should be available in all such facilities.
- Screen was not available in most facilities, more so in sub centres. There were some facilities where available screen was not used even at the time of examination of female patient at OPD. Screen is important for Privacy and dignity
- Among the latrines at BPHC 1 was fully blocked and was not usable. One was partially blocked & one partially usable while in two latrines doors and windows were either not existing or broken. Only 3 latrines were partly clean, 6 had stains, 3 were soiled with fecal matter & 1 had cobwebs. Only 2 SCs had latrine with water supply.
- All health facilities except one sub centre had electric connection
- Only 50% SC had staff quarters. Repair work was needed in all 9 BPHCs and 50%SC
- Almost all (7 out of 9) hospital buildings and 6 out of 8 subcentre buildings needed repair. Needs for painting was much less (25% in SC & 33% in BPHC
- Only 1 out of 8 sub centres provided twice weekly ANC services and rest weekly. In case of BPHC 4 offered this services weekly, 2 daily, 1 tri weekly, 2 biweekly and rest 4 weekly. Non of the sub centers studied conducted deliveries. The government suggested deliveries by all Sub centers. In some of the Sub centers of Murshidabad districts conduction of deliveries has been started as informed.
- Appropriate records regard delivery of postnatal care was not available. Frequency of PNC was not considered and even when it was considered, it was based on visits on second and subsequent days in health facilities after deliveries and probably for immunization
- Scope for Emergency Obstetric services was not available in any one of the BPHCs.

  Scope for Emergency Obstetric services: OBG specialist was not available 2, Anesthetist and blood transfusion facilities was not available in all these facilities while equipments were not found in 5 facilities

- Only less than one third of the BPHCs had tubectomy, vasectomy & MTP facilities
- Color coded bags for waste disposal were used only by 2 sub-centers
- Capacity building for sub centre staff was poor in past 12 months, while this group of staff needs more frequent training for strengthening both knowledge & skill.
- Time spent for explaining management was very less and patients wanted more time to be devoted there for their full satisfaction. In this regard Average time spent at Sub centre was 3.2 with a range of 1-5 minute while at the BPHC level it was more or less same with a range of 1-18 minutes
- Referral instructions were not given in any one of the cases. Such instructions were not given due importance at both the levels.
- Anti Snake venom was avail able in 7 BPHCs (not adequately), RCH kits were not available in majority of the health facilities

Summary Findings of Qualitative Survey

In depth Interview

D.M -"Use of sanitary latrines should be an indicator of the public health status and in this district, even in the 7 municipal areas, many did not have or use sanitary latrines- this picture was not all encouraging." In his opinion, major *problems were under nutrition precipitated by early marriage – "not only minority community, ami dekhechi shotero atharo bochorer bachcha meye tar duto tinte shontan "(I have seen not only minority communities were having more children but also I have seen adolescent girls of other communities were having 2 or 3 children)*

DOTS program has been improved, yet there were many "undetected cases" He also stated that *due to lack of food hygiene and improper water, water borne and diarrheal diseases were common.*

Common health problems were vaccine preventable diseases, under nutrition and arsenic poisoning. The BMOH also mentioned Filaria, TB, Kala azar and Malaria as common problems.

At Purulia, Government health facilities were chief providers of preventive and curative services

Few Private clinics and nursing homes provide curative services only.

Large network of quacks and barefoot doctors provide services at the grass root level

No unani or chandsi providers were found.

Health Facilities commonly utilized

Govt.health facilities are utilized by majority (>80%) – this was stated by the CMOH, BMOH and CDPO

According to the health workers the common health problems are diarrhea, fever, ARI, TB, Leprosy and skin diseases. PRI representatives focused on the problem of drinking water. They also stated that accumulation of water and improper sanitation is leading to breeding of mosquito's and germs – this leads to malaria and diarrhea.

According to the BPHN most preferred allopathic because of early cure. Some prefer homeopathy because they believe homeopathy has less side effects. BPHN *stated that basically people go to providers who are most accessible and available*.

She mentioned that people visited private doctor's chambers mostly for abortions and skin problem. According to the CDPO, *for preventive services and major illnesses, people went to govt. facilities and for minor illnesses to private facilities.*

The services most in demand are the curative ones. "30 beds are almost always occupied" – CMOH.

According to BMOH *minimal percentage of cases are referred*. Types of cases referred are, non progression of *labor, complications of labor, meningitis, CVA, road traffic accidents, cases requiring major surgical interventions or blood transfusion.* The *BPHN stated that some referrals ended up in private Doctors chambers.*

According to the *DM, preventive and curative services were optimally available, but were not optimally utilized.* Preventive services were more utilized – *immunization coverage is very satisfactory. Now, curative services are also being utilized more, after ensuring availability of life saving drugs at the centers along with medicines for snake bite and dog bite.*

"No. of nursing homes are an indicator of pattern of preference. I have seen where SES is better, there, nursing homes are flourishing. Here, there are less nursing homes- only 35 nursing homes in this district– this means people are utilizing govt. services."- CMOH

The DM opined that private facilities are sought as status symbols.

.Most of the interviewees opined that utilization depends on availability of services.

The demand is for ARI, Diarrhea, and TB treatment along with delivery. There is also demand for surgery – hydrocele, hernia,etc.- CMOH

Curative services were more utilized -now, with increasing awareness and education, preventive services are also being utilized more.

All of them opined that demand was higher for curative services, but with increasing awareness, preventive services were being more utilized.

Govt. facilities are mostly sought for family planning, immunization, TB and leprosy. Majority of clients opined that they prefer govt. doctors and facilities because of quality of care and services are free

They mostly went to local quacks especially for stomachaches or other emergency conditions occurring at night.

CMOH and BMOH also opined that people feel that the q*uality of curative care is better in govt. facilities. Patient management and doctor patient relationship is also better in govt. facilities, according to the BMOH.*

All of them opined that *demand was higher for curative services, but with increasing awareness, preventive services especially immunization was being more utilized.*

- Preference of service provider

According to the interviewees, where facilities were available, people go to allopath, especially specialists for curative service, but due to their continuous availability and affordability, quacks serve as the first line of management.

According to the BPHN the people go to other facilities for curative care because medicines are not available at the SC, but preventive care is mostly sought from govt. facilities as medicines available mostly.

Accessibility and affordability were the main reasons for going to quacks, as stated by most of the IDI respondents.

- Extent of utilization of existing govt. health facilities

According to the CMOH, *distance is a constraint to utilization of existing govt. health facilities.*

Majority of the respondents felt that *poverty* was one of the major reasons for utilizing govt. facilities which were provided free of cost.

They are compelled because alternative affordable services are not available - CMOH

About 5-7% of the beneficiaries, who are critical or not responding to treatment at this level, come to BPHC/PHC/pvt. Practitioners. Only 5% of these go to SD/District hospitals. So, load of these common ailments have decreased at secondary level hospitals ***Purulia****.*

- Strength of the government facilities
    - Office infrastructure has been improved
    - Computerization has been done
    - Ambulance facilities have been improved
    - Drugs are now available – provision is made for life saving drugs.
    - Health check up camps very day
    - Qualified doctors provide better diagnosis and care – CDPO

Weaknesses of existing govt. health facilities

BMOH

1. Lack of regular visits to the sub center
2. Lack of proper liaison with upper levels
3. Staff is worried with transfer postings
4. Improper Behavior with clients and many a time clients behavior with health staff was wrong
5. Delay in response/intervention
6. Punctuality
7. Gap in supervision
8. Doctor strength was a major weakness

CDPO

Excessive rush of patients – 600 to 800patients/doctor/day at outdoor – hence quality of care suffers

Strength of PVT

Promptness of response

BPHN

All investigations available e.g X Ray, ECG, USG – this cannot be done at govt facility

Nursing homes only conduct deliveries. They cannot attend critical cases or critical operations.

Expensive

Lack of skilled manpower – untrained nurses

N Dinajpur

- Strength of the government facilities

  The BMOH opined that *promptness of treatment and quality of services where the strengths of the govt. facilities*. The BPHN also felt that at the *govt. facilities, services is good, doctors are available, most medicines are available,* the *BPHN/PHN is residential* so they are available and approachable to solve problems. She also said *that "Janani Suraksha Yojna" had successfully increased*

the number of institutional deliveries. In her opinion, health education intervention at the grass root level have also been yielding good results – *"Diarrhea cases have reduced over last 3-4 years"*.

The CDPO attributed the strength to concerted effort from all HW & ICDS workers.

- Weakness of government facilities

  Lack of adequate drug supply particularly antibiotics was a major weakness according to the BMOH. He also pointed out that *despite the existence of an OT it was non functioning due to GDA shortage.*

  Lack of mobility support was pointed out by the BPHN as one of the reasons for poor supervision especially in remote areas. Inadequate drug supply was also pointed out by CDPO as a major weakness. He also mentioned that reaching the health center was difficult in some areas. *In emergency situations beyond the fixed hours, services are not available at the sub-centre*.

  Majority of interviewees also stated that the huge crowd and long ques at the hospital, daunted people – they do not want to spend such a lot of time.

