GOVERNMENT OF KARNATAKA

TASK FORCE ON HEALTH AND FAMILY WELFARE

A Commissioned Research Study

REVIEW OF EXISTING TRAINING PROGRAMMES FOR HEALTH PERSONNEL IN KARNATAKA

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Review of the existing training programmes for health personnel in Karnataka

The Department of Health and Family Welfare employs more than 60,000 personnel working in various cadres and in various institutions including the hospitals. The department has health administrators who look into the policies of the Government to improve service delivery through Public Health system. There are service providers like Medical Officers, Staff Nurses and paramedical staff working in the hospital to implement the programmes of the department. In the selection process, educational qualification is the key factor. However, provision of health services require many additional skills in addition to technical knowledge and skills like administrative and management skills. These are not adequately emphasized in basic education and at the time of entry to the health department, selected individuals greatly lack these skills so necessary for their effective functioning. It is also an established principle that professionals or administrators do require a sort of refresher course at periodical intervals in order to update the professional skills and managerial skills. Limited training programmes are being conducted by the Department of Health and Family Welfare and these have now widened under the Karnataka Health Systems Development Project, IPPIX, etc., However, the department does not carry out routine and planned training activities which are important and key factors in human resource development and management. Therefore, there is a need to review the activities of the training department and to develop suitable strategies at all levels for upgrading the knowledge and skills of the staff of the Department of Health and Family Welfare. This review was undertaken with the above mandate.

There are two components of this study. The Health Worker (Female)/Auxiliary Nurse Midwives and Health Assistant/Lady Health Visitor being such an important human resource in health care delivery it was felt that their training component should be studied and evaluated as a complete separate entity. **SECTION A** deals with all categories of health care providers *except* health worker (female) and Health Assistant (female) and **SECTION B** gives details on the health worker (female) and Health Assistant (female).

SECTION A

EVALUATION OF TRAINING PROGRAMMES FOR GOVERNMENT HEALTH CARE PERSONNEL IN KARNATAKA

EXCLUDING HEALTH WORKERS (FEMALE) AND HEALTH ASSISTANT (FEMALE)

EXECUTIVE SUMMARY

The Department of Health and Family Welfare employs more than 60,000 personnel working in various cadres and in various institutions including the hospitals. Limited training programmes are being conducted by the Department of Health and Family Welfare and have now widened under the Karnataka Health Systems Development Project, IPPIX, etc.. There is thus a need to look into this field and to develop suitable strategies to establish a continuous activity at all levels for upgrading the knowledge and skills of the staff of the Department of Health and Family Welfare. Hence, this review of "existing training programmes for health personnel in Karnataka" was initiated under the mandate of the Task Force on Health and Family Welfare.

There are two components of this study. **SECTION A** deals with all categories of health care providers *except* Health Worker (female) and Health Assistant (female) and **SECTION B** gives details on the Health Worker (female) and Health Assistant (female).

Section A of the report summarises the present status of training as a component of Human Resource Development in the Department of Health and Family Welfare and based on the interviews, opinions, observations and analysis identifies the lacunae and the changes required. It also gives details of an "ideal" training scenario for the future.

The **OBJECTIVES** of the study included studying a representative sample of the existing training systems and training programmes of various types of health personnel in the Department of Health and Family Welfare, classifying and determining details of various training programmes, identifying the methods used in training processes, evaluating the staff appropriateness and fitness of the venue, study of the training manuals and usage of teaching aids.

The **METHODOLOGY** adopted was

1. Key Informant Interviews and Discussions.
2. Primary Data Collection through Self Administered Questionnaire and Focus Discussions (Individual and Groups).
3. Desk Review.
4. Obtaining a very comprehensive training status and felt needs of the State health personnel by obtaining information from staff at the 1675 Primary Health Centres and 473 Primary Health Units of the State through a Kannada questionnaire prepared for data collection.
5. Review of as many training manuals as possible.
6. Utilising the valuable data recorded in the investigators logbook.

OBSERVATIONS

The review of the Training programme for the government health care personnel gave an unique opportunity and insight to the investigators to understand the existing machinery and mechanics of the training programmes in the Department of Health. The interaction and discussions with the implementing staff was not merely a methodology but also a sensitisation and motivation session.

The investigators found themselves with mixed feelings: frustration, indignation, hopelessness in some areas and rays of hope, happiness and satisfaction where few successful endeavours were being undertaken even in difficult circumstances. In general, there was a sense of apathy and a casual approach towards training. The enthusiasm was muted, existing as an exception.

Training was expressed as an activity that "one had to go through": the unwritten expression being that training programmes were not always necessary and that a pre-induction training in administration and medico-legal matters was all that was required. Also, it was felt that factors outside the immediate purview of the training programme most often determined its successful outcome.

A visit to the training institutions re-inforced the disappointment. The once premier training institute at Ramanagaram was found to be in a derelict and dilapidated condition – a result of neglect and abandonment of purpose.

The Heads of the Institutions clearly lacked the will and vision to take the issues forward and one wondered at the rationale of their occupying such an important post. Whether it was because of past actions of their predecessors or an inadequate support from the State level officials, it seemed they were "resigned to their fate" and had accepted "reality" and "non-action" as the best recourse. Obviously if the top level was not concerned, it is not surprising then to find the rest of the staff lacking any motivation or interest even to undertake their routine training activities let alone innovation.

During the skills development training courses, due to various reasons, hands on experience was either insufficient, inappropriate or inadequate. In essence – *"going through the motions"* was the general feeling amongst both the investigators and the "trained" personnel. Often, adequate and appropriate infrastructure was not made available to the trainees after the training course.

Regional requirements for training were not considered and factored while framing the curriculum or even during its implementation. Standardised syllabus had replaced the earlier freedom to innovate.

The Training section has not received its due in the directorate except in the recent past, a major reason being the lack of realisation of its importance in improving the quality of health care delivery services.

Another major reason was the lack of a forceful personality in leadership role - an individual who could demand and obtain the necessary support and finances for carrying out training programmes on a regular basis successfully. This led to a situation where the training section had hardly any funds and work to carry out. Even "induction training" - so important for a proper orientation and grounding of new staff was not being carried out.

With the projects and programmes setting their own training agendas and funding training programmes, routine training activities of the department took a back seat - leading to a lot of frustration and a sense of resignation and hopelessness amongst the senior staff of the training section in the directorate.

The limited time frame projects have demonstrated the need for training and given it the due importance. Of course, once the project funding is over, training will need to be financed from routine funding mechanisms of the department. There is therefore a genuine need to streamline the training section in the department so that it always receives its necessary importance, priority and support.

At present the department has training institutes (State, Regional and District and ANM training centres) where all State level training is carried out. In addition, institutes like the National Tuberculosis Institute also carry out training activities for the state health employees. The State and District level institutes have only recently been set up (in some districts - are still being set up under IPPIX).

The training staff in the directorate not having any budget for training purposes and the World Bank funded projects being able to fund many training activities in these institutes has created a dichotomy of interests in the department. The training department staff posted in the directorate feel completely bypassed and frustrated at these developments and their lack of information on training facilities and activities was indeed surprising but not completely unexpected under the circumstances.

There is also an absolute lack of coordination of training activities - training being ad hoc and project driven with no need based appraisals (including geographical distribution) being carried out. Being project driven, their regular maintenance once the project period is over will be necessitated from the funds allocated for training. Whether the budget at that stage will be able to absorb these additional costs needs to be seen specially since in the past the funds allocated for training activities were so meager and the priority given to training so low.

It is unlikely that training activities as envisaged and needed can be carried out unless an estimated Rs.5 crores (only around 1% of the proposed health budget) are annually allocated to training section (this amount excludes salaries to employees).

With the projects showing the way and giving training activities the necessary fillip and importance for improving the quality of health services being delivered by the department, allocating funds for training (to this amount at least) from the health budget should be done without any compromises in the future.

To streamline training activities of the department - a restructuring of the department staffing and line of reporting is required.

RECOMMENDATIONS

IDEAL (Desirable) TRAINING SCENARIO for Department of Health, Government of Karnataka

A] THE STATE INSTITUTE OF HEALTH AND FAMILY WELFARE

1. The State Institute of Health and Family Welfare becomes the apex training institute as well as an institute of excellence.
2. The State Institute will be completely autonomous and the funds for its activities and maintenance are to be allocated from the State Health and Family Welfare Department Budget directly.
3. The Institute will have a Director at the helm and this post will be a selection post with all the perks and privileges that are offered to a person of this level. Its tenure will be for a period of 5 years. He will report to the Health Secretary directly (Figure 1). The person occupying this chair should have a medical degree and should also have training and experience in medical education and training of trainers. Ideally, the individual should have spent some years working at various levels in the department in the field.
4. A Deputy Director will assist the Director with various administrative and technical matters. The post of the Deputy Director should be a selection post with requirements similar to the Director's post and should have a tenure of 5 years.
5. The institute should have a full complement of training, administrative and supportive staff with appropriate qualifications.
6. Considering the importance of social sciences and communication skills, the institute should have either full time or part time staff for these departments or engage the services of experts as and when required during training sessions.
7. The institute should have all necessary training equipment and facilities including teaching space and identified field training centres.

B] THE REGIONAL HEALTH AND FAMILY WELFARE TRAINING CENTRES AND THE DISTRICT TRAINING CENTRES

1. The Regional Health and Family Welfare Training Centres (RHFWTC) and the District Training Centres(DTCs) would administratively be under the State Institute.
2. Their budget will be released by the State Institute.
3. Their activities to be based on local needs and practices and to be planned and coordinated by the State institute.
4. At present there are 2 Regional Institutes in the Northern (West and East) and 2 in the Southern part of the State (Figure2). There are none in the Central part of the state. This anomaly needs to be rectified. Also, not all 27 districts have a DTC. Since the activities of a DTC are different from the RHFWTCs each district needs to have its own DTC or the RHFWTC should also undertake the activities of the DTCs without compromising on quality in districts where RHFWTCs exist but where there are no DTCs. However, the State needs to keep in mind the recurrent expenditure of so many institutes and based on needs appraisal if it is determined that 2 districts can share one DTC, for practical reasons and long term effective functioning, recourse to this may need to be taken and the plan of having so many DTCs reconsidered.
5. With the formation of the DTCs, many of the training activities can now be done at this level. This will require careful coordination and supervision to ensure quantity and quality of training.
6. The DTCs based on Needs Assessment will identify the training requirements of the district and forward this to the state institute for necessary plan of action. The DTCs will also directly oversee the functioning of the ANM training centres in their districts and provide all the necessary support.
7. As in the state Institute, all necessary facilities and equipment need to be provided to the RHFWTCs and DTCs at the earliest for their effective functioning. At present, many of them lack basic teaching aids and educational materials.
8. The effectiveness of these institutes will depend to a large extent on its human resources. The training institutes should be allotted staff based on qualifications or appropriateness and not on personal needs, contacts and political influence and the ability to take care of extraneous criteria (read favours). Merit and appropriateness should be the only criteria. Abundant precautions should be taken to ensure that these training institutes do not continue to be the islands of inefficiency they have been for so many years.
9. The Principals of these training centres should be selected with great care and should be given the right administrative and technical training themselves at the State Institute prior to their taking up these posts. This is important, as besides having adequate administrative duties, very often, they will be directly involved in training activities themselves.

10. Regular upgradation of knowledge and training skills, revision courses, as and when programmatic changes are introduced should be mandatory for all staff of all training institutes.

C] PLANNING the TRAINING PROGRAMMES

1. A committee consisting of the Director – State Institute and all Additional Directors of the Health Department will identify the training needs, prioritise activities and prepare the budget for training activities.
2. The Director of the State Institute will be the Secretary of this committee and will be assisted by the Deputy Director in formulating and drawing out the master plan of operations (based on the needs identified by the committee).
3. Approval for the formulated plans will be put forward during the committee meeting where the Health Commisioner/ Director General of Health Services are also invited.
4. Approved budgetary funds will be sought from the State and handed over to the State Institute for implementing the training activities.
5. To carry out the planned training activities funds as required will be made available in addition to the funds earmarked for training purposes in different programmes (e.g. Malaria, RCH, Tb. etc.).
6. The training needs of the different funding programmes will be respected and honored. However, to enhance effectiveness of training, avoid duplication and to cut down on unnecessary expenditure on travel, DA, etc., wherever feasible multiple training will be carried out in one training programme.
7. Rigorous district and person wise data of all training undergone will be maintained and computerised. This is to avoid wastage of resources and to ensure that everybody undergoes training and not just a favored few (as is the custom very often now - same people going for different training programmes whereas many others never obtaining a chance to enhance their knowledge and skills).
8. This Information system on training will be maintained District wise at the District level, the State Institute and Directorate. When a staff member moves out of one district to another district, necessary changes will be made and the data base will be continuously and constantly updated.
9. Since the committee now decides on training, there will not be any need to have a separate training section in the Directorate - its functions being taken over by the State Institute, its Director and the Training Committee of the Department. Adequate support from all necessary sectors in this scenario should be feasible unlike the present situation where funds are never or meagerly, miserly provided.
10. It will be advantageous to build up the State's own training resources and training institutes and depute Health staff for training in such institutes rather than at places outside the state. At present, because of lack of training facilities many of the State staff are deputed out of the

state for training purposes. If the training is done within the state we will strengthen and build up our own systems, strengthen our own resources, and provide training in our environment using case material which is similar to what the trainees will ultimately see.

11. As far as possible all training should be done within the state or at the most in some training institutes within the country. There is an unnecessary clamor for foreign training postings. Today, our country offers almost all training and skills required for the effective training of its staff or for the provision of quality health services. No carrots in the form of foreign training sessions are called for. With the money spent on such training a lot more can be achieved and many more people trained. Very often staff are posted for short term observation training. When the conditions and environment are so different and where training is "NOT SKILL BASED ACQUIRING OR HANDS ON", SUCH TRAINING OUTINGS BECOME ONLY OUTINGS RATHER THEN KNOWLEDGE/SKILLS ENHANCERS. In all fairness, good training opportunities with full scholarships are offered by international agencies like -WHO, Commonwealth organization, etc.. It is a shame to see such useful training opportunities being wasted because of non-recommendation of names on time or processing of papers on time or staff being released on time. Full use should be made of such opportunities for professional enrichment. The State Institute should have information of all such scholarships/grants availability and should decide on the staff for deputation for such training courses.

12. A major advantage in having the training programmes within the State is that the training can be done in Kannada using Kannada speaking patients and families which makes it much more easier for the participants to understand and absorb. Less financial resources will be required for such state conducted training and the resources saved could be utilised for further strengthening of our institutes.

13. Wherever the training is "technical" or the observation invite for technical matters - "technical" people (and not non-medical – non-technical administrators) are to be sent/deputed for such courses. There is merit in this recommendation. Our administrators are made to change departments quite frequently. Sending them for such sessions then is absolutely non-productive to the department as the technical training in the health sector (presuming that they are capable of absorbing the technical nuances involved) is not going to be of use to them in another department like Sericulture or WAKF. However, if the training is for strengthening administration related skills, the administrative staff should make full use of such scholarships.

14. There is an immediate identified need of training for about 470 Block Health Educators. Instead of deputing them in small batches to Gandhigram (and take years to complete the training for all of them), one of the Regional training institutes could be strengthened and provided the necessary infrastructure and human resources to carry out this training. All further induction training for BHEs could subsequently be carried out in this centre. Such judicious distribution of training activities is very necessary for optimal utilisation of limited resources.

15. Distance education methodology is a grossly underutilised training mechanism in our state. Today, such education facilities from reputed organizations like IGNOU, Jamia Millia, Manipal, is available in many health areas. They are well planned and so structured that they are practically useful to the trainees. The government should encourage such training and as an incentive offer one time payment of a lumpsum amount (one month's salary?) for every distance education course of 6 or more months duration completed successfully by the staff to a maximum of two such courses. In fact, once these universities offer more and more health related administrative, managerial and technical courses, the Government should make the successful completion of such a course a mandatory condition for promotion to a higher grade after a certain level of promotion.

16. If trainers for a particular training area are not available, for effective training to be conducted it may be necessary to tap the services of an outside expert. This is a must where institute staff lack the necessary knowledge/skills. It is therefore highly desirable to identify the right "consultants" and have a resource base of such individuals. Care must be taken to see that such consultants have the necessary field experience, as very often such "experts" tend to be very theoretical or out of tune with field based reality. However, having said that, care must also be taken to ensure that all such expert consultants are not retired staff from the Department. They do not necessarily make the best experts and the "buddy system" may not be the best way to utilise the limited resources of the training section.

17. Strengthening Public Health training is the need of the hour. The well planned and useful DPH course – post MBBS, had very few takers as it was not advantageous career wise to do such courses and over a period of time the number of seats available for such training decreased. That DPH was no longer a necessary criteria for promotion to higher categories in the Department gave it a final blow. **It is only recently that the Government has once again realised the need for such training for its staff.** At present, the medical colleges do offer a few seats. The Department should plan for the future and provide DPH training at the State Institute itself. The modalities need to be worked out with Rajeev Gandhi University of Health Sciences and necessary support for the infrastructure and resources sought so as to start these courses by 2005 at least. Simultaneously, the colleges providing these courses should be encouraged, infrastructure made available to them and Government Health staff deputed. Long term planning is the need of the hour for better and effective future functioning.

SUGGESTED VISION, GOALS AND OBJECTIVES FOR TRAINING ACTIVITY for the Department of Health and Family Welfare, Government of Karnataka

VISION

To provide technically competent, socially relevant, appropriate health services to the fullest satisfaction of the people of Kamataka.

GOALS

- By 2002 January, every health care personnel who joins the government health service will receive induction training.
- By 2005, every health care personnel will receive the identified and necessary refresher training and skills up-gradation.
- By 2010, systems are in place for the conduct of regular, ongoing, continuous refresher and induction training with adequate provision of resources.

OBJECTIVES

1. Preparing the individual's competence by enhancing communication skills and learning capabilities that are necessary for managing the day-to-day activities of the health centre and for delivery of quality health care in accordance with the existing health programmes and local health situation.
2. To nurture and enrich the organisation culture which supports and enhances team effort, harmonious interpersonal relationship, pursuit of excellence, spirit of enquiry and innovation as a way of work life and to create an organisation environment where each can share and contribute towards achieving the shared goals.
3. To create sensitivity to the needs of the society, discharge the multiple roles and responsibilities and fulfill the obligations as a health care provider.
4. To help and support each individual to develop their potential to realise their self-goals while contributing fully to the success of the organisation.
5. To achieve synchronisation of the goals and aspirations of the individual, organisation and society.
6. Enhancing preparedness for willing participation in development activities which have a bearing on health of the community.
7. Facilitate building a strong character of integrity, honesty and leadership.

INTRODUCTION

Human Resources development is a serious business. A business, which, requires specific knowledge and skills to make it run successfully. It is resource and labour intensive. The ultimate aim is to make a difference – to bring about the desired change amongst the participants and enhancement of knowledge and skills so as to function more effectively.

Training as a subsystem of the health care system has the objective of optimising the health resources input to the health care system through strengthening of knowledge, skills and attitudes of health care personnel. The knowledge, skills and attitude that enable health staff to contribute to the realisation of the goals of the health care system are usually derived from their basic education obtained before joining the service and from the experience obtained by working in the health care system. Proper training therefore plays a very important role in the effective functioning of the health system.

Changes in health care delivery interventions happen frequently. New technologies are regularly introduced and call for new skills for their use. The field personnel specially and other personnel too may become outdated in a short period of time in terms of their knolwedge and skills. This prevents their optimum utilisation and to their providing outmoded, less effective services. Skills if not used for a long time get attenuated. Continuous education will assist and motivate staff in improving their skills. The personnel enjoy the challenge of learning new skills or taking on a new responsibility or improving their existing skills.

TRAINING AND RETRAINING IS LIKE CHARGING A BATTERY. Training or continuous education has to be accorded high importance in human resource development and is crucial to the planning and implementation of any project.

Training as a signal component of HRD is best understood as a learning experience. A training programme is a learning experience for both the trainer and the trainee. It is also a learning experience for the system, which commissioned it. A training programme is said to be successful as long as it is a learning experience. The emphasis on learning and not just on training is important for it also includes the follow-up of the training as an integral component.

The broader agenda of HRD includes dimensions of undergraduate degree / diploma / certificate courses; the existing / creating environment in which the training / learning is facilitated; the media and methods adopted to assess / evaluate; organisation structure and job responsibilities. Hence to be more appropriate to this line of thinking this report should be titled Human Resources

Development for Health Care Delivery in the Public Health Sector. However due to the mandate given in the terms of reference and the time duration, the original title is retained.

This section of the report summarises the present status of training as a component of HRD in the department of Health and Family Welfare and based on the interviews, opinions, observations and analysis identifies the lacunae and the changes required. It also gives details of an "ideal" training scenario for the future.

The Objectives of the study were as follows:

1. Studying a representative sample of the existing training systems and training programmes of various types of health personnel in the department of health and family welfare.
2. Classifying the training programme into pre-induction, in-service, refresher courses, skills enhancement, additional qualification.
3. Determining details of training programmes like duration, selection process, eligibility, geographical distribution, their appropriateness and adequacy based on job description of health personnel.
4. Identifying the methods used in training process.
5. Evaluating the course content for their appropriateness, adequacy and effectiveness.
6. Evaluating the staff appropriateness and fitness of the venue for the various training programmes.
7. Study of the training manuals.
8. Availability, usefulness, appropriateness and frequency of usage of teaching aids in the training programmes.

METHODOLOGY

The following methodology was adopted for this section:

1. **Desk Review**: The existing organization infrastructure, the available past review reports and related literature were reviewed.
2. **Key Informant Interviews and discussions**: The key administrative personnel responsible for the training programmes for the Government Health Care Personnel at the level of the Directorate of Health Services, State Institute of Health and Family Welfare, Regional Health and Family Welfare Training Centres and District Training Centres were interviewed and their opinions, thoughts, concerns and suggestions were documented. In addition efforts were made to meet as many senior and retired Government officials as well as NGO representatives as possible for obtaining their inputs for the endeavour. Discussions were held with the Chairman and Members of the Task Force on Health and Family Welfare.

3. **Primary Data Collection** through

   a. Self Administered Questionnaire

      i. Focus Discussions - Individual

      - Groups

   b. Three sets of questionnaires were drafted, field-tested, finalised and used for data collection. The first set of questionnaire was meant for the Training Institutions. The second (English) and third (Kannada) sets were used to collect data from individual health staff - both medical and paramedical. (Annex1). The interactions with various key individuals commenced from 1st November 2000.

   c. Field data collection was undertaken during the period 12th November 2000 to 30th December 2000. The Four divisions and the respective Regional Health and Family Welfare Training Centres including selected District Training Centres were personally visited. In addition, one district other than the Divisional Headquarters district was also visited. In these regions as many Taluka Health Centres, Community Health Centres and Primary Health Centres as possible were visited during the survey period.

   d. Focus discussions were held with individuals and groups from these Health Institutions. Contents included: the need for training programmes, need, duration and contents of the Induction and continued training programmes, methodology and the location of the training programmes to be undertaken, staff to be involved, training of trainers and related issues.

   e. All the 1675 Primary Health Centres and 473 Primary Health Units of the State were posted three copies of the Kannada questionnaire for obtaining a very comprehensive training status and felt needs of the State health personnel.

   f. The data collected was processed using the MS Office Excel Worksheets and analysed using the WHO Freeware EPIInfo6 package.

4. As many training modules as possible were collected and reviewed.

5. The investigators logbook formed an important and valuable source of data for analysis and report preparation.

6. The names of Institutions and Individuals who participated in the study are given in Annex 2.

OBSERVATIONS

The following paragraphs document the findings of the researchers of the training endeavour and activities in the Department of Health and Family Welfare. The presentation includes three parts:

1. Summary tables of the information given by the Health Care Personnel in the structured format.

2. The information obtained during the focus discussions with the Health Care Personnel by the investigators.
3. The information processed from personal discussions and as a result of the documents made available.

[1] SUMMARY TABLES OF THE INFORMATION GIVEN BY THE HEALTH CARE PERSONNEL IN THE STRUCTURED FORMAT (English)

Table 1: The average age (in years) of the study population

Category	Number studied	Range	Mean	Median	Mode
Medial	87	25 to 58	52	51	52
Paramedical	93	28 to 58	47	50	52
Non Medical	43	25 to 57	48	50	50
Not mentioned	7	28 to 55	47	50	29

Since the Department does not have similar data on all its employees, the representativeness of this group could not be ascertained. However, all groups had persons with wide age ranges.

Table 2: Sex distribution of the study population

Category	Number studied	Male	Female	Not mentioned
Medial	087	55 (63%)	29 (33%)	03 (04%)
Paramedical	093	31 (33%)	62 (67%)	00 (00%)
Non Medical	043	36 (84%)	07 (16%)	00 (00%)
Not mentioned	007	06 (86%)	01 (14%)	00 (00%)
Total	230	128 (56%)	99 (43%)	03 (1%)

The lower female representation is partly because of their being studied in details separately, the findings of which are presented in the second part of this study.

Table 3: Average period of service (in years) of the study population

Category	Number studied	Range (years)	Mean	Median	Mode
Medial	87	1 month to 36	19	20	2
Paramedical	93	1 month to 37	25	27	30
Non Medical	43	1 month to 36	22	25	27
Not mentioned	7	1 month to 33	17	16	-

Again, a wide range helped give greater opportunity for representation of staff having had varying induction and in-service training opportunities.

Table 4: Qualification of the medical personnel

Qualification	Number (%)
MBBS	25 (29%)
Post graduate Diploma	24 (28%)
Post Graduate Degree	33 (38%)
Post doctoral	01 (01%)
Not mentioned	04 (04%)

Note: The specialist areas are given in Annex 3

Table 5: Desire of the study population for administrative knowledge

Required	Medical	Para Medical	Non Medical	Not stated	Total
Yes	52 (61%)	25 (27%)	11 (27%)	04 (57%)	92 (40%)
No	15 (17%)	15 (16%)	04 (09%)	01 (14%)	35 (15%)
Not mentioned	20 (22%)	53 (57%)	28 (64%)	02 (29%)	102 (45%)

The Medical staff are responsible for administrative supervision unlike the paramedical staff. The finding that 61% of them desired greater administrative knowledge is indicative of their interest, inadequacies in the basic training content and is a very positive sign to improve their administrative functioning.

Table 6: Desire of the study population for Technical knowledge

Required	Medical	Para Medical	Non Medical	Not stated	Total
Yes	37 (43%)	29 (31%)	07 (16%)	04 (57%)	77 (34%)
No	29 (34%)	10 (11%)	09 (21%)	01 (14%)	49 (21%)
Not mentioned	21 (23%)	54 (53%)	27 (63%)	02 (29%)	103 (45%)

Only 31% paramedical and 43% medical staff desired greater technical knowledge. These low percentages need to be further investigated, specially for the paramedical staff who do not have too many training opportunities.

Table 7: Desire of the study population for evaluation and supervision knowledge

Required	Medical	Para Medical	Non Medical	Not stated	Total
Yes	36 (42%)	32 (34%)	03 (7%)	03 (43%)	74 (32%)
No	30 (35%)	07 (8%)	13 (30%)	01 (14%)	51 (22%)
Not mentioned	21 (19%)	54 (52%)	27 (63%)	03 (43%)	104 (46%)

Supervision and evaluation activities are important activities of health care personnel specially of the medical category. Greater focus needs to be given to enhancing these knowledge and skills.

Table 8: Desire of the study population for administrative skills

Required	Medical	Para Medical	Non Medical	Not stated	Total
Yes	32 (37%)	22 (24%)	08 (19%)	01 (14%)	63 (28%)
No	35 (41%)	18 (19%)	08 (19%)	03 (43%)	64 (28%)
Not mentioned	20 (22%)	53 (57%)	27 (63%)	03 (43%)	102 (46%)

Table 9: Desire of the study population for technical skills

Required	Medical	Para Medical	Non Medical	Not stated	Total
Yes	20 (23%)	26 (28%)	05 (12%)	03 (43%)	54 (24%)
No	45 (52%)	12 (13%)	11 (26%)	01 (14%)	69 (30%)
Not mentioned	22 (25%)	55 (59%)	27 (63%)	03 (43%)	106 (46%)

Table 10: Desire of the study population for evaluation and supervision skills

Required	Medical	Para Medical	Non Medical	Not stated	Total
Yes	23 (27%)	29 (31%)	03 (7%)	03 (43%)	58 (25%)
No	42 (49%)	10 (11%)	13 (30%)	01 (14%)	66 (29%)
Not mentioned	22 (25%)	54 (58%)	27 (63%)	03 (43%)	105 (46%)

The large number of non-responses in skills enhancement section was rather unfortunate and prevents coming to any definite conclusions about them.

Table 11: Number of training programmes attended

Category	Number studied	Training programmes documented	Course type		
			Induction	In service	Not mentioned
Medial	87	280	10 (4%)	266 (95%)	04 (1%)
Paramedical	93	155	6 (5%)	98 (63%)	51 (32%)
Non Medical	43	65	1 (2%)	45 (69%)	19 (29%)
Total	223	500	17 (3%)	409 (82%)	74 (15%)

Note: The List of training programmes is given in Annex 4

Table 12: Duration of training programmes evaluated

Category	Number of personnel studied	Training programmes documented	Duration (in days)			
			Range	Mean	Median	Mode
Medial	87	280	1 to 90	19	10	03
Paramedical	93	155	2 to 365	49	14	30
Non Medical	43	65	3 to 90	37	21	90

Table 13: Type of training programmes

Nature of the Programme	Medical (n= 280)	Paramedical (n = 155)	Non Medical (n= 65)	Total (n=500)
Lecture demonstration	231 (83%)	83 (54%)	36 (56%)	350 (70%)
Workshop	91 (33%)	31 (20%)	07 (11%)	129 (26%)
Participatory	160 (57%)	78 (50%)	17 (26%)	255 (51%)
Role play	67 (24%)	60 (39%)	10 (15%)	137 (27%)
Hands on Training	64 (23%)	32 (21%)	08 (13%)	104 (21%)
Modular	52 (19%)	21 (14%)	04 (06%)	077 (15%)

In this group, there were only 23% amongst the medical group and 21% amongst paramedical who received hands on training.

Table 14a: Trainees comments on the training programmes

Training Programme	Medical (n= 280)	Paramedical (n = 155)	Non Medical (n= 65)	Total (n=500)
Highly useful	217 (78%)	97 (63%)	42 (65%)	356 (71%)
Adequate	212 (76%)	82 (53%)	29 (45%)	323 (65%)
Content adequate	197 (70%)	76 (49%)	31 (48%)	304 (61%)
Content relevant	211 (65%)	83 (54%)	35 (54%)	329 (66%)
Helped acquire knowledge	212 (76%)	83 (54%)	40 (62%)	335 (67%)
Helped acquire skills	195 (70%)	82 (53%)	35 (54%)	312 (62%)

Table 14b: Trainees comments on the training programmes

Training Programme	Medical (n= 280)	Paramedical (n = 155)	Non Medical (n= 65)	Total (n=500)
ADDITIONAL KNOWLEDGE				
Useful in every day activity	206 (74%)	84 (54%)	32 (49%)	322 (64%)
Used once in way	32 (11%)	11 (7%)	06 (9%)	49 (10%)
Occasionally	18 (6%)	02 (1%)	05 (8%)	25 (5%)
Not applicable	11 (4%)	0 (0%)	0 (0%)	11 (2%)

ADDITIONAL SKILLS				
Useful in every day activity	191 (69%)	82 (53%)	29 (45%)	302 (61%)
Used once in way	31 (11%)	12 (8%)	10 (15%)	53 (11%)
Occasionally	23 (8%)	03 (2%)	04 (6%)	30 (6%)
Not applicable	14 (5%)	0 (0%)	0 (0%)	14 (3 %)

The above table clearly depicts the benefits of training programmes to this group.

Table 15: Reasons for non-application of the knowledge and skills

Reason	Medical (n= 280)	Paramedical (n = 155)	Non Medical (n= 65)	Total (n=500)
KNOWLEDGE				
No opportunity	20 (7%)	7 (5%)	6 (9%)	4 (1%)
No interest	0 (0%)	0 (0%)	0 (0%)	0 (0%)
No freedom to act	6 (2%)	2 (1%)	0 (3%)	14 (3%)
Lack of technical support	35 (13%)	4 (3%)	2 (3%)	41 (8%)
Inadequate equipment	29 (10%)	3 (2%)	0 (0%)	32 (6%)
No encouragement	14 (5%)	1 (1%)	4 (6%)	19 (4%)
SKILLS				
No opportunity	15 (5%)	5 (3%)	5 (8%)	25 (5%)
No interest	0 (0%)	0 (0%)	0 (0%)	0 (0%)
No freedom to act	5 (2%)	2 (1%)	0 (0%)	7 (1%)
Lack of technical support	19 (7%)	4 (3%)	2 (3%)	25 (5%)
In adequate equipment	27 (10%)	3 (2%)	0 (0%)	30 (6%)
No encouragement	6 (2%)	1 (1%)	4 (6%)	11 (2%)

About a quarter of the participants were not able to utilise the knowledge and skills given in the training programmes – the major reasons being inadequate equipment and lack of technical support.

Table 16: Trainers ability as perceived by the trainee

Particular	Medical (n= 280)	Paramedical (n = 155)	Non Medical (n= 65)	Total (n=500)
Impart knowledge – good	223 (80%)	94 (65%)	34 (52%)	351 (70%)
Impart skills - good	204 (73%)	91 (59%)	24 (38%)	319 (64%)
Communication - good	204 (73%)	85 (55%)	24 (38%)	313 (63%)

The training ability of paramedical and non-medical trainers obtained quite low ratings. Since they are a very important component of health care delivery services, the trainers' abilities for these groups needs to be enhanced.

