SOME STANDARDS TO BE CONSIDERED

Governance

1. There is an established process and criteria that have been identified for selecting a competent and qualified Chief Executive Officer.
2. There is an established mechanism to ensure that the organization adheres to relevant statutory and regulatory requirements.

Organizational Planning

1. Planning includes setting a mission, a vision, and values for the organization and providing plans and policies to achieve the mission and vision.
2. The leaders communicate the organization's plan(s) throughout the organization.
3. The plans include patient care services in response to identified patient needs and is consistent with the mission.
4. The scope of services provided by each department is defined in writing.
5. The leaders and other representatives from the organization, as appropriate, participate in the organization's decision-making structures and processes.
6. The leaders develop programs to promote the recruitment, retention, development, and continuing education of all staff members.

Leadership

Key characteristics of leadership :

The process of leadership begins with establishing and promulgating the organization's mission, followed by renewing and revising it as necessary. Building on the organization's mission, effective leadership defines and establishes a clear vision and values for what the organization can be and resolves to become, encouraging staff participation in its development. Effective leadership develops other leaders at every level of the organization who help fulfill the organization's mission, vision, and values. Effective leadership also accurately assesses the needs of the organization's patients and other users of the organization's services and develops an organizational culture that focuses on improving performance to meet these needs. Effective leadership

- defines a strategic plan that is consistent with the organization's mission, vision, and values;
- clearly communicates the organization's mission, vision. and strategic plan throughout the organization; and
- fulfills the organization's vision by providing the framework to accomplish the goals of the strategic plan.

Developing this framework is accomplished through proper direction, implementation, coordination, and ultimately, improvement of services throughout the organization. In order to realize the organization's vision and values, leadership must have a role in teaching and coaching staff. This role is inherent to leadership.

Directing Departments

1. Each department of the organization has effective leadership.
2. Department directors or supervisors are responsible, either personally or through delegation for
    - integrating the service into the organization's primary function;
    - coordinating and integrating interdepartmental and intradepartmental services;
    - developing and implementing policies and procedures that guide and support the provision of services;
    - recommending a sufficient number of qualified and competent persons to provide care, including treatment;
    - continuously assessing and improving the performance of care and services provided;
    - maintaining quality control programs, as appropriate;
    - orienting and providing in-service training and continuing education of all persons in the department;
    - recommending space and other resources needed by the department.

Information Management

1. The information management processes provide for information confidentiality, security, and integrity.
2. The organization reviews the completeness, accuracy and timely completion of information in medical records at least quarterly.
3. There is a policy regarding the retention time of medical record information determined by law or by its use for patient care, legal, research, and/or educational purposes.
4. A medical record is maintained for every individual assessed or treated.
5. Medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results accurately and facilitate continuity of care among health care providers.
6. At discharge from patient care, a clinical summary gives reason for hospitalization, significant findings, procedures performed, treatment rendered, condition on discharge, and any specific instructions given to patient or family.
7. Written operative reports are included in the medical record of patients undergoing operative or other invasive procedures.

Human Resources Management

1. The organization's leaders define for their respective areas the qualifications and job expectations of staff and a system to evaluate how well the expectations are met.
2. The organization provides an adequate number of staff whose qualifications are commensurate with defined job responsibilities.
3. The organization has established methods and practices that encourage self development and learning for all staff.
4. A staff orientation process provides initial job training and information.
5. Ongoing inservice or other education and training maintain and improve staff competence.

Environment of Care

1. The organization has a documented management plan(s) for the environment of care that considers the following functions:
   - Safety
   - Security
   - Hazardous materials and wastes
   - Utility systems
   - Emergency preparedness
2. All areas of the facility are surveyed at least twice annually to identify environmental hazards and unsafe practices.
3. All incidents involving property damage, occupational illness, or patient, personnel or visitor injury are investigated and reported.
4. Written policies and procedures are strictly followed in regards to Infection Control.
5. Cleanliness is maintained in all areas with set standards to be achieved.

Dietary

1. Responsibility for preparing, storing, distributing, and administering food and nutrition products is defined and assigned.
2. Food and nutrition products are administered in a safe, timely, and acceptable manner to the patient.
3. Diet counselling and education by trained personnel is available and provided to patients.
4. Quality control measures are practiced in regard to therapeutic diets.

Pharmacy

1. Availability of appropriate medicines as determined by the medical staff
2. Availability of pharmacy services at all hours
3. Emergency medication systems
4. Formulary available to staff who use drugs
5. Pharmacy and therapeutic committee
6. Appropriate policies and procedures that support prescribing or ordering practices
7. Adherence to applicable law regulation, licensure, and professional standards of practice.

Laboratory

1. Clinical laboratory services and consultation are available at all times in a prompt manner to meet the needs of patients served by the hospital as determined by the medical staff.
2. Current written policies and procedures are readily available and address
   - Specimen Collection
   - Specimen Preservation
   - Instrument Calibration
   - Quality Control and Remedial Action
   - Equipment Performance Evaluation
   - Test Performance
3. Staff performing tests have adequate specific training and orientation to perform the tests.
4. Quality control checks are conducted on each procedure as defined by the organization.

X-Ray

1. Radio-Diagnostic services and consultation are available at all times in a prompt manner to meet the needs of patients served by the hospital as determined by the medical staff.
2. Current written policies and procedures are readily available and address
   - Patient preparation for special procedures
   - Radiation protection
   - Equipment performance evaluation
   - Quality control and remedial action
3. Staff performing tests have adequate specific training and orientation to perform tests.
4. Quality control checks are conducted as defined by the organization.

Spiritual Care

1. Spiritual care and counselling is available to all patients and families at all hours
2. Chaplains visit in all wards daily
3. The Christian nature of the hospital and its mission is communicated to patients, staff, and students.
4. Spiritual care is available to staff and students
5. Activities to encourage growth and meet spiritual needs of staff and students are planned regularly.

ST. MARTHA'S HOSPITAL—EVALUATION

SECTION: 1.NURSING EDUCATION

*Faculty
*Ancillary Staff
*Students

2.NURSING SERVICE

*Ward-in charges
*Nursing Staff

METHOD OF EVALUATION:

*Questionaire
*?Focused Group Interview

Note: All members of each category will not asked to take part in the evaluation process. Only a selected representative number will be included depending on the following criteria:

The staff be it in the Nursing Education or Service should -

*have worked in the institution for a continous period of six months.
*be willing to take part in the evaluation .

PERSONAL DATA

Department:

Designation:

Status (Religious/Layperson):

Duration of service /Stay in the institution:

Educational Qualification:

Institution where Nursing was completed:

Date of completion of Nursing course:

Have you undergone an Inservice Education Programme after joining St.Martha's hospital ?

Given below are certain aspects of the institution you are expected to be aware of. Please indicate your awareness , by encircling 'Y' if your awareness of each aspect listed is YES and 'N' if it is NO.

1.The vision of the Good Shepherd Congregation: Y/N

2.The philosophy of the institution : Y/N

3.The objectives and goals of the institution: Y/N

4.The policies regarding :

*Work Y/N

*Benefits/Salaries Y/N

*Promotions Y/N

*Recruitment of staff Y/N

*Selection of students Y/N

*Disciplinary action Y/N

5.The welfare facilities/schemes: Y/N

6.The worker's union: Y/N

7.Performance appraisal: Y/N

Given below are list of objectives /goals of your institution. Give your opinion to the extent to which you think the objective /goal should be fulfilled under column A & under column B theextent to which each of them are presently fulfilled .Please give your answer in the form of a number ranging fromONE to FIVE in the blank provided under each column.

1 2 3 4 5
Not fulfilled at all. Fulfilled completely

	COLUMN-A	COLUMN-B
1. The hospital provides to the the sick irrespective of caste/creed/race /social status.	_____	_____
2. The hospital strives to provide high quality care at a cost affordable for the common man.	_____	_____
3. The hospital focuses its services on health concerns of women and children mainly.	_____	_____
4. The hospital endeavours to provide competent and comprehensive health care thro' recent yet cost effective technology.	_____	_____
5. The hospital fosters a sense of dedication, moral & ethical integrity among its employees.	_____	_____
6. The professional skills of the employees are enhanced thro' continuing education programs	_____	_____
7. The hospital strives to develop in its employees a desire to serve the poor & weak sections of society.	_____	_____
8. An awareness of the social problems & injustices is developed in the employees, keeping in mind the National Health priorities	_____	_____
9. The hospital provides spiritual care to the sick respecting the individual's religious beliefs	_____	_____
10. The hospital provides subsidised care to those individuals in need	_____	_____
11. The hospital attempts to develop Urban & Rural centres of Health care for the underprivileged & oppressed women and children.	_____	_____
12. The hospital strives to expand its department & education programs as per the need of society.	_____	_____

13. The hospital constantly tries to improve the quality of the health care. _____ _____

14. The hopital creates awareness of a clean & healthy environment to the public. _____ _____

15. The hospital serves as a model of efficient health health care. _____ _____

16. The hospital fosters in all its employees a respect for respect for human life at all stages of life. _____ _____

17. The hospital tries to develop in its employees a team spirit & a family atmosphere. _____ _____

18. Rules &regulations of the institution are reasonable _____ _____

19. The hospital shows concern for the welfare of its employees. _____ _____

20. Give any *THREE POSITIVE aspects* of the hospital:

_____
_____
_____

21. Give any THREE NEGATIVE aspects of the hospital which you have experienced:

_____
_____
_____

22. Give any THREE suggestions for improving the hospital functioning:

_____
_____
_____

To what extent are you able to accomplish the following tasks . Give your answer honestly by encircling a number ranging from ONE to FIVE where 1 means you are 'not able to do the task at all' and 5 means you are ' able to do the task to the best of your ability'Given below is space provided for comment .Please give your comments if you have faced any problems /difficulties to do these tasks.

1. I am able to provide care to all patients irrespective of their caste/creed/social status. 1 2 3 4 5

_____

_____

2. I am able to provide the best possible care to all patients at all times. 1 2 3 4 5

_____

_____

3. I am able to ophold my moral/ethical values in dealing with all the patients /co-workers. 1 2 3 4 5

_____

_____

4. I am able to meet the spiritual needs of the patients daily respecting their own religious views. 1 2 3 4 5

_____

_____

5. I am able to participate in activities which will enhance my skills /professional abilities. 1 2 3 4 5

_____

_____

Given below are list of statements relating to various aspects of your education in St. Martha's School of Nursing. Give the extent to which you are satisfied with each aspect ,in the form of a number ranging from ONE to FIVE in the blank provided against each statement.

5	4	3	2	1.
Fully satisfied	moderately satisfied	partially satisfied	minimally satisfied	least satisfied

1. The encouragement you get from home to perform well in your studies. _____

2. The encouragement you get from teachers to do well in your studies. _____

3. The encouragement you get from the staff in the hospital to do well. _____

4. The encouragement you get from the warden to do well in studies. _____

5. The facilities on the campus for your personal/professional/spiritual development: _____
   - *classroom _____
   - *chapel _____
   - *canteen _____
   - *hospital services _____
   - *hostel _____
   - *library _____
   - *mess _____
   - *recreation _____
   - *sick room _____

6. The facilities for your social development: _____
   - *interaction with faculty/staff _____
   - *interaction with peers/seniors _____
   - *involvement in the campus activities _____
   - *S.N.A. activities _____
   - *C.N.G.I. activities _____
   - *sports _____

7. The faculty/staff who are directly involved in your education _____
   - *show genuine interest in your welfare _____
   - *show respect to all of you _____
   - *are available whenever needed by you _____
   - *discipline you when appropriate reasonably _____
   - *provide you with appropriate supervision _____
   - *are firm yet concerned with your welfare _____
   - *demonstrate fairness in dealing with you _____
   - *are competent in various teaching methods _____
   - *use appropriate evaluation methods fairly _____
   - *demonstrate moral/ethical values in dealing with you _____
   - *possess good personal skills &are confident in selves _____

ST. MARTHA'S HOSPITAL—EVALUATION

SECTION: 1.NURSING EDUCATION

*Faculty
*Ancillary Staff
*Students — 25 — 15 per batch - 1st/2nd - 45 Random

2.NURSING SERVICE

*Ward-in charges - 14-20
*Nursing Staff — 25/25 Alumni/Nonalum Random

METHOD OF EVALUATION:

*Questionairre
*?Focused Group Interview

Note: All members of each category will not asked to take part in the evaluation process. Only a selected representative number will be included depending on the following criteria

The staff be it in the Nursing Education or Service should -

*have worked in the institution for a continous period of six months.
*be willing to take part in the evaluation.

PERSONAL DATA

Department:

Designation:

Status (Religious/Layperson):

Duration of service /Stay in the institution:

Educational Qualification:

Institution where Nursing was completed:

Date of completion of Nursing course:

Have you undergone an Inservice Education Programme after joining St.Martha's hospital ?

Given below are certain aspects of the institution you are expected to be aware of. Please indicate your awareness , by encircling 'Y' if your awareness of each aspect listed is YES and 'N' if it is NO.

1.The vision of the Good Shepherd Congregation: Y/N

2.The philosophy of the institution : Y/N

3.The objectives and goals of the institution: Y/N

4.The policies regarding :

*Work Y/N

*Benefits/Salaries Y/N

*Promotions Y/N

*Recruitment of staff Y/N

*Selection of students Y/N

*Disciplinary action Y/N

5.The welfare facilities/schemes: Y/N

6.The worker's union: Y/N

7.Performance appraisal: Y/N

Given below are list of objectives /goals of your institution. Give your opinion to the extent to which you think the objective /goal should be fulfilled under column A & under column B theextent to which each of them are presently fulfilled .Please give your answer in the form of a number ranging fromONE to FIVE in the blank provided under each column.

1 2 3 4 5
Not fulfilled at all. Fulfilled completely

	COLUMN-A	COLUMN-B
1.The hospital provides to the the sick irrespective of caste/creed/race /social status.	_____	_____
2.The hospital strives to provide high quality care at a cost affordable for the common man.	_____	_____
3.The hospital focuses its services on health concerns of women and children mainly.	_____	_____
4.The hospital endeavours to provide competent and comprehensive health care thro' recent yet cost effective technology.	_____	_____
5.The hospital fosters a sense of dedication, moral & ethical integrity among its employees.	_____	_____
6.The professional skills of the employees are enhanced thro' continuing education programs	_____	_____
7. The hospital strives to develop in its employees a desire to serve the poor & weak sections of society.	_____	_____
8. An awareness of the social problems & injustices is developed in the employees, keeping in mind the National Health priorities	_____	_____
9. The hospital provides spiritual care to the sick respecting the individual's religious beliefs	_____	_____
10. The hospital provides subsidised care to those individuals in need	_____	_____
11. The hospital attempts to develop Urban & Rural centres of Health care for the underprivileged & oppressed women and children.	_____	_____
12. The hospital strives to expand its department & education programs as per the need of society.	_____	_____

13. The hospital constantly tries to improve the quality of the health care. _____ _____

14. The hopital creates awareness of a clean & healthy environment to the public. _____ _____

15. The hospital serves as a model of efficient health health care. _____ _____

16. The hospital fosters in all its employees a respect for respect for human life at all stages of life. _____ _____

17. The hospital tries to develop in its employees a team spirit & a family atmosphere. _____ _____

18. Rules &regulations of the institution are reasonable _____ _____

19. The hospital shows concern for the welfare of its employees. _____ _____

20. Give any THREE POSITIVE aspects of the hospital:

_____

_____

_____

21. Give any THREE NEGATIVE aspects of the hospital which you have experienced:

_____

_____

_____

22. Give any THREE suggestions for improving the hospital functioning:

_____

_____

_____

To what extent are you able to accomplish the following tasks . Give your answer honestly by encircling a number ranging from ONE to FIVE where 1 means you are 'not able to do the task at all' and 5 means you are ' able to do the task to the best of your ability'Given below is space provided for comment .Please give your comments if you have faced any problems /difficulties to do these tasks.

1. I am able to provide care to all patients irrespective of their caste/creed/social status. 1 2 3 4 5

2. I am able to provide the best possible care to all patients at all times. 1 2 3 4 5

3. I am able to ophold my moral/ethical values in dealing with all the patients /co-workers. 1 2 3 4 5

4. I am able to meet the spiritual needs of the patients daily respecting their own religious views. 1 2 3 4 5

5. I am able to participate in activities which will enhance my skills /professional ablities. 1 2 3 4 5

Given below are list of statements relating to various aspects of your education in St. Martha's School of Nursing. Give the extent to which you are satisfied with each aspect ,in the form of a number ranging from ONE to FIVE in the blank provided against each statement.

5	4	3	2	1.
Fully satisfied	moderately satisfied	partially satisfied	minimally satisfied	least satisfied

1. The encouragement you get from home to perform well in your studies. _____

2. The encouragement you get from teachers to do well in your studies. _____

3. The encouragement you get from the staff in the hospital to do well. _____

4. The encouragement you get from the warden to do well in studies. _____

5. The facilities on the campus for your personal/professional/spiritual development: _____
   - *classroom _____
   - *chapel _____
   - *canteen _____
   - *hospital services _____
   - *hostel _____
   - *library _____
   - *mess _____
   - *recreation _____
   - *sick room _____

6. The facilities for your social development: _____
   - *interaction with faculty/staff _____
   - *interaction with peers/seniors _____
   - *involvement in the campus activities _____
   - *S.N.A. activities _____
   - *C.N.G.I. activities _____
   - *sports _____

7. The faculty/staff who are directly involved in your education _____
   - *show genuine interest in your welfare _____
   - *show respect to all of you _____
   - *are available whenever needed by you _____
   - *discipline you when appropriate reasonably _____
   - *provide you with appropriate supervision _____
   - *are firm yet concerned with your welfare _____
   - *demonstrate fairness in dealing with you _____
   - *are competent in various teaching methods _____
   - *use appropriate evaluation methods fairly _____
   - *demonstrate moral/ethical values in dealing with you _____
   - *possess good personal skills &are confident in selves _____

Questionnaire for out-patients / casualty

1. Age
2. Sex
3. Occupation

4. Family Income
   a) Less than Rs. 2,000/- P.M.
   b) Rs. 2,000/- to Rs. 4,000/- P.M.
   c) Rs. 4,000/- to Rs. 6,000/- P.M.
   d) Over Rs. 6,000/- P.M.

5. Your House
   a) - Rented
      - Owned
   b) - No. of rooms _____
   c) - roof - Thatch
      - Tile
      - RCC
   d) - Floor - Earth
      - Cement
      - Mosaic tile
      - Marble granite

6. Do you own
   Cycle 2 wheeler Car
   TV set Refrigerator

7. Religion _____
   (specify)

8. Education (tick any one)
   No formal education
   Class VII or less
   Class VIII to X
   Pre degree
   Degree
   Post graduate / professional

9. Through whom did you come to know of St. Martha's (tick any one)
   Family doctor
   Friends
   Relatives
   Neighbours
   Other _____
   (specify)

10. Why did you come to St. Martha's Hospital (tick any one)
    - close to your home/office
    - doctor recommended it
    - friends/relatives recommended it
    - mission hospital
    - reputation of the doctors
    - other _____ (specify)

11. Is this the first visit to St. Martha's
    - Yes
    - No

12. Which department did you visit today _____
    (specify)

13. Do you like to see only one particular doctor or any doctor (tick any one)
    - One particular doctor
    - Any doctor

14. If particular doctor
    a) If he/she is not available (tick any one)
        - will you go back & return another day
        - see another available doctor
    b) If he/she leaves the hospital service (tick any one)
        - will you continue coming to St. Martha's Hospital
        - change the hospital

15. How long did you have to wait to see the doctor (tick any one)
    - less than one hour
    - one - two hours
    - more than 2 hours

16. Do you feel that the time you had to wait was acceptable ?
    - Yes
    - No

17. What diagnostic tests did you have today (tick one or more)
    - None
    - Laboratory (blood, urine, stool, sputum)
    - X-ray
    - ECG
    - Ultrasound
    - Endoscopy
    - Others _____ (specify)

18. Give your impressions of the services you received

- the doctor who treated you was knowledgeable and good	Yes/Somewhat/No
- the nursing care is caring and efficient	Yes/Somewhat/No
- the staff in general are courteous and helpful	Yes/Somewhat/No
- were you overall satisfied with the care given	Yes/Somewhat/No

19. Give your impressions of OPD / Casualty amenities

- general cleanliness is good	Yes/Somewhat/No
- toilets and water supply are satisfactory	Yes/Somewhat/No
- seats, fans and lights were adequate	Yes/Somewhat/No

20. Did you have any problem with getting your record from the Medical Record Department
    - Yes
    - No

If Yes, specify _____

21. Please tell us your opinion of the following
    - The hospital is meant mainly for those who can pay — Yes/Somewhat/No
    - The hospital serves the poor sections of the population even if they cannot pay for services — Yes/Somewhat/No
    - The hospital & its staff care for all patients with love and care — Yes/Somewhat/No
    - The religious sentiments of all patients are respected — Yes/Somewhat/No

22. Do you think the hospital charges are (tick any one)
    - correct
    - too high
    - too low

23. Name 3 things in the hospital you appreciate most
    -
    -
    -

24. Name 3 things in the hospital that need improvement most
    -
    -
    -

25. You must be aware that St. Martha's Hospital tries not to refuse treatment to any patient, no matter how poor. Can you suggest how the hospital can raise funds to treat more poor patients

26. Any other suggestions or comments

Questionnaire for In-patients
(at discharge)

1. Age 2. Sex 3. Occupation

4. Family Income
   a) Less than Rs. 2,000/- P.M.
   b) Rs. 2,000/- to Rs. 4,000/- P.M.
   c) Rs. 4,000/- to Rs. 6,000/- P.M.
   d) Over Rs. 6,000/- P.M.

5. Your House
   a) - Rented
      - Owned
   b) - No. of room
   c) - roof - Thatch
      - Tile
      - RCC
   d) - Floor - Earth
      - Cement
      - Mosaic tile
      - Marble granite

6. Do you own Cycle 2 wheeler Car
   TV set Refrigerator

7. Religion _____ (specify)

8. Education (tick any one)
   No formal education
   Class VII or less
   Class VIII to X
   Pre degree
   Degree
   Post graduate / professional

9. Through whom did you come to know of St. Martha's (tick any one)
   Family doctor
   Friends
   Relatives
   Neighbours
   Other _____ (specify)

10. Why did you come to St. Martha's Hospital (tick any one)
    - close to your home/office
    - doctor recommended it
    - friends/relatives recommended it
    - mission hospital
    - reputation of the doctors
    - other _____ (specify)

11. Is this the first time you have been admitted in St. Martha's Hospital ?
    - -Yes
    - - No

12. For how many days were you admitted ? _____ (specify)

13. Under which department have you been admitted ? _____ (specify)

14. What ward were you treated in
    - - General ward
    - - Shared private room
    - - Single private room

15. Did you choose to be admitted in this hospital for treatment mainly because (tick any one)
    - - of a particular doctor
    - - the reputation of the hospital

16. If for a particular doctor, if he/she leaves the hospital service (tick any one)
    - - would you still have been admitted in St. Martha's Hospital
    - - changed the hospital

17. Which of the tests below did you undergo while you were admitted : (tick one or more)
    - - None
    - - Laboratory (blood, urine, stool, sputum)
    - - X-ray
    - - ECG
    - - Ultrasound
    - - Endoscopy
    - - Others _____ (specify)

18. Give your impressions of the services you received
    - - the doctor who treated you was knowledgeable and good — Yes/Somewhat/No
    - - the nursing care is caring and efficient — Yes/Somewhat/No
    - - the staff in general are courteous and helpful — Yes/Somewhat/No
    - - were you overall satisfied with the care given — Yes/Somewhat/No

19. Give your impression of ward amenities
    - - general cleanliness is good — Yes/Somewhat/No
    - - toilets and water supply are satisfactory — Yes/Somewhat/No
    - - fans and lights worked well — Yes/Somewhat/No

20. Did you take diet from the hospital
    - - Yes
    - - No

21. If Yes, was it satisfactory — Yes/Somewhat/No

22. Did a chaplain visit you while you were admitted
    - Yes
    - No

23. If Yes, was his visit helpful — Yes/Somewhat/No

24. Please tell us your opinion of the following
    - The hospital is meant mainly for those who can pay — Yes/Somewhat/No
    - The hospital serves the poor sections of the population even if they cannot pay for services — Yes/Somewhat/No
    - The hospital & its staff care for all patients with love and care — Yes/Somewhat/No
    - The religious sentiments of all patients are respected — Yes/Somewhat/No

25. What is your opinion of the cost of
    - Room bed charges — Too low/Correct/Too high
    - Investigations — Too low/Correct/Too high
    - Doctors fees (if any) — Too low/Correct/Too high
    - Surgery/procedure charges — Too low/Correct/Too high
    - Medicines — Too low/Correct/Too high

26. Name 3 things in the hospital you appreciate most
    -
    -
    -

27. Name 3 things in the hospital that need improvement most
    -
    -
    -

28. You must be aware that St. Martha's Hospital tries not to refuse treatment to any patient, no matter how poor. Can you suggest how the hospital can raise funds to treat more poor patients

29. Any other suggestions or comments

EVALUATION OF ST. MARTHA'S HOSPITAL

AREAS ASSIGNED : NURSING SERVICE DEPT. & SCHOOL OF NURSING

Sample : *Nursing Service Dept* - * Ward in Charges (WI/C)
* Staff Nurses (S/N)

School of Nursing - * Faculty (F)
* Student nurses (St/N)

Description of the Sample:

Ward in Charges : There were totally 19 Ward in Charges in the hospital. All of them were included in the evaluation. All (100%) were lay persons. The mean duration of years of service was 10.4 years (n = 13), with a range of 1&1/2 years to 32 years. As six of them did not respond to the duration of their service in the institution , they hence were not included for computation of the mean duration of service. All (100%) had done the General Nursing Course , and only 2 (10.5%) had some additional qualification out of whom one had done a course on Administration .Twelve (63.2%) of them had there training from St. Martha's School of Nursing . One (5.3%) had completed her course as early as in the 1950s , 4(21.0%) in the 1960s , 5(26.3%) in the 1970s , 6(31.5%) in the 1980s and 2(10.5%) in the 1990s . Most 15 (78.9%) had In Service Education after having joined St. Martha's hospital .

Staff Nurses: The staff nurses were sampled from the total list of all categories , using the simple random sampling technique . Hence a total of 50 staff were selected ,of which 47 were accepted for analysis. Most of them were junior staff 37 (78.7%) , with just two or three years of service and 10 (21.3%) were interns with less than a year's service . Only 3 (6.4%) were religious and the rest 44 (93.6%) were lay persons . Most 31(66.0%) of the staff were alumnae of St. Martha's School of Nursing ,while 16 (34.0%) were from other institutions, of which 7 (43.7 %) were from institutions within Bangalore city itself and the rest from out of Karnataka state . The mean duration of service for the staff was 2.09 years with a range of 2 months to 10 years. Only 3 (4.3%) had not received any in-service education after having joined the institution . Majority 45 (95.7%) had done there G.N.M. course , 2 (4.3%) had done their Basic B.Sc.

Faculty : The total number of faculty in the School of Nursing were 15 . All were taken for the evaluation . Ten (66.6%) were tutors , 3 (20.0%) were clinical instructors and 2 (13.3$%) were senior tutors . Only 1(6.7%) was a religious while the rest ,14 (93.3%) were lay persons . The mean duration of years of service was 3.87 years with a range of 10 months to 16 years . Most 10 (66.6%) had a basic B.Sc. qualification , 4 (26.6%) had done their P.C.BSc. and 1(6.7%) had done her General Nursing after which she had done her Diploma in Nursing Education .Eleven (73.3%) had their nursing training in Karnataka of which 9 (81.1%) were trained within Bangalore itself . Eleven (73.3%) had inservice education after joining the institution .

Student Nurses : The students were selected from the 2nd , 3rd and the 4th year , although those in their 4th year have completed their training in the institution they were selected in the category of

students since they considered to be under the School of Nursing . The 1st year students were not selected since it was assumed that it would be too early to get a valid opinion from them . The students were selected through simple random technique , and comprised a total number of 45 , (i.e. 15 per batch . Only 4 (8 8%) were religious and the rest were laypersons . Most 42 (93.3%) were Christians while 3 (6.6%) were Non Christians .

Methodology :

The evaluation of these assigned areas was performed primarily from information provided by the selected sample through a questionnaire . The questionnaires were prepared based on the selected functions of the hospital or the School of Nursing , the individual functions of each category , their expectations and suggestions . All the members of the review committee had accepted the format proposed and a copy of the questionnaires for each category is attached .

Results :

1 *Awareness of Nursing Personnel in relation to ---*

	W/S	S/N	F	St/N
a . Vision of the hospital :	19(100.0%)	32(68.7%)	14(93.3%)	42(93.3%)
b . Philosophy :	18(94.7%)	32(68.7%)	15(100.0%)	----
c . Objectives / Goals :	19(100.0%)	37(78.7%)	15(100.0%)	----
d . Policy regarding				
work :	19(100.0%)	44(78.7%)	15(100.0%)	----
benefits :	16(84.2%)	35(74.5%)	15(100.0%)	----
promotion :	17(89.5%)	34(72.3%)	15(100.0%)	----
recruitment :	16(84.2%)	41(87.2%)	12(80.0%)	----
student selection :	15(78.9%)	43(91.5%)	14(93.3%)	----
discipline :	16(84.2%)	43(91.5%)	14(93.3%)	----
e . Welfare Facilities :	14(73.7%)	26(55.3%)	11(73.3%)	----
f . Workers Union :	15(78.9%)	15(31.9%)	8(53.3%)	----
g . Performance Appraisal :	17(89.5%)	21(44.7%)	9(60.0%)	----

It is obvious from the above data that most (more than 75%) of the nursing personnel from all categories were aware of the objectives and goals of the institution ; of the policies regarding work , benefits recruitment of staff , selection of students and disciplinary action . Among the three categories of nursing personnel the staff nurses seemed least aware of the philosophy of the institution , welfare facilities workers union and performance appraisal . The only question that student nurses were asked was in relation to their awareness of the vision and mission of the hospital . Majority (90% & >) said they were aware of the vision .

2. ***Extent to which the objectives / goals /functions of the hospital are met presently*** :

The ward in charges , staff nurses and the faculty were given a list of statements pertaining to the above mentioned aspects They were asked to rate each of the statements on a 5 -point scale according to the extent to which they believed these aspects were presently fulfilled and also to the extent to which they thought these aspects should be fulfilled However most of them did not answer to the latter part

The results of the extent to which the above aspects are met are presented in percentages .

		5	4	3	2	1
1 Service given to the sick irrespective of any factor	(W/S)	17(89 5)	2(10.5)	---	---	---
	(S/N)	23(48.9)	18(38.2)	4(8.5)	1(2.1)	1(2.1)
	(F)	10(66.7)	3(20.0)	2(13.3)	---	---
2. Quality care affordable to the common man						
	(W/S)	12(63.2)	5(26.3)	2(10.5)	---	---
	(S/N)	17(29.8)	14(29.8)	15(31.9)	1(2.1)	3(6.3)
	(F)	3(20.0)	6(40.0)	6(40.0)	---	---
3. Main beneficiaries - women / children						
	(W/S)	8(42.1)	4(21.0)	5(31.6)	1(5.3)	---
	(S/N)	7(15.0)	10(21.3)	15(31.6)	10(21.3)	5(10.7)
	(F)	---	3(20.0)	8(53.3)	3(20.0)	1(6.7)
4. Provides cost effective competent care						
	(W/S)	8(42.1)	7(36.8)	2(10.5)	2(10.5)	---
	(S/N)	3(6.3)	4(8.5)	17(36.2)	11(23.4)	12(25.5)
	(F)	1(6.7)	4(26.7)	8(53.3)	2(13.3)	---
5. Fosters dedication and ethical values						
	(W/S)	14(73.7)	4(21.0)	1(5.3)	---	---
	(S/N)	13(27.7)	17(36.2)	6(12.8)	6(12.8)	6(12.8)
	(F)	6(40.0)	7(46.6)	1(6.7)	---	1(6.7)
6. Enhances skills through CE programs						
	(W/S)	4(21.0)	7(36.8)	6(31.6)	2(10.5)	---
	(S/N)	7(14.9)	12(25.5)	17(36.2)	10(21.3)	1(2.1)
	(F)	1(6.7)	6(40.0)	7(46.6)	---	1(6.7)
7. Fosters a desire to serve the poor						
	(W/S)	11(57.9)	7(6.8)	1(5.3)	---	---
	(S/N)	14(29.8)	16(34.0)	13(27.7)	3(6.4)	1(2.1)
	(F)	6(40.0)	4(26.7)	5(33.3)	---	---
8. Builds social awareness among its staff						
	(W /S)	3(15.8)	9(47.4)	5(26.3)	1(10.5)	---
	(S/N)	6(12.8)	17(36.2)	18(38.3)	3(8.5)	1(4.2)
	(F)	---	2(4.3)	10(66.7)	4(26.7)	---

9. Meets spiritual needs of all patients					
(W/S)	17(63.1)	5(26.3)	2(10.5)	---	---
(S/N)	23(48.9)	16(34.0)	7(14.9)	1(2.1)	---
(F)	6(40.0)	5(33.3)	2(13.3)	2(13.3)	---
10. Provides care at subsidised cost to those in need					
(W/S)	15(73.7)	2(10.5)	2(15.8)	---	---
(S/N)	11(23.4)	23(48.9)	12(25.5)	2(2.1)	---
(F)	6(40.0)	5(33.3)	4(6.7)	---	1(6.7)
11. Develops community centres for those in need					
(W/S)	14(73.7)	5(21.0)	---	1(5.3)	---
(S/N)	14(29.8)	14(29.8)	14(29.8)	4(8.5)	1(2.1)
(F)	5(33.3)	4 (26.7)	6(40.0)	---	---
12. Expands depts. & education programs as per need					
(W/S)	12(63.2)	4(21.0)	3(15.8)	---	---
(S/N)	3(6.4)	12(25.5)	19(40.4)	9(19.1)	4(8.5)
(F)	---	6(40.0)	8(53.3)	1(6.7)	---
13. Attempts to improve quality of care					
(W/S)	14(73.7)	5(26.3)	---	---	---
(S/N)	16(34.0)	22(46.8)	8(17.0)	1(2.1)	---
(F)	2(13.3)	10(66.7)	2(13.3)	1(6.7)	---
14. Creates cleanliness awareness in public					
(W/S)	13(68.4)	4(21.0)	2(10.5)	---	---
(S/N)	28(59.5)	14(29.8)	2(4.3)	3(6.4)	---
(F)	5(33.3)	9(60.0)	1(6.7)	---	---
15. Serves as a model of efficient health care					
(W/S)	14(78.9)	4(21.0)	---	---	---
(S/N)	22(46.8)	20(42.6)	3(6.4)	---	2(4.2)
(F)	5(33.3)	7(46.7)	3(20.0)	---	---
16. Fosters respect for life in all its staff					
(W/S)	15(78.9)	4(21.0)	---	---	---
(S/ N)	14(29.8)	25(53.2)	6(12.8)	2(4.3)	---
(F)	5(33.3)	6(40.0)	2(13.3)	---	2(13.3)
17. Fosters a team spirit and family atmosphere					
(W/S)	14(73.7)	5(26.3)	1(5.3)	---	---
(S/N)	11(23.4)	19(40.4)	10 (21.2)	4(8.5)	3(6.4)
(F)	5(46.7)	4(26.7)	4 (26.7)	---	---
18. Has reasonable rules and regulations					
(W/S)	11(57.9)	7(36.8)	1(5.3)	---	---
(S/N)	12(25.5)	19(40.4)	11(23.4)	4(8.5)	1(2.1)
(F)	3(20.0)	5(33.3)	7(46.7)	---	---
19. Shows concern for its staff's welfare					
(W/S)	13(68.4)	3(15.8)	3(15.8)	---	---
(S/N)	5(10.6)	19(40.4)	16(34.0)	5(10.6)	2(4.3)
(F)	4(26.7)	8(53.3)	3(20.0)	---	---

It is obvious that most (80% & >)of the ward in charges believed / were of the opinion that the objectives / goals / functions of the hospital are met presently. They(36.8%) however felt that women / children were not the main beneficiaries and social awareness wasn't built amongst the staff. Only 57.8% felt that CE programs were planned to enhance the skill of the employees.

Most(80% & >) of the staff nurses felt that service was provided to the sick irrespective to any factor , the spiritual needs of the patients were met , that attempts were made to improve the quality of care always , to serve as a model for efficient health care , and create an awareness of cleanliness in the public.

The faculty(80% & >) also felt that the service was provided to all irrespective of any factor , a sense of dedication and ethical values was fostered , an awareness of cleanliness in the public was built , that the hospital served as a model of efficient health care.

The aspects that possibly need to be reviewed by the management are obviously in relation to the following objectives / goals :

- Who are its main beneficiaries ?
- What is the role of CE_ programmes in enhancing the skill of the staff and thus the quality of care?
- Should the hospital build a social awareness amongst its staff?
- Is the institution responsible for providing community health centres, expanding departments and educational programmes as per the need?
- Should there be concern for the welfare of the staff ?
- Does the hospital employees and the management really strive to provide high quality care at a rate affordable to the common man ?
- Is there any effort made to ensure that comprehensive and cost effective care is provided ?
- Are the rules and regulations fair for and reasonable to all the employees ?

3. The extent to which the Nursing personnel from the Nursing Service were able to perform certain tasks :

The ward in charges and the staff nurses were given an additional five statements relating to their functions or tasks. They were asked to rate these statements on a 5-point scale depending on their ability to perform the said functions. The results are presented below in percentages. They were also asked to comment if they were unable to perform these functions to the best of their abilities. The reasons provided are also summarised below this data.

		5	4	3	2	1
1.	Provides care to all irrespective of caste /creed /social status.					
	(W/S)	17 (89.5)	2(10.5)	---	---	---
	(S/N)	37 (78.7)	6(12.8)	4(8.5)	---	---
2.	Provides best possible care at all times					
	(W/S)	7 (36.8)	7(36.8)	4(21.0)	---	1(5.3)
	(S/N)	4 (8.5)	26(53.3)	15(31.9)	2(4.3)	---
3.	Upholds moral & ethical values					
	(W/S)	15 (78.9)	4(21.0)	---	---	---
	(S/N)	27 (57.4)	17(36.2)	2(4.3)	1(2.1)	---
4.	Meets spiritual needs of all patients					
	(W/S)	11 (57.9)	6(31.6)	1(5.3)	---	1(5.3)
	(S/N)	28 (59.6)	11(23.4)	5(10.6)	2(4.3)	1(2.1)
5.	Participates in activities to improve self					
	(W/S)	10 (52.6)	4(21.0)	2(10.5)	3(15.3)	---
	(S/N)	20 (42.6)	14(29.8)	7(14.9)	6(12.7)	---

Majority of the Ward Sisters and Staff Nurses said that due to lack of sufficient staff and overload in their work , they were unable to provide the best possible care to all patients. In relation to the ability to uphold their moral and ethical values, only the staff nurses responded that they were unable to do so at all times due to misunderstanding with their co-workers. None of them gave any reasons regarding their ability to meet the spiritual needs of the patients and their participation in activities which would enhance their skills and professional abilities.

Points to be considered from this data which is available :

- Is there a definite lack of staff ?
- Is the environmental climate of the staff conducive for upholding ones ethical & moral values ?
- Should the management look into the cultural activities of the staff?

4 ***Positive aspects of St. Martha's Hospital and School of Nursing***

The Ward in charges , staff nurses and the faculty were asked to give THREE positive aspects of the institution . These aspects were scrutinised and are categorised under headings such as

* Objectives * Administration * Satisfaction with the working environment.

	W / S n = 19	S / N n = 47	Faculty n = 15
(i) ***Objectives :***			
a) Helping the poor & neglected	7 (36.8)	41 (87.2)	2(13.3)
b) Care for all irrespective of caste	4 (21.0)	5 (10.6)	4(26.7)
c) Respect for life & spiritual care	4 (21.0)	11 (23.4)	3(20.0)
d) Giving work opportunities for the poor	2 (10.5)	---	---
e) Low cost & high quality care	---	11 (23.4)	3(20.0)
f) Spiritual care	1(5.3)	7 (14.8)	---
(ii) ***Administration :***			
a) Administrators are approachable	5 (26.3)	---	---
b) Good Supervision	1 (5.3)	---	---
c) Good Management	---	16 (34.0)	3(20.0)
d) Good co-ordination between nursing service & education	---	---	1(6.7)
e) Conducting Continuing Education programs	---	---	1(6.7)
(iii) ***Satisfaction with the Working Environment :***			
a) Care provided is appreciated	8 (42.1)	38 (80.9)	---
b) Family and friendly atmosphere	7 (36.8)	2 (4.3)	10(66.7)
c) Safety	6 (31.6)	---	---
d) Hygienic working environment	3 (15.8)	9 (19.1)	6(40.0)
e) Welfare of Staff considered	1 (5.3)	2 (4.3)	---
f) Freedom to work	---	---	2(13.3)
g) Rules & Regulations are fair	---	3 (6.4)	---
h) Dedicated staff	1 (5.3)	1 (2.1)	---

5. Negative aspects of the Institution :

The nursing personnel were asked to give THREE negative aspects of the institution . the comments were then categorised under specific headings such as : *Communication , * staffing and * administrative aspects .

	W/S n=19	S/N n=47	F n=15
i) *Communication :*			
a) Rules very rigid for ICUs	---	2(4.3)	2(10.6)
b) Inter departmental communication is poor	---	3(6.4)	2(10.6)
c) Enquiry is not satisfactory	2(10.5)	---	7(46.7)
d) Nonavailability of 24 hrs STD booth	1(5.3)	1(2.1)	1(5.3)
e) Communication gap	---	1(2.1)	2(10.6)
ii) *Staffing Problems :*			
a) Lack of supervision	3(15.8)	1(2.1)	4(26.6)
b) Indiscipline of security /class iv workers	---	4(8.7)	5(33.3)
c) Night duty for one month	---	11(23.0)	1(5.3)
d) Lack of promotional avenues	3(15.8)	---	---
e) Lack of concern for all staff	---	1(2.1)	2(10.6)
f) Lack of adequate staff	3(15.8)	34 (74.4)	---
g) Inadequate pay	9(47.4)	20 (43.0)	---
h) Health of staff not considered	---	3 (6.3)	---
i) Continuing education not planned regularly	3(15.8)	---	3(15.9)
iii) Administrative Aspects :			
a) Lack of an isolation ward	---	2(4.3)	---
b) Need for a waiting area for relatives	1(5.3)	1(2.1)	---
c) Salary is not adequate for the cost of living in the city	9(47.4)	9(17.1)	---
d) Equipment and articles inadequate	3(15.8)	3(6.4)	1(5.3)
e) Repair work and maintenance slow	4(21.0)	1(2.1)	---
f) Repairs allotted to outside agencies	---	1(2.1)	---
g) Lack of promotional opportunities	3(15.8)	2(4.3)	---
h) Cash counter not available for 24 hrs	---	2(4.3)	---
i) Lack of pharmacy & lab. for 24 hrs.	---	16(34.4)	---

6 ***Suggestions for improvement:*** The nursing personnel were asked to give THREE suggestions which they felt would help in the functioning of the hospital and the School of Nursing . After scrutinising the points given by the nursing personnel the points were categorised under headings such as : Administrative , Equipment and facilities , Staff welfare . Three ward in charges and faculty did not give any suggestions . All the staff nurses gave suggestions.

	W/S	S/N	F
i) ***Administrative***			
a) Supervision of staff nurses to improve	2(10.5)	2(4.3)	2(12.3)
b) Night supervision essential	1(5.3)	1(2.1)	1(6.7)
c) Appreciation of work done	1(5.3)	---	---
d) Maintenance dept. to improve	1(5.3)	1(2.1)	---
e) Clerks in the ward for clerical work to increase staff time with patient	---	---	1(6.7)
f) Communication between service and education	---	---	2(12.3)
g) Increase the number of staff	4(21.0)	15(32.0)	1(6.7)
h) Ambulance availability for transport of dead	---	2(4.3)	---
i) 24 hr lab and pharmacy services	---	15(32.0)	---
j) Atleast one relative to be allowed with an ICU patient	---	---	1(6.7)
ii)Need for more Facilities and Equipment			
a) Separate OT for Obstetrics	1(5.3)	---	---
b) Ventilators for new-borns and children to avoid referrals	1(5.3)	1(2.1)	---
c) More advanced technology	3(15.8)	15(32.0)	5(33.3)
d) Need for a geriatric ward	---	---	1(5.3)
e) Need for an isolation ward	---	4(8.7)	1(5.3)
f) Waiting room for relatives	1(5.3)	19(40.4)	---
g) Ambulance with emergency facilities	---	10(20.6)	---
h) Security to be trained to be courteous to all .	---	10(20.6)	---
iii) ***Staff Welfare:***			
a) Need for CE programs regularly	3(15.8)	---	3(10.9)
b) Staff health services to be improved	---	7(14.8)	---
c) Leave to be granted in emergencies	---	4(8.7)	---

NURSING STUDENTS (N= 45 ; 15/ Batch of 2nd , 3rd & 4th year)

The nursing students were selected from the 2nd and 3rd year on a random basis. Those who had completed their training and who in this institution are considered to be in their 4th year were also selected randomly using the table of random numbers. The 1st years were excluded from the evaluation since the committee felt that it would be too early to be able to get a valid opinion from them. These students were given a set of four statements relating to the encouragement they receive from various individuals ; facilities available ; facilities for their social development and characteristics of the faculty. Each of these statements had several items under them. The students had to rate each of these statements on a 5 - point scale reflecting the level of their satisfaction on each of the aspects. This tool was prepared based on a study conducted by

	1	2	3	4	5
1. Encouragement received from :					
home	0(---)	0(--)	0(--)	4(8.8)	41(91.1)
teachers	1(2.2)	0(--)	6(13.3)	14(31.1)	24(53.3)
staff	1(2.2)	8(17.7)	12(26.7)	20(44.4)	4(8.8)
warden	1(2.2)	4(8.8)	10(22.2)	19(42.2)	11(24.4)

It is obvious that the students are satisfied with the encouragement they receive from their parents , teachers and the warden to do well in their studies. The staff however do not seem to play a major role encouraging their juniors to perform well in their studies.

2. Facilities available :					
classroom (n=44)	0(---)	1(2.2)	5(11.1)	15(33.3)	23(51.1)
chapel (n=44)	0(---)	0(--)	0(--)	10(22.7)	34(77.3)
canteen (n=44)	6(13.6)	7(15.9)	11(25.0)	15(34.1)	5(11.4)
hospital services (n=45)	2(4.4)	4(8.8)	14(31.1)	14(31.1)	11(24.4)
hostel (n=45)	1(2.2)	3(6.6)	8(17.7)	17(37.8)	16(35.6)
library (n=45)	0(---)	2(4.4)	5(11.1)	14(31.1)	24(53.3)
mess (n=44)	5(11.1)	11(25.0)	12(27.3)	13(18.2)	3(6.8)
recreation (n=45)	3(6.6)	6(13.3)	10(22.2)	15(33.3)	11(24.4)
sick room (n=45)	6(13.3)	6(13.3)	14(31.1)	15(33.3)	4(8.8)

Most of the students again seem satisfied with their classroom , chapel , hostel , library facilities. They seem most dissatisfied in relation to canteen , mess , and sickroom facilities . They appear to be moderately satisfied with the hospital services and recreation facilities .

3 Activities required for their social development

interaction with faculty	1(2.2)	6(13.3)	14(31.1)	14(31.1)	10(22.2)
interaction with peers & seniors	1(2.2)	2(4.4)	12(26.7)	17(37.8)	13(28.9)
campus activities(n=44)	0(---)	3(6.8)	8(18.2)	26(59.0)	7(15.9)
SNA activities	1(2.2)	0(--)	6(13.3)	17(37.8)	21(46.7)
CNGI activities (n=44)	1(2.2)	5(11.3)	17(38.6)	11(25.0)	10(22.7)
sports activities	1(2.2)	2(4.4)	4(8.8)	26(57.8)	12(26.7)

The only area were the students appear to be quite satisfied is in relation to the SNA activities . The rest of the activities relating to their social development would have to be scrutinised more deeply for the overall development of the students

4. Characteristics of their faculty

shows genuine interest	1(2.2)	3(6.7)	8(17.6)	16(35.5)	17(37.8)
shows respect	1(2.2)	4(8.8)	15(33.3)	16(35.6)	9(20.0)
is available	1(2.2)	2(4.4)	8(17.8)	18(40.0)	15(33.3)
disciplines fairly (n=44)	0(---)	0(--)	6(13.6)	19(43.1)	19(43.1)
supervision good (n=44)	0(---)	0(--)	6(13.6)	16(36.4)	22(50.0)
firm yet concerned (n=44)	0(---)	1(2.3)	10(22.7)	17(38.6)	16(36.3)
fair in dealings (n=44)	1(2.3)	5(11.4)	11(25.0)	18(40.9)	9(20.5)
competent (n=44)	0(---)	4(9.0)	14(31.8)	15(34.1)	11(25.0)
evaluation fair (n=44)	1(2.3)	4(9.0)	13(29.6)	20(45.5)	6(13.6)
shows moral values in dealings (n=44)	1(2.3)	4(9.0)	9(20.5)	17(38.6)	13(29.5)
has good personal skills (n=44)	0(---)	3(6.8)	10(22.7)	16(36.3)	15(34.0)

In relation to the characteristics of the faculty the students again appear to be satisfied with most aspects except in relation to their ability to show genuine interest in the welfare of the student, being fair in their dealing with student , being competent in various teaching methodologies and being fair in their evaluation methods

The students were also given a set of questions relating to the goals and functions of the institution. They were expected to either answer 'yes' or 'no' to the questions. No clarifications were made in relation to their answers.