- Weakness of private facilities

Expenses were pointed out as the major weakness of private health care by majority of the interviewees and *the people ended up in constant debt in order to seek such care – "Ekta D &C koratei tin.char sho taka lage" – BPHN*.

Infrastructural network reaching out to villages was cited as a major strength by the CDPO. *He opined that Preventive services especially immunization are strong.*

The CMOH stated that prevention was 100% govt. responsibility –"*Tube well dorkar hole loke kothay jabe, private sectore ?*

- Weaknesses of existing govt.health facilities

"Govt. Services lack glamour/outward show – so *people feel that services are mechanically delivered. It is opposite at private sector – Ora mishti mukhe pocket kate"- CMOH*

Lack of publicity regarding what is available, what is being done, the workload undertaken in different programs- so much of so many different types of services – *The CMOH stated that the main problem was the lack of awareness in the community*

regarding the services available at the government facilities, especially the preventive services. This view was corroborated by the Swasthya Karmadhyaksha.

Lack of clear guidelines for work was another weakness according to the CMOH. The DM also felt that work culture was faulty.

Though essential drug supply is sufficient according to the CMOH, specialists sometimes, have preference for brands – this causes difficulty. He said that "We are trying to address this through allotment from 'district illness funds – even provisions are made for buying medicines for BPL patients who are admitted'

The BPHN stated that we are not able to optimally deliver whatever services we have so we should *try to improve the service delivery* – " shothik shomoye,shothik bhabe"

Lack of supply of IFA tablets – this has not been supplied for the past 1 year according to the BPHN. She also stated that Vit A in oil was supplied in small amounts.

Infrastructural deficiencies were emphasized by the BPHN. She stated that in the SCs(especially those in rented buildings) there was not even a proper space for the staff to sit .Now that supplies are improving there is no space to keep them properly. She also stated that *all the supervision of public health activities were difficult for her to manage alone, especially due to lack of adequate mobility support* – this was hampering field visits according to the BMOH – *the govt. norm of 2 doctors per 10 beds does not take care of the actual patient load and other workload. He also stated that the original clientele of 30,000 per PHC had now reached almost 2.5 lakhs and a reallocation of human resource was urgently necessary.*

According to the Swasthya Karmadhyaksha, there is a lot of waste of money in the govt. mechanism – *"lots of equipment had been bought for rural hospitals, but technicians have not been employed so the equipment are lying unused and are damaged. He also stated that in the 832 sub centers, many health workers stayed far away and a lot of time was spent in traveling – so service delivery suffers.* He stated – *" shorkari hashpatale byabohar bhalo kore na – tai manush hotash hoe jay".*

Quack doctors are always near the people. " chobbish ghonta manusher pashe thake" They *memoriz prescriptionsof specialists and apply them.Some of them can start iv drips an give first aid – this helps. But some also have dangerous practices. The DM stated that*

sometimes quacks even performed operations – which is very dangerous – they did cataract operations

Considering the existing geographical remoteness and lack of communication in some of the areas- *"Quack chara cholbe ekotha bolar moto buker pata amader ekhono hoyni"*-CMOH.

The DM stated that the cleanliness of the private facility may be a reason for utilization.

Quick delivery of services in exchange of money and availability of different specialists were stated as strengths by the CDPO.

- Weaknesses of local private health care provider

Quacks keep holding the cases even if they cannot treat them properly. This leads to complications and even death.-CMOH

Touts complicate the situation-*"I know of cases which had been referred to NRS medical college but ended up in a nursing home in North Calcutta because the ambulance driver took him there"*-CMOH

"People do not want to waste time in a queue so they go to private clinics but soon return to govt. facilities because they are disillusioned with the quality of services in the private sector."-CMOH

The CDPO stated that *private care cost a lot of money, the infrastructure was not so well developed and in case of complications, they were not equipped for management.*

According to the *Swasthya Karmadhyaksha there are less no. of qualified medical doctors in nursing homes*.

- Common problems and Suggestions for improving govt. health care facilities:

  Referrals have to be made when the limited number of specialists are on leave/when infrastructural facilities are not available. Referred cases are usually complications of labor,head injury or other serious severe injuries,complicated illnesses. According to the BMOH, last month the no. of referrals were 32 against 362 admissions(8.84%).

Complicated labour cases cannot be handled because of lack of anesthetist/blood – *according to the CMOH, this can be addressed by setting up referral units in Rural Hospitals with placement of gynecologist and anesthetists. He also suggested skill*

development or training for this purpose since currently on graduation, a doctor can only conduct normal delivery so with indication of any complication, he refers the case.

There is *no prefixed protocol for referral. The CMOH opined that it is difficult to implement according to protocols because patients and those accompanying them along with the local influencers, press for referral – it is difficult to resist such pressure."* The party keeps insisting *"parben to? kichu hobe na to? So the doctor thinks that if I take responsibility and some complication develops at odd hours – there will be no conveyance available – what will I do? It is better to refer"- CMOH*

- Opinion regarding ECCR maintenance and use

According to the CMOH, ECCR is mostly updated – it is a regular process- the HW updates it on the basis of information collected during H-H visits. He said that complete updation of ECCR is essential for adopting CNA.At first the understanding of (CNAA) was not good – all they did was adjust some of the available figures. Now their understanding has matured. We check it against the available statistics to see whether it conforms to expectations.

The BPHN stated that despite best efforts ECCR had not still been updated in some places mainly because of staff shortage. Although she stated that the AWW did not play much role in ECCR updating, the CDPO stated that the AWWs always helped in preparation and updating of ECCR.

The BMOH specifically stated that ECCR was prepared by ANM but link person helps her. Subcenter action plan is usually prepared in consultation with all subcenter staff at the second Saturday meeting. On receiving requests for help, the BPHN and Panchayat are also requested to help in updating.

Meetings on last Saturday of every month were a very fruitful mechanism for discussion and coordination with other stakeholders like Panchayat, NGOs, ICDS etc.

The CMOH opined that scope of PPP was very good but more professional approach was necessary. In his opinion, coordination with ICDS was good at the grass-root level but the mid level was resistant to suggestions. Some CDPOs are cooperative & supportive but others are not interested. He and the BMOH also said that successful PPP models existed in areas like immunization and other National Health Programs, with private practitioners

and professional bodies, helping in motivating beneficiaries and participating the program.

The BPHN also stated that private practitioners were cooperating to disseminate important health messages while interacting with their patients.

According to the BMOH, PPP would be a good proposal for laboratory and other investigations. “This would reduce harassment of the patients – in the govt. lab the lab assistant and X ray technician gets angry if they have to do more than 10 samples a day but these same people do 50-100 cases per day in the public facilities.The patient who now pays Rs 100 for an ECG can get it done for Rs 30 if PPP is established.”

The Swasthya Karmadhyaksha informed that pathological investigation was being delivered successfully through the PPP model at Krishnapur Rural Hospital and this will be scaled up at other Rural Hospitals.

The BMOH admitted that it was not possible to have more than 12 field visits a month. The rest was done during the monthly meetings on 1st Saturdays – the staff bring the ECCRs and they are checked here. From these meetings, he decides the plan of visit. He said that during field visits he mandatorily checked the records, filling up of DOTS cards, expenditure according to guidelines, components of antenatal care,(like weight recording, BP check up, urine test, Hb estimation)management of LBW cases referred by AWW, immunization coverage, untied fund expenses etc.

In the opinion of the BPHN, supervision is now allotted GP sector wise. Accordingly for 10 GP sectors in this block, there should be 10 supervisors, but there are only 2 in place – this affects quality of supervision. She also stated that males who had been deputed to work as supervisors performed less than females. She said that there is a plan for supervision with field visits at least 12 days a month but this could not always be followed – priority was given based on “emergency situations”.

- Suggestions for improvement.

All mentioned poor communication as a major problem especially for remote, underdeveloped areas

DM:

Infrastructural problem
Shabby unclean appearance of the facility
Lack of discipline
“shorkari hashpatale prothom ekta boundary wall deoa dorkar”-
Behavior with public is not proper
“extra poysha die service kinte hoy”

CMOH

Many vacant posts especially Gr D – There are doctors and nurses but units cannot be opened due to lack of pharmacists.There is no dearth of money but problem lies in organization and administration
The work culture is also disheartening – there is lack of motivation to work – the staff do not wear uniform,do not carry identity cards.

BMOH

Compound fractures and sever burn cases are referredto Bankura/Purulia
Other complicated cases are sent to Purulia
A register of referrals is maintained – a yellow card is given No formal feedback mechanism
Many people cannot go even if they are referred
Many go to Tatanagar hospital which is about 45 km away,some go to Purulia/Bankura Medical College

BPHN

Many are referred to Ranchi Medical College. Commonly obstructed labour,stroke etc. are referred

Opinion regarding ECCR maintenance and use

BMOH

ECCR is not updated
New ECCR register has not been opened
Supply of ECCR register is less

CDPO

AWW should help in ECCR updating but existing situation there is no coordination

BPHN during field visits. It was regularly checked.