[2] INFORMATION OBTAINED DURING FOCUS DISCUSSIONS WITH THE HEALTH CARE PERSONNEL BY THE INVESTIGATORS

The following issues were raised during the open ended discussions:

a) *(Health Personnel) Learnt PHC administration mostly through self-learning and through the guidance from non-medical and para-medical staff, perusal of records and scrutiny of the government circulars.*

b) *Many difficulties faced while managing the financial aspects, in the initial stages.*

c) *INDUCTION TRAINING*

- *Induction Training should be a must.*
- *Lack of induction training resulted in lack of self-confidence and competence to manage the administration of the PHC at the initial posting.*
- *Induction Training should be conducted before the selected candidates are posted to the respective PHCs.*
- *The duration should preferably be three (15 days to six months) months.*
- *Of these one month should be in theoretical aspects of administration and finance. In the remaining two months the selected candidates should be exposed to practical training including training at sub-centre and PHC levels rather than being trained only at the divisional level.*
- *The Training pattern should be 1/3 field-work, 1/3 discussion, 1/3 lectures.*
- *Induction training should commence from sub-centre level.*
- *Current Induction Training emphasized more on clinical aspects rather than office procedures.*
- *An opinion was also expressed that the newly recruited staff should be posted first to PHC for one or two months and then drawn for induction training. By doing so, they would be more focussed on their training requirements.*

d) *Topics suggested for inclusion in the Induction training for Medical Officers were:*

- *Administration*
- *Supervision*
- *Management (Finance, Vehicle, Materials, Stress and Personnel)*
- *Human relations*
- *Inter-sectoral co-ordination*
- *Job responsibilities*
- *Office procedures*
- *Medico-legal aspects including Law and Medicine*
- *Inter-personal relationship with staff and general public*
- *Human Resources Development*
- *How to deal with Non Governmental Organisations?*
- *Counselling for adjustment to rural areas.*
- *Use of computers*
- *Disciplinary powers*
- *P(reventive) & S(ocial) M(edicine)*
- *MTP*
- *Tubectomy*

- *Leadership qualities*

e) *PARA-MEDICAL TRAINING:*

- *Need for induction training for the Nursing staff.*
- *Pre-induction training for Para-medical staff to be between 2 to 3 weeks.*
- *Pre-induction Training for Lab technicians is a must. The present LT training is of poor standards.*
- *ANM training should be under DHO and not under District surgeon. Since they would be working under the supervision of the Programme Officers and the DHO.*
- *ANM Training to be 24 months rather than 18 months. Of these 6 months should be "internship" training in association with experienced ANMs.*
- *Minimum qualifications for ANM training should be PUC II year pass / graduation.*
- *The trainers should possess Diploma in Public Health Nursing.*
- *The ANM training centres to be under the supervision of the District Training Centre Principal and the staff of these institutions to be associated with ANM training.*

f) *IN-SERVICE TRAINING*

- *In-service Training should be need based rather than based on hierarchy. The training and postings at present are not need based.*
- *The training programmes are many a times repititous.*
- *The TA/ DA payment is delayed and inadequate.*
- *Ideal duration of the training programme should not be too long or too short. The best period is 3-5 days.*
- *Training schedules should not hamper regular and routine service delivery (problem of single medical officer).*
- *Need for better accommodation facilities and incentives for the trainees was mentioned by many.*
- *Many Medical Officers of Health are not attending TOT. There is confusion in deputation to training programmes. Late intimation precludes from attending the training programmes. Training not being mandatory / compulsory is a common reasons for poor attendance. There was divided opinion regarding private practice being a reason for poor attendance during the training sessions.*

- *In-service training of ANMs being promoted to LHV cadre for 6 months duration is insufficient.*

g) *TRAINING PROGRAMME*

- *Training groups to be Homogenous as heterogenous groups will result in loss of interest in training, the training being multilevel and more time-consuming.*
- *Training and other resource materials should reach the trainees well in time.*
- *Training in AIDS and Tuberculosis at Foreign institutes (!! sic).*
- *No incentive should be given for undergoing the training programme.*
- *Training should be on the lines of IAS / KAS.*
- *There are lacunae in training but certificates are issued.*
- *Equal importance should be given for training in all National Health Programmes.*
- *It was surprising to hear one of the trainee mentioning that Training in Communicable diseases is practically nil.*
- *ATI training for administrative Officers is a must from middle level onwards.*
- *Administrative re-inforcement training should be conducted once in three to five years.*
- *Health management training should be given at all levels.*
- *There should be periodical short course training in supervisory skills.*
- *Contract Doctors are not Administrative heads; so management training to them is a waste.*
- *Learning should be participatory rather than lecture based; skill based rather than theoretical; the theory practical ratio to be 10 to 20 to 40: 60 to 80 to 90; unlike at present - 60% theory and 40% practical (just the reverse).*
- *Practical sessions to have discussions, demonstrations and problem solving exercises and not just reading and by-hearting of notes.*
- *Hands-on training and workshops are better.*

h) *POST TRAINING SCENARIO*

- *Following training the Medical Officers do not practice what they have learnt.*
- *The required infrastructure is not available or provided.*

- *The trainees do not have confidence following (especially laproscopy) training.*
- *Feed back from the trainees is a must. Monitoring and follow up evaluation should also be undertaken. The present system of pre-test and post-test assessment needs a change.*
- *The trainees must be accountable to the official superior and to the general public. The responsibility for each trainee after the training should be decided prior to training.*
- *There should be periodical feed back from every cadre regarding the training undergone. This also should include their ability to apply the learning from the training in their day-to-day work.*
- *Inspectorate team should be formed to monitor and supervise training activities on the spot. Independent evaluation of training process by external agency should be provided for.*

i) *CME should be introduced for all categories of health personnel. For Medical Officers CME / refresher courses should be held at the district level and at Divisional level once in 6 months to three years. There should be re-inforcement training for taluka level and CHC level doctors for 7 working days and 2 weeks for DHO level. Training should include updates on National Health Programmes.*

j) *PROMOTIONAL TRAINING:*

- *Promotion should be need-based.*
- *Promotional training is very much required particularly in the areas of administration, finance and supervision at all levels.*
- *The topics should include administration, rules and regulations, finance, planning, supervision and personnel management.*
- *However a few expressed that promotional training was not required since the topics would have been covered during the induction training.*

k) *There should be more and more interaction between faculty of teaching institutions and health personnel.*

l) *Exposure to General or Family Practice during internship (is desirable).*

m) *All Circulars from the Directorate should be marked to the Principals of the Training Centres also.*

n) *Upgrade the post of the Principal, RHFWTC to the DJD level*

o) *Faculty at the training center require TOT re-orientation once in two to three years or whenever new programmes are introduced. A major training need identified was*

training in advanced and recent communication technology. Faculty at RFWTC should be screened for teaching competency before appointment.

p) *Changes in health and programme interventions are fast and frequent - so planning is not possible. (- in response to the preparation of the Annual Training Plan). There must be political will for allocating resources for undertaking training.*

q) *It is preferable to have Karnataka Health Administrative Services, KHAS like KAS.*

3] INFORMATION PROCESSED FROM THE DOCUMENTS

(A) The following paragraphs summarise the information collected from the training institutions:

State Institute of Health and Family Welfare, 1st Cross, Magadi Road, Bangalo - 23

This institute has been set up right next to the RHFWTC, Bangalore. The Total filled up Positions is 68%. (28 / 42). TEN Deputy Director Posts are sanctioned apart from those of office staff. A total of 06 are reported to be vacant including that of 02 Deputy Director posts. A Deputy Director and an Accounts officer are working part-time.

The facilities cover an area of 4200 Sq ft with 12 rooms for faculty, 9 rooms for other staff, 5 classrooms and 1 Seminar room.

The functional equipment are 1 OHP, 1 Slide projector, 1 Computer with Printer, 1 photocopying machine, 1 binder, 3 Audio cassette players, 3 VCPs, 4 TV monitors.

The two Transport vehicles (Jeep and an Ambassador car) are on road.

The Library with 563 books occupies an area of 400 Sq FT and there is No separate staff. There are plans for subscribing to Journals.

The Hostel has 16 rooms for trainees, 1 staff room, 1 dining hall, a kitchen and a recreation hall with a TV.

The sanctioned budget was released on time and was adequate. Seventy seven percent of the amount was utilised and Rs. 10,04,123 was surrendered. (reasons being non filling up of staff and non conduction of some training courses)

The training conducted at this center was RCH orientation training for faculty of ANMTC/LHVTC under the Government of India.

The Centre has NO PUBLICATIONS to its credit.

The Instructional materials available are 20 Modules / Manuals, 02 models, one set of 36 slides and 10 video films.

Regional Health & Family Welfare Training Center, Magadi Road, Bangalore- 23

Filled up posts 83 % (12 Teaching faculty, that include 03 Doctors) Vacancies of Health Education Instructor 01, Management Instructor 01, Artist cum photographer 01 and 02 Group 'D' staff.

An Urban Family Welfare Centre is also attached to the center with an additional staff of 05 out of the sanctioned 06. All the above staff are employed on a full time basis.

The facilities cover a floor area of 4000 SqFt for faculty and other staff including 01 classroom, 01 Seminar room, Audio Video room and a Library.

The equipment available consists of an overhead projector 01, Slide projectors 04, Audio cassette players 02, video cassette players 02, still camera 01 and TV monitors 02. Of these 03 Slide projectors and 01 Audio cassette player are Non-operable but can be repaired.

Transport consists of 01 Tempo, which is on road while the Mahindra Jeep 01, Mini Bus 01 are under repair. An Ambassador car is to be condemned. 25% Vehicles are on road:

There is no library staff. The library, contains 1095 Text Books including reference books and 04 subscriptions for periodicals.

The Hostel comprises of 02 buildings (old and new) with a total of 19. Each has its own dining hall and kitchen. Neither of the buildings have recreation facilities.

The Budget release for 1999 - 2000 was delayed. The center incurred an excess expenditure of Rs.4, 55,453 /-

02 Training programmes were conducted:
Generation Awareness Training Course (Composite group 2) in 1999-2000
and a Course on Management for Medical Officers of Health in the current year.

The Teaching staff's time during Non-training was spent as below:
60 % in preparing instructional materials,
10 % in staff interaction,
20 % in professional enrichment, and
10 % in Translation work and attending work assigned by DH&FWS and State Institute.

The 704 instructional materials include 300 Slides, 85 video films, 250 models and manuals. Remaining (69 - 9.8%) consist of charts, models, flip charts/books, flash cards, information kits, pamphlets, folders and posters.

Teaching materials prepared by the institute and used for training include the following:

1. Sukhee Kutumba (folder by the Faculty, HFWTC, Bangalore)
2. WHO day- April 7,2000 (folder) {translated by the center into Kannada }
3. CHETANA.... Training modules for
   - Block Health Educators.
   - Senior Health Assistants (M&F)
   - Junior Health Assistants (M&F)

The last two are English training modules translated into Kannada.

The other two publications to the credit of this institution are:

2. Nimma Arogya Kapadikolli by the Faculty, HFWTC, Bangalore
3. Surakshita Laingikate, by the Faculty, HFWTC, Bangalore

Regional Health & Family Welfare Training Centre, Metagally, Mysore 16

Positions filled up 87% (7 of 8). The faculty includes 02 Doctors. The one vacancy is that of Health Education Instructor.

The center has a building with 14 rooms (13 for the faculty and 1 for the other staff). In addition there are 02 classrooms and one each of the following, Seminar room, Demonstration room and a Recreation hall. The total floor space covered is approximately 350 SqMts.

The equipment available at the center consists of 02 OHP`s, one each of Slide projector, Audio cassette player and 16mm projector. Two each of Video Cassette player and TV Monitors. Of this equipment one Video Cassette Player is in need of repair while the Radio needs to be condemned.
Transportation is in the form of two vehicles - One a Swaraj Mazda Canter which is in service while the other is a Standard –20 which needs to be condemned.

The Library has 57.7 SqMts of floor area and has 927 books. However, no Journals or Periodicals are being subscribed to. A lending facility as well as a photocopier and computer are in the library. Working hours are 10 AM to 5 PM.

A hostel is also provided and it consists of 10 rooms for students and 15 for the staff and a dining hall , kitchen, and a recreation hall with a TV .

The Budget for the previous financial year was sanctioned and released on time. The amount utilised was Rs. 26,14,331. The amount released Rs. 27,55,860 was found to be adequate.

The training undertaken last year was an In–service training for Medical Officers and another for Zilla Parishadh members, BEO, NGO's CDPO and Taluka Panchayat members.
No publications have been made from this center.

The teaching staff's Non-training time usage was as follows:
10% in course planning,
15% in lesson planning,
20% in preparing instructional materials,
10% in field follow up
20% in staff interaction
25% in professional enrichment

The Instructional materials available at the center for teaching include 36 Charts, 160 Modules and Manuals, 3 Models, 120 Slides and 18 Video films.

No teaching materials have been prepared by the center.

Regional Health and Family Welfare Training Centre, KIMS Campus, Hubli 580 022.

Positions filled up: 76% (41 / 54) The 13 vacancies are for Office Supdt (01), Driver (01), Typist (01), Class D (02), Sanitation officer (01), Skilled Mechanics (05).

The faculty at the centre include apart from the Principal and 02 (Doctors) Chief Assistant Medical, Social Science, Health Education, Public Health Nurse Instructors,

Management Instructors, Health Supervisors, Communication Officers, Assistants, Office staff and Motor vehicle related positions.

The center covers a total floor space of approx 520 sq mts and includes 07 rooms for faculty, 02 for staff and one for the Projectionist apart from 04 classrooms as instructional areas. There are no Seminar Room, Demonstration room or Lab Facilities. The Hostel facilities comprise of 16 rooms for the trainees, a dining hall and kitchen. There is no recreational room but a few games, TV and radio are made available at the hostel.

The offices of Sample Survey and Assessment unit, the Taluka Health Office and Urban FW center are accommodated in the 118 sq mts area of the centre.

Functional equipment at the center include 1 Over head projector, 4 slide projectors, 3 video cassette players, 1 TV monitor, 1 each 16mm and 8mm slide projector and 1 Microscope.

The OHP (1), slide projector (1), audio cassette player (1), TV Monitor (1), and the PA System need to be repaired. Both the 8mm and 16mm projectors are to be condemned.

Of the 5 vehicles for Transport facilities the two mini vans are to be condemned. Three vehicles are on road, including a Jeep.

The Library with a floor area of 44.2 SqMts has 1323 Text Books and Reference books with a subscription to 11 Journals and Periodicals. There is photocopying facilities, but NO LIBRARIAN has been sanctioned.

A budget of Rs. 66,68,440 was sanctioned on time and was found to be adequate. An amount of Rs. 8,35,095 (12.5%) was surrendered for various reasons.

The training courses conducted were:

- In-Service training for Medical Officers in STD surveillance
- STD surveillance for Sr. Health Assts / Staff Nurses (13 batches)
- Awareness generation training under RCH for Medical Officers with NGO's (06 batches)
- RCH workshop for District Programme Officers (1 batch)
- Community Health Training for one batch of Ayurvedic Students.
- RCH training for two batches of SOSVA Personnel.
- Community Health for one batch of Staff Nurse students.
- Population Education training for four batches of ITI students.
- RCH training for NGO's.
- MLEC programme for In-service personnel.

The studies undertaken from the center are:

- A report on the evaluation of trained personnel under IPP IX.
- A report on the evaluation of Pulse-Polio Immunization coverage in Hubli-Dharward.
- KAP study report on Diarrhoea at Yaraguppi village.
- A Sample study on Birth-Death Report at Sulla and Kiresur villages.
- Knowledge study on ANC care and Breast feeding at Yellapur town.

The Teaching staff spend their time during the Non-training period as follows:
05% in lesson planning,
05% in preparing instructional materials,
05% in measuring learning,
20% in field follow-up,
05% in record keeping,
10% in staff interaction,
10% in professional enrichment.
The other 40% is taken up by other activities like Talk shows on AIR, School Health, etc.,.

The center has Charts (on health & FW programmes), 2 Modules and manuals, 1 Model Skeleton 1 FW programme Model, 82 video films and 16 strip films as Instructional material

The following Teaching materials has been prepared by the institute:

1) Kannada version of the Chetna training module for BHE's
2) Video-cassette for Ayurvedic practioners and FW in the field.
3) Folk literature , including songs, drama and Harikatha were developed for IEC Bangalore.

Regional Health & Family Welfare Training Centre, Old Hospital Premises, Gulbarga.

The filled up positions is 84% (16 / 19) with 7 Part Time faculty. Many of the faculty of the centre have a Diploma degree in Health Education.

In the floor area of about 3470 Sq ft, there are 7 rooms for the faculty, 04 for the staff, 2 classrooms, 1 Seminar room, 1 Dark room and an AV room. There is no Laboratory or Demonstration room.

The functional equipment include 1 OHP, 1 Audio cassette player, 1 Video camera, 3 TV monitors and 1 Video cassette player. The Still Camera is to be condemned and the 02 OHPs, 1 Side projector, 1 VCP and the Photocopying machine are in need of repair.
A total of two vehicles - a mini bus and a matador are on road. A Jeep is to be condemned.

The Library with an area of 300 Sq ft has 701 books. No Periodicals or Journals are being subscribed. There is no computer or photocopying facility.
The Hostel with a floor area of 1800 sq ft has 15 rooms including a room for the warden, a Dining hall, kitchen and a recreation hall.

Of the Budget released for the previous financial year 32% was utilised. Rs.2,48,082 was surrendered since no deputation was made for the RCH awareness programme resulting in non-conduct of these courses.

The Training programmes conducted were as follows:

- In-service RCH awareness programme for Medical Officers.
- SOSVA Field workers training under RCH.
- District level workshop on RCH.

No separate publications have been made from this center.

The Teaching Staff 's Non-training time activities were as follows:

21.4% in course planning,
21.4% in lesson planning,
10.7% in preparing instructional materials,
14.28% in Field training,
28.6% in record keeping, and,
03.6% in Professional enrichment.

The instructional materials available at the center are 6 Charts, 4 Modules / Manuals, 2 Models, 23 Slides and 32 videocassettes.
The teaching materials prepared at the center are:
- Module for BHE category " Chetana Module "
- CME training teaching lessons.

(B) ASSISTED / FUNDED PROJECTS AND TRAINING PROGRAMMES

International and Multilateral and Multinational Agencies

The international and multi lateral and multinational agencies including the World Bank have been assisting the Government of Karnataka and the Department of Health and Family Welfare directly or indirectly through Government of India. The assistance has been in terms of both soft credits and grants to undertake the health and disease related endeavours and training is an important component in these projects.

This has even got a historical context. The first public sector Family Planning clinic was started in Ramanagaram with assistance from the Rockfeller Foundation. The Induction training programmes was started in this centre during the pre-independence days.

The India Population Projects I and III though specifically concentrated on the development of infrastructure also undertook training endeavours. Programme specific training got a major boost both in terms of both methodology and content (MODULAR training programmes) with the Universal Immunisation Programme.

The Child Survival and Safe Motherhood Programme implemented in phases since 1992 by the Government of India with assistance from the World Bank attempted at "rationalising the (fragmented) services with a package". The well thought out situation analysis as a methodology of training which was a major component in the CSSM training programmes did not seem to be implemented with the spirit which it was intended to.

The current ongoing projects are **India Population Project VIII** (for Urban slums in Banglore Cities and recently extended to eleven other cities in the State), **India Population Project IX** (for upgrading the Primary Health care Infrastructure in select districts of the state with a major component of training - establishing the State Institute of Health and Family Welfare and the District Training Centres) and **Karnataka Secondary Health Systems Development Project** (for upgrading the network of Referral services at the secondary level care). The **Reproductive**

and Child Health Programme though a World Bank funded programme is being implemented through the Government of India. The World Bank is assisting the Government of India in the National AIDS Control endeavours by supporting the formation and sustenance of the **Karnataka Sate AIDS Prevention Society** (a major component is training in HIV / AIDS including management of Sexually Transmitted diseases). Two other programmes on similar lines are the **District Blindness Control Programme** and **the Revised National Tuberculosis Control Programme.** A comprehensive **Health, Nutrition, Population Project** is in the offing and is slated for the middle of 2002.

The following paragraphs highlight both the general and the programme specific review of training programmes in these projects.

1. Unfortunately, the Disease specific or programme related training programme was promoted at the cost of generic training programme. This lead to many health staff not receiving this very necessary and important entry level enabling capacity for appropriate functioning. It may be noted that the current very senior level functionaries who are about to retire are the only ones who have received the generic or induction training programmes exception being the new recruits over the last two years. However, the General Law and Accounts exam, which the health care personnel have to pass to obtain their increments was the only saving grace in this situation.

2. Overall training needs assessment of the system gave way to programme requirement training. The pros and the cons of such an approach cannot be dismissed as academic discussions. We have in the system today, people who have not been trained for their keeping in mind their job responsibilities and have learnt the trick of the trade of managing by trial and error (see vide supra - Focus discussion). This unfortunately is a highly undesirable method of learning.

3. **A major positve feature of the Externally funded projects have been the systematic independent Mid Term Reviews that have been undertaken. The strict monitoring of the progress of the planned activities has indeed resulted in the desirable mid course corrections.**

4. Efforts are now on to integrate the systems and sub-systems more so with regards to training - creation of the State Institute of Health and Family Welfare and the District Training Centres through India Population Project IX and the re-introduction of the Induction Training through the Karnataka Health Systems Development Project being examples.

5. A question still remains unanswered. **Do the time bound (5 years) project mode of these endeavours end up in merely 'having new buildings' without adequate, appropriate skilled human resources?** This needs to be seen beyond the rhetorical question for there is a distinct possibility that there would be the **double burden** of new buildings with inadequate trained staff and inappropriately trained health care providers. Unless this question is addressed as an immediate priority, there will be precious little to even think let alone talk about the Public Health and Primary Health Care for the future generations of the residents of the State.

The review of the IPP VIII, IPP IX and the KHSDP training programmes revealed the recent conduct of independent in-depth studies (Mid Term Reviews). One of the MTRs (for KHSDP Skills training evaluation) is being concluded. It is too very early to expect to asses the impact of the changes being brought in. There have been certain process shortfalls indicated in these MTRs. Given below is our finding on the progress made subsequent to the MTR based on our discussion with the concerned officials. Pending the submission of the final report of the Skills evaluation review for KHSDP, the gist of the informal personal interaction with the evaluator is documented below.

It was evident that training was now getting a relatively higher priority than earlier. The IPPVIII (Bangalore City component) is far ahead in terms of the training for its health care personnel in particular the new category of LINK WORKERS. The IPP IX demonstrated that despite the shortfall in the targets that were to be achieved both in terms of infrastructure and training programmes, there has been considerable progress documented. The KHSDP has re-introduced the Induction Training programme for the new recruits and also initiated the Clinical Skills upgradation programme. The HIV/AIDS training programme has introduced the participatory learning methods in the training sessions. The new training programme for RCH has taken the integration forward with administrative training, communication skills and supervision skills.

(c) TRAINING MANUALS

Multiple training manuals are being used for training purposes by various training institutions. Quite a few of these are manuals used in other states for training purposes or manuals recommended by Central Government (NIHFW, Manuals used in Andhra Pradesh, CHETNA manuals, etc.,.) Some of the above manuals have been translated into Kannada for the training of para-medical staff. A review of these manuals indicate a need for updating of information. Many of these were prepared for training purposes for earlier programmes and changes have happened since (for example – CSSM and the current RCH programme). By far and large, the manuals do not present knowledge in a training format. They read more like **textbooks or guide**

books. Training exercises, presentation of knowledge in a format which would be easy for the trainees to absorb, newer methods of training methodology, lack of learning objectives as well as essential knowledge, non-interactive format were some of the flaws noted (exceptions being the NIHFW manuals which are being used under IPPIX at DTCs, and a few others like the RCH, etc.,). The contents in these manuals seemed to be more theoretical and lacked the focus and emphasis on the field situation and ground realities. A change in focus of the concerned programme very often necessitates the training institute to commission a new training manual. Change is inevitable and programmes are constantly evolving. However, the change sometimes is rapid and frequent often leading to repeated trainings with very few new learning additions. Because it is a new programme the manuals also get redone with slight modifications.

(D) OTHER SPECIFIC ISSUES INCLUDE

1. All the heads of the Training institutions at the State and Regional level do not have the requisite experience and capability required for the posts. This necessarily has a bearing on the various endeavours of the institutes. Where the top is shaky, non-confident, not capable how much can one expect from the team.
2. The antecedents of the post of the Medical Lecturer Cum Demonstrator (MLCD) could not be ascertained.
3. Only Sixty percent of the personnel interviewed were able to understand the questions asked and give appropriate response.
4. Those who had cleared the Accounts Higher and General Law Part-I mentioned that it gave them greater confidence and competency to handle day-to-day PHC administration.
5. POL issue: POL was earmarked as per trainee per day. When the number of trainees was 30 this amount would be sufficient. But when the number of trainees was less which was usually the case the amount would be inadequate. This was more so, when the number of trainees were 10 or 15.
6. A finding which was disturbing was the "fees" paid to the staff of the training institutes for taking training sessions. Often about half the fees of an expert external consultant, the need to pay these "internal" department/training institute staff is hard to justify/explain considering that they have been employed to do training(!) and conducting/giving training is their job! So if they are required to be paid additionally for conducting training sessions of the various projects in their state or regional institutes then what is their salary being paid to them for? This matter obviously calls for some justification.

DISCUSSION AND CONCLUSION

a) The review of the Training programme for the government health care personnel gave an unique opportunity and insight to the investigators to understand the existing machinery and mechanics of the training programmes in the Department of Health. The interaction and discussions with the implementing staff was not merely a methodology but also a sensitisation and motivation session.

b) The investigators found themselves with mixed feelings: frustration, indignation, hopelessness in some areas and rays of hope, happiness and satisfaction where few successful endeavours were being undertaken even in difficult circumstances. In general, there was a sense of apathy and a casual approach towards training. The enthusiasm was muted, existing as an exception. Training was expressed as an activity that "one had to go through": the unwritten expression being that training programmes were not always necessary and that a pre-induction training in administration and medico-legal matters would suffice. This outlook decreased the effectiveness of the training programmes. Participants often looked at training as an "opportunity for change", "to go out" – rather than a learning and growing session. These naturally lead to enormous wastage of resources.

c) Factors outside the immediate purview of the Training programme most often determined its successful outcome – timely intimation, deputation and relieving of the personnel; the payment of adequate TA/DA on time; the training facility (infrastructure / staff / equipment including vehicle) available. A very critical determinant of success was the feeling of the usefulness of the training programme by the trainee. In the absence of strict monitoring and evaluation in general administration and with a relaxed disciplinary effort, training programmes depended on the individuals perception rather than systems requirement. In this regard, the Tubectomy and MTP training programmes were the main casualty.

d) Most of the trainees were at the fag end of their careers or they would be unable to put their training into practice.

e) A visit to the training institutions re-inforced the disappointment; the once premier training institute at Ramanagaram was found to be in a derelict and dilapidated condition – a result of neglect and abandonment of purpose. The available infrastructure at some of the regional Institutes was also found to be inadequate and this could be one reason for their gross underutilisation. The number of training days never exceeded 30 days in the previous calendar year in all the training centers visited. Amazingly, the Heads of the Institutions

clearly lacked the will and vision to take the issues forward and one wondered at the rationale of their occupying such an important post. Whether it was because of past actions of their predecessors or an inadequate support from the State level officials, it seemed they were "resigned to their fate" and had accepted "reality" and "non-action" as the best recourse. Obviously if the top level was not concerned, it is not surprising then to find the rest of the staff lacking any motivation or interest even to undertake their routine training activities let alone innovation.

f) Often, Adequate and appropriate infrastructure was not made available after training. During the skill development due to various reasons, hands on experience was either insufficient, inappropriate or inadequate. In essence – *"fooling ourselves"* was the general feeling amongst both the investigators and the "trained" personnel.

g) Regional requirements for training were not considered and factored while framing the curriculum or even during its implementation. Standardised syllabus had replaced the earlier freedom to innovate.

h) The Training section has not received its due in the directorate except in the recent past, a major reason being the lack of realisation of its importance in improving the quality of health care delivery services. Another major reason was the lack of a forceful personality in leadership role - an individual who could demand and obtain the necessary support and finances for carrying out training programmes on a regular basis successfully. This led to a situation where the training section had hardly any funds and work to carry out. Even "induction training" - so important for a proper orientation and grounding of new staff was not being carried out.

i) With the World Bank financed projects setting its own training agendas and funding training programmes, routine training activities of the department took a back seat - leading to a lot of frustration and a sense of resignation and hopelessness amongst the senior staff of the training section in the directorate.

j) The limited time frame projects have demonstrated the need for training and given it the due importance. Of course, once the project funding is over, training will need to be financed from routine funding mechanisms of the department. There is therefore a genuine need to streamline the training section in the department so that it always receives its necessary importance, priority and support.

k) At present the department has training institutes (State, Regional and District and ANM training centres) where all State level training is carried out. In addition, institutes like the National Tuberculosis Institute also carry out training activities for the state health employees. The State and District level institutes have only recently been set up (in some districts - are still being set up). The funding for this came from IPP IX / KHSDP. The training staff in the directorate not having any budget for training purposes and the World Bank funded projects being able to fund many training activities in these institutes has created a dichotomy of interests in the department. The training department staff posted in the directorate feel completely bypassed and frustrated at these developments and their lack of information on training facilities and activities was indeed surprising but not completely unexpected under the circumstances.

l) There is also an absolute lack of coordination of training activities - training being ad hoc and project driven with no need based appraisals (including geographical distribution) being carried out. Under these circumstances - the setting up of new District training centres adds an altogether new dimension in training funding and activities. Being project driven, their regular maintenance once the project period is over will be necessitated from the funds allocated for training. Whether the budget at that stage will be able to absorb these additional costs needs to be seen specially since in the past the funds allocated for training activities were so meager and the priority given to training so low.

m) It is unlikely that training activities as envisaged and needed can be carried out unless an estimated Rs.5 crores (only around 1% of the proposed health budget) are annually allocated to training section (this amount excludes salaries to employees). With the projects showing the way and giving training activities the necessary fillip and importance for improving the quality of health services being delivered by the department, allocating funds for training (to this amount at least) from the health budget should be done without any compromises in the future.

n) To streamline training activities of the department - a restructuring of the department staffing and line of reporting is required.

INFERENCES AND CONCLUSIONS

1.0 TRAINING POLICY / FINANCING / PLANNING / ADMINISTRATION

1.1 There has been an absolute neglect of the training component in the department. The approach of the directorate has been casual and not systematic.

1.2 There is an absolute paucity of "routine funds" with the training section in the Directorate. This has lead to a lack of interest, hopelessness and frustration amongst the training staff of the department specially in the Directorate

1.3 The externally funded projects have been able to give training a much needed focus and importance. They have assisted in setting up of new training institutions and provided the older ones with work and some "training funds".

1.4 The Training activity in the Department of Health and Family Welfare is "project driven". At the stage of the development of the different Project Proposals there has been noted a coherence of thoughts and activities for the Human Resource Development for the Government Health Care Sector.

1.5 Transforming of the thinking into action has been delayed or has not been achieved.

1.6 There exists no mechanism for centralised planning of training nor any needs based inputs from the field.

1.7 There is no database of the training undergone by the government health staff.

1.8 The different programmes and projects independently conduct some degree of needs assessment and plan the training activities. This leads to considerable wastage of resources. (Same individual obtaining a repeat training in the same or very similar area).

1.9 There has been noted an indifference with regards to proper administration of the training institutions. The Posting of the heads of these institutions seems to have been undertaken without regard to the requirements of the training centre. It is very unfortunate that these institutions for excellence have been considered as "accomodative posting centres" or "rehabilitation centres".

2.0 TRAINING INSTITUTIONS / ORGANISATION / EQUIPMENT

2.1 There exists a network of training organisations right down to district level with a great potential.

2.2 There exists human resources in the health sector who with adequate motivation and training could convert these institutions into centers of excellence. What is urgently needed is to match the needs with requirements and putting the right person in the right position.

2.3 The postings at the training institutions are sought more for convenience and selections are based more on "personal needs, ability to influence, etc.," than on

ability to train. For many others, training institution postings meant "loss of practice" and therefore was undesirable.

2.4 The training institutions are grossly underutilised. The SIHFW and the DTC are new institutions and are yet to become totally functional. The RHFWTC continue to be neglected.

2.5 The attention given to maintenance of the institutions is highly inadequate / insufficient.

2.6 Key vacancies remain unfilled / gets filled with wrong personnel.

3.0 TRAINING NEEDS ASSESSMENT

3.1 There is no systematic comprehensive Training needs assessment undertaken at any point of time and no training database exists.

3.2 The TNA when undertaken has not been correlated to the performance / achievement of the individual health care personnel (even as evidenced by the confidential reports of the department)

3.3 There is a need to delineate, specify and inform the personnel about the job responsibilites.

3.4 TNA should also incorporate the infrastructure that would be necessary for the trained personnel to effectively undertake specified endeavours.

4.0 FACULTY / TRAINERS

4.1 The Faculty in the training institution are demotivated and consider themselves unfit either because they are not adequately qualified or prepared for the post they are occupying or their training potential remains unutilised / grossly under-utilised.

4.2 A great felt need is the approapriate Training of Trainers in all the training institutes. The JIPMER Model used for RCH ToT is an example of success.

5.0 TRAINING MANUALS

5.1 Multiple training manuals are being used for training purposes by various training institutions.

5.2 These manuals need updating of information. By far and large, the manuals do not present knowledge in a training format. Some of the flaws noted include lack of training exercises, underutilization of newer methods of training methodology, lack of learning objectives and non-interactive format.

5.3 There is a dire need to have a very thorough and detailed analysis of the various manuals that are presently being used for training purposes. They need to be made more user-friendly, have a greater self-learning component and more

practical and field based exercises. The NIHFW has recently come out with the updated versions of many of their training manuals incorporating the latest programmatic changes. The training institutes have already been provided with copies.

5.4 The contents in these manuals seemed to be more theoretical and lack focus and emphasis on the field situation and ground realities.

5.5 With a change in focus of the concerned programme the training institutes commissioned new training manuals. With programmes constantly evolving, frequent changes lead to repeated trainings with very few new learning additions. However, the manuals get redone with slight modifications for almost all new training courses.

6.0 TRAINEES

6.1 There is a demand for Induction Training and Promotional Training by most health care personnel – both medical and paramedical.

6.2 There is also an expressed desire for regular periodic Continuing Education programmes.

6.3 There is a need for improving the facilities given to the trainees including TA/DA, Resource materials, quality of hostel accommodation, food, etc.,

7.0 FEEDBACK / FOLLOW UP / MONITORING

7.1 The existing system of monitoring and feedback is limited to Post-Test assessment related to the subject matter. No long-term or application of skills monitoring is carried out at present.

7.2 There exists no monitoring of the Training programmes and activities of the training department save for the budget spent.

RECOMMENDATIONS

The **RECOMMENDATIONS** have been made based on the following:

a) Observations made by the investigators during their personal visits

b) Discussions with the concerned health care personnel.

c) Information from the analysis of the Self-Administered Questionnaire.

d) Records and documents that were shared by the concerned officials with the investigators.

IDEAL (Desirable) TRAINING SCENARIO for Department of Health, Government of Karnataka

A] THE STATE INSTITUTE OF HEALTH AND FAMILY WELFARE

1. The State Institute of Health and Family Welfare becomes the apex training institute as well as an institute of excellence.
2. It is completely autonomous and the funds for its activities and maintenance are to be allocated from the Health and Family Welfare Department Budget directly.
3. The Institute will have a Director at the helm and this post will be a selection post with all the perks and privileges that are offered to a person of this level. Its tenure will be for a period of 5 years. He will report to the Health Secretary directly. The person occupying this chair should have a medical degree and should also have training and experience in medical education and training of trainers. Ideally, the individual should have spent some years working at various levels in the department in the field.
4. A Deputy Director will assist the Director with various administrative and technical matters. The post of the Deputy Director should be a selection post with requirements similar to the Director's post and should have a tenure of 5 years.
5. The institute should have a full complement of training, administrative and supportive staff with appropriate qualifications.
6. Considering the importance of social sciences and communication skills, the institute should have either full time or part time staff for these departments or engage the services of experts as and when required during training sessions.
7. The institute should have all necessary training equipment and facilities including teaching space and identified field training centres.

B] THE REGIONAL HEALTH AND FAMILY WELFARE TRAINING CENTRES AND THE DISTRICT TRAINING CENTRES

1. The Regional Health and Family Welfare Training Centres and the District Training Centres would administratively be under the State Institute.
2. Their budget will be released by the State Institute.