		YES	NO
1.	Knows vision and mission	42 (93.3)	3 (6.3)
2.	Feels part of the hospital	45 (100.0)	0 (--)
3.	Opportunities for spiritual growth	43 (95.6)	2 (4.4)
4.	Availability of guidance & counselling	29 (64.4)	16 (35.6)
5.	Remain as staff in the same hospital	34 (75.6)	11 (24.4)
6.	Stress on care of poor during training	37 (82.2)	8 (17.8)

It is evident from the above findings that majority (more than 80.0%) of the students who were selected to participate in the evaluation were aware of the vision of the hospital , felt a part of the hospital , felt that there were opportunities for their spiritual growth and that a stress on the care of the poor was made during their training. The need for personnel trained in guidance and counselling was evident in that atleast 36% of the students responded that this was not available . The fact that at least 76% of the students responded that they would like to remain as staff in the hospital is credible .

Points to possibly review :

- Encouragement to be given to the students by the staff and the warden , to perform well in their studies
- Canteen and mess facilities may have to be improved
- Hospital services for the students seem to be inadequate
- Recreational facilities for the students could be increased
- Interaction with the faculty / seniors at informal settings
- C.N.G.I. activities could help foster their spiritual development. It could also help to improve their interaction with other students
- Faculty characteristics such as ability to have respect for the students, to be firm yet concerned, to be fair and ethical in their dealings & to be skilful need to be enhanced.
- Availability of guidance and counselling for the students

GENERAL FUNCTIONS OF THE MANAGEMENT :

The ward in charges (W/S), faculty (F) and staff nurses (S/N) were also given a set of questions to which they had to respond 'Yes' or 'No' . These questions were relating to the general functions of the management . Here again they were neither asked to provide details or clarify their answer.

		Yes	No	N/A
1. Someone available to communicate problems	(W/S)	19 (100.0)	0 (--)	0 (--)
	(F)	14 (93.3)	1 (6.7)	0 (--)
	(S/N)	43 (91.5)	4 (8.5)	0 (--)
2. Complaints are heard	(W/S)	18 (94.7)	1 (5.3)	0 (--)
	(F)	13 (86.6)	1 (5.3)	1 (6.7)
	(S/N)	36 (77.0)	11 (23.0)	0 (--)
3. Feel part of a team	(W/S)	19 (100.0)	0 (--)	0 (--)
	(F)	14 (93.3)	0 (--)	1 (6.7)
	(S/N)	47 (100.0)	0 (--)	0 (--)
4. Knows the mission of the hospital	(W/S)	19 (100.0)	0 (--)	0 (--)
	(F)	15 (100.0)	0 (--)	0 (--)
	(S/N)	47 (100.0)	0 (--)	0 (--)
5. Promotional avenues available	(W/S)	9 (47.4)	10 (52.6)	0 (--)
	(F)	10 (66.7)	3 (20.6)	2 (13.7)
	(S/N)	30 (63.8)	17 (36.2)	0 (--)
6. Orientation received when joining institution	(W/S)	17 (89.4)	2 (10.5)	0 (--)
	(F)	14 (93.3)	1 (6.7)	0 (--)
	(S/N)	45 (95.7)	2 (4.3)	0 (--)
7. Feels appreciated	(W/S)	18 (94.7)	1 (5.3)	0 (--)
	(F)	14 (93.3)	1 (5.3)	0 (--)
	(S/N)	42 (89.4)	5 (10.6)	0 (--)
8. Feels policies/ rules are fair	(W/S)	18 (94.7)	1 (5.3)	0 (--)
	(F)	14 (93.3)	1 (5.3)	0 (--)
	(S/N)	42 (89.4)	5 (10.6)	0 (--)
9. Knows employee service rules	(W/S)	18 (94.7)	0 (--)	1 (5.3)
	(F)	15 (100.0)	0 (--)	0 (--)
	(S/N)	40 (85.1)	7 (14.9)	0 (--)

10. Opportunities to give suggestions	(W/S)	14 (73.7)	4 (21.0)	1 (5.3)
	(F)	13 (86.6)	2 (13.3)	0 (--)
	(S/N)	30 (63.8)	17(36.2)	0 (--)
11. Availability of personnel for guidance	(W/S)	19 (100.0)	0 (--)	0 (--)
	(F)	13 (86.6)	2 (13.3)	0 (--)
	(S/N)	22 (46.8)	25(53.2)	0 (--)
12. Work area comfortable and safe	(W/S)	17 (89.4)	2 (10.5)	0 (--)
	(F)	15 (100.0)	0 (--)	0 (--)
	(S/N)	45 (95.7)	2 (4.3)	0 (--)
13. New skill training received	(W/S)	12 (63.2)	7 (36.8)	0 (--)
	(F)	13 (86.6)	2 (13.3)	0 (--)
	(S/N)	40 (89.4)	7 (14.9)	0 (--)
14. Has a job description	(W/S)	17 (89.4)	2 (10.5)	0 (--)
	(F)	15 (100.0)	0 (--)	0 (--)
	(S/N)	44 (93.6)	3 (6.4)	0 (--)
15. Participates in special functions	(W/S)	9 (47.4)	10 (52.6)	0 (--)
	(F)	13 (86.6)	2 (13.3)	0 (--)
	(S/N)	35 (74.5)	12 (25.5)	0 (--)

In relation to the functions of the management majority of the nursing personnel (80% & >) were satisfied . The only aspects to be possibly looked into are as given below:

- Avenues for promotion
- Opportunities to give suggestions for improvement
- Need for in- service education programmes
- Participation in special functions

WARD IN CHARGES (N = 19)

The ward in charges were given 18 questions regarding their functions to which they had to either respond 'Yes' or 'No'. No clarification of their answers were sought .

	YES	NO	NA
1. Conducts regular meetings	11 (57.9)	6 (31.6)	2 (10.5)
2. Has good communication with management	17 (89.4)	1 (5.3)	1 (5.3)
3. Involved with plan of annual budget	5 (26.3)	13 (68.4)	1 (5.3)
4. Involved in selection of staff	1 (5.3)	17 (89.4)	1 (5.3)
5. Informed of financial process	4 (21.0)	13 (68.4)	2 (10.5)
6. Evaluates staff performance	17 (89.4)	1 (5.3)	1 (5.3)
7. Dept. has written policies	11 (57.9)	7 (36.8)	1 (5.3)
8. Sets goals each year for dept.	9 (47.4)	9 (47.4)	1 (5.3)
9. Feels part of planning &decision-making	7 (36.8)	10 (52.6)	2 (10.5)
10. Knows vision & mission of hospital	18 (94.7)	0 (--)	1 (5.3)
11. Communicates above to staff	18 (94.7)	0 (--)	1 (5.3)
12. Orients new employees	17 (89.4)	1 (5.3)	1 (5.3)
13. Provides ISE or on- the- job training	12 (63.2)	6 (31.6)	1 (5.3)
14. Attended CE- program on management	12 (63.2)	6 (31.6)	1 (5.3)
15. Written standards are there to guide work	11 (57.9)	7 (36.8)	1 (5.3)
16. Enough qualified staff available	14 (73.7)	4 (21.0)	1 (5.3)
17. All Staff have job description	15 (78.9)	2 (10.5)	2 (10.5)
18. Knows organisational plan	12 (63.2)	5 (26.3)	2 (10.5)

From the data available regarding the functioning of the ward in charges it is obvious that the following functions would have to be reinforced to them:

- The need to conduct regular meetings with their staff
- To have written policies and standards in the department
- To set goals each year for the department
- To see to their own and their staffs professional development by organising in-service education programmes and attending CE programmes

The management need to possibly get the ward in charges involved in the following aspects:

- Plan for the annual budget
- Selection of staff
- Financial process

- Ms. Mary Ann Charles,
School of Nursing,
St.John' Medical College,
Bangalore.

Ravi
Summary Analysis of the
doctors questionnaire
Ram
30/12

SURVEY OF DOCTORS

SUMMARY ANALYSIS

A survey of the opinion of full time doctors working for at least 1 year in St. Martha's Hospital was conducted. Of 67 staff who received the survey questionnaire, 41 responded.

Based on an analysis of the survey issues have been placed under one of three categories - 1. Issues that need urgent attention based on strongly negative assessment. 2. Issues of concern where a significant number of responses were negative. 3. Issues that seem satisfactory based on a generally positive response.

Responses were analysed from the questionnaire as follows:

1. Goals - the gap perceived by the respondent between the importance a goal should be given and is actually given by the hospital.
2. Hospital functioning - respondents scoring on a 5 point scale of various aspects of hospital functioning. A score of 3 or less was considered a negative response.
3. Comments and suggestions - The number of positive and negative responses by respondents in different areas.

It is strongly recommended that besides this summary the detailed evaluation report and especially individual comments and suggestions be studied for more complete and empathic understanding of the doctors' views.

I. Issues that need urgent attention.
   1. Inefficiency in health care delivery and planning
   2. Ignoring national priorities and programmes
   3. Resistance to ideas and innovation to improve quality of health care
   4. Failure to modernise equipment and technology
   5. Not motivating staff to work in a caring manner
   6. Not consulting concerned department heads when planning and budgeting
   7. Applying different rules and regulations for different people
   8. Lack of concern for welfare of staff
   9. Poor levels of salaries and remuneration.

II. Issues of concern

1. Should foster concern for respect for life among staff
2. Should emphasize health care of women and children
3. Should subsidize services for the poor
4. Should provide spiritual care to sick irrespective of their religious belief
5. Should foster moral and ethical integrity among staff
6. Should consider ways to generate additional income
7. Should encourage an atmosphere among doctors condusive to work
8. Should improve continuing education programmes.

III. Issues that seem satisfactory

1. Care provided to all irrespective of caste and creed
2. Providing low cost care
3. Cleanliness
4. Spirit of dedication
5. Past reputation

- Dr. Prem Pais,
Vice-Principal,
St. John's Medical College,
Bangalore.

EVALUATION BY DOCTORS

The evaluation instrument for doctors has 2 types of responses

a) **A scored response which is to evaluate**

i. Hospital goals - a list of goals has been specified. The respondent has been asked to grade them in a score of increasing importance from 1-5 in ascending order.
The respondent first grades the goals as he/she views them and secondly as he/she feels the hospital views them.

ii. Hospital functioning - a number of statements regarding hospital functioning have been given. The respondent has been asked to score them from 1 to 5 in ascending order of agreement.

b) **Open ended questions**.

The respondents have been given the opportunity to give open ended responses in the following areas:

- Hospital goals
- Major strenghths of the hospital
- Major weakness of the hospital
- Hospital rules
- Suggestions

Responses have been received from 41 of 67 full time medical staff

Analysis:
a)
Hospital Goals: Under each goal in part A of the questionnaire, the number (percentage) of respondents giving various scores are tabulated. Score have been grouped as lowest priority (1 or 2), highest priority (4 or 5) and intermediate priority (3). Responses have been scored in two rows - "should be" indicates the importance and respondent feels the stated goal should be given. "Is" gives the respondents perception of the importance the hospital gives the goal. In general a score of 3 or less will indicate a negative perception.

Hospital Functioning: Tabulation has been done in a manner similar to Hospital Goals. However in this section only the respondents perception of hospital functioning is called for. Once again a score of 3 or less will indicate a negative perception.

It may be noted that due to an error in cyclostyling the questionnaire the scoring system was not fully clarified. It is being assumed that the respondents have correctly understood the system.

HOSPITAL GOALS

1. The hospital should foster among all staff respect for human life from conception to its natural end.

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	-	(1 (2.4)	37(90.2)
Is	2(4.9)	2(4.9)	(13(31.7)	24(58.6)

2. Hospital should provide medical care to the public irrespective of caste, creed and social status.

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	_	-	38 (92.7)
Is	2(4.9)	_	7(17.1)	32 (78.1)

3. While providing high quality medical care the hospital should ensure use of appropriate, low cost yet effective care where ever possible.

	No response	1 or 2	3	4 or 5
Should be	3 (7.3)	-	-	38 (92.7)
Is	2 (4.9)	2(4.9)	7(17.1)	30 (73.1)

4. The hospital should serve as a model of efficient health care.

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	_	1(2.4)	37(90.2)
Is	2 (4.9)	7(17.1)	18(43.9)	14(34.2)

5. The hospital should treat all patients with human care and compassion .

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	_	_	38(92.7)
Is	2(4.9)	2(4.9)	11(26.8)	26(63.4)

6. The hospital should emphasize especially the health concerns of women and children.

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	_	3(4.9)	35(85.3)
Is	2(4.9)	1(2.4)	17(41.5)	21(51.2)

7. The hospital should subsidise services for the poor.

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	_	2(4.9)	36(87.8)
Is	2(4.9)	6(14.6)	12(29.3)	21(51.2)

8. The hospital should provide spiritual care to the sick respecting the individual's religious beliefs.

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	1(2.4)	6(14.6)	31(75.6)
Is	2(4.9)	10(24.4)	15(36.6)	14(34.1)

9. The hospital should serve as training institution where trainer doctors and nurses will learn to deliver competent health care ethically and compassionately.

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	_	_	38(92.7)
Is	2(4.9)	3(7.3)	12(29.3)	24(58.6)

10. The hospital should keep the national health priorities in mind when planning its services.

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	_	4(9.8)	34(82.9)
Is	2(4.9)	12(29.3)	15(36.6)	12(29.3)

11. The hospital should foster a sense of moral and ethical integrity among all its staff.

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	_	1(2.4)	37(90.2)
Is	2(4.9)	12(29.3)	10(24.4)	17(41.5)

Hospital functioning

1. The hospital constantly tries to improve quality of health care.

No response	1 or 2	3	4 or 5
_	4(9.8)	20(48.8)	17(41.4)

COM-IT-91-A

2. The hospital innovates to find means of reducing the cost of health care to make it more affordable.

No response	1 or 2	3	4 or 5
1(2.4)	11(26.8)	12(29.3)	17(41.4)

3. The hospital is kept clean.

No response	1 or 2	3	4 or 5
_	2(4.9)	4(9.8)	35(85.4)

4. The hospital functioning is such as to the efficient and reduce waste.

No response	1 or 2	3	4 or 5
_	4(9.7)	11(26.8)	26(63.4)

5. The hospital functioning is such as to provide prompt attention to patients.

No response	1 or 2	3	4 or 5
2(4.8)	4(9.8)	13(31.7)	22(53.6)

6. The hospital motivates all its staff to work in a caring and compassionate manner.

No response	1 or 2	3	4 or 5
_	8(19.5)	12(29.3)	21(41.2)

7. The hospital involves each department in preparing the department's budget.

No response	1 or 2	3	4 or 5
3(7.3)	12(29.2)	12(29.2)	14(34.1)

8. The hospital is concerned about ways to generate additional income.

No response	1 or 2	3	4 or 5
1(12.4)	10(24.4)	9(22.0)	21(51.2)

9. The hospital charges are reasonable compared to charges by other similar hospitals in the city.

No response	1 or 2	3	4 or 5
_	3(7.3)	9(22.0)	29(70.8)

10. The hospital has reasonable rules and regulations.

No response	1 or 2	3	4 or 5
7(17.1)	8(19.5)	9(22.0)	17(41.5)

11. The hospital is ready to accept innovations and new and better ways to do things.

No response	1 or 2	3	4 or 5
2(2.4)	16(39.1)	14(34.1)	10(24.4)

12. Relationship among staff is friendly and conducive to work

No response	1 or 2	3	4 or 5
1(2.4)	6(14.6)	10(24.4)	24(58.5)

13. The hospital shows concern for the staff and workers

No response	1 or 2	3	4 or 5
1(2.4)	12(29.3)	16(39.0)	12(29.3)

b) Open ended responses have great value as these may reflect opinions, emotions and feelings of respondents more accurately than scored responses. In view of this all responses have been reproduced below. They have been grouped under the five heads under which they were collected.

Under each head the responses pertaining to key areas have been grouped together. The number given against each statement is to identify the questionnaire from which is has been taken. Thus comments from the same questionnaire under different heads will all bear the same number.

It will be seen that generally respondents see the strength of the hospital in dedication of the sisters of the Good Shepherd, doctors and nurses and to the non-commercial nature of the hospital.

At same time a sense of frustration seems to come through the comments. The negative feelings lie mainly in the following areas:-

1. The hospital resists modernising and investing in newer technologies.
2. Poor salary structure for doctors. A repeated suggestion is to introduce an incentive scheme for private ward admissions and start special paying O.P. clinics.
3. "Unprofessional" management with inadequate communication with doctors. Doctors feel they are rarely consulted or made part of management decisions.
4. Different rules seem to apply for different people

OTHER GOALS / COMMENTS:

Questionnaire No.	Comments:
A. Issues related to modernising:	
3	Provide modern treatment at reasonable cost
6	Improve MICU
10	Get dialysis unit so that poor patients can benefit
11	Improve equipment in MICU and CCU
32	Keep up with technical advances
33	Should have basic infrastructure for investigations
36	Accept specialization as an integral part of health care
B. Issues related to treatment policies:	
6	Introduce sterilization proceedures but not MTP
7	Discourage alcoholic patients - do not give them concessions
15	- More stress on preventive medicine - Educate women about FP / immunisation - Create awareness about nutrition and diet - Adopt slum/village to create a model system
18	Introduce sterilization procedures as per National Family Planning Scheme.
22	Follow national family planning policies
23	Land was gifted to sisters to care for all sick people not only women and children
35	Should pursue national goals irrespective of religious beliefs.
37	Provide spiritual support for those whose loved ones die in hospital.
40	Improve maternal and child health facilities
C. Staff benefits:	
11	Provide transport to staff Provide benefits to staff dependants eg. Educational loan
33	Reward hard working staff

D. Management issues:

19	Junior doctors are not given respect
32	Improve staff discipline in certain departments
33	Have a good maintainance department
36	Modernise record keeping
40	Should be able to give a feeling of belonging to the staff
	Foster the old family spirit that St. Martha's was famous for.

E. Educational Matters:

9	Send Drs to other institutions for training
	- Encourage Drs to attend conferences and pay costs for this
18	Encourage Drs to develop specialised skills
32	Raise academic standards
36	Use company sponsorship for CME programmes for Drs, nurses and technical staff

F. Miscellaneous:

19	All religions should be equally respected

MAJOR STRENGTHS

Questionnaire No.	Comments

A. Dedication and Spirit of Service

1	Dedication of workers
3	Dedication of Drs and nurses
4	Dedication
5	Consistent commitment to the down trodden
6	Dedicated Drs and nurses
10	Dedicated compassionate service
11	Service to the poor
16	Commitment and dedication of sisters of the Good Shepherd
17	Sacrifice and Service
18	Dedication
19	Dedication
20	Missionary zeal
23	Strong faith
	Warmth kindness and concern

29	Dedication and hard work of staff
30	Good nursing care; dedicated Drs
31	Dedication of sisters, Drs, nursing staff
32	Sincerity and dedication
34	Showing compassion without consideration to cast or creed
36	Care and compassion of original IRISH nuns
39	Christian institution

B. Technical competence:

4	Competent staff - Efficiency
7	Good nursing care
12	Skilled doctors and competent nurses
26	Prompt service at admission time

C. Non commercial reputation:

6	No corruption
7	Subsidised service to the poor
13	Optimal care at reasonable cost
16	Not being overtly commercial
27	Cheap yet good care
33	Poor patients
39	Non profit organisation

D. Reputation past and present:

7	Following old rules and regulations
12	Past reputation
20	100 years experience
40	Past glory and dedication of people in the past

E. Others:

12	Location
36	Help from St. John's Medical College in 60s and 70s
37	Location and facilities available trainees & students eg. DNBE, nursing

MAJOR WEAKNESS

Questionnaire No. Comments

A. Doctors Remuneration and Financial aspects

2	No incentive scheme
4	Financial constraints
6	Low wages of doctors
7	Unaffordability of newer modes of therapy
13	Difficulty in getting competent doctors without incentive payment
15	Finances
18	Low morale among doctors
20	Economic factor
27	Lack of finances to upgrade
32	Frustration of staff because of low income
33	Monetary factors
35	Cost factors

B. Lack of modern technology:

5	Technology update is slow
10	Lack of equipment
12	Delay in accepting new technology
18	Inflexible to suggestions for developing, tertiary care facilities
19	No interest in upgrading hospital
29	Lack of initiative to upgrade facilities
31	Notion that "high tech" care detracts from care of poor people
32	Hospital has not kept up with other institutions technically

C. Administration & Management :

1	Inefficient administration
3	Unprofessional interference by authorities
5	No long terms vision
	- impersonal approach to staff
6	Rigid policies
11	Hierarchy
17	No long term plans
30	Absence of doctors in the administration
36	Lack of vision
	Poor interpersonal relations of present Indian nuns
	Active labour union
39	Large number of patients and less number of staff
40	Lack of vision
	Unprofessionalism of the management

D. Other factors:

12	Poor standard of private ward accommodation
13	Unrealistic expectation of patient s
22	Religious
26	Uncertain availability of 2nd level consultant - delay in getting specialist
29	Unhealthy competition
35	Religious factors
37	Some doctors and nurses are without commitment.

RULES AND REGULATIONS

Questionnaire No. Comments

A. Different rules for different people:

3	Different rules for different people
22	Favouritism
26	Rules vary with different departments and persons
30	Some get incentives, most dont
35	Disparity in rules depending on influence with administration
36	Different rules for different people - Visiting doctors allowed to earn more than in-house dedicated doctor

B. Impersonal and inefficient administration:

22	Administration is very poor Senior specialists not given respect
35	Unconcerned about doctors welfare Service expected even if doctors have to starve

C. Other issues:

5	Leave rules
12	Give incentives for doctors from private wards
15	Medical care should be free for all employees
35	Rules for doctors are unreasonable

SUGGESTIONS:

Questionnaire No.	Comments

A. Issues related to doctor's income :

2	Incentives for doctors
7	Provide adequate income for all staff
9	Increase pay scales & introduce incentive scheme
10	Increase pay of junior staff - introduce incentive scheme - start evening speciality pay clinics
11	Give staff better pay
12	Incentive from private wards
13	Impossible to get senior doctors with present pay find ways to pay reasonable salary to doctors and nurses
17	Private OP clinics
31	Allow incentives to improve employees income
35	Allow pay clinics; staff should be better paid
36	Not allowing incentives for admitted patients encourages doctors to go to nursing homes

B. Issues related to modernising the hospital

2	Improve equipment
5	Do not avoid technological growth
7	Open dialysis, neurosurgery a paediatric intensive care units - improve nursing care which has deteriorated of late - improve casualty facilities for tackling emergencies
9	CT scanner is a must
11	Better and more modern equipment
13	Give up fear of high tech. Equipment
16	Better equipment
17	CT scanner
19	Lab and ultrasound facilities round the clock CT, MRI, isotope scans
20	Replace old equipment with new
29	Ultrasound facilities should be available round the clock - Upgrade facilities including CT scanner
32	Buy new equipment and raise charges if necessary

33	Modernise; replace old equipment; computerise
34	Enhance standard of care of sick people
35	Facilities (technical) should be better

C. Issues related to administration and Management

3	Uniform rules, pay scales and promotional avenues for all staff - forum to hear and discuss staff grievances
5	Give doctors greater role in administration and policy making
8	Department / unit head should be given powers to give concession
9	Need to employee more SHOs and junior doctors
10	More flexibility with leave rules
11	Do not overwork staff
15	Categorise patients by economic status - create more special ward, ITU and graded care beds
16	More interaction between doctors and administration - consult doctors in matters of medicine, administration and police - better promotional avenues for doctors
17	Provide transport for staff using hospital vehicles/ BTS
22	Welfare of the staff should be looked after
23	Regular meetings between management and staff of each department for better exchange of ideas
26	Doctors to have more say in areas like admissions, transfers - Administration should work more quickly - More junior staff
32	Doctors or heads of departments should be given more power in the functioning of their department - improve private wards
33	Improve inter departmental relations - increase number of doctors and nurses
36	Too much "arm-chair" administration. Administrative staff should move out and see the problems of departments - sisters should be united. Their ego problems cause problems between departments
40	More fairness in dealing with staff - Less interference in medical matters by non medical people - management should show more care for the staff

D. Issues related to academic matters

4	Increase teaching programmes
5	Welcome commercial sponsorship of academic meeting
7	Improve library and get Medline services - start a clinical newsletter
36	Authorities have blinkers with respect to sponsorship of CME programmes

E. Other issues

7	Generate additional funds-philanthropies and increased OPD charges
34	Professionals and doctors should show more dedication
35	Goals should be based on national policies irrespective of religious beliefs

To :

Department :

St. Martha's Hospital Review – 1998

THE HEALTH COMMISSION SET UP BY THE PROVINCIAL CHAPTER OF THE GOOD SHEPHERD SISTERS, HAVE REQUESTED A TEAM OF RESOURCE PERSONS TO REVIEW THE HEALTH MINISTRY OF ST.MARTHA'S HOSPITAL THROUGH A PARTICIPATORY, INTERACTIVE AND REFLECTIVE PROCESS. AS PART OF THIS PROCESS, STAFF OF ST.MARTHA'S HOSPITAL AND A SAMPLE OF STUDENTS OF THE NURSING COLLEGE AND PATIENTS ARE BEING INVITED TO PARTICIPATE, BY FILLING IN SPECIAL QUESTIONNAIRES PREPARED BY THE REVIEW COMMITTEE. THESE WILL BE CIRCULATED / ADMINISTERED IN JULY 1998. APART FROM THE SPECIFIC QUESTIONS ASKED IN SPECIAL FORMAT, PLEASE FEEL FREE TO OFFER ANY OTHER SUGGESTIONS FOR CONSIDERATION BY THE REVIEW TEAM. YOUR PARTICIPATION IN THIS REVIEW IS CRUCIAL TO HELP US IDENTIFY THE FUTURE DIRECTIONS AND THRUSTS AND ALSO MEASURES TO MAKE THE HEALTH MINISTRY MORE MEANINGFUL. ALL YOUR RESPONSES AND SUGGESTIONS WILL BE CONFIDENTIAL. WE INVITE YOU TO JOIN US IN THE TASK AND MAKE THE REVIEW, A SUCCESS.

YOUR OPINION IS CRUCIAL

JOIN THE REVIEW

Dr. Ravi Narayan
Mr. Thomas Kandasami
Ms. Mary Ann Charles

Dr. Prem Pais
Dr.Rebekah naylor

15TH JULY 1998

S.M.H. BANGALORE

[All completed questionnaires must be returned to the **Medical / Nursing Superintendents** offices latest by 28th July 1998 and put in the box specifically provided for them]

Please detach this page from the proforma before submitting.

Questionnaire for Doctors

Part A

Hospital goals

Given below are a list of **objectives/goals** for an institution like St. Martha's Hospital. We would like you to indicate for each objective/goal, your impression on a) How important the objective/goal should be and enter your answer under the first column ("should be") and b) How much the hospital is fulfilling it at present. Enter this impression under the second column ("is"). For your answer choose a score ranging from 1 to 5 as shown below.

Score

1 2 3 4 5

Not important at all	**Of great importance**	**(For first column)**
or	**or**	
Not fulfilling it at all	**Fulfilling it completely**	**(For second column)**

	Should be	**Is**
1. The hospital should foster among all staff respect for human life from conception to its natural end		
2. Hospital should provide medical care to the public irrespective of caste, creed and social status.		
3. While providing high quality medical care the hospital should ensure use of appropriate, low cost yet effective care whenever possible		
4. The hospital should serve as a model of efficient health care.		
5. The hospital should treat all patients with human concern, compassion.		
6. The hospital should emphasise especially the health concerns of women and children		
7. The hospital should subsidise services for the poor.		
8. The hospital should provide spiritual care to the sick respecting the individuals religious beliefs		

	Should be	Is
9. The hospital should serve as a training institution where trainee doctors and nurses will learn to deliver competent health care ethically and compassionately		
10. The hospital should keep the national health priorities in mind when planning its services.		
11. The hospital should foster a sense of moral and ethical integrity among all its staff.		

12. Any other goals you think the hospital should / is pursuing

a) _____
_____
_____

b) _____
_____
_____

c) _____
_____
_____

13. What major factors have helped the hospital realise its goals ?

14. What major factors have hindered the hospital from realising its goals ?

Part B

Hospital Functioning:

Given below are different aspects of the **functioning** of St. Martha's Hospital. Please indicate against each to what extent you agree or disagree that the hospital follows these aspects. For your answer choose a score ranging 1 to 5 as shown below and enter it in the column ("Score")

Score:

1 2 3 4 5

Completely Disagree **Completely Agree**

Score

1. The hospital constantly tries to improve the quality of health care

2. The hospital innovates to find means of reducing the cost of health care to make it more affordable

3. The hospital is kept clean

4. The hospital functioning is such as to be efficient, and reduce waste.

5. The hospital functioning is such as to provide prompt attention to patients.

6. The hospital motivates all its staff to work in a caring and compassionate manner.

7. The hospital involves each department in preparing the departments budget

8. The hospital is concerned about ways to generate additional income

9. The hospital charges are reasonable compared to charges by other similar hospitals in the city

10. The hospital has reasonable rules and regulations
    If you score 1 or 2, specify unreasonable rules

    _____
    _____

Score

11. The hospital is ready to accept innovations and new and better ways to do things

12. Relationship among staff is friendly and conducive to work

13. The hospital shows concern for the staff and workers

14. Any suggestions to improve the functioning of the hospital

a) _____
_____
_____

b) _____
_____
_____

c) _____
_____
_____

Questionnaire for Doctors

Part C

QUESTIONNAIRE FOR ALL STAFF

For each item please circle Yes or No

1. Is there someone in the organization to whom you can communicate your problems ? Yes / No
2. Do you feel that your complaints or grievances are heard ? Yes / No
3. Do you feel a part of the health care team ? Yes / No
4. Do you know what is the mission of the hospital ? Yes / No
5. Do you have promotional avenues open to you ? Yes / No
6. Did you undergo orientation when you joined the hospital ? Yes / No
7. Do you feel appreciated in your work ? Yes / No
8. Do you think the rules and policies are fair ? Yes / No
9. Have you read and understood and Employee Service Rules ? Yes / No
10. Do you have opportunity to suggest ways that your department's work or function could improve ? Yes / No
11. If you have a personal or family problem, is there someone in the hospital who can guide or help you ? Yes / No
12. Is the area where you work comfortable and safe ? Yes / No
13. Since joining work, have you received any training or new skills ? Yes / No
14. Do you have a job description ? Yes / No
15. Do you participate in any special events or extra curricular activities in the hospital ? Yes / No

QUESTIONNAIRE FOR ASSISTANT ADMINISTRATOR

1. Please attach a list of supervisory and technical staff with their qualifications and experience.

2. Please attach a list of major equipments in these departments such as vehicles, generators, incinerators, etc.

3. Does the hospital provide ambulance service for patients to and from hospital ? Yes / No

4. Are ambulance equipped with life saving items such a s oxygen ? Yes / No

5. Is ambulance service available all 24 hours ? Yes / No

6. Does the transport department provide service for other departments such as purchase and administration ? Yes / No

7. Are there written procedures regarding :
   - maintenance of vehicles Yes / No
   - logging of trips Yes / No
   - accidents Yes / No

8. Are security services given over to a contractor ? Yes / No

9. Does the hospital maintain a security service ? Yes / No

10. Is there a procedure for investigation of security lapses or problems ? Yes / No

11. Do staff express any security concerns ? Yes / No

12. Is there adequate control of visitors in the patient care areas ? Yes / No

13. Are there written procedures regarding disposal of hazardous wastes, contaminated materials, tissues, food wastes ? Yes / No

14. Are legal requirements met regarding pollution control ? Yes / No

15. Does the hospital have one or more incinerators ? Yes / No

16. Is survey made of all areas at least annually to identify environmental hazards and unsafe practices ? Yes / No

17. Are essential services supported by generators during power outages ? Yes / No

18. Is there adequate planning to meet present and future needs for water and electricity ? Yes / No

19. Are measures enforced to conserve water and electricity ? Yes / No

20. Is there a preventive maintenance program for all hospital and biomedical equipments ? Yes / No

21. Is there timely response to complaints from departments regarding building and equipment maintenance ? Yes / No

22. Is there procedure for disposal of scrap materials ? Yes / No

23. Are there plans developed in case of disaster ? Yes / No

ATTACHMENT II B

QUESTIONNAIRE FOR PERSONNEL OFFICER

1. Please attach a list of staff in the Personnel department and their qualifications and experience.

2. What is the title of the person with responsibility for Personnel?

3. How many total employees are there ?

   Medical staff ----------
   Nursing staff ----------
   Clerical staff ----------
   Technicians ----------
   Others ----------

4. Is there a Policy Manual containing personnel policies ? Yes / No
   (Please enclose)

5. Does each department have a Head of the Department or Supervisor through which personnel administration is carried out ? Yes / No

6. Are there prescribed procedures for recruitment and selection of employees ? Yes / No

7. Does every employee receive an appointment letter and sign an appointment order ? Yes / No

8. Are all employee personnel files maintained in one place for the entire organization ? Yes / No

9. Are current health files kept on each employee ? Yes / No

10. Do all employees have job descriptions in a standardized form ? Yes / No

11. Are employee performance evaluations performed regularly ? Yes / No

12. Is there a written policy regarding promotions ? Yes / No

13. Is an exit interview conducted when an employee resigns ? Yes / No

14. Are employee records and files computerized ? Yes / No

15. Is payroll computerized ? Yes / No

16. Are salary scales revised at regular intervals ? Yes / No

17. Are salaries and compensation comparable to similar positions within the community ? Yes / No

18. Is there a formal orientation for new staff ? Yes / No

19. Is the Personnel Department responsible for enquiries and disciplinary procedures ? Yes / No

20. Are there prescribed cadre positions in each department ? Yes / No

21. Is there a superannuation or pension plan for all staff ? Yes / No

22. Is there a recognized union in the hospital ? Yes / No

23. Is there a Labour settlement in force at present ? Yes / No

24. Are medical staff and first level management staff subject to Employee Service Rules and Leave Rules as for other employees ? Yes / No

25. Is the Personnel Department responsible for staff welfare activities ? Yes / No

26. Does the hospital have a plan for human resource development at all levels ? Yes / No

27. Are programs in place to develop existing staff ? Yes / No

28. Are there "cross training" opportunities within the organization ? Yes / No

Questionnaire for Head of Departments (Ancillary)

1. How long have you been Head of the Department ?
2. Do you conduct regular meetings of employees whom you supervise ? Yes / No
3. Do you feel that there is good communication with management ? Yes / No
4. Are you involved in selection of staff for your department ? Yes / No
5. Are you involved in the annual budget process for your department ? Yes / No
6. Are you informed about the financial performance of your department ? Yes / No
7. Do you regularly evaluate the performance of the employees you supervise ? Yes / No
8. Do you know and understand the vision and mission of the hospital ? Yes / No
9. Do you communicate the vision and mission to your employees ? Yes / No
10. Does your department have written policies and procedures ? Yes / No
11. Do you set goals each year for your department ? Yes / No
12. Do you feel a part of planning and decision making in the organization? Yes / No
13. Do you orient new employees in your department ? Yes / No
14. Do you provide any inservice or on the job training for your employees ? Yes / No
15. Have you attended any seminar, program or course on management training ? Yes / No
16. Do you have written standards that guide the work of your department ? Yes / No
17. Do you have enough qualified staff to do the required work ? Yes / No
18. Do all of your employees have job description ? Yes / No
19. Do you know the organization plan or structure of the hospital ? Yes / No

Questionnaire for Staff (Ancillary Department)

1. Is there someone in the organization to whom you can communicate your problems ? Yes / No
2. Do you feel that your complaints or grievances are heard ? Yes / No
3. Do you feel a part of the health care team ? Yes / No
4. Do you know what is the mission of the hospital ? Yes / No
5. Do you have promotional avenues open to you ? Yes / No
6. Did you undergo orientation when you joined the hospital ? Yes / No
7. Do you feel appreciated in your work ? Yes / No
8. Do you think the rules and policies are fair ? Yes / No
9. Have you read and understood the Employee Service Rules ? Yes / No
10. Do you have opportunity to suggest ways that your department's work or function could improve ? Yes / No
11. If you have a personal or family problem, is there someone in the hospital who can guide or help you ? Yes / No
12. Is the area where you work comfortable and safe ? Yes / No
13. Since joining work, have you received any training or new skills ? Yes / No
14. Do you have a job description ? Yes / No
15. Do you participate in any special events or extra curricular activities in the hospital ? Yes / No

16. Any suggestions:

APPENDIX - II

PROVINCIAL DIRECTIVES

These can be modified by the

PROVINCIAL CHAPTER

OUR GOAL

Responding to the call of Jesus the Good Shepherd and experiencing the merciful love of the Father, we, the Contemplative and Active sisters modiate this love to all, in the Spirit of our Foundress.

We make real the incarnation of Christ in the India of today through an authentic religious life.

We share in the Church's mission of Evangelisation through our special ministry of reconciliation by praying for and working with girls and women deprived of hope and love and by responding to the crying needs of the poor, exploited and oppressed."

OUR THRUST

We work with the poor, exploited, oppressed and socially discriminated, especially girls and women in personnel, family and social difficulties, through institutionalised and non-institutionalised efforts in urban and rural areas.

OUR APOSTOLATE

In keeping with the Goal and Thrust of our province we set our priorities as follows:

Services to Children, girls and women through prevention, protection, rehabilitation and crisis intervention. We extend our services to commercial sex workers, twilight girls, persons with aids, working children (child labour) and domestic women workers.

PROGRAMS towards social change:

- faith formation

Non-formal education

- Conscientisation
- legal education
- community organisation
- pro-life programmes

study, research and publication

- pro-cana, net working
- ecological & environmental protection, gender and human rights issued,
- hospital chaplaincy/ pastoral care/ School counselling.

We make us of our existing institutions, land and property to meet the needs of our new ministries.

.....2

QUESTIONNAIRE FOR MEDICAL RECORDS DEPARTMENT HEAD

1. Please attach a list of Medical Records Officers and their qualification and experience .

2. Please attach a list of other staff positions in the departments.

3. Are inpatient and outpatient records maintained in the same department ? Yes / No

4. Is a medical record maintained for every patient treated or assessed ? Yes / No

5. Are any department functions computerized ? Yes / No

6. Is confidentiality, security, and integrity of information maintained ? Yes / No

7. Is there a policy regarding retention time of medical records ? Yes / No

8. Is there regular review of completeness of medical records with feedback to the concerned staff ? Yes / No

9. Are written operative reports included in the medical record of patients undergoing operative or other invasive procedures ? Yes / No

10. Is coding system used for inpatient diagnosis ? Yes / No

11. Is coding system used for outpatient diagnosis ? Yes / No

12. Is a discharge summary written for every patient admitted for 48 hours or more ? Yes / No

13. Are medicolegal charts kept separately and secured ? Yes / No

14. Is there a medical records committee ? Yes / No

QUESTIONNAIRE FOR HEAD OF PHARMACY

1. Please attach a list of staff and their qualifications.
2. What hours is the pharmacy open ?
3. Is there one central pharmacy ? Yes / No
4. Does the pharmacy serve both outpatient and inpatients ? Yes / No
5. Is the pharmacy located so that it is easily accessible ? Yes / No
6. Is pharmacy stores adjacent to the pharmacy ? Yes / No
7. Is a licensed pharmacist incharge of the stores ? Yes / No
8. Is the pharmacy license upto date ? Yes / No
9. Does the hospital have a Pharmacy and Therapeutic Committee ? Yes / No
10. Is there a hospital formulary or drug list available to all who prescribe and use drugs ? Yes / No
11. Is the pharmacy computerized ? Yes / No
12. Is the inventory in the pharmacy checked regularly ? Yes / No
13. Are emergency drugs in the patient care areas maintained by the pharmacist ? Yes / No
14. Are there written appropriate policies and procedures regarding prescribing and ordering practices ? Yes / No
15. Are any preparations manufactured by the pharmacy ? Yes / No
16. Is cost to the patient considered in the selection of drugs and brands ? Yes / No
17. Are inservice or continuing education programs conducted for staff ? Yes / No
18. Are books and journals available for staff ? Yes / No
19. Do drug representatives deal directly with the pharmacists ? Yes / No
20. Do you consider your space adequate ? Yes / No

QUESTIONNAIRE FOR HEAD OF X-RAY DEPARTMENT

1. Please attach a list of staff and their qualifications.
2. Please attach list of equipments and date of purchase.
3. Please attach list of procedures and X-rays available.
4. What hours are the services of the department available ?

5. Are there written procedures which are followed fro preparation of patients for special procedures ? Yes / No
6. Can emergency portable films be done in casualty and crucial care areas at all hours ? Yes / No
7. Are Quality Control procedures in place ? Yes / No
8. Are radiation protection procedures written and followed ? Yes / No
9. Are radiation badges worn by all staff ? Yes / No
10. Are inservice and continuing education programs available for staff ? Yes / No
11. Does the department have a recognized training program ? Yes / No
12. Is there an area for developing films in the operation theatre ? Yes / No
13. Are X-rays read and reported within 24 hours ? Yes / No
14. Do you consider space adequate ? Yes / No
15. Do you perform X-rays and procedures on patients referred from outside ? Yes / No

QUESTIONNAIRE FOR HEAD OF LABORATORY

1. Please attach a list of staff and their qualifications.

2. Please attach a list of equipment available and when purchased.

3. During what hours are laboratory services available ?

4. Are the following services provided ?

Haematology	Yes / No
Serology	Yes / No
Biochemistry	Yes / No
Microbiology	Yes / No
Histopathology	Yes / No
Cytology	Yes / No
Blood Gases	Yes / No

5. Does the hospital have a licensed blood bank ? Yes / No

6. Do you have an internal Quality Control Program ? Yes / No

7. Do you participate in an external Quality Control Program ? Yes / No

8. Do you use disposable needles and syringes ? Yes / No

9. Do you have written policies and procedures that address : (please enclose)

Specimen Collection	Yes / No
Specimen Preservation	Yes / No
Instrument Calibration	Yes / No
Quality Control & Remedial Action	Yes / No
Equipment Performance Evaluation	Yes / No
Test Performance	Yes / No
Disposable Needles & Syringes	Yes / No

10. Are there inservice and continuing education programs available for staff ? Yes / No

11. Does the laboratory have a recognized training program ? Yes / No

12. Do you consider your space adequate ? Yes / No

13. Are universal precautions followed by laboratory staff ? Yes / No

14. Do you have a licensed blood bank ? Yes / No

15. Do you perform tests for patients referred from outside ? Yes / No

QUESTIONNAIRE FOR HEAD OF PHYSIOTHERAPY

1. Please attach a list of staff and their qualifications.
2. Please attach a list of equipments and date of purchase.
3. What are the hours for the laboratory ?

4. Does the department serve inpatients and outpatients ? Yes / No
5. Is it easily accessible to the patients ? Yes / No
6. Do you consider the space adequate ? Yes / No
7. Do you also visit the wards to assess and treat patients ? Yes / No
8. Do you interact with medical and nursing staff to plan rehabilitation and treatment for the patient ? Yes / No
9. Do you make progress notes in the patient record ? Yes / No
10. Do all clinical units fully know and utilize the services of your department ? Yes / No
11. Are inservice and continuing education programs available for staff ? Yes / No
12. Does your department have a recognized training program ? Yes / No
13. Do you have written policies and procedures followed by the department ? Yes / No
14. Is an occupational therapist available in the department ? Yes / No
15. Does your department treat patients from outside not referred by the hospital ? Yes / No

QUESTIONNAIRE FOR HEAD OF PROSTHETIC AND ORTHOTIC CENTRE

1. Please attach a list of staff and their qualifications.
2. Please attach a list of equipments and date of purchase.
3. Please attach list of services and appliances provided.
4. Are goals set and treatment plans formulated for each patient ? Yes / No
5. Does the department receive patients referred from outside as well as St. Martha's patients ? Yes / No
6. Are funds or other resources available so that poor patients can be treated ? Yes / No
7. Do you consider your space to be adequate ? Yes / No
8. Does the Centre have a training program ? Yes / No
9. Do you have written policies or procedures fro your department ? Yes / No
   (Please enclose)

QUESTIONNAIRE FOR HEAD OF CSSD

1. Please attach a list of staff and their qualifications.
2. Please attach list of equipments and date of purchase.
3. What are the hours of the department ?
4. Does the department have written policies and procedures ? (Please enclose) Yes / No
5. Are Quality Control procedures followed ? Yes / No
6. Is there Infection Control surveillance in the department regularly ? Yes / No
7. Does the department serve all areas of the hospital including operation theatre ? Yes / No
8. Are inservice training programs available to staff ? Yes / No
9. Is the space adequate for the department ? Yes / No
10. Are there additional autoclaves in theatre or in other departments ? Yes / No

QUESTIONNAIRE FOR HEAD OF LAUNDRY

1. Please attach a list of all equipments in the laundry and date of purchase.

2. How many pieces or items are handled daily in the laundry ?

3. How may staff are employed in the laundry ?

4. What are the working hours of the laundry ?

5. Are there written policies and procedures which address :

Collection of linen	Yes / No
Disinfection of contaminated linen	Yes / No
Washing of linen	Yes / No
Equipment performance	Yes / No
Distribution of linen to patient care areas	Yes / No

6. Is there a central store for linen ? Yes / No

7. Is the supply of linen considered adequate in all patient areas ? Yes / No

8. Are universal precautions followed by staff in handling contaminated linen ? Yes / No

9. Is the rate of loss or damage of linen monitored ? Yes / No

10. Are there targets or standards set regarding rate of loss ? Yes / No

QUESTIONNAIRE FOR HEAD OF DIETARY DEPARTMENT

1. Please attach a list of staff and their qualifications.
2. At what hours is food service available ?

3. Is food service available to patients ?	Yes / No
4. Is food service available to staff and students ?	Yes / No
5. Is food service available to attenders and visitors ?	Yes / No
6. Does a Contractor provide part or all of the service ?	Yes / No
7. Are patients on therapeutic diets required to take food from the hospital ?	Yes / No
8. Is the kitchen regularly inspected regarding cleanliness ?	Yes / No
9. Do kitchen staff have health checkups ?	Yes / No
10. Do kitchen staff follow procedures for safe handling of food ?	Yes / No
11. Is there a Quality Control procedure or program fro therapeutic diets ?	Yes / No
12. Does a dietitian counsel and educate all inpatient department ?	Yes / No
13. Is diet counselling available in the outpatient department ?	Yes / No
14. Does the department have a recognized training program ?	Yes / No
15. Are inservice and continuing education programs available to the staff ?	Yes / No

QUESTIONNAIRE FOR CHAPLAINS

1. Please attach a list of staff and their qualifications.

2. Number of Christian staff or employees :
   Professional staff (medical & nursing) : ----------
   Administration : ----------
   Class III & IV : ----------

3. How many nuns or sisters of the order are working regularly in the hospital ?

4. How many services per week are conducted with ;
   Patients :
   Staff :
   Students :

5. How many visits or contacts are made with patients daily ?

6. In hiring or appointing employees, is preference or weightage given to Christian applicants ? Yes / No

7. Does the Chaplain have an adequate office where he can counsel patients or families ? Yes / No

8. Is there an adequate budget for the Chaplain's office ? Yes / No

9. Does the organization allow the Chaplain the freedom to minister and communicate the Christian faith ? Yes / No

10. Do hospital staff refer patients or families to you for help and counselling ? Yes / No

11. Do you pray with patients, especially in crisis or before surgery ? Yes / No

12. Is Christian literature available to patients in all areas of the hospital ? Yes / No

13. Is there adequate place fro private prayer and public worship ? Yes / No

14. Have there been any special emphases, or retreats for staff and students in the past one year ? Yes / No

15. Has there been improvement in the attitude of the community towards Christianity as a result of the hospital ? Yes / No

QUESTIONNAIRE FOR STAFF

1. Is there someone in the organization to whom you can communicate your problems ? Yes / No
2. Do you feel that your complaints or grievances are heard ? Yes / No
3. Do you feel a part of the health care team ? Yes / No
4. Do you know what is the mission of the hospital ? Yes / No
5. Do you have promotional avenues open to you ? Yes / No
6. Did you undergo orientation when you joined the hospital ? Yes / No
7. Do you feel appreciated in your work ? Yes / No
8. Do you think the rules and policies are fair ? Yes / No
9. Have you read and understood the Employee Service Rules ? Yes / No
10. Do you have opportunity to suggest ways that your department's work or function could improve ? Yes / No
11. If you have a personal or family problem, is there someone in the hospital who can guide or help you ? Yes / No
12. Is the area where you work comfortable and safe ? Yes / No
13. Since joining work, have you received any training or new skills ? Yes / No
14. Do you have a job description ? Yes / No
15. Do you participate in any special events or extra curricular activities in the hospital ? Yes / No

QUESTIONNAIRE FOR STUDENTS

1. Do you know the vision and mission of the hospital ? Yes / No
2. Do you feel a part of the hospital and its work ? Yes / No
3. Do you have any opportunities for spiritual development ? Yes / No
4. If you have a personal or family problem, is there someone to guide you or counsel you ? Yes / No
5. Is the hospital a place you would like to remain as an employee ? Yes / No
6. During your training do faculty and staff stress care of the poor ? Yes / No

ATTACHMENT V

QUESTIONNAIRE FOR HEAD OF DEPARTMENTS

1. How long have you been Head of the Department ?
2. Do you conduct regular meetings of employees whom you supervise ? Yes / No
3. Do you feel that there is good communication with management ? Yes / No
4. Are you involved in selection of staff for your department ? Yes / No
5. Are you involved in the annual budget process for your department ? Yes / No
6. Are you informed about the financial performance of your department ? Yes / No
7. Do you regularly evaluate the performance of the employees you supervise ? Yes / No
8. Do you know and understand the vision and mission of the hospital ? Yes / No
9. Do you communicate the vision and mission to your employees ? Yes / No
10. Does your department have written policies and procedures ? Yes / No
11. Do you set goals each year for your department ? Yes / No
12. Do you feel a part of planning and decision making in the organization? Yes / No
13. Do you orient new employees in your department ? Yes / No
14. Do you provide any inservice or on the job training for your employees ? Yes / No
15. Have you attended any seminar, program or course on management training ? Yes / No
16. Do you have written standards that guide the work of your department ? Yes / No
17. Do you have enough qualified staff to do the required work ? Yes / No
18. Do all of your employees have job description ? Yes / No
19. Do you know the organization plan or structure of the hospital ? Yes / No

4/5/99

David Nabarro — Evolving concept/Framework

Roll Back Malaria

1. Logo – Globe
Hand
Poverty
eradication ?

Partnership

2. Sustained Reduction in burden of malaria

- Cost effective appl. of current tools
- Including ↑ Health Sec Dev + Intersectoral collab
- Effective partnerships between dev agencies
- Sound movements to mobilise community level action
- Investment in new more effective technologies — Teaming with Pvt sector

3. Malaria index ↑ more in poorer countries
(Poor countries hampered in development by excess Com Diseases
(Jeff Sachs Harvard) (Important investment for Econ Development)

4. Background
- Eradication efforts – partially success but suffering confusion
- Initiative from Africa | SEARO
- Oct 1998 New York – WHO/UNDP/World Bank/UNICEF
- Dec 1998 Global RBM Partnership

5. Tools Extremely powerful new tools needed
(use existing tools well)
- Sustainable manner
- Poor people

(6) Tools

1. Rapid diagnostics
2. New Drugs - new means of delivery, means combined.
3. Domestic materials treated & Safe nets / Repes (25% reduction in mortality)
4. Effective means for environmental control
5. New means for predicting epidemics
6. Better system for Surveillance and Management NIH
7. New Approaches to effective training
8. Global Monitoring of disease burdens

(7) Vision (I) Most people able to prevent infection

1. Re-emphasis cost effective approaches
2. Vector control
3. Env. Measures
4. Bed Nets !!!
5. Promoting prevention strategies

(8) Vision II All malaria illness is treated quickly and effectively.