BMOH

Quacks and local practitioners are utilized as drug depot assistants
ICDS,Panchayat and CHG help Health Worker in CNA approach

BPHN

Program based coordination with Panchayat
The AWW helps in motivating drop outs in immunization and health worker helps in motivating for growth monitoring

Opinion regarding supervision

BPHN

Prioritized on the basis of weaknesses and supervision especially done in weak centers
Quality checks – setup,maintenance of sterility,immunization,health education, ECCR, DOTS coverage, Leprosy coverage, IFA supplementation,family planning services

Suggestions for improvement.

DM:

Allotment of specialist and non specialist according to bed strength
Discipline in service to be improved
Administrative functions should be allotted to non technical manager
Developing a database on no. of patients, type attending OPDs, types admitted – plan logistics and supply accordingly.

CMOH

Filling up vacant posts according to clearly formulated guidelines
Improve postnatal care by organizing joint training of public and private providers in collaboration with professional bodies
Increase malaria treatment coverage through dissemination pof information

BMOH

Bed strength should be increased – minimum 30-50 beds
No. of MOs should be increased
Other staff and nurse strength should also be increased
ECG & Xray facility should be available
2^{nd} line antimalarials and 3^{rd} generation antibiotics should be made available to some extent.
Instruments should be available and functioning
Regular supevisor should be appointed
IEC to inform people about what services are available

CDPO

Transportation to health care facilities should be improved
Community should be informed about availability of services and doctors
More awareness generation to improve utilization of services

BPHN

Panchayat can arrange for special transport to health care facility
Improve safe water facilities

U. Dinajpur

Strengths

The BMOH stated that **majority (80-90%) utilized govt. health facility**. Mostly because they were poor and could not afford to pay for treatment. However, since the quack doctors are located in the village itself and their base is fixed (no transfer) they are accessible. Some people also believe better care is obtained on payment. **According to the BPHN most preferred allopathic because of early cure.** Some prefer homeopathy because they believe homeopathy has less side effects. *She stated that basically people go to providers who are most accessible and available*.

She mentioned that ***people visited private doctor's chambers mostly for abortions and skin problem***. According to the CDPO***, for preventive services and major illnesses, people went to govt. facilities and for minor illnesses to private facilities***.

Improving outreach – according to the CMOH, this has helped in pulse polio immunization e.g by increasing no. of outreach booths to 1/125 beneficiaries.

Weaknesses

The CMOH suggested that to improve preventive services**, vacancies** should be filled up – the posting of 2nd ANM at the GPHQSC is expected to improve service delivery. at least contractual service should be urgently given stakeholders like Gram Samsad members, CHGs, AWWs,SHGs, Mahila Samity, School teachers – all should know what services are available and for whom.

A shift from a **robotic attitude of mechanical service delivery** to sympathetic attitude is the key to acceptance – " ektu dorod dichchi na bole eto bodnam – tobe sheta dite hole load komate hobe"

In his opinion,doctors should not be **burdened with administrative responsibilities** – this hampers their delivery of curative services.

"Dekhun **CMOH shob shomoy transfer posting niey byasto achen**" there should be a separate administrative wing.

Improvement in delivery of services had been made by involving the Panchayat and other sectors in making people aware of programs and deliverables.

The Swasthya Karmadhyaksha stated that there was **fault in the govt. policy**." **Manush onek protyasha nie hashpatale ashe.Hashpatale bed-er obhab – niche shute**

hoy.Ekjon daktar joto rugi dekhte pare tar beshi rugi dekhte hoy,fole,rugi satisfied hoy na – tai manush jomijoma bikri kore nursing home e jay."He also said that 22 out of 26 blocks in the district were affected by arsenicosis – there was no arrangement for treatment.People are sent to Tropical School where only advice is given, no medicine.

Regarding Monitoring and supervision - The BMOH admitted having an **informal plan** but he could not always be followed due to other pressing official commitments.

Supervision is usually entrusted to BMOH supervised by ACMOH and CMOH and regular feedback is provided in meetings.

Supervision of HW is not done with any regular periodicity, but CMOH opined – "Bhaloi hoy" – issues addressed during supervision are timely report submission and maintaining time at the SCs.

Regarding Coordination - *Both BPHN and CDPO opined that **routine coordination was minimal** though joint camps were held for leprosy, routine immunization and pulse polio.*

The BPHN stated that with different working hours (AWW 7-11 and HW 9-3) time adjustment difficult. Although at GPHQ meetings are held. Only supervisors attend so there is no direct feedback regarding it action in filed situation.

- **Suggestion for improvement**

  The BMOH suggested *increasing supply of medicines and equipment.* The *CDPO focused on improving water and sanitation facilities. The BPHN categorically stated that infrastructural strengthening should be priority – roofs should be repaired since even the limited supply of medicines is getting damaged*. More vehicular support should be arranged. *Some more investigation facilities like x-ray should be in place along with arrangements for attendance of specialist doctors. This was also the opinion of the CDPO who said that doctor population ratio should be maintained. The CDPO also suggested that the no. of outreach sessions should be increased and the venue should preferably be the AWC.* He also suggested supply of *equipment like newborn weighing machine at the AWCs*. In his opinion improving quality of *monitoring and supervision was essential.*

FGD

According to the health workers the common health problems were arsenic poisoning, low birth weight precipitated by early marriage . " baro tero holei meyeder biyer tara lege jay". Besides seasonally there is diarrhea and ARI. TB is also a problem along with leprosy.

Women also come after missing periods for a couple of months seeking abortion.

- All of them opined that the prime demand was for medicines. "ki korte eshecho? Oshudh jodi dite na parle to asho keno?" Preference of service provider and Reasons for such preference

  According to the participants, people always come to government facilities first and only if they are not cured or if further complications develop they shift to quacks.

  "People here have strong allegiance – if they are cured by a doctor for some illness they believe that the doctor is "bhogoban" and will go to him for all other illnesses.

  Quacks are close to people and provide treatment on credit.
- Strengths of existing govt. health facilities

  They opined that immunization services have good coverage and are well accepted.
- Weaknesses of existing govt.health facilities

  " ghorgulo choto choto bishesh kore jegulo bhara neyoa ghor – nichu, upore light fan er kono byabostha nei – amadero kosto hoy, lokero koshto hoy." *They complained that even in newly constructed BPHCs there is no provision of at least 2 rooms – one for check up of mothers and another for injections etc.*

  Lack of toilet facilities leads to problem in urine collection for testing.

Lack of supply of paper,forms even clinic register,monthly forms,etc are sometimes insufficient but recently there has been improvement.

Quality of equipment poor – they are mostly out of order.

Inadequate supply of Folifer,vitamin A in oil and ORS along with less amount of paediatric cotrimoxazole.

Earlier carrying vaccines was very difficult but now support is given on an average there are about10 to 15 referrals per month. Those who are entitled for specific services are sent with referral slips. No formal feedback mechanism – we come to know the outcome during field visits. However, referrals cause harassment at times – they do not receive any priority – if they reach late they have to go to private chamber of the concerned doctor and pay fees.

"When supply of medicines is good the attendance is very good but when medicines are lacking we have to send them back."

People feel that like DOTS all other medicines can be given by us – they do not realize that we cannot give all types of treatment.

On the days when we do not have doctors attending our GP, we have to send the patients to the closest HC.

There is lots of resentment because lap camps are not being held.

Teams are made with others especially with Panchayats but active support and cooperation is lacking. Team remains in paper.The panchayat members are not very eager – "dayshara gocher arki".AW supervisors also do not cooperate to the desired extent.

- Opinion regarding ECCR maintenance and supervision

  We try our best but cannot keep it fully updated – during field visits we have to provide maternal and child care "–

  All of them opined that it was impossible for the ANM to single handedly update the ECCR. People reach the clinics late so it is not possible to visit the fiels after clinic hours. Moreover on designated field visit days trainings, meetings etc are held and field visit is neglected.

  We had been told that pre-approach target would be adopted but in reality during the monthly meetings, the supervising officer is setting a target based on average of the district – e.g 23 but in Jalangi, despite the best efforts we are finding a birth rate of only 22 so how can we fulfill this target? " district er ta amader upor chapiye dey" District puts the targets on them

Community need assessment should have been done by discussion with the community but actually it is not done in that way – there is a gap. Time for CNA is a constraint. Monthly activity plans are made but the pressure of programs do not allow us to reach

the mothers in the community. The also said that their problems have to solved by themselves. None helps them

“amader ki shomoshya she to amader upor theke visit kore dekha uchit kintu amader shomoshya amaderkei bhugte hoy, amaderkei shomadhan korte hoy – pichone amader keu nei”

Supervision is lacking. In this block there are only 2 regular supervisors all the rest are acting –tara ki korbe? Tarao ekta clinic e kaj kore tar upor supervise korbe kokhon?” They were used to directly placing their problems to the BMOH in monthly meetings.

Some of them had been acting supervisors and opined that it was impossible to attend to their regular work, attend all trainings, meetings – barighor,chelepele shob chere dite hoy.

“Supervision ,mane compile – tachara ki kaj hochche ki korche ki korche na tar kono thik nei – shudhu report gulo compile kore block e pathano holo kina dekha.”