3. Their activities to be based on local needs and practices and to be planned and coordinated by the State institute.

4. At present there are 2 Regional Institutes in the Northern (West and East) and 2 in the Southern part of the State. There are none in the Central part of the state. This anomaly needs to be rectified. Also, not all 27 districts have a DTC. Since the activities of a DTC are different from the RHFWTCs each district needs to have its own DTC or the RHFWTC should also undertake the activities of the DTCs without compromising on quality in districts where RHFWTCs exist but where there are no DTCs. However, the State needs to keep in mind the recurrent expenditure of so many institutes and based on neeeds appraisal if it is determined that 2 districts can share one DTC, for practical reasons and long term effective functioning, recourse to this may need to be taken and the plan of having so many DTCs reconsidered.

5. The DTCs based on Needs Assessment will identify the training requirements of the district and forward this to the state institute for necessary plan of action. The DTCs will also directly oversee the functioning of the ANM training centres in their districts and provide all the necessary support.

6. As in the state Institute, all necessary facilities and equipment need to be provided to these institutes at the earliest for their effective functioning. At present, many of them lack basic teaching aids and educational materials.

7. The effectiveness of these institutes will depend to a large extent on its human resources. The training institutes should be allotted staff based on qualifications or appropriateness and not on personal needs, contacts and political influence and the ability to take care of extraneous criteria (read favours). Merit and appropriateness should be the only criteria. Abundant precautions to be taken to ensure that these training institutes will not become the islands of inefficiency they have been for so many years.

8. With the formation of the DTCs, many of the training activities can now be done at this level. This will require careful coordination and supervision to ensure quality of training.

9. The Principals of these training centres should be selected with great care and should be given the right administrative and technical training themselves at the State Institute prior to their taking up these posts. This is important as very often they will be directly involved in training activities besides having adequate administrative duties.

10. Regular upgradation of knowledge and training skills, revision courses, as and when programmatic changes are introduced should be mandatory for all staff of all training institutes.

C] PLANNING THE TRAINING PROGRAMMES

1. A committee consisting of the Director – State Institute and all Additional Directors of the Health Department will identify the training needs, prioritise activities and prepare the budget for training activities.

2. The Director of the State Institute will be the Secretary of this committee and will be assisted by the Deputy Director in formulating and drawing out the master plan of operations (based on the needs identified by the committee).

3. Approval for the formulated plans will be put forward during the committee meeting where the Health Commisioner/ Director General of Health Services are also invited.

4. Approved budgetary funds will be sought from the State and handed over to the State Institute for implementing the training activities.

5. To carry out the planned training activities funds as required will be made available in addition to the funds earmarked for training purposes in different programmes (e.g. Malaria, RCH, Tb. etc.).

6. The training needs of the different funding programmes will be respected and honored. However, to enhance effectiveness of training, avoid duplication and to cut down on unnecessary expenditure on travel, DA, etc., wherever feasible multiple training will be carried out in one training programme.

7. Rigorous district and person wise data of all training undergone will be maintained and computerised. This is to avoid wastage of resources and to ensure that everybody undergoes training and not just a favoured few (as is the custom very often now - same people going for different training programmes whereas many others never obtain a chance to enhance their skills).

8. This Information system on training will be maintained District wise at the District level and at the State Institute and Directorate. When a staff member moves out of the district to another district, necessary changes will be made and constantly updated.

9. The committee now decides on training, This therefore means that there is no need to have a separate training section in the Directorate - its functions being taken over by the State Institute, its Director and the Training Committee of the Department. Adequate support from all necessary sectors in this scenario should be feasible. Unlike the present situation where funds are never or meagerly, miserly provided.

10. It will be advantageous to build up our training resources and institutes and depute staff for training in such places. At present, because of lack of training facilities many of our staff are deputed out of the state for training purposes. If the training is done within the state we will strengthen and build up our own systems, strengthen our resources, and provide training in our environment using case material which is similar to what they will ultimately see.

11. As far as possible all training should be done within the state or at the most in some training institutes within the country. There is an unnecessary clamor for foreign training postings. Today, our country offers almost all training and skills required for the effective training of its staff or for the provision of quality health services. No carrots in the form of foreign training sessions are called for. With the money spent on such training a lot more can be achieved and many more people trained. Very often staff are posted for short

term observation training. When the conditions and environment are so different and where training is "NOT SKILL BASED ACQUIRING OR HANDS ON", SUCH TRAINING OUTINGS BECOME ONLY OUTINGS RATHER THEN KNOWLEDGE/SKILLS ENHANCERS. In all fairness, good training opportunities with full scholarships are offered by international agencies like -WHO, Commonwealth organization, etc.. It is a shame to see such useful training opportunities being wasted because of non-recommendation of names on time or processing of papers on time or staff being released on time. Full use should be made of such opportunities for professional enrichment. The State institute should have information of all such scholarships availability and should decide the staff for deputation for such training courses.

12. A major advantage in having the training programmes within the State is that the training can be done in Kannada using Kannada speaking patients and families which makes it much more easier for the participants to understand and absorb. Less financial resources will be required for such state conducted training and the resources saved could be utilised for further strengthening of our institutes.

13. Wherever the training is "technical" or the observation invite for technical matters - "technical" people (and not non-medical – non-technical administrators) are to be sent/deputed for such courses. There is merit in this recommendation. Our administrators are made to change departments quite frequently. Sending them for such sessions then is absolutely non-productive to the department as the technical training in the health sector (presuming that they are capable of absorbing the technical nuances involved) is not going to be of use to them in another department like sericulture or WAKF. However, if the training is for strengthening administrative related skills the administrative staff should make full use of such scholarships.

14. There is an immediate identified need of training for about 470 Block Health Educators. Instead of deputing them in small batches to Gandhigram (and take years to complete the training for all of them), one of the Regional training institute could be strengthened and provided the necessary infrastructure and human resources to carry out this training. All further induction training for BHEs could subsequently be carried out in this centre. Such judicious distribution of training activities is very necessary for optimal utilisation of limited resources.

15. Distance education methodology is a grossly underutilised training facility in our state. Today such education facilities from reputed organizations like IGNOU, Jamia Millia, Manipal, is available in many health areas. They are well planned and so structured that they are practically useful to the trainees. The government should encourage such training and as an incentive offer one time payment of a lumpsum amount (one month's salary?) for every distance education course of 6 or more months duration completed successfully by the staff to a maximum of two such courses. In fact, once these universities offer more and more health related administrative, managerial and technical courses, the Government should make this a mandatory condition for promotion to a higher grade after a certain level of promotion.

16. For effective training to be done it may be necessary to tap the services of an outside expert. This is a must where institute staff lack the necessary knowledge/skills. It is therefore highly desirable to identify the right "consultants" and have a resource base of such individuals. Care must be taken to see that such consultants have the necessary field experience, as very often such "experts" tend to be very theoretical or out of tune with field based reality. However, having said that, care must also be taken to ensure that all such expert consultants are not retired staff from the Department. They do not necessarily make the best experts and the "buddy system" may not be the best way to utilise the limited resources of the training section.

17. Strengthening Public Health training is the need of the hour. The well planned and useful DPH course – post MBBS, had very few takers as it was not advantageous career wise to do such courses and over a period of time the number of seats available for such training decreased. That DPH was no longer a necessary criteria for promotion to higher categories gave it a final blow. It is only recently that the Government has once again realised the need for such training for its staff. At present the medical colleges do offer a few seats. The Department should plan for the future and provide this training at the State Institute. The modalities need to be worked out with Rajeev Gandhi University and necessary support for the infrastructure and resources sought so as to start these courses by 2005 at least.

There are many advantages to the above suggestions. Not only will less staff be required but there will be less friction as now only one agency - the Training Institutes and its staff are involved in training activities. The Director - State Institute with a lot more independent charge will have no hindrance from Directorate training staff as there are none envisaged in the above proposal. Even though there is no representation of training staff based in the Directorate, the Training Committee is formed with representatives of all sectors who are based in the Directorate. This committee advises the Director State Institute on training activities and approves the required budget. This hopefully should be more effective, less competitive, frictitious and threatening. The above proposal though radical and quite different from the present scenario is being recommended so as to provide a more long term commitment, sustainability and effectiveness to the training programmes in the Department. Training is best left to trainers. True. But what is also very necessary for training to succeed is to have a coherent and not divergent/competitive viewpoints as very often happens under the present structure because of fragmentary funding and training activities as well as multiple implementing sectors.

1. TRAINING POLICY / PLANNING / FINANCING / ADMINISTRATION

a. The Department of Health and the Directorate of Health and Family Welfare need to spell out their Vision, Policy, Goal and Objectives for a comprehensive Human Resource Development particularly for training its personnel.

b. The Department of Health and Family Welfare needs to set up a functional, co-ordinated, central mechansim to assess the systems training requirements and its monitoring.

c. There is a need to set up mechanisms to undertake both internal and external evaluation of its training programmes.

d. There is a need to streamline the administration and functioning of the training activities sub-centre upwards.

e. For achieving the planned training activities, an exclusive financial support to the extent of 0.5 to 1% of the total budget of the health department should be made available.

2. TRAINING INSTITUTIONS / ORGANISATION / EQUIPMENT

a. The SIHFW should be made functional as an apex, nodal centre and an institution of excellence. All the existing Training Institutions to be administratively and functionally linked up to perform as an effective organization under the leadership of SIHFW.

b. The existing RHFWTCs should be strengthened and steps taken to ensure their adequate utilization.

c. The existing DTCs need to be made functional at the earliest.

d. Prioritisation of allocation of limited resources would very much be required so as to achieve its efficient and effective utilization, specially since the number of training institutions have now increased.

e. There is an urgent need to address the release of funds for repairs and maintenance of the institutions including non-functional but repairable equipment in the existing centres.

f. A uniform standard of personnel and equipment need to be specified for the training institutions across the State.

3. TRAINING NEEDS ASSESSMENT

a. The TNA should be taken up systematically for all levels and should be co-ordinated with the Individual Performance assessment of the health care personnel.

b. Health Management Information Systems HMIS) need to be put in place on a priority basis for the training needs and training undergone of all health care personnel. This has to be generated from the district level upwards and the information base and accession should also be made available district level upwards.

4. FACULTY / TRAINERS

a. Only individuals with relevant and appropriate qualifications and experience should be posted to these centres.

b. All the faculty including the heads of the institutions should undergo a pre-posting training in Educational Technology before taking charge of their posts.

c. The Trainers should be given a periodic refresher course to upgrade their knowledge and skills.

d. More models like the JIPMER model need to be immediately formulated and implemented. This is all the more necessary considering the spurt of training activities planned for in the coming months and recruitment of staff for the newly established DTCs.

e. Consultants should be empanelled for key support areas of training like Communication, Social Sciences, Statistics, etc., at each training institute. These consultants are to be chosen on their merits and experience in training. They need not necessarily be selected from retired or functioning government officials.

f. The Training activities of all trainers including consultants should be evaluated for each session not only by the trainees but also by institute staff and feed back for making the necessary changes provided.

5. TRAINING MANUALS

a. There is a dire need to have a thorough and detailed analysis of the various manuals that are presently being used for training purposes. They need to be made user-friendly with a greater emphasis on self-learning and more practical and field based exercises. The manuals need to present knowledge in a training format and not as textbooks or guide books. Training exercises, presentation of knowledge in a format which would be easy for the trainees to absorb, newer methods of training methodology, stating of learning objectives and essential knowledge and use of interactive format are required.

b. A set of essential training manuals should be provided to all training and health care institutions including PHCs. Appropriate mechanisms for their storage and safety at these institutions need to be worked out.

c. A process needs to be evolved that would make it feasible to update the manuals with the additional inputs / changes rather than completely redoing them with

changes happening in the programmes. This would result in saving of precious resources.

d. Whereever feasible, the training manuals instead of being freshly written should be adopted / adapted from existing manuals on the same or similar subjects.

6. TRAINEES

a. Trainees should be released on time, and they should report at the beginning of the training course. Very often the introductory sessions are the most important sessions in the training programmes and missing these sessions greatly weakens the effectiveness of the rest of the training programme. Also the trainees should be present through out the training course. Mechanisms to make this feasible should be developed and instituted (for example linking the monthly emoluments to the successful completion of the course as per defined parameters).

b. Induction Training and Promotional Training to be made mandatory for all categories of Health Care Personnel.

c. Follow-up mechanisms should be instituted to assess the post-training performance of the individual trainees periodically.

7. FEEDBACK / FOLLOW UP / MONITORING

a. A system of immediate Post-training assessment regarding the training programme needs to be carried out. This should look into subject matter, methodology of the training and effectiveness of the faculty. A system needs to be instituted for the reporting of feedback to the concerned faculty and action taken on the post-test assessment.

b. A periodic (once in three years) review / evaluation of all the existing training programmes for the health care personnel should be undertaken. Evaluation also needs to be carried out whenever any new component is added to the on-going training programmes.

c. The performance appraisal (Confidential Reports, etc.,) of the individual staff should include the training undergone and identify further training needs.

An effort has been made to define the vision, goals and objectives for the department. This needs to be adopted with appropriate modifications by the department so as to increase the commitment towards training. Also given below is the outline of a proposed pilot endeavour for training activity in one division.

VISION, GOALS AND OBJECTIVES FOR TRAINING ACTIVITY FOR THE Department of Health and Family Welfare, Government of Karnataka

VISION

To provide technically competent, socially relevant, appropriate health services to the fullest satisfaction of the people of Karnataka.

GOALS

- By 2002, January every health care personnel who joins the government health service will receive induction training.
- By 2005, every health care personnel will receive the identified and necessary refresher training and skills up-gradation.
- By 2010, systems are in place for the conduct of regular, ongoing, continuous refresher and induction training with adequate provision of resources.

OBJECTIVES

1. Preparing the individual's competence by enhancing communication skills and learning capabilities that are necessary for managing the day-to-day activities of the health centre and for delivery of quality health care in accordance with the existing health programmes and local health situation.
2. To nurture and enrich the organisation culture which supports and enhances team effort, harmonious interpersonal relationship, pursuit of excellence, spirit of enquiry and innovation as a way of work life and to create an organisation environment where each can share and contribute towards achieving the shared goals.
3. To create sensitivity to the needs of the society, discharge the multiple roles and responsibilities and fulfill the obligations as a health care provider.
4. To help and support each individual to develop their potential to realise their self-goals while contributing fully to the success of the organisation.
5. To achieve synchronisation of the goals and aspirations of the individual, organisation and society.
6. Enhancing preparedness for willing participation in development activities which have a bearing on health of the community.
7. Facilitate building a strong character of integrity, honesty and leadership.

PILOT ACTIVITY

It is absolute necessary that any radical surgery is attempted a pilot endeavour be planned in a smaller sub system which provides for opportunity and facilitates for an adequate and in-depth learning of the crisis management in the system. Additionally,

this approach accomplishes the much-needed involvement of a larger select group of the system who, are the stakeholders for change.

The following needs have been considered while formulating the Pilot Activity of the **Team of Excellence in Training (TOEIT).**

a) There is a need for co-ordinated decentralised planning for the endeavours towards Training. This includes Training Needs Assessement, framing of the curricula and identifying the resources at each level of training before implementing the activity.

b) The State Institute of Health Family Welfare to be recognized as the apex and premier Institution for training in the state. The RHFWTC and the DTCs to be identified as the regional and peripheral wings of the apex institute.

c) The existing organisation structure of the Training "wing" of the department needs to be restructured. There should be a similar staffing pattern at the three levels - District, Division / Region and State. There should be a well laid out and comprehensible hierarchy with specified responsibilities. The lines of authority with their attendant network linkages to be identified..

d) The system also needs to factor the future training requirements of the state with regards to the health sector.

The following points delineate the components of the proposed Pilot endeavour for Training activity. The final Plan of Action may be arrived at after further consultations.

1. Gulbarga division to be the focus of the endeavour.
2. The Divisional Joint Director, Gulbarga to be the team leader for the activities. Twenty to twenty five members selected from amongst the existing staff / faculty / officials in the Division would constitute the TOEIT.
3. Necessary support could be drawn from the District Training Centres, the Regional Health and Family Welfare Training Centre and the State Institute of Health and Family Welfare.
4. The current research team would be the key facilitators for the endeavour.
5. The Task Force on Health and Family Welfare and the team involved in the preparation of HNP Policy for the Department of Health and Family Welfare to facilitate and also provide the required technical inputs.
6. The TOEIT would undertake a systematic training needs assessment in the division keeping in mind the existing realities of service delivery, the proposed activities of the department and the future requirement of the system.
7. The TOEIT would then involve themselves in the preparation of the curriculum, methodology (including identification of resource persons, resource materials and training environment) and schedule for the training for the next three years. They would also prepare the required annual and total budget for the endeavour.
8. The Pilot Activity would be monitored on a regular and pre-identified intevals and will be based on suitable indicators (both qualitative and quantitative).

SECTION B

EVALUATION OF TRAINING PROGRAMMES FOR GOVERNMENT HEALTH CARE PERSONNEL IN KARNATAKA

HEALTH WORKERS (FEMALE) AND HEALTH ASSISTANT (FEMALE)

INTRODUCTION

Health status of people in India has shown remarkable improvements during the last two decades. The Crude Death Rate (CDR), Infant Mortality Rate (IMR) and Crude Birth Rate (CBR) have shown sharp fall and key health indicator `Life Expectation at Birth' which was about 42 in early Fifties has crossed 60 years in the early Nineties. Wide differentials across states in India, however, have persisted throughout suggesting the need to take corrective measures to bring in much desired equity in health to reach the goal `Health For All by 2000' India has committed at Alma-Ata in 1978 (See Table 1 for differentials).

The data presented in Table 1 clearly brings out the fact that Southern States – Kerala, Tamil Nadu, Karnataka and Andhra Pradesh have shown relatively better performance as compared to Hindi speaking BIMARU States - Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh and Orissa.

Wide differentials within state by rural-urban residence, gender and social class exist across the Districts. The Human Development Report 1999 - Karnataka provides CDR, CBR and Life expectancy at Birth for all the districts that reveal the differentials. IMR another sensitive health indicator shows that Dakshina Kannada reported the lowest IMR (27) in the state while Gulbarga, Bijapur, Bellary had IMR about 3 times higher than Dakshina Kannada district. There is other strong evidence to support the IMR estimates – institutional deliveries in Dakshina Kannada accounted for 77 percent while in Gulbarga it was only about 27.9 percent suggesting the strong negative association between IMR and institutional deliveries - safer deliveries.

TABLE 1 : HEALTH SITUATION IN INDIA AND SELECTED STATES

State	IMR 1996			CDR 1996			Maternal mortality ratio 1986	Sex Ratio 1991	CBR 1996
	R	U	T	R	U	T			
India	77	46	72	9.7	6.5	9.0	580	927	27.5
AP	73	38	65	9.2	5.9	8.4	394	972	22.8
Karnataka	63	25	53	8.6	5.4	7.6	439	960	23.0
Kerala	13	16	14	6.3	6.0	6.2	247	1036	18.0
Tamil Nadu	60	39	53	8.7	6.6	8.0	372	974	19.5
Uttar Pradesh	88	67	85	10.7	8.2	10.3	920	879	34.0
Rajasthan	90	60	85	9.6	7.1	9.1	627	910	32.4
MP	102	61	97	11.8	7.6	11.1	507	931	32.3
Bihar	73	54	71	10.6	6.9	10.2	813	911	32.1
Orissa	99	65	96	11.2	7.5	10.8	844	971	27.0
Maharashtra	58	31	48	8.7	5.4	7.4	439	934	23.4
Gujarat	68	46	61	8.3	6.2	7.6	373	934	25.7

Source: 1) Family Welfare Programme in India, 1996-97, Government of India.
2) Mari Bhat P.N., 1995.

The latest data-set (1998-1999) collected in National Family Health Survey and Reproductive and Child Health Survey (NFHS II and RCH) provide valuable insights for effective policy

interventions to reduce the disparities across districts by rural-urban residence, social class and gender. Findings from both the surveys suggest that the out reach services of maternal and child health hold the key to bridge the differentials and these services are to be delivered by Female Health Workers popularly known as Auxiliary Nurse Midwives (ANMs) and Lady Health Visitors (LHVs).

The Present Study

The present study is an attempt to examine the role of these grass root level female health workers and adequacy of their training to discharge their responsibilities satisfactorily that can help to reduce considerably the disparities observed across districts.

Objectives

Taking into consideration the major midwifery responsibilities assigned to the ANMs and LHVs after a rigorous foundation training of 18 months the study proposes to achieve the following objectives.

- To examine the knowledge of ANMs regarding the Ante-Natal care service and its delivery to pregnant woman.
- To assess their knowledge of identifying the high-risk pregnancies and ensuring safe delivery that will help to reduce maternal mortality.
- To examine the knowledge of supplementary nutrition to be advised and supplied to all pregnant women to reduce malnutrition.
- To examine their knowledge of identifying high risk infants and measures to be taken to ensure their survival to reduce IMR further.
- To identify inadequacies in the training of ANMs/LHVs if any, and suggest corrective measures.

The Sample

The study was conducted in three districts of Karnataka that differ widely in indicators relevant to reduce IMR and MMR. These indicators were drawn from the RCH Survey (First Phase – Kanbargi et.al., 1998). They are :

- Percent women who received full Ante-natal care package (At least 3 ANC visits + 2TT injections and 100 IFA Tablets)
- Percent institutional deliveries.
- Percent children in 12-23 months age who did not receive any immunization.
- Percent women who had knowledge of all modern contraceptive method.

Based on these criteria following three districts were selected.

TABLE 2 : SELECTION OF THE SAMPLE DISTRICTS

	District / State	Full ANC (percent)	Institutional deliveries (percent)	Children not immunised (percent)	Family Planning knowledge of all modern methods Percent
1	Udupi (DK)	78.9	76.6	0.5	70.7
2	Tumkur	68.7	48.4	0.5	40.8
3	Gulbarga	21.2	27.9	31.1	27.2
	State	52.2	52.4	8.3	46.1

Source: Rapid Household Survey RCH, 1998, Kanbargi et. Al.

The three Districts selected differed maximally in several other variables also. For example the percent girls marrying before 18 years - legally approved age was highest in Gulbarga about 59 percent, 29 percent in Tumkur and only 5 per cent in Udupi (which was part of Dakshina Kannada then. We selected Udupi District based on the data of Dakshina Kannada district as data for Udupi are yet to be made available. The observed early marriage and its impact on CBR is clearly reflected in these districts (Gulbarga 32, Tumkur 24.7 and 21.4 in Udupi).

The three selected districts - one highly advanced - Udupi, one with medium progress - Tumkur and one backward - Gulbarga in terms of demography and health would be able to provide insights sought in the functioning of the ANMs and LHVs in the state. For data collection 8 Taluks 22 PHCs and 87 sub-centres were selected randomly. The following table provides these details.

TABLE 3 : THE STUDY AREA

District	Taluks	PHCs	SC (ANMs)
Udupi	Udupi Kundapur	8	26
Tumkur	i) Gubbi ii) Madhugiri iii) Kunigal	6	41
Gulbarga	i) Afzalpur ii) Gulbarga iii) Chitapur	8	20
Total	8 Taluks	22 PHCs	87 ANMs

Methodology

The relevant data was collected from all ANMs available in the selected PHC/Sub-Centres by employing survey methodology. A standardised questionnaire was constructed for administering to each ANM/LHV in the selected PHC/Sub-centre. The administering of the questionnaire was preceded by a brief introduction about the survey and assurance that the information collected will be kept confidential and used only for research purpose. In PHC we met the medical officer (MO) and other staff present and briefed them about the study. We assured all that they will not be harassed by Health Department or any authorities for sharing their honest views on the functioning of the Health Care Services.

There were focus group discussions to get insights in the functioning of the Institutions that provided valuable information. This information is exploited to supplement the hard data collected in the survey.

Each questionnaire administered to ANMs/LHVs took over an hour. The interviews were abrupted often when many ANMs broke down who were to be consoled to start the interview again. The respondents reported that it is first time in their entire service someone is enquiring about their problems and welfare. When they were asked whether they would be happy if their daughter (those having one) was offered ANMs job, it was revealing that most of them reported that they do not mind if their daughter goes for agricultural labour but they don't want them to become an ANM like their mother. It indicated harsh working environment they are situated in, their frustration and helplessness.

Data and Analysis

The brief profile presented in Table 4 suggest that most of the Female Health Workers are currently married, have at least 10 years of schooling and in their middle ages with long experience. As there are limited opportunities of advancement in the career they feel dejected struck with the same work for years. Those who were on the verge of retirement were eagerly looking forward for the day to free themselves and lead a relaxed life.

TABLE 4: FEMALE HEALTH WORKERS IN THE STUDY AREA : A PROFILE (87 ANMs and LHVs)

	Variable	Frequency	Per cent
1	Age (years)		
	Below 40	31	35.6
	41 - 49	33	37.9
	50 - 58	23	26.4
2	Marital Status		
	Single	04	4.6
	Currently Married	77	88.5
	Widowed/Divorced	06	6.9
3	No.of living children		
	0	11	13.3
	1	17	20.5
	2	41	49.4
	3+	14	16.9

TABLE 4: FEMALE HEALTH WORKERS IN THE STUDY AREA : A PROFILE (87 ANMs and LHVs) *(continued)*

	Variable	Frequency	Per cent
4	Education		
	Below SSLC	18	20.7
	SSLC Pass	54	62.1
	PUC	11	12.6
	PUC +	04	4.6
5	Length of Service (in years)		
	Less than 5	9	10.3
	- 14	22	25.3
	- 29	39	44.8
	30 +	17	19.5

One of the major problems faced by the respondents was shortage of housing - only 40 percent of them had housing facility provided by the Government, whereas 23 per cent of ANMs were residing in rented houses in the sub-centre villages. Another 23 percent were in a rented house in the sub-centre village and the rest 37 percent were commuting to their place of work that required about an hour. Udupi had an excellent net work of public transport with very good road that was found to be a very important factor to improve accessibility to health care services whereas Gulbarga had bad roads or no roads and poor public transport that badly affected easy accessibility. Tumkur can be placed in between these two districts with some area with good roads - Kunigal section whereas Madhugiri was having serious problem of roads and public transport. It would be of interest to mention here that during our visit to observe an ANC camp at a sub-centre village in Gulbarga we had to leave our car at a point and hire a Land Rover jeep to reach the Sub-Centre as the road was full of boulders and ditches which only jeep could negotiate with great difficulty. To cover a distance of 15 kilometers it took an hour at high cost.

Lady Health Visitors have to supervise the work of ANMs. In the study area we could get only 10 LHVs who had to cover on an average 40 villages in addition to their administrative work of compiling service statistics from each ANM on maternity, immunisation, etc. The fact as reported by both LHVs and ANMs is that supervision/work monitoring in the villages has almost ceased to exist. Many senior ANMs recalled that when they joined service they had to cover larger areas – population but they used to enjoy the work. There was a team spirit, co-operation and guidance from M.O and DHO. Work was taken very seriously. The Medical Officers provided home visits to sterilised cases for follow-up services. Deliveries were supervised and post natal care then was good. Now hardly anybody bothers about supervision and monitoring. ANMs feel lonely and helpless in the job as there is neither any help nor guidance and no supervision but if anything goes wrong they will be held responsible. The information collected from ANMs show that exceptionally large number of villages 11 to 18 villages were to be covered by 13 ANMs in Tumkur. Whereas in Udupi and Gulbarga despite vacancies that add burden to ANMs work they were found to be covering about 3 – 4 villages as size of population is large. As over half of the

ANMs were natives of the same district they were quite familiar with sociology and culture of the area. While more villages add only to travelling time, size of the population, average number of couples to be served in RCH seem to be well within manageable limits of ANMs with very few exceptions.

The Foundation Course

The female health workers have to complete the foundation course specially designed for them to be eligible for consideration for the job. But some had 2 years training while over 80 percent had completed 18 months course at different District Head Quarters. Surprisingly it was found that there was a long time gap before they got the job. About 20 percent had joined after 3 - 4 years of their completion of the course and they took considerable time to refresh their training skills they had almost forgotten. Indeed, 6 ANMs had joined service after 5 years gap. In addition to the foundation course LHVs have to undergo another 6 months training to become LHV.

They were asked to assess the quality of their foundation training course in terms of (a) Curriculum (b) Duration (c) Regularity of Faculty (d) Quality of training (e) Practical training in hospital and (f) Practical training in the field. Their response was classified in 3 categories. The distribution of r sponses are reported below.

TABLE 5 : ASSESSMENT OF THE FOUNDATION TRAINING BY THE TRAINEES (PERCENT)

		Good	Fair	Poor	Can't say
1	Curriculum	78.2	15.0	2.3	4.5
2	Duration	34.5	63.2	--	2.3
3	Regularity of Faculty	70.0	25.3	2.3	2.3
4	Quality of training	24.1	64.4	8.0	3.4
5	Practicals in hospital	19.5	57.5	19.5	3.4
6	Practical in field	25.3	59.8	11.5	3.4

It is to be noted that 18 months duration is divided as 12 months theory and 6 months practicals in hospital and field. The majority of ANMs (63.2 percent) considered that duration was too short as they had to complete 10 theory papers. It is also reflected in the assessment of practicals in hospital as 57.5 percent reported that on job training was too short to master the art of good midwifery. Almost 60 percent felt that the field training that forms the most important component of their job was inadequate.

Majority of the ANMs opined that the curriculum is good but heavily biased towards theory whereas most important for their job is field work where they have to manage themselves with midwifery that put heavy responsibility. Communication skills which they need most in their field work was found to be lacking. It seems there is an assumption, that all ANMs have that skill.

During discussion with ANMs we asked how confident they were when they conducted the first delivery of their career. Majority response was they were very shaky. Few were fortunate to

have a LHV who was good to instill confidence in them giving guidance in the conduct of delivery that went a long way in building their confidence. But many were not that fortunate but could manage the situation without any serious problem.

How the training received several years back is relevant now? Several respondents mentioned that except midwifery hardly anything is relevant. AIDS, RCH, Target free approach are all new and are relevant now. More skills are required for day to day work and to recorded them properly in the registers provided.

SECTION I

In this section we have tried to review the training programmes that respondents have completed and how they perceived their utility in their day to day work. The major programme in this regard was the Child Survival and Safe Motherhood training followed by several other short term skill knowledge enhancing programmes.

Child Survival and Safe Motherhood (CSSM) Training

Reduction in maternal and child mortality was highlighted in the National Health Policy 1983. The sustained high levels of immunisation programme that increased contacts of female health workers with women and children demonstrated that about 2million children were saved during 1984-92 (the difference in child mortality rates of 1984-92 which was monitored). It was followed by Universal Immunisation Programme that envisaged that every child would be protected by all the preventable killer diseases of children.

In order to accelerate the declining trends observed in child mortality 'Child Survival and Safe Motherhood' programme was launched in August 1992. It was fine tuning of the earlier programme with emphasis on quality and outreach. It is very relevant for this study to consider the objectives of CSSM programme and examine the ANM/LHV training impact on their performance.

The CSSM had set the following goals:

1. By 1995

a) Eliminate neonatal tetanus.

b) Reduction in Measles by 90 percent, deaths by 95 percent.

2. By 2000

   a) Elimination of Poliomyelitis.

   b) Reduction in diarrhoea deaths by 70 percent.

   c) Reduction in ARI deaths by 40 percent.

   d) Reduction in maternal mortality to 2 per 1000 deliveries.

   e) Reduction in IMR to 60 or less per 1000 live births.

   f) Reduction in under 5 mortality to 10 per 1000 children under 5 years of age.

   g) Reduction of perinatal mortality to 35 per 1000 births.

In order to equip the Female Health Workers for the huge programme massive training programmes were launched in the states began. An earlier study conducted in Karnataka that covered Channapatna and Hoskote Taluks (all PHCs and Sub centres) found that CSSM training given to ANMs/LHVs had significantly improved their midwifery skills and improved immunisation in the area resulting in reduction in IMR (Kanbargi, 1997).

In the study area only 60 percent of the respondents had undergone CSSM training. The duration of training varied between 3 days to 21 days at different locations where the training was imparted. It was not possible for us to verify the wide ranging duration and the reasons for it. However, most of the respondents expressed their appreciation for providing training that refreshed their memory. There is hardly any continuing education programme for them. An important fact that came out during the study was how CSSM changed some age old practices that were routinely followed. For instance, babies were given bath soon after birth that often led to complications. The CSSM training has changed it. Now baby is kept warm for a day before giving bath. This practice may reduce considerably the incidence of diseases peculiar to childhood. The training also, as reported by all those trained, enhanced their knowledge on ANC, PNC and midwifery skills many of whom had learnt 20-25 years back. The five cleans or Pancha Shuchitwa was very much valuable learning. Some of the respondents expressed their happiness that CSSM training not only improved their skills but was accompanied by a booklet and a Disposable Dai Kit (DDK). The booklet which should be given to every ANM/LHV as they reported it has proved invaluable for them for all time. (Unfortunately the Research Team could not see the booklet).

The respondents were asked about other skill based short term special training programmes that are imparted. There does not seem to be any systematic approach in organising these training programmes nor there seem to be any compulsion that say those who have put in 20 years of service should have some minimum number of training programmes. As one ANM (very senior) told us that often they do not know that their colleague from other sub-centre had gone for a training programme about which MO had not even informed others. It was only after her return they learnt.

We had listed 10 important programmes to check how many of them were attended by the respondents. They were training programme pertaining to Malaria, Cataract, Tuberculosis, Family Planning Target Free Approach, RCH, Leprosy, AIDS, IUD, MPW, MTP and an open ended `others'. The response and ratings recorded are presented below:

TABLE 6 : TRAINING PROGRAMMES AND THEIR ASSESSMENT

Training	No.of ANMs trained	Percent	Rating		
			Very good	Some what useful	Not useful
Malaria	15	17.2	26.6	60.0	13.3
Cataract	60	69.0	25.0	41.7	33.3
TB	23	26.5	17.4	65.2	17.4
Target free	59	67.8	16.9	59.3	23.8
RCH	37	42.5	32.4	54.1	13.5
Leprosy	67	77.0	19.4	55.2	25.4

TABLE 6 : TRAINING PROGRAMMES AND THEIR ASSESSMENT (continued)

AIDS	39	44.8	41.0	35.9	23.1
IUD	18	20.7	61.0	33.3	5.6
MPW	20	23.0	50.0	45.0	5.0
MTP	04	4.6	100.0	--	--
Others	45	51.0	46.7	48.9	4.4

The rating and percent trained for different health programmes reveal some interesting facets. Even during our discussion the findings in the table were repeated. Short term programmes particularly one-day training was disliked by most of the respondents. It was reported in all sub-centres that the faculty would arrive, generally, late and by the time the programme starts it is time for lunch and post lunch session - after heavy lunch is not very conducive for learning. The administration might have to confront with several problems in encouraging training courses lasting for at least a week. Given the large number of vacancies in the sub-centres, withdrawing ANMs for training for a week will certainly disrupt the skeletal services that reach the community. Arranging right resource person for the programme, communicating with the trainees etc. do pose hurdles in efficient organisation. However, given the rating of the trainees and assessment of the utility of these programmes it may be more productive to enhance the duration and enforce discipline of the resource persons.

There is also the problem of the size of the trainees. An elderly ANM reported that she was one of the 30 trainees in a programme and was sitting in the back row, hardly could hear what was lectured and instrument to be used was only one which she could not see at all. By the end of the day she thought she would not have missed anything by not attending it.