(9) Summary Social Movement that Reflects local level realities

(10) New Approaches Intensive Advocacy

11 WHO Role

RBM is all of us

Technical Standards
Technical guidance
cost effective actions
reduce needless duplication
monitor progress
promote achievements - Cross organisation working
mobilise human

Roll Back Malaria

Participants

1. Dr Shiv Lal NMEP
2.
3. Renu Sahni Dhir GOI
4. Kamini Mendes WHO
5. Rudolf UNICEF
6. Dond Peters World Bank
7. Dond Nabarro WHO
8.
9. Dr. Fernando Srilanka
10. Gunawardene "
11. Deepika Perera Srilanka (
12. PEEM-WHO
13. Tshering Wangdhak Bhutan
14. Dr Sandrup Wangchuk "
15. Dr. Soulang Indones
16.
17. Wickramsinghe
18. VP Sharma MRC
19. Mohamed
20. Stephen Alwood UNICEF
21. RS Sharma
22. Seshu Babu
23.
24.
25. Monteiro WHO-SEARO
26. Robert Bos PEEM
27. Ron Snyder Per Econ-
28. Dr Murgendrappa - Steve Berg. Ker Mal
29.
30. VK Monga - IMA
31. Vinay Aggarwal IMA
32. RS Sharma - NMEP
33.
34. Dr Arboleda SEARO
35. Dr Vijay Kumar Dir-Com Dis SEARO
36. Dr Aryan - Gujarat Stat - NMEP
37. Dr DP Mandal: Bihar " "
37. Dr GP Mathur Rajasthan " Addl Direct Hlth.
38
39
40.

UNICEF - Dr Rudolf

1. Dramatic Decline of U5MR/IMR in Asia
2. Main Cause: improved access to health services and high coverage of PHC
3. Reduction/slowing decline - Malaria
   Pneumonia

Reasons for UNICEF Role in Malaria

1. Epidemiology - Major cause of U5M and MoRand morbidity, and enem
2. [redacted]uld Rights - Malaria disproportionately affects poorest and marginal groups
3. Feasibility - cost effective interventions exist for prevention
4. Can build on community models
5. Family Care

Consensus on cost effective health care packages
delivery strategies
- unprecedented communication potential to raise demand for PHC
- [redacted]ealth sector reform in many countries focusing on protecting poor children (Protecting poor Good policies)

Strategic levels

1. Family Care practice
2. Strengthen community linkages
3. Improve/sustain equitable access to Quality Health Services
4. Linked to

1. Malaria Relevant Family Care Practices

- ensure malaria endemic areas ensure children sleep ITN
- continue to feed + fluids for sick children
- Referral to health worker
- basic IPC
- pregnant women support

- Build capacity of community based organisations to support families.

Care Advocacy Messages — Antimalarials ITMN RDTs/Sticks

WHO-UNICEF Complementarity

Other partners

1. Epid Surveillance
2. Update treatment Guidelines
3. Technical Trg of health staff
4.

Joint Inter-Country malaria project

?

RBM

Technical Issues	Implementation Programme	Movement?

RBM in India

1. Make Public Health Systems work
   - Revitalise sub centre
   - increase community demand by ec

Get copy of DHPS

Other partners

1. Mum Hum Raj Der (ICDS, AWWs)
2. DAIs & TBAs
3. UNICEF Opportunities
4. The Border Cluster Strategy
5. 4-5 clusters of 6-7 dists each Ref Cross state by
6. Represent the work of on the com
7. convergence of all health serv.

UNICEF Conclusion

1. Malaria is complete entry point for Health Rights of women & children
2. Clear deliverables to hold health sector accountable
3. Strengthening access and quality of mother c.
4. empowering families

Reorientation of Malaria Co

Shirt Lai

1. Malone Bogrenne is everybodys cousin

5/5/99

Robert Bos

① POPs negotiations

- intergovt under auspices of NMEP
- one of the POPs is DDT more pesticides may be added.
- Wider member dialogue on risk management issues for exemptions' etc

② Bandung consensus (1937) (Get a copy from Robert Bos)

- Malaria is a health and a social problem
- it must be attacked simultaneously from both angles
- malaria is feed disease — should not be stereotyped not flexible
- operational research
  - intervention in Agriculture / Fisheries / Animal husbandry

③ Indoor residual sprays

+ Millions of life saved
malaria eradicated in large areas
health service reached all to community level

⊖ flexible intersectoral activities replaced by a monolithic vertical programme explosive reaction ...
- reduction multidisciplinary dialogue ignored
- vector biology - ignored ↓

④ Strategy

1. Decentralised - local solutions to local problem
2. Health sector role:
   - proper distribution of operational and regulatory responsibility
3. intersectoral ensure policy adjustment and legislation
4. Flexible - rapid response to changing situation.
5. integrated - an optimal combination of intervention tools meeting local needs & reality.

Robert Bos (contd)

⑤ Five Strands of RBM

① Health sector development and intersectoral action
- decentralisation
- reorientation

leading to
- a shift from operational to regulatory roles
- local action
- intersectoral collaboration.

● Malaria in development planning
- improved policy framework
- better HIA procedures
- increased health sector capacity for the intersectoral dialogue

- investment in new more effective technologies
-

● Social movements to mobilise community action
The IPM experience Agricultural extension in Rice fields (Schools of Agriculture)

- cost effective application of current tools
- the methodology of economic evaluation
- Best practice methods/guidelines by professional
- Partnerships
  - with the environment/conservationist sectors
  - with GEF on issues of biodiversity

Dr. Amerasinghe

Environment and Malaria

- Historical experiences of malaria associated with human settlements.

- Ecosystem Approach
  (watershed / irrigation command)
  - what is the major vector of epidemiological significance
  - what is the main breeding habitat of the vector
  - are there identifiable

Water management for Malaria Control: Case Study from Sri Lanka

- Selective breeding of:
- vector (major)
- distance from breeding site

Conclusions

1. Major vector. An classification
2. Stream - Key breeding habitat in watershed
3. Distance from stream - vector dispersal and malaria
4. Viable options for vector control by water management
5. Possibility of system wide impact on malaria
6. Potentially cost effective

- DDT
- mall. cs cpt
- Problem A.
- use dis-

// Task Force or Cell / Committee to Problem Analysis

History
Anthr
Soc
Ecological
Vector Biology

Dr Mohamed Aden (RH Section in Inner Juba)

Malaria Control

40 years - s

- Active & passive case detection
- Have to have malaria case detection by nurse aides
- passive clinics in town and villages
- weekly epidemiological assessment
-
-

Dr Francois Nosten

Anti malarial combinations

- Drug combinations are used for TB/K/HIV
- Candidate drugs for combination must have well modeled pk/pd
-

RBM Communication Strategy
(Harsaran Bir Kaur Pandey)

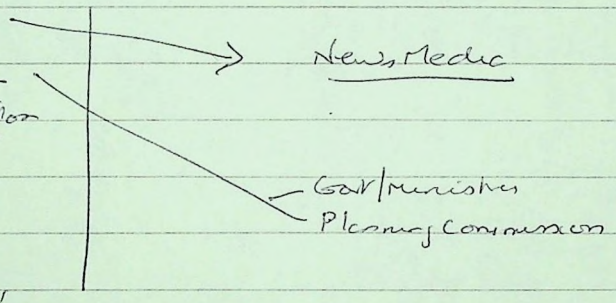
1. RBM - what is difference?

half of malaria can be rolled back in 10 yrs

2. How - Combined Global effort
   - Intersectoral
   - Community participation

   | Local problem
   | Local means

3. Advocacy
   Communication
   Social Mobilisation



Global level

4. Make malaria an important issue
   - Support research → SEPCE Research
   - Develop new tools | → communication MIS
   - Raise funds

5. National level
   - close intersectoral action needed
   - need for top political commitment
     National/Planning Commission levels → UPE Example: Universal Primary Education
   - Mission mode (eg Technology mission) → recognises urgency
   - Make it a public/media issue → 6% GDP in India → Right
   - Strengthen Health Delivery System
   - Mobilise Resources for the programme

Poverty (contd)

6. Recharge Health Sector to take Malaria as a serious health problem
   - Position it as a key cause of poverty
   - Promote RBM as a social movement
   - Focus on new tools
   - community action focus

7. Advocacy strategies
   1. clarify on key message
   2 explicit intervent.
   3
   4 Partnerships

8. Media Messages
   - National leaders → cause of suffering/death/poverty
   -

Communities

Film

Folk Media

Interpersonal

Sensationalism

Dr Charles Delacollerie

Malaria Epidemics

Dena Nabarro

- Working ε Communities — working ε countries
- How can RBM be owned/developed by
  countries by communities

Pressure to be Global

Globalised indicators
Package deals
Programme

← Needed by Funders Supports

DN

Countries ↙ ↘ Donors

Listening
Shaping it to local needs

Confidence
Certainty

16th of indicators predictions about risk

Local disease
Local Knowledge

vs

Global opportunity

Learning → Let's continue evolving Dialogueing → Not all seem up → Really unkay RBM Box → Plans

Values ← Strategies ←

1. — Social movement
2. — owned by all
3. — Decisions made on consensus
4. Country priorities drive RBM
5. Partners Function independently but in concert
6. Partners contribute where they have a comparative advantage or interest

- Action plans are clear, evidence based
  promoted/adapted to local realities
- RBM is about broadening and strengthening the
  capacity of health sector to fight all diseases
-
-

Values - Globally | Nationally | Locally

Criteria for overall RBM Partnership success

County Partnerships Are they being developed
Are they owned by national authority with
inclusive membership
Are strategies harmonised?
Are good opportunities being taken?
Are outcomes being monitored?
Is technical guidance being monitored
- Health sector Development (Public + Private)
-

Questions in Handouts

Dr Monkenan

Standardisation

- State level needs

District level need

- Geog
- Gender
- Social exclusion

← Disaggregation

Rural/urban

Slum/Non Slum

Quality Validity

- Local use of MIS (who uses)
- 'Fudging' options
- Integrated MIS

Dr Burke Nepal

Problems

Shortage of (microscopist/microscope) active cases

No lab or dial for cases detected.

Diminished no of surveillance agents Jaya & Bali

Limited quantity/quality of entomologist

Lack experience of manual.

Lack of sense of emergency among decision makers.

Lack of HE

Lack of legislation of Pvt Sector

Dr Sarono

Participation of community and other sectors

Community

Cadres of Village Health Posts (POD or Integrated Health care post (PSSYDNIU) to monitor larva breeding places

Village chief: To report imported cases

Agr

(Pvt Sector) Excellent Indonesia (Erien Jaya)

- ACD by Surveillance team
- larva monitoring and control

Transmigration Dept

To prevent importation of cases in Jaya & Bali.

(Pvt Sector) Bintan Beach international Resort (BIBU)

- ACD by construction workers supervisor
- Larva monitoring and contr.

Dr Wickremasinghe

GIS as surveillance tool

Computerised System

Present system good for evaluation not response

Data is it valid ;
reliable ?
outdated ?

Data processing
- is it being done efficiently
- is processing ...
- is it adequate
-
- feedback

Problem come From control person

Researcher Responsed to them

Concern
- Are we using all data
- How to improve system

Can we set up a system to tell us
- situation
- problem areas
- problem trend

6/5/99

Piency (after Group Discussion)

I

	Pros	Cons
(a) Diagnosis		
1. Microscopy	Availability	Longer Trg
2 Rapid Test	Simple	US 3$ (Not cost effective)

(b) Drug Resistance

(c) Trainig and information

Recommendations

(1) – Rapid Test price ↓

(2) Mapping AM Drug Resistance

(3) Drug combinations

Not simplify but Simple

Diagnostic Policy
Buffy coat

RDP

Drug Policy ← →

II

1. Advocacy for change in line with RBM

2

AIDAN DAFAK

Irrational practices (Depromoting)

Dissemination of information on Resistance to local/Post levels

National Law School

Construction workers PH Act ←

Model Bye Laws

PIL

Reps

Srilanka
~~Bangladesh~~ F.P Amerasinghe Vice Pid
M. Perera – DMO
DM Goonewardene DMO
Fernando Dirc
Wickremasinghe Comp.

Bhutan Tshering Wangchuk
Sandrup Wangchuk

Nepal Dr Bista
Som Aryal

Indonesia Dr Mohd Asri
Thomas Swox
R Sinulingga
Lauhad

Bangladesh Manas Bengali
Huq

India Murugendrappi (Karnataka)
Mathur (Rajasthan)
Mondol (Bihar
Iyer (Gujarat)

Information/surveillance

R

1

GROUP – III

VENUE – TAGORE – B

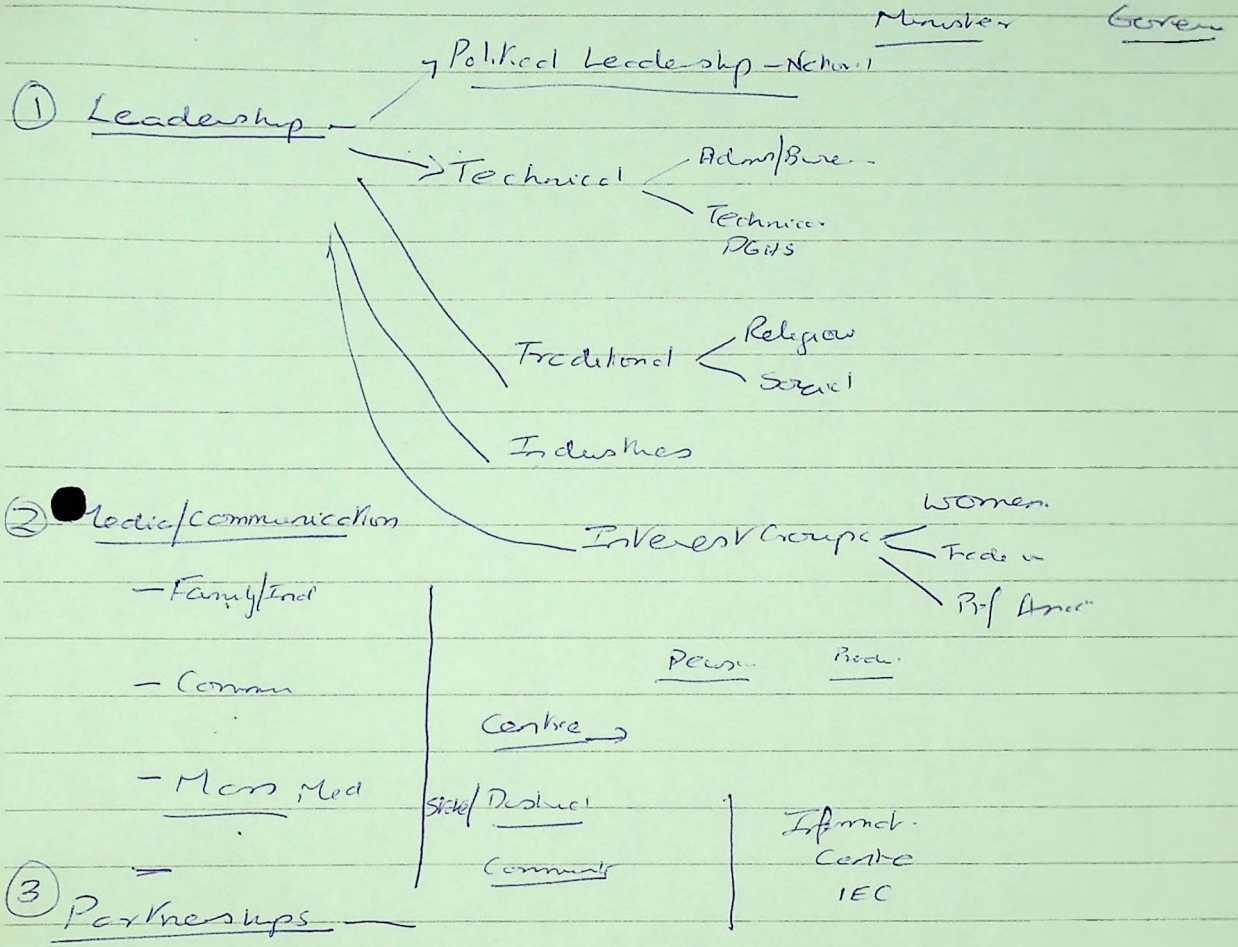
1. Mr. Sinulingga
2. Mrs. Parera
3. Dr. Neeraj Sethi
4. Dr. Mohammad Asri
5. Mr. Seshu Babu
6. Dr. Ranjini Saxena
7. Dr. Heyword
8. Mr. David Peters
9. Dr Rani Narayana

GROUP – III

Leadership

Management of Partnerships, Private sectors, NGOs, Media and Communication, maximising the benefits.

NMEP of each Country



Partnerships

Making Malaria — multisectoral partnership

— 'everyones concern'

Means (1) Within Health Ministry (all depts)

(2) With other Ministries esp

Indonesia	Indic	(Different nomenclature)
– Inland Affairs	HRD – Health	
– Education	Education	
– Agriculture	Social Welfare	
– Irrigation	Women	Advocacy Meetings with other Ministry / Dev sector were envisaged
– Social welfare	Agr	
– women	Irrigation	
– Industry	Rural Devt	
– Environment	Environment etc.	
– Forestry		

(3) With National Institutions or Universities / Professional association

- Public Health / Com Med Dept
- Medical college
- Env. Depts
- NGOs

Parasitology Assoc

(4) With NGOs / Voluntary Sec.

(5) Pvt sector / Corporate

(6) Community ← community organisation
→ civic society

NMEP–IMA–MOU

NMEP / CMAI / MOU

Trg for ~~HS~~ Bihar MP Orissa N. East

NMEP–NGO Trg

Irrigation Experience (Ecopark AEA)

– Take Jamshedpur experience

– In Re peak Tea plantation

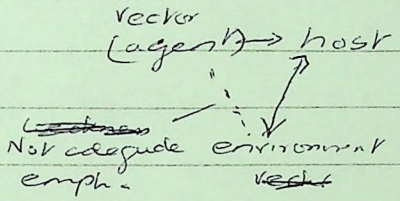
9 There must be some 'evaluation' and monitoring ongoing to ensure the
a) messages are getting across correctly
b) local adaptations

9. KAP for Malaria should be studied
— traditional beliefs that could be barriers
eg Malaria does not come to strong people (Kabal)
— traditional beliefs that could be bridges
e.g herbal remedies / alt. medicine / folk medi.

Caution: what is malaria / fever in local language identified.

10. Gender Vector education

— people accept blood smear and treatment but often oppose vector / environment action
— not willing to do action themselves / expect payment from project
— must enhance ownership



New Forms

11. School health / Child to child approach
(i) Involve children (10-12 yrs) to promote malaria message
(ii) Orient teachers (to give some hrs) voluntarily.
(iii) Activity based — collect larva / mosquito
examine
(iv) Involve schools in competition
(v) use opportunities — i) SUPW in Schools (India)
ii) Prakarya in Schools (Indon.
vi) Involve NSS / NIC / Scout Movement in Malaria program (India)
vii) Indonesia - Subdistrict (Timika) — involved High School Children in water hyacinth clearance

Media/Communication

1. Constantly conscious and clear messages | Key
2. Focused on Families →
   Communities →
   Mass Media
   (explanations for messages → For Health workers and others)
3. Focused on Interactive approaches
   - Folk media/low cost communications

e.g. Indonesia: Ludruk – Clown introduces messages through dialogue
Dalang/Wayang (Java)

India: Kathas (Contemporary) / Jathas — Sagak — Poetry & Song
Street Theatre

To reach communities esp of Poor
For whom this is free entertainment / like to sit together / be together learn together
- Not expensive

4. Posters/Television/Film not so effective | Too costly not cost effective
5. Radio – more effective – local language
   - can reach more
6. Information Dept – Indonesian (Dept Penerangan)
   India DAVP vs CHEB
7. Mass Media – need to orient journalists to the problem
   give – information/orientation
   - 'not to sensationalise'
   - to focus on what to do/what can be done
   - success & failure stories
   - focus on local/personal news media in local language
   - vernacular translation

Concern

1. Technomanagerial approach

2 Top down – we know it all communication

3 General principles/Guidelines not prescriptions
strategies

4. HE materials – flexibility / Diversity DOTS vs RBM
Cultural sensitive

5 Tools – Too much
marketing
Social/educational/organisational

6. – Community based monitoring | community involved
what does it mean

Community mobilised based | vs | participation involvement

Awareness
Posters
Dropsticks

Simple solutions !! to complex problem
Simplistic ??

David Peters

Rolling Back Malaria & HSec Dev

False choice
or
integrated approaches

HSD

- Cost of isolated approaches — HSR for reform sake
- c

Compatibly ?

Cost effective
tools

How can Health Sector Development ?
help to reduce the burden of malaria

1. Foster an environment for good public health practice, social engagement, and innovation
2. Better use of existing and new tools to control malaria
3. Better use of existing financial resources

SOME STANDARDS TO BE CONSIDERED

Governance

1. There is an established process and criteria that have been identified for selecting a competent and qualified Chief Executive Officer.
2. There is an established mechanism to ensure that the organization adheres to relevant statutory and regulatory requirements.

Organizational Planning

1. Planning includes setting a mission, a vision, and values for the organization and providing plans and policies to achieve the mission and vision.
2. The leaders communicate the organization's plan(s) throughout the organization.
3. The plans include patient care services in response to identified patient needs and is consistent with the mission.
4. The scope of services provided by each department is defined in writing.
5. The leaders and other representatives from the organization, as appropriate, participate in the organization's decision-making structures and processes.
6. The leaders develop programs to promote the recruitment, retention, development, and continuing education of all staff members.

Leadership

Key characteristics of leadership :

The process of leadership begins with establishing and promulgating the organization's mission, followed by renewing and revising it as necessary. Building on the organization's mission, effective leadership defines and establishes a clear vision and values for what the organization can be and resolves to become, encouraging staff participation in its development. Effective leadership develops other leaders at every level of the organization who help fulfill the organization's mission, vision, and values. Effective leadership also accurately assesses the needs of the organization's patients and other users of the organization's services and develops an organizational culture that focuses on improving performance to meet these needs. Effective leadership

- defines a strategic plan that is consistent with the organization's mission, vision, and values;
- clearly communicates the organization's mission, vision. and strategic plan throughout the organization; and
- fulfills the organization's vision by providing the framework to accomplish the goals of the strategic plan.

Developing this framework is accomplished through proper direction, implementation, coordination, and ultimately, improvement of services throughout the organization. In order to realize the organization's vision and values, leadership must have a role in teaching and coaching staff. This role is inherent to leadership.

Directing Departments

1. Each department of the organization has effective leadership.
2. Department directors or supervisors are responsible, either personally or through delegation for
    - integrating the service into the organization's primary function;
    - coordinating and integrating interdepartmental and intradepartmental services;
    - developing and implementing policies and procedures that guide and support the provision of services;
    - recommending a sufficient number of qualified and competent persons to provide care, including treatment;
    - continuously assessing and improving the performance of care and services provided;
    - maintaining quality control programs, as appropriate;
    - orienting and providing in-service training and continuing education of all persons in the department;
    - recommending space and other resources needed by the department.

Information Management

1. The information management processes provide for information confidentiality, security, and integrity.
2. The organization reviews the completeness, accuracy and timely completion of information in medical records at least quarterly.
3. There is a policy regarding the retention time of medical record information determined by law or by its use for patient care, legal, research, and/or educational purposes.
4. A medical record is maintained for every individual assessed or treated.
5. Medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results accurately and facilitate continuity of care among health care providers.
6. At discharge from patient care, a clinical summary gives reason for hospitalization, significant findings, procedures performed, treatment rendered, condition on discharge, and any specific instructions given to patient or family.
7. Written operative reports are included in the medical record of patients undergoing operative or other invasive procedures.

Human Resources Management

1. The organization's leaders define for their respective areas the qualifications and job expectations of staff and a system to evaluate how well the expectations are met.
2. The organization provides an adequate number of staff whose qualifications are commensurate with defined job responsibilities.
3. The organization has established methods and practices that encourage self development and learning for all staff.
4. A staff orientation process provides initial job training and information.
5. Ongoing inservice or other education and training maintain and improve staff competence.

Environment of Care

1. The organization has a documented management plan(s) for the environment of care that considers the following functions:
   - Safety
   - Security
   - Hazardous materials and wastes
   - Utility systems
   - Emergency preparedness
2. All areas of the facility are surveyed at least twice annually to identify environmental hazards and unsafe practices.
3. All incidents involving property damage, occupational illness, or patient, personnel or visitor injury are investigated and reported.
4. Written policies and procedures are strictly followed in regards to Infection Control.
5. Cleanliness is maintained in all areas with set standards to be achieved.

Dietary

1. Responsibility for preparing, storing, distributing, and administering food and nutrition products is defined and assigned.
2. Food and nutrition products are administered in a safe, timely, and acceptable manner to the patient.
3. Diet counselling and education by trained personnel is available and provided to patients.
4. Quality control measures are practiced in regard to therapeutic diets.

Pharmacy

1. Availability of appropriate medicines as determined by the medical staff
2. Availability of pharmacy services at all hours
3. Emergency medication systems
4. Formulary available to staff who use drugs
5. Pharmacy and therapeutic committee
6. Appropriate policies and procedures that support prescribing or ordering practices
7. Adherence to applicable law regulation, licensure, and professional standards of practice.

Laboratory

1. Clinical laboratory services and consultation are available at all times in a prompt manner to meet the needs of patients served by the hospital as determined by the medical staff.
2. Current written policies and procedures are readily available and address
   - Specimen Collection
   - Specimen Preservation
   - Instrument Calibration
   - Quality Control and Remedial Action
   - Equipment Performance Evaluation
   - Test Performance
3. Staff performing tests have adequate specific training and orientation to perform the tests.
4. Quality control checks are conducted on each procedure as defined by the organization.

X-Ray

1. Radio-Diagnostic services and consultation are available at all times in a prompt manner to meet the needs of patients served by the hospital as determined by the medical staff.
2. Current written policies and procedures are readily available and address
   - Patient preparation for special procedures
   - Radiation protection
   - Equipment performance evaluation
   - Quality control and remedial action
3. Staff performing tests have adequate specific training and orientation to perform tests.
4. Quality control checks are conducted as defined by the organization.

Spiritual Care

1. Spiritual care and counselling is available to all patients and families at all hours
2. Chaplains visit in all wards daily
3. The Christian nature of the hospital and its mission is communicated to patients, staff, and students.
4. Spiritual care is available to staff and students
5. Activities to encourage growth and meet spiritual needs of staff and students are planned regularly.

30/6/98 SMH Review Committee Meeting

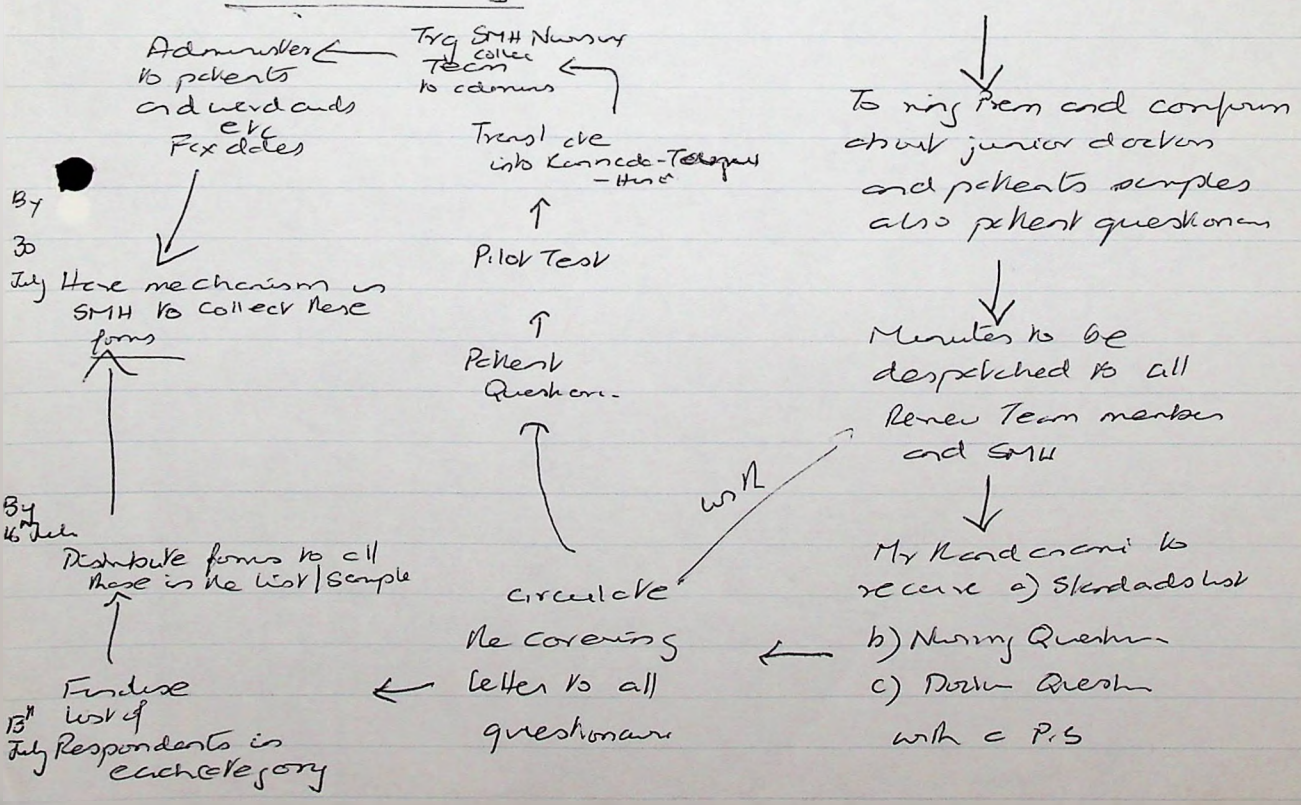
1. R/Naylor
   i) Get all except Dietary/Laundry
   ii) Tour of the hosp.
   iii) Standards — Get feedback from SMH Rev. Comm. ± a week
   iv) Interviews —
   v) Plans to analyse — narrative + stats

2. MAC — Nursing

See minutes for remaining decisions

Action

1. Minutes of key discussion of meeting — Completed and sent for typing



Evaluation of St. Martha's Hospital

Evaluation of Clinical departments functioning

1. This will involve questionnaire for in-patients, out-patients, residents and staff doctors. In-patients may be further classified by speciality and as general or private ward cases and doctors by their departments.

2. When questionnaires are prepared, a single questionnaire should be prepared for each category to include elements of management, finance, ethical issues etc.

3. Some interviews may also be required.

Draft questionnaires are enclosed.

Dr. Prem Pais,
Professor of Medicine & Vice Principal,
St. John's Medical College.

Questionnaire for out-patients / casualty

1. Age 2. Sex 3. Occupation

4. Family Income
   a) Less than Rs. 2,000/- P.M.
   b) Rs. 2,000/- to Rs. 4,000/- P.M.
   c) Rs. 4,000/- to Rs. 6,000/- P.M.
   d) Over Rs. 6,000/- P.M.

5. Your House
   - Rented
   - Owned
   - No. of room
   - roof - Thatch
     - Tile
     - RCC
   - Floor - Earth
     - Cement
     - Mosaic tile
     - Marble granite

6. Do you own
   Cycle 2 wheeler Car
   TV set Refrigerator

7. Religion

8. Education
   No formal education
   Class VII or less
   Class VIII to X
   Pre degree
   Degree
   Post graduate / professional

9. Through whom did you come to know of St. Martha's
   Family doctor
   Friends
   Relatives
   Neighbours
   Other _____

10. Why did you come to St. Martha's Hospital
    - close to your home/office
    - doctor recommended it
    - friends/relatives recommended it
    - mission hospital
    - reputation of the doctors
    - other _____

11. Is this the first visit to St. Martha's
    - Yes
    - No

12. Which department did you visit today

13. Do you like to see only one particular doctor or any doctor

14. If particular doctor
    a) If he/she is not available
        - will you go back & return another day
        - see another available doctor
    b) If he/she leaves the hospital
        - will you continue coming to St. Martha's Hospital
        - change the hospital

15. How long did you have to wait to see the doctor
        - less than one hour
        - one - two hours
        - more than 2 hours

16. What diagnostic tests did you have today
        - None
        - Laboratory (blood, urine, stool, sputum)
        - X-ray
        - ECG
        - Ultrasound
        - Endoscopy
        - Others _____

17. Give your impressions of the service you received

- Doctors know their job and are good	Yes/Somewhat/No
- All staff are courteous & helpful	Yes/Somewhat/No
- OPD amenities (seats, fans, toilets, water)	Yes/Somewhat/No
- Were you satisfied with care given	Yes/Somewhat/No

18.Please tell us your opinion of the following

- The hospital is meant mainly for those who can pay	Yes/Somewhat/No
- The hospital serves the poor sections of the population even if they cannot pay for services	Yes/Somewhat/No
- The hospital & its staff care for all patients with love and care	Yes/Somewhat/No
- The religious sentiments of all patients are respected	Yes/Somewhat/No

19. Do you think the hospital charges
        - are correct
        - too high
        - too low

20. Name 3 things in the hospital you appreciate most

-
-
-

21. Name 3 things in the hospital that need improvement most

-
-
-

22. You must be aware that St. Martha's Hospital tries not to refuse treatment to any patient, no matter how poor. Can you suggest how the hospital can raise funds to treat more poor patients

23. Any other suggestions or comments

Questionnaire for In-patients
(at discharge)

1. Age 2. Sex 3. Occupation

4. Family Income
   a) Less than Rs. 2,000/- P.M.
   b) Rs. 2,000/- to Rs. 4,000/- P.M.
   c) Rs. 4,000/- to Rs. 6,000/- P.M.
   d) Over Rs. 6,000/- P.M.

5. Your House
   - Rented
   - Owned
   - No. of room
   - roof - Thatch
     - Tile
     - RCC
   - Floor - Earth
     - Cement
     - Mosaic tile
     - Marble granite

6. Do you own
   Cycle 2 wheeler Car
   TV set Refrigerator

7. Religion

8. Education
   No formal education
   Class VII or less
   Class VIII to X
   Pre degree
   Degree
   Post graduate / professional

9. Through whom did you come to know of St. Martha's
   Family doctor
   Friends
   Relatives
   Neighbours
   Other _____

10. Why did you come to St. Martha's Hospital
    - close to your home/office
    - doctor recommended it
    - friends/relatives recommended it
    - mission hospital
    - reputation of the doctors
    - Other _____

11. Is this the first time you have been admitted in St. Martha's Hospital ?
    - -Yes
    - - No

12. For how many days were you admitted ? _____

13. Under which department have you been admitted ? _____

14. Did you choose to be admitted in this hospital for treatment mainly because
    - - of a particular doctor
    - - the reputation of the hospital

15. If for a particular doctor, if he/she leaves the hospital
    - - will you still have been admitted in St. Martha's Hospital
    - - changed the hospital

16. Which of the tests below did you undergo while you were admitted :
    - - None
    - - Laboratory (blood, urine, stool, sputum)
    - - X-ray
    - - ECG
    - - Ultrasound
    - - Endoscopy
    - - Others _____

17. Give your impression of the care you received

- generally satisfied with the care given	Yes/Somewhat/No
- Doctors know their job & are good	Yes/Somewhat/No
- good nursing care is given	Yes/Somewhat/No
- wards and rooms are clean	Yes/Somewhat/No
- ward room facilities (lights fans, etc.)	Yes/Somewhat/No

18. Please tell us your opinion of the following

- The hospital is meant mainly for those who can pay	Yes/Somewhat/No
- The hospital serves the poor sections of the population even if they cannot pay for services	Yes/Somewhat/No
- The hospital & its staff care for all patients with love and care	Yes/Somewhat/No
- The religious sentiments of all patients are respected	Yes/Somewhat/No

19. What ward were you treated in
    - - General ward
    - - Shared private room
    - - Single private room

20. What is your opinion of the cost of

- Room bed charges — Too low/Correct/Too high
- Investigations — Too low/Correct/Too high
- Doctors fees (if any) — Too low/Correct/Too high
- Surgery/procedure drugs — Too low/Correct/Too high

21. Name 3 things in the hospital you appreciate most

-
-
-

22 Name 3 things in the hospital that need improvement most

-
-
-

23. You must be aware that St. Martha's Hospital tries not to refuse treatment to any patient, no matter how poor. Can you suggest how the hospital can raise funds to treat more poor patients

24. Any other suggestions or comments

Questionnaire for Doctors

Department: _____

Status: Resident / Permanent staff

Years of service: _____

Hospital goals

Score

1 2 3 4 5

Not at all **Very much**

	Should be	**Is**
1. Hospital should provide the public irrespective of caste, creed and social status high quality medical care at reasonable cost		
2. While providing high quality medical care the hospital should ensure use of appropriate, low cost yet effective care whenever possible		
3. The hospital should serve as a model of efficient health care, cleanliness, human concern, compassion and ethical and spiritual values		
4. The hospital should emphasise especially the health concerns of women and children		
5. The hospital should ensure that the poor benefit from hospital services by concessions.		
6. The hospital should provide spiritual care to the sick respecting the individuals religious beliefs		
7. The hospital should serve as a training institution where trainee doctors and nurses will learn to deliver competent health care ethically and compassionately		
8. The hospital should keep the national health priorities in mind when planning its services.		
9. The hospital should foster a sense of dedication and moral and ethical integrity among all its staff.		

	Should be	Is
10. The hospital should foster among all staff respect for human life from conception to its natural end		

11. Any other goals you think the hospital should / is pursuing

a) _____
_____
_____

b) _____
_____
_____

c) _____
_____
_____

12. What major factor have helped the hospital realise its goals ?

13. What major factor have hindered the hospital from realising its goals ?

Hospital Functioning:

1 2 3 4 5

Completely Disagree **Completely Agree**

Score

14. The hospital constantly tries to improve the quality of health care

15. The hospital innovates to find means of reducing the cost of health care to make it more affordable

16. The hospital is kept clean

17. The hospital functioning is such as to be efficient; reduce waste and provide patients prompt care

18. The hospital motivates all its staff to work in a caring and compassionate manner.

19. The hospital involves each department in preparing the departments budged

20. The hospital is concerned about ways to generate additional income

21. The hospital charges are reasonable compared to charges by other similar hospitals in the city

22. The hospital has reasonable rules and regulations

23. The hospital is ready to accept innovations and new and better ways to do things

24. Relationship among staff is friendly and conducive to work

25. The hospital shows concern for the staff and workers

26. Any suggestions to improve the functioning of the hospital

a) _____
_____
_____

b) _____
_____
_____

c) _____
_____
_____

Dr Ravi Narayan
Community Health Cell

SURVEY OF PATIENTS

Methodology: An administered questionnaire was used to obtain the views of patients attending St. Martha's Hospital on different aspects of hospital functioning. The questionnaire was administered by interviewers who had been given some training. Since the instrument was in English, the interviewer had to interpret the questions to the patient as well as interpret open ended comments. This process may have vitiated the latter. Open end comments were often missing or unsatisfactorily expressed. The present analysis has therefore been restricted to scored questions which are less likely to be biased by the interviewer.

Subjects: The questionnaire was administered to both inpatients (on the day of discharge) and out patients. The subjects were selected by the interviewers to generally represent various areas and departments and is thus not strictly random.

I. Patient Profile

a) No. of proformae filled 159, 60 (38%) from inpatients and 96(60%) from out patients. In 3 this data was not filled.

b) 65 (41%) of the patients were male and 91 (57%) were female. In 3 data was not filled.

c) Income of patients per month

< Rs. 2000	30	19%
Rs.2000-3999	44	28%
Rs.4000-5999	30	19%
≥ Rs. 6000	29	18%
Missing data	26	16%

d) Educational status

No formal education	20	13%
7th Std. or less	19	12%
S.S.L.C.	45	28%
P.U.C.	38	24%
Degree	24	15%
PG/Professional	10	6%
Missing data	3	2%

e) Religion of respondents

Hindu	107	67%
Christian	33	21%
Muslim	12	8%
Missing data	7	4%

f) Of the inpatients (60 respondents) 46 (77%) were from general ward and 13(22%) from private wards. In 1 case the data was missing.

This data suggests that the sample has a representative socio-economic mix... and is probably representative of the hospital patient population.

II. Reasons for coming for treatment to St. Martha's Hospital.

a) Who referred the patient to SMH?

Relative	55	35%
Friend	46	29%
Neighbours	23	15%
Family doctor	13	8%
Others	18	11%
Missing data	4	2%

b) Why did the patient come to SMH?

Recommended by relative / friend	67	42%
Reputation of hospital doctors	27	17%
Near home / office	23	15%
Because it is a mission hospital	14	9%
Recommended by doctor	12	8%
Other	12	8%
Missing data	4	2%

Both a) and b) provide consistent data that the reputation of the hospital and its doctors among the general public is good. It is, however, noteworthy that few patients are referred to SMH by their doctors. Since family doctors form an important source of patient referrals for a secondary hospital, this area needs to be corrected.

III. Outpatient services

a) Do patients visiting the OP come to see a particular doctor or are they willing to see any doctor?

(n = 96)

Any doctor	37	66%
Specific doctor	33	34%

b) How long did the patient have to wait in OP to see the doctor?

(n = 96)

< 1 Hour	70	39%
1-2 Hours	40	42%
≥ 2 hours	19	19%

c) Was this waiting time acceptable?

(n = 96)

Yes	70	73%
No	25	26%
Missing data	1	1%

Two points emerge 1. That 61% of patients had to wait over an hour to see a doctor and 26% felt that the delay was too long. Given that patients visiting a general hospital are resigned to wait, these figures suggest that action is required to reduce waiting time. 2. From a) and c) it would appear that about 30% of patients may be ready to pay a fee to see a doctor of their choice with less waiting time.

IV Staff Quality

a) Doctors are knowledgeable and good

Yes	147	92%
Somewhat	8	5%
No	0	0%
Missing data	4	3%

b) Nurses are caring and efficient

Yes	136	85.5%
Somewhat	17	11.0%
No	1	0.5%
Missing data	5	3%

c) Staff in general are courteous and helpful

Yes	144	90.5%
Somewhat	7	4.5%
No	1	0.5%
Missing data	7	4.5%

d) Overall satisfied with care given

Yes	134	84%
Somewhat	16	10%
No	1	0.5%
Missing data	8	4.5%

A fairly satisfactory picture on the whole

V. Amenities

a) General cleanliness is good

Yes	142	89%
Somewhat	12	8%
No	2	1%
Missing data	3	2%

b) Toilets and water supply are satisfactory

Yes	125	79%
Somewhat	24	15%
No	3	2%
Missing data	7	4%

c) Fans and lights function adequately

Yes	137	86%
Somewhat	15	10%
No	2	1%
Missing data	5	3%

d) Hospital diet taken (IP only)
n = 60

No	58	97%
Yes	2	3%

Water, toilets, lights and fans are generally judged satisfactory although not as unequivocally as was the case for personnel. Bangalore residents are accustomed to water and electricity shortages yet 17% are not entirely happy with water and toilets and 11% with electricity. The dietary service is conspicuous by its disuse.

VI. Some special services

a) Medical records - any problem in getting records out (OPD only)
n = 96

No	84	87%
Yes	12	13%

b) Chaplaincy services

- Did the chaplain visit you (IP only)
n = 60

Yes	16	27%
No	43	71.5%
Missing date	1	0.5%

- If yes, were his visits helpful
n = 16

Yes	14	88%
No	2	12%

Considering the mission of the hospital, visits by the chaplain are inadequate. However, those who were visited seem satisfied.

VIII Perception of hospital mission

a) The hospital is mainly meant for those who can pay.

No	104	65%
Somewhat	28	18%
Yes	22	14%
Missing data	5	3%

b) The hospital serves the poor even if they cannot pay.

Yes	99	62%
Somewhat	35	22%
No	12	8%
Missing data	13	8%

c) All patients are loved and cared for by the hospital staff.

Yes	134	84%
Somewhat	16	10%
No	2	2%
Missing data	6	4%

d) Religious sentiments of all patients are respected.

Yes	145	91%
Somewhat	7	5%
No	2	1%
Missing date	5	3%

On the whole a satisfactory image. In view of the current controversy in the political world, the last question and response could well be sent to the VHP!

VIII Hospital charges

a) Out patient charges and costs
n = 96

Correct	61	64%
Too high	16	17%
Too low	15	16%
Missing data	4	4%

b) In patient bed charges

n = 60

Correct	40	67%
Too high	10	16%
Too low	1	2%
Missing data	9	15%

c) In patient (investigation costs in bill)

n = 60

Correct	46	77%
Too high	6	10%
Too low	0	0%
Missing data	8	13%

d) In patients (doctors fees, if any)

n = 60

Correct	37	62%
Too high	7	12%
Too low	0	0%
Missing data	16	26%

e) In patient (surgery / procedure costs)

n = 60

Correct	35	59%
Too high	5	8%
Too low	0	0%
Missing data	20	33%

f) In patients (medicine charges)

n = 60

Correct	42	70%
Too high	12	20%
Too low	0	0%
Missing data	6	10%

On the whole more patients seem to feel that the charge are reasonable. Among inpatients a significant minority of patients (15 - 20%) feel that bed charges and medication costs are too high. Similarly 17% of out patients felt that out patient charges were too high.