“Supervision means whether you have compiled the report or not”. Sometimes supervisor was asking ‘whether you have done something on certain issues or not’

- Opinion regarding ECCR maintenance and supervision

  We try our best but cannot keep it fully updated – during field visits we have to provide maternal and child care ”–

UD

- Common health problems

  According to the health workers the *common health problems are diarrhea, fever, ARI, TB, Leprosy and skin diseases*. PRI representatives focused on the problem of drinking water. They also stated that *accumulation of water and improper sanitation is leading to breeding of mosquitos’ ad germs – this leads to malaria and diarrhea.*

  The clients mentioned *ARI, diarrhea, fever, stomach ache, headache and measles as common problems.*

- *Types of services sought*

  According to health workers, govt. facilities are mostly sought for family planning, immunization, TB and leprosy. Majority of clients opined that they prefer govt. doctors and facilities because of quality of care and services are free – they mostly went to local quacks especially when stomach aches or other

emergency occurred at night. If they were not cured of if the illness was severe or serious, they came to govt. facilities. They also came for delivery.

- Preferences

  "Jara shikkhito tara Karandinghi ospitale chale ashe. Jara shikkhito noy – ei shonkhatai besi, tara gram-e quack daktarer kache treatment korce". – PRI member.

  The health workers stated that people preferred to come to them first – even before going to the doctor because the doctor's chamber was more crowded and the doctors are so busy, they do not explain how to take the medicines. Even the pharmacist gives all the medicines together. *They said that for services like abortion, people prefer to seek services from a distance where they are less known.* In their opinion quacks *are preferred because they treat on credit. Someone has to accompany the patient to the health centre – besides transport cost, this escort also has to be given some money – the quacks accompany the patient whom they refer free of cost.*

  A few people went to quacks because according to the PRI group, distance to hospital is a constraint – especially at night, this is difficult. They opined that people living in the remote interior areas, think that if they come to the hospital no one listen to them – they feel if they bring dome political person or influencer they will get good service. Some of the rural inhabitants still take recourse to "jhar-fuk" from ojha.

  In the opinion of the clients private allopaths rendered better quality of care than govt. doctors- "private-e gele, buk-e jontro die bukta bhalo kore dekhe". "je rogi private-e bhorti hoy she beshi share".

- **Strength of govt. facility**

  According to the health workers the main gain has been "awareness generation". *The PRI presentations opined that good antenatal care and immunization services were the strengths. Leprosy and TB treatment were also done well. The clients were satisfied with the quality of care at govt. facilities but resented the non-availability of most drugs. In their opinion, a lot of awareness campaigns are now undertaken for pulse polio, personal hygiene, healthy diet etc.*

- **Weaknesses of govt. health facilities**

  Poor supply of antibiotics was the major weakness according to the health workers; since demand is more for curative.

  According to the PRI group, the quality of services were good but medicines are a problem – they have to be bought from outside.

  Clients stated – "hashpatale shuddhu nam bhorte ashi, shab kintei hoy – kali salineta paoa jay".

  The long waiting hours are a major deterrent. Cost of curative treatment was excessive, even in govt. facilities – "poysha kori nai, ki kosthto kore ashte hoy – gohona bandhok die meyeke bhorti korechi – ekta injectioner dam to 70/." According to clients the doctors did not have any time for giving instructions and the other workers tell us only about immunization and ORS.

  "Haspatale je report take ki noyeche boley dey na".

- **Problems**

  According to the health workers, communication and vehicular mobility us their main problem. They also stated that *time and distance were constraint for referral – hence despite referral they continue to take only paracetamol and metrogyl.*

  PRI group emphasized on inadequacy of drugs,

  "ECCR preparation and maintenance is entirely done by us". Claimed the health workers – they said that nobody helped them.

  According to the health workers, *supervisor visits almost every week, but sometimes there is no interaction* – "Uni je soptahe gechen, sei shoptahe ami jaini" – they are helped by the supervisor who also provides feedback.

  The PRI group opined that awareness should be backed up by services – "darun bola holo jor hole rokto porikjkha karun – haspatale gie deklen rokto porikha hoche na".

  The health worker stated tat they had received training for DOTS and leprosy- this had improved their efficiency for program implementation. They wished to receive regular trainings, not ad-hic ones only on program requirements.

  According to the health workers currently they have to cover huge population leading to *excessive workload. The health workers resented that now they have to*

work on most Sundays too – "It is mandatory, this is inhuman. We do not even have time to wash our clothes".

The *PRI group stated that acceptance of pulse polio was still limited in minority community due to misconception – "projonan khomta kome jay*".

- **Suggestions for improvements**

  The health workers suggested increasing number of vaccine receiving centres to facilitate outreach sessions.

  Coverage for each health worker should be reduced to less than 5000 population. They also wanted that AWW should jointly share responsibility for organizing outreach sessions.

  Lack of awareness is the is the main cause for ill health and focus on improving such awareness was suggested by all groups. The PRI group also wanted *attention to be given to safe water, along with availability of drugs*. They stated tat since demand *for ligation was high, number of ligation camps should be increased.* They also suggested posting of specialists along with facilities for oxygen and blood bank.

  Clients suggested that equipments should be improved. "Bhalo daktar ante obe – daktarke bhalo kore dekhte bolte hobe".

Purulia

Common Problems :

Client

Malaria dengue,typhoid,TB, jaundice,skin disease

PRI

Hepatitis,Malaria, diarrhea,infant mortality earlier –TB filarial

HW

Diarrhea,anemia,undernutrition

Facilities utilized and reason for preference

Govt.health facilities are utilized by majority

Majority of the respondents felt that *poverty* was one of the major reasons for utilizing govt. facilities which were provided free of cost.

PRI – Those who can afford,go to private facilities

Preference

Client - TB,Malaria,maternal and child services at Govt but minor illnesses and jaundice from local quacks

PRI - Pvt facilities are preferred because they provide medicines.

Strengths of govt facilities

Good outreach – household visits

Good provision of vaccines

Good treatment for leprosy available

Weakness of govt facilities

Client

Medicines are not availableAll medicines have to be bought

“We bring the patient with lot of difficulty, get the investigations done from private, buy medicines but again they refer – what is the use of bringing here?”

“Daktarbabura bolchen bichana nai, oshudh nai”

OPD load is so much that the doctor cannot even attend emergencies

No ambulance

Lack of proper equipment – daktarbabu bolen jontro nei ami thik kore dekhte parbo na tai baire jeye hoy.

No oxygen

No injection except TT

PRI

No availability of anti snake venom and anti rabies vaccine

HW

Lack of equipment – no facility for sterilization/boiling

No electricity

Problems

Client

Loss of wages for coming to health care facility

No hotel/provision for accommodation/food for patient party

No separate latrines for men and women. Existing facilities very dirty

Ligation camps are not being held – hre only ligation is accepted tough the women work harder than men- vasectomy is not at all popular.

PRI

Too much load at govt facility – long que especially problematic for children and old people.. No one is willing to give them preference

Bed strength is based on local population but people from Bihar, Jharkhand are also coming and getting admitted.

HW

Water leaks from roof of SC – impossible to sit inside during monsoon – there are no shutters in windows

People are so ignorant they cannot express their problems properly – they have to bring someone to explain

Mothers cannot come alone

Transport is difficult and expensive

Due to pressure of so many programs home visits are declining

Supervisors are not available everywhere

BPL cards have not been allotted properly so those in need are not availing JSY

Suggestions

Client

Increase no. of doctors – there are patients coming from far off places – tremendous load

Increase no. of beds/provision for beds and bedding

Provide separate latrines/bathrooms

Improve BP check ups and TT services for women

Improve school health services

Provide a boundary wall

PRI

Increase availability of medicines and anti snake venom.

Increase community awareness by joint campaign of panchayat and health

Family planning camps have to be increased

HW

Improve manpower- especially volunteers to provide health education,maintain registers etc.

Improve awareness

Improve referral transport

Recruit male workers especially for remote and forest areas

Report of the Interview of BMOH who just joined a New Service

5 blocks were selected for further in-depth investigation into the administrative and managerial issues. The study revealed the following:

1. Avg. population catered by BPHCs were 155000
2. Avg. population served by SCs were 7675
3. Avg. number of deliveries conducted in one BPHC was 200- 500 deliveries/yr. No delivery was conducted in Sub-centres.
4. Doctors of modern medicine were posted in all the BPHCs but AYUSH practitioners & dental surgeons were not present in 3 of the 5 BPHCs. Where-ever AYUSH practitioners or dental surgeon is there , they only serve for the OPD.

Attendance registrars were maintained for all staff in **BPHC**s but not in the SCs Leave registrars were not routinely maintained .General opinion is that attendance registrars may not always reflect the actual situation.

5. Usually 2-3 doctors attend the patients in OPD every day. The OPD hours starts at the morning around 9:00 hrs. to 12;00 hrs. In Puruliya district they have to reschedule OPD hours especially during the summer season.2 of the 5 BPHCs organize outreach sessions for out patient clinic in distant villages.