A shocking observation which the earlier study (Kanbargi 1996) had found was substantiated here that only one in five ANMs knows how to insert an IUD. It is widely acknowledged now that Indian Family Planning Programme is synonym with massive female sterlisation as they account for 80 – 90 percent of all acceptors. The programme managers argue that if women prefer only sterilisation what can be done? This argument is hollow as the eligible women who need contracepting method are not even fully aware of the choice they have. The district level information provided in Table 2 makes it very clear. It is only female sterilisation which is universally known in rural areas. Spacing methods ignored in the family welfare programme need urgent redressal.

SECTION II

Review of Training Impact : Insights from the Field

This section has tried to review the impact of training programmes on day-to-day practice of the respondents. It is classified as (I) Antenatal care, (ii) Identification of high risk pregnancies – (during Ante-natal care), (iii) Midwifery services and (iv) child care. These are all part of safe motherhood and child survival programme which is being implemented in the state for few years now. As it was revealed that only 60 percent of respondents have undergone CSSM training but interaction among trained and not trained possibly will improve overall performance of all respondents.

Antenatal Care

The antenatal period is of great importance in determining future course of events for an expectant mother. During pregnancy traditional practices are followed despite some modern knowledge. It surely influences the health care seeking behaviour of women and their health status that will have a great bearing on outcome of the pregnancy. One of the most important fact that affect pregnant women's health is the suggested strict diet regime - severe restrictions on food - what to eat and what not to eat. The strong dietary taboos can further adversely affect the nutritional status of women most of whom are already malnourished. But there are also traditional norms that put restriction on activities that may have some beneficial impact.

The knowledge about conception is widely known to all - pregnancy is recognised by the absence of periods or nausea. If the ANMs are regular in their beat and meet all the potential women they are likely to know that a particular woman has missed her period and if she had a fairly regular cycle guess that she is pregnant. The care should start from registering such women.

The recently completed RCH survey (Kanbargi et.al. 1998) considered at least 3 ANC visits to each pregnant woman during her pregnancy, 2 anti tetanus injection and supplementing nutrition by providing folic-acid tablets for 100 days as minimum package to be ensured to each pregnant woman. The survey found wide variations across districts ranging between 78 percent in Dakshina Kannada - Coorg districts to only 21 percent in Gulbarga. There could be a variety of reasons to be explored. Many researchers have questioned the efficacy of this approach in reducing maternal mortality in the states e.g. a study conducted in Kanakpura rural areas found "ante natal care provided by the government was only "contact service" and are often routine that leaves much to be desired. Weight of most of the women was not recorded, not haemoglobin estimated nor urine test done. This is in marked contrast to services provided by private practioners. Apart from providing tetanus toxoid and iron folic acid very little is done in government health care" (Jayashree Ramakrishnan et.al., 1999).

The findings from the present study fully agree with the above observations. The questionnaire had a check list of 14 items like (I) Registering a pregnant woman which should be the beginning of the service and when is it done? When a woman informs about pregnancy or during 3 - 5 months of pregnancy? It was assumed that ANM is supposed to visit the households routinely and during her visit a woman may report that her periods are post-poned or missed. However, the respondents could not distinguish the nuance and the objective behind splitting the question in two parts and it was of not much use in over 50 percent of respondents. (ii) When they start supplying IFA Tablets, (iii) When the Tetanus Toxide injections are given, (iv) When is the blood pressure measured, (v) When urine test is done, (vi) when is the blood test done, (vii) when is the taken, (viii) when is the abdominal examination done, (xi) when is the vaginal examination is done, (x) Whether diet advise is given (xi) Whether advice on breast feeding given (xi) Whether the woman is informed about possible complications in pregnancy (xii) Whether contraceptive advice is given to either post-pone next pregnancy or avoid it and lastly whether need for post-natal check-up is explained? The following chart provides the responses of ANMs/LHVs to these questions.

TABLE 7 : ANTENATAL CARE KNOWLEDGE : PERCENT

Sl No	Check list	Frequency	
		Yes	No
1	Registration	100.0	0
2	IFA tablets	100.0	0
3	TT injection	98.5	1.5
4	BP	92.0	8.0
5	Urine test	96.6	3.4
6	Blood test	93.1	6.9
7	Weight test	96.5	3.5
8	Weight taken	100.0	0
9	Abdominal check	74.7	25.3
10	Diet advised	100.0	0
11	Breast feeding advise	100.0	0
12	Pregnancy complications explained	83.9	16.1
13	Contraception advised	94.3	5.7
14	Post-natal check advised	86.0	14.0

Most of the ANMs were aware of what is ANC and its importance. But they had problems with discharging these responsibilities because of lack of instruments required like BP instruments and stethoscope, chemicals needed for testing urine etc. In addition many ANMs were not sure what is high BP that need attention? Weighing machines were provided to only 10 percent of ANMs. Only one ANM in a sub-centre (Gulbarga) showed me two weighing machines - one for just born babies and other for adults. She had another weighing machine for babies who can be placed in the panel weighing. But this was an exception, checking haemoglobin content and RH - ve was not possible even in Community Health Centres and PHCs.

It was clear that the knowledge of ANMs is not fully exploited in providing quality care during pregnancy. To explore further we visited two ANC camps in Gulbarga district —one held in a sub-centre and another at a CHC. The Registers maintained revealed that in CHC about 20 percent of women were examined for blood pressure and taken their weight. It was reported that large crowd about 100 – 150 women makes it impossible to provide the text book - prescribed services to all pregnant women.

The sub-centre clinic was held in a school - an opology for the absence of quality service. There was one table and a chair courtesy the school and the room was partitioned by a thin dirty bed sheet for examining women. Hardly there was any privacy. There was a crowd of 50 - 60 women at noon still waiting for their turn to be examined. The Lady Medical Officer was tired but committed to do her best to the pregnant women who had walked long distances to come here. They had very little choice as the ANM staying in the sub-centre village was hardly equipped with her needs. She had hired a room at the back of the school, she had to collect water from a well and go to field for her natural calls. Her husband was staying in Gulbarga.

We observed that because ANMs have not been provided with required facilities they request the pregnant women to come to a ANC camp held once in a week or once in two weeks. The Sub-Centre we observed held ANC camps every week and serves about 10 near by village women. The camp naturally gets crowded making it difficult to do all required tests for each one. A seasoned medical practioner will take the blood pressure if she has reason to doubt otherwise in

such situation no. Maintaining record of blood pressure, weight gain chart that immensely help in identifying high risk pregnancies/babies and planning safe deliveries is not possible. If the ANMs who are trained for ANC and used only for distributing IFA tablets and abdominal check-up it is gross under utilisation of their talents and putting more pressure on limited resources at the Sub-Centre causing great inconvenience to women clients.

The ANC section has two very important questions that are generally ignored. One was whether the expecting mother knows when she is expecting a baby – probable date of delivery. The ANM should be able to suggest the same. We observed 82 out of 87 were aware how to estimate the date of delivery. Another crucial factor is where it will take place? It is crucial because during ANC period there will be clear indication regarding the type of delivery - whether it will be normal or complicated. Depending on the need ANM can suggest the place. If it is going to be a normal delivery certainly can take place at home. If not, the family has to arrange for a hospital delivery including the resources. But surprisingly only two in three ANMs reported that they often suggest to women where they should go for the delivery. But the rest said it is to be decided by the family based on their economic situation. Our broad impression was, as mentioned early, the ANC means 3 visits to pregnant woman, 2TT injections and IFA supply of 3 months. Though it may be considered as minimum needed, much more has to be done to do justice to CSSM programme and improve the situation of women and children.

Identification of High Risk Pregnancies

Identification of high-risk pregnancies is the first and single most important step to be followed by going to a referral hospital fully equipped to provide efficient services to ensure safe delivary.

The responsibilities of the ANMs and LHVs listed in the Training Manual prepared by State Department of Health and Family Welfare under India Population Project (IPP IX) include urine test and blood test of all pregnant women for albumin, sugar and hemoglobin contents during their home visits. It also mentions that at least 50 percent of the deliveries are to be conducted by ANMs and the rest conducted by Trained Dais are to be monitored or supervised by ANMs.

The questionnaire has prepared an exhaustive list of symptoms that indicate high- risk pregnancies. Each ANM was asked whether they know what constitute risk to pregnant woman. The list prepared included risks related to last pregnancy termination, history of systemic illness, reported complaints during pregnancy in addition to the generally known factors like first birth or higher order births, height of the woman, status of blood pressure, etc.

The knowledge reported in the following tables is based on combined responses – some spontaneous and others received after a little probing. The responses are presented in two formats for the convenience and understanding of the reader.

TABLE 8 : IDENTIFICATION OF HIGH RISK PREGANCIES

Sl No	Symptoms	Aware (percent)	Not aware percent
1	Age less than 18 and over 35 years	88.5	11.5
2	1st or 4th and higher order births	74.7	25.3
3	Current pregnancy within two years of previous	62.1	37.9
4	Height less than 4'. 10"	81.6	18.4
5	Abnormal wieght gain – over 10 kg. Weight gained during pregnancy	52.9	47.1
6	Sustained high blood pressure over 140/90	50.6	49.4
7	Poor weight gain 5 – 6 kg only	48.3	51.7
8	Mal presentation of foetus	78.0	22.0
9	Weak or no movement of foetus	54.0	46.0
10	Convulsions in pregnancy	70.0	30.0

It may be mentioned here that many ANMs in Tumkur District reported that for this interview they had spent two sleepless nights to go through their notes/books of training period to refresh their memory like they used to prepare for their theory examination. However, the information provided in Table 8 and 9 is disappointing picture. It was the respondents in 50+ age who had more problems in responding as they frequently said "we have forgotten many things taught long back". There were two respondents who were deaf and posed problems for communicating effectively.

It may be noted here that most of the respondents knew that short women constitute high risk during their pregnancy but they could not define what is short? Similarly they knew that sustained high blood pressure during pregnancy carry high risks but did not know exactly what is high blood pressure. As mentioned earlier most ANMs do not possess the instrument and those few who had it, was not in working condition.

TABLE 9 : IDENTIFICATION OF HIGH RISK PREGNANCIES

Sl. No.	**History of last pregnancy**	**Aware Percent**	**Not Aware Percent**
1	i) Last pregnancy terminated as		
	Abortion	64.4	35.6
	Still birth	57.5	42.5
	Premature birth	55.1	44.9
	ii) In complicated delivery with prolonged labour ended with	55.1	44.9
	Retained placenta	60.9	39.1
	Sepsis	16.1	71.3
	In neonatal death		
2	Systemic illness		
	Heart disease	71.3	28.7
	(ii) Diabetics	77.0	23.0
	(iii) TB	57.0	43.0
	(iv) Hyper tension	83.0	17.0

TABLE 9 : IDENTIFICATION OF HIGH RISK PREGNANCIES (continued)

3	Woman complains of		
	Breathlessness	32.2	67.8
	Excessive tiredness	44.8	55.2
	Palpation	48.3	51.7
	Puffiness of face	35.6	64.4
	Tightening of ring/bangles/chappals	62.1	37.9
	Vaginal bleeding	52.9	46.9
	Pain in abdomen	36.8	63.2
	Fevers	18.4	81.6

The responses presented in tables 8 and 9 reveal inadequate knowledge about identification of high risk pregnancies among the ANMs. The focus group discussion clearly brought out the problem of ensuring safe delivaries even in cases of identified high risk pregnancies as the required facilities were not available even at Community Health Centres supposed to be first referral centres.

An example of a maternal death reported in one PHC area would explain the situation on ground level. The woman who delivered a baby with the help of a trained Dai and developed complications on third day. She was bleeding. The PHC kept her for a day with medication. The bleeding did not stop and she was advised to go to District hospital in the night. The family could not arrange transport and resources. Instead they took her home and she died next day. Some enquiry was conducted and the case was hushed up.

The data collected on ANC services and ability to identify high-risk pregnancies reveal that there is a long way to go to achieve effective reduction in maternal mortality and infant mortality. As noted earlier ANC means three visits to pregnant woman, 2TT injections and 100 IFA tablets. Even this minimum package of services have made considerable impact in bringing down IMR in the state, further decline depends upon improving the services of ANMs, infrastructures of PHCs and CHCs to reach the goal of IMR 30 mentioned in the policy statement of 2000.

Institutional Births

Institutional deliveries are meant to provide safe motherhood and the resultant significant reduction in maternal deaths. Wide variations were observed in them in the selected districts – from about 79 percent in Dakshina Kannada to only 21 percent in Gulbarga. ANMs in Udupi reported that many of them have not conducted a single delivery during last five years because women prefer to go to maternity homes or Government hospitals at District level. The private sector health services in Udupi – particularly the Manipal Hospital have expanded their maternity services to rural areas that has almost ensured safe delivery to any woman – poor or rich. Our visit to a remote place in Udupi where we had to cross a river to reach the village revealed that just a telephone call to the Manipal Hospitals maternity home situated at a distance of 14 kilometers will provide them not only free delivery but also free ambulance service to transport the pregnant woman to the hospital. The public-private co-operation observed in the district is really remarkable to try in other poor districts like Gulbarga or Bellary that can improve accessibility to good care and go a long way in ameliorating the sufferings of poor women.

As a contrast to Udupi ANMs who have not conducted a single home delivery during last five years, committed ANM in Gulbarga where there is hardly any choice for most rural women reported that she conducted 120 deliveries this year of which 20 were high risk whom she referred to CHC and ensured safe births. Another ANM reported to have conducted 94 out of 99 births in her areas this year - 5 being conducted by a trained dai. These two ANMs stay in the sub-centre quarter and a visit there will convince that they were model sub-centres. The two ANMs were residents there, available any time for service, had BP instrument, weighing machines for babies and adults, providing good ANC by testing urine, keeping records of weight to know the gain, recording BP of all women and ensuring the pregnant woman at least one check-up by a lady medical officer to confirm that every thing is OK with all her clients. The sub-centre that as conceptualised at the starting of out reach programme, perhaps was like this. The outreach programme might have conceptualised such sub-centres as modesl. But they are exceptions now as ANMs having no housing facilities stay in a place where she can get a house on rent and naturally night deliveries can not be attended by her.

Identification of High Risk Babies (Who weighed less than 2500 gms at the time of Birth)

The data collected in Reproductive and child Health (RCH Phase 1) survey in the selected three districts revealed that only about 7 percent of babies born in rural areas in Gulbarga district were weighed after birth and 58.3 percent of them were under weight (less than 2500 gms). On the other hand in Udupi (Dakshina Kannada) 62 percent babies born were weighed and only 13 percent of them were under weight and in Tumkur about 28 percent of babies' weight was recorded and 20 percent of them were reported weighing less than 2500 gms. These findings present a grim picture for Gulbarga and also to some extent Tumkur that certainly fare better than Gulbarga for underweight babies who carry high risk of death. Though one of the simple measure to reduce this incidence of low weight babies is to improve the nutritional level of the mother by supplementing her diet and providing IFA tablets. The ANMs have knowledge of the under nourished mother and the need to supply IFA tablets to them in their area

The RCH survey reports that in Gulbarga where the proportion of low birth weight babies is highest in the study area only 48 percent of pregnant women had received IFA tablets, it was 87 percent in Tumkur and 92.3 percent in Udupi (Dakshina Kannada). It is difficult to understand why this simple low cost remedy available is not taken seriously in Gulbarga where it is absolutely essential.

It would be interesting to note here our observations and the community perceptions about how these essential services are delivered by ANMs.

Our interaction with community leaders and women in particular provided surprising data. We met a Lady Panchayat Chairman in Gulbarga who was in her late forties, literate and was having concern for women's issues including their health. She said that the ANM stays in the village (only village she is to serve as it is quite large with 3500+ population), has a telephone at home and also keep some essential drugs for emergency. She conducts most of the deliveries in the village by charging anywhere between Rs.300 - 1000 depending upon the economic status of the family. But she never visits any home for providing services. People have to call her on phone or meet her personally if they require any service – of course at a price. The Lady

Panchayat Chairperson did not know that ANM is supposed to visit all families in her jurisdiction to enquire the welfare of women, their pregnancies, children health etc. Even her husband and many others who gathered there during our focus group discussion reported ignorance and said the panchayat will issue a letter to the Medical Officer in this regard soon to ensure her services to all homes in the village. It would not be surprising in such situation that poor and scheduled caste women may not be able to avail her services free.

This was not an exceptional example in Gulbarga. In three more sub-centre areas we observed similar things. Absence of good roads and transport facility may be important hurdles to ANMs in addition to inadequate housing facilities. But administration both in the health department and at Zilla Parishad should try to improve the situation to ensure accessibility to health care for all. Rarely, except in ones we could see a chart showing ANMs travel programme for the week usually displayed in all PHCs. It was also surprising that many ANMs/LHVs in Gulbarga were not found earing uniform white saree during working hours. But in Tumkur and Udupi we did not see any ANM/LHV not in the uniforms.

However an effort was made to know respondents abilities to identify high risk new born babies (who weigh less than 2500 gms) if check listing some symptoms.

TABLE 10: IDENTIFYING HIGH RISK NEW BORN BABIES (WEIGHING <2500 gms)

Symptoms	Aware (percent)
Refusal of feed	78.2
Increased drowsiness	56.3
Difficult breathing	75.0
Cold to touch	55.0
Yellow staining of skin	62.0
Convulsions	26.4
Others	14.9

The data presented in Table 10 reveal that there is much to be desired. However, some ANMs were aware that if the baby is cold, they would keep it under 200 watt electric bulb to improve the body temperature of the baby.

Acute Respiratory Infection (ARI)

Only about half (52 percent) of the ANMs were aware about Acute Respiratory disease and 85 percent of them had knowledge of at least one symptom of ARI and also were aware that it is an important reason for high IMR.

Pneumonia

Most of the ANMs, (91 percent) were aware about pneumonia and more than half of them knew one or more symptoms of pneumonia like excessive drowsiness, respiratory grunting, convulsion and inability to drink.

Diarrhoea and Dysentry

Diarrhoea, a major killer of infants and its symptoms like passage of watery stools 3 – 4 times a day was known to 92 percent of ANMs. However, there was confusion among many in distinguishing diarrhoea from dysentry which has symptoms like blood in faces, abdominal

cramps, fever and weight loss. Only one in five respondents were aware that diarrhoea/dysentry is a major killer of infants. All respondents were aware (100 pr cent) of dehydration that follows dysentry/diarrhoea and could mention all the symptoms like restlessness, decreased skin tugor, dry mouth-tongue, sunken eyes and lethargic appearance of the baby. Management of dehydration through measures such as giving ORS or home made syrup of sugar and salt, plenty of gluids, and continue to breast feeching was known to all respondents.

The strong emphasis given to the child immunisation was reflected in every respondent knowing what immunisation is to be given when. Liquid IFA, however, to be given to malnourished babies was known to only one in four perhaps it is not supplied in the state. It was reported that children are given small IFA tablets.

Knowledge about Cold Chain

While immunisation coverage has shown remarkable improvement over time, quality of immunisation has remained a question to be answered. Is cold chain maintained to ensure the required vaccine potency? We wanted to test whether personnel who play a key role in immunising children know about cold chain?

It was revealing experience for the research team which visited a Primary Health Centre in Gulbarga district. It seems a diary is to be maintained and the temperature shown on the thermometer of the new type refrigerator in the PHC where vaccine is stored is to be recorde ' by the Medical Officer. We were surprised the recording in the diary was up to date with recorded temperature, date and signature of the Medical officer but the thermometer that indicates temperature was not working for several days and not repaired. It was also clear from the observation of the diary that all the entries for the month were made the previous day. Neither the staff nor the clients who receive were aware of the importance of maintaining cold chain to ensure effective immunisation.

Compare this with what was reported by almost all respondents in Udupi. They said that the immunisation day for them will become a nightmare if power in the area was shutdown even for half an hour as mothers would object for immunising their children as there was power shut down yesterday as such what guarantee is there of the vaccine potency? With all the explanation by the ANMs about the advantages of new freezers that they have, some mothers would still prefer to go to private practitioners for immunisation. These observations, though accidental, reveal the casual approach adopted by qualified responsible authority whom the illiterate and ignorant community trusts and it deserves serious consideration in the department to ensure that there is responsible approach how immunisation under the circumstances it was not surprising that about 40 percent of respondents expressed their ignorance about the required temperature to maintain the vaccine potency.

Infant Feeding

There was a question to check the respondents' knowledge on exclusive breast-feeding. What does it mean? How long a baby should be exclusively breast-fed? Response of all the respondents was that babies should be breast-fed for 3 months. They also knew the advantages that exclusive breast-feeding provides more nutrition (90 percent), protects against infections (87

percent) but only 46 percent knew about its contraceptive effect. The RCH survey 1998 found that in Gulbarga babies being breast fed within two hours of birth accounted for only 9.5 percent while it was 36 percent in Tumkur and 47 percent in Dakshina Kannada District. Continuously repeated advantages of cholestrum milk that provides effective immunisation to babies is almost denied in Gulbarga. The general opinion of ANMs was their advice during ANC and delivery does not make much sense against the strong traditional beliefs that still govern the community behaviour.

Weaning

We also enquired whether the respondents are aware about weaning? And when to start it? Each ANM reported that breast milk will be inadequate to babies growth after three months and babies will have to be introduced to some other semi solid foods like `Ragi Sari', `Rice Ganji', `Bele kattu or liqufied pulses' etc. which can be prepared at home with locally available food. Few of them reported that they also suggest to mothers to go for baby food available in the market. More than 70 per cetn of ANMs in Udupi reported that weaning food also can be purchased from market.

While the latest WHO recommendation is that exclusive breast milk should continue for 6 months and only afterwards weaning foods be introduced, all available evidence in Karnataka show that there is need to improve the understanding of mothers in rural areas about the advantages of cholostrum milk and exclusive breast feeding. Surveys have reported wide spread practice of squeezing cholostrum milk and feeding just born babies with variety of liquids like sugar and syrup castoroil with enormus, health hazards. The respondents reported that during mothers club meetings as well as during ANC they explain all the advantages of breast-feeding including cholestrum milk however the outcomes are poor. In this regard there is need to consider for vigorous campaign and improved IEC programme. Several babies we saw in ANC camps in Gulbarga and Tumkur convinced about the poor health status of surviving children. They were looking thin with sunken eyes. It is possible that under-nourished mothers even though supplied IFA tablets were not regularly consuming them to derive the benefits.

General Knowledge

We perceived ANMs/LHVs as backbone of rural health delivery system. They are the link between the vast rural illiterate women and modern health care providing PHCs. They are expected to visit every household in their area and are familiar with each of the household that make them not only a health worker but a friend, philosopher and guide to those women. During their visit they may conduct mothers meeting to provide them important information on their own or have to answer some questions raised by their clients. Therefore their knowledge and advice carries great impact as such this study attempted to assess how familiar they are with the population problem – particularly whether they knew that India's population has crossed 100 crore mark. We asked what is India's population and gave three hints – 50 crore, 150 crore and 100 crore. Only 46 percent of them could say it is 100 crore.

It was noted earlier about the low age at marriage of females and its consequences on IMR, MMR and also fertility levels. Marriages before a girl attains 18 years of age are legally

prohibited. But its impact is negligible on the marriage age. Only 79 percent of respondents were aware of legally approved age at marriage of boys and girls. One in five respondents were not aware themselves and they may not have discussed about it is the meetings of mothers. If female age at marriage continues to rise as slowly as is observed despite all efforts than what are the options left to policy makers to reduce its consequences? Or should this area be left as nothing can be done as it is parents of the bride and groom who decide the marriage who and are not bothered about the age? Marriage is certainly a complex social and economic issue. Good harvests see more marriages in any village and droughts few or no marriage and difficult to bring interventions to drastically change the pattern.

In this situation female health workers can play a very important role of motivating the young married couples to postpone the first birth by a couple of years or till the young woman attains 20 years. The focus group discussion revealed that talk about contraception will begin only after the couple has one or two children and intensive efforts begin only after 2 children. It is obvious that if sterilisation is considered as the only suitable method for the couple by the ANM, there is no alternative. But can they not advise them to use condoms or safe period or even least harmful orals that are available in the market? They are not trained to motivate couples for adopting spacing methods.

The focus group discussions also brought out some interesting problems ANMs face in the field. It was reported that the distribution of IFA tablets to pregnant woman generally starts in fifth month of pregnancy. If given soon after registration of pregnancy of the woman and the pregnancy is terminated in abortion women hold the ANM responsible for it. Because it is she who supplied IFA tablets saying that her health will improve and on the contrary she had abortion. Such news spread very fast in villages the whole village may turn out hostile and ask her not to give those tablets to any pregnant woman in their village. Similarly motivating for contraception is confronted with the problem of child survival. If the only son among the two the couple has dies, ANM will not be forgiven for motivating them to accept sterilisation. So to play safe they said it is better a couple should have two sons and a daughter before undergoing tubectomy. It is not surprising that NFHS II found 90 percent of sterilised women had not adopted any other contraceptive method before. Distribution of Bill and condom through public sector, therefore, constitute insignificant proportion in rural Karnataka.

This background is aptly reflected in the responses of ANMs/LHVs as 18 percent of them could not say what is safe period and explain it correctly. But 95 percent could explain what tubectomy is and how it is performed because they reported that they explain it to all potential acceptors.

Medical Termination of Pregnancy

Abortions were legalised in India in early 1970s and the number of legal abortions have increased significantly over the time as also approved places for conducting abortions. But rural women are deprived of this facility as most of the PHCs in the study area do not have the equipment or person / approved by the government to provide abortion facility to women. None of the ANMs are trained to conduct MTP and when we asked them when will they recommend MTP to women? It was disappointing that none of them had suggested any woman to go for an abortion. Looking at the clandestine abortions reported and observed by the hospital records

showing sepsis/infections caused by quacks while aborting and admitted to hospitals in serious conditions, there is need to examine what ANMs can do in rural areas. While ANMs took a moral stand and their response was very firm in reporting that they neither perform nor recommend MTP to any woman that does not reflect reality.

The job responsibilities listed by the Department of Health and Family Welfare 1999 clearly has mentioned that ANMs should identify women in need of MTP and inform them the nearest approved place for MTP to obtain an MTP. We think there is an urgent need debate on the issue of providing this facility to rural needy women.

The Eligible Couple Register

Eligible Couple Register the Female Health Workers are supposed to maintain and keep it up to date with all relevant information. It is a valuable document that guides in her work. It has all information she needs – how many currently married women are there by contracepting status and number of children, helps in identifying children is need of immunisation, and women in need of advice on nutrition, etc. A general complaint emerged in all our meetings was the shortage of EC Registers - some places not supplied for 7 - 8 years and ANMs have to purchase a Note pad and record the information to the best of their abilities. Non-supply or irregular supply certainly creates serious problem in compiling service statistics from Sub-Centre.

We wanted to learn from ANMs whether still they feel EC Register serves an important purpose and help them. There was a unanimous response that it is important and they should be supplied EC Register so that they will be able to improve their performance.

Mothers Meeting

The respondents also informed that they routinely conduct mothers' meetings and discuss different health issues and about nutrition. They think that these meetings will become more effective if the ANMs are provided with educational materials for use during the meeting to make the meetings more productive.

Advise to Adolescents

The needs of the adolescent girls that were ignored for long is getting attention now. There are special programmes designed for their benefit. To improve their knowledge about personal hygiene and health. There were few reports of providing Tetanus Toxide injection to these adolescent girls. What was interesting to learn from many ANMs was that often in mothers meeting some adolescent girls also participate and when the topic of contraception / pregnancy is to be discussed they are asked to go out as they need not learn about contraception because educating these unmarried girls in Family Planning methods because of the fear of using them before marriage. Given the sea change that is being realised through recent research on changing sexuality in the society and the AIDS threat becoming more and more serious there is need to think about what should be the policy for these girls. Most of whom are illiterate and ignorant of many vital issues concerned with their own person. If they are educated about contraception will that enchance its use after they get married?

The Working Environment

We examined the training programmes that the ANMs/LHVs have undergone so far and the extent they are utilising the skills – knowledge that they were able to retain from them. The focus of the study however was confined to issues concerned with the health and survival of women and children who still constitute a major component in the crude-death rate.

It was mentioned that the grass root female health workers are considered as backbone of our rural health delivery system in Karnataka and with several drawbacks in the system considerable progress has been made during the last two decades. The widely differing indicators of achievements among different districts and by gender and social class within each district is a cause for concern and further improvements will be faster if backward districts, deprived sections within backward districts get relatively more attention. As it is, there is uniform policy and strategies in the state. We did not come across any special efforts to improve health care delivery services in Gulbarga or Tumkur.

The three districts selected for this brief intensive study present three unique settings. Udupi has very high female literacy, high age at marriage, wider knowledge of contraceptive methods

Box 1
PHC 1 – Gulbarga

The Research Team reached here by 10 AM. There was only an Attender and no responsible staff member. The Attender – the only person in the PHC was not aware of our visit nor about reasons for the absence of the I/c MO and other staff. The PHC had conducted Tubectomy Camp two days earlier and there were six women (who had come from different villages). One of them had developed complications and was advised to go to Gulbarga for consultations by Head Quarters ANM. Who had undergone Tubectomy operation.

The Head Quarter ANM who is supposed to provide care to the sterilised women had gone on leave as her husband seriously took ill and she admitted him in a hospital in Sholapur. The MO had not come to the PHC for a week without any reason nor informed any authority – like Taluk Medical Officer and resides at Gulbarga situated at a distance of about 45 kms. Journey takes about 2 hours because of bad road conditions.

We contacted the DHO and reported the situation who in turn telephoned taluk Medical Officer who rushed to our place. He reported his helplessness as he had warned the MO a couple of times. We also learnt that the local MLA also had warned him to be punctual but of no consequence. In-charge MO was not able to improve his functioning. The Taluk Medical Officer who looked committed and honest also expressed his helplessness regarding the verification of drugs in the PHU as the pharamacist never met him nor showed the tock during his last three visits.

while it is a contrast in Gulbarga – a district perhaps politically very influential as 6 ministers hail from that district in the contemporary political scene with two of them may be considered as very heavy weight politicians in every sense. Things could have been better with their interventions in the district. But unfortunately health, sector, perhaps, does not command much attention. To make things worse any disciplinary action against an erring official in health sector-from an ANM to Medical officer is extremely difficult as there will be instructions from top that he or she is our person and nothing should be done to him/her and there ends the matter. This benevolent attitude of powerful personalities of the district has almost demoralised the health department in the district. The crucial services are casually taken. The Box 1, 2 and 3 present the contrasting picture to high light the issues in three different settings.

The three senarios presented depict differing consequences on the people of the area. Gulbarga Pulic Health Care service is a single most important provider of services to the people

Box 2
Contrast : A PHC in Udipi District

We arrived at this PHC, without prior intimation, at 9.30 A.M. We were surprised that the PHC was busy functioning – MO, Lab Technician and other staff were attending the patients. On an average there are 50 – 60 patients a day. The young MO here is appointed on a contract basis but is very regular to his work and fully committed.

The PHC building, though old is very clean. The MO's chamber had privacy for patients. It had a clean wash-basin, running water, soap and a clean towel. The toilet was also clean. All the records were up-to-date and well maintained. The PHC had displayed prominently at the entrance that if any visitor to the PHC had any complaint on its functioning they can get a free post card to write the complaint which they can mail to the concerned authorities whose addresses were mentioned in bold letters.

The MO reported that the drugs supplied to him are of very good quality and adequate. The drugs that private sector hospitals provide to their patients is certainly not of better quality than that of PHCs. Therefore the visitors to the PHC are happy that the centre works not only very efficiently but also supplies quality drugs. He had only one complaint – that the patients who visit his PHC have simple ailments while he was interested in attending to chronic/serious cases also and improve his abilities. For this he goes to a Private Hospital in the night – not for earning more money but to improve his understanding.

with negligible presence of private sector even in the District Town. If the Public Health Services are inaccessible to people, will have serious health consequences.

Udupi on the other hand strong presence of private sector which has social commitment as seen by the free delivery services with free transport just with a Telephone Call. The Public health

Box 3

We reached this PHC in Tumkur by 9.30 am. All the staff including ANMs/LHVs were waiting for us. The Medical Officer was a young man with 3 years of experience in PHC. He was in a neatly pressed white coat and any visitor would recognise him as a Doctor.

The PHC was crowded with patients. But lacked many facilities. There was no running water. Toilets were there but not clean. The PHC did not have a compound wall and in the evening cattle, drunkerds squatted in the compound creating scare among inmates (Delivery cases).

All the feamle health workers complained that they are not supplied registers to record for several years, cholirination of wells, DDT spraying has been stopped since three years. The ointment, paracetemol supplied to them is inadequate – does not last even for 4 months but people.

It was surprising with all the problems the PHC was still serviving people as seen by the large crowd of outpatients. There are 70 – 80 patients on an average visiting the PHC for consultation and treatment.

We contacted the DHO and reported the situation who in turn telephoned taluk Medical Officer who rushed to our place. He reported his helplessness as he had warned the MO a couple of times. We also learnt that the local MLA also had warned him to be punctual but of no consequence. In-charge MO was not able to improve his functioning. The Taluk Medical Officer who looked committed and honest also expressed his helplessness regarding the verification of drugs in the PHU as the pharamacist never met him nor showed the stock during his last three visits.

care services are equally efficient and competant but suffers from inadequate infrastructure and equipment. The end result is that the educated population can make a reasonable choice and there is choice for the rich and also for the poor. Poor are assured of good health care at Public Health Institutions. PHCs function efficiently – maintain working hours, ensure presence of Doctor and supply of drugs of as good as quality that of private sector quality. It is not surprising that health indicators, health seeking behaviour indicators are most impressive. Tumkur district on the other hand is certainly better than Gulbarga in several ways. The PHCs work regularly though there were complaints of shortage of drugs, quality of drugs etc. General public, though heavily depend on Public health Institutions, there are large number of quacks having presence in every village having a population of 4 – 5000. Shivashakti Clinic, Unani Davakhana and a hot of other clinic try to provide some relief to needy poor. We did not come across any untoward

incident occuring because of quacks as we were informed that if the `Quack' realise that he can not handle the case, he will advise them to go to Tumkur District hospital and will not take any risk.

In this background it may be noted that increasing number of Institutional deliveries affect work burden of female health workers as it has happened in Udupi. Our information collected from ANMs report that only 6 percent of deliveries are conducted by them and the rest occurred at the Institutions. In Gulbarga about 40 kilometers away a PHC reported that during April 2000 – December 2000 had 627 births about 200 at PHC and the rest 427 by 8 ANMs in the PHC. There were 7 still births. 27 infant deaths reported.

Not a single birth had taken place in private nursing homes. The Medical Officer of the PHC stays in the quarter and is always accessible to the needy. His wife is a lady Medical Officer whose services are also easily availed any time. As they stay in PHC they have full control over other staff who also show concern and commitment to the health concerns of the public. But such PHCs are exception in the District. The general rule in Gulbarga is that either Medical Officer's post is vacant, if it is filled the person is erratic in discharging his responsibilities as the authorities are hesitant to discipline them because of political interference. While the situation is continuing like this the social costs are too high even to measure or community suffers enormously. The case of Kunchoor illustrates this. Kunchoor or Kunchavaram is a village situated at the border of Karnataka —Andhra Pradesh in Gulbarga. The village has a PHC and for last five months there is no medical officer (vacant). Lady Medical Officer's post is filled but she never turns up. The Chairman of the Taluk Panchayat died three days ago (when we were enquiring) without any medical assistance, 2 children died during the week and causes for these deaths are not known. The member of the Zilla Parishat, a resident of this village has tried his best to get a `couple' husband-wife' team to this PHC but without any success. In such a situation expecting ANMs/LHVs to be committed in discharging their responsibilities in futile. The Kunchoor PHC area is dominated by a Scheduled Tribe-Lambadies.