Summary: The 159 patients interviewed seem to be fairly representative of a cross-section of those who attend the hospital. It must be recognised that a survey of this nature is presently biased as only patients who come to the hospital (and hence approve of the hospital) have been included. Keeping this in mind, the survey shows:

1. Patients are not often being referred to the hospital by the medical practitioners. They come because of its reputation with the lay public.
2. Waiting time in the out patient department is too long.
3. About 30% of out patients may be ready to pay for services if these can be stream-lined.
4. Patients are generally satisfied about the medical and non medical staff.
5. Dietary department services are grossly under used and could be stopped.
6. There is scope to improve water and electricity supply.
7. Chaplaincy services cover only a small proportion of patients.
8. Hospital has good image among patients attending it.

From 30/6/99 Presentations

Community Actions/Civic Society

Branding Education

Target group

Social process indicator

Strengths
- Enthusiasm
- Global Partnership
-

Civic Society

Community
- (Mass) Awareness/Commitment
- Action
- Partnership

Weaknesses
- R&D - SEPC Analysis
- Biomedical
- Flexibility/Diversity

Interventions

Teachers (Mass)

Agric Ext (Mass)

Opportunities
- Partnerships
- Go beyond stereotyped thinking
- Learning from Experience

Comm

Benefit Partn

Community/Civic Society Movement

Threats
- Money crashdowns HRD harness
- Market Economy

Dr Board (contd)

Core concepts

1. Focus on Results
2. Making Action Human Resource Dr
3. Cross cost cut
4. Evidence based action
5. Social Movement
6.

Process

Continued Dev of Coherent Project
↓
Project Management (Appraisal, Board Meeting)
↓
Areas for Action

Strategy Dev
Communication / Advocacy
Advocacy Approach Cut
Building Up

Draft Strategy and Work Plan Document ← Advocacy Approach at Country level

↓

Inception Process
Africa Asia, Europe
Six Elements del.

↓

Building and sustaining Global Partnership
UNICEF/WHO Malaria del.

↓

Promoting consistent Technical Guidance

↓ Continued conceptual Dr
Dev of Tech Support Nets
Country & Partner information Note
Briefing of Six elements of RBM Strategy

↓

Strategic support to Research/Dev — Low cost products
— Combine Drug therapy

SEPC Analysis

↓

Measures for Malaria Control

M IM

Monitoring — Draft Framework

Tendering for Dev of Internet based system.

Wide Approval For RBM

↓

Advocacy Method

↓

Build of Communication Linkages at higher level of partnership

Strategic Support

Dr Bond (cont'd)

Extended Next Steps

- RBM - WHO
- RBM Africa
- Community Actn

↓

RBM - Mech for Better Health integrat. Ledge & IMCI - Comm Level Actn

Extension, WHO ground WHOunde approach (addition fragmented leadership)

→ Capacity requirements for Regional + country offices

Management Processes

Mechanisms for Global and Regional Coordination

↓

organising principles

↓

Resource Mobilisation for short term

Finances

- Resource Flow 7m/20 mill budget
- Lead time for country resource mobilisat.
- $2 Bill on next projects (Priority for next 12 mon.

↓

Partnerships in Practice

1 Institutional frame for Global coord.

2 Institutional for coord in Africa.

3 Institutional country level partners

Malaria in Africa

1 Major cause of Poverty & Inequi

2 300 billion dollars loss (could use

Objectives

1 Reduce malaria burden to

contribute health & SE Dev

2 Halve malaria mobility by 2010

3 By 2030 — Malaria ceases major mobility/morbidity

nor major SE Dev problem

↓

Repeating Phase - Sept 98 - Aug 99

Launching Phase -

Full Implementation Phase

↓

WHO Role

1 Conceptualization & development of Roll

2 Advocacy with WHO & outside

3 Encouraging partners

4 Organizing technical support to coun

↓

Objectives - County specific needs/appropriate

Joint Planning in WHO

Joint County Mission

Dec 99

1 Building consen — West Africa block 15

East Africa - 14 cou

including 6 countries from EMRO

Southern Africa = 10

Central Africa - 10

49

Outcomes

1. Accelerated Malaria Control Programs (Community Awareness
Strengthened Capacity building

2. More emphasis needed on Health Sys Organ°

3. Agreed 5 main indicators (concepts
including social mar

4. Emphasis for RBM in countries supplies ongoing ed

5. Agreement on need to involve all part
(in country situation Analysis)

6. Malaria Consensus Mtg

7. National Malaria Forum in Tanzania

8. National " Conf in Eritrea

9. Joint Mission WHO/WB/UNICEF in Zambia

SEPR in Pregnancy

Civic Society

Community Participation

Civic Society

Social mark

1999 - 17 out of 42 (40%)

- Some Statements to be modified
- Plans reviewed and feedback given to countries
- Support to countries
- Inception meeting 24 countries

Challenges/Problems

1. Limited involvement of Private Sector/Private individuals

↓

Means of Planning/Financial

2. Managing Transition

- Country capacity for priority setting
- Resource Mobilisation to be improved
- RBM Regional Partnership
- Regional capacity to be increased
- Capacity of countries to be strengthened

(contd)

Capacity of an city offices to be changeless

↓

Yes - Approach - No of cases

- No of reactive/Proactive approaches

- Need for flexibility - conclusion

- Delay in making timely decisions

-

Conclusion

① Major

1. Shift to rational change

2. Managing transition from AMC → RBM (implementation)

② Sub major - Managing change process

need for continuous adaptation

+ Proactive approach

Discussion

1. Dil Parivartan Some Tayele

2. Each country - Have its own needs

Mozambique

1. Geography
2. Situation Analysis — Major Public Health Problems
   Major Cause of Morbidity/Mortality
   Falciparum - Chloroquine resistance 40%
   Reversible Measures - focused house to house
3. Transmission — Endemic
   Perennial Transmission
   Vectors - An. gambiae & An. funestus
4. Disease Burden — Prevalence overall - 40%
   Outpatient Consultations - 41%
   Paediatric Admissions - 57%
   Women are pregnant - 20%
   Hospital Mortality - 32% in
   Case fatality Rates varies in Zones
5. NMCP — established in 1982
   - Limited Insecticide spraying for control of vectors
   - IEC
   - Health Education at health unit
6. Funding — WHO/UNICEF/Swiss Cooperation/DANIDA/NORAD
7. Health Sector Reform — Now implemented
   Decentralisation of Admin & Implementation
   Planning/Coordination/Evaluation at Central level
8. Private Sector participation - Business -
9. Potential community participation involvement - Some community with
   - large scale business
   -
   - Primary school teachers

Management Control

Results

1. Fall [illegible] Control Committee on Use
2. [illegible] Formation of National Plan/Action
3. Draft [illegible]
4. Training Responsibility
5. National Malaria Control Programme Framework Manual
6. Type and Duration of Pupil Education
7. Training of School Teachers
8. Health education/community mobilization

Next Steps/Options

a) Meeting/Documentation for integrated and community effort

b) Plan/Action

c) Technical Com

d) Support from bodies partnership
- Inter Sectoral coordination
- Advocacy and Conviction
- Facilitation
- Accountability

Key issues for consideration

1. Practicality
2. Human/Incredible resource capital
3. Efficacy
4. Convincing community public
5. Sustainability

30/6/99

Tea Time

- Sec of Health - All agencies
- 2 Budget - Level of activity - Health
  - Move activities to
  - Consider the components to
  - Fix the system
- 3 Control Measures - Re-introduce?
  - Colonel M.O.H
  - Pesticides - Collapse of Central Services
    - Abuse of Command Enterprises
    - Cessation of Malaria Control
    - Effected for Workers
  - 1995-96 - Tsetse control - Ubaa/Ahl Shiko
  - Urged Reinstated prevent reduction
  - Tsetse Board
    - ↓
    - New Spirit for Malaria Control
    - Review of Endemic Proceedings policy shift
    - ↓
    - Mapping
    - Social Marketing of ITNN
    - Support of supplies and equipment
    - Nets introduced mainly for pregnancy

Workshop Recommendations

1. Political Commitment
2. MOH Discussion at Ker Meeting
3. Community Involvement
4. MOH to provide clear statements on recommended drug for chemo.
5. Budgetary allocation - Treatment costs
   Continue domestic
6. NMCP to define policy measures/actions/roles/responsibilities
7. Situation Analysis - Desk Review Studies | Inventory of Policies Review Legislation | Adequacies

Transaction (contd.)

Challenges

- Capacity for implementation
  - Human Resources
  - Financial Resources (Accounting)
  - Coordination/reporting from/to all levels
  - Efficacy vs resistance
  - Transparency

Complex Emergency

Acute Crisis

Large Civilian Population / war & civil strife

Types: 1. Natural disasters with host country & Stable govt

2. Ethnic Stable govt

3. Internal displacement

4. War / civil strife

Countries affected

Angola

Congo Brazzaville. 15 countries

Official Reports: Refugees (small)

Congo-F (Kin)

All 15 countries / Malawi extra

Few data published on Malawi

How different from Stable situations

1. Malnutrition (increased vulnerability)

2. Increased risk of epidemics

3. Environmental degradation

4. Breakdown of health Services or overwhelmed by numbers

5. Unstable or no govt

6. Many partners

7. Ongoing conflict / insecurity

8. Physical and Ipk barriers

Network

1. Participation of 32 Malawi experts - Core group

2. UNDP/UNICEF/UNHCR/FEWSNET/SADC/Malawi Govt

3. Experts based at Country / regional and HQ level

4. 16 Target countries

Problems

1. Lack of/poor knowledge

2. Lack of info on drug resistance

3. Delayed Access to Supplies/Appl Res

4. NGO - UN agencies - Govt coordination

5. Operational Research

6. Lack of data on malaria burden in complex emergencies

ToR of Network

1. Prevent ill-informed and unsubstantiated comments
2. Develop a document to request for funding
3. Training in health
   Who should be [illegible]

David Nabarro

1. Health is a Dev issue
2. Health caused by other
3. Health outcomes
4. Health system under-performance
   contribution
5. Other key groups — Pvt sector
   - outside the govt
6. Health Sector Reform — How can RBM improve
   speed of change

Partners - Issues of concern

1. UNICEF - Multisectoral

(Short Action is needed now?

1. We need to update our global support info of the plan for Afr
2. Bonde support but countries need to access such info more pur
3. Extra financial support
4. Global/Regional and country goals
5. We need to demonstrate that partnerships can work at county level
6. RRM should consolidate achievements through H.S.D
7. We need to define mechanism of partnership
8. Global/National targets
9. Need to move quickly from planning to implementation with support of donor partners

UNICEF Advantages

1. Decentralized country programme
2. Community focus
3. Ability to work c NGO, women & youth agencies
4. Multisectoral involvement with programme in (Health/Education/Water/Sanitation/Children rights/Social welfare information and communication)

What should we do?

1. Conclude mechanism of partnership
2. Agree with National counterparts on roles
3. Need to harmonise our financial and reporting guidelines
4. Assist countries to complete assessment
5. Trust fund review
6. Launch National programme

7 Advocacy - Govt to reduce elimination barriers on medicines and facilitate availability of fast use referral care.

8 Health Education

UNICEF ——— RBM = ITMN = 5c million

= what programme to use advantages of UNICEF

(Social mobilization?)

(B) Defining Role of WB in RBM Partnership (Ravenborg)

1 Impact on Development - Loss of productivity

Absenteeism from work and school

Acute illness and death

Long term impact on children

Costs - household expenditure on malaria channels resources away from potential investment into education and innovations which could increase employment/income

Inefficiency Resources from public sector households donors and other / is ineffectively allocated

(2) Malaria as Corporate Priority

Joint consultation Mission

Formation of Malaria Team

Country examples of RBM partnership

Exploring partnership with HIV — New Drugs/New Vaccines

Economics of Malaria (MIM) — Econ Res consortium

DGF Support to RBM in Africa

Placement of staff in RBM/Geneva

CDC Secondee to Bank

Task Constraints

Objectives

Respond to requests from African countries

Overview of country specific and cross country needs

and opportunities for achieving a sustainable response

Common barriers - routine, surveillance, level of magnitude and people)

Prevent to Scale Response

- Prevention Tools

- Reduction supply and distribution

- Access to use of expensive

Research & Development

Infrastructure & Malaria

Infrastructure objectives that cost effective malaria control initiatives

Role of infrastructure in sustaining potential from

Incorporate infrastructure Expert opinion

Next steps in Africa

1. Produce some success — Promote endorsement / EBM Partnership

— demonstrate examples regional

2. Promise action at country level

3. Strengthen Africa Secretariat

Partnership Concerns

1. WB is low Key partner — countries ask for it

2. No vertical malaria programme countries want WB in partnership

3. Malaria is a priority in pediatric approach — not in maternal (TB, AIDS also a priority)

4. Funding — National budget must indicate priority

↓ Then external partners can support country

5. Collective support (to make it happen)

Dr. Hoje Sukra - USAID

1. Raised Awareness by advocacy
2. Responds for Wide reform
3. Broad participation including private sector
4. Concern on stockouts — drugs/logistics / How to do it
5. Leader to Health sector reform
6. Emphasis on results — positive ones to get more support more for...

N/A

Problem

1. Rising morbidity in under fives — HIV/AIDS
2. High maternal mortality
3. Increasing contribution of malaria to both

Nature of the Problem

- Drug Resistance
  - case management
  - ineffective treatment
- Treatment and deaths in the community
  - reaching the community
  - engaging the private sector

USAID Approach

- Policy dialogue
- Improved case management through child survival
- Reaching communities
- Promoting public-private partnership
- Research and Development

USAID - Support to AFRO

- Leadership
- Guidelines and Standards
- Policies and Strategies
- Communication / Coordination

USAID at country

1. Malaria policy / Program
2. IMCI
3. Maternal / Reproductive Health
4. Integrated disease surveillance
5. Health sector reform and financing
6. Community Response with NGOs
7. Commercial sector for ITNs

USAID Technical Assistance

- CDC
- BASICS (Child survival)
- Environmental Health Project
- Netmark (Bed Nets)
- Others

USAID – Research and Development

- Long term vaccine development
- Home management and contraception therapy
- [illegible] malaria in pregnancy, HIV and malaria
- Diagnostics
- AIMI – integrated implementation in districts

Challenges to Partners

1. Operationalising RBM within existing efforts
2. HRD Management and implementation capacity within health se.
3. Engage/engage the commercial sector
4. Reaching the community
5. Institutionalising coordination

Challenges to USAID

- Project orientation and short time frame
- Limited Number of countries.
- Communication and strategy within a decentralised organisation

4. Dr Caroline Sergeant (DFID)

Presentation

1. Supports commitment
2. What does RBM mean to ...
3. Challenges we [illegible]
4. DFID help RBM
5. RBM can help ...
6. Take forward

DFID commitment

£48 million over next 4 yrs

Bilaterally multilateral support

Stick by the principles of movement

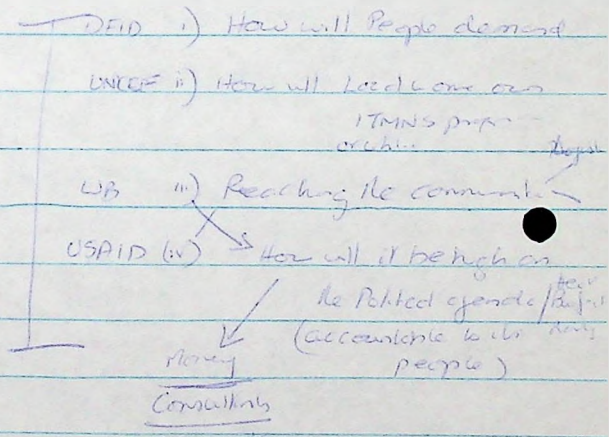
RBM wants DFID

DFID obj

Challenges actually

1. Delivery and Results / RBM
2. Roles and responsibilities of different levels / who
3. On our responsibility to demand the contribution we can make
4. On what is do + how to do it and the mechanisms for measuring progress

"Counting things that we can count rather than counting things that count"



Synthesis of Issues

Dr Kabale

National level

Grassroots level actors

- Private sector

- Mobilizing funds at County level

- Conducive environment we have

- Inter-county collaboration

↓

Challenges

1. How to operationalize activities at County level

2. How to enforce National agenda

3. How to get child of County concept

4. How to institutionalize partnership at each level

5. At County level — often exclusive

Daniel Nabena

Themes

1. Drama briefly the potential that the pic offers will back malaria in country

2. How we operationalize awareness

Are there role examples/lessons that can guide

Community

Gender — Links to Com Dev (Training committee Need Based)

— Link to what community needs & wants

UN

1. Funding Needs

How to prevent it from undermining ownership that we've had here.

2. Debt Relief

Debt relief ⇒ to Social Sectors

Investment in

How to monitor?

How to focus?

DFID

1. Demand from inside which is empowered

Uganda — Universal Education Rights approach

2. Solutions are here — mobilize support for it

USAID

1. Innovative Communications Study

↓

2. Community Approaches

3. Advocacy sensitization

4. Research/Technical papers From Govt / to Media (Linkages)

Group Issues (Day 2 N)

Group I
- How can partners contribute to sustained human capacity within countries to RBM?
- How can they work within the context of Health Sector Dev?
- what capacities are needed
- how influence by H Seeker

Group II
- How can Private Sector contribute (health sector interest)
- Role in the pub sector?
- who are the key partners?
- linkage between intersectoral linkage collaboration and public private partnership
- what motivates each party to become involved
- Alternatives of different mechanism
- How to ensure effective outcomes & household/community Needs

Group III Partnership that need Community (esp-)
- How can partnership be made effective - at supporting community level actions and reducing people morbidity burden
- who are county level partners
- what are their role in community level action

More Questions

Group IV Financing full back malaria

Challenges
- Clarify concept
- Help implement at country

Decentralization
- Monitoring
- Technical (DDC)
- Forum

1/7/99

RBM Partnerships in Africa

↓

Private Sector

1. Agnevo
2. ENI — Seed consortium

Brief

Comm to Public well Being

Public Relations

Legal Framework/Guide

Beneficiaries - Env & Culture

Improved - Educ & Health care

Principle

- Strengthen capacity of Local health s.
- Access to Health care etc

PHC Approach ←

Vaccination

Diarrhea Control

Malaria - Hep B Ry & Immun

3 Smith Kline Beecham

4 Seneca — Canek - ICO

5 Glaxo/Wellcome — Malaria

POPs Persistent organochlorine Pollutants

1. DDT will being phased out due to economic reasons
2. Stock Schedule of Negotiations → I UNEP 98 London
3. Work Paper - Ministry of Env & For Affairs
   II Feb 99 Nairobi ← WHO Action Plan
   III Sept 99 Geneva
4. Public Health People Not adequately involved (WHO only observer) IV Bonn Feb 2000
   V End 2000
5. Action Plan —
   i) Needs assessment — To help transition to alternatives ← Pesticide, Vec Mc, Fish etc
   ii) Look at Needs — organise research
   iii) Inventory of DDT for PH purpose
   iv) MoH to dialogue c MoE & MoFA ← get involved in Dealers

1/21/99

Group III — Supporting/Catalyzing Community Action

Dr Mahgoub — UNICEF

Paul Gallagher IFRC

Rena Salgado BASICS

Sicmen Kombi

Kelvin Cham

Magwende Mavunga

Needs/Appro...

Mali

Women Work

1/7/99

Group Reports

(2)

Pvt Sector

1 Drug available/excess capacity

2 Motivation - marginal additional profit
- Image & PR
- use of centralized distribution systems

Actions - National

1 Strategies for enabling Env for Pshp Build.

2 National Regulatory Framework

3 Building National Capacities
- Policy Framework
- Attitudes & Skills in intersectoral planning

Actions - Global

1 Document - exemplary case studies / distribution outreach strategies

2 Work ε Pvt Sector to develop incentives

(1)

- RBM is critical to Rolling back Health
- Value of RBM co-loop to new and promote progress ε WSP
- Country context crucial
- Partners have shared Vision
- Consultation/Clarity/Consensus
- Results to build confidence
- More effective communication
- Leadership & Ownership
- sustained partnerships

County level Actions

↓

within next 6 months
(County ownership/leadership RBM)

↓ Establish shared Vision

↓ Assessment - locally generated

↓ Access to technical support as needed

↓ Pysce ↓ Advocacy Strategies

↓ Mobilize supports Resources

Mechanisms

AMREF

1. Cohesion
2. Super Market
3. Multi-skilled Person
4. Modular
5. Work Shared Rotated/Guideline
6. JV Committee/Teamwork
7. Mixed bag

Financing

Survey of Governance, Hospital Management, Personnel Management, Associated and Ancillary Departments

As a member of the Review Committee which was formed to evaluate St. Martha's Hospital through a reflective process, I was assigned the following specific areas for review:

1. Governance / Advisory Board
2. Hospital Organisation / Administration
3. Personnel Management Policy
4. Departments including prosthetic and orthotic centre, physiotherapy, pharmacy, radiology, laboratory, CSSD, medical records, laundry, and dietary
5. Ancillary services including security, telephone, water, electricity, maintenance, transport
6. Spiritual care of patients

Evaluation was undertaken in such a way that the questions posed in the terms of reference could be answered. The goal is to gather information and propose recommendations which could further strengthen the institution as it moves into a new century.

The methodology adopted was as follows:

1. Standards for evaluation in the assigned areas were proposed and accepted by the review committee (attachment I) **(Appendix 10(viii))**
2. Documents obtained for review included the 1996 - 97 annual report, employee service rules, organisation chart, list of members of Governing Body, current salary scales, list of employee benefits, sample job description, performance evaluation form, sample appointment letter and appointment order.
3. An interview was conducted with the Administrator, Mr. A.C. Saldhana.
4. Questionnaires were completed by the heads of the departments and services assigned to me for review (attachment II) **(See Annexures)**
5. Questionnaires were given to staff (attachment III),students (attachment IV), and all department heads / supervisors (attachment V). **(See Annexures)**
6. Questionnaires were also given to patients (not yet completed).

Data collected are presented in attachment VI (staff), attachment VII (students), attachment VIII (department heads / supervisors). The staff and department heads were asked to give their suggestions.

This report summarises the information which was gathered and then makes conclusions and recommendations in each assigned area.

Vision and Mission

The entire review committee was given the responsibility to reflect on the vision and mission of the hospital and its expression in all activities and functions of the hospital.

The vision and mission as stated in the stated papers given to the committee is that of the sisters of the Good Shepherd and it is assumed that these statements also apply to the hospital. There are statements of belief, objectives, and strategies that arise from this vision and mission.

Among heads of departments, 94.3% said that they understood the mission of the hospital and 82.9% communicate it to their employees. Among the 200 staff questioned, 91.5% indicated that they know the mission of the hospital. These figures are not verified in the sense that no one was asked to state the mission.

It was observed that the hospital does not have immediate goals or a five or a ten year plan. Only 34.3% of department heads set goals for their departments each year. Reasons given by Administration for lack of planning include age of the institution, changing government policies, and unpredictable economic conditions.

The recommendations suggested are as follows:

1. Based on the vision and mission statement of the order, the hospital management should prepare a specific vision and mission statement and submit it to the Governing Body and the Sisters of Good Shepherd for approval.
2. Based on this vision, organisational planning should take place. Departments should be required to set annual goals that are measurable. The organisation should have annual goals as well as longer term goals. The five year plan can be reviewed and modified on a regular basis as required by internal and external circumstances.

Governance / Advisory Board

The hospital is owned by the Good Shepherd Sisters. The order is represented in the hospital by the Sister Superior. The Chief Executive Officer of the hospital (Administrator) is appointed by the order. The Administrator is accountable to the Sister Superior.

There is a Governing Body which meets usually twice annually. The majority of this Board are from within the hospital or order. Only six members, a minority, are from outside. The Governing Body does approve the annual budget. The Board has a wide range of power for review and supervision. They approve major policies and new projects. It is assumed that this group along with the Chief Officer ensure that the organisation adheres to relevant statutory and regulatory requirements.

It is recommended that there be more voice in the Governing Body from outside including the community, experts in hospital management and experts in finance. There should be an established process and criteria identified for selection of the Chief Executive Officer, perhaps including a recommendation from the Governing Body to the order on the selection.

Hospital Organisation and Administration

An organisational structure is in place and most management and supervisory personnel are aware of it. The channels of communication are clear.

The Planning and Executive Committee, chaired by the Administrator, consists of the top officers and meets on regular basis. All decisions that affect the whole of the organisation or all employees are taken by this group. This represents a good participative management style.

In the area of finance, middle management seems less involved. Of the 35 heads of departments / supervisors who responded, only 31% were involved in the annual budgeting process for their departments, and only 28.6% were informed about the financial performance of the department. Just over half (54.3%) have regular department meetings with their employees. Only 28.6% were involved in selection of staff. These data suggest that the organisation would be stronger if middle management was strengthened and participated in decision making.

An administrative policy manual is needed in order that decisions will be consistent, fair and objective.

Human Resources (Personnel Management)

The personnel department of the hospital seems adequately staffed. records are maintained for all employees. There are cadre positions determined by the Governing Body in all areas of the hospital. This results in adequate but not excessive staffing.

Salaries are similar or higher in all categories when compared to other non-profit voluntary hospitals in the city of Bangalore. It is noted that in each major job category there are only two, or at most three grades limiting avenues for promotion. For class four staff, there appears to be only one grade. Other employee benefits are available including adequate leave, uniforms, festival advance, education advance, salary advance, and medical benefits.

The Employee Service Rules are proper and are printed in booklet form. Staff indicated that most are aware of these rules and have read part or all.

Job descriptions are prepared for many employees. Performance evaluations in various formats are used during probation and for consideration for promotion.

No administrative or personnel policy manual is available. There is no written promotion policy.

There is a recognised labour union in the hospital. There are regular settlements between the management and the union. Union dues are paid by salary deduction. Most decisions involve the union. Administration believes that this situation has resulted in a more relaxed attitude toward work, some avoidable indiscipline, and increasing demands resulting in financial pressures that must be met by increased charges to patients.

The Administration has an "open door" policy towards employees. There is effort to remedy grievances quickly as well as to resolve discipline matters quickly.

Many staff indicated that they did not undergo orientation when they joined. Many stated that they had not received any further training or developed any new skills while employed.

Some recommendations regarding personnel management are as follows:

1. Have a standard job description format for all departments and staff. Ensure that all employees have a job description and fully understand what is expected from them.
2. Develop a promotion policy and more avenues for promotion in each job category. Promotions should be based on merit and longevity.
3. Have a common performance appraisal form for all employees throughout the hospital. This could be completed by the supervisors quarterly during probation and annually after confirmation.
4. Appointment letters and appointment orders should be standardised and made common for all employees.
5. All personnel policies and other administrative policies should be written and organised into a policy manual. These may be written in a standard format and be available with supervisors for reference.
6. There should be a standard organised orientation program for all new employees.
7. Supervisors should participate in the selection of staff for their departments.
8. The management as a whole along with supervisors should have human resource development plans, both to enhance performance of existing staff as well as to plan for future needs.

Specific Departments Reviewed

Generally the departments assigned to me for review seem to be functioning adequately. For the purpose of report, I will comment on each one briefly.

The Prosthetic and Orthotic Centre treats poor patients including outside referrals. They have adequate staff and space to manage a busy workload. They have a treatment plan for each patient. They do not have any written polices and procedures for the department.

Physiotherapy is well integrated into the patient care team contributing to good patient care for both inpatients and outpatients. The level of staffing, equipment, patient load, hours and record keeping are good. They have no written policies and procedures. The department has been without a department head for nine months at the time of this evaluation.

The clinical laboratory is well staffed, providing 24 hour service to patients. The tests available are wide-ranging and internal and external quality control procedures are in place. The question regarding space was not answered. Disposable syringes are not being used though they stated that universal precautions are being followed. They have no written policies or procedures.

The radiology department provides 24 hour service to patients with good equipment and staff. Reports are given in a timely manner. They have written policies regarding patient preparation and radiation protection.

In the medical records department the basic standards for information management are being met. Staff are not technically trained and the number of staff appears to be less when the patient load is considered.

The pharmacy also is meeting the basic standards. The department does not have written policies and procedures. Adequate staff are in place to provide service to inpatients and outpatients. They state that their space is not adequate. The staff do not have any continuing education or inservice training opportunities.

The CSSD has good written procedures for their functions. They follow quality control and infection control procedures. They state that their space is not adequate. Safety of staff as well as patients is of concern especially with needles that are being reused. Service is not available on Sundays and holidays, but it is not known from data obtained whether there is any supply problem.

The laundry is fully mechanised. The department has written policies and procedures. They are apparently not following universal precautions in the handling of dirty or contaminated linen. With only one dryer, it is not clear if their hours are adequate to supply needed linen.

The dietary service to patients apparently supplies very few diets per day. Diet counselling is available to patients on request. There is no quality control on their diets. Food service for staff is on contract.

Recommendations regarding these areas are as follows:

1. In those departments which see their space as inadequate (pharmacy, CSSD), the management should assess this-and identify solutions if indicated.
2. All departments should develop written policies and procedures relating to their function.
3. Universal precautions, including use of disposable needles and syringes and disposal of sharps, should be strictly followed in all areas.

4. Staffing in medical records department should be reviewed. As vacancies occur, trained medical record officers or medical record technicians can be appointed.
5. Inservice education and continuing education opportunities should be provided for staff at all levels.
6. Adequacy of supply of linen and sterile items on weekends and holidays can be reviewed by the management.
7. Professional staff in dietary department may be increased to provide more patient education. Daily rounds by dietetians in the wards will allow them to identify all patients needing special diets as a part of their long term treatment.
8. Laundry should set standards for rate of loss of linen with targets to decrease present losses.

Ancillary Services

The transport department provides ambulance service for patients as well as transportation for administrative services of the hospital. Staff and vehicles are apparently adequate for needs. There are no written policies or procedures for maintenance of vehicles or accidents.

Security services are provided by an outside contractor. Considering the size of the property as well as buildings, staffing may not be adequate.

Surveys are made regularly to identify hazards in the hospital. Bore wells and generators ensure adequate supply of water and electricity. There is also a plan to meet these needs in future. A disaster plan is in place. The hospital has an incinerator. There are no written procedures for disposal of various kinds of wastes.

The hospital has a program of preventive maintenance for buildings and equipment. There is timely response to complaints from departments regarding building and equipment maintenance.

Recommendations regarding these areas are as follows:

1. All departments should have written policies and procedures.
2. Management should review adequacy of staffing in security, including frequency of complaints and thefts, control of visitors, and maintenance of order within the property
3. Particularly in regard to waste disposal there should be written policies. Not only is this important for the institution, but it is also important in case of further legal requirements.

Spiritual Care

The hospital includes in its objectives provision of competent and comprehensive care of the whole person with love and compassion as taught by Jesus Christ. Spiritual needs are to be met even while respecting the religion of the individual patient or family member. A commitment has been made to provide counselling and support to people in crisis.

Standards by which spiritual care is evaluated were accepted by the review committee. A questionnaire was submitted to the chaplaincy department which was returned in a very incomplete form. Therefore it is assumed that answers to the many questions are unknown or are negative. There appears to be only one chaplain on the staff. There is no report on how many employees are Christian or whether preference is given to Christian applicants when hiring new staff. There was no reply to the question regarding improvement in the attitude of the community towards Christianity as a result of the hospital. It is not clear whether patients have opportunity to hear about Jesus and His peace while in the hospital.

Thirty-eight percent of the staff questioned felt that there was no one to whom they could go to share their problems or personal needs. One staff expressed need for help with an alcohol problem. There has been no special programs or retreats for staff and students in the past year.

One could conclude from this that there is not an emphasis on spiritual care. Rather it is perhaps viewed as incidental. As a Christian institution, this emphasis would be essential in order to justify fully the existence of the hospital in the face of competition and costs of health care in today's world. Feedback from patients is still awaited.

However, it is recommended that the basic purpose and reason for existence be reviewed. If affirmed it should be reflected in a strong Christian attitude and activity from spiritual development of students to hiring and nurturing of staff to spiritual care of patients. Such an emphasis will require human and material resources. But it could be the key to the future of the institution.

Responses from Staff

The majority of staff (94.5%)felt that they were a part of the health care team. Eighty percent felt appreciated in their work. Over 75% felt there was someone in the organisation to whom they could communicate their problems. These are positive points on which further good will and spirit can be developed.

The staff responded with a wide variety of requests, suggestions, and comments. Some did express concern that love and compassion are less evident than before, that care of the poor has decreased, and that quality of care and caring has declined. Many made requests regarding salary, increments, more loan facilities, promotion avenues, resting room, better uniform, easier access to care when sick, more free drugs and crepe bandages, and jobs for staff children. Several requested retreats, staff get togethers, and restoration of Christmas lunch.

There were suggestions regarding their work situation including improved procedures to control infection and protect staff, better availability of supplies like adex and bleach, aprons in lab, improved brooms and rubber gloves for handling contaminated linen. Some felt there was partiality with some staff allowed to work less while others carried a heavier load.

There were numerous suggestions to improve hospital services:

1. Special fund to care for poor people
2. 24 hour reception and enquiry
3. 24 hour pharmacy
4. More security in OPD
5. Drinking water in OPD
6. Improved casualty care
7. Buildings and facilities to be modernised
8. More tertiary care services to be initiated

9. Day care centre for mentally ill
10. Family counselling service
11. Guest rooms for patient relatives
12. Linen to be returned to the ward from which it came
13. Rats to be controlled

Some of these may already exist. Feasibility studies would be required for others. No specific recommendations are made in this section of the report. These responses are included in the report for the information of the management and their consideration as indicated.

Summary

In conclusion, the overall function of the areas of the hospital evaluated is satisfactory. There are many strengths in the institution including its long history of service and good reputation in the city of Bangalore. Certain weaknesses have been identified which may suggest actions to be taken in order that the future will be bright and contribution to the community great in the years ahead.

- Dr. Rebekah Naylor,
Baptist Hospital,
Bangalore.

Subunit N

SUMMARY OF STAFF RESPONSES

TOTAL SAMPLE = 200

QUESTION	N=41 DOCTORS			N= 47 STAFF NURSES			N= 19 WARD INCHARGES			N=15 FACULTY			N= 35 ANCILLARY STAFF			N= 43 CLASS IV			TOTAL		
	Yes (No.%)	No (No.%)	NA (No.%)	YES (No. %)	NO (No. %)	NA (No. %)	YES (No. %)	NO (No. %)	NA (No. %)	Yes (No.%)	No (No.%)	NA (No.%)	YES (No. %)	NO (No. %)	NA (No. %)	YES (No. %)	NO (No. %)	NA (No.%)	YES (No.%)	NO (No.%)	NA (No.%)
1.Someone availble to communicate problems	27(65.8)	14(34.1)	0	43(91.5)	4(8.5)	0	19(100.0)	0	0	14(93.3)	1(6.7)	0	27(77.1)	8(22.9)	0	24(55.8)	19(44.2)	0	154(77.0)	46(23.0)	0
2.Complaints are heard	21(51.2)	18(43.9)	2(4.9)	36(77.0)	11(23.4)	0	18(94.8)	1(5.3)	0	13(86.7)	1(6.7)	1(6.7)	27(77.1)	7(20.0)	1(2.9)	17(39.5)	24(55.8)	2(4.7)	132(66.0)	62(31.0)	6(3.0)
3.Feel part of team	38(92.7)	3(7.3)	0	47(100.0)	0	0	19(100.0)	0	0	14(93.3)	0	1(6.7)	29(82.9)	5(14.3)	1(2.9)	42(97.7)	1(2.3)	0	189(94.5)	9(4.5)	2(1.0)
4.Know mission of hospital	37(90.2)	3(7.3)	1(2.4)	47(100.0)	0	0	19(100.0)	0	0	15(100.0)	0	0	29(82.9)	4(11.4)	2(5.7)	36(83.7)	6(14.0)	1(2.3)	183(91.5)	13(6.5)	4(2.0)
5.Promotion avenues available	11(26.8)	28(68.3)	2(4.9)	30(63.8)	17(36.2)	0	9(47.4)	10(52.6)	0	10(66.7)	3(20.0)	2(13.3)	13((37.1)	21(60.0)	1(2.9)	6(14.0)	36(83.7)	1(2.3)	79(39.5)	115(57.5)	6(3.0)
6.Orientation received when joining institution	14(34.1)	25(61.0)	2(4.9)	45(95.7)	2(4.3)	0	17(89.5)	2(10.5)	0	14(93.3)	1(6.7)	0	9(25.7)	26(74.3)	0	8(18.6)	35(81.4)	0	107(53.5)	91(45.5)	2(1.0)
7.Feels appreciated	21(51.2)	18(44.0)	2(4.9)	42(89.4)	5(10.6)	0	18(94.7)	1(5.3)	0	14(93.3)	1(6.7)	0	24(68.6)	11(31.4)	0	41(95.3)	2(4.7)	0	160(80.0)	38(19.0)	2(1.0)
8.Feels policies/rules fair	23(56.1)	15(36.6)	3(7.3)	42(89.4)	5(10.6)	0	18(94.7)	1(5.3)	0	14(93.3)	1(6.7)	0	29(82.9)	6(17.1)	0	33((76.7)	5(11.6)	5(11.6)	159(79.5)	33(16.5)	8(4.0)
9.Knows Employee Service Rules	34(83.0)	5(12.2)	2(4.9)	40(85.1)	7(14.9)	0	18(94.7)	0	1(5.3)	15(100.0)	0	0	33(94.3)	2(5.7)	0	38(88.4)	5(11.6)	0	178(89.0)	19(9.5)	3(1.5)
10.Opportunity to give suggestion	30(73.2)	9(22.0)	2(4.9)	30(63.8)	17(36.2)	0	14(73.7)	4(21.1)	1(5.3)	13(86.7)	2(13.3)	0	17(48.6)	17(48.6)	1(2.9)	31(72.1)	12(27.9)	0	135(67.5)	61(30.5)	4(2.0)
11.Availability of personnel for guidance	14(34.1)	21(51.2)	6(14.6)	22(46.8)	25(53.2)	0	19(100.0)	0	0	13(86.7)	2(13.3)	0	23(65.7)	12(34.3)	0	23(53.5)	17(39.5)	3(7.0)	114(57.0)	77(38.5)	9(4.5)
12.Work area comfortable and safe	29(70.7)	11(26.8)	1(2.4)	45(95.7)	2(4.3)	0	17(89.5)	2(10.5)	0	15(100.0)	0	0	30(85.7)	5(14.3)	0	38(88.4)	5(11.6)	0	174(87.0)	25(12.5)	1(.5)
13.New skill/training received	17(41.5)	17(41.5)	7(17.1)	40(85.1)	7(14.9)	0	12((63.2)	7(36.8)	0	13(86.7)	2(13.3)	0	23(65.7)	12(34.3)	0	9(21.0)	34(79.1)	0	114((57.0)	79(39.5)	7(3.5)
14.Have job description	26(63.4)	15(36.6)	0	44(93.6)	3(6.4)	0	17(89.5)	2(10.5)	0	15(100.0)	0	0	25(71.4)	10(28.6)	0	40(93.0)	3(7.0)	0	167(83.5)	33(16.5)	0
15.Participates in special/ extracurricular functions	27(65.6)	14(34.1)	0	35(74.5)	12(25.5)	0	9(47.4)	10(52.6)	0	13(86.7)	2(13.3)	0	16(45.7)	19(54.3)	0	1((2.3)	42(97.7)	0	101(50.5)	99(49.5)	0

ATTACHMENT VI

draft

Section 9 Background Reading

~~Chapter - 9~~

The Review drew upon the following background papers, many of which were circulated to all the members of the Team.

1. St. Martha's Hospital - Objectives (Mimeographed Handout)*
2. Provincial Directives - January 1998*
3. Guidelines and Terms of Reference for Reflective Process drawn up by Hospital Commision - January 1998*
4. Framework of Review - approved by Review Committee and Hospital Commission - March 1998*
5. Survey of patients.
6. Mission, Philosophy, Objectives and Strategies of St. Martha's Hospital (Revised Document 1998)*
7. Memorandum of Association of St. Martha's Hospital - September 1965*
8. A Framework for the Establishment/maintenance of a Community Health Department at St. Martha's Hospital - Bangalore, August 1992.
9. Summary of the Discernment of St. Martha's Hospital from November 1988 to November 1986 and its follow up procedures.
10. Working draft of proposed Handing over of SMH to another Church Society (Proposal to CBCI Society of Medical Education).
11. SMH Hospital - 6 options post Discernment with reasons for and against (Handout).
12. New orientation of St. Martha's Hospital - (handout) 21st November, 1986.
13. Some Standards to be considered for the Hospital (Rebekah Naylor)*
14. Annual Report 1997-98, ST. Martha's Hospital, Bangalore - 560 009.
15. Annual Report 1996-97. "
16. Annual Report 1995-96. "
17. Annual Report 1994-95. "
18. Annual Report 1993-94. "
19. Annual Report 1992-93. "
20. Annual Report 1991-92. "
21. Annual Report 1990-91. "
22. Seeking the Signs of the times - A Discussion Document for Study and Action arising out of the CHAI Golden Jubilee Evaluation Study October 1992

23 ?
24 ?
] See original list

Report from Dr. Naylor to the Evaluation Committee
14 September, 1998

Much data has been obtained relative to the areas assigned to me for review. The following work has so far been completed:

1. Documents obtained: Employee Service Rules, organization chart, list of members of the Governing Body, current salary scales, list of employee benefits, sample job description, performance evaluation form, sample appointment letter and appointment order.
2. Some standards for evaluation written and circulated to the committee.
3. Interview with the Administrator, Mr. Saldhana.
4. Questionnaires from departments assigned to me for review: personnel, chaplaincy, Assistant Administrator, dietary, laundry, Prosthetic and Orthotic Center, physiotherapy, laboratory, pharmacy, X-ray, medical records, CSSD
5. General questionnaires from ancillary staff (35) and heads of ancillary departments (initial analysis attached)

The work still to be done is as follows:

1. General questionnaire from other staff - nurses, doctors, and Class IV
2. General questionnaires from other heads of departments
3. Student questionnaires
4. Patient questionnaires
5. If time permits, a visit to some of the departments assigned to me for review.

Any conclusions becoming apparent are actually not valid since so much data is not yet in. Having only seen questionnaires from ancillary staff, I would make the following observations:

1. At all levels, there is very little setting of goals, either long or short term
2. Most have an idea of the mission of the hospital but there is little communication regarding it
3. There is no administrative policy manual available
4. Most departments have no written standards or procedures
5. Orientation of new staff is weak
6. Promotional avenues and policies need review.

It remains to be seen if these observations apply to the rest of the hospital.

Generally the departments which I am requested to evaluate seem to be functioning adequately. Some stated that they have space problems. Several do not have written procedures or standards. Staffing generally seems adequate. I will prepare a detailed summary of each department in view of standards agreed upon.

It would seem that the spiritual ministry is generally not emphasized or is not a priority with the administration. This may not be correct and I will pursue with more questions before making a final report.

Ancillary

QUESTIONNAIRE FOR STAFF

		Blank
1. Is there someone in the organization to whom you can communicate your problems ?	Yes / No 27 8	
2. Do you feel that your complaints or grievances are heard ?	Yes / No 27 7	
3. Do you feel a part of the health care team ?	Yes / No 29 5	1
4. Do you know what is the mission of the hospital ?	Yes / No 29 4	2
5. Do you have promotional avenues open to you ?	Yes / No 13 21	1
6. Did you undergo orientation when you joined the hospital ?	Yes / No 9 26	
7. Do you feel appreciated in your work ?	Yes / No 24 11	
8. Do you think the rules and policies are fair ?	Yes / No 29 6	
9. Have you read and understood the Employee Service Rules ?	Yes / No 33 2	
10. Do you have opportunity to suggest ways that your department's work or function could improve ?	Yes / No 17 17	1
11. If you have a personal or family problem, is there someone in the hospital who can guide or help you ?	Yes / No 23 12	
12. Is the area where you work comfortable and safe ?	Yes / No 30 5	
13. Since joining work, have you received any training or new skills ?	Yes / No 23 12	
14. Do you have a job description ?	Yes / No 25 10	
15. Do you participate in any special events or extra curricular activities in the hospital ?	Yes / No 16 19	

Healthy

QUESTIONNAIRE FOR HEAD OF DEPARTMENTS

		Blank
1. How long have you been Head of the Department ?		
2. Do you conduct regular meetings of employees whom you supervise ?	Yes / No 4 3	3
3. Do you feel that there is good communication with management ?	Yes / No 7 2	1
4. Are you involved in selection of staff for your department ?	Yes / No 5 4	1
5. Are you involved in the annual budget process for your department ?	Yes / No 3 6	1
6. Are you informed about the financial performance of your department ?	Yes / No 4 5	1
7. Do you regularly evaluate the performance of the employees you supervise ?	Yes / No 4 3	3
8. Do you know and understand the vision and mission of the hospital ?	Yes / No 9 1	
9. Do you communicate the vision and mission to your employees ?	Yes / No 5 3	2
10. Does your department have written policies and procedures ?	Yes / No 4 5	1
11. Do you set goals each year for your department ?	Yes / No 1 6	3
12. Do you feel a part of planning and decision making in the organization?	Yes / No 5 4	1
13. Do you orient new employees in your department ?	Yes / No 6 1	3
14. Do you provide any inservice or on the job training for your employees ?	Yes / No 3 4	3
15. Have you attended any seminar, program or course on management training ?	Yes / No 4 5	1
16. Do you have written standards that guide the work of your department ?	Yes / No 3 7	
17. Do you have enough qualified staff to do the required work ?	Yes / No 6 2	2
18. Do all of your employees have job description ?	Yes / No 6 2	2
19. Do you know the organization plan or structure of the hospital ?	Yes / No 7 2	1

8. CHALLENGES AND TASK AHEAD

This chapter will try to answer the seven questions which was included in the Framework of the Review during the Review committees first discussion with the Hospital Commission on 18th March, 1998 {See Appendix 10(ix)}.

It will then enumerate some challenges and tasks before the Hospital sisters and management as they reflect and evolve the vision-mission-growth-development-management plan of the Hospital into 2000 AD.

Finally a short reflection will try to provide a glimpse of the future scenario if the review committee suggestions are internalised by the management. This is hypothetical and perhaps reflects some of the many options the 'hospital sisters' can seek to choose as components of the vision-mission-structure of the ftiure. The Review can only provide some ideas about the 'existing realities' and some ideas about 'future options'. Ultimately the choices and the options must come from within.....

(This Chapter will be the focus of the final meeting on 16th June, 1999. The key suggestions from the remaining chapters have been highlighted and integrated. At the time of action however the previous chapters must be read in context and as complementary / supplementary to the final chapter.)

Question One : Is the Hospital Apostolate in tune/consistent with the charism; mission, vision and philosophy of the Good Shepherd Sisters?

NO

The hospital is a relatively well managed, secondary care oriented mission hospital trying to survive with some difficulty and constraints - many internal; in an increasingly complex 'market economy' and changing external environment and challenges with its own vision and mission.

Not in consonance with the Good Shepherd Sisters modified directives of 1995.

- It is not focussed ***on poor women*** (exploited, oppressed and socially discriminated) ***and children*** though they form a part of the clientele.
- Its not adequately prevention, protection, rehabilitation, and crisis intervention oriented as it could be and all the initiatives be it community health, family welfare, orthotic and rehabilitation unit etc., which add to this dimension are marginal/peripheral to the central focus of ***'acute care for sick and ailing'***.
- Its hospital based and outreach programmes are not adequately linked or supportive off the outreach programmes and initiatives of the other sisters of the Congregation in Bangalore, Karnataka or South India - so that it could be such that it was supportive of more charism oriented initiatives of the others.

YES? But ....

- In its training policy and staff recruitment policy there is some focus on women and some effort in some grades e.g., nursing students and aides to give selective advantage to those from more disadvantaged or difficult backgrounds but this seems more incidental rather than the result of clearly stated policy supported by management guidelines.

(The sisters by taking up professional responsibilities and supported by a large team of committed nurses and some female professional and ancillory staff at all levels are a good role model for women in today's society. This role could be enhanced by clearly stated policy and enhancing the focus towards charismal directive).

Question Two : Does the hospital reach out to the less affluent sections / poor in the population of Bangalore?

NO (in hospital care) not adequately .....

Inspite of an expressed keenness to reach out to less affluent section / poor in Bangalore and some commitment to policies of low cost care (keeping cost of investigation procedures and hospitalisation down), the hospital is able to invest less and less of its funds and income for free and subsidised care over the last few years since its overall position is fast moving into deficit financing further compunded by increasing cost of medical care.

- Has not at governing body or management level seriously addressed this issue recently to evolve any fund raising schemes or initiatives to subsidise this vision to reach the poor.
- While this is marginally compensated for by the very slowly increasing 'outreach efforts' of the newly established CH Department which is establishing 'Primary Health Care' contact with urban slums in Bangalore - even this has not been adequately supported by subsidised referral support which could allow poor in the urban slums served by the hospital to avail of secondary care facilities.