6. Inventory control: indent requisition thrice yearly, stocks were usually checked after receiving it. Shortage and excess of supply was not uncommon.
7. Most of the staff are trained in RCH, RNTCP, leprosy,
8. The problem areas identified were as follows:

- Staff shortage: MBBS and specialist doctors in BPHCs. For example; In one BPHC a new-born platform with radiant warmer, phototherapy unit, oxygen hood was available along with neonatal resuscitation kit. But as no pediatrician was available, the instruments were locked in one corner of a room. Obstetrician was also not available. Any difficult delivery was sent to the higher centre, about 50 km. away and it causes discomfort and disquiet to the staff and the local people.

- Dental surgeon was not having a surgical chair /instruments for him/her. The dental surgeon was attending regular OPDs and BMOH was having difficult time managing the issue.
- Some of the doctors are not staying locally and are not regular in their duties.
- Some BMOHs expressed their dissatisfaction over the pay structure. They felt that AYUSH practitioners are getting salary at par with the allopath doctors although the working hours are far less.
- PRI helped in provision of drinking water supply. But there still persists the problem regarding waste disposal.
- Sometimes there is lack of communication between PRI, ICDS, Health department. Usually ICDS and Heath staff meet in the monthly meeting. But there is no routine communication for regular activities in block level monthly meet. Usually outreach sessions are conveyed in the GP monthly meeting.
- For special/crisis situation, coordination is established for the specific labyrinth.
- One BMOH opined that in spite of round the clock cover by doctors sometimes there are grievances regarding duty schedule of doctors. General expectation is all the doctors should be present all the 7 days.
- A suggestion came for rationalizing and structuring the inventory and stock maintenance with details of time frame.

There may be innumerable other lacunae and loopholes in the health care delivery infrastructure and system in our state. But our study highlighted these few. Future studies would be relevant to analyze relationship between available resource, present delivery system and impact of it in development. For further understanding the nuances of strength and weaknesses in the health care system we should focus more in the updating routine reporting system. The potential huge resource from that would be an asset for future planning.

Discussion and Recommendation

A. Based on the findings of house to house and qualitative survey

A cross sectional observational study was carried out in three districts of the state of West Bengal by following observational , quantitative and qualitative methods. The study was carried out during the period from July to December 2006.The main objectives of the study was to find out the strengths, weaknesses & gaps as well as suggest recommendations.

Observation revealed that majority of the clients (25%) utilized government health facilities, followed by private practitioners (18.3%) and quacks or unqualified practitioners (19.64%). Free drug supply, round the clock availability of the services and low cost were the main reasons for utilizing the government health facilities. On the other hand good treatment was considered to be the main reason for utilizing the private health facilities (>60%). Qualitative survey report suggested that Private health facilities were used more for some specific diseases and their commitment for maintenance of confidentiality, privacy, *personal attention to the patients as well as the accompanying persons.* Proximity to the beneficiaries (43%) was the principle reason for availing services of quacks.

Opinion gathered from qualitative survey revealed some important aspects. According to one FGD group, people visited private doctor's chambers mostly for abortions and skin problems (this was linked with privacy & confidentiality). They also felt that people went to govt. facilities mostly for preventive services as well as for treatment of major illnesses and to private facilities for minor illnesses. Another group however opined that 'services most in demand' are the curative ones at the government health facilities. According to a CMOH-"30 beds are almost always occupied". One BMOH stated that 'very few cases are referred to higher centers'. Types of cases, which were referred, were "non progression of labor, complications of labor, *complications of New Born,* meningitis, *cerebro-vascular & cardio-vascular emergencies including* CVA, road traffic accidents and cases requiring major surgical *& orthopedic interventions &* blood transfusion. One BPHN stated that some referrals ended up in private doctors' chambers. ADM expressed that "basically people go to providers who are most accessible and available". Preventive

services that were more utilized were immunization services and according to him immunization coverage was very satisfactory. This was supported by the findings of the house to house survey data. DM also said, curative services were being utilized more after ensuring availability of life saving drugs at these centers along with medicines while *Promotive & Rehabilitative services appeared to be deficient.*

"Number of Nursing homes is an indicator of pattern of preference. I have seen in those areas where socio-economic status appeared to be better, nursing homes were flourishing. In this area, there is less number of nursing homes in this district- only 35 nursing homes– this means people are utilizing govt. services."- CMOH of one district commented.

Majority of the respondents felt that poverty was one of the major reasons for utilizing govt. facilities *where services* were provided free of cost. 'This was evident from the scene at the government hospitals' – the CMOH said. There were 4 patients admitted in 2 beds in the free ward whereas the paying beds were empty. Further to state that people prefer government health facilities due to certain weaknesses of private sectors as follows:

- Nursing homes only conduct deliveries. They could not attend critical cases & critical operations.
- Expensive
- Lack of skilled manpower, specially trained nurses

Expenses were pointed out as the major weakness of private health care

"Ekta D&C koratei tin-charsho taka lage (One DC costs Rs 300-400)" – BPHN

"Govt. *Services* ***lack glamour/outward show"*** – so people feel that services are mechanically delivered. It is opposite at private sector – (Ora mishti mukhe pocket kate i.e with sweet wards they take out money from the purse) Distance and poor communication is a constraint to utilization of existing govt. health facilities". -CMOH

Clients had expressed their satisfaction regarding the services provided by the Government health facilities. In-depth interview and focus group discussion carried out as part of study showed interest of community to use government health facilities more. However, it was noted that distance and time taken to reach the centre is a constraint for

utilizing the *Government* health facilities. However the following measures have been suggested to improve its utilization.

- The problem of communication could be resolved to a large extent when roads and communication facilities would be improved upon with the help of PRI & PWD.
- PRI could also play some role by providing hired transport for emergency medical care & referral.
- An attempt should be made to motivate community more to use government health facilities by giving due consideration on face-lifting & maintenance of building, confidentiality, privacy, *more personal care to the patients & their accompanying persons.*

One of the major constraints was non-availability of a list of services provided by the government health facilities displayed at the appropriate location. This will help clients to know about the different types of health services that are available at different level of health care delivery systems (Informed choice) based on which they could choose . None of the BPHC and sub-centers displayed such list of services provided by them. Therefore, client gets confused about the services available there and sometimes unnecessarily been harassed. In such situation they opted for other health care providers or choose a wrong provider. The display of 'services available' will help them to have 'informed choices'. This was corroborated by one CMOH. The CMOH stated that the main problem was the lack of awareness in the community regarding the services available at the government facilities. This view was corroborated by the Swasthya Karmadhyaksha. One client went to a BPHC for abortion services but that BPHC was not performing this service (most BPHCs). As a result client went back home and did abortion by a quack and ultimately died due to sepsis. Display of list of services could have prevented such incident.

Around 30% respondents said free drug supply was one of the incentives for using govt. health facilities and quantitative survey showed that very few people had any complaints regarding the problem of getting drugs. But FGD with clients revealed a different picture. Clients stated – "hashpatale shuddhu nam bhorte asi, shab kintei hoy –

khali saline-ta paoa jay" ***(we only go to hospitals to register ourselves. Most of the medicines were purchased from outside).***

The recommendations would be to supply essential drugs. ***Hospital should find out the morbidity pattern in their areas from OPD, Emergency and Indoor records and procure medicine as per requirement. The study also revealed that only few drugs in sufficient amount would solve their medicine demand as observed from both house to house and exit interview data.*** Presently the medicines were supplied arbitrarily based on a list of essential drugs. When the surveyors had gone through the list of medicines it was found out that most of the drugs were available at the BPHCs & Sub-centres. This meant that drugs needed and drugs available were not same. Therefore the need for drug supply should be assessed first from the *Field, Emergency,* Indoor and OPD records and then demand should be placed in a rational way.

"The long waiting hours are a major deterrent". The data from exit interview revealed that more than 56% had to wait for more than 30 minutes to 4 hrs to meet the doctor in addition to their travel time. 17% spent 1 to 4 hours to meet the doctors. Engaging two doctors and starting OPD in time could easily reduce this time. Further, if the health workers stay at Sub centers and are involved in treating minor illnesses, the OPD load will be much reduced while community will get treatment at an accessible health facilities run by the government. "Distance and poor communication is a constraint to utilization of existing govt. health facilities"-would also be solved.

Exit interview data showed that major causes for which patient attends the OPD were ANC, Fever, Cough & Cold, Diarrhea etc which could be managed at Sub- center level. Skill based capacity building program should be introduced in a continuous manner for providing quality of care at BPHC level. MOs should be given additional incentives for continuous skilled based training. ***Training at district level neither operationally feasible nor cost & time effective for health workers or paramedical staff.***

The cost of treatment is more or less same in all the facilities considered for seeking care as first choice. While in case of second choice facility the cost of treatment was much higher to the extent of around Rs. 300/-. Cost of curative treatment was excessive, even in government facilities as revealed from a FGD – "poyshakori nai, ki

kosto kore aste hoy – gohona bandhok die meyeke bhorti korechi – ekta injectioner dam to 70/."

- Medical officer should understand this fact and should not prescribe any medicine unnecessarily. Prescription of antibiotic for No pneumonia, some dehydration in diarrhea was not needed. PRI should make the client understand about this. Frequent prescription audit study has been recommended for rational use of drug.
- Whenever any costly medicine or life saving drug is urgently required, PRI and Government Health facilities should work together to support clients with such essential medicine.