SUMMARY AND CONCLUSIONS

The short term intensive study was carried out in three districts of Karnataka State that widely differ in health and demographic indicators. The main objective of the study was to assess the various training programmes the grass root level female health workers (ANMs/LHVs) have undergone, extent of their utilisation by them in their day to day work. The study went beyond the stated main objectives to examine whether providing training per se will improve health care services as its effective exploitation is related with a host of other factors like infrastructure, equipment and team spirit at PHC level from where these services are organised, supervised and monitored.

The focus of the study was confined to those training programmes that were designed to improve the health status of women and children – more specifically in reducing further IMR and MMR. For this intensive study 3 districts – Udupi, Tumkur and Gulbarga were selected. From these

three districts 8 Taluks and 22 Primary Health Centres were selected. All Female Health Workers (ANMs/LHVs) at these centres were administered a standard questionnaire that was specially constructed to check their skills required in their work. The 87 respondents were covering a population of 2, 61, 155.

All respondents had successfully completed the foundation course – 18 months and few had 2 years training programme. The gap between the completion of course and joining the service for many was as large as 4 – 5 years in few exceptional cases.

The general impression of the respondents regarding their training that some had completed 30 years back was that there was inadequate attention to practical hospital training and training in field work. An indication of this was the reported `shaking of hands' during the first delivery conducted by most of them. There were one-or-two exception to this general observation. An ANM in Gulbarga mentioned she had the best opportunity of conducting 24 deliveries during her training period under the able supervision and guidance of a gynecologist. It was suggested that training programmes should be need-based and practical in real life situation and not just lecturing with lot of information.

There was long gap between Foundation course and the next most important training programme related to maternal and child health viz. CSSM training. The findings show that still 40 percent of ANMs have to undergo this programme that has great relevance to reduce further IMR and MMR.

It was shocking to find that most of the ANMs are not trained to insert IUD. Policy studies have repeatedly highlighted the urgent need to enhance use of spacing methods particularly among rural women as it will have directly impact on the health of women and children. This needs serious attention.

Similarly ANMs/LHVs need to be more sympathetic to women's need for Abortion. Whether they can be trained to perform medical termination of pregnancies is a technical question to be decided by experts, we strongly recommend that at least MTP service be made available at PHC level and ANMs/LHVs should be trained in the legal aspect of MTP and when they can recommend it to needy women.

In addition to CSSM, a host of training programmes have been conducted for the respondents. A general observation is that the short term training programmes of one or two days have been rated as not very satisfactory by the respondents. There was a strong suggestion of all respondents in Tumkur and Gulbarga that Continuing Education programme for a week should be a regular feature to update their skills and knowledge of maternity and child health. This

programme should be holistic and may cover other relevant contemporary health problems in the state / district.

Identifying high risk Pregnancies

The findings suggest that there is a need to have as suggested above, one week Continuing Education programme to enhance the knowledge and skills of ANMs/LHVs of pregnancy management. Except in Udupi/Dakshina Kannada and Kodagu districts where Institutional deliveries have become a rule in all other districts where domiciliary deliveries dominate, the improvement of the knowledge of ANMs with intensive training should be given serious attention. ANMs/LHVs must have knowledge of measuring blood pressure, testing urine for albumin and sugar and keeping these records for all pregnant women (at least I readings for a woman). These services should be provided in the yield to women by ANMs apart from. TT injections, IFA tablets. It should be followed by blood test of each woman for haemoglobin content at least at PHC level. It may be noted that we had trained Field Investigators of NFHS II Survey to measure haemoglobin of all women in the sample at their home in each village. It was possible because very simple to use technology was made available from USAID. It should not be difficult to obtain this technology by the state government for use of ANMs/LHVs. The time taken for the test is very little-just 1 minute per woman at their door step. Unless minimum package of services are provided to all pregnant women and each high risk pregnancy is identified and taken to nearest referal unit for safe delivery, MMR will continue to be very high.

Identifying high risk babies needs serious attention. Knowledge of Acute Respiratory Injection is very poor among the respondents. NFHS II reports that about 34 percent of children were suffering from ARI in Karnataka indicating the serious nature of the illness and its consequences. The present study found that ANMs were confused when asked to distinguish between the symptoms of diarrhea and dysentery. As 15 per cent of children in the state were found to be suffering from these illness improving the knowledge of ANMs and LHVs in identification of these illness and ARI is to be given immediate attention. It was, however, satisfying that Oral Rehydration Therapy (ORT) is universally known not only to ANMs but also to mothers.

Immunisation coverage in the state has shown gradual improvement as seen by the service statistics. We came across a report in Gulbarga that a baby afflicted by polio in a village was living next door to the sub-centre. But looking at the crowd in Immunisation Centres with several agencies participating, a child might have missed immunising. ANMs were found to be well versed with immunisation process and were confident that all children in their area are protected.

While in Udupi Rotary, Lions, Womens Organisations, College Students and many enlightened women participated in pulse polio in a big way even in rural areas such support in Tumkur and Gulbarga was more concentrated in District towns.

Respondents knowledge about benefits of exclusive breast feeding and weaning was appreciably good and needs periodic updating. Their understanding of India's population and legally approved age at marriage for males and females was found poor that needs to be up-dated.

The most glaring lacunae reported by ANMs and LHVs in their training is lack of communication skills and inadequate attention to it in any of their training. Simple observation is that to combat with strong traditional practices having serious adverse impact on women and children like squeezing of colostrum milk needs intensive campaign. It would be effective only when ANMs can play an important important role. Similarly introduction of spacing methods to young married couples would be facilitated greatly if ANMs are properly trained to convince the young village couple of its advantages.

Most crucial issue to be considered here is that training, upgrading skills and information becomes inevitable to improve overall health status measured in several ways. The goals set in the health sector can be achieved when such relevant training programmes bring in qualitative changes in the services provided to clients. If all that is told in training programme is difficult to put in practice because of lack or absence of infrastructure, equipment and other supplies the purpose of training cannot be served.

It was observed that vast expansion of health care services – personnel during the decade is not followed by adequate care and required resources. The quick expansion perhaps created a problem of finding professionally trained personnel. A look at the staff position at district level is surprising if not shocking. If health care service delivery is ensured with or without these large number of vacancies, it is in itself an indicator of quality care.

At policy level, it is desirable to think of a district or a group of districts for intervention. For example in Gulbarga and Tumkur and such districts there is need for greater attention to improve the management of pregnancies and their outcomes which may need more resources like improving PHC/Sub-Centre infrastructure, equipment to ANMs such as BP instrument, chemicals to test urine, haemoglobin/blood test etc. Where as in Udupi, Dakshina Kannada, Coorg with good adequate support from private sector this problem is not there. But AIDS is looming large in these districts with large out migration of males and females. We heard reports of AIDS deaths caused in every village we visited with documentary evidence. All the deaths had occurred to the return migrants and it seemed as if they all came home only to die.

At state level there is a uniform policy of resource allocation for health sector. If some districts perform poor as indicated by several indicators it would be necessary to ensure that administration in these districts are pulled up. The poor perception of people regarding the public health care system in health poor districts needs serious attention. Precious public resources deserve more productive use. The backward nature of some districts is known for long for over four decades and these districts have remained at the bottom even now. Unless some fundamental change is brought in the administration for improvement they will continue to be at the bottom.

GOVERNMENT OF KARNATAKA

TASK FORCE ON HEALTH AND FAMILY WELFARE

A Commissioned Research Study

FEMALE HEALTH WORKERS IN KARNATAKA: AN ASSESSMENT OF THEIR TRAINING

By

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Introduction

Health status of people in India has shown remarkable improvements during the last two decades. The Crude Death Rate (CDR), Infant Mortality Rate (IMR) and Crude Birth Rate (CBR) have shown sharp fall and key health indicator `Life Expectation at Birth' which was about 42 in early Fifties has crossed 60 years in the early Nineties. Wide differentials across states in India, however, have persisted throughout suggesting the need to take corrective measures to bring in much desired equity in health to reach the goal `Health For All by 2000' India has committed at Alma-Ata in 1978 (See Table 1 for differentials).

The data presented in Table 1 clearly brings out the fact that Southern States - Kerala, Tamil Nadu, Karnataka and Andhra Pradesh have shown relatively better performance as compared to Hindi speaking BIMARU States - Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh and Orissa.

Wide differentials within state by rural-urban residence, gender and social class exist across the districts. The Human Development Report 1999 - Karnataka provides CDR, CBR and Life expectancy at Birth for all the districts that reveal the differentials. IMR another sensitive health indicator shows that Dakshina Kannada reported the lowest IMR (27) in the state while Gulbarga, Bijapur, Bellary had IMR about 3 times higher than Dakshina Kannada district. There is other strong evidence to support the IMR estimates - institutional deliveries in Dakshina Kannada accounted for 77 percent while in Gulbarga it was only about 27.9 percent suggesting the strong negative association between IMR and institutional deliveries - safer deliveries.

TABLE 1 : HEALTH SITUATION IN INDIA AND SELECTED STATES

State	IMR 1996			CDR 1996			Maternal mortality ratio 1986	Sex Ratio 1991	CBR 1996
	R	U	T	R	U	T			
India	77	46	72	9.7	6.5	9.0	580	927	27.5
AP	73	38	65	9.2	5.9	8.4	394	972	22.8
Karnataka	63	25	53	8.6	5.4	7.6	439	960	23.0
Kerala	13	16	14	6.3	6.0	6.2	247	1036	18.0
Tamil Nadu	60	39	53	8.7	6.6	8.0	372	974	19.5
Uttar Pradesh	88	67	85	10.7	8.2	10.3	920	879	34.0
Rajasthan	90	60	85	9.6	7.1	9.1	627	910	32.4
MP	102	61	97	11.8	7.6	11.1	507	931	32.3
Bihar	73	54	71	10.6	6.9	10.2	813	911	32.1
Orissa	99	65	96	11.2	7.5	10.8	844	971	27.0
Maharashtra	58	31	48	8.7	5.4	7.4	439	934	23.4
Gujarat	68	46	61	8.3	6.2	7.6	373	934	25.7

Source: 1) Family Welfare Programme in India, 1996-97, Government of India.
2) Mari Bhat P.N., 1995.

The latest data-set (1998-1999) collected in National Family Health Survey and Reproductive and Child Health Survey (NFHS II and RCH) provides valuable insights for effective policy interventions to reduce the disparities across districts by rural-urban residence, social class and gender. Findings from both the surveys suggest that the out reach services of maternal and child health hold the key to bridge the differentials and these services are to be delivered by Female Health Workers popularly known as Auxiliary Nurse Midwives (ANMs) and Lady Health Visitors (LHVs).

The Present Study

The present study is an attempt to examine the role of these grass root level female health workers and adequacy of their training to discharge their

responsibilities satisfactorily that can help to reduce considerably the disparities observed across districts.

Objectives

Taking into consideration the major midwifery responsibilities assigned to the ANMs and LHVs after a rigorous foundation training of 18 months the study proposes to achieve the following objectives.

1. To examine the knowledge of ANMs regarding the Ante-Natal care service and its delivery to pregnant woman.
2. To assess their knowledge of identifying the high-risk pregnancies and ensuring safe delivery that will help to reduce maternal mortality.
3. To examine the knowledge of supplementary nutrition to be advised and supplied to all pregnant women to reduce malnutrition.
4. To examine their knowledge of identifying high risk infants and measures to be taken to ensure their survival to reduce IMR further.
5. To identify inadequacies in the training of ANMs/LHVs if any, and suggest corrective measures.

The Sample

The study was conducted in three districts of Karnataka that differ widely in indicators relevant to reduce IMR and MMR. These indicators were drawn from the RCH Survey (First Phase - Kanbargi et.al., 1998). They are

1) Percent women who received full Ante-natal care package (At least 3 ANC visits + 2TT injections and 100 IFA Tablets)
2) Percent institutional deliveries.
3) Percent children in 12-23 months age who did not receive any immunization.
4) Percent women who had knowledge of all modern contraceptive method.

Based on these criteria following three districts were selected.

TABLE 2 : SELECTION OF THE SAMPLE DISTRICTS

	District/State	Full ANC (percent)	Institutional deliveries (percent)	Children not immunised (percent)	Family Planning knowledge of all modern methods Percent
1	Udupi (DK)	78.9	76.6	0.5	70.7
2	Tumkur	68.7	48.4	0.5	40.8
3	Gulbarga	21.2	27.9	31.1	27.2
	State	52.2	52.4	8.3	46.1

Source: Rapid Household Survey RCH, 1998, Kanbargi et.al.

The three Districts selected differed maximally in several other variables also. For example the percent girls marrying before 18 years - legally approved age was highest in Gulbarga about 59 percent, 29 percent in Tumkur and only 5 per cent in Udupi (which was part of Dakshina Kannada then. We selected Udupi District based on the data of Dakshina Kannada district as data for Udupi are yet to be made available). The observed early marriage and its impact on CBR is clearly reflected in these districts (Gulbarga 32, Tumkur 24.7 and 21.4 in Udupi).

The three selected districts - one highly advanced - Udupi, one with medium progress - Tumkur and one backward - Gulbarga in terms of demography and health would be able to provide insights sought in the functioning of the ANMs and LHVs in the state. For data collection 8 Taluks 22 PHCs and 87 sub-centres were selected randomly. The following table provides these details.

TABLE 3 : THE STUDY AREA

District	Taluks	PHCs	SC (ANMs)
Udupi	1) Udupi 2) Kundapur	8	26
Tumkur	i) Gubbi ii) Madhugiri iii) Kunigal	6	41
Gulbarga	i) Afzalpur ii) Gulbarga iii) Chitapur	8	20
Total	8 Taluks	22 PHCs	87 ANMs

Methodology

The relevant data was collected from all ANMs available in the selected PHC/Sub-Centres by employing survey methodology. A standardised questionnaire was constructed for administering to each ANM/LHV in the selected PHC/Sub-centre. The administering of the questionnaire was preceded by a brief introduction about the survey and assurance that the information collected will be kept confidential and used only for research purpose. In PHC we met the medical officer (MO) and other staff present and briefed them about the study. We assured all that they will not be harassed by Health Department or any authorities for sharing their honest views on the functioning of the Health Care Services.

There were focus group discussions to get insights in the functioning of the Institutions that provided valuable information. This information is exploited to supplement the hard data collected in the survey.

Each questionnaire administered to ANMs/LHVs took over an hour. The interviews were abrupted often when many ANMs broke down who were to be consoled to start the interview again. The respondents reported that it is first time in their entire service someone is enquiring about their problems and welfare. When they were asked whether they would be happy if their daughter (those having one) was offered ANMs job, it was revealing that most of them reported that they do not mind if their daughter goes for agricultural labour but they don't want them to become an ANM like their mother. It indicated harsh working environment they are situated in, their frustration and helplessness.

Data and Analysis

The brief profile presented in Table 4 suggest that most of the Female Health Workers are currently married, have at least 10 years of schooling and in their middle ages with long experience. As there are limited opportunities of advancement in the career they feel dejected struck with the same work for years. Those who were on the verge of retirement were eagerly looking forward for the day to free themselves and lead a relaxed life.

TABLE 4: FEMALE HEALTH WORKERS IN THE STUDY AREA : A PROFILE (87 ANMs and LHVs)

	Variable	Frequency	Per cent
1	Age (years)		
	Below 40	31	35.6
	40 - 49	33	37.9
	50 - 58	23	26.4
2	Marital Status		
	Single	04	4.6
	Currently Married	77	88.5
	Widowed/Divorced	06	6.9
3	No.of living children		
	0	11	13.3
	1	17	20.5
	2	41	49.4
	3+	14	16.9
4	Education		
	Below SSLC	18	20.7
	SSLC Pass	54	62.1
	PUC	11	12.6
	PUC +	04	4.6
5	Length of Service (in years)		
	Less than 5	9	10.3
	5 - 14	22	25.3
	15 - 29	39	44.8
	30 +	17	19.5

One of the major problems faced by the respondents was shortage of housing - only 40 percent of them had housing facility provided by the Government, whereas 23 per cent of ANMs were residing in rented houses in the sub-centre villages. Another 23 percent were in a rented house in the sub-centre village and the rest 37 percent were commuting to their place of work that

required about an hour. Udupi had an excellent net work of public transport with very good road that was found to be a very important factor to improve accessibility to health care services whereas Gulbarga had bad roads or no roads and poor public transport that badly affected easy accessibility. Tumkur can be placed in between these two districts with some area with good roads - Kunigal section whereas Madhugiri was having serious problem of roads and public transport. It would be of interest to mention here that during our visit to observe an ANC camp at a sub-centre village in Gulbarga we had to leave our car at a point and hire a Land Rover jeep to reach the Sub-Centre as the road was full of boulders and ditches which only jeep could negotiate with great difficulty. To cover a distance of 15 kilometers it took an hour at high cost.

Lady Health Visitors have to supervise the work of ANMs. In the study area we could get only 10 LHVs who had to cover on an average 40 villages in addition to their administrative work of compiling service statistics from each ANM on maternity, immunisation, etc. The fact as reported by both LHVs and ANMs is that supervision/work monitoring in the villages has almost ceased to exist. Many senior ANMs recalled that when they joined service they had to cover larger areas – population but they used to enjoy the work. There was a team spirit, co-operation and guidance from M.O and DHO. Work was taken very seriously. The Medical Officers provided home visits to sterilised cases for follow-up services. Deliveries were supervised and post natal care then was good. Now hardly anybody bothers about supervision and monitoring. ANMs feel lonely and helpless in the job as there is neither any help nor guidance and no supervision but if anything goes wrong they will be held responsible. The information collected from ANMs show that exceptionally large number of villages 11 to 18 villages were to be covered by 13 ANMs in Tumkur. Whereas in Udupi and Gulbarga despite vacancies that add burden to ANMs work they were found to be covering about 3 – 4 villages as size of population is large. As over half of the ANMs were natives of the same district they were quite familiar with sociology and culture of the area. While more villages add only to travelling time, size of the population, average number of couples to be served in RCH seem to be well within manageable limits of ANMs with very few exceptions.

The Foundation Course

The female health workers have to complete the foundation course specially designed for them to be eligible for consideration for the job. But some had 2 years training while over 80 percent had completed 18 months course at different District Head Quarters. Surprisingly it was found that there was a long time gap before they got the job. About 20 percent had joined after 3 - 4 years of their completion of the course and they took considerable time to refresh their training skills they had almost forgotten. Indeed, 6 ANMs had joined service after 5 years gap. In addition to the foundation course LHVs have to undergo another 6 months training to become LHV.

They were asked to assess the quality of their foundation training course in terms of (a) Curriculum (b) Duration (c) Regularity of Faculty (d) Quality of training (e) Practical training in hospital and (f) Practical training in the field. Their response was classified in 3 categories. The distribution of responses are reported below.

TABLE 5 : ASSESSMENT OF THE FOUNDATION TRAINING BY THE TRAINEES (PERCENT)

		Good	Fair	Poor	Can't say
1	Curriculum	78.2	15.0	2.3	4.5
2	Duration	34.5	63.2	--	2.3
3	Regularity of Faculty	70.0	25.3	2.3	2.3
4	Quality of training	24.1	64.4	8.0	3.4
5	Practicals in hospital	19.5	57.5	19.5	3.4
6	Practical in field	25.3	59.8	11.5	3.4

It is to be noted that 18 months duration is divided as 12 months theory and 6 months practicals in hospital and field. The majority of ANMs (63.2 percent) considered that duration was too short as they had to complete 10 theory papers. It is also reflected in the assessment of practicals in hospital as 57.5 percent reported that on job training was too short to master the art of good midwifery. Almost 60 percent felt that the field training that forms the most important component of their job was inadequate.

Majority of the ANMs opined that the curriculum is good but heavily biased towards theory whereas most important for their job is field work where they have to manage themselves with midwifery that put heavy responsibility. Communication skills which they need most in their field work was found to be lacking. It seems there is an assumption, that all ANMs have that skill.

During discussion with ANMs we asked how confident they were when they conducted the first delivery of their career. Majority response was they were very shaky. Few were fortunate to have a LHV who was good to instill confidence in them giving guidance in the conduct of delivery that went a long way in building their confidence. But many were not that fortunate but could manage the situation without any serious problem.

How the training received several years back is relevant now? Several respondents mentioned that except midwifery hardly anything is relevant. AIDS, RCH, Target free approach are all new and are relevant now. More skills are required for day-to-day work and in recording them properly in the registers provided.

Section I

In this section we have tried to review the training programmes that respondents have completed and how they perceived their utility in their day-to-day work. The major programme in this regard was the Child Survival and Safe Motherhood training followed by several other short term skill knowledge enhancing programmes.

Child Survival and Safe Motherhood (CSSM) Training

Reduction in maternal and child mortality was highlighted in the National Health Policy 1983. The sustained high levels of immunisation programme that increased contacts of female health workers with women and children demonstrated that about 2million children were saved during 1984-92 (the difference in child mortality rates of 1984-92 which was monitored). It was

followed by Universal Immunisation Programme that envisaged that every child would be protected by all the preventable killer diseases of children.

In order to accelerate the declining trends observed in child mortality 'Child Survival and Safe Motherhood' programme was launched in August 1992. It was fine tuning of the earlier programme with emphasis on quality and outreach. It is very relevant for this study to consider the objectives of CSSM programme and examine the ANM/LHV training impact on their performance. The CSSM had set the following goals:

1. By 1995
   a) Eliminate neonatal tetanus.
   b) Reduction in Measles by 90 percent, deaths by 95 percent.
2. By 2000
   a) Elimination of Poliomyelitis.
   b) Reduction in diarrhoea deaths by 70 percent.
   c) Reduction in ARI deaths by 40 percent.
   d) Reduction in maternal mortality to 2 per 1000 deliveries.
   e) Reduction in IMR to 60 or less per 1000 live births.
   f) Reduction in under 5 mortality to 10 per 1000 children under 5 years of age.
   g) Reduction of perinatal mortality to 35 per 1000 births.

In order to equip the Female Health Workers for the huge programme massive training programmes were launched in the states. An earlier study conducted in Karnataka that covered Channapatna and Hoskote Taluks (all PHCs and Sub centres) found that CSSM training given to ANMs/LHVs had significantly improved their midwifery skills and improved immunisation in the area resulting in reduction in IMR (Kanbargi, 1997).

In the study area only 60 percent of the respondents had undergone CSSM training. The duration of training varied between 3 days to 21 days at different locations where the training was imparted. It was not possible for us to verify the wide ranging duration and the reasons for it. However, most of the

respondents expressed their appreciation for providing training that refreshed their memory. There is hardly any continuing education programme for them. An important fact that came out during the study was how CSSM changed some age old practices that were routinely followed. For instance, babies were given bath soon after birth that often led to complications. The CSSM training has changed it. Now baby is kept warm for a day before giving bath. This practice may reduce considerably the incidence of diseases peculiar to childhood. The training also, as reported by all those trained, enhanced their knowledge on ANC, PNC and midwifery skills many of whom had learnt 20-25 years back. The five cleans or Pancha Shuchitwa was very much valuable learning. Some of the respondents expressed their happiness that CSSM training not only improved their skills but was accompanied by a booklet and a Disposable Dai Kit (DDK). The booklet which should be given to every ANM/LHV as they reported it has proved invaluable for them for all time. (Unfortunately the Research Team could not see the booklet).

The respondents were asked about other skill based short term special training programmes that are imparted. There does not seem to be any systematic approach in organising these training programmes nor there seem to be any compulsion that say those who have put in 20 years of service should have some minimum number of training programmes. As one ANM (very senior) told us that often they do not know that their colleague from other sub-centre had gone for a training programme about which MO had not even informed others. It was only after her return they learnt. This aspect, it is hoped, is covered by other study by Dr Mehta and Dr Shivram.

We had listed 10 important training programmes to check how many of them were attended by the respondents. They were training programme pertaining to Malaria, Cataract, Tuberculosis, Family Planning Target Free Approach, RCH, Leprosy, AIDS, IUD, MPW, MTP and an open ended 'others'. Others category included IPP and continuing education programmes that were of relatively longer duration were appreciated by the respondents. The ANMs opined that the programmes were broad based and more practical. The response and ratings recorded are presented below:

TABLE 6 : TRAINING PROGRAMMES AND THEIR ASSESSMENT

Training	No.of ANMs trained	Percent	Rating		
			Very good	Some what useful	Not useful
Malaria	15	17.2	26.6	60.0	13.3
Cataract	60	69.0	25.0	41.7	33.3
TB	23	26.5	17.4	65.2	17.4
Target free	59	67.8	16.9	59.3	23.8
RCH	37	42.5	32.4	54.1	13.5
Leprosy	67	77.0	19.4	55.2	25.4
AIDS	39	44.8	41.0	35.9	23.1
IUD	18	20.7	61.0	33.3	5.6
MPW	20	23.0	50.0	45.0	5.0
MTP	04	4.6	100.0	-- -	--
Others	45	51.0	46.7	48.9	4.4

The rating and percent trained for different health programmes reveal some interesting facets. Even during our discussion the findings in the table were repeated. Short term programmes particularly one-day training was disliked by most of the respondents. It was reported in all sub-centres that the faculty would arrive, generally, late and by the time the programme starts it is time for lunch and post lunch session - after heavy lunch is not very conducive for learning. The administration might have to confront with several problems in encouraging training courses lasting for at least a week. Given the large number of vacancies in the sub-centres, withdrawing ANMs for training for a week will certainly disrupt the skeletal services that reach the community. Arranging right resource person for the programme, communicating with the trainees etc. do pose hurdles in efficient organisation. However, given the rating of the trainees and assessment of the utility of these programmes it may be more productive to enhance the duration and enforce discipline of the resource persons.

There is also the problem of the size of the trainees. An elderly ANM reported that she was one of the 30 trainees in a programme and was sitting in the back row, hardly could hear what was lectured and instrument to be used

was only one which she could not see at all. By the end of the day she thought she would not have missed anything by not attending it.

A shocking observation which the earlier study (Kanbargi, 1996) had found was substantiated here that only one in five ANMs knows how to insert an IUD. It is widely acknowledged now that Indian Family Planning Programme is synonym with massive female sterlisation as they account for 80-90 percent of all acceptors. The programme managers argue that if women prefer only sterilisation what can be done? This argument is hollow as the eligible women who need contracepting method are not even fully aware of the choice they have. The district level information provided in Table 2 makes it very clear. It is only female sterilisation which is universally known in rural areas. Spacing methods ignored in the family welfare programme need urgent redressal.

Section II

Review of Training Impact : Insights from the Field

This section has tried to review the impact of training programmes on day-to-day practice of the respondents. It is classified as (I) Antenatal care, (ii) Identification of high risk pregnancies - (during Ante-natal care), (iii) Midwifery services and (iv) child care. These are all part of safe motherhood and child survival programme which is being implemented in the state for few years now. As it was revealed that only 60 percent of respondents have undergone CSSM training but interaction among trained and not trained possibly will improve overall performance of all respondents.

Antenatal Care

The antenatal period is of great importance in determining future course of events for an expectant mother. During pregnancy traditional practices are followed despite some modern knowledge. It surely influences the health care seeking behaviour of women and their health status that will have a great bearing on outcome of the pregnancy. One of the most important fact that affect pregnant women's health is the suggested strict diet regime - severe restrictions on food - what to eat and what not to eat. The strong dietary taboos can further

adversely affect the nutritional status of women most of whom are already malnourished. But there are also traditional norms that put restriction on activities that may have some beneficial impact.

The knowledge about conception is widely known to all - pregnancy is recognised by the absence of periods or nausea. If the ANMs are regular in their beat and meet all the potential women they are likely to know that a particular woman has missed her period and if she had a fairly regular cycle guess that she is pregnant. The care should start from registering such women.

The recently completed RCH survey (Kanbargi et.al., 1998) considered at least 3 ANC visits to each pregnant woman during her pregnancy, 2 anti tetanus injection and supplementing nutrition by providing folic-acid tablets for 100 days as minimum package to be ensured to each pregnant woman. The survey found wide variations across districts ranging between 78 percent in Dakshina Kannada - Coorg districts to only 21 percent in Gulbarga. There could be a variety of reasons to be explored. Many researchers have questioned the efficacy of this approach in reducing maternal mortality in the states e.g. a study conducted in Kanakpura rural areas found "ante natal care provided by the government was only "contact service" and are often routine that leaves much to be desired. Weight of most of the women was not recorded, not haemoglobin estimated nor urine test done. This is in marked contrast to services provided by private practioners. Apart from providing tetanus toxide and iron folic acid very little is done in government health care" (Jayashree Ramakrishnan et.al., 1999).

The findings from the present study fully agree with the above observations. The questionnaire had a check list of 14 items like (I) Registering a pregnant woman which should be the beginning of the service and when is it done? When a woman informs about pregnancy or during 3 - 5 months of pregnancy? It was assumed that ANM is supposed to visit the households routinely and during her visit a woman may report that her periods are post-poned or missed. However, the respondents could not distinguish the nuance and the objective behind splitting the question in two parts and it was of not much use in over 50 percent of respondents. (ii) When they start supplying IFA Tablets, (iii) When the Tetanus Toxide injections are given, (iv) When is the blood

pressure measured, (v) When urine test is done, (vi) when is the blood test done, (vii) when is the weight taken, (viii) when is the abdominal examination done, (xi) when is the vaginal examination is done, (x) Whether diet advise is given (xi) Whether advice on breast feeding given (xi) Whether the woman is informed about possible complications in pregnancy (xii) Whether contraceptive advice is given to either post-pone next pregnancy or avoid it and lastly whether need for post-natal check-up is explained? The following chart provides the responses of ANMs/LHVs to these questions.

TABLE 7 : ANTENATAL CARE KNOWLEDGE : PERCENT

Sl No	Check list	Frequency	
		Yes	No
1	Registration	100.0	0
2	IFA tablets	100.0	0
3	TT injection	98.5	1.5
4	BP	92.0	8.0
5	Urine test	96.6	3.4
6	Blood test	93.1	6.9
7	Weight test	96.5	3.5
8	Weight taken	100.0	0
9	Abdominal check	74.7	25.3
10	Diet advised	100.0	0
11	Breast feeding advise	100.0	0
12	Pregnancy complications explained	83.9	16.1
13	Contraception advised	94.3	5.7
14	Post-natal check advised	86.0	14.0

Most of the ANMs were aware of what is ANC and its importance. But they had problems with discharging these responsibilities because of lack of instruments required like BP instruments and stethoscope, chemicals needed for testing urine etc. In addition many ANMs were not sure what is high BP that need attention? Weighing machines were provided to only 10 percent of ANMs. Only one ANM in a sub-centre (Gulbarga) showed me two weighing machines - one for just born babies and other for adults. She had another weighing machine for babies who can be placed in the panel for weighing. But this was an

exception, checking haemoglobin content and RH - ve was not possible even in Community Health Centres and PHCs.

It was clear that the knowledge of ANMs is not fully exploited in providing quality care during pregnancy. To explore further we visited two ANC camps in Gulbarga district - one held in a sub-centre and another at a CHC. The Registers maintained revealed that in CHC about 20 percent of women were examined for blood pressure and taken their weight. It was reported that large crowd about 100-150 women makes it impossible to provide the text book - prescribed services to all pregnant women.

The sub-centre clinic was held in a school - an apology for quality service. There was one table and a chair courtesy the school and the room was partitioned by a thin dirty bed sheet for examining women. Hardly there was any privacy. There was a crowd of 50 - 60 women at noon still waiting for their turn to be examined. The Lady Medical Officer was tired but committed to do her best to the pregnant women who had walked long distances to come here. They had very little choice as the ANM staying in the sub-centre village was hardly equipped with her needs. She had hired a room at the back of the school. she had to collect water from a well and go to field for her natural calls. Her husband was staying in Gulbarga.

We observed that because ANMs have not been provided with required facilities they request the pregnant women to come to a ANC camp held once in a week or once in two weeks. The Sub-Centre we observed held ANC camps every week and serves about 10 near by village women. The camp naturally gets crowded making it difficult to do all required tests for each one. A seasoned medical practioner will take the blood pressure if she has reason to doubt otherwise in such situation no. Maintaining record of blood pressure, weight gain chart that immensely help in identifying high risk pregnancies/babies and planning safe deliveries is not possible. If the ANMs who are trained for ANC and used only for distributing IFA tablets and abdominal check-up it is gross under utilisation of their talents and putting more pressure on limited resources at the Sub-Centre causing great inconvenience to women clients.

The ANC section has two very important questions that are generally ignored. One was whether the expecting mother knows when she is expecting a baby - probable date of delivery. The ANM should be able to suggest the same. We observed 82 out of 87 were aware how to estimate the date of delivery. Another crucial factor is where it will take place? It is crucial because during ANC period there will be clear indication regarding the type of delivery - whether it will be normal or complicated. Depending on the need ANM can suggest the place. If it is going to be a normal delivery certainly can take place at home. If not, the family has to arrange for a hospital delivery including the resources. But surprisingly only two in three ANMs reported that they often suggest to women where they should go for the delivery. But the rest said it is to be decided by the family based on their economic situation. Our broad impression was, as mentioned early, the ANC means 3 visits to pregnant woman, 2TT injections and IFA supply of 3 months. Though it may be considered as minimum needed, much more has to be done to do justice to CSSM programme and improve the situation of women and children.

Identification of High Risk Pregnancies

Identification of high-risk pregnancies is the first and single most important step to be followed by going to a referral hospital fully equipped to provide efficient services to ensure safe delivery.

The responsibilities of the ANMs and LHVs listed in the Training Manual prepared by State Department of Health and Family Welfare under India Population Project (IPP IX) include urine test and blood test of all pregnant women for albumin, sugar and hemoglobin contents during their home visits. It also mentions that at least 50 percent of the deliveries are to be conducted by ANMs and the rest conducted by Trained Dais are to be monitored or supervised by ANMs.

The questionnaire has prepared an exhaustive list of symptoms that indicate high- risk pregnancies. Each ANM was asked whether they know what constitute risk to pregnant woman. The list prepared included risks related to last pregnancy termination, history of systemic illness. reported complaints during

pregnancy in addition to the generally known factors like first birth or higher order births, height of the woman, status of blood pressure, etc.

The knowledge reported in the following tables is based on combined responses - some spontaneous and others received after a little probing The responses are presented in two formats for the convenience and understanding of the reader.