(This is particularly significant because inspite of the development of many corporate hospitals/modern hospitals in Bangalore with sophisticated technology and gadgets and highly professional staff; the mushrooming of small nursing homes and 'specialist' private practitioners; the declining quality of services in government hospitals there is, still urgent need in the presence of 'plenty' for low cost quality secondary care for the poor and marginalised who are increasing in the slums of Bangalore. ***So a Hospital with a mission for the poor and that too poor and exploited women and children (who form the bulk of the poor in Bangalore is still relevant.***)

YES (in training) But .....

- There is some policy in selection of nursing students to increase the number of students from disadvantaged backgrounds and for the tutors to help these students catch up and be equal to the others. However this policy needs to be sharpened; faculty need clear direction and more motivation / encouragement to facilitate this policy; and the numbers in this category must be increased gradually so that its 'central to the training challenge' not marginal to it.

- Also it seems well established that most of the nursing students after graduation and after the bond-phase serve in big city hospitals or go to the gulf to carry on their profession as nurses. Serious consideration must be given to more from just 'excellence in Nursing education' which makes Nurses advantaged in an emerging market economy for trained nurses - to a conscious Social and Community Orientation of the course at all levels and by all faculty so that more are motivated to serve those which the Congregations seek to serve'.

Question Three : Are the Hospital policies in various departments spiritually sound?

Yes, but .....

The overall consensus among patients, nurses, doctors, ancillary staff and reviewers are that the hospital has by and large a committed / dedicated bind of sisters of Good Shepherd and a committed / dedicated bind of doctors / nurses and ancillary staff who are competent and compassionate, courteous and committed to patient care providing this to

all irrespective of caste, creed or income level but ....

1. There seemed to be no clearly stated policy statement on ethics, pastoral care and teachings of the church promoted and upheld by the hospital in its work including the justice dimension.

2. There was no emphasis on spiritual or pastoral care for all the patients.

3. Many staff expressed that there was no one to whom they could go to share their problems or personal needs. Many felt that staff welfare was a low priority concern. This is particularly crucial because those who need to minister a 'value concern' must experience strongly this concern in their working relationship with the institution!

4. There were no special reflections, group discussions, retreats or vision-mission reflections with the staff at the time of joining, or on an ongoing basis to keep up their motivation and commitment to ethics, and a 'pastoral approach to patient care'.

5. While all religions were respected and patients and staff from all religious groups felt accepted there was no pro-active policy or other initiative to enhance the multi religious / multi cultural ethos of the Hospital.

6. There was also a challenge to involve the progressionals more pro-actively in developing a secular (multi religious) humanist autonomous ethical code for hospital practice and not have just a heteronomous ethical code that is thrust on a top-down basis by management. ***This would need a much stronger chaplaincy and a more proactive pastoral care policy for the institution including pro-active introduction of the teaching of ethics in all the training programmes of the institutions.***

Question Four : Is the hospital technically well administered / managed?

YES (technically)

Overall from all sections of stake holders there seemed an overall consensus that the technical quality of the services provided by the hospital was good though there were some concerns that

- The hospital was failing to modernise some of its equipment and technology
- Was resistant some times to ideas, innovations to improve quality of health care.
- Was ignoring some of the national priorities and programmes

However these can be addressed by a more proactive, dialogue and participation of the professional resource persons on the hospital staff with the technical policy planning.

NO with regard to Hospital management / administration

At present there seems to be ***many lacunae*** inspite of committed and overworked Medical Superintendent; a busy Administrator; and a hospital Planning and Executive Committee supported by a Governing Body.

a. The Survey of governance / management identified

- ⇨ No immediate goals or short or long term plans
- ⇨ Inadequate involvement and participation of heads of department and middle management in the decision making processes and planning
- ⇨ No administrative or personnel policy manual and no written promotion policy

- ⇨ No orientation to staff at the time of joining or on a continuous basis regarding hospital policy and goals
- ⇨ No written policies or procedures for many departments that provide crucial and important services. Also for hospital waste disposal procedures
- ⇨ No staff continuing education, inservice training opportunities or policies
- ⇨ No staff safety policy and inadequate attention to staff welfare.

This has resulted in lowering staff morale and staff initiative and creativity.

b. ***The 'Doctors Survey' has identified*** key issues for urgent attention as

- ⇨ inefficiency in health care delivery and planning
- ⇨ not consulting concerned department heads when planning and budgeting
- ⇨ not motivating staff to work in a caring manner
- ⇨ applying different rules and regulations for different people

c. The Nurses Survey has identified some others as

- ⇨ are rules and regulations fair for an reasonable to all the employees?
- ⇨ to have regular meetings with staff?
- ⇨ to set goals each year for the departments
- ⇨ to have written policies and standards in the department
- ⇨ to see to staff professional development and inservice education

(Many individual respondents have given comments and suggestions which are a very good check list for reflection and policy action - see earlier chapters)

ap

Question Five : Does the running of the hospital faithfully reflect the philosophy objectives, strategies as laid out in the papers prepared for the Review?
(with reference to Appendix 10 (iv))

A.	**Objectives**	Findings / Comment	Suggestion / Response
1.	Promote, respect and dignity of all human life.	By and large as reported by staff	Better proactive counselling services are required to further this respect.
2.	Serve all irrespective of caste, creed or race	Good record in this.	Keep it up !
3.	Case of high quality at a cost that common people can afford	Trying to do this in many ways	Needs much more attention by all staff. Creative / socially relevant low cost options to be further explored.
4.	Develop a team spirit and collaborative ethos.	Very weak in this aspect even among the hospital sisters though staff have reported that this spirit was so with the Irish Sisters phase.	Needs more active efforts to build team spirit and common vision ethos among sisters and all grades of staff.
5.	Provide competent / comprehensive health care for whole person.	Care is competent but not wholistic.	Communication and pastoral skills to be enhanced among all staff.
6.	Provide care with honesty and integrity.	Good record in this.	Keep it up !
7.	To conduct educational / teaching programmes with higher standards of competence.	Competence of all courses except perhaps the aides course is very high.	Need greater social and community level skill competence in all cadres.

A.	**Objectives**	Findings / Comment	Suggestion / Response
8.	Provide alternative systems of Health Care.	Except Siddha system doctors in CH team this is a major blind spot.	Need much more attention to low cost plural health systems/ care building dialogue between practitioners and systems.
9.	Participate in improvement of quality of life of people in community.	CH Department work still strongly bio-medical.	This needs a more comprehensive planning and support for CH Department to evolve initiatives in the slums.
10.	Provide counselling and support to people in crisis.	Very little is done by a few. No proactive policy.	Could be a strong component of a more proactive / comprehensive pastoral care policy.
11.	Create awareness of importance of preserving ecologically sound environment.	No action on this as yet.	Could start with effective hospital waste management strategy followed by more eco-sensitive management initiatives.

B.	**Strategies**	Findings / Comment	Suggestion / Response
1.	Promote good and high quality services	Relatively good and quality service.	Need to evolve inhouse quality control measures and indicators.
2.	Rational use of drugs / therapeutics and methods of treatment and care.	Past contribution to CHAI - CMAI formulary supplemented by hospital drug policy well known.	Of late this has become more adhoc / routinised. A more proactive rationalising policy is needed going beyond drugs to technology use and 'procedures' indication.
3.	Selectively upgrade medical technology to keep pace with advancement.	Have been relatively slow in keeping pace not always due to 'secondary care' vision constraint.	Needs to evolve a selection / updating procedure in consonance with evolving vision.

B.	**Strategies**	Findings / Comment	Suggestion / Response
4.	Courteous and considerate to patients / visitors and general public.	Generally good record in this matter.	Keep it up - and evolve proactive staff sensitization.
5.	Create a climate conducive to a pursuit of excellence.	This strategy needs greater clarity.	Excellenece without social / community relevance is not enough.
6.	Motivate all in hospital to be dedicated / committed and give off their best.	No strategy as yet how to do this.	Dialogue and continuing motivation / orientation sessions must be part of ongoing staff development and inhouse training.
7.	Promote health care for all.	This is still rather rhetorical. Needs greater clarity and focus.	What Health Care? Who is the 'all'?
8.	Lay strong emphasis on value education of patients, public, staff, and students.	This strategy needs further clarity on what values? How value education?	Values cannot be taught easily but need to be 'caught'. These need to be gradually internalised into ethos of institution. So all staff absorb it by experience and example.
9.	Readily accessible to those suffering from sickness or those in crisis.	While the first strategy is well developed, the second one needs further clarity and policy evolution.	What crisis? What type of access to be provided?
10.	Create awareness of sound health and evils of smoking / drinking / addiction.	Laudable objective but strategy needs greater clarity and commitment. Health education in hospital is still somewhat adhoc.	Health education in Hospital situation needs much greater emphasis than at present. on all these aspects and many others as well.
11.	Create awareness of clean and healthy environment and living in harmony with nature.	Laudable objective but at present seems mostly rhetorical. Needs greater clarity and framework.	Clarify context of clean / healthy environment. Where? For Whom? Living in harmony with nature - how?

Question Six : Does the financial management of the hospital reflect the objectives and strategies of the hospital?

and

Question Seven : Is the Hospital Sustainable and financially viable?

NO

The comprehensive financial management review which had to function within the constraint of the data that was made available has shown

- Decreasing occupancy rate
- Deficit finances
- Ability to serve poor as target decreasing over the year
- Need for better control and monitoring systems to keep costs down, avoid waste or inefficient expenditure and enhance better resource mobilization and more effective utilization.
- Funds committed not represented adequately by fixed investments
- Do not have a professionally qualified and experienced Financial Team

(Further details in report)

There is urgent need for proactive, professional financial management to enhance financial viability of the hospital which is itself critical to sustain its vision / mission.

+ve

Accounts updated daily

Cash Control is adequate

Interim audit is being done

Donor scheme under section 80G is obtained

Doing their best within their capacity

TASKS AHEAD

The Hospital sisters and the Hospital Management have some important tasks ahead which need urgent, policy consideration and action. Atleast *Five* become somewhat crucial.

1. ***Multidisciplinary Advisory Committee***

   The Governing Body and Hospital Management need the advise and support of a larger body of experts to help them evolve guidelines and strategic responses to the emerging challenges. This must include atleast experts in Hospital Management, Finances; Law; Community Health, Pastoral Care and representatives of the community / civic society especially Women's Organisations, Social Scientists / Social workers and community organisers.

2. ***Fostering Participatory Management and Lay leadership***

   In addition to evolving a more responsive and multi disciplinary advisory structure the hospital should urgently widen the scope of dialogue with and involve more proactively the professional leadership among its doctors and the committed lay leadership among the nurses and other categories of staff especially those who have shown long standing commitment. They should be involved proactively in the vision, mission, objective setting, planning exercises and in the development of strategies to address the dilemmas and challenges that face the hospital.

3. ***Translating Vision/Mission to Hospital Policy guidelines***

   The Vision / Mission / Objectives of the hospital need to be translated into guidelines and hospital policies that are communicated to all concerned and are reviewed from time to time - so that there is consistent experimentation and evolution of policies / action in keeping with the goals. The discernment process at the time of the centenary and the reviews / dialogue since then have thrown up large number of ideas and thrusts. Somewhere along the line the translation of these ideas into specific hospital policy has been a casualty. The present review could meet same fate if commitment to this translation is not strong.

Sometimes earlier directors/administrators have attempted relevant policy evolution and change but these have not been sustained.

Some areas where this needs to be addressed urgently are

i) Financial management towards sustainability
ii) Pastoral Care
iii) Staff development and inservice training including Continuing Education
iv) Quality control of services (standards and benchmarks to be evolved)
v) Long term and short term planning including annual plan at departmental level
vi) Ethical and social / community orientation of all training programmes in consonance with hospital vision.

4. ***Strengthening Management / Administration Capacity***

A more professional approach to Hospital Management particularly personal management and financial management are urgently required. Adhoc, personality oriented decision making is counterproductive and does not allow for the building up of 'systems'.

Identification of full time resource persons including lay / religious trained in hospital management or health care administration with experience in similar hospitals with similar vision / mission is imperative.

Alternatively suitable candidates from existing staff / sisters could be identified and sent for suitable training as a long-term investment.

Financial management skills which must include ability for short term and long term planning and commitment / especially to ensuring sustainability of the hospital must be developed or suitable professionals with relevant experience recruited.

5. ***Towards further integration of 'Hospital' and 'Congregational' charism***

The most important challenge for the 'Hospital Sisters' and management is to 'proactively' and 'confidently' work towards the reduction of the dissonance between the 'Congregational Charism' and the hospital missions, thrusts and existing realities by continuous inhouse participatory discernment and dialogue in active collaboration with the Congregation and all those who share the same vision.

At least five component action initiatives are crucial for meeting this challenge.

a. Serious efforts to strengthen the Community Health Department and the Hospital outreach / extension work as an institutional mandate involving all faculty and departments supported by strong policy commitments and not the 'adhoc amateurism' that is the reality today.

policy

All items underlined
note it well

b. Exploring and establishing links with all the 'charismal initiatives of the sisters of the congregation so that all their institutional and non institution work with poor women and children (particularly those marginalised and exploited is supported socio-medically as much as possible.)

c. Establishing meaningful linkages with women's groups and other voluntary agencies who are working with women focussing on poor / oppressed / marginal / exploited and evolving concrete support strategies and collaborative projects e.g,

Some possibilities are:

i. An AIDS ward and AIDS care and counselling centre is an urgent need in Bangalore.
ii. A Burns ward with an associated counselling service to handle the increasing phenomenon of dowry deaths and suicides and violence against women.
iii. Providing 'training' facilities and space for women's groups in Bangalore with some involvement of socially sensitive sisters and faculty.
iv. A more proactive family life education centre which is committed to more than just NFP and skilled to tackle a wider range of family problems.
v. An active 'Women's Health' initiative with women's colleges in Bangalore that could help prepare women students for greater autonomy in Health through active health education and counselling services.

There could be many more

d. Serious efforts to share vision / mission with all staff and students not as top down directives but through creative dialogue and collective action at all levels encouraging their involvement in a, b and c.

e. There is need for greater unity of purpose and team work and collectivity among the hospital sisters themselves since they form the 'Core' of the human resource team of the hospital that has to constantly and consciously outline and operationalise the hospitals vision / mission in consonance with the congregational charism. Any compartmentalisation; competition; problems of communication; strong divergence of views and styles; lack of coordination; and lack of constant commitment to group decision making over individuality can be detrimental to the whole process and affect staff enthusisasm and morale and 'divert' or distract the hospital team from its commitment to quality action. While this many often be inadvertent or accidental or even incidental to job responsibilities and demands of specific roles - taking the onus for a 'charismatic collectivity' is a crucial responsibility.

In the final analysis St. Martha's Hospital is a hospital today with its ***strengths*** far outweighing its ***weaknesses*** and its ***opportunities*** far outweighing its ***threats***. With a Core group of experienced and committed sisters and a large number of very conscientous, committed and quality docotrs, nurses and staff - whose creativity and

potential is waiting to be harnessed by a more proactive Hospital Management policy that is strengthened in some of the directions identified by the multidisciplinary review committee, the hospital can look forward to becoming a role model of a Mission Hospital with a Vision / Mission to reach out to "poor exploited, oppressed and socially discriminated especially girls and women in personal family and social difficulties .... Working with girls and women deprived of hope and love ..... prevention, protection, rehabilitation and crisis intervention"....

A pioneer Mission Health care Institution for the next millenium

SMH

ST. MARTHA'S HOSPITAL - 2000 A.D.

A Scenario

The St. Martha's Institute of Women and Childrens Health is a Centre dedicated to providing clinical and counselling support to a growing network of initiatives in Women and Children's Health in Bangalore City, which is now one of the twenty largest metropolitan cities of the world. . .

The Institute includes under its jurisdiction the old St. Martha's Hospital which phased out some of its older departments and focussed all the remaining department on Women and Children's health; the college of nursing; the institute of allied health professionals (now located in the old Priests quarters) and which trains members of the health team - nursing aids, laboratory technicians, CBR workers, lay counsellors, community health organisers and Family life educators through a wide range of short courses. Some at certificate and diploma level recognised by the Karnataka Government and the three national Health Coordinating agencies - VHAI, CHAI and CMAI and their member hospitals; the Uttarahalli Rural health centre, now a key field practice area of the insitute extending its outreach services to a 100 villages on the periurban fringe of Bangalore; the Integrated Community Health Department which has a Network of eight urban primary health care units of which three are centres built with full participation of urban slum committees where the hospital worked in the later 1990s; three are centre run by Women's organisations in Bangalore with a memorandum of understanding with the institute and two are IPP-8 urban MCH units that have memorandum of understanding between corporation and the Institute.

The Institute has a multidisciplinary advisory committee consisting of well known women professionals from Social Sciences, Psychology, Management, Law, Pastoral Care and Theology and Community Health and representatives of eight women's organisations who work focussed on groups similar to the Institutes charism. This committee meets once a quarter and helps the Instiutte's planning and advisory Committee and Academic committee to sharpen its focus on women's health issues and supports all the institutes service, training and research initiatives in other ways.

The staff of the Institute are professionally quallified and highly dedicated group of women resource persons both lay and religious who are inspiring role models for students, trainess and all the beneficiaries of the Institutes initiatives. The institute has a strong women focussed policy and the campus is women friendly providing a well run creche for working mothers, a women's health insurance scheme, a women's

counselling service that caters to women particularly of the poor and low income groups from all over the city.

The clinical work of the hospital has some distinctive features. There is a 30 bed Burns unit which offers a wholistic care and counselling programme and is actively involved in supporting women through this crisis and working in other ways to reduce violence against women at family level; there is 15 bed HIV/AIDS ward that caters to women with an HIV problem and provides all types of clincial support and procedures; the medicine and OBG department are working specially on women's health issues such as cervical cancer, and 'women and drugs' issues; the psychiatry department specialises in Family Counselling and works closely with Child Health work on care of girl children and adolescent girls at community level.

All these departments run extension clinics and contact centres for education and counselling services especially in the urban network of centres and support self help groups among women in this areas.

The Institute is affiliated to the Women's Study programme of the Bangalore University and closely collaborates with various faculty from different departments of the university in providing socio-medical support to thei research and training initatives.

The Community Health Department of the Institute is also the affiliated Urban Primary Health Care training centre for the Catholic Health Association of India; the Nursing College is the founder facilitator of a network of community oriented and socially relevant nurse trainers in Karnataka; the Pastoral Care unit specialises in women's couselling and has a collaborative training with Christian Medical Association of India in training female chaplains and pastoral care workers; the alternative medicine unit is part of a network of holistic health centres in the CHAI network and also works closely with the Foundation for Revitalization of Local Health Traditions on evaluation and then endorsing local herbal remedies and local home remedies (including grandmother recipes). As part of the support to the health movement the institute has also provided space on its campus on long term lease of the CHAI-Karnataka health office; the Voluntary Health Association of Karnataka and two Women's support group NGO's. Staff of these centres also support many of the initiatives of the Institute. The relationship is mutually supportive. The cadre of the Institute include some of the senior / experienced sisters of SMH and some younger ones who have had special training in pastoral care, management including personnel and financial management, social welfare, alternative systems of medicine, Counselling, which are some of the newer policy thrusts of the institute. They are supported by experienced 'religious' from other congregations and an increasing team of lay women professionals who form an essential component of the emerging generation of women in Health and Development. The institute has many men on its

staff at various positions who are gender sensitive and supportive of the new thrust and agenda.

The institute is supported by i) A corpus or endowment fund that emerged from an active fund raising drive that included approaching all the alumni, nurses, doctors and well wishes of SMH.

ii) The training and research activities are funded by a range of governmental and non-governmental funding agencies and trusts both local and foreign who are keen to support the women's health thrust of the institute.

iii) Three nationalised banks, and two public sector units and three private sector units also support the institute under their corporate social responsibility initiative.

iv) Finally the Core group of sisters have believed in providence and grace for more than a century and that source has never let them down!!

FRAMEWORK OF REVIEW

{For consideration of Review Committee and Health Commission on 18th March, 1998}

Review of St. Martha's Hospital through a reflective process (March - September 1998).

A. Some Key Questions / Issues to be considered by Review Committee in the context of the TOR, the background papers and Annual Report of 1996-97 provided by the Health Commission.

1) **Is the Hospital Apostolate in tune/consistent with charism, mission, vision, and philosophy of the Good Shepherd Sisters? Which is:**

i) "Poor, exploited, oppressed and socially discriminated, especially girls and women, in personal, family and social difficulties through institutionalised and non-institutionalised efforts in urban and rural areas ....." (January 1995)

ii) "Children, girls and women....including commercial sex workers, twilight girls, persons with AIDS, working children (child labour) and domestic women workers ....." (January 1995)

- *How does this 'charism' figure in the:*
  - *a) Focus of the work of the hospitals?*
  - *b) Focus of the type of staff/team members in the institution?*
  - c) *Focus of the nurses training institution?*

- *Does the charism mean the hospital should focus on women, women's ill health and women's problems ?*
  If yes, then how ?
  If No, then why not ?

2) **Does the hospital reach out to the less affluent sections/poor in the population of Bangalore?**

a) What percentage of outpatient/inpatient are provided free/subsidised care?
b) Is this trend increasing, status quo or decreasing?

c) What other measures are being taken to make the services of the hospital, become more accessible or utilised by the poor and marginalised?
d) What problems have been faced to increase the percentage of free and subsidised care?

3) Are the hospital policies in various departments spiritually sound?

a) Are all practices, rules, mode of functioning ethical?
b) Are all religions respected?
c) Is adequate compassion shown to patients through pastoral care?
d) Is care taken to avoid negligence? / dehumanization?
e) Are the teachings of the Church promoted and or upheld by the hospitals work?
f) Is the justice dimension in Health and health care addressed by the hospital?
g) Any others?

4) Is the hospital technically well administered / managed?

a) Are the policies/programmes/activities rational?
b) Are the policies/programmes/activities logical?
c) Are the policies/programmes/activities efficiently managed?
d) Are the programmes/activities adequately utilized by the public?
e) How are the policies/programmes planned, monitored, evaluated?
f) Are there any weaknesses in the functioning of the hospital services? If so, what can be identified as specific remedial measures?

5) Does the running of the hospital faithfully reflect the philosophy, objectives, strategies as laid out in the papers prepared for the review?
(Issues not covered above)

Objectives

a) Promote, respect and dignity of all human life
b) Serve all irrespective of caste, creed or race
c) Care of high quality at a cost that common people can afford
d) Develop a team spirit and collaborative ethos
e) Provide competent/comprehensive health care for whole person
f) Provide care with honesty and integrity
g) To conduct educational/teaching programmes with high standard of competence
h) Provide alternative systems of health care (!)

i) Participate in improvement of quality of life of people in the community.
j) Provide counselling and support to people in crisis
k) Create awareness of importance of preserving ecologically sound environment

Strategies

a) Promote good and high quality service
b) Rational use of drugs/therapeutics and methods of treatment and care
c) Selectively upgrade medical technology to keep pace with advancements
d) Courteous and considerate to patients, visitors and general public
e) Create a climate conducive to a pursuit of excellence
f) Motivate all in hospital to be dedicated/committed and give off their best.
g) Promote health care for all.
h) Lay strong emphasis on value education of patients, public, staff and students
i) Readily accessible to those suffering from sickness/or those in crisis
j) Create awareness of sound health and evils of smoking, drinking and addiction
k) Create awareness of clean and healthy environment and living in harmony with nature

{Please note there is some overlap between objectives and strategies as enunciated in the background note}

6) **Does the Financial Management of the hospital reflect the objectives and strategies of the hospital?**

a) The budget
b) The income and expenditure of the hospital
c) The processes of financial management (Accounting - Auditing)
d) Is the hospital financially sound? (Next 10 years)

7) Is the hospital sustainable and financially viable?

{Note: All members of the Review team will consider these questions and issues extracted from the TOR and background papers, and contextualise them to the areas/sectors of the hospital which they are studying}

B. Areas/Sectors for Review (identified from Annual Report 1996-97)

1) Vision / Mission
2) Governance / Advisory Board
3) Hospital organisation/Administration
4) Income / Expenditure
5) Financial Management policy
6) Concessional care
7) Capital Investments
8) Donations
9) Personnel Management policy
10) Endowment fund
11) Community Health Department
12) Nursing/Midwifery Training
13) Community Health Nursing
14) National Board of Examination
15) Radiographers Training
16) Clinical laboratory Technician course
17) Hospital Aids
18) Professional Meetings - Clinical Societies
19) Infection control Committee
20) Drugs/Therapeutics Committee
21) Medicine Department
22) Coronary Care Unit
23) Intensive Therapy Unit
24) Graded care unit
25) Paediatrics
26) Premature Unit
27) Sick Nursery
28) Dermatology
29) Psychiatry
30) General Surgery
31) Surgical ICU
32) Paediatric surgery
33) Plastic Surgery
34) Opthalmology
35) ENT
36) Orthopaedics
37) OBG
38) Day care ward
39) Anaesthesiology
40) Family Welfare Centre
41) Prosthetic and Orthotic Centre
42) Physiotherapy Department
43) Medico Social Unit

Allotment of Areas to Review Team Members

RNE = 1, 11, 12-20, 40, 43, 50 55, 59-62

PP = 21-39, 49

HAC = 12, 13, 55, 57 Nurses in 21-39, 49

Rdg = 2, 3, 9, 41, 42, 44-47 51-53, 56

TK = 2-8, 10,

Bring 44-62 in same page

44) Pharmacy
45) CSSD
46) Central Clinical Laboratory
47) Radiology
48) Dental/Oral Surgery
49) Casualty Department
50) Staff Health Service
51) Medical Records Department
52) Laundry
53) Dietary Department/Canteens
54) Library
55) Perpetual Help Health Centre - Uttarahalli
56) Ancillary Services - Security, Telephone, Fpr/Water/Maintenance
57) Nursing College
58) Future/Ongoing Plans

Others

59) Linkages - Church
60) Linkages - Non-Church
61) Congregational expectations
62) Women's Groups expectations

C. Time Framework & Schedule of Review

1. Preliminary Meetings {March 1998}:

TOR: Objectives / Issues / Questions
Distribution of Responsibilities
Planning

2. Preliminary Data Collection: Two Months (April - May 1998)

Each member will review the areas allotted to them and do their own data collection in coordination with Sr. Mercy/Sr. Ann Marie of the Health Commission

3. First Interactive Dialogue of Review Committee and Health Commission (June 1998)

Focus on key questions and gather ideas/datas for each question from different reviews conducted by members of the review committee

4. Next round of Data Collection / Analysis / Preliminary Reports (June - July 1998)

5. Second Interactive Dialogue of Review Committee & Health Commission (August 1998)

Draft Report in sections to be circulated for perusal before dialogue

6. Final Meeting of Review Committee to finalise report and recommendations (Early September 1998).

{The Chairperson of the Review Committee will keep in touch with all the members, and the members should also keep him informed about the progress of the review Dialogue and ongoing clarification will go on through the process through informal meetings and telephonic and postal communications}

To :

Department :

St. Martha's Hospital Review – 1998

THE HEALTH COMMISSION SET UP BY THE PROVINCIAL CHAPTER OF THE GOOD SHEPHERD SISTERS, HAVE REQUESTED A TEAM OF RESOURCE PERSONS TO REVIEW THE HEALTH MINISTRY OF ST.MARTHA'S HOSPITAL THROUGH A PARTICIPATORY, INTERACTIVE AND REFLECTIVE PROCESS. AS PART OF THIS PROCESS, STAFF OF ST.MARTHA'S HOSPITAL AND A SAMPLE OF STUDENTS OF THE NURSING COLLEGE AND PATIENTS ARE BEING INVITED TO PARTICIPATE, BY FILLING IN SPECIAL QUESTIONNAIRES PREPARED BY THE REVIEW COMMITTEE. THESE WILL BE CIRCULATED / ADMINISTERED IN JULY 1998. APART FROM THE SPECIFIC QUESTIONS ASKED IN SPECIAL FORMAT, PLEASE FEEL FREE TO OFFER ANY OTHER SUGGESTIONS FOR CONSIDERATION BY THE REVIEW TEAM. YOUR PARTICIPATION IN THIS REVIEW IS CRUCIAL TO HELP US IDENTIFY THE FUTURE DIRECTIONS AND THRUSTS AND ALSO MEASURES TO MAKE THE HEALTH MINISTRY MORE MEANINGFUL. ALL YOUR RESPONSES AND SUGGESTIONS WILL BE CONFIDENTIAL. WE INVITE YOU TO JOIN US IN THE TASK AND MAKE THE REVIEW, A SUCCESS.

Dr. Ravi Narayan
Mr. Thomas Kandasami
Ms. Mary Ann Charles

Dr. Prem Pais
Dr.Rebekah naylor

15TH JULY 1998

S.M.H. BANGALORE

[All completed questionnaires must be returned to the **Medical / Nursing Superintendents** offices latest by 28th July 1998 and put in the box specifically provided for them]

YOUR OPINION IS CRUCIAL

JOIN THE REVIEW

Please detach this page from the proforma before submitting.

Survey of Governance, Hospital Management, Personnel Management, Associated and Ancillary Departments

As a member of the Review Committee which was formed to evaluate St. Martha's Hospital through a reflective process, I was assigned the following specific areas for review:

1. Governance / Advisory Board
2. Hospital Organisation / Administration
3. Personnel Management Policy
4. Departments including prosthetic and orthotic centre, physiotherapy, pharmacy, radiology, laboratory, CSSD, medical records, laundry, and dietary
5. Ancillary services including security, telephone, water, electricity, maintenance, transport
6. Spiritual care of patients

Evaluation was undertaken in such a way that the questions posed in the terms of reference could be answered. The goal is to gather information and propose recommendations which could further strengthen the institution as it moves into a new century.

The methodology adopted was as follows:

1. Standards for evaluation in the assigned areas were proposed and accepted by the review committee (attachment I)
2. Documents obtained for review included the 1996 - 97 annual report, employee service rules, organisation chart, list of members of Governing Body, current salary scales, list of employee benefits, sample job description, performance evaluation form, sample appointment letter and appointment order.
3. An interview was conducted with the Administrator, Mr. A.C. Saidhana.
4. Questionnaires were completed by the heads of the departments and services assigned to me for review (attachment II)
5. Questionnaires were given to staff (attachment III),students (attachment IV), and all department heads / supervisors (attachment V).
6. Questionnaires were also given to patients (not yet completed).

Data collected are presented in attachment VI (staff), attachment VII (students), attachment VIII (department heads / supervisors). The staff and department heads were asked to give their suggestions.

This report summarises the information which was gathered and then makes conclusions and recommendations in each assigned area.

Vision and Mission

The entire review committee was given the responsibility to reflect on the vision and mission of the hospital and its expression in all activities and functions of the hospital.

The vision and mission as stated in the stated papers given to the committee is that of the sisters of the Good Shepherd and it is assumed that these statements also apply to the hospital. There are statements of belief, objectives, and strategies that arise from this vision and mission.

Among heads of departments, 94.3% said that they understood the mission of the hospital and 82.9% communicate it to their employees. Among the 200 staff questioned, 91.5% indicated that they know the mission of the hospital. These figures are not verified in the sense that no one was asked to state the mission.

It was observed that the hospital does not have immediate goals or a five or a ten year plan. Only 34.3% of department heads set goals for their departments each year. Reasons given by Administration for lack of planning include age of the institution; changing government policies, and unpredictable economic conditions.

The recommendations suggested are as follows:

1. Based on the vision and mission statement of the order, the hospital management should prepare a specific vision and mission statement and submit it to the Governing Body and the Sisters of Good Shepherd for approval.
2. Based on this vision, organisational planning should take place. Departments should be required to set annual goals that are measurable. The organisation should have annual goals as well as longer term goals. The five year plan can be reviewed and modified on a regular basis as required by internal and external circumstances.

Governance / Advisory Board

The hospital is owned by the Good Shepherd Sisters. The order is represented in the hospital by the Sister Superior. The Chief Executive Officer of the hospital (Administrator) is appointed by the order. The Administrator is accountable to the Sister Superior.

There is a Governing Body which meets usually twice annually. The majority of this Board are from within the hospital or order. Only six members, a minority, are from outside. The Governing Body does approve the annual budget. The Board has a wide range of power for review and supervision. They approve major policies and new projects. It is assumed that this group along with the Chief Officer ensure that the organisation adheres to relevant statutory and regulatory requirements.

It is recommended that there be more voice in the Governing Body from outside including the community, experts in hospital management and experts in finance. There should be an established process and criteria identified for selection of the Chief Executive Officer, perhaps including a recommendation from the Governing Body to the order on the selection.

Hospital Organisation and Administration

An organisational structure is in place and most management and supervisory personnel are aware of it. The channels of communication are clear.

The Planning and Executive Committee, chaired by the Administrator, consists of the top officers and meets on regular basis. All decisions that affect the whole of the organisation or all employees are taken by this group. This represents a good participative management style.

In the area of finance, middle management seems less involved. Of the 35 heads of departments / supervisors who responded, only 31% were involved in the annual budgeting process for their departments, and only 28.6% were informed about the financial performance of the department. Just over half (54.3%) have regular department meetings with their employees. Only 28.6% were involved in selection of staff. These data suggest that the organisation would be stronger if middle management was strengthened and participated in decision making.

An administrative policy manual is needed in order that decisions will be consistent, fair and objective.

Human Resources (Personnel Management)

The personnel department of the hospital seems adequately staffed. records are maintained for all employees. There are cadre positions determined by the Governing Body in all areas of the hospital. This results in adequate but not excessive staffing.

Salaries are similar or higher in all categories when compared to other non-profit voluntary hospitals in the city of Bangalore. It is noted that in each major job category there are only two, or at most three grades limiting avenues for promotion. For class four staff, there appears to be only one grade. Other employee benefits are available including adequate leave, uniforms, festival advance, education advance, salary advance, and medical benefits.

The Employee Service Rules are proper and are printed in booklet form. Staff indicated that most are aware of these rules and have read part or all.

Job descriptions are prepared for many employees. Performance evaluations in various formats are used during probation and for consideration for promotion.

No administrative or personnel policy manual is available. There is no written promotion policy.

There is a recognised labour union in the hospital. There are regular settlements between the management and the union. Union dues are paid by salary deduction. Most decisions involve the union. Administration believes that this situation has resulted in a more relaxed attitude toward work, some avoidable indiscipline, and increasing demands resulting in financial pressures that must be met by increased charges to patients.

The Administration has an "open door" policy towards employees. There is effort to remedy grievances quickly as well as to resolve discipline matters quickly.

Many staff indicated that they did not undergo orientation when they joined. Many stated that they had not received any further training or developed any new skills while employed.

Some recommendations regarding personnel management are as follows:

1. Have a standard job description format for all departments and staff. Ensure that all employees have a job description and fully understand what is expected from them.
2. Develop a promotion policy and more avenues for promotion in each job category. Promotions should be based on merit and longevity.
3. Have a common performance appraisal form for all employees throughout the hospital. This could be completed by the supervisors quarterly during probation and annually after confirmation.
4. Appointment letters and appointment orders should be standardised and made common for all employees.
5. All personnel policies and other administrative policies should be written and organised into a policy manual. These may be written in a standard format and be available with supervisors for reference.
6. There should be a standard organised orientation program for all new employees.
7. Supervisors should participate in the selection of staff for their departments.
8. The management as a whole along with supervisors should have human resource development plans, both to enhance performance of existing staff as well as to plan for future needs

Specific Departments Reviewed

Generally the departments assigned to me for review seem to be functioning adequately. For the purpose of report, I will comment on each one briefly.

The Prosthetic and Orthotic Centre treats poor patients including outside referrals. They have adequate staff and space to manage a busy workload. They have a treatment plan for each patient. They do not have any written polices and procedures for the department.

Physiotherapy is well integrated into the patient care team contributing to good patient care for both inpatients and outpatients. The level of staffing, equipment, patient load, hours and record keeping are good. They have no written policies and procedures. The department has been without a department head for nine months at the time of this evaluation.

The clinical laboratory is well staffed, providing 24 hour service to patients. The tests available are wide-ranging and internal and external quality control procedures are in place. The question regarding space was not answered. Disposable syringes are not being used though they stated that universal precautions are being followed. They have no written policies or procedures.

The radiology department provides 24 hour service to patients with good equipment and staff. Reports are given in a timely manner. They have written policies regarding patient preparation and radiation protection.

In the medical records department the basic standards for information management are being met. Staff are not technically trained and the number of staff appears to be less when the patient load is considered.

The pharmacy also is meeting the basic standards. The department does not have written policies and procedures. Adequate staff are in place to provide service to inpatients and outpatients. They state that their space is not adequate. The staff do not have any continuing education or inservice training opportunities.

The CSSD has good written procedures for their functions. They follow quality control and infection control procedures. They state that their space is not adequate. Safety of staff as well as patients is of concern especially with needles that are being reused. Service is not available on Sundays and holidays, but it is not known from data obtained whether there is any supply problem.

The laundry is fully mechanised. The department has written policies and procedures. They are apparently not following universal precautions in the handling of dirty or contaminated linen. With only one dryer, it is not clear if their hours are adequate to supply needed linen.

The dietary service to patients apparently supplies very few diets per day. Diet counselling is available to patients on request. There is no quality control on their diets. Food service for staff is on contract.

Recommendations regarding these areas are as follows:

1. In those departments which see their space as inadequate (pharmacy, CSSD), the management should assess this and identify solutions if indicated.
2. All departments should develop written policies and procedures relating to their function.
3. Universal precautions, including use of disposable needles and syringes and disposal of sharps, should be strictly followed in all areas.

4. Staffing in medical records department should be reviewed. As vacancies occur, trained medical record officers or medical record technicians can be appointed.
5. Inservice education and continuing education opportunities should be provided for staff at all levels.
6. Adequacy of supply of linen and sterile items on weekends and holidays can be reviewed by the management.
7. Professional staff in dietary department may be increased to provide more patient education. Daily rounds by dietetians in the wards will allow them to identify all patients needing special diets as a part of their long term treatment.
8. Laundry should set standards for rate of loss of linen with targets to decrease present losses.

Ancillary Services

The transport department provides ambulance service for patients as well as transportation for administrative services of the hospital. Staff and vehicles are apparently adequate for needs. There are no written policies or procedures for maintenance of vehicles or accidents.

Security services are provided by an outside contractor. Considering the size of the property as well as buildings, staffing may not be adequate.

Surveys are made regularly to identify hazards in the hospital. Bore wells and generators ensure adequate supply of water and electricity. There is also a plan to meet these needs in future. A disaster plan is in place. The hospital has an incinerator. There are no written procedures for disposal of various kinds of wastes.

The hospital has a program of preventive maintenance for buildings and equipment. There is timely response to complaints from departments regarding building and equipment maintenance.

Recommendations regarding these areas are as follows:

1. All departments should have written policies and procedures.
2. Management should review adequacy of staffing in security, including frequency of complaints and thefts, control of visitors, and maintenance of order within the property
3. Particularly in regard to waste disposal there should be written policies. Not only is this important for the institution, but it is also important in case of further legal requirements.

Spiritual Care

The hospital includes in its objectives provision of competent and comprehensive care of the whole person with love and compassion as taught by Jesus Christ. Spiritual needs are to be met even while respecting the religion of the individual patient or family member. A commitment has been made to provide counselling and support to people in crisis.

Standards by which spiritual care is evaluated were accepted by the review committee. A questionnaire was submitted to the chaplaincy department which was returned in a very incomplete form. Therefore it is assumed that answers to the many questions are unknown or are negative. There appears to be only one chaplain on the staff. There is no report on how many employees are Christian or whether preference is given to Christian applicants when hiring new staff. There was no reply to the question regarding improvement in the attitude of the community towards Christianity as a result of the hospital. It is not clear whether patients have opportunity to hear about Jesus and His peace while in the hospital.

Thirty-eight percent of the staff questioned felt that there was no one to whom they could go to share their problems or personal needs. One staff expressed need for help with an alcohol problem. There has been no special programs or retreats for staff and students in the past year.

One could conclude from this that there is not an emphasis on spiritual care. Rather it is perhaps viewed as incidental. As a Christian institution, this emphasis would be essential in order to justify fully the existence of the hospital in the face of competition and costs of health care in today's world. Feedback from patients is still awaited.

However, it is recommended that the basic purpose and reason for existence be reviewed. If affirmed it should be reflected in a strong Christian attitude and activity from spiritual development of students to hiring and nurturing of staff to spiritual care of patients. Such an emphasis will require human and material resources. But it could be the key to the future of the institution.

Responses from Staff

The majority of staff (94.5%)felt that they were a part of the health care team. Eighty percent felt appreciated in their work. Over 75% felt there was someone in the organisation to whom they could communicate their problems. These are positive points on which further good will and spirit can be developed.

The staff responded with a wide variety of requests, suggestions, and comments. Some did express concern that love and compassion are less evident than before, that care of the poor has decreased, and that quality of care and caring has declined. Many made requests regarding salary, increments, more loan facilities, promotion avenues, resting room, better uniform, easier access to care when sick, more free drugs and crepe bandages, and jobs for staff children. Several requested retreats, staff get togethers, and restoration of Christmas lunch.

There were suggestions regarding their work situation including improved procedures to control infection and protect staff, better availability of supplies like adex and bleach, aprons in lab, improved brooms and rubber gloves for handling contaminated linen. Some felt there was partiality with some staff allowed to work less while others carried a heavier load.

There were numerous suggestions to improve hospital services:

1. Special fund to care for poor people
2. 24 hour reception and enquiry
3. 24 hour pharmacy
4. More security in OPD
5. Drinking water in OPD
6. Improved casualty care
7. Buildings and facilities to be modernised
8. More tertiary care services to be initiated

9. Day care centre for mentally ill
10. Family counselling service
11. Guest rooms for patient relatives
12. Linen to be returned to the ward from which it came
13. Rats to be controlled

Some of these may already exist. Feasibility studies would be required for others. No specific recommendations are made in this section of the report. These responses are included in the report for the information of the management and their consideration as indicated.

Summary

In conclusion, the overall function of the areas of the hospital evaluated is satisfactory. There are many strengths in the institution including its long history of service and good reputation in the city of Bangalore. Contain weaknesses have been identified which may suggest actions to be taken in order that the future will be bright and contribution to the community great in the years ahead.

Certain

Dr Rebekah Naylor
Baptist Hospital
Bangalore.

Subunit N

SUMMARY OF STAFF RESPONSES

TOTAL SAMPLE = 200

QUESTION	DOCTORS N=41			STAFF NURSES N=47			WARD INCHARGES N=19			FACULTY N=15			ANCILLARY STAFF N=35			CLASS IV N=43			TOTAL		
	Yes (No.%)	No (No.%)	NA (No.%)	YES (No. %)	NO (No. %)	NA (No. %)	YES (No. %)	NO (No. %)	NA (No. %)	Yes (No.%)	No (No.%)	NA (No.%)	YES (No. %)	NO (No. %)	NA (No. %)	YES (No. %)	NO (No. %)	NA (No.%)	YES (No.%)	NO (No.%)	NA (No.%)
1.Someone availble to communicate problems	27(65.8)	14(34.1)	0	43(91.5)	4(8.5)	0	19(100.0)	0	0	14(93.3)	1(6.7)	0	27(77.1)	8(22.9)	0	24(55.8)	19(44.2)	0	154(77.0)	46(23.0)	0
2.Complaints are heard	21(51.2)	18(43.9)	2(4.9)	36(77.0)	11(23.4)	0	18(94.8)	1(5.3)	0	13(86.7)	1(6.7)	1(6.7)	27(77.1)	7(20.0)	1(2.9)	17(39.5)	24(55.8)	2(4.7)	132(66.0)	62(31.0)	6(3.0)
3.Feel part of team	38(92.7)	3(7.3)	0	47(100.0)	0	0	19(100.0)	0	0	14(93.3)	0	1(6.7)	29(82.9)	5(14.3)	1(2.9)	42(97.7)	1(2 3)	0	189(94.5)	9(4.5)	2(1.0)
4.Know mission of hospital	37(90.2)	3(7.3)	1(2.4)	47(100.0)	0	0	19(100.0)	0	0	15(100.0)	0	0	29(82.9)	4(11.4)	2(5.7)	36(83.7)	6(14.0)	1(2.3)	183(91.5)	13(6.5)	4(2.0)
5.Promotion avenues available	11(26 8)	28(68.3)	2(4.9)	30(63 8)	17(36.2)	0	9(47.4)	10(52.6)	0	10(66.7)	3(20.0)	2(13.3)	13((37.1)	21(60.0)	1(2.9)	6(14.0)	36(83.7)	1(2.3)	79(39.5)	115(57.5)	6(3.0)
6.Orientation received when joining institution	14(34.1)	25(61.0)	2(4.9)	45(95.7)	2(4 3)	0	17(89.5)	2(10.5)	0	14(93.3)	1(6.7)	0	9(25.7)	26(74.3)	0	8(18.6)	35(81.4)	0	107(53.5)	91(45.5)	2(1.0)
7.Feels appreciated	21(51.2)	18(44.0)	2(4.9)	42(89.4)	5(10.6)	0	18(94.7)	1(5.3)	0	14(93.3)	1(6.7)	0	24(68.6)	11(31.4)	0	41(95.3)	2(4.7)	0	160(80.0)	38(19.0)	2(1.0)
8.Feels policies/rules fair	23(56.1)	15(36.6)	3(7.3)	42(89.4)	5(10.6)	0	18(94.7)	1(5.3)	0	14(93.3)	1(6.7)	0	29(82.9)	6(17.1)	0	33((76.7)	5(11.6)	5(11.6)	159(79.5)	33(16.5)	8(4.0)
9.Knows Employee Service Rules	34(83.0)	5(12.2)	2(4.9)	40(85.1)	7(14.9)	0	18(94.7)	0	1(5.3)	15(100.0)	0	0	33(94.3)	2(5.7)	0	38(88.4)	5(11.6)	0	178(89.0)	19(9.5)	3(1.5)
10.Opportunity to give suggestion	30(73.2)	9(22.0)	2(4.9)	30(63.8)	17(36.2)	0	14(73.7)	4(21.1)	1(5.3)	13(86.7)	2(13.3)	0	17(48.6)	17(48.6)	1(2.9)	31(72.1)	12(27.9)	0	135(67.5)	61(30.5)	4(2.0)
11.Availability of personnel for guidance	14(34.1)	21(51.2)	6(14.6)	22(46.8)	25(53.2)	0	19(100.0)	0	0	13(86.7)	2(13.3)	0	23(65.7)	12(34.3)	0	23(53.5)	17(39.5)	3(7.0)	114(57.0)	77(38.5)	9(4.5)
12.Work area comfortable and safe	29(70.7)	11(26.8)	1(2.4)	45(95.7)	2(4.3)	0	17(89.5)	2(10.5)	0	15(100.0)	0	0	30(85.7)	5(14.3)	0	38(88.4)	5(11.6)	0	174(87.0)	25(12.5)	1(.5)
13.New skill/training received	17(41.5)	17(41.5)	7(17.1)	40(85.1)	7(14.9)	0	12((63.2)	7(36.8)	0	13(86.7)	2(13.3)	0	23(65.7)	12(34.3)	0	9(21.0)	34(79.1)	0	114((57.0)	79(39.5)	7(3.5)
14.Have job description	26(63.4)	15(36.6)	0	44(93.6)	3(6.4)	0	17(89.5)	2(10.5)	0	15(100.0)	0	0	25(71.4)	10(28.6)	0	40(93.0)	3(7.0)	0	167(83.5)	33(16.5)	0
15.Participates in special/ extracurricular functions	27(65.6)	14(34.1)	0	35(74.5)	12(25.5)	0	9(47.4)	10(52.6)	0	13(86.7)	2(13.3)	0	16(45.7)	19(54.3)	0	1((2.3)	42(97.7)	0	101(50.5)	99(49.5)	0

ATTACHMENT VI

RESPONSES FROM STUDENTS

SAMPLE No. 45

	YES No. (%)	NO No. (%)
1. Do you know the vision and mission of the hospital ?	42(93.3)	3(6.7)
2. Do you feel a part of the hospital and its work ?	45(100)	0
3. Do you have any opportunities for spiritual development ?	43(95.6)	2(4.4)
4. If you have a personal or family problem, is there someone to guide you or counsel you ?	29(64.9)	16(35.6)
5. Is the hospital a place you would like to remain as an employee?	34(75.6)	11(24.4)
6. During your training do faculty and staff stress care of the poor ?	37(82.2)	8(17.8)

RESPONSES FROM HEADS OF DEPARTMENTS

SAMPLE No. = 35

	YES No.(%)	NO No.(%)	N/A No.(%)
1. Do you conduct regular meetings of employees whom you supervise ?	19(54.2)	11(31.4)	5(14.2)
2. Do you feel that there is good communication with management ?	26(74.2)	6(17.1)	3(8.6)
3. Are you involved in selection of staff for your department ?	10(28.5)	23(65.7)	2(5.7)
4. Are you involved in the annual budget process for your department ?	11(31.4)	22(62.8)	2(5.7)
5. Are you informed about the financial performance of your department ?	10(28.5)	22(62.8)	3(8.6)
6. Do you regularly evaluate the performance of the employees you supervise ?	26(74.2)	5(14.3)	4(11.4)
7. Do you know and understand the vision and mission of the hospital ?	33(94.2)	1(2.8)	1(2.8)
8. Do you communicate the vision and mission to your employees ?	29(82.8)	3(8.6)	3(8.6)
9. Does your department have written policies and procedures ?	17(48.6)	16(45.7)	2(5.7)
10. Do you set goals each year for your department ?	12(34.3)	18(51.4)	5(14.3)
11. Do you feel a part of planning and decision making in the organization?	15(42.8)	17(48.6)	3(8.6)
12. Do you orient new employees in your department ?	29(82.8)	2(5.7)	4(11.4)
13. Do you provide any inservice or on the job training for your employees ?	20(57.1)	10(28.6)	5(14.3)
14. Have you attended any seminar, program or course on management training ?	18(51.4)	15(42.8)	2(5.7)
15. Do you have written standards that guide the work of your department ?	16(45.7)	18(51.4)	1(2.8)
16. Do you have enough qualified staff to do the required work ?	23(65.7)	9(25.7)	3(8.6)
17. Do all of your employees have job description ?	25(71.4)	6(17.1)	4(11.4)
18. Do you know the organization plan or structure of the hospital ?	24(68.6)	8(22.8)	3(8.6)

SURVEY OF PATIENTS

Methodology: An administered questionnaire was used to obtain the views of patients attending St. Martha's Hospital on different aspects of hospital functioning. The questionnaire was administered by interviewers who had been given some training. Since the instrument was in English, the interviewer had to interpret the questions to the patient as well as interpret open ended comments. This process may have vitiated the latter. Open end comments were often missing or unsatisfactorily expressed. The present analysis has therefore been restricted to scored questions which are less likely to be biased by the interviewer.