Client satisfaction in regard to services provided appeared to be more or less same at Government & private health facilities, as revealed from house to house survey. Exit interview also revealed more or less same findings. 29.75% of the clients were fully satisfied. According to clients in qualitative interview, 'the doctors did not have any time for giving instructions and the other workers tell us only about immunization and ORS'. "Haspatale je report thake ki hoyeche boley dey na (nobody explains what is there in the report)".

Therefore, Government *Sector* service providers should be oriented to provide care which satisfy the client and which would bring the clients more to government health facility. One could understand that simple explaining instructions either by doctor or SWO or pharmacist will resolve the issue. In this regard a module based training should be introduced at the time of ***Interne ship training as well as*** at the time of entry into the health services for all public health professionals and group D staff. They should be taught about the interpersonal relationship *& communication skills.* Such a module was developed earlier which contains the basic principles of communication along with case studies regarding the interpersonal relationship but it was never been used. It is expected that such training will help the public health professionals to deal with their *beneficiaries* in a more professional way, who will go back home, satisfied.

Internship program in the Medical Colleges should be oriented in such a way that they will be able to serve better in Health Services as basic doctors and work towards client satisfaction. Thus, their training should emphasize on:

- *Medical Ethics*

- *Medical Record Keeping & its Importance*
- *Health Information Management System*
- *Medical Data Analysis*
- *Health Economics & Health Budgeting*
- *Clinical Dietetics*

Basically, the decision of referral from the sub centre, primary health centre and BPHC was taken either by self or by family members (61%). The study highlighted that decision for such referral was taken for getting better treatment as well as when they were not cured in the first facility. Majority of the client went to another BPHC and a few to secondary and tertiary level facilities. Another BPHC provided more or less same type of care. They traveled a longer distance and spent more money, while many of them were yet to be cured as revealed from the data of House to House survey. Referral to another BPHC will involve cost and time only without much result. The decision to take their patient to another institution was made by the concerned patient or their family members even when it was, possibly, not needed from the medical point of view. People should be oriented that services at BPHCs are more or less same. More than half of the clients, referred to second health facility were satisfied with the services. *It should be looked upon to* improve their satisfaction further. Only 58% were cured. Appropriate referral by a health professional would have definitely improved the satisfaction level further & cure rate. This could be achieved through involvement of opinion leaders of community & appropriate BCC. It might be pertinent to mention that referral from the BMOH was negligible.

Unnecessary referral to another BPHCs (28.3%) and private practitioners (25.3%) should be minimized through development and use of appropriate referral protocol and circulating it to private practitioners through their professional bodies. Display of informed choices will also help to some extent.

*Greatest strength of govt. health facility is immunization services. Free supply of immunization and cordial approach of health workers in delivering immunization services were the main reasons for availing the immunization services by the community to the extent of 80%***.** Those who are not availing immunization services from government institution belonged mostly from the upper socio economic group. Inter personnel

communication as well as frequent communication through electronic media will further improve the utilization of services.

It might be recalled that amount of expenditure spent for disseminating the message on HIV/AIDS was appeared to be high.

Some *more Funds* could also be utilized in the same way for whole gamut of RCH services. These should be disseminated either by print media or by electronic media & through interpersonal communication. The fund should be available for these activities or else HIV/AIDS fund might be linked or integrated with RCH services as both are intimately associated. The evaluation mechanism should be existed with the involvement of experts from apex institution or with the involvement of professional bodies like IPHA. They should examine the correctness of the content and methods for dissemination The key messages for RCH services like:

- Immunization,
- Antenatal care,
- Institutional delivery,
- Post natal care including new born care,
- Breast feeding
- Family planning
- *Adolescent health*
- *Infertility management-where available*
- *Prevention & Management of STIs & RTIs*
- *The messages which helps clients to have Informed choices*

Sub centre and BPHC *were* mostly chosen by the beneficiaries for antenatal care. However, it was sad to note that one third of the clients were not utilizing the antenatal care services for at least 3 times or more. Utilization of antenatal services was shown an marginal increase in comparison to other studies (IJPH, NFHS 2). A joint training on RCH with the help of health, ICDS and panchayat functionaries will further improve the utilization of Antenatal care services. Health worker females should be trained time to time, especially on their Skill.

Post natal care was provided through sub centre and BPHC mainly. The quality of care was appeared to be poor. No postnatal care was provided to 22.31% of the clients.

The care provided was mainly advised on breast feeding. Advice on positioning and attachment was not included at all during message disseminations. Until and unless breast feeding advice contains such information along with exclusive breast feeding & timely complementary feeding, advice will not be complete. Advice on Care of stitch and perinatal toileting was hardly given. However, the advice on immunization was given to the extent of more than 90%. Post natal care appeared to be a neglected issue. The public health professionals did not take it seriously as it did not have immediate impact. Experience suggested that this area was also neglected even at the time of RCH training and it was felt that emphasis on post natal care should be given due emphasis in view of reduction Neonatal and Maternal morbidity & mortality.

Family planning services are provided by government sectors without any cost involvements of clients. Around 69% utilized family planning methods & mostly sterilization. ***The effort to improve condom use through IEC, appeared to us, has yielded very little results (only 6.8% were using condoms).*** Further some court order had made the doctors apprehensive of taking up sterilization operation for family planning as mentioned by some. These must be seriously looked into, otherwise; sterilization operation will be reduced with further reduction in the couple protection rate.

Some other suggestions, which came out, were included as follows

- *Adolescent Health should be taken into account.*
- *Components of RCH should be taken with importance.*
- *Planning & Programming on Life Style Diseases & Non Communicable Diseases having high morbidity & mortality (like Cerebro & Cardio-vascular Diseases, Diabetes, Neuropsychiatric Diesaes, Anemia related disorder, Cancers, Asthma etc)*
- *Local level Health Planning should be done on the basis of Data-Based approach.*
- *Community Need Assessment Approach*

B. Based on the findings of qualitative survey

Strength/Comments	Weakness	Gap	Recommendations
	Use of sanitary latrines should be an indicator of the public health status and in this district even in the 7 municipal areas many did not have or use sanitary latrines PRI representatives focused on the problem of drinking water. They also stated that accumulation of water and improper sanitation is leading to breeding of mosquitoes and germs – this leads to malaria and diarrhea	Use of Sanitary Latrines	BCC with special emphasis on disease prevented as well as example of the districts where sanitary movement was successful should be shared with the community. Low cost sanitary latrine should be available
	"I have not only seen in minority communities had more children but also I have seen adolescent girls of other communities were having 2 or 3 children) -One DM	Gap in knowledge about the ill-effects of too early, too close & too many pregnancies	Intensive BCC on too early, too close & too many pregnancies
	Due to lack of food hygiene and improper water, water borne and diarrhea diseases were common	Not only Food Hygiene but also knowledge on hand washing is also poor as revealed in recent studies	Intensive BCC Hand washing Food Hygiene to prevent water borne diseases
The common health problems are diarrhea, fever, ARI, TB, Leprosy and skin diseases.	Client Medicines are not available. All medicines have to be purchased "We bring the patient with lot of difficulty, get the investigations done from private, buy medicines but again they refer – what is the use of bringing here?" "Daktarbabura bolchen bichana nai, oshudh nai" OPDload is so much that the doctor cannot even	The medicines had to be purchased	The medicines for ARI, Fever, skin infections should be available in sufficient quantities.

	attend emergencies		
	Lack of regular visits to the sub center	Gap in supervision	Arrangement of transport like cycle /moped or regular sanction of TA/DA for field visits and also supervisory visits
	Lack of proper liaison with upper levels& gap in supervision	Gap in Regular monitoring & supervision	Discussion on monthly meeting should be directed towards how this could be achieved and sustained
	Staff is worried with transfer postings	Frequent transfer especially of Medical Officers was occurring.	Too frequent transfer in any form should be avoided
Client Medicines are not available. All medicines should be avaiable "We bring the patient with lot of difficulty, get the investigations done from private sources, buy medicines but once again if they refer – what is the use of bringing here?" "Daktarbabura bolchen bichana nai, oshudh nai" OPD load is so much that the doctor cannot even attend emergencies. No ambulance Lack of proper equipment – daktarbabu bolen jontro nei ami thik kore dekhte parbo na tai baire jeye hoy. No oxygen No injection except TT	*Improper Behavior with clients and many a time clients behavior with health staff was wrong*	The problem of interpersonal relationship.	Behavior with client should be palliative & vice versa. As suggested earlier a module based training resource material should be developed for each category of workers & clients giving some examples where such behavior fails Arrangement for ambulance, supply of equipment, Oxygen supply, Life saving drugs & injections
	Delay in response/intervention	Quantitative house to house research also pointed out this gap	Prompt response to the client will bring their confidence back particularly when one is dealing with emergency cases. As a result clientage or utilization of government health facilities will be more