TABLE 8 : IDENTIFICATION OF HIGH RISK PREGNANCIES

Sl No	Symptoms	Aware (percent)	Not aware percent
1	Age less than 18 and over 35 years	88.5	11.5
2	1st or 4th and higher order births	74.7	25.3
3	Current pregnancy within two years of previous	62.1	37.9
4	Height less than 4'. 10"	81.6	18.4
5	Abnormal weight gain – over 10 kg. Weight gained during pregnancy	52.9	47.1
6	Sustained high blood pressure over 140/90	50.6	49.4
7	Poor weight gain 5 – 6 kg only	48.3	51.7
8	Mal presentation of foetus	78.0	22.0
9	Weak or no movement of foetus	54.0	46.0
10	Convulsions in pregnancy	70.0	30.0

It may be mentioned here that many ANMs in Tumkur District reported that for this interview they had spent two sleepless nights to go through their notes/books of training period to refresh their memory like they used to prepare for their theory examination. However, the information provided in Table 8 and 9 is disappointing picture. It was the respondents in 50+ age who had more problems in responding as they frequently said "we have forgotten many things taught long back". There were two respondents who were deaf and posed problems for communicating effectively.

It may be noted here that most of the respondents knew that short women constitute high risk during their pregnancy but they could not define what is short? Similarly they knew that sustained high blood pressure during pregnancy carry high risks but did not know exactly what is high blood pressure. As

mentioned earlier most ANMs do not possess the instrument and those few who had it, was not in working condition.

TABLE 9 : IDENTIFICATION OF HIGH RISK PREGNANCIES

Sl. No.	History of last pregnancy	Aware Percent	Not Aware Percent
1	i) Last pregnancy terminated as		
	a) Abortion	64.4	35.6
	b) Still birth	57.5	42.5
	c) Premature birth	55.1	44.9
	ii) In complicated delivery with prolonged labour ended with		
	a) Retained placenta	55.1	44.9
	b) Sepsis	60.9	39.1
	c) In neonatal death	16.1	71.3
2	Systemic illness		
	(i) Heart disease	71.3	28.7
	(ii) Diabetics	77.0	23.0
	(iii) TB	57.0	43.0
	(iv) Hyper tension	83.0	17.0
3	Woman complains of		
	(i) Breathlessness	32.2	67.8
	(ii) Excessive tiredness	44.8	55.2
	(iii) Palpation	48.3	51.7
	(iv) Puffiness of face	35.6	64.4
	(v) Tightening of ring/bangles/chappals	62.1	37.9
	(vi) Vaginal bleeding	52.9	46.9
	(vii) Pain in abdomen	36.8	63.2
	(viii) Fevers	18.4	81.6

The responses presented in tables 8 and 9 reveal inadequate knowledge about identification of high risk pregnancies among the ANMs. The focus group discussion clearly brought out the problem of ensuring safe deliveries even in cases of identified high risk pregnancies as the required facilities were not

available even at Community Health Centres supposed to be first referral centres.

An example of a maternal death reported in one PHC area would explain the situation on ground level. The woman who delivered a baby with the help of a trained Dai and developed complications on third day. She was bleeding. The PHC kept her for a day with medication. The bleeding did not stop and she was advised to go to District hospital in the night. The family could not arrange transport and resources. Instead they took her home and she died next day. Some enquiry was conducted and the case was hushed up.

The data collected on ANC services and ability to identify high-risk pregnancies reveal that there is a long way to go to achieve effective reduction in maternal mortality and infant mortality. As noted earlier ANC means three visits to pregnant woman, 2TT injections and 100 IFA tablets. Even this minimum package of services have made considerable impact in bringing down IMR in the state, further decline depends upon improving the services of ANMs, infrastructures of PHCs and CHCs to reach the goal of IMR 30 mentioned in the policy statement of 2000.

Institutional Births

Institutional deliveries are meant to provide safe motherhood and the resultant significant reduction in maternal deaths. Wide variations were observed in them in the selected districts - from about 79 percent in Dakshina Kannada to only 21 percent in Gulbarga. ANMs in Udupi reported that many of them have not conducted a single delivery during last five years because women prefer to go to maternity homes or Government hospitals at District level. The private sector health services in Udupi - particularly the Manipal Hospital have expanded their maternity services to rural areas that has almost ensured safe delivery to any woman - poor or rich. Our visit to a remote place in Udupi where we had to cross a river to reach the village revealed that just a telephone call to the Manipal Hospitals maternity home situated at a distance of 14 kilometers will provide them not only free delivery but also free ambulance service to transport the pregnant woman to the hospital. The public-private co-operation observed in the

district is really remarkable to try in other poor districts like Gulbarga or Bellary that can improve accessibility to good care and go a long way in ameliorating the sufferings of poor women.

As a contrast to Udupi ANMs who have not conducted a single home delivery during last five years, committed ANM in Gulbarga where there is hardly any choice for most rural women reported that she conducted 120 deliveries this year of which 20 were high risk whom she referred to CHC and ensured safe births. Another ANM reported to have conducted 94 out of 99 births in her areas this year - 5 being conducted by a trained dai. These two ANMs stay in the sub-centre quarter and a visit there will convince that they were model sub-centres. The two ANMs were residents there, available any time for service, had BP instrument, weighing machines for babies and adults, providing good ANC by testing urine, keeping records of weight to know the gain, recording BP of all women and ensuring the pregnant woman at least one check-up by a lady medical officer to confirm that every thing is OK with all her clients. The outreach programme might have conceptualised such sub-centres as models. But they are exceptions now as ANMs having no housing facilities stay in a place where she can get a house on rent and naturally night deliveries can not be attended by her.

Identification of High Risk Babies (Who weighed less than 2500 gms at the time of Birth)

The data collected in Reproductive and Child Health (RCH Phase 1) survey in the selected three districts revealed that only about 7 percent of babies born in rural areas in Gulbarga district were weighed after birth and 58.3 percent of them were under weight (less than 2500 gms). On the other hand in Udupi (Dakshina Kannada) 62 percent babies born were weighed and only 13 percent of them were under weight and in Tumkur about 28 percent of babies' weight was recorded and 20 percent of them were reported weighing less than 2500 gms. These findings present a grim picture for Gulbarga and also to some extent Tumkur that certainly fare better than Gulbarga for underweight babies who carry high risk of death. Though one of the simple measure to reduce this incidence of

low weight babies is to improve the nutritional level of the mother by supplementing her diet and providing IFA tablets, the ANMs should have knowledge of the under nourished mother and the need to supply IFA tablets to them in their area.

The RCH survey reports that in Gulbarga where the proportion of low birth weight babies is highest in the study area only 48 percent of pregnant women had received IFA tablets, it was 87 percent in Tumkur and 92.3 percent in Udupi (Dakshina Kannada). It is difficult to understand why this simple low cost remedy available is not taken seriously in Gulbarga where it is absolutely essential.

It would be interesting to note here our observations and the community perceptions about how these essential services are delivered by ANMs.

Our interaction with community leaders and women in particular provided surprising data. We met a Lady Panchayat Chairman in Gulbarga who was in her late forties, literate and was having concern for women's issues including their health. She said that the ANM stays in the village (only village she is to serve as it is quite large with 3500+ population), has a telephone at home and also keep some essential drugs for emergency. She conducts most of the deliveries in the village by charging anywhere between Rs.300 - 1000 depending upon the economic status of the family. But she never visits any home for providing services. People have to call her on phone or meet her personally if they require any service - of course at a price. The Lady Panchayat Chairperson did not know that ANM is supposed to visit all families in her jurisdiction to enquire the welfare of women, their pregnancies, children health etc. Even her husband and many others who gathered there during our focus group discussion reported ignorance and said the panchayat will issue a letter to the Medical Officer in this regard soon to ensure her services to all homes in the village. It would not be surprising in such situation that poor and scheduled caste women may not be able to avail her services free.

This was not an exceptional example in Gulbarga. In three more sub-centre areas we observed similar things. Absence of good roads and transport facility may be important hurdles to ANMs in addition to inadequate housing

facilities. But administration both in the health department and at Zilla Parishad should try to improve the situation to ensure accessibility to health care for all. Rarely, except in one we could see a chart showing ANMs' travel programme for the week usually displayed in all PHCs. It was also surprising that many ANMs/LHVs in Gulbarga were not found wearing uniform white saree during working hours. But in Tumkur and Udupi we did not see any ANM/LHV not in the uniforms.

However, an effort was made to know respondents' abilities to identify high risk new born babies (who weigh less than 2500 gms) by check-listing some symptoms.

TABLE 10 : IDENTIFYING HIGH RISK NEW BORN BABIES (WEIGHING LESS THAN 2500 gms)

Symptoms	Aware (percent)
Refusal of feed	78.2
Increased drowsiness	56.3
Difficult breathing	75.0
Cold to touch	55.0
Yellow staining of skin	62.0
Convulsions	26.4
Others	14.9

The data presented in Table 10 reveal that there is much to be desired. However, some ANMs were aware that if the baby is cold, they would keep it under 200 watt electric bulb to improve the body temperature of the baby.

Acute Respiratory Infection (ARI)

Only about half (52 percent) of the ANMs were aware about Acute Respiratory disease and 85 percent of them had knowledge of at least one symptom of ARI and also were aware that it is an important reason for high IMR.

Pneumonia

Most of the ANMs (91 percent) were aware about pneumonia and more than half of them knew one or more symptoms of pneumonia like excessive drowsiness, respiratory grunting, convulsion and inability to drink.

Diarrhoea and Dysentry

Diarrhoea, a major killer of infants and its symptoms like passage of watery stools 3 – 4 times a day was known to 92 percent of ANMs. However, there was confusion among many in distinguishing diarrhoea from dysentry which has symptoms like blood in faeces, abdominal cramps, fever and weight loss. Only one in five respondents were aware that diarrhoea/dysentry is a major killer of infants. All respondents were aware (100 pr cent) of dehydration that follows dysentry/diarrhoea and could mention all the symptoms like restlessness, decreased skin turgor, dry mouth-tongue, sunken eyes and lethargic appearance of the baby. Management of dehydration through measures such as giving ORS or home made syrup of sugar and salt, plenty of fluids, and continue breast feeding was known to all respondents.

The strong emphasis given to the child immunisation was reflected in every respondent knowing what immunisation is to be given when. Liquid IFA, however, to be given to malnourished babies was known to only one in four, perhaps it is not supplied in the state. It was reported that children are given small IFA tablets.

Knowledge about Cold Chain

While immunisation coverage has shown remarkable improvement over time, quality of immunisation has remained a question to be answered. Is cold chain maintained to ensure the required vaccine potency? We wanted to test whether personnel who play a key role in immunising children know about cold chain?

It was revealing experience for the research team which visited a Primary Health Centre in Gulbarga district. It seems a diary is to be maintained and the temperature shown on the thermometer of the new type refrigerator in the PHC

where vaccine is stored is to be recorded by the Medical Officer. We were surprised the recording in the diary was up to date with recorded temperature, date and signature of the Medical officer but the thermometer that indicates temperature was not working for several days and not repaired. It was also clear from the observation of the diary that all the entries for the month were made the previous day. Neither the staff nor the clients who receive were aware of the importance of maintaining cold chain to ensure effective immunisation.

Compare this with what was reported by almost all respondents in Udupi. They said that the immunisation day for them will become a nightmare if power in the area was shutdown even for half an hour as mothers would object for immunising their children as there was power shut down yesterday as such what guarantee is there of the vaccine potency? With all the explanation by the ANMs about the advantages of new freezers that they have, some mothers would still prefer to go to private practitioners for immunisation. These observations, though accidental, reveal the casual approach adopted by qualified responsible authority whom the illiterate and ignorant community trusts and it deserves serious consideration in the department to ensure that there is responsible approach to immunisation. Under the circumstances it was not surprising that about 40 percent of respondents expressed their ignorance about the required temperature to maintain the vaccine potency.

Infant Feeding

There was a question to check the respondents' knowledge on exclusive breast-feeding. What does it mean? How long a baby should be exclusively breast-fed? Response of all the respondents was that babies should be breast-fed for 3 months. They also knew the advantages that exclusive breast-feeding provides more nutrition (90 percent), protects against infections (87 percent) but only 46 percent knew about its contraceptive effect. The RCH survey 1998 found that in Gulbarga babies being breast fed within two hours of birth accounted for only 9.5 percent while it was 36 percent in Tumkur and 47 percent in Dakshina Kannada District. Continuously repeated advantages of cholostrum milk that provides effective immunisation to babies is almost denied in Gulbarga. The

general opinion of ANMs was their advice during ANC and delivery does not make much sense against the strong traditional beliefs that still govern the community behaviour.

Weaning

We also enquired whether the respondents are aware about weaning? And when to start it? Each ANM reported that breast milk will be inadequate to babies growth after three months and babies will have to be introduced to some other semi solid foods like `Ragi Sari', `Rice Ganji', `Bele kattu or liqufied pulses' etc. which can be prepared at home with locally available food. Few of them reported that they also suggest to mothers to go for baby food available in the market. More than 70 percent of ANMs in Udupi reported that weaning food also can be purchased from market.

While the latest WHO recommendation is that exclusive breast milk should continue for 6 months and only afterwards weaning foods be introduced, all available evidence in Karnataka show that there is need to improve the understanding of mothers in rural areas about the advantages of cholostrum milk and exclusive breast feeding. Surveys have reported wide spread practice of squeezing cholostrum milk and feeding just born babies with variety of liquids like sugar syrup and castor oil with enormous health hazards. The respondents reported that during Mother's Club meetings as well as during ANC they explain all the advantages of breast-feeding including cholostrum milk however, the outcomes are poor. In this regard there is need to consider for vigorous campaign and improved IEC programme. Several babies, we saw in ANC camps in Gulbarga and Tumkur convinced about the poor health status of surviving children. They were looking thin with sunken eyes. It is possible that under-nourished mothers even though supplied IFA tablets were not regularly consuming them to derive the benefits.

General Knowledge

We perceived ANMs/LHVs as backbone of rural health delivery system. They are the link between the vast rural illiterate women and modern health care

providing PHCs. They are expected to visit every household in their area and are familiar with each of the household that make them not only a health worker but a friend, philosopher and guide to those women. During their visit they may conduct mothers' meeting to provide them important information on their own or have to answer some questions raised by their clients. Therefore their knowledge and advice carries great impact as such this study attempted to assess how familiar they are with the population problem - particularly whether they knew that India's population has crossed 100 crore mark. We asked what is India's population and gave three hints – 50 crore, 150 crore and 100 crore. Only 46 percent of them could say it is 100 crore.

It was noted earlier about the low age at marriage of females and its consequences on IMR, MMR and also fertility levels. Marriages before a girl attains 18 years of age are legally prohibited. But its impact is negligible on the marriage age. Only 79 percent of respondents were aware of legally approved age at marriage of boys and girls. One in five respondents were not aware themselves and they may not have discussed about it in the meetings of mothers. If female age at marriage continues to rise as slowly as is observed despite all efforts then what are the options left to policy makers to reduce its consequences? Or should this area be left as nothing can be done as it is parents of the bride and groom who decide the marriage and who are not bothered about the age? Marriage is certainly a complex social and economic issue. Good harvests see more marriages in any village and droughts few or no marriage and difficult to bring interventions to drastically change the pattern.

In this situation female health workers can play a very important role of motivating the young married couples to postpone the first birth by a couple of years or till the young woman attains 20 years. The focus group discussion revealed that talk about contraception will begin only after the couple has one or two children and intensive efforts begin only after 2 children. It is obvious that if sterilisation is considered as the only suitable method for the couple by the ANM, there is no alternative. But can they not advise them to use condoms or safe period or even least harmful orals that are available in the market? They are not trained to motivate couples for adopting spacing methods.

The focus group discussions also brought out some interesting problems ANMs face in the field. It was reported that the distribution of IFA tablets to pregnant woman generally starts in fifth month of pregnancy. If given soon after registration of pregnancy of the woman and the pregnancy is terminated in abortion women hold the ANM responsible for it. Because it is she who supplied IFA tablets saying that her health will improve and on the contrary she had abortion. Such news spread very fast in villages the whole village may turn out hostile and ask her not to give those tablets to any pregnant woman in their village. Similarly motivating for contraception is confronted with the problem of child survival. If the only son among the two the couple has, dies, ANM will not be forgiven for motivating them to accept sterilisation. So to play safe they said it is better a couple should have two sons and a daughter before undergoing tubectomy. It is not surprising that NFHS II found 90 percent of sterilised women had not adopted any other contraceptive method before. Distribution of Pill and Condom through public sector, therefore, constitute insignificant proportion in rural Karnataka.

This background is aptly reflected in the responses of ANMs/LHVs as 18 percent of them could not say what is safe period and explain it correctly. But 95 percent could explain what tubectomy is and how it is performed because they reported that they explain it to all potential acceptors.

Medical Termination of Pregnancy

Abortions were legalised in India in early 1970s and the number of legal abortions have increased significantly over the time as also approved places for conducting abortions. But rural women are deprived of this facility as most of the PHCs in the study area do not have the equipment or person/approved by the government to provide abortion facility to women. None of the ANMs are trained to conduct MTP and when we asked them when would they recommend MTP to women? It was disappointing that none of them had suggested any woman to go for an abortion. Looking at the clandestine abortions reported and observed by the hospital records showing sepsis/infections caused by quacks while aborting and admitted to hospitals in serious conditions, there is need to examine what

ANMs can do in rural areas. While ANMs took a moral stand and their response was very firm in reporting that they neither perform nor recommend MTP to any woman that does not reflect reality.

The job responsibilities listed by the Department of Health and Family Welfare 1999 clearly has mentioned that ANMs should identify women in need of MTP and inform them the nearest approved place for MTP to obtain an MTP. We think there is an urgent need for a debate on the issue of providing this facility to rural needy women.

The Eligible Couple Register

Eligible Couple Register the Female Health Workers are supposed to maintain and keep it up to date with all relevant information. It is a valuable document that guides in her work. It has all information she needs - how many currently married women are there by contracepting status and number of children, helps in identifying children is need of immunisation, and women in need of advice on nutrition, etc. A general complaint emerged in all our meetings was the shortage of EC Registers - some places not supplied for 7 - 8 years and ANMs have to purchase a Note pad and record the information to the best of their abilities. Non-supply or irregular supply certainly creates serious problem in compiling service statistics from Sub-Centre.

We wanted to learn from ANMs whether still they feel EC Register serves an important purpose and help them. There was a unanimous response that it is important and they should be supplied EC Register so that they will be able to improve their performance.

Mothers Meeting

The respondents also informed that they routinely conduct mothers' meetings and discuss different health issues and about nutrition. They think that these meetings will become more effective if the ANMs are provided with educational materials for use during the meeting to make the meetings more productive.

Advise to Adolescents

The needs of the adolescent girls that were ignored for long is getting attention now. There are special programmes designed for their benefit to improve their knowledge about personal hygiene and health. There were few reports of providing Tetanus Toxide injection to these adolescent girls. What was interesting to learn from many ANMs was that often in mothers meeting some adolescent girls also participate and when the topic of contraception / pregnancy is to be discussed they are asked to go out as they need not learn about contraception because educating these unmarried girls in Family Planning methods because of the fear of using them before marriage. Given the sea change that is being realised through recent research on changing sexuality in the society and the AIDS threat becoming more and more serious there is need to think about what should be the policy for these girls. Most of whom are illiterate and ignorant of many vital issues concerned with their own person. If they are educated about contraception will that enchance its use after they get married?

Summary and Conclusions

The short term intensive study was carried out in three districts of Karnataka State that widely differ in health and demographic indicators. The main objective of the study was to assess the various training programmes the grass root level female health workers (ANMs/LHVs) have undergone, extent of their utilisation by them in their day-to-day work. The study went beyond the stated main objectives to examine whether providing training per se will improve health care services as its effective exploitation is related with a host of other factors like infrastructure, equipment and team spirit at PHC level from where these services are organised, supervised and monitored.

The focus of the study was confined to those training programmes that were designed to improve the health status of women and children – more specifically in reducing further IMR and MMR. For this intensive study selected 3 districts – Udupi, Tumkur and Gulbarga. From these three districts 8 Taluks and 22 Primary Health Centres were selected. All Female Health Workers

(ANMs/LHVs) numbering 87 of these centres were administered a standard questionnaire that was specially constructed to check their skills required in their work. The 87 respondents were covering a population of 2, 61, 155.

All respondents had successfully completed the foundation course - 18 months and few had 2 years training programme. The gap between the completion of course and joining the service for many was large and few exceptional cases it was 4 – 5 years.

The general impression of the respondents regarding their training that some had completed 30 years back was that there was inadequate attention to practical hospital training and training in field work. An indication of this was the reported `shaking of hands' during the first delivery conducted by most of them. There were one-or-two exception to this general observation. An ANM in Gulbarga mentioned she had the best opportunity of conducting 24 deliveries during her training period under the able supervision and guidance of a gynecologist. It was suggested that training programmes should be need-based and practical in real life situation and not just lecturing with lot of information.

There was long gap between Foundation course and the next most important training programme related to maternal and child health viz. CSSM training. The findings show that still 40 percent of ANMs have to undergo this programme that has great relevance to reduce further IMR and MMR.

It was shocking to find that most of the ANMs are not trained to insert IUD. Policy studies have repeatedly highlighted the urgent need to enhance use of spacing methods particularly among rural women, as it will have direct good impact on the health of women and children. This needs serious attention.

Similarly ANMs/LHVs need to be more sympathetic to women's need for Abortion. Whether they can be trained to perform medical termination of pregnancies is a technical question to be decided by experts, we strongly recommend that at least MTP service be made available at PHC level and ANMs/LHVs should be trained in the legal aspect of MTP and when they can recommend it to needy women.

In addition to CSSM, a host of training programmes have been conducted for the respondents. A general observation is that the short term training

programmes of one or two days have been rated as not very satisfactory by the respondents. There was a strong suggestion of all respondents in Tumkur and Gulbarga that Continuing Education programme for a week should be a regular feature to update their skills and knowledge of maternity and child health. This programme should be holistic and may cover other relevant contemporary health problems in the state / district.

Identifying high risk Pregnancies

The findings suggest that there is a need to have as suggested above, one week Continuing Education programme to enhance the knowledge and skills of ANMs/LHVs of pregnancy management. Except in Udupi/Dakshina Kannada and Kodagu districts where Institutional deliveries have become a rule in all other districts where domiciliary deliveries dominate. the improvement of the knowledge of ANMs with intensive training should be given serious attention. ANMs/LHVs must have knowledge of measuring blood pressure, testing urine for albumin and sugar and keeping these records for all pregnant women. These services should be provided to women in their homes by ANMs in addition to TT injections and IFA tablets. It should be followed by blood test of each woman for haemoglobin content at PHC level. It may be noted that we had trained Field Investigators of NFHS II Survey to measure haemoglobin of all women in the sample at their home in each village. It was possible because very simple to use technology was made available from USAID. It should not be difficult to obtain this technology by the state government for use of ANMs/LHVs. The time taken for the test is very little-just 1 minute per woman at their door step. Unless minimum package of services are ensured to all pregnant women and each high risk pregnancy is identified and taken to nearest referal unit for safe delivery, MMR will continue to be very high.

Identifying high risk babies also needs serious attention. Knowledge of Acute Respiratory Infection is very poor among the respondents. NFHS II reports that about 34 percent of children were suffering from ARI in Karnataka indicating the serious nature of the illness and its consequences. The present study found that ANMs were confused when asked to distinguish between the

symptoms of diarrhea and dysentery. As 15 per cent of children in the state were found to be suffering from these illness improving the knowledge of ANMs and LHVs in identification of these illness and ARI is to be given immediate attention. It was, however, satisfying that Oral Rehydration Therapy (ORT) is universally known not only to ANMs but also to mothers.

Immunisation coverage in the state has shown gradual improvement as revealed in the service statistics. We came across a report in Gulbarga that a baby afflicted by polio in a village was living next door to the sub-centre. Looking at the crowd in Immunisation Centres with several agencies participating, a child may miss immunisation. ANMs were found to be well versed with immunisation process and were confident that all children in their area are protected. While in Udupi Rotary, Lions, Womens Organisations, College Students and many enlightened women participated in pulse polio in a big way even in rural areas such support in Tumkur and Gulbarga was more concentrated only in District towns.

Respondent's knowledge about benefits of exclusive breast feeding and weaning was appreciably good and needs periodic updating. Their understanding of India's population and legally approved age at marriage for males and females was found poor that needs to be up-dated.

The most glaring lacunae reported by ANMs and LHVs in their training is lack of communication skills and inadequate attention to it in any of their training. Simple observation is that to combat with strong traditional practices having serious adverse impact on women and children like squeezing of cholostrum milk needs intensive campaign. It would be effective only when ANMs can play an important important role. Similarly introduction of spacing methods to young married couples would be facilitated greatly if ANMs are properly trained to convince the young village couple of its advantages.

Most crucial issue to be considered here is that training, upgrading skills and information becomes inevitable to improve overall health status measured in several ways. The goals set in the health sector can be achieved when such relevant training programmes bring in qualitative changes in the services provided to clients. If all that is told in training programme is difficult to put in

practice because of lack or absence of infrastructure, equipment and other supplies the purpose of training cannot be served.

It was observed that vast expansion of health care services - personnel during the decade is not followed by adequate care and required resources. The quick expansion perhaps created a problem of finding professionally trained personnel. A look at the staff position at district level is surprising if not shocking. If health care service delivery is ensured with or without these large number of vacancies, it is in itself an indicator of quality care.

At policy level, it is desirable to think of a district or a group of districts for intervention. For example in Gulbarga and Tumkur and such other districts there is need for greater attention to improve the management of pregnancies and their outcomes which may need more resources like improving PHC/Sub-Centre infrastructure, equipment to ANMs such as BP instrument, chemicals to test urine, haemoglobin/blood test etc. Where as in Udupi, Dakshina Kannada, Coorg with good adequate support from private sector this problem is not there. But AIDS is looming large in these districts with large out migration of males and females. We heard reports of AIDS deaths caused in every village we visited with documentary evidence. All the deaths had occurred to the return migrants and it seemed as if they all came home only to die.

At state level there is a uniform policy of resource allocation for health sector. If some districts perform poor as indicated by several indicators it would be necessary to ensure that administration in these districts are pulled up. The poor perception of people regarding the public health care system in health poor districts needs serious attention. Precious public resources deserve more productive use. The backward nature of some districts is known for long for over four decades and these districts have remained at the bottom even now. Unless some fundamental change is brought in the administration for improvement they will continue to be at the bottom.

Nayak Committee recommended that PRIs should have powers of transferring group 'C' and 'D' employees, the State government is yet to accept it.

The Present Study

In this background of one step forward and two steps backward policies persued during the last two decades the present study has attempted to examine the working of Public Health Care System under the contemporary Panchayat Raj System in Karnataka.

Objectives

The main objectives of the study are :

1) To identify areas of confrontation/friction between elected representatives and the officials of health departments at district level and below and identify the underlying causes as attitudinal, legal, procedural and others.
2) To examine the legal procedural factors that need modification for smooth effective functioning of PRIs and health functionaries.
3) To study the disparities in health indicators across the districts and across social class within the districts and how PRIs intervention can reduce them.
4) To study the delivary of public health care services, identify best practices followed that can be replicated in the state to improve the outreach services.

Data and Methodology

Considering the limited time and resources it was decided that the study would confine to three districts of the state. The required data was collected from various elected representatives at district, taluk and gram panchayat levels, from health staff working at various levels like District Health Officer, Taluk Medical Officer Medical Officer at PHCs, PHUs, CHCs, Para medical staff, staff dealing with administrative work and most importantly the general public from 31 villages randomly selected. It was focus group discussion on various issues that provided valuable insights for the study. The general public, however, was

administered a questionnaire to understand the extent of their participation in PRIs and their understanding of quality of health care services delivared

At the outset we met the members of the Karnataka Government Medical Officers Association – a strong body of over 500 medical officers as its members. The discussion revolved around various issues confronting them in general like the reported corruption in the department – particularly charges against the medical officers, their perception of decentralised governance and its pros-cons on their functioning and the contemporary service conditions.

Emerging Issues : Confrontation

The prolonged discussion with the office bearers at the state brought out the issue of working under decentralised system of governance and their strong resistance to it. It was also revealed that in the current situation all the medical officers would not aspire for the post of District Health Officer as compared to the earlier days when there was a rush to hold the coveted post that carry not only enormous responsibilities but also a high status – equivalent to any other district level high officials like Deputy Commissioner. Today he is at the receiving end only – ZP will hold him responsible for every thing that may go wrong like a cholera cases, malaria cases detection in his area which rightly cannot be considered as his responsibility only. It is concerned with water supply or supply of DDT for spraying that cuts across the departments.

The health department officials also are harassed by the elected representatives as revealed by the Association of office bearers. It was told that DHO has left with little time to attend to his enormous responsibilities because of several meetings he has to attend during a month (at least 6 statutory) and there are visits from Ministers that need DHOs presence and there is hardly any time left for his work that results in poor supervision and monitoring the health programmes in the district. In addition, the elected representatives who are drawn from different socio-economic background and new to their work do not know how to conduct themselves with the bureaucrats who expect respect – regard from every one. The Association expressed strong reservation about the

way Medical Officers are treated by the elected representatives and reported that it was most inappropriate.

In addition to the above mentioned confrontations the Association was more disturbed with the way promotions were given, how a very junior medical officer became his senior boss because he possessed a Diploma / Degree in Public Health. Their view was that public health and its intricacies can be learnt by any medical officer through his experience and he may perform better than a person who possesses the degree/diploma in public health. It is not very relevant for this study to deal with this issue in detail as the ZPs or TPs are not authorised to deal with such issues which lies with the State government. It was clear from the above discussion that the strong resistance to work under PRI by the Karnataka Government Medical Officers Association was not on any ideological or legal – structural issue but based more on their stray – scattered experience with some elected representatives. The meeting, however, provided valuable insights for conducting the study.

The Study Area

The study was to be confined to three districts but another district was added to it based on the reported problems of confrontation between health bureaucracy and ZP there. The three districts were selected on the achievements in health sector. Udupi – a newly carved district is much ahead of most of the districts in the state in terms of education particularly female education, health and also other development indicators. Tumkur is situated in the middle level and Gulbarga district is still a backward district (Table 1).

Table 1 provides valuable insights in the existing disparities in the selected districts in terms of health and education. Udupi is an advanced district, whereas Gulbarga has retained its backward status during last five decades of reorganisation of States. Tumkur has performed better than Gulbarga but is poorer compared to Udupi. Thus the findings from this study would present a representative picture of the state.

Table 1 : Development Indicators in the Selected Districts

District/ State	Crude Birth Rate 1999	Percent women contra-cepting	Percent safe deliveries	Crude Death Rates 1990-91	Percent females literates 1996	Percent children aged 12-36 months immunised fully	Per capita income 1995-96 (Rs.)
	1	2	3	4	5	6	7
Udupi	19.7	63.7	91.5	7.0	78.5	86.0	2632
Tumkur	24.1	61.3	63.5	8.2	51.1	88.0	2047
Gulbarga	30.1	39.2	47.7	10.7	30.9	25.3	2431
State	22.5	58.1	68.2	8.5	52.7	70.5	2558

Source: 1,2,3 and 6. RCH Survey 1998 (Phase 1)

4,5 & 7. Human Development Report (Karnataka) 1999, p.78, 255, 212.

The presentation of the report will be in four sections. The first section would present the health status of people and highlight the observed disparities by social class and caste. The second part would discuss, given these disparities, what the PRIs can do to improve the situation and the third part would present the findings of the data collected from the PRI visits followed by summary of the findings and recommendations.

Section I

Health status of a population is determined by several factors including health care services. It is closely associated with genetic, social, economic, cultural and political factors. Although interaction among these factors is multidirectional and complex, it is increasingly being realised that an integrated approach to development would minimise conflicts and undesirable side effects of sectoral approach. But what should be the critical mix of these interventions to obtain the desired results is not very clear and planning in most of the countries and at states within the country is still dominated by sectoral approach. The significance of health care services is that they can reduce pain, sufferings and deaths many of which could have been minimised by an integrated approach to

development. The health care services have to ensure quality at an affordable cost to the population. There are differentials in access to health care services in India and also in the State of Karnataka by urban / rural residence Good health care services are concentrated in urban areas and do provide a choice to people – either avail public health care services – which are also relatively better in urban areas as compared to rural, or and also avail private health care services that are more concentrated in urban areas. Residents in rural areas have to increasingly depend on public health care services particularly deprived sections like Scheduled Caste and Scheduled Tribe population or those living in remote inaccessible areas where either private services are not existing or scarcely available. If public health care services are not easily accessible it will have more adverse impact on rural poor particularly the SC/ST population.

In order to improve the accessibility to public health care services the Central and State governments have been trying to expand these services hoping that all sections in rural areas are benefited from them. As a result it is observed that during 1960-61 on an average a Primary Health Centre (PHC) served 81,000 population whereas at present (1996-97) a PHC serves only about 21,500 persons. Similarly a female health worker (ANM) was serving about 8000 persons during 1980-81 while in 1996-97 she is serving only about half of that population. These public health care services are supposed to be free and therefore the poorer sections who may find private health care relatively expensive may use them more than the affluent rural population. Particularly the women belonging to SC/ST may benefit from the free care provided by the government. But intensive research studies carried out in the state present a different picture which is very disturbing.

It would be in order to note how the public health care services are delivared before presenting the observed disparities reported in the research studies. Looking at the disproportionately high mortality and morbidity among women and children at national and state level delivary of services are concentrated on women and children. The grassroot female health worker popularly known as ANM provides these basic services. In order to make child

births safe she is trained to provide antenatal care at the home of the pregnant women in her area that has about 4000 population. On an average there are 165 – 170 eligible couples per 1000 population. She has about 500 – 600 eligible women some of whom need this service. The ANC package includes a list of services that she is supposed to provide to every pregnant woman to ensure safe delivery, survival of woman and her baby. The following table provides some insights into how these services widely differ among the community by caste, economic status, education of the woman and by rural/urban residence in 10 districts of Karnataka.

Table 2 : Access to Antenatal Care by Social and Economic Background of Women in 10 Districts of Karnataka 1998

Sl No	Type of service	Residence		Caste		Education		Type of H	
		Rural	Urban	SC/ST	Others	[illegible]	SSLC +	Kuchha	Pu
1)	No ANC	12.9	5.6	17.0	8.9	18.9	0.6	22.6	
2)	First ANC visit during								
	a) First Trimester	52.6	72.0	48.5	62.0	42.7	84.1	37.9	
	b) Second Trimester	28.9	20.1	29.4	25.1	31.7	14.5	32.4	15.
	c) Third Trimester	5.6	2.3	5.1	4.0	6.8	0.8	7.1	1
3)	All 3+ ANC visits	74.0	88.0	68.7	81.0	65.3	95.9	58.9	
	Percent women								
4)	Whose weight was taken	41.7	77.5	37.1	56.1	32.9	58.7	23.5	80.
5)	Whose B/P was recorded	57.2	86.3	49.8	70.3	46.3	78.0	39.7	9
6)	Who were given IFA tablets	72.5	72.5	66.9	75.2	65.9	77.7	61.1	7
7)	Who were given 2TT injections	65.0	78.7	58.9	72.3	56.5	75.0	49.0	
8)	Whose abdominal check-up was done	72.2	91.9	74.4	84.2	69.7	97.4	65.3	9
	Total No.of women	2222	896	772	1811	1571	692	685	61

The data clearly brings out the differential access to the public health care services in the State. It is the Scheduled Caste women, illiterate and those who

live in kuchha house, in other words 'poor' are relatively more deprived of these essential services. Though we do not have data on infant mortality and maternal mortality the NFHS II reports very high IMR in rural Karnataka areas for SC/St and illiterate women.