Subjects: The questionnaire was administered to both inpatients (on the day of discharge) and out patients. The subjects were selected by the interviewers to generally represent various areas and departments and is thus not strictly random.

I. Patient Profile

a) No. of proformae filled 159, 60 (38%) from inpatients and 96(60%) from out patients. In 3 this data was not filled.

b) 65 (41%) of the patients were male and 91 (57%) were female. In 3 data was not filled.

c) Income of patients per month

< Rs. 2000	30	19%
Rs.2000-3999	44	28%
Rs.4000-5999	30	19%
≥ Rs. 6000	29	18%
Missing data	26	16%

d) Educational status

No formal education	20	13%
7th Std. or less	19	12%
S.S.L.C.	45	28%
P.U.C.	38	24%
Degree	24	15%
PG/Professional	10	6%
Missing data	3	2%

e) Religion of respondents

Hindu	107	67%
Christian	33	21%
Muslim	12	8%
Missing data	7	4%

f) Of the inpatients (60 respondents) 46 (77%) were from general ward and 13(22%) from private wards. In 1 case the data was missing.

This data suggests that the sample has a representative socio-economic mix... and is probably representative of the hospital patient population.

II. Reasons for coming for treatment to St. Martha's Hospital.

a) Who referred the patient to SMH?

Relative	55	35%
Friend	46	29%
Neighbours	23	15%
Family doctor	13	8%
Others	18	11%
Missing data	4	2%

b) Why did the patient come to SMH?

Recommended by relative / friend	67	42%
Reputation of hospital doctors	27	17%
Near home / office	23	15%
Because it is a mission hospital	14	9%
Recommended by doctor	12	8%
Other	12	8%
Missing data	4	2%

Both a) and b) provide consistent data that the reputation of the hospital and its doctors among the general public is good. It is, however, noteworthy that few patients are referred to SMH by their doctors. Since family doctors form an important source of patient referrals for a secondary hospital, this area needs to be corrected.

III. Outpatient services

a) Do patients visiting the OP come to see a particular doctor or are they willing to see any doctor?

(n = 96)

Any doctor	37	66%
Specific doctor	33	34%

b) How long did the patient have to wait in OP to see the doctor?

(n = 96)

< 1 Hour	70	39%
1-2 Hours	40	42%
➢ 2 hours	19	19%

c) Was this waiting time acceptable?

(n = 96)

Yes	70	73%
No	25	26%
Missing data	1	1%

Two points emerge 1. That 61% of patients had to wait over an hour to see a doctor and 26% felt that the delay was too long. Given that patients visiting a general hospital are resigned to wait, these figures suggest that action is required to reduce waiting time. 2. From a) and c) it would appear that about 30% of patients may be ready to pay a fee to see a doctor of their choice with less waiting time.

IV Staff Quality

a) Doctors are knowledgeable and good

Yes	147	92%
Somewhat	8	5%
No	0	0%
Missing data	4	3%

b) Nurses are caring and efficient

Yes	136	85.5%
Somewhat	17	11.0%
No	1	0.5%
Missing data	5	3%

c) Staff in general are courteous and helpful

Yes	144	90.5%
Somewhat	7	4.5%
No	1	0.5%
Missing data	7	4.5%

d) Overall satisfied with care given

Yes	134	84%
Somewhat	16	10%
No	1	0.5%
Missing data	8	4.5%

A fairly satisfactory picture on the whole

V. Amenities

a) General cleanliness is good

Yes	142	89%
Somewhat	12	8%
No	2	1%
Missing data	3	2%

b) Toilets and water supply are satisfactory

Yes	125	79%
Somewhat	24	15%
No	3	2%
Missing data	7	4%

c) Fans and lights function adequately

Yes	137	86%
Somewhat	15	10%
No	2	1%
Missing data	5	3%

d) Hospital diet taken (IP only)
n = 60

No	58	97%
Yes	2	3%

Water, toilets, lights and fans are generally judged satisfactory although not as unequivocally as was the case for personnel. Bangalore residents are accustomed to water and electricity shortages yet 17% are not entirely happy with water and toilets and 11% with electricity. The dietary service is conspicuous by its disuse.

VI. Some special services

a) Medical records - any problem in getting records out (OPD only)
n = 96

No	84	87%
Yes	12	13%

b) Chaplaincy services

- Did the chaplain visit you (IP only)
n = 60

Yes	16	27%
No	43	71.5%
Missing date	1	0.5%

- If yes, were his visits helpful
n = 16

Yes	14	88%
No	2	12%

Considering the mission of the hospital, visits by the chaplain are inadequate. However, those who were visited seem satisfied.

VIII Perception of hospital mission

a) The hospital is mainly meant for those who can pay.

No	104	65%
Somewhat	28	18%
Yes	22	14%
Missing data	5	3%

b) The hospital serves the poor even if they cannot pay.

Yes	99	62%
Somewhat	35	22%
No	12	8%
Missing data	13	8%

c) All patients are loved and cared for by the hospital staff.

Yes	134	84%
Somewhat	16	10%
No	2	2%
Missing data	6	4%

d) Religious sentiments of all patients are respected.

Yes	145	91%
Somewhat	7	5%
No	2	1%
Missing date	5	3%

On the whole a satisfactory image. In view of the current controversy in the political world, the last question and response could well be sent to the VHP!

VIII Hospital charges

a) Out patient charges and costs
n = 96

Correct	61	64%
Too high	16	17%
Too low	15	16%
Missing data	4	4%

b) In patient bed charges

n = 60

Correct	40	67%
Too high	10	16%
Too low	1	2%
Missing data	9	15%

c) In patient (investigation costs in bill)

n = 60

Correct	46	77%
Too high	6	10%
Too low	0	0%
Missing data	8	13%

d) In patients (doctors fees, if any)

n = 60

Correct	37	62%
Too high	7	12%
Too low	0	0%
Missing data	16	26%

e) In patient (surgery / procedure costs)

n = 60

Correct	35	59%
Too high	5	8%
Too low	0	0%
Missing data	20	33%

f) In patients (medicine charges)

n = 60

Correct	42	70%
Too high	12	20%
Too low	0	0%
Missing data	6	10%

On the whole more patients seem to feel that the charge are reasonable. Among inpatients a significant minority of patients (15 - 20%) feel that bed charges and medication costs are too high. Similarly 17% of out patients felt that out patient charges were too high.

Summary: The 159 patients interviewed seem to be fairly representative of a cross-section of those who attend the hospital. It must be recognised that a survey of this nature is presently biased as only patients who come to the hospital (and hence approve of the hospital) have been included. Keeping this in mind, the survey shows:

1. Patients are not often being referred to the hospital by the medical practitioners. They come because of its reputation with the lay public.
2. Waiting time in the out patient department is too long.
3. About 30% of out patients may be ready to pay for services if these can be stream-lined.
4. Patients are generally satisfied about the medical and non medical staff.
5. Dietary department services are grossly under used and could be stopped.
6. There is scope to improve water and electricity supply.
7. Chaplaincy services cover only a small proportion of patients.
8. Hospital has good image among patients attending it.

SURVEY OF NURSES, NURSING SERVICES & NURSING COLLEGE

AREAS ASSIGNED : NURSING SERVICE DEPT. & SCHOOL OF NURSING

Sample : *Nursing Service Dept* - * Ward in Charges (W/S)
* Staff Nurses (S/N)

School of Nursing - * Faculty (F)
* Student nurses (St/N)

Description of the Sample:

Ward in Charges : There were totally 19 Ward in Charges in the hospital . All of them were included in the evaluation . All (100%) were lay persons . The mean duration of years of service was 10.4 years (n = 13), with a range of 1&1/2 years to 32 years . As six of them did not respond to the duration of their service in the institution , they hence were not included for computation of the mean duration of service. All (100%) had done the General Nursing Course , and only 2 (10.5%) had some additional qualification out of whom one had done a course on Administration .Twelve (63.2%) of them had there training from St. Martha's School of Nursing . One (5.3%) had completed her course as early as in the 1950s , 4(21.0%) in the 1960s , 5(26.3%) in the 1970s , 6(31.5%) in the 1980s and 2(10.5%) in the 1990s . Most 15 (78.9%) had In Service Education after having joined St. Martha's hospital .

Staff Nurses: The staff nurses were sampled from the total list of all categories , using the simple random sampling technique . Hence a total of 50 staff were selected ,of which 47 were accepted for analysis. Most of them were junior staff 37 (78.7%) , with just two or three years of service and 10 (21.3%) were interns with less than a years service . Only 3 (6.4%) were religious and the rest 44 (93.6%) were lay persons . Most 31(66.0%) of the staff were alumnae of St. Martha's School of Nursing ,while 16 (34.0%) were from other institutions, of which 7 (43.7 %) were from institutions within Bangalore city itself and the rest from out of Karnataka state . The mean duration of service for the staff was 2.09 years with a range of 2 months to 10 years. Only 3 (4.3%) had not received any in-service education after having joined the institution . Majority 45 (95.7%) had done there G.N.M. course , 2 (4.3%) had done their Basic B.Sc.

Faculty : The total number of faculty in the School of Nursing were 15 . All were taken for the evaluation . Ten (66.6%) were tutors , 3 (20.0%) were clinical instructors and 2 (13.3$%) were senior tutors . Only 1(6.7%) was a religious while the rest ,14 (93.3%) were lay persons . The mean duration of years of service was 3.87 years with a range of 10 months to 16 years . Most 10 (66.6%) had a basic B.Sc. qualification , 4 (26.6%) had done their P.C.BSc. and 1(6.7%) had done her General Nursing after which she had done her Diploma in Nursing Education .Eleven (73.3%) had their nursing training in Karnataka of which 9 (81.1%) were trained within Bangalore itself . Eleven (73.3%) had inservice education after joining the institution .

Student Nurses : The students were selected from the 2nd , 3rd and the 4th year , although those in their 4th year have completed their training in the institution they were selected in the category of

students since they considered to be under the School of Nursing . The 1st year students were not selected since it was assumed that it would be too early to get a valid opinion from them . The students were selected through simple random technique , and comprised a total number of 45 , (i.e. 15 per batch . Only 4 (8.8%) were religious and the rest were laypersons . Most 42 (93.3%) were Christians while 3 (6.6%) were Non Christians .

Methodology :

The evaluation of these assigned areas was performed primarily from information provided by the selected sample through a questionnaire . The questionnaires were prepared based on the selected functions of the hospital or the School of Nursing , the individual functions of each category , their expectations and suggestions . All the members of the review committee had accepted the format proposed and a copy of the questionnaires for each category is attached .

Results :

1. *Awareness of Nursing Personnel in relation to ---*

	W/S	S/N	F	St/N
a. Vision of the hospital	19(100.0%)	32(68.7%)	14(93.3%)	42(93.3%)
b. Philosophy	18(94.7%)	32(68.7%)	15(100.0%)	----
c. Objectives / Goals	19(100.0%)	37(78.7%)	15(100.0%)	----
d. Policy regarding				
work	19(100.0%)	44(78.7%)	15(100.0%)	----
benefits	16(84.2%)	35(74.5%)	15(100.0%)	----
promotion	17(89.5%)	34(72.3%)	15(100.0%)	----
recruitment	16(84.2%)	41(87.2%)	12(80.0%)	----
student selection	15(78.9%)	43(91.5%)	14(93.3%)	----
discipline	16(84.2%)	43(91.5%)	14(93.3%)	----
e. Welfare Facilities	14(73.7%)	26(55.3%)	11(73.3%)	----
f. Workers Union	15(78.9%)	15(31.9%)	8(53.3%)	----
g. Performance Appraisal	17(89.5%)	21(44.7%)	9(60.0%)	----

It is obvious from the above data that most (more than 75%) of the nursing personnel from all categories were aware of the objectives and goals of the institution ; of the policies regarding work , benefits recruitment of staff , selection of students and disciplinary action . Among the three categories of nursing personnel the staff nurses seemed least aware of the philosophy of the institution , welfare facilities workers union and performance appraisal . The only question that student nurses were asked was in relation to their awareness of the vision and mission of the hospital . Majority (90% & >) said they were aware of the vision .

2. ***Extent to which the objectives / goals /functions of the hospital are met presently*** :

The ward in charges , staff nurses and the faculty were given a list of statements pertaining to the above mentioned aspects .They were asked to rate each of the statements on a 5 -point scale according to the extent to which they believed these aspects were presently fulfilled and also to the extent to which they thought these aspects should be fulfilled. However most of them did not answer to the latter part .

The results of the extent to which the above aspects are met are presented in percentages .

		5	4	3	2	1
1. Service given to the sick irrespective of any factor	(W/S)	17(89.5)	2(10.5)	---	---	---
	(S/N)	23(48.9)	18(38.2)	4(8.5)	1(2.1)	1(2.1)
	(F)	10(66.7)	3(20.0)	2(13.3)	---	---
2. Quality care affordable to the common man						
	(W/S)	12(63.2)	5(26.3)	2(10.5)	---	---
	(S/N)	17(29.8)	14(29.8)	15(31.9)	1(2.1)	3(6.3)
	(F)	3(20.0)	6(40.0)	6(40.0)	---	---
3. Main beneficiaries - women / children						
	(W/S)	8(42.1)	4(21.0)	5(31.6)	1(5.3)	---
	(S/N)	7(15.0)	10(21.3)	15(31.6)	10(21.3)	5(10.7)
	(F)	---	3(20.0)	8(53.3)	3(20.0)	1(6.7)
4. Provides cost effective competent care						
	(W/S)	8(42.1)	7(36.8)	2(10.5)	2(10.5)	---
	(S/N)	3(6.3)	4(8.5)	17(36.2)	11(23.4)	12(25.5)
	(F)	1(6.7)	4(26.7)	8(53.3)	2(13.3)	---
5. Fosters dedication and ethical values						
	(W/S)	14(73.7)	4(21.0)	1(5.3)	---	---
	(S/N)	13(27.7)	17(36.2)	6(12.8)	6(12.8)	6(12.8)
	(F)	6(40.0)	7(46.6)	1(6.7)	---	1(6.7)
6. Enhances skills through CE programs						
	(W/S)	4(21.0)	7(36.8)	6(31.6)	2(10.5)	---
	(S/N)	7(14.9)	12(25.5)	17(36.2)	10(21.3)	1(2.1)
	(F)	1(6.7)	6(40.0)	7(46.6)	---	1(6.7)
7. Fosters a desire to serve the poor						
	(W/S)	11(57.9)	7(6.8)	1(5.3)	---	---
	(S/N)	14(29.8)	16(34.0)	13(27.7)	3(6.4)	1(2.1)
	(F)	6(40.0)	4(26.7)	5(33.3)	---	---
8. Builds social awareness among its staff						
	(W /S)	3(15.8)	9(47.4)	5(26.3)	1(10.5)	---
	(S/N)	6(12.8)	17(36.2)	18(38.3)	3(8.5)	1(4.2)
	(F)	---	2(4.3)	10(66.7)	4(26.7)	---

9. Meets spiritual needs of all patients					
(W/S)	17(63.1)	5(26.3)	2(10.5)	---	---
(S/N)	23(48.9)	16(34.0)	7(14.9)	1(2.1)	---
(F)	6(40.0)	5(33.3)	2(13.3)	2(13.3)	---
10. Provides care at subsidised cost to those in need					
(W/S)	15(73.7)	2(10.5)	2(15.8)	---	---
(S/N)	11(23.4)	23(48.9)	12(25.5)	2(2.1)	---
(F)	6(40.0)	5(33.3)	4(6.7)	---	1(6.7)
11. Develops community centres for those in need					
(W/S)	14(73.7)	5(21.0)	---	1(5.3)	---
(S/N)	14(29.8)	14(29.8)	14(29.8)	4(8.5)	1(2.1)
(F)	5(33.3)	4 (26.7)	6(40.0)	---	---
12. Expands depts. & education programs as per need					
(W/S)	12(63.2)	4(21.0)	3(15.8)	---	---
(S/N)	3(6.4)	12(25.5)	19(40.4)	9(19.1)	4(8.5)
(F)	---	6(40.0)	8(53.3)	1(6.7)	---
13. Attempts to improve quality of care					
(W/S)	14(73.7)	5(26.3)	---	---	---
(S/N)	16(34.0)	22(46.8)	8(17.0)	1(2.1)	---
(F)	2(13.3)	10(66.7)	2(13.3)	1(6.7)	---
14. Creates cleanliness awareness in public					
(W/S)	13(68.4)	4(21.0)	2(10.5)	---	---
(S/N)	28(59.5)	14(29.8)	2(4.3)	3(6.4)	---
(F)	5(33.3)	9(60.0)	1(6.7)	---	---
15. Serves as a model of efficient health care					
(W/S)	14(78.9)	4(21.0)	---	---	---
(S/N)	22(46.8)	20(42.6)	3(6.4)	---	2(4.2)
(F)	5(33.3)	7(46.7)	3(20.0)	---	---
16. Fosters respect for life in all its staff					
(W/S)	15(78.9)	4(21.0)	---	---	---
(S/ N)	14(29.8)	25(53.2)	6(12.8)	2(4.3)	---
(F)	5(33.3)	6(40.0)	2(13.3)	---	2(13.3)
17. Fosters a team spirit and family atmosphere					
(W/S)	14(73.7)	5(26.3)	1(5.3)	---	---
(S/N)	11(23.4)	19(40.4)	10 (21.2)	4(8.5)	3(6.4)
(F)	5(46.7)	4(26.7)	4 (26.7)	---	---
18. Has reasonable rules and regulations					
(W/S)	11(57.9)	7(36.8)	1(5.3)	---	---
(S/N)	12(25.5)	19(40.4)	11(23.4)	4(8.5)	1(2.1)
(F)	3(20.0)	5(33.3)	7(46.7)	---	---
19. Shows concern for its staff's welfare					
(W/S)	13(68.4)	3(15.8)	3(15.8)	---	---
(S/N)	5(10.6)	19(40.4)	16(34.0)	5(10.6)	2(4.3)
(F)	4(26.7)	8(53.3)	3(20.0)	---	---

It is obvious that most (80% & >)of the ward in charges believed / were of the opinion that the objectives / goals / functions of the hospital are met presently . They(36.8%) however felt that women / children were not the main beneficiaries and social awareness wasn't built amongst the staff. Only 57.8% felt that CE programs were planned to enhance the skill of the employees.

Most(80% & >) of the staff nurses felt that service was provided to the sick irrespective to any factor , the spiritual needs of the patients were met , that attempts were made to improve the quality of care always , to serve as a model for efficient health care , and create an awareness of cleanliness in the public.

The faculty(80% & >) also felt that the service was provided to all irrespective of any factor , a sense of dedication and ethical values was fostered , an awareness of cleanliness in the public was built , that the hospital served as a model of efficient health care.

The aspects that possibly need to be reviewed by the management are obviously in relation to the following objectives / goals :

- Who are its main beneficiaries ?
- What is the role of CE_ programmes in enhancing the skill of the staff and thus the quality of care?
- Should the hospital build a social awareness amongst its staff?
- Is the institution responsible for providing community health centres, expanding departments and educational programmes as per the need?
- Should there be concern for the welfare of the staff ?
- Does the hospital employees and the management really strive to provide high quality care at a rate affordable to the common man ?
- Is there any effort made to ensure that comprehensive and cost effective care is provided ?
- Are the rules and regulations fair for and reasonable to all the employees ?

3. The extent to which the Nursing personnel from the Nursing Service were able to perform certain tasks :

The ward in charges and the staff nurses were given an additional five statements relating to their functions or tasks . They were asked to rate these statements on a 5-point scale depending on their ability to perform the said functions . The results are presented below in percentages . They were also asked to comment if they were unable to perform these functions to the best of their abilities . The reasons provided are also summarised below this data .

		5	4	3	2	1
1. Provides care to all irrespective of caste /creed /social status .						
	(W/S)	17 (89.5)	2(10.5)	---	---	---
	(S/N)	37 (78.7)	6(12.8)	4(8.5)	---	---
2. Provides best possible care at all times						
	(W/S)	7 (36.8)	7(36.8)	4(21.0)	---	1(5.3)
	(S/N)	4 (8.5)	26(53.3)	15(31.9)	2(4 3)	---
3. Upholds moral & ethical values						
	(W/S)	15 (78.9)	4(21.0)	---	---	---
	(S/N)	27 (57.4)	17(36.2)	2(4.3)	1(2.1)	---
4. Meets spiritual needs of all patients						
	(W/S)	11 (57.9)	6(31.6)	1(5.3)	---	1(5.3)
	(S/N)	28 (59.6)	11(23.4)	5(10.6)	2(4.3)	1(2.1)
5. Participates in activities to improve self	(W/S)	10 (52.6)	4(21.0)	2(10.5)	3(15.3)	---
	(S/N)	20 (42.6)	14(29.8)	7(14.9)	6(12.7)	---

Majority of the Ward Sisters and Staff Nurses said that due to lack of sufficient staff and overload in their work , they were unable to provide the best possible care to all patients. In relation to the ability to uphold their moral and ethical values, only the staff nurses responded that they were unable to do so at all times due to misunderstanding with their co-workers. None of them gave any reasons regarding their ability to meet the spiritual needs of the patients and their participation in activities which would enhance their skills and professional abilities.

Points to be considered from this data which is available :

- Is there a definite lack of staff ?
- Is the environmental climate of the staff conducive for upholding ones ethical & moral values ?
- Should the management look into the cultural activities of the staff?

4. ***Positive aspects of St. Martha's Hospital and School of Nursing*** :

The Ward in charges , staff nurses and the faculty were asked to give THREE positive aspects of the institution . These aspects were scrutinised and are categorised under headings such as:

* Objectives * Administration * Satisfaction with the working environment.

	W / S n = 19	S / N n = 47	Faculty n = 15
(i) ***Objectives :***			
a) Helping the poor & neglected :	7 (36.8)	41 (87.2)	2(13.3)
b) Care for all irrespective of caste :	4 (21.0)	5 (10.6)	4(26.7)
c) Respect for life & spiritual care :	4 (21.0)	11 (23.4)	3(20.0)
d) Giving work opportunities for the poor :	2 (10.5)	---	---
e) Low cost & high quality care :	---	11 (23.4)	3(20.0)
f) Spiritual care :	1(5.3)	7 (14.8)	---
(ii) ***Administration :***			
a) Administrators are approachable :	5 (26.3)	---	---
b) Good Supervision :	1 (5.3)	---	---
c) Good Management :	---	16 (34.0)	3(20.0)
d) Good co-ordination between nursing service & education :	---	---	1(6.7)
e) Conducting Continuing Education programs :	---	---	1(6.7)
(iii) ***Satisfaction with the Working Environment :***			
a) Care provided is appreciated :	8 (42.1)	38 (80.9)	---
b) Family and friendly atmosphere :	7 (36.8)	2 (4.3)	10(66.7)
c) Safety :	6 (31.6)	---	---
d) Hygienic working environment :	3 (15.8)	9 (19.1)	6(40.0)
e) Welfare of Staff considered :	1 (5.3)	2 (4.3)	---
f) Freedom to work :	---	---	2(13.3)
g) Rules & Regulations are fair :	---	3 (6.4)	---
h) Dedicated staff :	1 (5.3)	1 (2.1)	---

5. Negative aspects of the Institution :

The nursing personnel were asked to give THREE negative aspects of the institution . the comments were then categorised under specific headings such as : *Communication , * staffing and * administrative aspects .

	W/S n=19	S/N n=47	F n=15
i) ***Communication :***			
a) Rules very rigid for ICUs	---	2(4.3)	2(10.6)
b) Inter departmental communication is poor	---	3(6.4)	2(10.6)
c) Enquiry is not satisfactory	2(10.5)	---	7(46.7)
d) Nonavailability of 24 hrs STD booth	1(5.3)	1(2.1)	1(5.3)
e) Communication gap	---	1(2.1)	2(10.6)
ii) ***Staffing Problems :***			
a) Lack of supervision	3(15.8)	1(2.1)	4(26.6)
b) Indiscipline of security /class iv workers	---	4(8.7)	5(33.3)
c) Night duty for one month	---	11(23.0)	1(5.3)
d) Lack of promotional avenues	3(15.8)	---	---
e) Lack of concern for all staff	---	1(2.1)	2(10.6)
f) Lack of adequate staff	3(15.8)	34 (74.4)	---
g) Inadequate pay	9(47.4)	20 (43.0)	---
h) Health of staff not considered	---	3 (6.3)	---
i) Continuing education not planned regularly	3(15.8)	---	3(15.9)
iii) Administrative Aspects :			
a) Lack of an isolation ward	---	2(4.3)	---
b) Need for a waiting area for relatives	1(5.3)	1(2.1)	---
c) Salary is not adequate for the cost of living in the city	9(47.4)	9(17.1)	---
d) Equipment and articles inadequate	3(15.8)	3(6.4)	1(5.3)
e) Repair work and maintenance slow	4(21.0)	1(2.1)	---
f) Repairs allotted to outside agencies	---	1(2.1)	---
g) Lack of promotional opportunities	3(15.8)	2(4.3)	---
h) Cash counter not available for 24 hrs.	---	2(4.3)	---
i) Lack of pharmacy & lab. for 24 hrs.	---	16(34.4)	---

6. ***Suggestions for improvement:*** The nursing personnel were asked to give THREE suggestions which they felt would help in the functioning of the hospital and the School of Nursing . After scrutinising the points given by the nursing personnel the points were categorised under headings such as : Administrative , Equipment and facilities , Staff welfare . Three ward in charges and faculty did not give any suggestions . All the staff nurses gave suggestions.

	W/S	S/N	F
i) ***Administrative***			
a) Supervision of staff nurses to improve	2(10.5)	2(4.3)	2(12.3)
b) Night supervision essential	1(5.3)	1(2.1)	1(6.7)
c) Appreciation of work done	1(5.3)	---	---
d) Maintenance dept. to improve	1(5.3)	1(2.1)	---
e) Clerks in the ward for clerical work to increase staff time with patient	---	---	1(6.7)
f) Communication between service and education	---	---	2(12.3)
g) Increase the number of staff	4(21.0)	15(32.0)	1(6.7)
h) Ambulance availability for transport of dead	---	2(4.3)	---
i) 24 hr lab and pharmacy services	---	15(32.0)	---
j) Atleast one relative to be allowed with an ICU patient	---	---	1(6.7)
ii)Need for more Facilities and Equipment			
a) Separate OT for Obstetrics	1(5.3)	---	---
b) Ventilators for new-borns and children to avoid referrals	1(5.3)	1(2.1)	---
c) More advanced technology	3(15.8)	15(32.0)	5(33.3)
d) Need for a geriatric ward	---	---	1(5.3)
e) Need for an isolation ward	---	4(8.7)	1(5.3)
f) Waiting room for relatives	1(5.3)	19(40.4)	---
g) Ambulance with emergency facilities	---	10(20.6)	---
h) Security to be trained to be courteous to all .	---	10(20.6)	---
iii) ***Staff Welfare:***			
a) Need for CE programs regularly	3(15.8)	---	3(10.9)
b) Staff health services to be improved	---	7(14.8)	---
c) Leave to be granted in emergencies	---	4(8.7)	---

NURSING STUDENTS (N= 45 ; 15/ Batch of 2nd , 3rd & 4th year)

The nursing students were selected from the 2nd and 3rd year on a random basis . Those who had completed their training and who in this institution are considered to be in their 4th year were also selected randomly using the table of random numbers . The 1st years were excluded from the evaluation since the committee felt that it would be too early to be able to get a valid opinion from them . These students were given a set of four statements relating to the encouragement they receive from various individuals ; facilities available ; facilities for their social development and characteristics of the faculty . Each of these statements had several items under them . The students had to rate each of these statements on a 5 - point scale reflecting the level of their satisfaction on each of the aspects . This tool was prepared based on a study conducted by

	1	2	3	4	5
1. Encouragement received from :					
home	0(---)	0(--)	0(--)	4(8.8)	41(91.1)
teachers	1(2.2)	0(--)	6(13.3)	14(31.1)	24(53.3)
staff	1(2.2)	8(17.7)	12(26.7)	20(44.4)	4(8.8)
warden	1(2.2)	4(8.8)	10(22.2)	19(42.2)	11(24.4)

It is obvious that the students are satisfied with the encouragement they receive from their parents , teachers and the warden to do well in their studies . The staff however do not seem to play a major role encouraging their juniors to perform well in their studies .

2. Facilities available :					
classroom (n=44)	0(---)	1(2.2)	5(11.1)	15(33.3)	23(51.1)
chapel (n=44)	0(---)	0(--)	0(--)	10(22.7)	34(77.3)
canteen (n=44)	6(13.6)	7(15.9)	11(25.0)	15(34.1)	5(11.4)
hospital services (n=45)	2(4.4)	4(8.8)	14(31.1)	14(31.1)	11(24.4)
hostel (n=45)	1(2.2)	3(6.6)	8(17.7)	17(37.8)	16(35.6)
library (n=45)	0(---)	2(4.4)	5(11.1)	14(31.1)	24(53.3)
mess (n=44)	5(11.1)	11(25.0)	12(27.3)	13(18.2)	3(6.8)
recreation (n=45)	3(6.6)	6(13.3)	10(22.2)	15(33.3)	11(24.4)
sick room (n=45)	6(13.3)	6(13.3)	14(31.1)	15(33.3)	4(8.8)

Most of the students again seem satisfied with their classroom , chapel , hostel , library facilities. They seem most dissatisfied in relation to canteen , mess , and sickroom facilities . They appear to be moderately satisfied with the hospital services and recreation facilities .

3. Activities required for their social development

interaction with faculty	1(2.2)	6(13.3)	14(31.1)	14(31.1)	10(22.2)
interaction with peers & seniors	1(2.2)	2(4.4)	12(26.7)	17(37.8)	13(28.9)
campus activities(n=44)	0(---)	3(6.8)	8(18.2)	26(59.0)	7(15.9)
SNA activities	1(2.2)	0(--)	6(13.3)	17(37.8)	21(46.7)
CNGI activities (n=44)	1(2.2)	5(11.3)	17(38.6)	11(25.0)	10(22.7)
sports activities	1(2.2)	2(4.4)	4(8.8)	26(57.8)	12(26.7)

The only area were the students appear to be quite satisfied is in relation to the SNA activities . The rest of the activities relating to their social development would have to be scrutinised more deeply for the overall development of the students

4. Characteristics of their faculty

shows genuine interest	1(2.2)	3(6.7)	8(17.6)	16(35.5)	17(37.8)
shows respect	1(2.2)	4(8.8)	15(33.3)	16(35.6)	9(20.0)
is available	1(2.2)	2(4.4)	8(17.8)	18(40.0)	15(33.3)
disciplines fairly (n=44)	0(---)	0(--)	6(13.6)	19(43.1)	19(43.1)
supervision good (n=44)	0(---)	0(--)	6(13.6)	16(36.4)	22(50.0)
firm yet concerned (n=44)	0(---)	1(2.3)	10(22.7)	17(38.6)	16(36.3)
fair in dealings (n=44)	1(2.3)	5(11.4)	11(25.0)	18(40.9)	9(20.5)
competent (n=44)	0(---)	4(9.0)	14(31.8)	15(34.1)	11(25.0)
evaluation fair (n=44)	1(2.3)	4(9.0)	13(29.6)	20(45.5)	6(13.6)
shows moral values in dealings (n=44)	1(2.3)	4(9.0)	9(20.5)	17(38.6)	13(29.5)
has good personal skills (n=44)	0(---)	3(6.8)	10(22.7)	16(36.3)	15(34.0)

In relation to the characteristics of the faculty the students again appear to be satisfied with most aspects except in relation to their ability to show genuine interest in the welfare of the student, being fair in their dealing with student , being competent in various teaching methodologies and being fair in their evaluation methods

The students were also given a set of questions relating to the goals and functions of the institution . They were expected to either answer 'yes' or 'no' to the questions . No clarifications were made in relation to their answers.

	YES	NO
1. Knows vision and mission	42 (93.3)	3 (6.3)
2. Feels part of the hospital	45 (100.0)	0 (--)
3. Opportunities for spiritual growth	43 (95.6)	2 (4.4)
4. Availability of guidance & counselling	29 (64.4)	16 (35.6)
5. Remain as staff in the same hospital	34 (75.6)	11 (24.4)
6. Stress on care of poor during training	37 (82.2)	8 (17.8)

It is evident from the above findings that majority (more than 80.0%) of the students who were selected to participate in the evaluation were aware of the vision of the hospital , felt a part of the hospital , felt that there were opportunities for their spiritual growth and that a stress on the care of the poor was made during their training . The need for personnel trained in guidance and counselling was evident in that atleast 36% of the students responded that this was not available . The fact that at least 76% of the students responded that they would like to remain as staff in the hospital is credible .

Points to possibly review :

- Encouragement to be given to the students by the staff and the warden , to perform well in their studies
- Canteen and mess facilities may have to be improved
- Hospital services for the students seem to be inadequate
- Recreational facilities for the students could be increased
- Interaction with the faculty / seniors at informal settings
- C.N.G.I. activities could help foster their spiritual development . It could also help to improve their interaction with other students
- Faculty characteristics such as ability to have respect for the students, to be firm yet concerned, to be fair and ethical in their dealings & to be skilful need to be enhanced.
- Availability of guidance and counselling for the students

GENERAL FUNCTIONS OF THE MANAGEMENT :

The ward in charges (W/S), faculty (F) and staff nurses (S/N) were also given a set of questions to which they had to respond 'Yes' or 'No' . These questions were relating to the general functions of the management . Here again they were neither asked to provide details or clarify their answer.

		Yes	No	N/A
1. Someone available to communicate problems	(W/S)	19 (100.0)	0 (--)	0 (--)
	(F)	14 (93.3)	1 (6.7)	0 (--)
	(S/N)	43 (91.5)	4 (8.5)	0 (--)
2. Complaints are heard	(W/S)	18 (94.7)	1 (5.3)	0 (--)
	(F)	13 (86.6)	1 (5.3)	1 (6.7)
	(S/N)	36 (77.0)	11 (23.0)	0 (--)
3. Feel part of a team	(W/S)	19 (100.0)	0 (--)	0 (--)
	(F)	14 (93.3)	0 (--)	1 (6.7)
	(S/N)	47 (100.0)	0 (--)	0 (--)
4. Knows the mission of the hospital	(W/S)	19 (100.0)	0 (--)	0 (--)
	(F)	15 (100.0)	0 (--)	0 (--)
	(S/N)	47 (100.0)	0 (--)	0 (--)
5. Promotional avenues available	(W/S)	9 (47.4)	10 (52.6)	0 (--)
	(F)	10 (66.7)	3 (20.6)	2 (13.7)
	(S/N)	30 (63.8)	17 (36.2)	0 (--)
6. Orientation received when joining institution	(W/S)	17 (89.4)	2 (10.5)	0 (--)
	(F)	14 (93.3)	1 (6.7)	0 (--)
	(S/N)	45 (95.7)	2 (4.3)	0 (--)
7. Feels appreciated	(W/S)	18 (94.7)	1 (5.3)	0 (--)
	(F)	14 (93.3)	1 (5.3)	0 (--)
	(S/N)	42 (89.4)	5 (10.6)	0 (--)
8. Feels policies/ rules are fair	(W/S)	18 (94.7)	1 (5.3)	0 (--)
	(F)	14 (93.3)	1 (5.3)	0 (--)
	(S/N)	42 (89.4)	5 (10.6)	0 (--)
9. Knows employee service rules	(W/S)	18 (94.7)	0 (--)	1 (5.3)
	(F)	15 (100.0)	0 (--)	0 (--)
	(S/N)	40 (85.1)	7 (14.9)	0 (--)

10. Opportunities to give suggestions	(W/S)	14 (73.7)	4 (21.0)	1 (5.3)
	(F)	13 (86.6)	2 (13.3)	0 (--)
	(S/N)	30 (63.8)	17(36.2)	0 (--)
11. Availability of personnel for guidance	(W/S)	19 (100.0)	0 (--)	0 (--)
	(F)	13 (86.6)	2 (13.3)	0 (--)
	(S/N)	22 (46.8)	25(53.2)	0 (--)
12. Work area comfortable and safe	(W/S)	17 (89.4)	2 (10.5)	0 (--)
	(F)	15 (100.0)	0 (--)	0 (--)
	(S/N)	45 (95.7)	2 (4.3)	0 (--)
13. New skill training received	(W/S)	12 (63.2)	7 (36.8)	0 (--)
	(F)	13 (86.6)	2 (13.3)	0 (--)
	(S/N)	40 (89.4)	7 (14.9)	0 (--)
14. Has a job description	(W/S)	17 (89.4)	2 (10.5)	0 (--)
	(F)	15 (100.0)	0 (--)	0 (--)
	(S/N)	44 (93.6)	3 (6.4)	0 (--)
15. Participates in special functions	(W/S)	9 (47.4)	10 (52.6)	0 (--)
	(F)	13 (86.6)	2 (13.3)	0 (--)
	(S/N)	35 (74.5)	12 (25.5)	0 (--)

In relation to the functions of the management majority of the nursing personnel (80% & >) were satisfied . The only aspects to be possibly looked into are as given below:

- Avenues for promotion
- Opportunities to give suggestions for improvement
- Need for in- service education programmes
- Participation in special functions

WARD IN CHARGES (N = 19)

The ward in charges were given 18 questions regarding their functions to which they had to either respond 'Yes' or 'No'. No clarification of their answers were sought .

	YES	NO	NA
1. Conducts regular meetings	11 (57.9)	6 (31.6)	2 (10.5)
2. Has good communication with management	17 (89.4)	1 (5.3)	1 (5.3)
3. Involved with plan of annual budget	5 (26.3)	13 (68.4)	1 (5.3)
4. Involved in selection of staff	1 (5.3)	17 (89.4)	1 (5.3)
5. Informed of financial process	4 (21.0)	13 (68.4)	2 (10.5)
6. Evaluates staff performance	17 (89.4)	1 (5.3)	1 (5.3)
7. Dept. has written policies	11 (57.9)	7 (36.8)	1 (5.3)
8. Sets goals each year for dept.	9 (47.4)	9 (47.4)	1 (5.3)
9. Feels part of planning &decision-making	7 (36.8)	10 (52.6)	2 (10.5)
10. Knows vision & mission of hospital	18 (94.7)	0 (--)	1 (5.3)
11. Communicates above to staff	18 (94.7)	0 (--)	1 (5.3)
12. Orients new employees	17 (89.4)	1 (5.3)	1 (5.3)
13. Provides ISE or on- the- job training	12 (63.2)	6 (31.6)	1 (5.3)
14. Attended CE- program on management	12 (63.2)	6 (31.6)	1 (5.3)
15. Written standards are there to guide work	11 (57.9)	7 (36.8)	1 (5.3)
16. Enough qualified staff available	14 (73.7)	4 (21.0)	1 (5.3)
17. All Staff have job description	15 (78.9)	2 (10.5)	2 (10.5)
18. Knows organisational plan	12 (63.2)	5 (26.3)	2 (10.5)

From the data available regarding the functioning of the ward in charges it is obvious that the following functions would have to be reinforced to them:

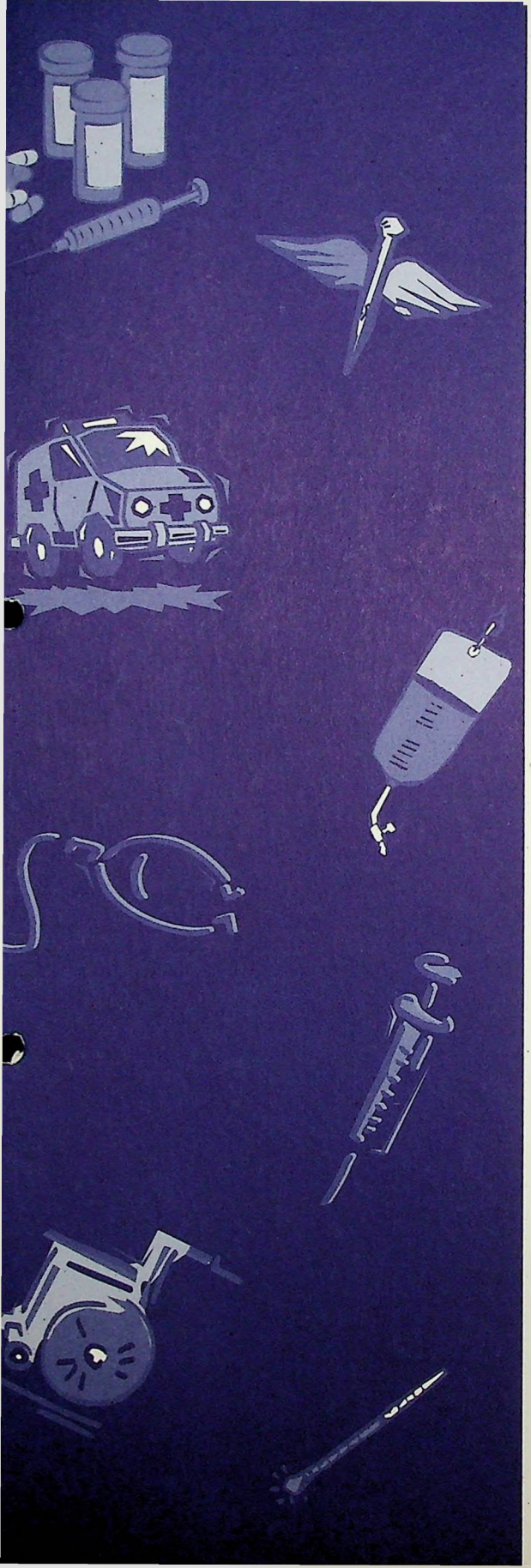
- The need to conduct regular meetings with their staff
- To have written policies and standards in the department
- To set goals each year for the department
- To see to their own and their staffs professional development by organising in-service education programmes and attending CE programmes

The management need to possibly get the ward in charges involved in the following aspects:

- Plan for the annual budget
- Selection of staff
- Financial process

- Ms. Mary Ann Charles,
School of Nursing,
St.John' Medical College,
Bangalore.

Com H 6791-A



HEALTH CARE WITHOUT HARM

The campaign for environmentally responsible health care

HCWH's Mission

To transform the health care industry so it is no longer a source of environmental harm by eliminating pollution in health care practices without compromising safety or care. We will accomplish this mission by:

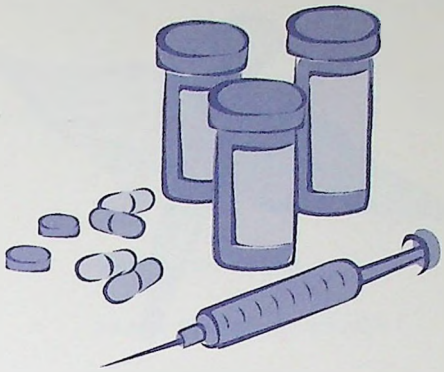
1. Promoting comprehensive pollution prevention practices.

2. Supporting the development and use of environmentally safe materials, technology and products.

3. Educating and informing health care institutions, providers, workers, consumers, and all affected constituencies about the environmental and public health impacts of the health care industry and solutions to these problems.

HEALTH CARE WITHOUT HARM

Health care professionals and the institutions in which they work are the ultimate defense against illness. Nurses, physicians and other health care practitioners strive to provide this protection for our families and our communities. Yet, unknown to many of us, the purchasing and waste disposal practices of health care institutions often undermine their own purpose, and our expectations of them, by contributing to sickness.



WHEN HEALTH CARE DOES HARM

The 1994 draft Dioxin Reassessment done by the United States Environmental Protection Agency (USEPA) brought this to light. At the time of its release, the draft Reassessment identified the incineration of medical waste as the single largest source of dioxin air pollution. Dioxin is a carcinogen which has been linked to birth defects, decreased fertility, immune system suppression and other hormonal dysfunction. Responding to this serious problem, several organizations formed the Health Care Without Harm campaign in 1996.

Looking further, Health Care Without Harm campaign members found that hospitals are not only a major source of dioxin, but a significant source of mercury as well. Mercury is a dangerous and potent neurotoxin and reproductive toxin. Mercury can interfere with the development of the fetal brain and is directly toxic to the central nervous system, kidneys and liver.

Cost-effective solutions are available for the health care industry's dioxin and mercury problems. Just as the Hippocratic Oath promises to "first, do no harm," the Health Care Without Harm campaign is based on the premise that health care practitioners have a responsibility to work toward the elimination of environmental harm resulting from health care practices.

HEALTH CARE PRACTITIONERS HAVE A RESPONSIBLITY TO WORK TOWARD THE ELIMINATION OF ENVIRONMENTAL HARM

In September 1996, representatives of 28 organizations met and created a campaign to provide a remedy for the pollution from health care practices. By April 1999, 178 organizations in nine different countries, including 41 hospitals, joined Health Care Without Harm (HCWH). The coalition has already had a significant impact on large health care systems, government regulatory bodies and industry leaders.

The Health Care Without Harm coalition is a broad-based international campaign to reform the environmental practices of the health care industry. HCWH advocates for policies that eliminate the indiscriminate incineration of medical waste, and calls for change in purchasing and materials management

HCWH: WHO WE ARE

practices of hospitals and purchasing groups. In communities, HCWH supports local campaigns against medical waste incinerators and works toward improvements in the purchasing and waste disposal practices of local hospitals and other health care institutions.

Health Care Without Harm researches and advocates for safer waste disposal alternatives, and educates the broader public about dioxin, mercury and other endocrine-disrupting chemicals and the health care industry's contribution to these problems. HCWH works with religious organizations, labor unions, health issue groups and other constituencies ready to join a campaign that makes explicit links between environmental contamination and public health.

The campaign's organizers believe that as health care professionals learn to "clean up their own house," they will increasingly become advocates for stronger environmental health policies and programs in society at large.

The work of Health Care Without Harm affects the health of every person and every community. We welcome your support and involvement.

HCWH IS A BROAD-BASED INTERNATIONAL CAMPAIGN TO REFORM THE ENVIRONMENTAL PRACTICES OF THE HEALTH CARE INDUSTRY

1 To work with a wide range of constituencies for an ecologically sustainable health care system;

2 To eliminate the nonessential incineration of medical waste and to promote safe materials use and treatment practices;

3 To phase out the use of PVC (polyvinyl chloride) plastics and persistent toxic chemicals in health care and to build momentum for a broader PVC phase out campaign;

4 To phase out the use of mercury in all aspects of the health care industry;

5 To develop health-based standards for medical waste management and to recognize and implement the public's right to know about chemical use in the health care industry;

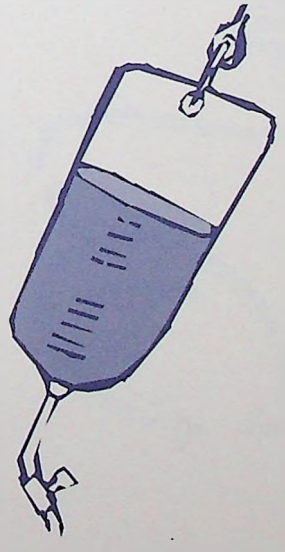
6 To develop just siting and transportation guidelines that conform to the principles of environmental justice: No communities should be poisoned by medical waste treatment and disposal;

7 To develop an effective collaboration and communication structure among campaign allies.

WORK WITH A WIDE RANGE OF CONSTITUENCIES FOR AN ECOLOGICALLY SUSTAINABLE HEALTH CARE SYSTEM

HCWH: OUR GOALS

For more information or to join the campaign, contact one of the campaign's three coordinators: **Charlotte Brody** at the Center for Health, Environment and Justice at 703-237-2249 or cbrody@essential.org; **Jackie Hunt Christensen** at the Institute for Agriculture and Trade Policy at 612-870-3424 or jchristensen@iatp.org; or **Gary Cohen** at the Environmental Health Fund at 617-524-6018 or gcohen@igc.apc.org. You can also e-mail the campaign at noharm@iatp.org or visit our website at www.noharm.org. Our website contains a library of HCWH educational materials as well as recent press releases and information on upcoming events.