	Punctuality	Lacking	Monthly meeting should ensure it through motivation and emotional involvement rather than threatening them with punitive measures
	Doctor strength was a major weakness The govt. norm of 2 doctors per 10 beds does not take care of the actual patient load and other workload.	A gap in number of doctor. Medical Officer's in-depth interview revealed general expectation of the community is that all the doctors should be available 24 hours for all the 7 days	Doctors should be motivated to stay in rural areas. They should be allowed Pvt practice beyond office hours officially at rural area. Alternatively nurses may take up treatment of minor illnesses in case of non availability of doctors. All interns in the state might be posted for 3 months in one of the BPHCs as a part of the interns training in Community Medicine with incentive. Regarding the expectation of 7 days stay and all the time availability, PRI members should explain to the people about this issue. This will deteriorate quality of care if doctors are not given rest and relaxation.
	Excessive rush of patients – 600 to 800 patients / doctor / day at outdoor – hence quality of care suffers		

	No ambulance Lack of proper equipment – daktarbabu bolen jontro nei ami thik kore dekhte parbo na tai baire jete hoy. No oxygen No injection except TT	No ambulance Lack of proper equipment No oxygen No injection except TT	Every BPHC should be provided with an ambulance for carrying patient. In case of lack P. Oil the cost may be borne by PRI or patient party on no loss no profit basis. Oxygen cylinder should be available sufficiently based on the need of the BPHC as well as wastage should be prevented. List of life saving drug and urgently needed equipment stock should be prepared as well as supply should be given. Remember the quotes "lots of equipment had been bought for rural hospitals, but technicians have not been employed so the equipment are lying unused and are damaged"
Government health facilities are utilized by majority (>80%) – this was stated by the CMOH, BMOH and CDPO Malaria treatment is mostly taken from the govt. facility- CMOH The demand is for ARI,Diarrhea,and TB treatment along with delivery . Curative services were more utilized - now,with increasing awareness and education, preventive services are also being utilized more	There is also demand for surgery – hydrocele, hernia,etc.- CMOH	Conduction of Minor surgery is a gap. Although many BPHCs are doing while many of them were not doing. Lack of equipments to perform, willingness and confidence of MOs to perform and co-operation of community are the major issues	Supply of equipment at BPHC or CHC for performing minor surgical intervention according to IPHS standard Building of confidence of doctor with the involvement of PRI as well as skill based training at Sub district and district level
CMOH and BMOH also opined that people feel that the quality of curative care is better in govt. facilities. Patient management and doctor patient relationship is		Sustaining the quality of care is an important issue.	Supervision at all level i.e equipment, cleanliness, appropriate skill and a checklist should be

also better in govt. facilities, according to the BMOH			prepared
	A BMOH opined that despite the existence of an OT it was non-functioning due to GDA shortage.	OT non-functioning due to lack of Staff	At the time of opening an OT both skilled and non-skilled staff recruitment should be done first
but preventive care is mostly sought from govt. facilities as medicines are available mostly	Lack of adequate drug supply particularly antibiotics was a major weakness people go to other facilities for curative care because medicines are not available at the SC	Lack of drugs like antibiotics	Funds should be kept for purchase of life saving drugs and antibiotics
Essential drug supply is sufficient according to the CMOH,	Specialists sometimes, have preference for brands – this causes difficulty	Prescription by Brand	MOs should be motivated as well as informed about the availability of drugs. He should be allowed to comment on quality of drug and based on his suggestions the drug should be changed for the interest of the patients. He should be motivated to avoid brand name
	In emergency situations beyond the fixed hours, services are not available at the sub-centre.	Non availability of HW (F) for emergency situation	Construction and face lifting of sub-centre. Finding out the ways & means so that HW (F) stays. Her security should be supervised by PRI & Police with the facilities for schooling of their children. They should be from the same or nearby community
	Majority of interviewees also stated that the huge crowd and long ques at the hospital, They do not want to spend a lot of time.	Huge crowd & long waiting time	Spread the timing of BPHC or engage two or three doctors. Sub centre OPD should be conducted on regular basis, which will reduce the load at BPHC OPD

	The CMOH stated that the main problem was the lack of awareness in the community regarding the services available at the government facilities	lack of awareness on services available	A hoarding on services available at the BPHC
BPHN/PHN is residential so they are available and approachable to solve problems. She also said that "Janani Suraksha Yojna" had successfully increased the number of institutional deliveries. In her opinion, health education intervention at the grass root level have also been yielding good results – "Diarrhea cases have reduced over last 3-4 years"		"Janani Suraksha Yojna" not functioning at all the blocks in the same way	Implement it to increase the number of institutional deliveries
Referred cases are usually complications of labor, head injury or other serious severe injuries, complicated illnesses. According to a BMOH, last month the no. of referrals were 32 against 362 admissions (8.84%).	*Referrals have to be made when there was limited number of specialists or they were on leave or when infrastructural facilities were not available.* Complicated labour cases could not be handled because of lack of anesthetist/blood transfusion facilities – *according to the CMOH, this can be addressed by setting up referral units in Rural Hospitals with placement of gynecologist and anesthetists.* *The CMOH opined that it is difficult to implement according to protocols because patients and those accompanying them along with the local influencers, press for referral – it is difficult to resist such pressure."*	Lack of specialist like anesthetist mainly. There is *no prefixed protocol for referral.* The party keeps insisting *"parben to? kichu hobe na to? So the doctor thinks that if I take responsibility and some complication develops at odd hours – there will be no conveyance available – what shall I do? It is better to refer"- CMOH "currently on graduation, a doctor can only conduct normal delivery so with indication of any*	*MOs should be oriented through skill development training management of complications of labor, head injury or other serious severe injuries, complicated illnesses. Lack of specialists like Gynecologist and anesthetist is a problem throughout the country. It is a policy issue. The government should sit with MCI and professional body to resolve the long pending issue. It was suggested that skill development training in this regard on these two subjects may solve this issue partly. It should be reminded that before CPA many doctors used to conduct life saving measure on their own initiative. But due to fear of CPA they refrain from doing so.*

		complication, he refers the case".	*PRI should motivate the people through mothers and fathers meeting that unnecessary referral may lead to their harassment and will bring down the confidence of doctor to treat the cases.*
Opinion regarding ECCR maintenance and use BMOH ECCR is not updated New ECCR register has not been opened. Supply of ECCR register is less CDPO AWW should help in ECCR updating but existing situation there is no coordination The BPHN She stated that ECCR was updated from clinic data after completion of clinic and carried during field visits. It was regularly checked. BMOH Opinion regarding ECCR maintenance ***"****We try our best but cannot keep it fully updated – during field visits we have to provide maternal and child care "–* *All of them opined that it was impossible for the ANM to single handedly update the ECCR. People reach the clinics late so it is not possible to visit the fields after clinic hours. Moreover on designated field visit days trainings, meetings was held and field visit is neglected.* *We had been told that pre-approach target would be adopted but in reality during the monthly meetings, the supervising officer is setting a*		No updating Lack of supply of ECCR register ECCR is updated from clinic data ANM could not do single handedly No CNAA CDPO wants AWW's participation in ECCR but no co-ordiantion More time was devoted to MCH care and little time is left for ECCR Target is given based on district data for the blocks Staff shortage	*After going through the observation, it was revealed that ECCR was not a priority to anyone. It was done in a ritual way although many expressed that it was done properly with regular updating* *It was also understood that ECCR can't be done by health workers alone* *CNAA might be the only answer but prior to that a co-ordination meeting is needed between health, ICDS, Health & Panchayet functionaries. For updating in future Self help group or ASHA may be involved*

target based on average of the district. District puts the targets on them ECCR still not been updated in some places mainly because of staff shortage *Community need assessment should have been done by discussion with the community but actually it is not done in that way – there is a gap. Time for CNA is a constraint. Monthly activity plans are made but the pressure of programs do not allow us to reach the mothers in the community. The also said that their problems have to solved by themselves. None helps them* " amader ki shomoshya she to amader upor theke visit kore dekha uchit kintu amader shomoshya amaderkei bhugte hoy, amaderkei shomadhan korte hoy – pichone amader keu nei"			
"Supervision means whether you have compiled the report or not". Sometimes supervisor was asking 'whether you have done something on certain issues or not'		Meaning of supervision was not correctly understood	*Training how to do supervision* *Supervision of supervisors to understood whether they understood the meaning of supervision and particularly supportive supervision*