The information on place of delivery also reveal differentials by caste. While for the state as a whole RCH First Phase reported 52.4 percent institutional deliveries it was only 42.4 percent in rural areas while it was 77.3 percent in urban areas. Among Scheduled Caste women only one in 3 deliveries were in an institution whereas it was 57 percent among others. Out of those who lived in kuchha houses only 29.6 percent were able to go for delivery to a health facility while those better of 81.7 percent delivered in a health facility. It is worth noting that the home deliveries of SC women mainly were attended by neighbours/relatives or untrained dai (74 percent). In other words, even those who give birth at home are deprived of ANMs' or trained dais' services that increase the risks associated with child-birth among the poorer sections.

The new born babies are protected against killer diseases by vaccinations. The data provided by the RCH Survey reveal wide disparities in its utilisation and poor accessibility.

Table 3 : Accessibility to Immunisation Services in Karnataka by Social – Economic Background of Children Born During 1.1.1995 to 10.6.1997 (percent not received)

Type of Service	Residence		Gender		Caste		Education		Housing	
	Rural	Urban	M	F	SC/ST	Others	Illit-	10 yrs+	Kuchha	Pucca
1) O Polio	61.8	30.8	53.0	53.0	69.7	50.0	72.6	22.9	75.5	22.9
2) BCG	18.5	9.4	13.7	18.2	27.6	11.5	26.6	1.3	34.6	4.7
3) DPT	18.3	11.3	14.7	18.1	26.6	12.6	26.7	1.1	32.6	5.2
4) Polio	11.6	8.2	9.0	12.3	17.3	8.2	17.8	1.4	21.7	3.7
5) Vitamin A	52.8	49.2	49.8	53.9	59.1	48.0	61.2	35.6	66.1	39.7

The differentials observed at state level hide the regional differentials which are more pronounced. The following table provides these differentials in the selected districts.

Table 4 : Access to Antenatal Care in the Study Area by Socio-Economic Background of Women 1998 (per cent not received)

District	Residence		Caste		Education		Housing	
	Rural	Urban	SC/ST	Others	Illit.	10 years +	Kuchha	Pucca
Udupi	2.0	00	5.2	00	4.7	00	2.2	00
Tumkur	4.8	2.4	5.9	3.8	8.5	00	4.8	00
Gulbarga	34.0	14.8	28.5	26.8	35.5	3.1	32.1	27.2

The tables 4 and 5 are self explanatory and in this background it was not surprising that the RCH survey reports maximum number of infant deaths in Gulbarga district (17) during the reference period and all in rural area whereas Tumkur reported 9 deaths – 8 in rural areas whereas Udupi reported only 3 infant deaths all in rural areas.

Table 5 : Access to Immunisation of Children Born During 1.1.1995 to 30.6.1997 (per cent not received)

District	Residence		Sex		Caste		Education		Housing	
	Rural	Urban	M	F	SC/ST	Others	Illit.	10 yrs+	Kuchha	Pucc
Udupi	15.0	8.0	17.0	10.0	20.0	13.0	17.0	4.4	15.0	14.1
Tumkur	13.0	6.0	11.4	12.8	16.0	11.5	13.7	3.00	20.0	4.5
Gulbarga	80.0	53.6	76.0	73.3	78.9	73.8	83.4	25.0	72.3	45.2

The information for 10 districts of Karnataka and the 3 districts in the study area bring out clearly that delivary of public health care services do not reach all those who need them because of various factors. Given the skewed distribution

of basic health care services related with maternity and child survival it is not surprising that health outcomes differ widely among districts – regions and also social class in the state.

Reasons for such poor delivary of public health services in Gulbarga as compared to other districts were not difficult to understand. The Research Teams' visit to Community Health Centres. Primary Health Centres and Sub-Centres revealed that many of these health centres do not function regularly. Infact, the day of our visit to selected health institutions in Gulbarga they were locked and we learnt from the villagers that medical officers are very irregular in attending to their work. Similarly the ANMs instead of visiting the households in the sub-centre jurisdiction expect that women or children with problems should come to them. No PHC had displayed the scheduled travel programme of ANMs as is done in other districts. It is not, therefore, surprising that old women in the neighbourhood or village 'Soolagitti' (village untrained dai) conduct most of the deliveries in rural areas (every 3 of 4).

The problem is more complicated by the large number of vacancies particularly of ANMs which is crucial in ensuring delivary of health care services. When the vacancies of ANMs by taluks and PHCs within taluks were obtained from the DHO's office and examined we were in for several surprises. In the district of Gulbarga about 28 per cent – more than one in four positions were vacant for ANMs (see table 6) and the LHVs. Supervision of their work and monitoring the performance has stopped for several years. The result of such an apathy is very clearly reflected in several indicators reported earlier. One of the major cause for poor performance reported by the staff at PHC/CHC was the existing poverty in the rural parts of the district where traditional practices still dominate and the department cannot be blamed for all the ills in health sector.

Table 6 : Vacancies of Female Health Workers (ANMs and LHVs) in Gulbarga District by Taluks

Sl. No.	District/Taluk	Per cent Vacant			
		P – V	ANMs	LHVs	Per cent
1)	Gulbarga Dist.	484/134	27.7	83/40	48.2
2)	Gulbarga Taluk	58/00	0.0	6/0	00
3)	Jevargi	39/2	30.8	10/2	20.0
4)	Aland	57/18	31.6	6/4	66.7
5)	Afzalpur	40/11	27.5	9/7	77.8
6)	Chincholi	41/10	24.4	8/1	12.5
7)	Chitapur	57/15	26.3	10/5	50.0
8)	Sedam	35/13	37.1	7/2	28.6
9)	Shahpur	48/17	35.4	7/5	71.4
10)	Surpur	56/18	32.1	10/7	70.0
11)	Yadagir	53/20	37.7	10/7	70.0

Note: P = Total Positions: V – Vacant Positions.

But the traditional practices have to continue because the modern health services provided by the public services have miserably failed to entrench in the society. It was repeatedly emphasised that rural people prefer to conduct deliveries at home and ANMs are helpless. But when there are so many uncertainties in the services – medical officer may not be there, drugs may be in short supply and ANMs posts are vacant and naturally people stick to their traditional practices. The positions of specialists in the district showed that 37 per cent positions were vacant.

In Udupi district also about 30 per cent of ANMs positions were vacant but easy accessibility to quality care in Private Sector Hospitals either free or at an affordable cost has not made any adverse impact on the health of women and children. Most of the births about 92 percent take place in institutions that has sharply reduced Infant Mortality Rate in the district (lowest in the State). The ANMs working in sub-centre reported that most of them have not conducted a single delivery during last 5–6 years as there are maternity homes run by

missionaries, Manipal group and other private trusts that provide a choice to everyone irrespective of their economic position. The public make an informed choice of public and private services and have benefited to a large extent as revealed by several indicators.

Tumkur district placed in between these two extremes provide different problems. The public health care providing institutions generally work regularly. Our visits to several PHCs, CHCs and Sub-Centres convinced us that there is regularity in attendance of the staff to a large extent except in a few pockets. But accessibility to the services is severely restricted to the poorer sections because of corrupt practices in these institutions. The Medical Officer in a PHC working for more than 15 years, people reported, has ensured that the Lady Medical officer's post remains vacant. A child birth conducted in this PHC will cost about Rs.1000/-. If there is a LMO this income will be reduced to a large extent. In another PHC it was found that LMO frowns at ANMs if they conduct home deliveries and insists that they should bring delivery cases to the PHCs and charges a minimum of Rs.500/- per delivery. Efficient and competent ANMs complained of harassments by the MOs and LMOs. With Malaria incidence still high in some pockets spraying of DDT has been stopped for 3 years and water sources like wells have not received chlorination to make them safe for drinking. The public health measures have affected badly.

The vacant positions in the department has its own adverse impact but is not severe as there were only 15 percent ANMs' and about 20 percent LHVs' positions were vacant for varying periods some for 4–5 years that has compounded the problem of outreach services in the district. Even then there is some semblance of service in the district. The buildings and other infrastructure are in poor shape and are begging for some action to improve but not received any attention from authorities.

What the Panchayat Raj Institutions Can Do?

The decentralisation of governance in Karnataka in its first 'avatara' came with the perception of "Power to the People'. The 1983 Act was based on the

principles enunciated in the Ashok Mehta Committee Report. The objectives of the Act were to give highest priority to rural development, increase agricultural development, eradicate poverty and bring in overall development. To attain these objectives the Act provided maximum degree of decentralisation both in Planning and implementation.

But there were unresolved issues, with the planning structure at the national level and state level is it feasible to have district planning with the consent of people and their participation? If not how the PRIs would participate – only implementation of the plans that come from the State with resources? Who would ensure 'good governance' at lower levels? And How? are not cleared yet. But the State government that provides resources to PRIs – resources that have reached four to five fold increase during the decade believes that there has to be greater transparency, social justice and accountability in PRIs to achieve the twin goals of development and social justice. The voluminous writings on decentralised governance at sub-state level are more concerned with reservations, elections, provisions of rules, rights and procedures to be followed than assessing what positive changes the new system has achieved and how to improve it further. which can reduce the 'politics only' attitude observed at PRIs. Despite our serious efforts to find some special studies that have examined functions of the health sectors under decentralised system we could not trace a single except the evaluation report submitted in 1989 that praised PRIs eloquently for the good changes they had observed.

We conceptualise a very simple mechanism that exists in PRI system to a large extent useful in streamlining the functioning of health care service delivary system and bring in much needed discipline in the sector. The importance given to 'holding gramasabhas' of village voters who are ultimately the masters can be exploited. Already in six districts "Citizens Initiatives in Elementary Education" an NGO initiative to activate Grama Sabhas to improve primary education is going on. People who are not happy with the delivary of services, can bring it in the meeting which will be passed on to Gram Panchayat that in turn can reach Taluk and Zilla Parishad for action. The ZP based on the resolutions passed by the

Gram Sabhas can keep themselves abreast of developments in health sector and plan for its improvements.

The Zilla Parishad also has a statutory Committee called "Standing Committee on Health and Education" that includes elected ZP members and also some experts co-opted. They have to meet once a month and transact business pertaining to health. However, the role of Zilla Parishad in decentralised governance and planning is one of a facilitator and co-ordinator. Integrating plans submitted by Taluk Panchayats, approving employment generating action plans, allocation of resources to development programmes and monitoring functioning of Taluk and Gram Panchayats. The President and Chief Executive Officer (CEO) have been endowed with powers to supervise and inspection. However, CEO has upper hand (section 180) to ask any record from TPs and GPs pertaining to property, recovering arrears of land revenue, and supervise and control the execution of ZP works.

Gram Panchayats are entrusted with regulatory, licence - giving, prohibitory, supervisory and sanctioning powers. They have powers for taxation and acquire movable and immovable properties. Providing civic amenities, promoting health and educational services are other responsibilities entrusted with Gram Panchayats.

The Taluk Panchayat have controlling and supervisory powers over Gram Panchayats. They are perceived as highly resourceful and powerful intermediary level institutions. They approve employment generating action plans, they give concurrence to action plans pertaining to education, health and family welfare etc. The executive officer can supervise in functioning of PHCs, Sub-centres and report to DHO for action. He does not enjoy powers to take disciplinary action on health staff.

There is a mechanism to receive the public grievances regarding health care services through the powerful Grama Sabhas for further action to improve the equity and accessibility – both if there is a desire. In addition the Taluk Medical Officer has supervisory powers to report for action to DHO. DHO is head of the department and is responsible officer at district level. In addition

there is Executive Officer at Taluk Panchayat with supervisory powers and report his findings to DHO. It is very clear from the above that there are enough ways and means to improve the health care services directly through PRIs, through the live of control existing in the departments and also more importantly through the Grama Sabhas. Given the situation described in the study area it would be in order to examine how they work.

The Grama Sabha

The Gram Sabha is a statutory requirement that provides a unique opportunity to village residents to vent their grievances which will reach the concerned authority for redressal. It also provides an opportunity to the voters to make their elected representatives accountable to them. One of the main architects of decentralisation in Karnataka considered Gram Sabha as a "more powerful weapon created for the sake of accountability is Grama Sabha which will not be elected nor has it vested with any executive power. But it is going to play a crucial role in real politics because of their voting power and all elected members are accountable to Grama Sabha". It is mandatory on the part of PRIs to explain their activities within the jurisdiction of the village. It also leads to right to information.

Section II

How the Grama Sabhas are conducted if at all they are conducted? Whether people bring their grievances to the forum? The Household Survey conducted in the study area enquired from the randomly selected 82 heads of the households whether the Gram Panchayat, Taluk Panchayat or Zilla Parishad of their area are taking any interest for the improvement of the local PHC? Not surprisingly in Tumkur and Gulbarga districts the response was an emphatic 'No' from each head of the household (100 percent in negative). They were very firm about their view. But in Udupi district one in four felt that they are trying to improve further the services in PHC (Table 7).

The selected heads of the households were also asked whether there was any discussion in the Grama Sabha meeting held recently on the functioning of the ANM. LHV, PHC doctor and PHC. The findings of these are presented below.

Table 7 : Peoples Assessment of PRIs interest in Public Health

Sl No	Activity	Districts							
		Udupi		Tumkur		Gulbarga		Total	
		Yes	No	Yes	No	Yes	No	Yes	No
1)	PRIs try to improve the PHC	23.0	77.0	00	100.0	00	100.0	11.0	89.0
2)	Gram Sabha Discussed about the Functioning								
	i) Of ANMs	8.6	91.4	13.0	87.0	12.5	87.5	11.0	89.0
	ii) Of LHVs	8.6	91.4	13.0	87.0	12.5	87.5	11.0	89.0
	iii) Of MO in PHC and PHC	8.6	91.4	13.0	87.0	12.5	87.5	11.0	89.0

It is clear from the data that public view of PRIs interest in improving health care service delivery of PHC level or about the functioning of crucial personnel like ANM, LHV or MO of PHC is extremely poor. An important route to bring critical assessment of health services for improvement was found to be very insignificant.

The Bureaucracy

There are multiple authorities who are supposed to supervise functioning of their subordinates, monitor the performance and enforce discipline in the health department. They are Taluk Medical officers, Executive Officers at Taluk Panchayats, Chief Executive Officer, President at ZP and also DHO the Head of the department of health at district. In addition to all these levels of supervision, there is another Deputy Secretary 1 in ZP who is entrusted with supervisory powers who will report to the CEO.

With so many authorities entrusted with powers to ensure free flow of services it was surprising that Public Health Care Services are of so poor quality

in the two districts of the study area viz. Gulbarga and Tumkur. Our discussion with the young and energetic CEO in Gulbarga was surprising. He was unaware of the way PHCs are functioning in the district. On the contrary he said often he receives representations from people to retain some Medical officers in their place and cancel the transfer order issued that gave him an impression that the MO must be good and therefore people want to retain him. We met the Deputy Commissioner of Gulbarga also and briefed him about our observation. Both the CEO and DC asked for a copy of our findings for initiating action against erring officials in the health department. Similarly we discussed with the Deputy Secretary (Dy S 1) and briefed him of our observations and he was non-commital. Our discussion with the Secretary ZP Council, Gulbarga was little revealing. He reported that the meetings of the Standing Committees on Health and Education mainly deal with approval of plans, proposals and programmes. There is hardly any scope to discuss about the services their quality or its out reach to all sections of the society. How well the DHO is informed about the happenings in his department? Does he also think that everything is fine with the functioning of PHCs, CHCs and Sub-Centres in his district? Our discussion with him was frank and free. He is aware about the irregular attendance of Medical officers and has initiated disciplinary action against one or two. But taking disciplinary action takes a very long time. There are interference from higher authorities, elected representatives to thwart these initiatives because the authorities take a benevolent view of such things and consider it on humanitarian grounds – the person accused is married and have children why punish him/her? The whole work culture in the district reflects that even for a petty issue there is interference from the highest authority. Every one in public service has links upward and use it to save himself from any punitive action.

Tumkur district was slightly better as the Executive Officers at Taluk level also visit some PHCs and reported that if the MO is absent on the day it will be reported to DHO for treating it as leave without pay. But whether DHO acts on that report or not was not clear. DHO Tumkur is aware about corruption that is making public health care services inaccessible to the poor in the district but

reported like Executive Officer at Taluk level that they have not received a single complaint from people in this regard and hence cannot act without evidence.

It was in Udupi that the in-built mechanism of monitoring and supervision was working. Even the MOs appointed on contract basis are regular in their work and provide service to the people. If there is regularity in the functioning of health institutions that itself satisfies the clients who arrive there for relief. Our visit to PHCs, CHCs and some remote-placed Sub-Centres was very satisfying. Perhaps if one wants to see what is equity and accessibility to health care services should visit this part for getting acquainted with. The results are visible.

ZP Presidents

The Executive Head of the district is the President and certainly they can make considerable impact on the quality services provided and their accessibility to people. The Presidents of the ZPs in the study area were very enlightening. In addition to 3 ZP presidents of Udupi, Gulbarga, and Tumkur, we met ZP President of Kolar. They were all young, educated and enthusiastic about their office that they were holding only for few months. The women presidents of Tumkur and Udupi were keen to improve health services. One of them was very young, just married with no experience of either politics or holding a public office. But her father was a leader and was holding a public office by getting elected. The other was having some experience at Gram Panchayat. Tumkur ZP President was keen to learn the ropes of administration to act and improve. She had visited some PHCs and believed that women still prefer to give births at home as it is more convenient. She was aware that some MOs and ANMs are not regular and was planning to discuss with the administration for possible action.

The Gulbarga ZP president was very open and said that "MOs not only are irregular but also sell the medicines in the open market. For days they do not visit PHCs. But I do not have powers to set things right". The President said that he would set things right in two weeks if he had powers. He was sorry that the State Government that belongs to his party is not receptive to their views.

The ZP President of Kolar was more dynamic and when we met he had visited a PHC (where he had gone for attending a public function) on the request of the public who complained that the MO is very irregular. Indeed MO was absent when the ZP president visited the PHC. He called DHO to know how they can take action against such officials. He reported that he is new (like other 3 presidents) to the intricacies of the administration and though he attended some training programmes organised for ZP presidents he has a long way to go to master the art. He had kept a Rule Book prepared by the state government and would refer to it often when he had some confusion. He was also of the opinion that ZP has little scope to bring in discipline among the staff working in the district on deputation. He often requests the DHO to be strict and wants to support him in improving the health services for the benefit of the people.

The Vice Presidents

The Vice Presidents also echoed the views of their Presidents. ZP cannot take any action. They have to write to the Government for action and there are long delays or no action. Vacant positions in the Health Department is reported routinely to the Government for filling but nothing is heard from them. The CEO position was vacant for 2 months and during that time DC was incharge CEO. One can imagine how things will move. It was clear that transfers, recruitments or suspension of any health staff is not vested with ZP. Under the circumstances poor accessibility and inequity in health care services become the order of the day and both elected representatives and the bureaucracy become used to it.

It is to be noted here that none of top leadership in ZP – elected members, members of the Standing Committee on Health and Education, CEOs and DCs were totally aware of the disparities that exist in the health status of people in different districts, by gender, caste and economic status within the districts. The next line of authority Deputy Secretary 1 were also equally ignorant of health outcomes, indicators and job responsibilities of various categories of staff. The Administration at Taluk and Districts were busy with construction of new structures, equipments or drugs more than their use for public good. There was

a unanimous demand in Tumkur, Kolar and Gulbarga that there is need for training to make them more informed and effective. Why the DHO does not provide them the insights of the Department? He has no time as all his time is spent in the meetings. The DHO also has several constraints. Since he has hardly any time his visits to Primary health Centres have reached minimum. It is only when a dignitary like District-in-charge Minister (another authority over all the happenings in the district) has a public function he may visit a PHC. The staff at PHC could recall the past practice of frequent visits of DHO for supervision. It was not only to their PHC but even to a nearby PHC would keep them alert with a chance visit to their PHC on the way back. This practice has almost disappeared now.

This brief description provides how the in-built mechanisms to ensure accessibility to health care services have become ineffective. It is not surprising that the health status of people in health poor districts continue to be poor even though public resources – more valuable looking at the scarcity, become less and less productive. One of the important reasons for the observed delay could be the faster expansion without consideration to the enormous resources needed for it. Earlier the quality of services, as reported by senior staff was much better. Now even though the scarcity of equipment, maintenance of assets etc. is reported to the authority may not be heard that leads to the weakening of the authority because of the inability to solve it quickly. The only positive change is the improved drug supply after decentralisation. Rest every thing is highly unsatisfactory in health poor districts.

Section III

Areas of Conflicts

Given the situation described so far where lies the conflict between the health bureaucracy and ZP or PRIs? The focus group discussion often led to mudslinging exercise. That PRIs arrival have lead to more corruption and harassment of personnel. To start with, the bottom line ANMs complained that elected representatives demand service on priority basis, call the ANMs to their

residence even for headache and stomach ache and demand medicines free and often ANMs have to bear the costs. As most of them (elected representatives) are not educated their behaviour is curt and without etiquettes and manners that hurts ANMs. The MOs at PHC complained similarly in addition they reported that the elected representatives question them if an ANM is not posted in a sub-centre which is not under his powers. The DHOs office complained of interference in day to day administration by the Elected Representatives.

A Taluk Medical Officer complained that there was out break of cholera because of the contaminated water supply by the Taluk Panchayat. When he reported that water supply has to be improved by taking some measures like chlorination, he was abused for dereliction of his duties. When they send a proposal to repair a collapsing building to DHO with a copy to ZP the CEO just does not bother. Medicines are not supplied regularly. They dump several useless drugs which are of no use. PHC and MOs indent is often ignored.

The Quarters of ANM built by the PRI are of extremely poor quality. An ANM was in tears to report how she has to cover the roof with polythene sheet to protect her from leakage and to re-do the electrification to save from the shocks spent Rs.3,700 from her pocket. Complaints made to DHO, ZP and TPs were of no use. She was told that she has to stay there the Quarter on which lot of money is spent to make it according to the specification given.

A meeting with all medical officers of a Taluk brought out their vent against elected representatives. A LMO reported that new PHC was built but the quarters for staff are not. The PHC is in the outskirts of a village and no body dare to stay there in the night not even a watchman. If they had constructed housing along with the PHC it would have facilitated. Another LMO who commutes to PHC every day from Gulbarga complained that the people and elected representatives harass her to stay in the PHC quarter which she has not occupied because there is no water, electricity and building is 25 year old needs repairs. They are not keen to do anything to facilitate the services. Most of the drugs that ZP supplies are about to expire and become useless.

The months Feb-March are two months when ZP administration is too busy to approve medical reimbursals of staff of Health Department and they not even consult the DHO. Registers required to compile statistics are not supplied for over a decade. All files move only if currency notes are enclosed with them. RCH building fund of Rs.10 lakhs is lying for over an year but even the plan is yet to be made and approved. Nothing moves.

Taluk Medical Officer has to write to DHO who in turn has to forward to ZP for any action. Taluk Medical officers can not even sanction Travelling bills of his subordinate staff and those who approve it may not know whether the travel was made to those places. ZP sanctions all such TA bills with a cut of 10–20 percent.

Even the DHO's office in Gulbarga has several stories of delays. Power connection to his office is not done though they have spent Rs.37,000 for it about 19 months back but ZP is still silent. The list is endless.

What ultimately emerges is that the conflict arise from multiple points of authority with not a single source taking any interest in improving things. The question that arise is who should set things right with quick decision to solve the problem. It is only CEO who is authorised to act after waiting for instructions from the Government on any of the complaints made. We did not come across any such action except issuing a memo or deducting a days salary in some one or two complaints against ANMs. But suspension orders can be issued only by the Government. Generally when there is such a serious complaint against a MO or other officials. ZP elected members or a Minister interfere and nullifies all efforts. Some ZP Presidents had complained against unclean PHCs and a couple of staff coming late when they had visited.

The PRI elected members have many stories against the health staff. Irregularity, showing unconcern and asking money were very common. It was surprising a lady member of the Standing Committee on Health and Education whose husband (aged 44 years) died on Jan 4th 2001 because of the neglect of MO in treating him. He died of massive heart attack and MO had given him treatment for acidity the previous day to his death. He did not check his blood pressure nor examined him. But she did not complain as he is well connected.

But the elected members of such statutory high power committees also are ignorant as reported by many about the health situation – no idea about death rate, infant deaths or maternal mortality which are very high in their area and there was a strong demand to enlighten them on health issues to strengthen them and to improve the situation.

In addition the bureaucrats at ZP believe that Medical Officers at PHC. CHC and district office lack badly administrative skills and management skills to work in a team. The lack or absence of such skills go on accumulating and turn into major issues. We also believe that managing the staff is an art that many medical graduates who join the service as MO at PHC may not have and already some programmes to train them as managers of PHC is on.

The proceedings of the Standing Committee on Health and Education of Tumkur District however reflects what we noted about the district. It says "..... administration in health department has collapsed and DHO has no control over his department" (page 4 of 24/10/2000). It also notes the ZP Presidents suggestion that priority should be given to patients in rural areas by the Medical Officers. It also questions about MOs saying that there is no medicines in the PHCs and prescribing drugs to be purchased by the patients in the market.

The proceedings of Udupi ZP's Standing Committee that meets every month regularly reveal that there is evidence of some efforts to improve the services further. PHCs in Udupi display boldly that if the visitors to PHC have any complaint to make about the functioning of the PHC they are provided a post card free and they can mail it to the concerned authority for action. Based on such complaints the Committee resolved to examine such complaints and recommend action to be taken (either terminate the services of contract MOs or transfer them). It also instructed the DHO to recruit group 'D; employees on temporary basis in place where there is need to ensure cleanliness of health institutions. It notes of disciplinary action by issuing show cause notice to unauthorised absence of a Taluk Medical Officer to consider his absence as leave without pay. These resolutions certainly indicate the efficient mechanism

of receiving complaints and quick action within the limitations of ZP which are worth emulating by other ZPs in the State.

The proceedings of Gulbarga ZP is silent on the situation in health service delivary system in the district but emphasise more on building model Primary Health Centre, resource mobilisation, etc. that shows there is no in-built mechanism of receiving public grievances or they are ignored.

Section IV

Summary of the Findings and Recommendations

The intensive study carried out with time constraint has been able to effectively explore a complicated area ignored so far in academic circles. The policy statement issued recently on population by the Government of India has given the prominence to PRIs that they deserve. It is brought out by the study that multiple power centres and poor co-ordination among them for effective decision making is hampering the smooth functioning of ZP and Health Department at district level. Appointment, transfer, suspension are the crucial areas where ZP acts only as a Post Office. Unless the State Government approves they cannot act. The key post of DHO has been weakened because of interference of elected representatives. Even simple act like posting a Laboratory Technician from a place where there is no serious demand for his services to a place where there is an out break of an epidemic is resisted by highest authority. Infact instructions come to him if he acts in his way he will be in trouble. Such instances have demoralised him. Transferring an ANM to another place has become just impossible. Time constraint is imposed by several meetings he has to attend. This was the view of all high officials also in Bangalore that they find little time to work in their office.

The Grama Sabha – a most powerful instrument the people have to air their grievances for redressal and which is given lot of importance in decentralised system of governance is almost non-functional as found in the household survey responses. People complained in Gulbarga and Tumkur districts that meeting is not announced by Tam-Tam (drum beating) and contrary

it is held when most of the residents go for work and only few whom they want attend it and non complaints are entertained. The Udupi District that is in the forefront in health sector has developed a good system of receiving public grievances directly by the authorities concerned and redressal is quick. In other two districts complaints are unheard and neglected on the ground that there are no written complaints.

Decentralisation is still in infancy in the state and suffers from several constraints to be effective government at district level. How to monitor the functioning of the system of health care services delivery? Is not known to even top officials like CEO, Dy. Secretary 1 and other officers at Taluk levels. Official inspections are more ceremonial and unproductive even though such inspections by different categories of authority are rare and routine. There is no effort to understand the problems and solve to improve the performance is not seen any where except in Udupi. Therefore there was a strong demand to enlighten them with one day programme at ZP for all concerned officers. The officers in health department were not even aware of research finding that should guide them in their work.

The guiding principle of any public health care service delivery is equity and universal accessibility. The state has a very very long way to go to achieve it. Even then equity and universal accessibility will not be an automatic fall back from expanding services or bringing in a semblance of quality in care. It can be achieved by monitoring crucial services like basic primary care which is absolutely missing at ZP level. There is need to intensify the efforts, if already there are, to reach the goal of equity. For this there is need to equip PRI elected members, general public about the importance of health and its effective utilisation. The elected representatives have to develop responsibility towards their activities. They come from diverse socio-economic and cultural background and over the years grow as leaders. They have started asking questions about services which is in the right direction. Health personnel who were used to departmental control are perturbed over the authority of representatives. They

will have to realise that their services are for them and they are the real masters in a democratic system. There is nothing to worry.

But till the PRIs become more effective in their functions the department has the crucial role to play. Efficiency and quality care and ensuring its outreach of services have to be managed by them which will go a long way in building of credibility of the department which is at a very low ebb now. PRIs will be happy and stop interfering if they are convinced about good services to all.

The main questions that still remains to be answered is how decentralised the state is really? Can ZPs be considered as Local Self Government? A short term study such as this would not try to explain the extent of decentralisation in the state today. It seems there is a make–believe effort to show we are decentralised while all the powers are centralised with the state (because of several reasons stated and believed). One of the important factor for the mess in health department is the multiple power centre without any direction – pulling the cart in different direction. The lost aura of DHOs and reluctance of efficient Medical Officers to occupy this role reflects very clearly the situation. If health care services are to be improved his position has to be strengthened. Such studies ideally need at least an year but an effort is made here to bring out several complex issues that a longitudinal study should explore in the future.

Recommendation

1) There is an urgent need to make ZPs to consider health sector as an important input in development and to educate officials ranging from Chief Executive officer to Executive Officer at Taluk level on monitoring health services and on health indicators that reflect it. There is unbelievable ignorance in the administration and also in the health department who are major health care providers in rural areas on the status of health of their people.
2) The Elected Representatives from Gram Panchayat to ZP level also need to be educated about importance of health and their role in monitoring

health outcomes. Only ensuring presence of doctor or supply of drugs is not adequate to achieve equity. Monitoring plays a crucial role and it is totally absent at all levels.

3) The Health Department should be made responsible in improving health care services in the districts and they should be ensured the support of ZP, TP and GP in carrying out their responsibilities efficiently. For this there is need to build-up the credibility that is lost. The health services would be considered good if the indicators of health improve and become comparable with the best in the state to start with.

4) There is an urgent need to establish fool proof mechanism to receive public grievances for redressal as is effectively done in Udupi District. Strengthening Grama Sabhas would play an important role if they are conducted properly. PHCs in health poor district should provide free post cards to public who should mail it to responsible authority for redressal and quick action on the complaints will strengthen this mechanism in due course of time.

5) Whether ZP Presidents should be fully empowered for taking any action or not is a wider question we would avoid answering here. But they can play an important role within the powers they enjoy now. Just calling an erring officer and reprimanding him in public will do the trick. Even an indication that they are serious will go a long way than proceeding on legal terms.

6) The ZP and health bureaucracy at district level should learn to respect each other and the need to understand their complimentary role. Health is a technical subject best known to health staff and they need all the support, encouragement and appreciation when they do a good job. Health staff should realise that elected members to PRI though may not be educated represent peoples views and respect them for that. There is need to meet informally for achieving this by both.

GOVERNMENT OF KARNATAKA

TASK FORCE ON HEALTH AND FAMILY WELFARE

A Commissioned Research Study

DISPARITIES IN HEALTH AND HEALTH CARE SERVICES

(Draft Report)

By

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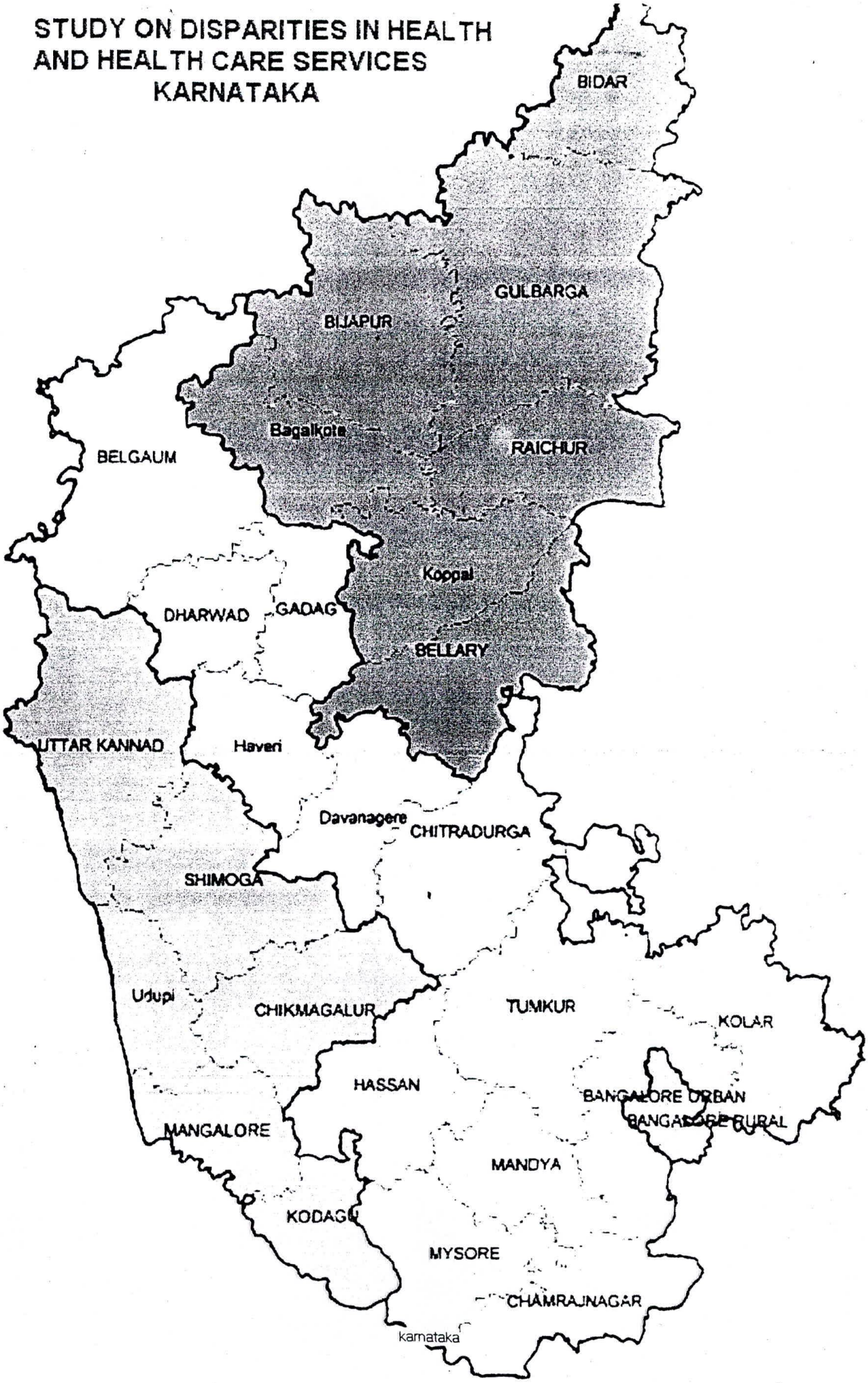
STUDY ON DISPARITIES IN HEALTH AND HEALTH CARE SERVICES KARNATAKA



STUDY ON DISPARITIES IN HEALTH AND HEALTH CARE SERVICES:

Karnataka State with 27 Administrative Districts has an estimated population of 540.27** lakhs as per the estimates for 2001. The state of Karnataka ranks 131✪ on Human development index scale at Global level and has 33.16% of the population below poverty level. It has been observed that there exists disparities in health and health care facilities in between:

- Regions:- North & South Karnataka
- Districts : 27 Districts
- Disadvantaged:- Lower class and Caste
- Vulnerable groups: Age and sex.