HARMFUL HEALTH CARE: How We Got Here and What We Can Do About It

HOSPITAL WASTE PILES UP

Since 1955, the amount of waste generated per hospital patient has more than doubled. Changes in technology and increased use of plastics and disposable products have substantially increased waste amounts, as have the indiscriminate use of "red bags" for non-infectious waste and inefficiencies in hospital waste management and purchasing programs.

Medical waste on the beaches of New Jersey and Long Island and the increased incidence of hepatitis and HIV/AIDS led to a universal precautions concept that all body fluids were potentially infectious. Thus, massive amounts of what was believed to be infectious waste were "red-bagged". ("Red-bagging" is the practice of discarding infectious medical waste in red garbage bags earmarked for disposal as "regulated" medical waste, most often in medical waste incinerators.) Yet detailed analyses of red bag contents show this disposal method has been overused in most health care institutions, and surveys show that most hospitals do little to monitor the contents of the bags or educate workers on proper waste disposal.

RED BAG REALITIES

The Society for Hospital Epidemiology of America has found that "household waste contains more microorganisms on average than medical waste." Only ten to fifteen percent of hospital waste is properly described as "infectious" or "red bag" material. The rest is solid waste made up of paper and paperboard, plastics, food waste, metal, glass, wood and other non-infectious materials. While health care facilities vary widely, most medical waste can be reduced by using the same waste minimization techniques increasingly found in our homes and offices.

According to the Centers for Disease Control, no more than two percent of a typical hospital's waste stream must be incinerated to protect public health and safety. That two percent is primarily pathological waste (mostly body parts). Yet many hospitals routinely burn 75 to 100 percent of their waste. The unnecessary burning of polyvinyl chloride (PVC) plastic, paper, batteries, discarded equipment and other non-infectious materials leads to emissions of dioxins and mercury, as well as other toxins such as furans, arsenic, lead and cadmium — and it creates toxic ash.

USEPA currently cites medical waste incinerators as the second largest source of dioxin and the fourth largest source of mercury pollution of our environment and food supply.

DIOXIN — TOXIC, PERSISTENT, AND WIDESPREAD

Dioxin is the common name for a class of 75 chemicals. Dioxin has no commercial use. It is a toxic waste by product formed when waste that contains chlorine is burned—or when products containing chlorine are manufactured. PVC plastic is a major source of the chlorine in medical

waste. The primary medical use of PVC is in intravenous (IV) bags and tubing.

Dioxin is atmospherically transported and enters the food chain long distances from its point of origin. Dietary sources of dioxin, which account for 90% of human exposure, include meat, dairy products, eggs, and fish. Dioxin bioaccumulates, building up in fatty tissues and concentrating in organisms as it moves up the food chain. According to the USEPA, adults eating an average diet are consuming 300 to 500 times the daily "safe" dose of dioxin. Because of the high fat content of breast milk, nursing infants are exposed to about 50 times the average adult dose and may receive more than 10% of their total lifetime exposure during the nursing period, a time when they are extremely vulnerable to dioxin's toxic effects.

Dioxin can cause:

Cancer. Dioxin is a known human carcinogen according to the International Agency for Research on Cancer (IARC) and a probable human carcinogen according to the USEPA. Liver, lung, stomach and connective tissue cancers as well as non-Hodgkin's lymphoma have all been associated with dioxin.

Reproductive and developmental effects. In animals, dioxin causes decreased sperm count, congenital malformations (cleft palate, kidney disorders), decreased testis size, premature onset of puberty, feminization of behavior and endometriosis. In humans, dioxin has been shown to cause altered sex ratio, small penis size and endometriosis. Birth defects (spina bifida) have also been found in children of Vietnam veterans exposed to dioxin-contaminated Agent Orange.

Developmental neurotoxic effects. Dioxin causes decreased psychomotor ability, hearing deficits, cognitive defects and behavioral alterations in infants.

Hormone effects. In animals, dioxin causes decreases in testosterone at relatively high doses and decreases in thyroid hormones following perinatal exposure. In humans, testosterone levels were slightly decreased in exposed workers. In infants exposed prenatally, thyroid hormone levels were decreased.

Immune system effects. In animals, dioxin suppresses the immune system making animals more susceptible to bacterial, viral, and parasitic disease. In humans, dioxin has been found to slightly suppress the immune system in adults and to cause more marked suppression in infants exposed prenatally.

POLYVINYL CHLORIDE (PVC) PLASTIC: PRECURSOR TO DIOXIN

To stop the production of dioxin, health care institutions can minimize the amount of waste from their facilities that is incinerated and eliminate the purchase, and disposal by incineration, of chlorine-containing substances that create dioxin. In hospital waste, polyvinyl chloride plastic (PVC) is a major source of chlorine.

Commonly used PVC items in health care include IV bags, tubing, blood bags, endotracheal tubes, oxygen tents, mattress covers, packaging and office supplies such as binders.

Dioxin is released both when PVC is manufactured and incinerated. The production of PVC plastic involves many toxic feedstocks, additives or by-products, resulting in a product that is 57% chlorine by weight. When PVC is incinerated, the chlorine is released and combines with organic matter to produce dioxin.

Even while it is in use, PVC may be dangerous to patients. The plasticizer

SINCE 1955, THE AMOUNT OF WASTE GENERATED PER HOSPITAL PATIENT HAS MORE THAN DOUBLED

HEALTH CARE DECISION-MAKERS SHOULD CONSIDER THE ENVIRONMENTAL HEALTH IMPACTS OF THE PRODUCTS THEY CHOOSE

di-ethylhexyl phthalate, or DEHP, is added to PVC to make it more flexible for applications such as IV bags and tubing. DEHP has been identified by the USEPA as a probable human carcinogen. Scientific studies have shown that DEHP may also damage the heart, liver, testes and kidneys, and interfere with sperm production. PVC IV bag manufacturers Abbott Laboratories and Baxter Healthcare International both include labels on their flexible plastic (PVC) containers warning patients of the possibility of the leaching of small amounts of the plastic's chemical components into the solutions being administered intravenously.

SOLUTIONS: NEW PURCHASING PRACTICES

Health care decision-makers, including hospital materials managers and purchasing directors, should consider the environmental health impacts of the products they choose as part of their health care mission. Chlorine- and DEHP-free alternatives exist for many of the uses of PVC in health care. Easily replaced items include patient identification bracelets and cards, IV bags, compression stockings and fluid collection devices. IV containers made of non-chlorinated plastics such as polyethylene or other polyolefins are currently available. These plastics do not produce dioxin when burned or manufactured. In addition, plasticizers are not used in the formulation of these plastics. Rigid PVC products often have alternatives made of metal or non-chlorinated plastic such as polypropylene and polycarbonate. New non-chlorinated plastic polymers are being developed that will provide even more alternatives for current manufacturers of PVC products.

Health Care Without Harm has issued a health alert on PVC IV bags and is working with hospitals, group purchasing organizations and health care professional organizations to encourage the development of alternatives to products made with polyvinyl chloride.

MERCURY: POLLUTING PREGNANCIES

Mercury can be found throughout many hospitals in patient and laboratory thermometers, blood pressure devices (sphygmomanometers), dilation and feeding tubes, batteries, and fluorescent lamps. Because of the significant use of these items in many hospitals, medical waste may account for 20 percent of the mercury in the solid waste stream. The USEPA estimates that medical waste incinerators are responsible for ten percent of mercury air emissions.

Mercury cannot be destroyed through incineration. Following release through an incinerator smokestack, mercury is deposited back to land or to surface waters where it can remain indefinitely, either in an inorganic form (elemental mercury) or in an organic form (methyl mercury). Microorganisms can convert elemental mercury to methyl mercury, which is more biologically available or more able to interact with cells and damage them. Methyl mercury accumulates in the muscle tissues of animals, especially fish, and through consumption of mercury-contaminated foods, it bioaccumulates in humans.

Mercury pollution is already widespread. Both the United States and Canada have targeted mercury for virtual elimination of human uses and releases. According to the USEPA's 1997 Report to Congress, 39 states have determined that all or some of their lakes, streams and rivers are too contaminated with mercury to allow people to eat fish and seafood from those bodies of water.

Mercury is a potent neurotoxin, which means it attacks the body's central

nervous system. Neurotoxic risks to developing fetuses and young children are the primary reasons for fish consumption advisories, which aim to discourage pregnant women, women of child-bearing age, and young children from eating too much fish. Studies done on women who ate methyl mercury-contaminated fish or grain showed that even when the mothers showed few effects of exposure, their infants demonstrated nervous-system damage.

Mercury not only attacks the body's central nervous system; it can also harm the brain, kidneys and lungs. It can cross the blood-brain barrier as well as the placenta. Methyl mercury from contaminated fish easily crosses the placenta and enters the brain of the developing fetus. The critical effect from prenatal exposure to methyl mercury is mental retardation.

SOLUTIONS: ELIMINATING MERCURY FROM HOSPITALS

Mercury has many properties that have made it useful. It responds to temperature and pressure changes (making it useful for thermometers and blood pressure devices), conducts electricity and forms alloys with other metals. However, alternative products have emerged for most commonly used mercury-containing medical equipment. Mercury thermometers and blood pressure gauges can be replaced with electronic devices. Tungsten can replace mercury in feeding tubes and dilators. Instead of mercury batteries, rechargeable batteries can be used.

In 1998, HCWH participated in the process which led to the American Hospital Association's decision to sign a memorandum of understanding with the USEPA. This memorandum, which pledges to reduce waste within the hospital system by half by the year 2010, also calls for phasing out the use of mercury in hospitals by the year 2005. Working within this agreement, HCWH, the AHA and USEPA seek to help hospitals achieve these goals.

Other HCWH mercury-related activities include a mercury-free pledge for hospitals and health care providers, and an educational booklet entitled "Mercury Thermometers and Your Family's Health," which discusses household use of mercury in thermometers, explains how to clean up mercury spills and advocates non-mercury alternatives.

NEW RULES FOR MEDICAL WASTE INCINERATION

In August 1997, the USEPA released the first federal standards and guidelines (the "MACT Rule") regulating hospital and medical waste incinerators. New facilities have approximately six months after startup to comply with the rule. Existing facilities will have three to five years to comply. Crematoria and incinerators that burn only pathological waste, expired pharmaceuticals, or radioactive medical waste are not covered by this rule.

Health Care Without Harm advocated for stricter, more protective emission limits than were in the final rule, and urged USEPA to focus on waste reduction and waste segregation in health care facilities rather than on pollution control equipment — which protects us less at a higher cost. States must now create rules that are at least as protective as the federal standard. Health Care Without Harm is working with states to adopt regulations that provide more protection for people and wildlife than the federal rule.

SOLUTIONS: REDUCE, SEGREGATE, RECYCLE AND REUSE

USEPA's medical waste incinerator rule offers advanced and expensive technology as the solution to pollution from medical waste incinerators. Wet and dry scrubbers

and emission control monitoring equipment do make air emissions less toxic. But such solutions cost more and accomplish less than a "preventive medicine" approach that integrates purchasing and disposal decisions and emphasizes non-toxic, recyclable, and reusable materials.

Reduce

The most important part of waste management is waste reduction, which begins with procurement. Purchasing professionals can work with vendors to buy items that decrease the amount of waste generated, especially toxic waste. More durable products and products with less packaging also help to reduce the waste stream.

Segregate

Waste segregation, already widely practiced with our household waste, is crucial to reducing the volume and toxicity of the medical waste stream. Paper and cardboard products, glass, some plastics, and metals can readily be recycled in existing markets. Waste segregation requires commitment and education up front, but little additional time if systems are properly designed. For example, strategically locating red bags only in the necessary areas and liberally offering non-red bag options where possible will substantially reduce red bag volume. Hospitals can post signs clearly designating certain types of waste for the red bag. But staff are not likely to change current behavior without education, persuasion and a regulatory "stick."

For hospital administrators, the ethical and public relations value of being "green" can be substantially enhanced by the data that shows that waste reduction saves money. There are many examples of institutions saving money by saving the environment, including Beth Israel Medical Center in New York which saves $900,000 per year through product purchasing and disposal modifications, including reducing, reusing and recycling.

Assess Your Waste

Each hospital facility has a mix of solid waste much like that in any institution, as well as waste generated specifically as a result of its patient care. A waste assessment can identify the waste types and generation patterns in all areas of the hospital, and thus areas for potential improvement. A waste assessment can range from looking in trash receptacles and compactors or taking a trip to the landfill with the hospital's hauler, up to a more comprehensive waste assessment procedure, conducted in-house or with an outside consultant. Such a comprehensive waste assessment will give hospital staff a clear idea of how their waste is managed on a daily basis.

Recycle

Recycling (and buying products made with recycled materials) reduces the pollution from resource extraction (mining, forestry) and manufacturing products, and reduces the pollution associated with incineration, landfills and other waste disposal methods.

Health care facilities can use mostly conventional recycling methods. Health care waste is not primarily needles, body parts, blood and bandages. The dominant materials are paper and cardboard, followed by plastics, metals, glass and other materials which are commonly recycled by other entities such as hotels, restaurants and office buildings. Recycling can save institutions thousands of dollars in waste disposal costs.

Reuse

Hospitals can also reduce their waste stream, cut costs, and reduce their negative impact on the environment through a conscious procurement preference for reusable products that meet the needs of

health care workers and their patients. Many common single-use disposable products have safe, reusable alternatives including underpads (chux), eggcrate mattresses, dishware, sharps containers, gowns, wash cloths, pillows, bedpans and urinals. Single-use cardboard packaging can be replaced with reusable tubs.

Alternatives to Incineration

Even the hospital with the best waste reduction, segregation, recycling and reuse program will still produce waste that is potentially infectious. But most of this "true" infectious waste does not need to be incinerated to be made harmless and unidentifiable. Various technologies have been developed to sterilize and reduce the volume of medical waste without incineration. Note: HCWH does not specifically endorse *any* of these technologies.

Autoclaves are the most commonly used medical waste treatment alternative in the United States. Like most disinfection techniques, an autoclave destroys infectious agents through the use of steam heat, like a high technology dishwasher. Unlike incineration, however, the materials are not burned, reducing the risk of dioxin production. Frequently, wastes are shredded prior to autoclaving, in order to facilitate the process. Another alternative, microwaves, use radiant energy to heat water that is sprayed onto waste. Once the water reaches its boiling point, it boils the microbes, rendering most of them harmless.

Microwaves, autoclaves and other alternative waste treatment technologies must be independently evaluated for safety and effectiveness. Any medical waste treatment technology approved by a state or federal agency should be subject to stringent regulations, which have been developed with worker safety, public health and environmental considerations in mind.

SOLUTIONS: NINE STEPS TOWARDS ENVIRONMENTALLY RESPONSIBLE HEALTH CARE

Every health care facility can take immediate steps to reduce the environmental harm that results from its purchasing and waste disposal practices. By doing so, it can benefit financially, improve staff morale, increase worker safety, avoid liability costs, improve regulatory compliance and strengthen its relationship with the community.

STEP ONE: Establish a "green team." Convene a task force of administrators, housekeepers and others who are currently responsible for waste handling. Authorize this team to:
1. Identify the percentage and content of your facility's waste stream that is currently being incinerated and what is currently being recycled.
2. Conduct a waste audit with either in-house staff or an outside consultant to identify wasteful practices and design a waste management strategy that incorporates waste reduction, reuse, and recycling measures.

STEP TWO: Put someone in charge. Assign or hire staff for the full time responsibility of developing and implementing a new and more environmentally thorough waste management program. This program should integrate materials-purchasing with waste segregation and recycling to reduce the waste stream volume and toxicity through environmentally sensitive work practices.

STEP THREE: Train staff about the environmental consequences of medical waste incineration. Waste handlers, nurses, purchasing staff, boards of directors, medical ethicists, physicians, medical assistants, administrative staff and food service personnel all need to be aware of the problems and costs of

EVERY HEALTH CARE FACILITY CAN TAKE IMMEDIATE STEPS TO REDUCE THE ENVIRONMENTAL HARM THAT RESULTS FROM ITS PURCHASING AND WASTE DISPOSAL PRACTICES

BEGIN A PROGRAM TO ELIMINATE THE USE OF MERCURY-CONTAINING PRODUCTS WITHIN THE INSTITUTION AND BECOME A MERCURY-FREE FACILITY

unnecessary red-bagging and the availability of less expensive and more protective waste disposal alternatives.

STEP FOUR: Don't throw out what you can recycle. Implement or expand your recycling program. Cardboard, glass, office paper, drink cans, newspapers and magazines, and PETE (#1) and HDPE (#2) plastic have nationwide recycling markets. Implement a purchasing program that favors products made of recycled paper that has not been bleached with chlorine. Communicate with suppliers about the need for totally recyclable or reusable packaging materials.

STEP FIVE: Don't throw out what you can reuse. Create a plan to assess, on an ongoing basis, the availability of reusable products, and when feasible, substitute them for disposable items.

STEP SIX: Don't incinerate what you can safely dispose of by other methods. The small percentage of hospital waste that is infectious can be made harmless and unidentifiable by autoclaving, microwaving or other alternatives to incineration.

STEP SEVEN: Begin a program to eliminate the use of mercury-containing products within the institution and become a mercury-free facility by the year 2003. Mercury is present in batteries, thermometers, Miller-Abbott tubes, Cantor tubes, sphygmomanometers, electrical equipment, fluorescent lamps, laboratory reagents and disinfectants. Alternatives already exist for most of these. Where they do not — for example in energy efficient fluorescent light bulbs — engage in recycling to avoid releasing mercury into the environment. You can refer to the University of Massachusetts at Lowell's Sustainable Hospitals Project for a list of mercury alternatives. The web address is www.uml.edu/centers/LCSP/hospitals.

STEP EIGHT: Create a plan to reduce the use of chlorinated plastics, such as polyvinyl chloride (PVC), with the five-year goal of its near-complete phase-out from your institution. PVC may be present in ventilator and oxygen therapy tubing, endotracheal tubes, ambu bags, facemasks and oral airways, IV bags and tubing, dialysis equipment, patient ID bracelets, gloves, protective covers, record binders and mattress covers.

STEP NINE: Assign materials management staff to research and communicate with suppliers concerning the substitution of materials (sterilizing solution, floor cleaners, cooling unit biocides) to reduce toxic chemical inputs, protect the health and safety of health care employees and reduce environmental pollution emissions and impacts.

Health Care Without Harm strives to help hospitals and other health care facilities achieve these nine steps. We can provide educational materials, refer experts, suggest speakers, and identify health care facilities willing to share their experience in becoming environmentally responsible. Our web site is www.noharm.org.

Action for Women's Health, Albuquerque NM
AFL-CIO, Washington DC
American Indian Health, Dearborn MI
American Nurses Association, Washington DC
American Public Health Association, Washington DC
Asia Pacific Environmental Exchange, Seattle WA
Bangladesh Environmental Lawyers Association (BELA), Bangladesh
Beth Israel Medical Center, New York NY
Blue Ridge Environmental Defense League, Wadesboro NC
Breast Cancer Action, San Francisco CA
The Breast Cancer Fund, San Francisco CA

St. John's Regional Medical Center, Oxnard CA
St. Joseph's Hospital & Med. Center, Phoenix AZ
St. Joseph's Medical Center, Stockton CA
St. Mary Medical Center, Long Beach CA
St. Mary's Medical Center, San Francisco CA
St. Rose Dominican Hospital, Henderson NV
St. Vincent Medical Center, Los Angeles CA
Woodland Healthcare, Woodland CA

Cebu Environmental Initiatives for Development Center, Inc., Cebu City Philippines
Center for a Livable Future, Johns Hopkins University School of Hygiene & Public Health, Baltimore MD
Center for Environmental Health, San Francisco CA

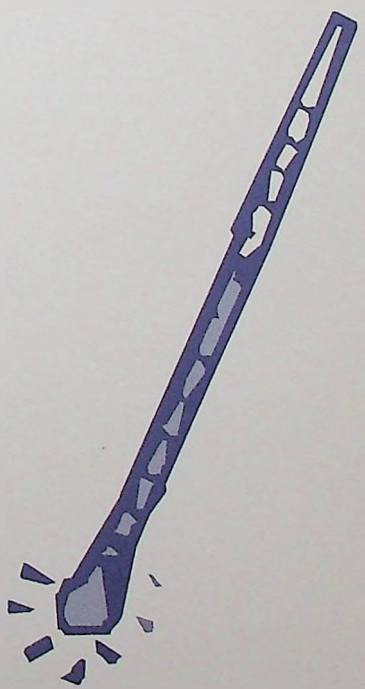
HCWH PARTICIPATING ORGANIZATIONS

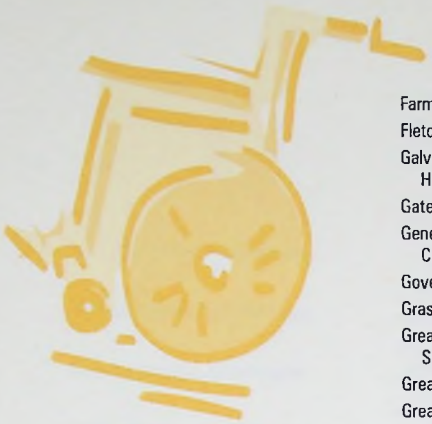
(AS OF MAY 1999)

California Communities Against Toxics, Rosamond CA
California Nurses Association, Sacramento CA
California, Nevada Board of Church & Society, United Methodist Church, Santa Cruz CA
Canadian Association of Physicians for the Environment, Kleinburg, ON Canada
Cathedral of Saint John the Divine, New York NY
Catholic Healthcare West, San Francisco CA

Bakersfield Memorial Hospital, Bakersfield CA
Dominican Hospital, Santa Cruz CA
Marian Medical Center, Santa Maria CA
Mark Twain St. Joseph's Hospital, San Andreas CA
Mercy American River Hospital/Mercy San Juan Hospital Carmichael CA
Mercy General Hospital, Sacramento CA
Mercy Hospital, Bakersfield CA
Mercy Hospital and Health Services, Merced CA
Mercy Hospital of Folsom, Folsom CA
Mercy Medical Center Mt. Shasta, Mt. Shasta CA
Mercy Medical Center Redding, Redding CA
Mercy Southwest Hospital, Bakersfield CA
Mercy Westside Hospital, Taft CA
Methodist Hospital of Sacramento, Sacramento CA
O'Connor Hospital, San Jose CA
Robert F. Kennedy Medical Center, Hawthorne CA
Saint Francis Memorial Hospital, San Francisco CA
Saint Louise Hospital, Morgan Hill CA
San Bernadino Community Hospital, San Bernadino CA
Sequoia Hospital, Redwood City CA
Seton Medical Center Coastside, Moss Beach CA
Seton Medical Center, Daly City CA
Sierra Nevada Memorial Hospital, Grass Valley CA
St. Bernardine Medical Center, San Bernardino CA
St. Dominic's Hospital, Manteca CA
St. Elizabeth Community Hospital, Red Bluff CA
St. Francis Medical Center, Lynwood CA
St. Francis Medical Center, Santa Barbara CA
St. John's Pleasant Valley Hospital, Camarillo CA

Center for Health, Environment and Justice, Falls Church VA
Center for the Biology of Natural Systems, Flushing NY
Central Conference of American Rabbis, New York NY
Centre national d'information indépendante sur les déchets (CNIID), Paris France
Centro Ecologista Renacer, Santa Fe Argentina
CGH Environmental Strategies, Burlington VT
Chemical Impact Project, Kentfield CA
Citizens Environmental Coalition, Albany NY
Citizens for a Better Environment, Chicago IL
Citizens for a Better Environment, Madison, WI
Citizens for a Better Environment, Minneapolis MN
Citizens for a Healthy and Safe Environment, Colchester VT
Clean North, Sault St. Marie ON
Cleanup Coalition, Baltimore MD
Committee of Interns and Residents, New York NY
Commonweal, Bolinas CA
Community Coalition for Environmental Justice, Seattle WA
Connecticut Coalition for Environmental Justice, Hartford CT
Děti Země- Children of the Earth, Praha, Czech Republic
Department of Environmental Health, Boston University School of Public Health, Boston MA
DES Cancer Network, Washington DC
Detroiters Working for Environmental Justice, Detroit MI
Earth Day Coalition, Cleveland OH
EarthSave, Louisville KY
Ecology Center, Ann Arbor MI
Endometriosis Association, Milwaukee WI
Environmental Association for Great Lakes Education, Duluth MN
Environmental Stewardship Concepts, Richmond VA
Environmental Working Group, Washington DC
Equis, Langley WA
Essential Action, Washington DC





Farm-Verified Organic, Medina ND
Fletcher Allen Health Care, Burlington VT
Galveston-Houston Association for Smog Prevention, Houston TX
Gateway Green Alliance, St. Louis MO
General Board of Church & Society, United Methodist Church, Washington DC
Government Purchasing Project, Washington DC
Grass Roots Environmental Organization, Rahway NJ
Great Lakes Center for Occupational & Environmental Safety & Health, Chicago IL
Great Lakes United, Buffalo NY
Greater Boston Physicians for Social Responsibility, Boston MA
Greater Cleveland Coalition for a Clean Environment, Cleveland OH
Greenaction, San Francisco CA
Greenpeace, Washington DC
Hamtramck Environmental Action Team, Hamtramck MI
Human Action Community Organization, Harvey IL
Illinois Student Environmental Network, Champaign IL
Indigenous Environmental Network, Bemidji MN
International Society for Doctors for the Environment (ISDE), Santa Fe Argentina
Institute for Agriculture & Trade Policy, Minneapolis MN
Intravenous Nursing Society, Cambridge MA
Jenifer Altman Foundation, Bolinas CA
Judith Helfand Productions, New York NY
The Katahdin Center for Education and Research, Brunswick ME
Kirschenmann Family Farms, Windsor ND
Lawrence Environmental Justice Council, Lawrence MA
Learning Disabilities Association, Pittsburgh PA
Legal Environmental Assistance Foundation, Tallahassee FL
Lightning Environmental Systems, Shrewsbury MA
Living/Dying Project, Fairfax CA
Lone Star Chapter of the Sierra Club, Austin TX
Massachusetts Breast Cancer Coalition, Waltham MA
Massachusetts Nurses Association, Canton MA
Massachusetts Public Interest Research Group (MASSPIRG), Boston MA
Methodist Federation for Social Action, Mason City IL
Michigan Nurses Association, Okemos MI
Mid-Michigan Environmental Action Council, E. Lansing MI
Minnesota Center for Environmental Advocacy, St. Paul MN
Mt. Sinai School of Medicine , New York NY
Multinationals Resource Center, Washington DC
Mumbai Med-Waste Action Group, Mumbai India
National Environmental Law Center, Boston MA
National Medical Waste Resource Center, Iowa City IA
National Women's Health Network, Moretown VT
National Wildlife Federation, Washington DC
Natural Resources Defense Council, Washington DC
New England Medical Center, Boston MA
New Girl Times, New York NY
New Hampshire Nurses Association, Concord NH
New York State Nurses Association, Latham NY
North Carolina Waste Awareness & Reduction Network, Durham NC
The Nightingale Institute for Health & the Environment, Essex Jct. VT
Ohio Network for the Chemically Injured, Parma OH
Oil, Chemical and Atomic Workers Union, Lakewood CO
Oncology Nursing Society, Washington DC
Oregon Center for Environmental Health, Portland OR
People United for a Better Oakland (PUEBLO), Oakland CA
Physicians for Social Responsibility, Washington DC
Physicians for Social Responsibility — Bay Area Chapter, San Francisco CA
Pollution Probe, Toronto ONT
Reconstructionist Rabbinical Association, Philadelphia PA
Reduce Recidivism by Industrial Development, Inc., Chicago IL
Save Our County, East Liverpool OH
Science and Environmental Health Network, Windsor ND
Sierra Club, Washington DC
Society for Conservation and Protection of the Environment, Karachi Pakistan
South Bronx Clean Air Coalition, Bronx NY
South Carolina Nurses Association, Columbia SC
Southeast Michigan Sierra Club, Detroit MI
Srishti, New Delhi India
Stanly Citizens Opposed to Toxic Chemical Hazards (SCOTCH), Albemarle NC
Student Environmental Action Coalition, Philadelphia PA
Students for a Healthy Hospital, Ann Arbor MI
Students for a Healthy Hospital, Eugene OR
Student Physicians for Social Responsibility, Urbana IL
Surfer's Medical Association, San Francisco CA
Toronto Environmental Alliance, Toronto ONT Canada
Toxics Action Center, Boston MA
Toxics Action Center, West Hartford CT
Unidad Ecologica Salvadorena, San Salvador El Salvador
Vermont Public Interest Research Group, Montpelier VT
Vietnam Veterans of America- Michigan Chapter, Saline MI
Washington Toxics Coalition, Seattle WA
West Michigan Environmental Action Council, Grand Rapids MI
White Lung Association, Baltimore MD
Women's Cancer Resource Center, Berkeley CA
Women's Cancer Resource Center, Minneapolis MN
Women's Community Cancer Project, Cambridge MA
Women's Environment and Development Organization (WEDO), New York NY
Work on Waste, Canton MA
1199, the National Health & Human Services Employees Union, New York NY

HEALTH CARE WITHOUT HARM

P.O. BOX 6806 ‹ FALLS CHURCH, VA 22040

T: 703.237.2249 ‹ F: 703.237.8389

EMAIL: NOHARM@IATP.ORG ‹ WWW.NOHARM.ORG

11 Barriers to the Quality of Care: The Experience of Auxiliary Nurse-Midwives in Rural Maharashtra

ADITI IYER & AMAR JESANI

The notion of quality in the public health system is becoming increasingly an issue for policymakers and planners in India. The Eighth Five-Year Plan identified the poor quality of family welfare services as one of the factors hindering the achievement of a lower birth rate (GOI, Planning Commission 1992, p. 333). More recently, the Indian government has outlined elements of a quality-oriented, or quality-focused, approach in the Reproductive and Child Health Programme (GOI, MOHFW 1996).

As a concept, quality is attuned to the needs and satisfaction of the users of health services. By that token, a quality approach lends itself easily to the fulfillment of desired outcomes, whether these are measured by better health status or improved demographic indicators. Such a result is possible only when quality efforts are sufficiently backed up by adequate and rationally distributed infrastructure and material resources. The relationship between quantity and quality is best expressed at the ground level. This chapter reflects these ground realities from the perspective of auxiliary nurse-midwives (ANMs) in Maharashtra.

ANMs are auxiliary kers employed by the district administration to occupy the lowest rung of the public health bureaucracy. The World Health Organization has broadly defined auxiliary workers as technical workers in a particular field who have less than full

qualifications (WHO 1961, p. 4). India's Second Five-Year Plan described the role of auxiliary health workers as supplementing the contributions made by doctors and other highly trained personnel for promoting preventive and curative health activities (GOI, Planning Commission 1956, p. 540). In their capacity as technicians, vaccinators, and assistant midwives, auxiliary workers support both the medical and the nursing professions. Therefore, auxiliary workers derive their legitimacy from their interactive relationship with professionally trained personnel, and they derive their effectiveness from the network of physical and professional support structures to which they belong.

The role of ANMs in India has changed markedly over the past four decades. ANMs were initially seen as assistants to midwives in maternal and child health (MCH) centers. All of this changed during the 1960s and 1970s. Family planning was integrated with MCH activities and projected as a program deserving the highest priority (GOI, Planning Commission 1968). The committee appointed to review the staffing pattern and financial provision of the Family Planning Programme, now called the Family Welfare Programme, recommended a system of targets and incentives and identified ANMs and other village-level workers as agents for the popularization of the program (Mukherjee Committee 1966).

Further discussions on integrating the functions of the primary health centers (PHCs) and of village-level health workers led to the formation of a full-fledged Committee on Multipurpose Workers in 1972 at the initiative of the Executive Committee of the Central Family Planning Council. The committee transformed ANMs and the host of malaria workers into multipurpose workers (MPWs). ANMs were now required to provide child health services and primary curative care to villagers. Thus ANMs have long ceased to play the peripheral role conceived for them at the time of national independence. Their heightened accountability and increasing visibility in the community have transformed them into key workers at the interface of health services and ' ommunity. The realization of this potential, however, is dependent upon support systems such as preparatory training, ongoing professional and interpersonal support, facilities, and equipment. This chapter reviews and evaluates the adequacy and quality of these systems.

According to national norms, a PHC should serve a population numbering 30,000 under the leadership of a medical officer (doctor). Even if a PHC has two medical officers, it still has only one doctor for 15,000 people. In view of the demands of their work, these doctors are hardly in a position to provide constant supervision to ANMs and male health workers posted at the subcenters. The problem is exacerbated by vacancies in the post of medical officer. This absence of a team leader effectively forces the ANMs to carry out the day-to-day work of the subcenter in an independent fashion. Thus, contrary to their status as auxiliaries, ANMs become de facto independent workers—quasi doctors—with neither the recognition nor the wherewithal necessary to play such a role in the health service and the community.

The situation of ANMs is rendered more complex because it incorporates a social dimension. Although both ANMs and male workers work under the jurisdiction of the district health administration, ANMs have several inherent disadvantages. First, although they are registered with the Nursing Council and their affiliation with the nursing profession provides them with a better legal status than male workers (who are unregistered), ANMs are only paraprofessionals by training. Therefore they do not enjoy the same status as fully trained nurses and find themselves marginalized within the council. Second, the cadre of ANMs is composed exclusively of women, unlike the nursing profession, which allows the participation of males, however marginal that participation might be (in 1990, only 4 percent of nurses registered with the Maharashtra Nursing Council were men). The inequalities rooted in ANMs' gender thus add another dimension to their subordinate status. Their affiliation to nursing carries a negative social image, in view of the specific requirements of their work. ANMs bear the additional burden of a reputation—a stereotype—that portrays them as immoral women, and this represents a major handicap when they work with rural communities (Jesani 1990).

The gender differential is also manifested in a division of labor between male and female workers. Whereas male workers are expected to assume an active role in controlling malaria, tuberculosis, and other communicable diseases, ANMs are principally responsible for MCH activities. One reason for this division of labor is undoubtedly the carryover effect of their previous functions. Its outcome, which draws its ultimate justification from the "natural functions" argument, is striking. On the one hand, the sex of the male health

worker and his use of laboratory slides and other "clinical" devices conspire to project his image in the community as a malaria "doctor" (Jesani 1990); on the other hand, the female worker is regarded merely as a "nurse *bai*" (*bai* being a common form of addressing women in the area). The difference is not merely a matter of semantics; the associations suggest that the male worker is more competent than his female counterpart.

In addition, unlike her male counterpart, an ANM is expected to maintain the subcenter. In fact, the female worker's responsibility with regard to the subcenter goes beyond hygiene. She is expected to stay there and run it on a day-to-day basis. This responsibility, however, which is not entrusted to the male worker, is not matched with administrative authority over the subcenter. As a result, the male worker does not report his activities to the female worker or even necessarily feel accountable to the subcenter.

We recognize that the axes around which ANMs' experiences revolve are the quality of their relationship with the community, their positioning in the occupational hierarchy of the health services, the nature and location of their health work (whether in a PHC or subcenter, a developed or underdeveloped district, an accessible or remote area), and their support mechanisms (professional, infrastructural, and personal). An examination of how these diverse elements interact with one another and how they influence the quality of care rendered by ANMs forms the core of this chapter.

Methodology and Sample

Our study is designed to generate an understanding of the socioeconomic background of ANMs, their role expectations, performance, satisfaction, and problems from the health system and the community. It focuses on ANMs not as an operational category, but as women in the hierarchical structure of the health services, and attempts to document the many ways in which the health system affects their lives and experiences.

The study is set in the four districts of Maharashtra that represent its major geographic divisions: Ratnagiri District in Konkan, Pune District in western Maharashtra, Beed District in Marathwada, and Wardha District in Vidarbha. These districts are also representative of particular levels of socioeconomic development as measured by

the Centre for Monitoring the Indian Economy's (CMIE's) index of socioeconomic development.[1] In the mid-1980s, Pune District, with an above-average index of 175, was considered to be an industrially advanced district; Wardha and Beed Districts, with average figures of 85 and 50, respectively, were moderately developed; and Ratnagiri District, with a below-average index of 35, was classified as a backward district (CMIE 1987).

With the purposive selection of three *talukas* (subdistricts) in each of these districts and two talukas in the tribal belt of Pune, and with the random selection of two PHCs per taluka from a list provided by the Directorate of Health Services, we identified 27 PHCs for participation in the study. Using an open-ended interview schedule, we interviewed all ANMs working at the PHC and each of the subcenters. The interview schedule was designed to generate qualitative data and to provide respondents with the opportunity to express themselves freely. In addition, we selected five ANMs in each district for in-depth interaction over a maximum period of three days. This enabled the female researcher, who accompanied ANMs on their rounds, to engage in lengthy discussions and witness health activities undertaken at the village level. She was aided by an interview guidebook designed to help generate the same range of information as the interview schedule but in greater depth. Data collection commenced in the winter of 1990 and lasted until midsummer of the following year.

The total sample listing consisted of 210 ANMs; however, only 183 ANMs could be interviewed. The remaining 27 were on leave (maternity or extended leave), in training, simply unavailable, or their posts were vacant. Among the 183 respondents, 68 were from Pune (42 from six PHCs in nontribal areas and 26 from three PHCs in tribal areas), 50 from six PHCs in Wardha, 36 from six PHCs in Beed, and 29 from six PHCs in Ratnagiri. Of these 183 ANMs, 41 were posted at their PHCs, 140 were in subcenters, and two were enrolled in training courses at the district headquarters.

Findings

Our analysis focuses first on the social and economic backgrounds of the ANMs, their training as health providers, and their professional and interpersonal support within the health care system. Subsequent sections examine the political and social conditions at the PHCs and subcenters, the quality of their facilities, deficiencies in the performance of the ANMs, and problems caused by family planning targets.

TABLE 11.1
Profile of ANMs: Rural Maharashtra, 1990–91

Socioeconomic indicators	
Mean age at beginning of training (years)	20.5
Mean age at first posting (years)	22.7
Marital status at first posting (%)	
Unmarried	69
Married	25
Separated, deserted, or divorced, widowed	6
Location of current posting (%)	
In native district	72
Outside native district	28
Rural versus urban background (%)	
Rural	66
Semiurban or urban	34
Community of origin (%)	
High caste	34
Middle caste	38
Scheduled caste or tribe	19
Christian or Muslim	9
Education (%)	
Some secondary or high school	10
Matriculation	67
Intermediate license, junior college, or graduation	24
(No. of ANMs)	(183)

Note: Percentages may not add to 100 because of rounding.
ANM: auxiliary nurse midwife

Socioeconomic Background of the ANMs

ANMs are accepted into training schools at a young age (an average of only 20.5 years in our study) (Table 11.1). By the time they graduate from the training schools and receive their first posting in PHCs and subcenters, they are two years older (the mean age in our study was 22.7 years). More than two-thirds of all ANMs in our sample were single when they began working in the rural health system. Instead of using place of birth as the sole criterion for determining their backgrounds, we sought information on the places where they had studied to understand their exposure to rural or urban life. Accordingly, we classified ANMs who were born in rural areas and had their primary and secondary education in rural areas as having rural backgrounds. The rest, by default, were considered to have urban [illegible]

grounds. Two-thirds of the ANMs had rural backgrounds, and a third were from semiurban or urban areas. The one-third of ANMs with urban backgrounds—mainly Christians and Muslims—had had little exposure to rural life before their recruitment. Therefore, the ANMs brought with them youth and inexperience, which made working in conservative and patriarchal social settings an especially daunting challenge.

To be effective, ANMs must establish a strong, credible presence in the community. Because they are seldom posted in their native villages (although nearly three-fourths of those in our sample were posted within their native districts), they are expected to build rapport with strangers. Nor is this a one-time expectation. Transfers, which occur every four years on average, ensure that ANMs spend a large part of their career attempting to establish amicable relations with largely unfamiliar communities.

Nearly three-fourths of the ANMs in our sample belonged to upper and middle castes, nearly one-fifth belonged to lower castes (scheduled castes and tribes), and fewer than one-tenth were Christian or Muslim. Middle-caste Hindus dominated our sample, accounting for 38 percent. Scheduled castes were overrepresented (nearly 18 percent as compared with 11 percent in the state, according to the 1991 census), and scheduled tribes were underrepresented (at nearly 2 percent as against 9 percent in the state). Similarly, within the group of minorities, Muslims were underrepresented (nearly 2 percent as against the 1981 census figure of 9 percent) and Christians overrepresented (nearly 8 percent as against the 1981 census figure of 1 percent). The representation of lower castes (chiefly scheduled castes) and upper castes, as evidenced by the caste variation among ANMs of different ages, has increased since 1980; the percentages of minorities (Christians and Muslims) and middle castes has correspondingly declined.

Two-thirds of the ANMs in our sample had completed their secondary education, a fourth had earned an intermediate certificate or attended a junior college, and the remainder had received some secondary education. Nearly a third of the sample had acquired additional training, mostly in clerical skills such as typing and stenography.

Although a majority of the ANMs came from middle- and upper-caste families, many came from somewhat precarious socioeconomic situations. At the time of recruitment, 64 percent of the ANMs

TABLE 11.2
ANMs' current economic role: Rural Maharashtra, 1990–91

Role	Unmarried ANMs %	Unmarried ANMs (No.)	Ever-married ANMs %	Ever-married ANMs (No.)	All ANMs %	All ANMs (No.)
Sole earner	8	(3)	22	(32)	13	(35)
One of two earners						
Earning more than husband or father	37	(14)	32	(46)	33	(60)
Earning as much as husband or father	3	(1)	7	(10)	6	(11)
Earning less than husband or father	16	(6)	26	(37)	24	(43)
No knowledge or cash income not earned	37	(14)	14	(20)	19	(34)
(No. of ANMs)	100	(38)	100	(145)	100	(183)

Notes: Percentages do not add to 100 because of rounding. Brother's income considered if father had died.
ANM = auxiliary nurse-midwife

from rural areas belonged to landless and poor peasant families. Further, the monthly cash income of the ANMs' fathers averaged Rs738, the amount varying only slightly across the four study sites. Worsening the precarious financial position of the family were economic dependencies in the household at the time of the ANMs' recruitment: on average, three to four dependents per earner or productive family member. This was due in part to the fact that at the time of recruitment, one in four of the ANMs came from households in which the father either had died or was economically inactive.

Consequently, the ANMs' wages contributed important economic stability to their households. One-fifth were the sole earners in their families, and one-third of all ANMs commanded higher wages than their husbands, fathers, or brothers (in the absence of a father) (Table 11.2). The ability to alleviate the economic hardship of their households motivated many of these women to join the government service. Over time, the ANMs encountered numerous obstacles in their work but could not dare to contemplate a job switch. Their dependence on their current employers was heightened by a realization that avenues of alternative employment were limited.

ANMs did not find many options in the labor market prior to their employment in the Family Welfare Programme. Indeed, the role of choice in their decision to work as ANMs was small. The most favored occupation—one with fixed hours of duty, an attractive salary, job permanence, and a reassuringly large female representation—was teaching, which nearly three out of four perceived as a concrete

option after their matriculation but were unable to achieve. Moreover, four-fifths would have liked to pursue higher studies but were prevented from doing so by the fragile economies of their households. All these factors contributed to the vulnerability of ANMs and, consequently, their bargaining power vis-à-vis the health bureaucracy and the community.

Training

In the 1950s and 1960s, training courses for ANMs focused on midwifery and MCH, with 9 out of 24 months earmarked for those subjects. In 1973 the government integrated the various functions of the health services, changing the ANMs' role (Kartar Singh Committee 1973). Two years later, a government committee called for an expansion of their training to prepare them for multipurpose health work (Srivastava Committee 1975). In response, the Indian Nursing Council approved an expanded syllabus in 1977 (Indian Nursing Council 1977). However, the expansion in training requirements was not matched by a longer period of training. On the contrary, with the new syllabus came the decision to reduce the training period from 24 to 18 months, which some nurse trainers consider inadequate to prepare ANMs for work at the village level (Deodhar 1994). Compromises in the length and quality of training affect recruits' confidence and efficiency (Prakasamma 1989).

In Maharashtra the training standards received another setback in the 1980s, when vacancies in the public health system in rural areas generated an urgent demand for ANMs there. A frenzied attempt to recruit women for the job ensued. By the end of the decade, with 7,471 additional ANMs pressed into service, the cadre had swollen to twice its earlier size. This came about not by a redistribution of the 3,797 fully trained ANMs from the nongovernmental sector (who represented nearly one-half of all registered ANMs), but rather by expanded enrollments in training schools and by the induction of unregistered personnel. The unregistered ANMs accounted for 71 percent of all recruits during the 1980s (Iyer and Jesani 1995). This trend is reflected in our data. Three out of four ANMs currently employed were recruited during the period 1981–91. Among that group, 42 percent were still unregistered with the Nursing Council at the time of our interviews.

The chief architect of this trend was the state government. In 1982 it introduced a so-called Step Ladder Course, which further reduced the training period from 18 to 12 months and located nearly all its instruction in the field instead of the training school. Given the reduced standards of this course, it failed to win the immediate approval of the Maharashtra Nursing Council. Eventually the Nursing Council and the state government worked out a compromise: the Council agreed to register probationary workers provided they were put through another six months of training and examinations at the end of it, and the state instituted Step Ladder Promotional Courses at several training centers and began sending its workers to them.

This reduction in minimal training standards and its subsequent legitimization has had several far-reaching implications. First, by not providing enough time for students to assimilate the course material, it inadequately prepares young and inexperienced women for their jobs. Most ANMs trained under the Step Ladder Course complained to us that too much information had been imparted in too short a time. Second, ANMs' registration is now controlled by two agencies, the state bureaucracy and the Nursing Council. For ANMs, who are considered to be temporary workers until they are registered, the politics surrounding their formal acceptance by the health system only intensifies the insecurity that their deficient training has engendered. Their temporary status prevents them from receiving wages commensurate with their full-time work, and their eligibility for basic employee benefits is subject to the whims of the district-level administration.

Although the 18-month MPW course is superior to the Step Ladder Course, it places an unwarranted emphasis on hospital-based and nonnursing activities, even though ANMs' role requires an orientation to outreach work. A radical reorientation of the content and pedagogy of training is needed not only in the Step Ladder Course but also in the 18-month MPW course.

In sum, young and vulnerable women who aspire to become ANMs receive an unrealistic preview of their future career in the training schools. In shielding them from responsibilities, nursing schools fail to build trainees' confidence, a vital asset in unassisted health work, which requires independent decisionmaking. Moreover, their cloistered existence in the school does little to prepare them for work in unfamiliar, often uninviting, village communities. The threat of sexual harassment and abuse mars the careers of most ANMs, but

trainees are not informed of their legal rights or channels of redress. In the end, ANMs learn their lessons of village-level health work not in training schools, but while negotiating the numerous hurdles they encounter in everyday life.

Professional and Supervisory Support

Once ANMs are out of training schools, they need professional support to help them carry out the tasks assigned to them. This need is particularly acute in subcenters, where ANMs are deprived of the reassuring environment of a health campus. ANMs need to go through periodic retraining programs and ongoing, continuous supervision.

In the PHC setup, the medical officer and health assistants (male and female) are responsible for supervising ANMs as well as male MPWs, *dais* (traditional birth attendants), and community health volunteers (CHVs). Lady health visitors (LHVs), the female supervisors of ANMs, are no more than experienced paramedical staff who are given additional training for six months. Besides supervising ANMs, their duties include providing guidance to ANMs, strengthening their knowledge and skills, helping them to plan and organize their activities, making weekly visits to subcenters, and making home visits to observe and guide them in their day-to-day activities. Medical officers are also expected to make weekly visits to the subcenters and attend clinics organized there to examine and treat difficult cases. They are also expected to hold monthly staff meetings at the PHC to evaluate workers' progress and suggest improvements. During those meetings, they convey information from their meetings with the district health officer, inform staff about campaigns and surveys proposed by the district-level administration, monitor existing activities, and outline work schedules for the next month. Sometimes they accompany this with a short lecture on a health activity of their PHC.