C. Based on the findings of facility survey

Sl.	Strength	Weakness	Gap & Recommendations
1.	Standard space present in 5 out of 9 sub centre and 8 out of 9 CHC or BPHC	Waste papers were seen in 5 BPHC/CHC and spitting stain in, 4, Dust bins were seen in 5 sub centre & 3 BPHCs. It should be available in all such facilities	Gap: Un-cleanliness Use of Waste paper basket. PRI should be involved to motivate the people to use it and prevent them from spitting here & there with a view to keep the hospital premises clean
2.	Waiting space was present in 5 sub center out of 9 and 7 BPHC/CHC out of 9	Screen was not available in most facilities, more so in sub centers. In some facilities though screen was available it was not used, not even at the time of examination of female patient at OPD. Screen is important for Privacy and dignity	Gap: Non-availability and non-usage of screen. Screen should be available at all health facilities as well as used for privacy and confidentiality. If any doctor or HW is found to be not using, he should be informed & then punitive measures should be applied Enough waiting space should be provided in all the health facilities particularly at sub-centre with the construction of new Sub-centre buildings
3.	Mopping of floors was done in 7 out of 9 BPHC/CHC & in 5 out of 9 SC while waste papers were only found in 2 sub centre & spitting stains in 1 sub centre. The later could be due to less patient load in sub centers as well as these were private owned. Latrine was present almost in all the BPHC/CHCs (8 out of 9). Out of them 5 were usable. Water for toilets were present in 7 and running water at toilets were present in 6.	Among the latrines at BPHC, 1 was fully blocked and was not usable. One was partially blocked & one partially usable while in two latrines doors and windows were either not existing or broken. Only 3 latrines were partly clean, 6 had stains, 3 were soiled with fecal matter & 1 had cobwebs. Only 2 SC had latrine with water	Latrine should be not only available in all BPHCs & SCs but also it should be clean as well as without any stain. Privacy is a must. In one ward it should be usable
4.	Drinking water through Tube-well/ tap was present in all the studied health facilities except one SC	All health facilities except one sub centre had electric connection	Sustain
5.	Quarters for staff was present in all BPHCs. Majority of sub centers were government's own building	Only 44.4% SC had staff quarters. Repair work was needed in all BPHCs and all SCs	Repair of staff quarter at BPHC along with painting of the building, is an urgent need. Fund should be

		Almost all (7 out of 9) hospital buildings and 6 out of 9 sub-centre buildings needed repair. Needs for painting was much less (25% in SC & 33% in BPHC	allotted for this activity in the coming plan. Qualitative data revealed that one of the reasons for choosing Private health facilities was poor look and glamour of such faciliities. Therefore repair, painting, availability of drinking water, adequate waiting space, clean environment with usable toilets, privacy and face-lifting will definitely attract client to utilize it's services more All sub-centres should have their own building with quarters where local health workers will stay and provide services. Proper budgetary allocation in the next plan
6.	Antenatal care was provided by all BPHCs and all SCs. Deliveries were conducted by all BPHCs. On an average 75 deliveries were conducted per month in each BPHC with a range of 50-125.		Sustain & attract more
7.	In 7 out of 9 SCs and in all 9 BPHCs post natal care was given. The average is 33 per month for SCs and 97 per month for BPHCs with a range of 50-225. Family planning services were provided in all the facilities. Condom, Oral pill and Copper T were available in the all the facilities except one SC where Copper T was not available. The State government has recommended deliveries by all Sub centers as far as practicable. In some of the Sub centers of Murshidabad districts conduction of deliveries has been started as has been reported.	Only 1 out of 9 sub centres provided ANC services twice weekly and all the rest provided weekly services. In case of BPHCs, 4 offered ANC services weekly, 1 thrice weekly, 2 twice weekly and only 2 daily. None of the sub centers studied conducted deliveries.	ANC & PNC services should be available as per state government norms at all BPHCs & SCs. Encourage institutional deliveries by a trained personal. If TBA is trained and willing she might be allowed to conduct deliveries at sub-centre during odd hours, if HW(F) was not staying there. But until the environment of institution is clean deliveries will not be safe. Ensure safe and clean deliveries at BPHC & SC level
8.	Treatment of minor illnesses was done in all the facilities except in one sub centre.	In regard to delivery of postnatal care appropriate records were not available. Frequency of PNC was	Postnatal care was a neglected issue. As recommended it should be

		not considered. When it was considered, it was considered based on visit on second and subsequent days in health facilities after deliveries and probably for immunization	given due importance at the time of training and should not be done ritually for the care of the mother and newborn, who were considered as vulnerable population. Knowledge and skill for providing postnatal care should be imparted during training of RCH in such a way that it could be implemented at the BPHC & SC level. It was thought no. of visits suggested for PNC will not be operationally feasible
9.	In connection with the disease control programme, specific actions were narrated by health personnel. At sub centre level malaria, filaria & acute diarrhoel disease were reported. Kalaazar, TB, Leprosy, filaria and malaria etc were also considered. Outbreak response in case of these disease includes disinfection of water sources, Mass & contact survey & health / mobile camp	Scope for Emergency Obstetric services was not available in any one of the BPHCs. OBG specialist was not available. Anesthetist and blood transfusion facilities was not available in all these facilities while equipments were not found in 5 facilities	Emergency Obstetric services as per IPHS standard which was laid down in NRHM should be implemented without delay
10.	Environmental sanitation activity includes disinfection with bleaching powder & insecticide spray		Use of Bleaching powder and insecticide should be done in a rational way.
11.	All BPHCs are performing minor operations. Some of these are performing operations like Hydrocele, abscess, FB extraction, small tumors.	Only less than one third of the BPHCs were performing tubectomy, vasectomy & MTP facilities	Minor surgery at the BPHC should be done as per Indian Public Health Standard. Scope of tubectomy operation should be available at all BPHC. Relaxation of rules should be considered by Honorable Supreme Court.
12.	In all BPHCs except 2, sterilizers were used while autoclaves were available in 4. Laboratory facilities were available for Malaria, sputum for AFB, aldehyde test	Color coded bags were used only by 2 sub-centers	Laboratory Facilities as per IPHS should be available at all BPHCs. Qualitative survey revealed that due to lack of investigation facilities people were opting

			for private health facilities All equipments should be supplied & used with special reference to Sterilizers & Autoclave There should not be any reasons why color coded bags should not be available at Government facilities. It should be ensured whether doctors and health workers were knowledgeable about it or not.
13.	Referral services was provided for few common events like MI, CVA, Eclampsia, complicated labor, Intestinal obstruction, Accident, head injury, poisoning from BPHCs. From sub centre Pneumonia & risk pregnancy were referred to BPHC	Capacity building for sub centre staff was poor in past 12 months, while this group of staff need more frequent training for sustenance of both knowledge & skill.	Capacity Building should be organized in a decentralized manner. Fund should be given to BPHC for this activity with concurrent evaluation of training followed by terminal evaluation. Referral protocol development is urgently needed
14.	In past 12 months training was conducted mainly at subcentre for malaria, RNTCP, Leprosy ,IPPI, Dai training.	Time spent for explaining management was very less as patient wanted more time to be devoted there to have their full satisfaction. In this regard Average time spent at Sub centre was 3.2 with a range of 1-5 minute while at the BPHC level it was more or less same with a range of 1-18 minutes Referral instructions were not given in any one of the cases. Such an instruction was not given due importance at both the levels.	Paramedical workers should be engaged for explaining medicine, management, referral & IEC about the diseases. PRI may also be involved in this process.
15.	In last 6 months births & deaths were recorded at BPHC mainly.	.	Recording should be done at SC also. At BPHC birth and death register should be meticulously supervised.
16.	All sub centers had ECCR & all updated in last 6 months as told by them. Records verification at field level could not be done. 3 out 9 mentioned few problems in maintaining it e.g. Population increasing, No helper, High workload, Too many information, Time consuming, Previous records	BPHC usually supervises it. Records could not give us information whether updating the ECCR records was done or not. Around 3 of them mentioned like Lack of motivated staff as well as more participation is needed, increase in population and HWs and ICDS functionaries are not	In regard to ECCR already suggestions were given in Recommendation no3. District authority should monitor the supply of RCH kit

	not available, No HA (M) posted.	participating jointly in updating data Anti Snake venom was not sufficiently available. RCH kits were not available in majority of the health facilities	
17.		Out of 30 patients followed at the OPD at sub center level, cordial behavior was observed in 80% patients. At BPHC level out of 35 observations it was noted in 82.86 % cases. Average time taken for registration was 7.6 and 16. 3 minute with a range of 5-10 minutes and 5-60 minutes at Sub centre and BPHC respectively. Average time to examine a patient at sub centre and BPHC was 13.7 minute with a range of 5-20 minutes and 3.37 minutes with a range of 0.25 minute to 10 minutes respectively. At the time of giving the prescribed medicine also average time was more in Sub centre (9.4 minutes with a range of 2-20 minutes) than in BPHC (average 6.7 minute with a range of 1-35 minute). As the work load was comparatively less more time was given at the sub centre.	Sustain cordial behavior. However qualitative survey revealed that cordial behavior was lacking in many places. Due consideration should be given by the health care provider. ***This does cost anything.*** OPD Registration and patient management should be started in time simultaneously, so that there will be little rush at OPD. Most of the time staff for registration and doctors came late. Therefore there is more waiting time. Exit interview made the doctors possibly conscious therefore there was more time devoted by the doctors in attending the patients. Usually time devoted for examination was too less as confirmed by FGD data
	Albendazol, Antacid, Chloroquin,, Metronidazol, Co-trimoxazol, ORS, Paracetamol,Salbutamol, TT & all vaccines under UIP, B complex tablets were available in all the BPHCs. In all the subcentres Cloroquin,, Metronidazol, Co-trimoxazol ORS, Paracetamol, TT & all vaccines under UIP during the clinic day.	It was not clear whether medicines were sufficiently available or not. In OPD register as usual there was no diagnosis and there was no scope to understand whether supply and requirement was going hand in hand or not	However clients and PRI opined there was scarcity of medicine. Medicine requirement should be based on morbidity pattern of the area