Supervision should consist not merely of technical guidance but also of moral support and encouragement. In reality, this does not happen. In one of the PHCs, for example, ANMs belonging to the same caste as the medical officer were given preferential treatment; in another, the medical officer's wife, who was an ANM, did no work, but was not reprimanded. An ANM in Wardha was convinced that her medical officer was penalizing her for her assertiveness by refusing to cooperate with her. Once, she told us, he kept putting off performing a tubectomy for a woman she had recruited. Another time, when there were no empty beds in the ward, he ordered her to bring a cot from home for one of her sterilization cases and after the operation refused to let her take it back home in the PHC's jeep. His behavior made her job especially difficult.

The hierarchical relationship between medical officers and ANMs erects barriers between the two functionaries that reduce whatever bargaining power ANMs might otherwise muster. An authoritarian medical officer in Wardha required his staff to stand at attention while addressing him. He discouraged staff unity by inviting tattling, which created an atmosphere of mistrust. ANMs were sometimes expected to help the medical officer in his private practice or to manage the clinic for outpatients with the compounder (medicine dispenser) in the medical officer's absence. An ANM who was separated from her husband reported the medical officer made sexual advances toward her, suggesting that they "have fun" at a lodge in the town. When she refused, he retaliated by issuing a memorandum critical of her performance. Countering these reports of harassment, however, were reports by other ANMs who gratefully acknowledged interventions by their medical officers that helped resolve difficult confrontations with community leaders. One of the medical officers even reduced an ANM's work load when she was undergoing a personal crisis.

Another criticism voiced by our informants was that their supervision consisted of little more than monitoring contraceptive-acceptor targets and making perfunctory inspections. Their supervisors treated the achievement of targets as the only indicators of performance, zealously emphasizing them in individual interactions and in monthly meetings at the PHC. This finding is echoed in other studies (Durgaprasad et al. 1989; IIHMR 1991; Nichter 1986). Indeed, monthly meetings often became trials at which ANMs were publicly reprimanded for not completing targets assigned to them. This pressure intensified toward the end of the fiscal year (in March). As a result, the ANMs were sometimes driven to falsifying their records to exaggerate their accomplishments. They expected to gain little useful information from the monthly meetings; in fact, few looked forward to them, and many set aside their routine health activities for one or two days before those encounters to complete their records.

The content of supervision ranged from active encouragement to indifference, non-cooperation, and even antagonism, depending

on the medical officer's attitude to nurses in general and individual ANMs in particular. Most medical officers issued reprimands more often than praise. Some ANMs received no supervision at all. Those in the more remote subcenters complained that the LHVs rarely visited them because they were put off by the prospect of walking long distances on their own. We came across some instances in which ANMs worked in close association with their health assistants, but these were the exception. In general, the intent, consistency, and quality of supervision left much to be desired.

Social Conditions and Vulnerability of ANMs

ANMs are posted either at a PHC or at any of the subcenters under its jurisdiction. Some 77 percent of the ANMs in our study were posted at subcenters, while 23 percent were working in PHCs, a distribution not markedly different from the average for the state of Maharashtra as a whole. PHCs tend to be located in more developed villages, whereas subcenters are located in remote villages or in outlying areas of larger villages. At the PHCs, ANMs work within the structure of a health campus or at least have a visible backdrop for their work in the community. This includes the presence of the health team, headed by a doctor, and health infrastructure with facilities for a daily outpatient department. In contrast, ANMs posted to subcenters work unassisted, receiving only transient professional guidance from the medical officer or female health assistant. The presence of a medical officer at a weekly clinic organized by the ANM at the subcenter, though mandatory, is a rarity. Therefore, rather than operate clinics at the subcenter building, ANMs tend to deliver health care to their communities through house-to-house visits. While taking stock of the activities conducted by ANMs on the day of our interview and the time spent on each activity, we found that slightly more than one-half (55 percent) of the ANMs posted at subcenters made house visits, compared with only one-quarter of those posted at PHCs (Table 11.3). Both groups of workers spent an average of four hours, or three-fifths of their working day, on house-to-house visits.

The mandated population size of an ANM's territory is 5,000 (3,000 in tribal and hilly areas). Among the ANMs in our study it was 4,565, somewhat less than the average of 5,168 for the state in 1991. However, most ANMs were without transport and had to walk long

TABLE 11.3
Time utilization of ANMs on the last working day prior to interview: Rural Maharashtra, 1990–91

Location and activity	ANMs %	ANMs (No.)	Average duration of activity (hours:minutes)	Percentage of average workday
PHCs				
Home visits	24	(10)	3:47	52
Travel	10	(4)	1:49	25
Outpatient departments or clinics	73	(30)	4:56	68
Record writing	22	(9)	1:40	23
Universal immunization Programme camps	12	(5)	3:18	46
Deliveries	20	(8)	3:11	44
Meetings	7	(3)	4:50	67
Transporting family planning cases	—	(0)	—	—
Other activities	15	(6)	4:00	55
Not applicable or on leave	2	(1)	—	—
(No. of ANMs) and average workday		(41)	7:13	
Subcenters				
Home visits	55	(77)	4:10	62
Travel	41	(57)	2:03	31
Outpatient departments or clinics	15	(21)	4:05	61
Record writing	30	(42)	2:21	35
Universal immunization Programme camps	16	(22)	3:58	60
Deliveries	6	(8)	4:09	62
Meetings	9	(13)	5:01	75
Transporting family planning cases	3	(4)	2:45	41
Other activities	17	(24)	2:34	38
Not applicable or on leave	5	(7)	—	—
No response	1	(1)	—	—
(No. of ANMs) and average workday		(140)	6:40	
All locations				
Home visits	48	(87)	4:08	60
Travel	34	(61)	2:02	30
Outpatient departments or clinics	28	(51)	4:35	67
Record writing	28	(51)	2:17	33
Universal immunization Programme camps	15	(27)	3:51	56
Deliveries	9	(16)	3:40	54
Meetings	9	(16)	4:59	73
Transporting family planning cases	2	(4)	2:45	40
Other activities	17	(30)	2:51	42
Not applicable or on leave	4	(8)	—	
No response	1	(1)	—	
(No. of ANMs) and average workday		(181)	6:50	

Notes: Numbers of ANMs exclude those in training. The average duration of individual activities in each of the subgroups does not add up to the average work day because of multiple responses.

ANM=auxiliary nurse-midwife, PHC=primary health center.

TABLE 11.4
Provision of government accommodation: Rural Maharashtra, 1990–91

Type of accommodation	PHC ANMs	Subcenter ANMs	All ANMs
Government quarters	58	17	26
No government quarters	42	83	74
Total	100	100	100
(No. of ANMs)	(41)	(140)	(181)

ANM = auxiliary nurse-midwife; PHC = primary health center

distances under the blazing sun, sometimes through desolate and dangerous terrain. One-third of all ANMs spent an average of two hours, or a third of their workday, commuting between their workplace and the villages under their charge. Among those assigned to subcenters, 41 percent spent that much time commuting, as compared with 10 percent among those posted at PHCs. This travel time was in addition to the time it took ANMs who lived outside the village where they were posted to reach the subcenter.

ANMs have numerous reasons for preferring not to live in their subcenters. Personal safety is a major concern, especially for unmarried and separated women, who are most vulnerable to sexual harassment. All ANMs, particularly those living in subcenter villages, require secure living quarters. However, a distinct bias favors ANMs posted at PHCs: 58 percent of ANMs posted at PHCs, as compared with only 17 percent of those posted at subcenters, were provided with government quarters, whether they occupied them or not (Table 11.4). Despite the shortage of living quarters, 59 percent of all subcenter ANMs were residing in the villages to which they were posted (data not shown), and three out of four of them were doing so without being provided with quarters.

In the course of their health work, ANMs are exposed to community politics and prejudices. As we have mentioned, the disadvantages already imposed on women by a patriarchal and caste-based social system are compounded in their case by the association, in many Indians' minds, of the nursing profession with pollution and disrepute. Because ANMs' work requires them to speak openly about contraceptives, to interact with men as well as with women, and to keep itinerant schedules, they are viewed as women of loose morals. This negative social image and their low status within the health system

make them easy prey to sexual harassment—a prospect that plagues them throughout their careers.

Unmarried or maritally disrupted women, who are believed to be unspoken for or who do not visibly display the protection of their families, are particularly vulnerable to sexual harassment. A number of the ANMs in our sample recalled how their social position in the community changed after their marriage. The lewd propositions and taunts that came their way before marriage stopped as soon as they had the protection of their husbands. This was particularly the case in Wardha District, where social relationships tended to be more feudal. One of the ANMs in Pune District, a young divorcee, also recalled an unpleasant incident involving a man who approached her late one evening for a medical certificate. It soon became apparent that he had an ulterior motive; had she not slammed the door shut against him, she believed he would have molested her.

Another kind of harassment emanates from village leaders, who demand special services, such as immunizations, at their homes. In one village, a *sarpanch* (elected village head person) kept a close eye on the ANM; another insisted that he be allowed to inspect her records; yet a third badgered the ANM because she did not dispense vitamin tablets (a difficult task since she had no supplies); and a fourth made unjustified complaints to the district health officer before ordering the ANM to leave the village and never return.

A third pretext for mistreating ANMs is their caste affiliation. In Wardha several ANMs from lower castes mentioned that they faced overt discrimination. One of them, a 36-year-old neo-Buddhist, reported that higher-caste groups who were dominant in the area gave her tea in broken cups, made her sit on a sack on the floor, did not allow her to touch them, and before her own eyes would throw away the medicines she gave them. Conversely, a few of the ANMs from higher castes in Ratnagiri were visibly uncomfortable dealing when people of lower castes.

When an ANM arrives in a new village, she usually undergoes a period of testing by certain groups in the community (often youths), who accost, tease, or even sexually harass her. One of the older ANMs in Ratnagiri recalled the problems she had in her first posting. Her clients would become agitated over the onset of fever after an immunization. When she approached them with family planning information and contraceptives, they would say: "Why are you bringing us

what you have left over?" or "Why don't you use them yourself?" An ANM in Wardha described the early days of her stay in the subcenter village to which she was currently posted. People would stone her house in a bid to drive her out, so that the previous ANM would return. Young boys would drive to the steps of the subcenter on their bicycles and frighten her and her young daughter. The harassment lasted for a year and a half.

The Quality of PHC and Subcenter Facilities

Ideally, PHCs should be staffed with two ANMs, one handling work within the PHC itself, and the other conducting outreach activities in the community. Disguised understaffing exists, however, the magnitude of which can be gauged from state-level statistics compiled by the Directorate General of Health Services. In 1991, Maharashtra's 1,650 PHCs, which should have had 3,300 ANMs, had a shortfall of 1,376, a figure more than 14 times higher than the number of vacancies reported in official statistics that year. Under such circumstances, ANMs, many of whom are forced to handle the jobs of two individuals, naturally feel overburdened.

Despite an increase in the number of PHCs during the 1980s, the provision of buildings to house the new centers came only later. In 1987 fewer than one-half of the PHCs had regular buildings, but by late 1993 nearly all of them did (GOI, CBHI 1988–94; GOI, DGHS 1988–94; GOI, MOHFW 1988–94). In contrast, only about one-half of the state's subcenters had regular buildings by late 1993. The PHCs and subcenters remain inadequately equipped and supplied. These problems affect the system's capacity to provide health care services of satisfactory quality, and ANMs bear the brunt of those problems.

To perform their work, the ANMs assigned to subcenters require not only secure living quarters but also a well-constructed building and essential equipment and supplies. Their physical working conditi fall far short of that ideal. Fewer than one-fourth (24 percent) of t NMs posted at subcenters in our study had a specially constructed building. Thirty percent either had no subcenter space at all or had to conduct health activities from their homes, and the remainder worked in a rented room or in space provided by the *panchayat* (village council) or local government (Table 11.5). Of the 118 structures used for subcenter activities, one-third were poorly constructed.

TABLE 11.5
Subcenter facilities, essential furniture, and basic equipment: Rural Maharashtra, 1990–91

Facilities and equipment	Percentage of ANMs reporting
Facilities	
Rented room/other government premises	46
Specially constructed building	24
No subcenter space	16
No separate building; run from ANM's house	14
Basic equipment or furniture	
Stove	79
Fetoscope	64
Weighing machine	64
Chair/stools	45
Table	39
Autoclave	35
Cupboard	32
Delivery/examination table	31
Bench	29
Stethoscope	21
Blood pressure instrument	16
(No. of ANMs posted at subcenter villages)	(140)

Note: Percentages do not add to 100 because of multiple responses.
ANM = auxiliary nurse midwife

More than a quarter of them lacked electricity, and as many as 70 percent did not have a piped water supply (data not shown).

Although subcenters constructed by the government were better than makeshift rental arrangements, they were usually located at the village periphery or outside the protection of the main village cluster. ANMs were afraid to live in those structures unless they had their families with them. Rented rooms that served as subcenters were located within the villages but were often dark and dingy, and most offered no privacy to the ANM or her patients.

The subcenters were not adequately or uniformly equipped. For example, a common item is the stove, because it has many general as well as health uses. Yet, out of the 140 ANMs posted at the su ters, one in five lacked this basic amenity. Apart from the stove, only other instruments we found in most of the subcenters were a fetoscope, either as part or independent of a delivery kit (64 percent), and a weighing machine (64 percent). Certain essential instruments for preventive and curative care were found in fewer than half of subcenters. These included the autoclave (35 percent), stethoscope (21 percent), and instrument for measuring blood pressure (16 percent).

Essential items of furniture such as chairs or stools (45 percent), cupboards (32 percent), a delivery/examination table (31 percent), and a bench (29 percent) were also found in a minority of instances.

These inadequacies affected the ability of ANMs to work with degree of confidence in the community. Three-fourths of all ANMs in our study had multiple complaints about their working conditions. Besides being overburdened, they cited the inadequacy of facilities, equipment, and medicine stocks. They also complained about the lack of proper accommodation and inadequate transport facilities.

ANMs are expected to conduct at least half of the deliveries in their areas; but, by our estimates, ANMs based at PHCs and subcenters conducted no more than 19 and 13 percent of deliveries, respectively. They attributed their inability not only to their sense of inadequacy, due in part to their deficient training in this area, but also to the limited facilities available to them and their having to function in isolation. That is why two-thirds of the deliveries they attended took place in the women's homes, in most cases under far from ideal conditions.

Having to leave their subcenters for this work exposed them to sexual harassment. Stories of the experiences of ANMs who had been drawn out of their homes at night under false pretenses, only to be molested or raped, spread among ANMs and were lodged in their collective experience. As a result, the ANMs tended either to shun health work after 8.00 p.m. or to live outside their assigned villages so that they would not be expected to make night visits. Many ANMs refused to budge after dark unless their attendants or CHVs could accompany them.

Divergent Health Priorities

The ANMs in our study, including those posted at PHCs, conducted an estimated 15 percent of all deliveries in their areas, fulfilled 64 percent of their targets for sterilization and 65 percent of their targets for intrauterine device insertions, and reported that they were providing curative services to 68 percent of all those who approached them. If ANMs could do all the work expected of them, they would indeed be regarded as important workers at the village level. The reasons why they cannot do this lie in their assigned priorities, their resulting allocation of time, and the highly deficient support mechanisms available to them.

The Family Welfare Programme has steadily overshadowed all other programs and services of the primary health care system. Changes in health policy affect ANMs directly. They are expected to implement health policies through their activities at the village level. By virtue of their position in the community, however, ANMs are faced also with demands for other health services by the people they are supposed to help. The government and villagers do not always share the same priorities, and, in trying to accommodate both, ANMs often end up caught in the middle.

We asked the ANMs we surveyed to rank eight health activities from the perspective of the government and the people. Their combined ranking reveals a conflict between the community members, whose highest priority is curative services, and the government, whose perceived priority remains family planning.

Government priorities directly affect budgetary and financial allocations, which in turn affect the provision of equipment and supplies. As a result, PHCs may experience gross deficiencies in essential drugs but are invariably well-stocked with contraceptives (ICMR 1991). This deficiency not only limits the ANMs' ability to provide tangible services at the point of contact with the community but also reduces their credibility. "You don't give us medicines when we need them; why should we listen to you when you tell us about family planning?" was a refrain that the ANMs in our study were obliged to hear over and over again. To rectify the communities' perception of their role as superfluous and self-serving, they placed great emphasis on their curative work and less emphasis on their function as midwives.

ANMs attempted to honor as many requests for medicines as possible in an effort to gain acceptance in the community, a practice that has also been documented elsewhere (Paul, Singh, and Sharma 1988). Every year subcenters in Maharashtra receive an annual provision of drugs and supplies valued at only Rs3,000. Despite that inadequate level of support, ANMs posted at subcenters and PHCs in our study reported that they were able to provide curative care to an average of two-thirds of all clients who approached them.

Pressed for medications, the ANMs referred patients to the PHC, rationed their stocks by giving patients medicines in smaller doses than indicated, or simply turned them down. A few were driven to dispensing innocuous drugs or placebos to satisfy clients. Others pur-

chased and dispensed medicines in a private capacity. Inadequacies in drug provision—and ANMs' deficient training in drug use—thus threaten the rationality and quality of health care available from PHCs and especially from subcenters. This conclusion is reinforced by findings reported by Phadke and colleagues (1995) in Maharashtra and by Paul, Singh, and Sharma (1988) in Uttar Pradesh.

ANMs told us they hoped that their curative activities would have a positive effect on their family planning performance. To increase their credibility, most (64 percent) conducted antenatal care, deliveries, postnatal care, and immunizations (Table 11.6). And through all of this, ANMs continued to promote the economic benefits of small families (mentioned by 52 percent of the ANMs) or the health benefits to the women and their children of limiting their family size (mentioned by 39 percent). Accompanying these strategies were a host of monetary and material incentives they offered clients, including the provision of meals and snacks to the women and the relatives who accompanied them to the PHC, medicines and injections during and after sterilization, and a personal monetary contribution to augment the government's monetary incentive of Rs130 for each sterilization.

Interestingly, ANMs were reluctant to admit that they relied on incentives; a mere 16 percent did so at first. It was only when we asked them to outline the motivational strategy they had employed in their last case that they admitted having offered incentives. Nearly two-thirds had given their last client food, 57 percent had bought her medicine or an injection, 37 percent had topped up the regular motivation fee offered by the government with their own contribution of approximately Rs200, and nearly a third had reimbursed the woman for her travel expenses.

The Burden of Family Planning Targets

Since their institution, family planning targets have become yardsticks by which ANMs are judged and accordingly rewarded or punished. The rewards consist of praise at monthly meetings of PHC staff, a cash prize, or a certificate from the district health officer. Punishment includes the withholding of an ANM's salary (sometimes for three months at a stretch), a reprimand in the presence of other staff at a monthly PHC meeting, a memorandum criticizing the worker's performance, and on rare occasions, termination of employment. ANMs tend to receive more punishments than rewards.

TABLE 11.6
Strategies and material incentives employed by ANMs to motivate women to use family planning methods: Rural Maharashtra, 1990–91

Strategies and incentives	PHC ANMs	Subcenter ANMs	All ANMs
Motivational strategy (% of ANMs using)			
Building credibility through other health services	63	64	64
Promoting the ideal of a small family for nation's development	46	54	52
Advising women to have fewer children to protect their health	37	39	39
Building rapport, explaining things in identifiable terms	42	34	35
Providing monetary and other material incentives	7	19	16
Promoting the ideal of gender equality	5	9	8
Excluding men, targeting only women for motivation	5	5	5
Other methods	2	1	1
Motivation not required	5	0	1
Not stated	7	0	2
Incentives given for sterilization (% of ANMs offering)			
Meals or snacks for patient and relatives during stay	62	66	65
Medicines or tonics before, during, or after acceptance	57	57	57
Augmentation of sterilization incentive fee	29	39	37
Reimbursement of travel expenses	33	30	30
Other	10	7	7
(No. of ANMs offering incentives)	(21)	(74)	(95)
(Total no. of ANMs)	(41)	(140)	(181)

Note: Percentages do not add to 100 because of multiple responses.
ANM = auxiliary nurse midwife; PHC = primary health center.

Targets, we were informed, worked wonders for some workers in more remote districts. Recruitment of one or two family planning acceptors often resulted in a desired transfer or extraordinary favor from the district administration. This saw several government servants—teachers, *gram sevaks* (village clerks), and *talatis* (revenue settlement officers) joining the fray and competing with ANMs for clients. Because they had no quotas to fulfill, however, they could afford to be extravagant. Some offered women as much as Rs400 to agree to have a tubectomy. This set up a market economy at the village level, and women began demanding a proper price for their impending sterilization. ANMs were now expected to make more out-of-pocket payments. They offered travel expenses for the women and their accompanying relatives in addition to food during the women's stay at the PHC. Some offered a six-month course of vitamin B complex injections following the operation. The most extraordinary request came

from one woman's husband, who asked the ANM to take his wife's place while she was away at the PHC.

Targets distort what might otherwise become mutually beneficial relationships between ANMs and women in the community. This problem is particularly acute in areas ridden with competition for family planning acceptors. Many of the ANMs in our study inculcated a narrow perspective on women's health, regarding women primarily as reproducers and targets for acceptance. This view often contributed to the alienation of ANMs from the community.

Male leaders and youths used the ANMs' anxiety about meeting targets as leverage to establish political control over them or as a pretext for sexual exploitation. In one area, a gram sevak promised to recruit acceptors for an ANM if she would accompany him to a lodge in town. In another instance, the police *patil* (village official appointed to oversee law and order) wanted her to provide his sexual partner, an unmarried woman who had no children, with a Copper-T. When the ANM refused, he complained about her to the district health officer. An unmarried ANM recounted how the village sarpanch had approached her for an injection that would cause his pregnant sexual partner to abort the fetus. Since ANMs were not supposed to conduct abortions, she refused. He then complained to her supervisor. Instead of supporting her, the supervisor explained her behavior by saying that because she was unmarried, she did not know about such an injection. The supervisor even offered to administer the injection herself. The sarpanch decided that the village should henceforth have a married ANM and demanded that the ANM who had refused his request be transferred.

Despite many negative experiences, caused in part by their association with family planning targets, many ANMs were unwilling to denounce the system of targets. One-third of them believed that removing targets would harm other aspects of their work (Table 11.7). An equal proportion, however, favored the removal of targets, and one-fifth thought that the removal of targets would have no effect, either negative or positive, on their work.

The reason mentioned by most of those who took a negative view of removing targets was that workers would be tempted to neglect other health-related duties, because many ANMs tend to carry out non–family-planning tasks with the expectation that they will have a positive impact on their family-planning performance (that is, target

TABLE 11.7
ANMs' views on the effect of removing family planning targets: Rural Maharashtra, 1990–91

Effect of target removal	Percentage having specified view
Positive effect	33
Negative effect	33
No effect	20
Positive and negative	7
Cannot say	2
Other response	1
Not applicable (targets not given)	2
No response	3
Total	100
(No. of ANMs)	(181)

Note: Percentages do not add to 100 because of rounding.
ANM=auxiliary nurse-midwife

TABLE 11.8
ANMs' views on the hypothesized effects on health work of the removal of targets, Rural Maharashtra, 1990–91

Hypothesized effects	Percentage of ANMs having specified view
Negative	
Other health activities will suffer	44
ANMs will suffer from a lack of direction	30
Family planning work will suffer or population will increase	18
There will be no substantial difference	23
Positive	
Quality of family planning work will improve	21
Harassment, tension, expenses will diminish	20
Other health activities will improve	17
Relationship with community will improve	10
Relationship with colleagues will improve	2
Not applicable or no response	5
(No. of ANMs)	(181)

Note: Percentages do not add to 100 because of multiple responses.
ANM=auxiliary nurse-midwife

fulfillment); 44 percent of the ANMs gave this reason (Table 11.8). This argument found ideological resonance among 30 percent who believed that they would lose a sense of purpose and direction. About 18 percent thought that the removal of targets would lead to large increases in the population. One-fifth of the ANMs, on the other hand, felt that the quality of their family planning work would improve. Nearly as many

believed that the removal of targets would reduce the harassment aimed at them, alleviate their tension, or lower their expenses. Seventeen percent felt optimistic that their other work would improve. One in 10 mentioned that their relationship with the community would improve.

Thus, although activities related to family planning were an onerous burden for many ANMs, not all of them were willing to criticize the program. Nor were all of them willing to discard acceptor targets, despite the problems they created in their working lives. Their induction and subsequent socialization into the existing health service program had given them a narrow view of their role and responsibilities in the health of rural communities.

Conclusion

The achievement of a high standard of care presupposes a concern for quality assurance. Integral to quality assurance is the setting of optimal standards for service delivery and outcomes. These concerns have never been adequately emphasized in India's public health system. Instead, the achievement of targets has, until recently, been an obsession at all levels of the health bureaucracy. The removal of targets may be seen as a first step in the establishment of a quality framework. However, this will have to be backed up by uniformly available and accessible health institutions and practitioners. Some of these preconditions have not been achieved in India.

First, the quantitative expansion of the health system has been a bureaucratic exercise; it has been created on paper and only later provided with personnel and infrastructure. By the time the expanded infrastructure attains an optimal level of performance, it is thoroughly discredited among the people whom it is meant to benefit. Health workers then require years to change people's negative opinion about the services provided.

Second, selective health care has been the single most important cause of the low utilization and negative image of the health care services. In rural areas, where people have few alternatives, selective health care has meant ignoring people's basic health needs. The Indian program's overemphasis on family planning, coupled with the neglect of basic curative care, has created the impression among the populace that the government is interested in little more than meeting its family planning targets. Paradoxically, the extremely high priority assigned to those targets has worked to the detriment of the public health system as a whole.

Third, it is difficult, if not impossible, to achieve a high quality of health care without having basic facilities for delivering it. Unfortunately, the government's rural health care system is woefully deficient in basic physical standards of care, even though its own departments and agencies have laid out guidelines for them. This is one of the reasons why the government has no moral authority to enforce minimal standards of care in the unregulated and often irrational private sector. The deplorable conditions that exist in many PHCs and subcenters require tremendous effort on the part of the health workers to provide even minimal care.

A fallout of poor public health services has been the increasing dependence on home-based care. In contrast with the situation in developed countries, home-based care in India does not complement high-quality institutional services that can be relied upon in emergencies. Rather, those who are driven to home-based care have hardly any support systems—such as transport and communication—that they can call upon in emergencies or when they need specialized referral care.

Fourth, ANMs are currently expected to function without close and continuous supervision from medical and nursing professionals. It is ironic that whereas institution-based paramedical workers and auxiliaries in urban areas are precluded from an independent role in health care delivery, rural auxiliaries, with virtually no medical supervision, hospital facilities, or means for transporting patients during emergencies, are expected to perform above their level of training and without the assistance of medical professionals. The role of auxiliary workers in health care and the quality of care expected from them need to be carefully reconsidered and possibly redefined.

Finally, no health worker, let alone an ANM, can meet work expectations in an atmosphere ridden with insecurity and anxiety. The fact that the health care system is insensitive to concerns about their security, and that some superiors contribute immeasurably to such insecurity, undermines their ability to perform at optimal levels. An unsafe and inhospitable workplace does little to promote quality assurance.

The emerging concern among policymakers about the quality of health care at PHCs and subcenters, though welcome, is belated.

Health workers have complained in various ways about the problems they face in the workplace. The present concern for quality must now be translated into practical programs to alleviate their problems. Otherwise, the objective of making quality an integral part of the public system is likely to remain a distant goal rather than become a concrete reality.

Acknowledgments

The study on which this chapter is based was conducted at the Foundation for Research in Community Health, Mumbai, with financial assistance from the Danish International Development Agency (DANIDA). We are grateful to Audrey Fernandes, Seema Hirani, and Sandeep Khanvilkar, fellow researchers, not just for participating in the study but for shaping its contours. We are also thankful to our colleague Sunil Nandraj at the Centre for Enquiry into Health and Allied Themes (CEHAT) and to Michael Koenig for their valuable comments on an earlier draft of the chapter.

Note

1 The CMIE index, which is a rough proxy indicator of the gross national product, is a weighted average of indicators for three sectors of the economy: the agricultural sector (per capita value of output of 26 major crops and per capita bank credit for agriculture); the mining and manufacturing sector (number of mining and factory workers per *lakh* [100,000] population, number of household manufacturing workers per lakh population, and per capita bank credit for the manufacturing sector); and the service sector (per capita bank deposit, per capita bank credit to services, percentage of the population literate, and percentage of the population urban).

References

Centre for Monitoring Indian Economy (CMIE). 1987. *District Level Data for Key Economic Indicators with 70 Maps*. Bombay (Mumbai): CMIE.

Deodhar, S. 1994. "Training of ANMs: An assessment," *FRCH [The Foundation for Research in Community Health] Newsletter*: 8(5): 1–3.

Durgaprasad, P., S. Srinivasan, N.G. Reddy, and P.K. Bhowmick. 1989. *Health Care Delivery System in Rural Areas: A Study of the Multipurpose Health Worker Scheme*. Hyderabad: National Institute of Rural Development.

Government of India (GOI), Central Bureau of Health Intelligence (CBHI). Various years. *Health Information of India*. New Delhi: Ministry of Health and Family Welfare.

Government of India (GOI), Directorate General of Health Services (DGHS). Various years. *Bulletin on Rural Health Statistics in India*. New Delhi: Ministry of Health and Family Welfare.

Government of India (GOI), Ministry of Health and Family Welfare (MOHFW). 1996. *Manual on Target Free Approach in Family Welfare Programme*. New Delhi: MOHFW.

———. Various years. *Family Planning Year Book*. New Delhi: MOHFW.

Government of India (GOI), Planning Commission. 1956. *Second Five Year Plan, 1956–61*. New Delhi: Planning Commission.

———. 1968. *Fourth Five-Year Plan, 1969–74*. New Delhi: Planning Commission.

———. 1992. *Eighth Five-Year Plan, 1992–97*, vol. 2. New Delhi: Planning Commission.

Indian Council of Medical Research (ICMR). 1991. *Evaluation of Quality of Family Welfare Services at Primary Health Centre Level: An ICMR Task Force Study*. New Delhi: ICMR.

Indian Institute of Health Management Research (IIHMR). 1991. *Training Needs of Health System Functionaries in the State of Maharashtra*. Jaipur: IIHMR.

Indian Nursing Council. 1977. *Syllabi and Regulations for the Courses of Studies for Auxiliary Nurse Midwife*. New Delhi: Indian Nursing Council.

Iyer, A. and A. Jesani. 1993. *Women in Health Care: Auxiliary Nurse Midwives*. Bombay (Mumbai): Foundation for Research in Community Health.

Jesani, Amar. 1990. "Limits of empowerment: Women in rural health care," *Economic and Political Weekly* 25(20): 1098–1103.

Kartar Singh Committee. 1973. *Report of the Committee on Multipurpose Worker Under Health and Family Planning*. New Delhi: Government of India.

Mukherjee Committee. 1986. *Report of the Committee Appointed to Review Staffing Pattern and Financial Provision under Family Planning Programme*. New Delhi: Government of India.

Nichter, M.A. 1986. "The primary health centre as a social system. PHC, social status and the issue of team-work in South Asia," *Social Science and Medicine* 23(4): 347–355.

Paul, D., J.V. Singh, and A.K. Sharma. 1988. "Qualitative and quantitative assessment of medication of sick persons provided by ANMs in a primary health centre," in *National Seminar on Essential Drugs in Primary Health Care in India: A Report*. New Delhi: National Institute of Public Cooperation and Child Development.

Phadke, A., A. Fernandes, L. Sharda, and A. Jesani. 1995. *A Study of Supply and Use of Pharmaceuticals in Satara District*. Bombay (Mumbai): Foundation for Research in Community Health.

Prakasamma, M. 1989. *Analysis of Factors Influencing Performance of ANMs in Nizamabad District*. Ph.D. thesis, Jawaharlal Nehru University, New Delhi.

Srivastava Committee. 1975. *Report of the Group on Medical Education and Support Manpower*. New Delhi: Government of India.

World Health Organization (WHO). 1961. *The Use and Training of Auxiliary Personnel in Medicine, Nursing, Midwifery, and Sanitation*. Technical Report Series, No. 212. Geneva: WHO.

SURVEY OF DOCTORS

SUMMARY ANALYSIS

A survey of the opinion of full time doctors working for at least 1 year in St. Martha's Hospital was conducted. Of 67 staff who received the survey questionnaire, 41 responded.

Based on an analysis of the survey issues have been placed under one of three categories - 1. Issues that need urgent attention based on strongly negative assessment. 2. Issues of concern where a significant number of responses were negative. 3. Issues that seem satisfactory based on a generally positive response.

Responses were analysed from the questionnaire as follows.

1. Goals - the gap perceived by the respondent between the importance a goal should be given and is actually given by the hospital.
2. Hospital functioning - respondents scoring on a 5 point scale of various aspects of hospital functioning. A score of 3 or less was considered a negative response.
3. Comments and suggestions - The number of positive and negative responses by respondents in different areas.

It is strongly recommended that besides this summary the detailed evaluation report and especially individual comments and suggestions be studied for more complete and empathic understanding of the doctors' views.

I. Issues that need urgent attention.
   1. Inefficiency in health care delivery and planning
   2. Ignoring national priorities and programmes
   3. Resistance to ideas and innovation to improve quality of health care
   4. Failure to modernise equipment and technology
   5. Not motivating staff to work in a caring manner
   6. Not consulting concerned department heads when planning and budgeting
   7. Applying different rules and regulations for different people
   8. Lack of concern for welfare of staff
   9. Poor levels of salaries and remuneration

II. Issues of concern.

1. Should foster concern for respect for life among staff
2. Should emphasize health care of women and children
3. Should subsidize services for the poor
4. Should provide spiritual care to sick irrespective of their religious belief
5. Should foster moral and ethical integrity among staff
6. Should consider ways to generate additional income
7. Should encourage an atmosphere among doctors condusive to work
8. Should improve continuing education programmes.

III. Issues that seem satisfactory

1. Care provided to all irrespective of caste and creed
2. Providing low cost care
3. Cleanliness
4. Spirit of dedication
5. Past reputation

- Dr. Prem Pais,
Vice-Principal,
St. John's Medical College,
Bangalore.

EVALUATION BY DOCTORS

The evaluation instrument for doctors has 2 types of responses

a) **A scored response which is to evaluate**

i. Hospital goals - a list of goals has been specified. The respondent has been asked to grade them in a score of increasing importance from 1-5 in ascending order.
The respondent first grades the goals as he/she views them and secondly as he/she feels the hospital views them.

ii. Hospital functioning - a number of statements regarding hospital functioning have been given. The respondent has been asked to score them from 1 to 5 in ascending order of agreement.

b) **Open ended questions**

The respondents have been given the opportunity to give open ended responses in the following areas:

- Hospital goals
- Major strenghths of the hospital
- Major weakness of the hospital
- Hospital rules
- Suggestions

Responses have been received from 41 of 67 full time medical staff

Analysis:
a)
Hospital Goals: Under each goal in part A of the questionnaire, the number (percentage) of respondents giving various scores are tabulated. Score have been grouped as lowest priority (1 or 2), highest priority (4 or 5) and intermediate priority (3). Responses have been scored in two rows - "should be" indicates the importance and respondent feels the stated goal should be given. "Is" gives the respondents perception of the importance the hospital gives the goal. In general a score of 3 or less will indicate a negative perception.

Hospital Functioning: Tabulation has been done in a manner similar to Hospital Goals. However in this section only the respondents perception of hospital functioning is called for. Once again a score of 3 or less will indicate a negative perception.

It may be noted that due to an error in cyclostyling the questionnaire the scoring system was not fully clarified. It is being assumed that the respondents have correctly understood the system.

HOSPITAL GOALS

1. The hospital should foster among all staff respect for human life from conception to its natural end

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	-	(1 (2.4)	37(90.2)
Is	2(4 9)	2(4 9)	(13(31.7)	24(58.6)

2. Hospital should provide medical care to the public irrespective of caste, creed and social status

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	_	-	38 (92.7)
Is	2(4 9)	_	7(17.1)	32 (78.1)

3. While providing high quality medical care the hospital should ensure use of appropriate, low cost yet effective care where ever possible.

	No response	1 or 2	3	4 or 5
Should be	3 (7.3)	-	-	38 (92.7)
Is	2 (4.9)	2(4.9)	7(17.1)	30 (73.1)

4. The hospital should serve as a model of efficient health care.

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	_	1(2.4)	37(90.2)
Is	2 (4.9)	7(17.1)	18(43.9)	14(34.2)

5. The hospital should treat all patients with human care and compassion .

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	_	_	38(92.7)
Is	2(4.9)	2(4.9)	11(26.8)	26(63.4)

6. The hospital should emphasize especially the health concerns of women and children.

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	_	3(4.9)	35(85.3)
Is	2(4.9)	1(2.4)	17(41.5)	21(51.2)

7. The hospital should subsidise services for the poor.

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	_	2(4.9)	36(87.8)
Is	2(4.9)	6(14.6)	12(29.3)	21(51.2)

8 The hospital should provide spiritual care to the sick respecting the individual's religious beliefs.

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	1(2.4)	6(14.6)	31(75.6)
Is	2(4.9)	10(24.4)	15(36.6)	14(34.1)

9. The hospital should serve as training institution where trainer doctors and nurses will learn to deliver competent health care ethically and compassionately.

	No response	1 or 2	3	4 or 5
Should be	3(7.3)		_	38(92.7)
Is	2(4.9)	3(7.3)	12(29.3)	24(58.6)

10. The hospital should keep the national health priorities in mind when planning its services.

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	_	4(9.8)	34(82.9)
Is	2(4.9)	12(29.3)	15(36.6)	12(29.3)

11. The hospital should foster a sense of moral and ethical integrity among all its staff.

	No response	1 or 2	3	4 or 5
Should be	3(7.3)	_	1(2.4)	37(90.2)
Is	2(4.9)	12(29.3)	10(24.4)	17(41.5)

Hospital functioning

1 The hospital constantly tries to improve quality of health care.

No response	1 or 2	3	4 or 5
_	4(9.8)	20(48.8)	17(41.4)

2. The hospital innovates to find means of reducing the cost of health care to make it more affordable.

No response	1 or 2	3	4 or 5
1(2.4)	11(26.8)	12(29.3)	17(41.4)

3. The hospital is kept clean.

No response	1 or 2	3	4 or 5
_	2(4.9)	4(9.8)	35(85.4)

4. The hospital functioning is such as to the efficient and reduce waste.

No response	1 or 2	3	4 or 5
_	4(9.7)	11(26.8)	26(63.4)

5. The hospital functioning is such as to provide prompt attention to patients.

No response	1 or 2	3	4 or 5
2(4.8)	4(9.8)	13(31.7)	22(53.6)

6. The hospital motivates all its staff to work in a caring and compassionate manner.

No response	1 or 2	3	4 or 5
_	8(19.5)	12(29.3)	21(41.2)

7. The hospital involves each department in preparing the department's budget.

No response	1 or 2	3	4 or 5
3(7.3)	12(29.2)	12(29.2)	14(34.1)

8. The hospital is concerned about ways to generate additional income.

No response	1 or 2	3	4 or 5
1(12.4)	10(24.4)	9(22.0)	21(51.2)

9. The hospital charges are reasonable compared to charges by other similar hospitals in the city.

No response	1 or 2	3	4 or 5
_	3(7.3)	9(22.0)	29(70.8)

10. The hospital has reasonable rules and regulations

No response	1 or 2	3	4 or 5
7(17.1)	8(19.5)	9(22.0)	17(41.5)

11. The hospital is ready to accept innovations and new and better ways to do things

No response	1 or 2	3	4 or 5
2(2.4)	16(39.1)	14(34.1)	10(24.4)

12. Relationship among staff is friendly and conducive to work

No response	1 or 2	3	4 or 5
1(2.4)	6(14.6)	10(24.4)	24(58.5)

13. The hospital shows concern for the staff and workers

No response	1 or 2	3	4 or 5
1(2.4)	12(29.3)	16(39.0)	12(29.3)

b) Open ended responses have great value as these may reflect opinions, emotions and feelings of respondents more accurately than scored responses. In view of this all responses have been reproduced below. They have been grouped under the five heads under which they were collected.

Under each head the responses pertaining to key areas have been grouped together. The number given against each statement is to identify the questionnaire from which is has been taken. Thus comments from the same questionnaire under different heads will all bear the same number.

It will be seen that generally respondents see the strength of the hospital in dedication of the sisters of the Good Shepherd, doctors and nurses and to the non-commercial nature of the hospital.

At same time a sense of frustration seems to come through the comments. The negative feelings lie mainly in the following areas:-

1. The hospital resists modernising and investing in newer technologies.
2. Poor salary structure for doctors. A repeated suggestion is to introduce an incentive scheme for private ward admissions and start special paying O.P. clinics.
3. "Unprofessional" management with inadequate communication with doctors. Doctors feel they are rarely consulted or made part of management decisions.
4. Different rules seem to apply for different people

OTHER GOALS / COMMENTS:

Questionnaire No	Comments
A Issues related to modernising:	
3	Provide modern treatment at reasonable cost
6	Improve MICU
10	Get dialysis unit so that poor patients can benefit
11	Improve equipment in MICU and CCU
32	Keep up with technical advances
33	Should have basic infrastructure for investigations
36	Accept specialization as an integral part of health care
B Issues related to treatment policies	
6	Introduce sterilization proceedures but not MTP
7	Discourage alcoholic patients - do not give them concessions
15	- More stress on preventive medicine - Educate women about FP / immunisation - Create awareness about nutrition and diet - Adopt slum/village to create a model system
18	Introduce sterilization procedures as per National Family Planning Scheme.
22	Follow national family planning policies
23	Land was gifted to sisters to care for all sick people not only women and children
35	Should pursue national goals irrespective of religious beliefs.
37	Provide spiritual support for those whose loved ones die in hospital
40	Improve maternal and child health facilities
C Staff benefits:	
11	Provide transport to staff Provide benefits to staff dependants eg. Educational loan
33	Reward hard working staff

D Management issues

19	Junior doctors are not given respect
32	Improve staff discipline in certain departments
33	Have a good maintainance department
36	Modernise record keeping
40	Should be able to give a feeling of belonging to the staff
	Foster the old family spirit that St Martha's was famous for

E Educational Matters

9	Send Drs to other institutions for training
	- Encourage Drs to attend conferences and pay costs for this
18	Encourage Drs to develop specialised skills
32	Raise academic standards
36	Use company sponsorship for CME programmes for Drs, nurses and technical staff.

F Miscellaneous

19	All religions should be equally respected

MAJOR STRENGTHS

Questionnaire No.	Comments

A. Dedication and Spirit of Service

1	Dedication of workers
3	Dedication of Drs and nurses
4	Dedication
5	Consistent commitment to the down trodden
6	Dedicated Drs and nurses
10	Dedicated compassionate service
11	Service to the poor
16	Commitment and dedication of sisters of the Good Shepherd
17	Sacrifice and Service
18	Dedication
19	Dedication
20	Missionary zeal
23	Strong faith
	Warmth kindness and concern

29	Dedication and hard work of staff
30	Good nursing care; dedicated Drs
31	Dedication of sisters, Drs, nursing staff
32	Sincerity and dedication
34	Showing compassion without consideration to cast or creed
36	Care and compassion of original IRISH nuns
39	Christian institution

B Technical competence

4	Competent staff - Efficiency
7	Good nursing care
12	Skilled doctors and competent nurses
26	Prompt service at admission time

C Non commercial reputation

6	No corruption
7	Subsidised service to the poor
13	Optimal care at reasonable cost
16	Not being overtly commercial
27	Cheap yet good care
33	Poor patients
39	Non profit organisation

D. Reputation past and present

7	Following old rules and regulations
12	Past reputation
20	100 years experience
40	Past glory and dedication of people in the past

E. Others

12	Location
36	Help from St. John's Medical College in 60s and 70s
37	Location and facilities available trainees & students eg. DNBE, nursing

MAJOR WEAKNESS

Questionnaire No. Comments

A. Doctors Remuneration and Financial aspects

2	No incentive scheme
4	Financial constraints
6	Low wages of doctors
7	Unaffordability of newer modes of therapy
13	Difficulty in getting competent doctors without incentive payment
15	Finances
18	Low morale among doctors
20	Economic factor
27	Lack of finances to upgrade
32	Frustration of staff because of low income
33	Monetary factors
35	Cost factors

B. Lack of modern technology

5	Technology update is slow
10	Lack of equipment
12	Delay in accepting new technology
18	Inflexible to suggestions for developing, tertiary care facilities
19	No interest in upgrading hospital
29	Lack of initiative to upgrade facilities
31	Notion that "high tech" care detracts from care of poor people
32	Hospital has not kept up with other institutions technically

C. Administration & Management

1	Inefficient administration
3	Unprofessional interference by authorities
5	No long terms vision
	- impersonal approach to staff
6	Rigid policies
11	Hierarchy
17	No long term plans
30	Absence of doctors in the administration
36	Lack of vision
	Poor interpersonal relations of present Indian nuns
	Active labour union
39	Large number of patients and less number of staff
40	Lack of vision
	Unprofessionalism of the management

D. Other factors

12	Poor standard of private ward accommodation
13	Unrealistic expectation of patient s
22	Religious
26	Uncertain availability of 2nd level consultant - delay in getting specialist
29	Unhealthy competition
35	Religious factors
37	Some doctors and nurses are without commitment

RULES AND REGULATIONS

Questionnaire No. Comments

A. Different rules for different people:

3	Different rules for different people
22	Favouritism
26	Rules vary with different departments and persons
30	Some get incentives, most dont
35	Disparity in rules depending on influence with administration
36	Different rules for different people - Visiting doctors allowed to earn more than in-house dedicated doctor

B. Impersonal and inefficient administration:

22	Administration is very poor Senior specialists not given respect
35	Unconcerned about doctors welfare Service expected even if doctors have to starve

C. Other issues:

5	Leave rules
12	Give incentives for doctors from private wards
15	Medical care should be free for all employees
35	Rules for doctors are unreasonable

SUGGESTIONS:

Questionnaire No	Comments
A Issues related to doctor's income	
2	Incentives for doctors
7	Provide adequate income for all staff
9	Increase pay scales & introduce incentive scheme
10	Increase pay of junior staff - introduce incentive scheme - start evening speciality pay clinics
11	Give staff better pay
12	Incentive from private wards
13	Impossible to get senior doctors with present pay find ways to pay reasonable salary to doctors and nurses
17	Private OP clinics
31	Allow incentives to improve employees income
35	Allow pay clinics; staff should be better paid
36	Not allowing incentives for admitted patients encourages doctors to go to nursing homes
B Issues related to modernising the hospital	
2	Improve equipment
5	Do not avoid technological growth
7	Open dialysis, neurosurgery a paediatric intensive care units - improve nursing care which has deteriorated of late - improve casualty facilities for tackling emergencies
9	CT scanner is a must
11	Better and more modern equipment
13	Give up fear of high tech. Equipment
16	Better equipment
17	CT scanner
19	Lab and ultrasound facilities round the clock CT, MRI, isotope scans
20	Replace old equipment with new
29	Ultrasound facilities should be available round the clock - Upgrade facilities including CT scanner
32	Buy new equipment and raise charges if necessary

33	Modernise; replace old equipment; computerise
34	Enhance standard of care of sick people
35	Facilities (technical) should be better

C. Issues related to administration and Management

3	Uniform rules, pay scales and promotional avenues for all staff - forum to hear and discuss staff grievances
5	Give doctors greater role in administration and policy making
8	Department / unit head should be given powers to give concession
9	Need to employee more SHOs and junior doctors
10	More flexibility with leave rules
11	Do not overwork staff
15	Categorise patients by economic status - create more special ward, ITU and graded care beds
16	More interaction between doctors and administration - consult doctors in matters of medicine, administration and police - better promotional avenues for doctors
17	Provide transport for staff using hospital vehicles/ BTS
22	Welfare of the staff should be looked after
23	Regular meetings between management and staff of each department for better exchange of ideas
26	Doctors to have more say in areas like admissions, transfers - Administration should work more quickly - More junior staff
32	Doctors or heads of departments should be given more power in the functioning of their department - improve private wards
33	Improve inter departmental relations - increase number of doctors and nurses
36	Too much "arm-chair" administration. Administrative staff should move out and see the problems of departments - sisters should be united. Their ego problems cause problems between departments
40	More fairness in dealing with staff - Less interference in medical matters by non medical people - management should show more care for the staff

D Issues related to academic matters

4	Increase teaching programmes
5	Welcome commercial sponsorship of academic meeting
7	Improve library and get Medline services - start a clinical newsletter
36	Authorities have blinkers with respect to sponsorship of CME programmes

E Other issues

7	Generate additional funds-philanthropies and increased OPD charges
34	Professionals and doctors should show more dedication
35	Goals should be based on national policies irrespective of religious beliefs