This is unnecessary and unjust. Such issues should no longer be curiosities for mere speculation but demand close attention at the earliest for policy review and implementation.

Health is a state subject, and it is the responsibility of Government to ensure an equitable distribution of minimum and adequate health care that is accessible to the whole population. Considering the inadequacies in terms of infrastructure and relatively poor health indicators, there is a need to understand the disparities in the health and health care services in the state.

OBJECTIVES:

The **goal** of this study is to highlight the extent of disparities that exist in health and health care facilities between districts in the state and within the districts and to suggest steps to be taken to reduce these disparities.

The **objectives** of the study therefore include:

1. To determine the disparities in Health determinants.
2. To determine the disparities in Health status
3. To determine the disparities in Health Care resources allocation.
4. To determine the disparities in Health Care utilization.
5. To determine the most disadvantaged districts in Karnataka to evolve and initiate more focussed projects in these districts.

** : *Revised National Tuberculosis Control Program: Action Plan, Govt. of Karnataka, 1998*

✪ *Human Development Report – Karnataka State, 1999.*

METHODOLOGY

Given the constraints of time available only quantitative data that is available from the following secondary sources on various characteristics was collected.

1. Multi Indicator Cluster Survey – 1998 – UNICEF
2. Rapid Household survey under RCH project, Karnataka State – 1999
3. Human Development Report, Karnataka State – 1999
4. Directorate of Health and Family Welfare Services, Govt. of Karnataka Sept.2000
5. ICDS – Women and Child Development Department Report – Nov. 2000
6. Census of India 1991, Karnataka State District Profile 1991.
7. Rural Development Panchayati Raj Department, Statement on Below Poverty Line Families, Govt. of Karnataka

Data was checked for its quality and quantity and **regional disparities** were assessed on the basis of available data on indicators in following essential categories: (Annexure– I)

- Health Determinants
- Health Status
- Health Resource Allocation
- Health Care Utilization indicators and
- Over all indicators

Each indicator in the above-mentioned categories was standardized and algebraically added for each district. The total was re-standardized and a composite index as Standardized "Z" Score was obtained for each district, which gives the relative position of the districts on the scale in Karnataka State.

It has been observed in many studies that lower class and caste suffer with disproportionate burden of diseases and mortality. Different types of morbidity and mortality have different patterns with respect to the age, sex and social class. So to assess the equity with respect to these characteristics, it is necessary to get the primary data in disaggregated form at various levels right from taluk to state level.

However, disparities in health on the basis of class, caste, age, sex and the religion could not be assessed, as data does not exist in disaggregated form for districts of Karnataka.

FINDINGS - A

DISPARITIES IN HEALTH DETERMINANTS OF DISTRICTS IN KARNATAKA STATE

DISTRICTS	Edn15+	HHP	Cwater	ELC98	ACClatrin	ABPL	TOTAL INDEX
Bangalore Urban	73.3	82.7	97.2	79.4	90	85	2.80
Bangalore Rural	41.8	38.4	98	96.3	26.4	66	0.55
Bagalkot	48.2	19.4	100	51.4	5	53	-1.12
Bellary	40.8	30.6	84.1	57.5	12.3	55	-1.21
Belgaum	46.8	46.1	73.7	66.7	18	77	-0.23
Bijapur	48.2	19.4	94.7	51.4	3.1	58	-1.14
Bidar	37.5	70.6	90.3	60.5	12.3	60	-0.30
Chamrajnagar	41.5	35.8	96	67.1	20	64	-0.29
Chitradurga	49.8	45.1	96.8	72.5	30	59	0.14
Chikkamagalur	55.3	32.8	88	74.4	40.5	72	0.37
Davengere	49	36.9	98.6	69.6	36.3	66	0.24
Dakshina Kannada	71	30.1	98.6	69	73.4	78	1.35
Dharwad	53.5	29.1	99.9	75.4	39	61	0.26
Gadag	53.5	29.1	67.9	75.4	6	55	-1.05
Gulbarga	33.2	55.6	63.1	54.5	15	66	-1.22
Hassan	50.1	19.2	86.8	78.3	14	79	-0.02
Haveri	53.5	29.1	99	75.4	16	69	0.19
Kodagu	64.4	36.3	84.5	56.5	44	82	0.47
Kolar	43.2	55.3	93.3	80.9	35.2	61	0.37
Koppal	32	17.4	83	54.3	5.3	57	-1.73
Mandya	39.9	41.5	95.5	85.9	19	70	0.30
Mysore	41.5	35.8	95.9	67.1	44	69	0.12
Raichur	32	17.4	76.6	54.3	20	57	-1.71
Shimoga	56.2	35.6	94.8	78.9	31.8	68	0.48
Tumkur	47.2	45.3	99	77.5	19	69	0.39
Uttar Kannada	62.2	34.1	97.1	79.4	38	70	0.78
Udupi	71	30.1	98	69	60	79	1.20

☹ Most of North Karnataka Districts are poor in health determinants.

Disparities in Health Determinants have been assessed on:

Edn15+ : Percentage of Literate in 15+ age group.

HPP : Percentage of Houses in which both wall and roof are made of permanent Materials

Cwater : Percentage of households with access of clean water

Elc98 : Percentage of households with Electricity

ACClatrin : Percentage of households with Latrine

ABPL : :Percentage of families above poverty line – as per BPL census for 9th Plan

It is an established fact that environment has direct impact on those living in it. Good housing, availability of safe water and sanitation facilities have positive fact on health which has been measured in the present study by HPP, Cwater, Elc98 and ACClatrin. Studies have also indicated that education to some extent compensates the effect of poverty on health irrespective of availability of health facilities and in this study the education has been assessed by Edn15+.

Economic status determines the purchasing power, standard of living, quality of life and the pattern of disease in the community. This aspect has been assessed by ABPL i.e., families above the poverty line as per the BPL census for 9th Plan.

FINDINGS - B

DISPARITIES IN HEALTH STATUS OF DISTRICTS IN KARNATAKA STATE

DISTRICTS	U5 MR	%Normal under 5	API Malaria	Pt. Prev TB	Incident DIARR	TOTAL INDEX
Bangalore Urban	67	45.34	1.06	1.88	5.8	0.05
Bangalore Rural	67	44.83	0.21	1.88	10.1	0.26
Bagalkot	88	34.56	3.3	1.37	7.1	-0.53
Bellary	119	26.51	3.71	1.72	17.1	1.87
Belgaum	69	40.37	1.09	1.67	9.4	-0.19
Bijapur	88	36.41	4.95	1.37	7.3	-0.47
Bidar	85	28.94	1.05	2.08	4	-0.89
Chamrajnagar	89	44.5	0.12	1.66	4.9	0.52
Chitradurga	104	39.58	2.14	1.81	8.9	-1.00
Chikkamagalur	75	47.11	0.41	1.6	15.3	0.09
Davengere	104	34.61	0.12	1.52	11	-0.27
Dakshina Kannada	46	51.59	2.58	1.34	4.3	1.16
Dharwad	95	41.21	0.28	1.19	20.9	-0.05
Gadag	95	33.07	0.39	1.19	14.1	-0.43
Gulbarga	86	34.3	3.72	1.46	16.2	-0.74
Hassan	78	48.64	1.12	1.55	12.5	0.00
Haveri	95	35.42	0.15	1.19	14.5	0.07
Kodagu	66	54.61	0.1	0.94	16	2.11
Kolar	100	41.84	2.19	2.12	12.5	1.05
Koppal	80	29.08	3.76	1.32	14.1	-0.68
Mandya	84	49.28	6.55	1.68	8.5	-0.18
Mysore	89	40.68	0.64	1.66	5.5	-0.34
Raichur	80	29.71	9.05	1.32	20	0.71
Shimoga	88	39.25	0.12	1.03	13.1	0.77
Tumkur	102	47.37	1.62	1.17	10.9	-0.11
Uttar Kannada	69	45.22	0.13	0.86	11.9	1.68
Udupi	46	55.41	0.56	1.34	1.1	2.76

- *U5MR which is available only for 1991 has been extra polated for newly formed districts as they have been part of old districts.*

☺ Health status of Kodagu, UK, Udupi, DK, Chamrajnagar and Bangalore Urban was found to be good and most of the North Hyderaad-Karnataka region districts has poor Health status

Disparities in Health Status have been assessed on

U5MR : Under five Mortality Rate - probability of dying in between birth and age 5, expressed as number of deaths among children under the age of five per 1000 live births.

%Normal : Percentage under five children whose nutritional status is within normal limits based on weight for age.

API MALARIA: Annual Parasite Incidence of malaria, which is number of confirmed cases of malaria per 1000 population under surveillance.

Pt.Prv.TB : Point Prevalence of Tuberculosis includes pulmonary and extra pulmonary tuberculosis cases per 1000 population.

Incident diarrhoea: Percentage of children below the age of five reporting current diarrhoea or diarrhoea during the last two weeks.

As no single indicator can adequately describe the situation it is desirable to concentrate on limited number of specific indicators. Child health indicators are more sensitive to Socio-economic differentials, and investment in child health has long term impact on equity. Therefore under-five mortality, incidence of diarrhoea and percentage of normal children have been used for assessing the health status. These indicators also reflect the nutritional health and health knowledge of mother, availability of maternal and child services including prenatal care, income and food availability in the family, the availability of clean water and safe sanitation and overall safety of the child's environment. These measures are also sensitive measures of gap in health status that are generally judged to be avoidable, unnecessary and unfair.

Other indicators of health status included are API malaria and point prevalence rate of tuberculosis including extra pulmonary TB which are the leading causes of deaths among communicable diseases.

FINDINGS - C

DISPARITIES IN GOVT. PRIMARY HEALTH CARE FACILITIES IN DISTRICTS OF KARNATAKA STATE

DISTRICTS	PHC/LAKH POPULATION	MOW/LAKH POPULATION	PARA/10,000 POPULATION	TOTAL INDEX
Bangalore Urban	2.59	3.31	2.01	-1.55
Bangalore Rural	5.27	6.62	3.33	0.16
Bagalkot	3.02	2.20	3.03	-1.30
Bellary	3.48	5.05	2.42	-0.88
Belgaum	3.62	4.93	2.74	-0.76
Bijapur	3.80	5.11	3.51	-0.44
Bidar	3.78	6.80	3.61	-0.12
Chamrajnagar	4.60	5.86	2.85	-0.30
Chitradurga	5.58	7.84	4.81	0.93
Chikkamagalur	7.69	10.62	4.89	2.01
Davengere	5.44	6.02	2.71	-0.09
Dakshina Kannada	3.72	4.95	3.62	-0.45
Dharwad	1.97	2.58	2.53	-1.68
Gadag	3.61	5.16	3.25	-0.56
Gulbarga	4.34	5.72	3.23	-0.27
Hassan	7.29	9.09	3.95	1.34
Haveri	4.77	5.68	3.28	-0.15
Kodagu	5.90	10.55	7.60	2.38
Kolar	4.63	6.14	3.34	-0.09
Koppal	3.91	5.47	2.72	0.60
Mandya	5.59	8.41	3.46	0.60
Mysore	5.79	8.28	4.46	0.95
Raichur	3.23	4.70	2.34	-1.03
Shimoga	5.30	7.64	4.27	0.65
Tumkur	5.14	6.88	3.33	0.17
Uttar Kannada	5.57	8.40	5.20	1.15
Udupi	5.71	5.24	3.02	-0.06

☺ Kodabu. Chikkamagalur, Hassan, UK, Mysore Chitradurga and Shimoga had good Primary Health Care Facilities

☹ Many North Karnataka districts and even Bangalore Urban lack in Primary Health Care facilities.

Disparities in Health Care Facilities have been assessed on

PHC : Number of Primary Health Care Centres per lakh population

MOW : Medical Officers working per lakh population

Para : Para Medical (Staff Nurse, BHE, Lab. Techn., ANM and Male workers) working per 10,000 population

These indicators refer to how resources actually are allocated. Primary health care provided by network of PHC and sub-centres with community participation is first level of contact between the individual and health system. Majority of prevailing health complaints and problems can be satisfactorily dealt with at this level.

These indicators reflect the distribution of Government health care resources in different districts of state and of the provision of health care. The purpose of health services to improve the health status of people.

FINDINGS: D

DISPARITIES IN UTILIZATION PATTERN OF HEALTH SERVICES IN DISTRICTS OF KARNATAKA

DISTRICTS	Immunization	ANC3	TT 2	Safe DEL.	CFPU	TOTAL INDEX
Bangalore Urban	77.7	86.9	85.8	92.9	60.1	0.75
Bangalore Rural	83.7	80.7	85.9	77.6	63	0.56
Bagalkot	53.2	42.3	80.7	45.3	47.1	-1.44
Bellary	52.6	63.9	79.4	46.6	50.4	-1.02
Belgaum	64.8	68	42.1	63.1	61.8	-0.72
Bijapur	53.2	94	83.9	60.4	47.1	-0.35
Bidar	50.3	61.8	72.4	58.3	50.6	-0.98
Chamrajnagar	92.7	70.3	43.4	57.8	65.4	-0.31
Chitradurga	88.4	94.9	75.1	90.7	59.9	0.82
Chikkamagalur	83.5	91.6	93.4	97.5	71.4	1.38
Davengere	88.4	92.2	75.9	61.3	59.9	0.32
Dakshina Kannada	86.0	89.1	94.5	91.5	63.7	1.08
Dharwad	74.8	72	80.1	80.4	61.2	0.23
Gadag	74.8	66.5	78.3	56.2	61.2	-0.27
Gulbarga	25.3	41.9	35.9	53.5	39.2	-2.48
Hassan	92.8	75.1	38.3	75	75.1	0.24
Haveri	74.8	80.5	84.2	60.6	61.2	0.10
Kodagu	94.8	83.6	85.6	85.4	70.6	1.07
Kolar	90.6	56.1	94.3	78.2	57.1	0.22
Koppal	37.2	35	68.5	48.9	45.4	-1.91
Mandya	88	80.2	37.6	73.3	71.7	0.13
Mysore	92.7	83.3	83.3	77.5	65.4	0.74
Raichur	37.2	70.5	52.9	59.1	45.4	-1.40
Shimoga	92.9	90.9	72.3	83.9	69.3	0.92
Tumkur	88	67.6	92.1	77.8	61.3	0.45
Uttar Kannada	89.9	81.2	84.9	88.6	66	0.89
Udupi	86	85.9	93.9	89.5	63.7	0.99

☹ Most of North Karnataka Districts have poor utilization pattern of existing Health services

Disparities in Utilization of Health Services have been assessed on

Immunization : Percentage of 12-23 months children completely immunized with BCG, DPT-3/OPV-3 and Measles

ANC3 : Percentage of pregnant women who have received 3 or more ANC visits received during recent pregnancy

TT2 : Percentage of ANC received TT2/Booster during recent pregnancy

Safe Del. : Percentage of deliveries conducted by Trained Health personnel during recent delivery.

CFPU : Percentage of current users of any Family Planning methods

Utilization of Primary Health Services included the utilization of Public and Private health services.

Utilization of services is expressed as the proportion of people in need of a service who actually receive it in given period. A relationship exists between utilization of health care services and health needs and status. Health care utilization is also affected by factors such as availability and accessibility of health services and the attitude of an individual towards his health and the health care system.

Utilization of public health services is often inequitable with the higher quality, more expensive services disproportionately used by more privileged segments of society.

FINDINGS - E

DISTRIBUTION OF DISTRICTS ON THE BASIS OF VARIOUS CHARACTERISTICS OF KARNATAKA STATE:

DISTRICTS	HEALTH DET.	HEALTH UTILIZ.	HEALTH FACILITY	HEALTH STATUS	TOTAL
Bangalore Urban	2.80	0.75	-1.55	0.05	0.92
Bangalore Rural	0.55	0.56	0.16	0.26	0.54
Bagalkot	-1.12	-1.44	-1.30	-0.53	-1.42
Bellary	-1.21	-1.02	-0.88	-1.87	-1.53
Belgaum	-0.23	-0.72	-0.76	-0.19	-0.57
Bijapur	-1.14	-0.35	-0.44	-0.47	-0.79
Bidar	-0.30	-0.98	-0.12	-0.89	-0.81
Chamrajnagar	-0.29	-0.31	-0.30	0.52	-0.18
Chitradurga	0.14	0.82	0.93	-1.00	0.31
Chikkamagalur	0.37	1.38	2.01	0.09	1.20
Davengere	0.24	0.32	-0.09	-0.27	0.13
Dakshina Kannada	1.35	1.08	-0.45	1.16	1.06
Dharwad	0.26	0.23	-1.68	-0.05	-0.20
Gadag	-1.05	-0.27	-0.56	-0.43	-0.71
Gulbarga	-1.22	-2.48	-0.27	-0.74	-1.58
Hassan	-0.02	0.24	1.34	0.00	0.45
Haveri	0.19	0.10	-0.15	0.07	0.13
Kodagu	0.47	1.07	2.38	2.11	1.80
Kolar	0.37	0.22	-0.09	-1.05	-0.07
Koppal	-1.73	-1.91	0.60	-0.68	-1.64
Mandya	0.30	0.13	0.60	-0.18	0.27
Mysore	0.12	0.74	0.95	-0.34	0.43
Raichur	-1.71	-1.40	-1.03	-0.71	-1.56
Shimoga	0.48	0.92	0.65	0.77	0.93
Tumkur	0.39	0.45	0.17	-0.11	0.35
Uttar Kannada	0.78	0.89	1.15	1.68	1.41
Udupi	1.20	0.99	-0.06	2.76	1.15

☹ Complete Hyderabad-Karnataka region including districts of Bidar, Gulbarga, Raichur, Koppal, Bellary, Bijapur and Bagalkot lack in Health Determinants, Health Status and Health Utilization including availability of Government Primary Health Care services.

☹ Districts like Belgaum, Gadag also have negative indices but at low level.

☹ Chamaraja nagar district has negative value of indices except on health status. This may be due to few indicators on health status have been taken from Mysore.

☹ Dharwad and Bangalore Urban were also lacking in Government Primary Health Care services.

☺ Kodagu, UK, Chikkamagalur, Udupi, DK, Shimoga and Bangalore Urban districts have good Health Determinants, Health Status, and Health Utilization of existing Health Services.

LAST 7 DISTRICTS ON THE BASIS OF VARIOUS INDICES

OVERALL	HEALTH DET.	HEALTH STATUS	HEALTH UTILIZATION	GOVT.HEALTH PRIMARY
Koppal (95)	Koppal(96)	Bellary(97)	Gulbarga (99)	Dharwad (95)
Gulbarga (94)	Raichur (96)	Kolar (85)	Koppal (97)	Bangalore (U) (94)
Raichur (94)	Gulbarga (89)	Chitradurga (84)	Bagalkot (93)	Bagalkot (90)
Bellary (94)	Bellary (89)	Bidar (81)	Raichur (92)	Raichur (85)
Bagalkot (94)	Bijapur (87)	Gulbaga (77)	Bellary (85)	Bellary (81)
Bidar (79)	Bagalkot (87)	Raichur (76)	Bidar (84)	Belgaum (78)
Bijapur (79)	Gadag (85)	Koppal (75)	Belgaum (76)	Koppal (73)

Figure in brackets indicates the position on 100 point scale

TOP 7 DISTRICTS ON THE BASIS OF VARIOUS INDICES

OVERALL	HEALTH DET.	HEALTH STATUS	HEALTH UTILIZATION	GOVT.HEALTH PRIMARY
Kodagu (4)	Bangalore (U)(1)	Udupi (1)	Chikkamagalur (8)	Kodagu (1)
Uttar Kannada (8)	Dakshina Kannada (9)	Kodagu (2)	Dakshina Kannada (14)	Chikkamagalur (2)
Chikkamagalur (12	Udupi (12)	Uttar Kannada (5)	Kodagu (14)	Hassan (9)
Udupi (13)	Uttara Kannada (22)	Dakshina Kannada (12)	Udupi (16)	Uttar Kannada (13)
Dakshina Kannada(15)	Bangalore (R) 29)	Shimoga (22)	Shimoga (18)	Mysore (17)
Shimoga (18)	Shimoga (32)	Chamrajnagar (30)	Uttar Kannada (19)	Chitradurga (18)
Bangalore-U(18)	Kodagu (32)	Bangalore–R (40)	Bangalore U (23)	Shimoga (26)

Figure in brackets indicates the position on 100 point scale

☹ However, disparities in health on class, caste, age, sex and the religion could not be assessed, as data does not exist in disintegrated form for districts of Karnataka.

Relationship in between Health Status and Health Determinants among the Districts of Karnataka State:

HEALTH STATUS	HEALTH DETERMINANTS		
	LOW	MODERATE	HIGH
LOW	BELLARY GULBARGA KOPPAL RAICHUR	CHITRADURGA KOLAR BIDAR	
MODERATE	BAGALKOT BIJAPUR GADAG	DAVANGERE BELGAUM CHIKKAMAGALUR DHARWAD, HASSAN, HAVERI MANDYA,MYSORE TUMKUR	BANGALORE (U)
HIGH		CHAMARAJNAGAR	DAKSHINA KANNADA UTTAR KANNADA UDUPI, KODAGU SHIMOGA, BANGALORE (R)

Observed Agreement 19/27 - 70.4%

Kappa Coefficient: 0.532, P = 0.000059

It is obvious from the above table that the districts with the low value on health determinants have low health status and districts with high value of health determinants have the high value of health status with an agreement of 70.4% and Kappa Coefficient 0.532, which is significant.

Relationship in between Health Status and Primary Health Care Facilities among the Districts of Karnataka State:

HEALTH STATUS	PRIMARY HEALTH CARE FACILITIES		
	LOW	MODERATE	HIGH
LOW	BELLARY KOPPAL, RAICHUR	GULBARGA KOLAR BIDAR	CHITRADURGA
MODERATE	. BAGALKOT BANGALORE (U) BELGAUM DHARWAD	BIJAPUR DAVANGERE, 'GADAG, HAVERI MANDYA,TUMKUR	CHIKKAMAGALUR HASSAN MYSORE
HIGH		DAKSHINA KANNADA UDUPI, BANGALORE (R) CHAMRAJNAGAR	KODAGU UTTAR KANNADA SHIMOGA

Observed Agreement 12/27 - 44.44%

Kappa Coefficient: 0.1234, P = 0.1862

Government Primary Health Care services and health status are not very much related with observed agreement of 44.44% and Kappa Coefficient 0.1234 which is not significant. This may be due to the utilization and availability of private health services.

Chitradurga district has low Health status even though it has good Government Primary Health Care services.

Relationship between Health Status and Utilization of Primary Health Care services among the Districts of Karnataka State:

HEALTH STATUS	UTILIZATION OF PRIMARY HEALTH SERVICES		
	LOW	MODERATE	HIGH
LOW	BELLARY, GULBARGA, BIDAR KOPPAL, RAICHUR	KOLAR CHITRADURGA	
MODERATE	.BAGALKOT BELGAUM	BIJAPUR DHARWAD, ' DAVANGERE HASSAN, HAVERI MANDYA,GADAG TUMKUR, MYSORE	BANGALORE (U) CHIKKAMAGALUR
HIGH		BANGALORE (R) CHAMRAJNAGAR	DAKSHINA KANNADA UTTAR KANNADA UDUPI, KODAGU SHIMOGA

Observed Agreement 19/27 - 70.4%

Kappa Coefficient: 0.532, P = 0.000059

All districts with high health status continue to use Primary Health Care services and the districts with low health status have low utilization of primary health care services. The above table, observed agreement and kappa coefficient denotes that the health status is more related to the utilisation rather than the availability of services.

Relationship in between Primary Health Care Facilities and Health Facilities Utilization among the Districts of Karnataka State

HEALTH FACILITIES UTILIZATION	PRIMARY HEALTH CARE FACILITIES		
	LOW	MODERATE	HIGH
LOW	BELLARY BAGALKOT BELGAUM RAICHUR KOPPAL	GULBARGA BIDAR	
MODERATE	DHARWAD	'BANGALORE (R) BIJAPUR CHAMRAJNAGAR DAVANGERE, GADAG, HAVERI MANDYA,KOLAR TUMKUR	HASSAN CHITRADURGA MYSORE
HIGH	BANGALORE (U)	DAKSHINA KANNADA UDUPI	CHIKKAMAGALUR KODAGU UTTAR KANNADA SHIMOGA

Observed Agreement 18/27 - 66.7%

Kappa Coefficient: 0.474, P = 0.00031

It is clear from the above table the relationship between Primary Health Care utilisation and Primary Health Care facilities is significant where observed agreement is 66.7% and Kappa Coefficient is 0.474. This shows the availability of health services leads to utilization of the health services.

In case of Bangalore Urban though the availability of government primary health care facilities is low, the utilization of health services is high. This may be due to availability of health care services in the private sector.

findings it is clear that the Hyderabad - Karnataka region (Bidar, Gulbarga, Koppal and Bellary), Bijapur and Bagalkote lack on all indicators in the [illegible] categories.

Equity in Health requires equity in the distribution of the determinants, availability of primary health care services and the utilization of health care services.

The map enclosed indicates the districts which require top priority (red), moderate attention (yellow) and districts where existing facilities, utilization and health status should be maintained at an acceptable level (green).

RECOMMENDATIONS

- Environment Sanitation including availability of clean water, housing and access to latrine and amenities like electricity should be improved in entire Hyderabad-Karnataka region, Bijapur, Bagalkote, Gadag, Hassan and Haveri districts. For this scheme like Nirmal Karnataka Program under Rural Development and Panchyat Raj should be implemented with creating awareness on sanitation and provision of facilities simultaneously.

- Literacy Status 15+ should be improved in Hyderabad-Karnataka region, Bijapur, Bagalkote, Chamrajnagar, Mandya and Bangalore Rural districts.

- Efforts to be made to improve the economic status of household in Hyderabad-Karnataka region, Bijapur, Bagalkote, Chamrajnagar, Chitradurga, Dharwad, Gadag and Kola districts.

- Nutrition status of under five should be improved in entire Hyderabad-Karnataka region, Bijapur, Bagalkote, Davengere, Gadag and Haveri District.

- Malaria incidence to be reduced in Hyderabad-Karnataka region, Bijapur, Bagalkote, Chitradurga, Dakshina Kannada, Hassan, Kolar and mandya districts by implementing National Anti Malaria Program aggressively.

- Prevalence of TB should reduced in Hyderabad-Karnataka region, Bijapur, Bagalkote Chamrajnagar, Chitradurga, Kolar, Mandya, Mysore and Bangalore Urban and Rural districts by extending RNTCP to these districts on priority basis.

- Primary Health Care facilities to be improved in Hyderabad-Karnataka region, Bijapur, Bagalmote Bangalore Urban, Dharwar and Gadag districts.

- More than establishing new primary health care facilities the utilization of existing primary health care services should be encouraged. This could be done by making existing primary health care facilities functional in real sense through monitoring of availability of staff including MOH and drugs.

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ANNEXURE – 1

I. HEALTH DETERMINANTS INDICATOR

a. Prevalence and level of poverty * - 1998
b. Educational levels * - 1991
c. Adequate sanitation and Safe water coverage * - 1998
d. Housing * - 1991

II. HEALTH STATUS INDICATORS

a. Under five year mortality rate * - 1991
b. Nutrition of children * - Nov. 2000
c. Maternal mortality ratio: Not Available
d. Life expectancy at birth: Not Available
e. Incidence & Prevalence of relevant infectious diseases * - 1999
f. Infant mortality ratio: Not Available
g. Child mortality (1-4 years) : Not Available

III. HEALTH CARE RESOURCES ALLOCATION INDICATORS

a. Per capita distribution of qualified personnel in selected categories eg., medical officers: physician, obstetrician, paediatrician, surgeons & paramedical workers. * - Sept. 2000.

b. Per capita distribution of services facilities at Primary, Secondary and Tertiary levels. * - 1999

h. Per capita distribution of total health allocation and expenditure on personnel and supplies as well as facilities: Not Available

IV. HEALTH CARE UTILIZATION INDICATORS

a. Immunization coverage * - 1998
b. Antenatal Coverage * - 1998
c. Percentage of births attended by qualified attendant * - 1998
d. Current use of contraception * - 1998

*** Indicators used in the present report**

GOVERNMENT OF KARNATAKA

TASK FORCE ON HEALTH AND FAMILY WELFARE

A Commissioned Research Study

ROLE OF PRIVATE SECTOR IN HEALTH CARE: QUALITY AND ACCESS

By

A. F. FERGUSON & CO
MANAGEMENT CONSULTANT DIVISION
BANGALORE

1. Background

Introduction

1.1 Health care and public health being one of the thrust areas for development and improvement, the Government of Karnataka has considered the need for review of the current state of Health System so as to ensure 'Health for all' with equity and quality.

1.2 In order to propose measures to improve the public health care systems in the State of Karnataka, the Department of Health and Family Welfare (DHFW) has set up a Task Force, consisting of eminent persons in various fields, which will examine the issues involved and propose measures which could be adopted by the Government.

1.3 In this regard, the Task Force has conducted a preliminary study and presented an interim report dealing mainly with short-term recommendations, which can be implemented within a period of 6 months. It has also identified areas of concern, which can be accomplished in the medium and long term.

1.4 A.F.Ferguson & Co. – MCS division (AFF) has been retained by Karnataka Health Systems Development Project (KHSDP) for review of private sector role in improving health service programs (access and quality).

Terms of Reference

1.5 The Terms of Reference (ToR) for the study is as follows :

- To review existing role of the different sectors viz. voluntary-not for profit hospitals, for profit hospitals and public (Government) hospitals in providing health care services and determining the possibility of a partnership between them
- To review the various health care services offered by private sector in terms of access and qualities and suggest improvements thereof
- To review the role of private sector in preventive/promotive and rehabilitative Health Care delivery
- To determine the willingness of private sector to be regulated in delivery of their services either by legislation, self-regulation or accreditation.

Approach & Methodology

1.6 Our approach to the study included:

- Preliminary Study
- Primary Survey
- Analysis – Findings and Recommendations

Preliminary Study:

1.7 This phase of the study involved the following

- **Discussions with Relevant Personnel:** Detailed discussions were held with the members of the Task Force and other relevant personnel, regarding the various aspects of the proposed study.
- **Secondary Data Research**: Based on the discussions, information was compiled from various secondary sources viz., Government of India publications, Government of Karnataka publications, World Bank reports, other research findings etc., on the factors affecting public health programmes and the private sector.

Primary Survey

1.8 A primary survey of a sample comprising of private hospitals, Government hospitals, nursing homes, private practitioners, Government doctors and alternate systems of medicine. For every hospital and clinic visited exit proformas from both in-patients and out-patients were administered to assess the quality of care delivered. The details of coverage is given in chapter 2.

Analysis – Findings and Recommendations

1.9 The information collected from the primary and secondary sources was analysed to determine the role of private sector in public health services. The perceptions on the existing services received from the cross section of society was considered while providing recommendations on enhancement of private sector role in health care distribution. Recommendations are provided on the improvements in *Quality and Access* to be incorporated by the private sector in line with their proposed additional role.

1.10 The various aspects of the study are presented in different chapters.

- Chapter 2: Primary Survey Coverage
- Chapter 3: Review of Quality and Level of Care
- Chapter 4: Access to Healthcare
- Chapter 5: Regulation and Accreditation
- Chapter 6: Public Private Partnerships
- Chapter 7: Conclusions and Recommendations

2. Primary Survey Coverage

2.1 This chapter presents the objectives, methodology followed and coverage of primary survey made as part of the study.

Objectives of the Survey

2.2 The primary survey was made with the following objectives

- Comparative study of quality of services offered as perceived by patients - Reviewing the level of care in private hospitals vis-à-vis public hospitals at the Primary, Secondary, Tertiary levels to the extent relevant for the study.
- Private Sector hospital review in terms of
  - Physical Access
  - Social Access:
  - Services Availability
  - Quality as perceived by patients
- Involvement of private sector in national programmes
- Whether the private sector can be motivated towards greater access to society
- Willingness of Private sector for regulation, self-regulation and accreditation.

Methodology

2.3 Exhaustive questionnaires were prepared covering all aspects of the study. The questionnaire (please refer Annexure 1) which served as a basis for fact finding were

- Private Hospital Proforma
- Government Doctors Proforma
- Private Practitioners Proforma
- Exit Proforma – Patient Satisfaction

2.4 Discussions with key Department of Health members/ Task Force were also held. Their suggestions were duly incorporated in the questionnaires.

2.5 The concerned hospitals/health care centres were visited by the consultants of AFF covering the following :

- A tour of all services/ facilities
- Detailed discussions with the management to obtain their views on key issues.

2.5.1 The results of primary survey are as provided by the respondents verbally/or in the filled-up questionnaires, these could not be verified with their documents as the hospitals/practitioners were reluctant to provide any records or statements to substantiate their claims especially in cases like percentage of patients provided free treatment.

Coverage

2.6 Adequate care was taken to make the sample representative in terms of

- Category of respondents - Hospitals, Practitioners and Patients
- Geographical Coverage – Urban/Rural composition and Spread

Hospitals

2.7 **By Management:** All categories of hospitals with different management styles were part of the study as is shown in table 2.1.

Table 2.1: Coverage as per Different Category of Hospitals - Management

S.No.	Particulars	Number In urban Areas	Number In Rural Areas	Total Number
1.	**Private Hospitals**	**6**	**2**	**8**
	- Corporate Hospitals	2	-	2
	- Trust Hospitals	2	-	2
	- Teaching Hospitals	1	1	2
	- Missionary Hospitals	1	1	2
2.	Nursing Homes	2	7	9
3.	Indian System of Medicine	1	1	2
4.	Government Hospitals	3	8	11
	Total	**12**	**18**	**30**

2.8 **By Level of Care:** To the extent possible, a mix of primary, secondary and tertiary level of care offered by different hospitals was provided for in the sample.

Table 2.2: Coverage as per Level of Care Provided

S.No	Particulars	Number In urban Areas	Number In Rural Areas	Total Number
1	**Private Sector**	**8**	**9**	**17**
	- Primary	2	7	9
	- Secondary	4	2	6
	- Tertiary	2		2
2	**Government Hospitals**	**3**	**8**	**11**
	- Primary Health Centre		6	6
	- Community/Taluk Health Centre		2	2
	- District Hospital	3		3
3	**Indian System of Medicine**	**1**	**1**	**2**
	Total	**12**	**18**	**30**

Practitioners

2.9 Adequate coverage of general physicians, specialists in private sector and Government doctors was provided for in the sample as is shown in table 2.3.

Table 2.3: Coverage of Practitioners

S.No.	Particulars	Number In urban Areas	Number In Rural Areas	Total Number
1	Private Practitioners	13	11	24
	- General Physicians	8	7	15
	- Specialists	5	4	9
2	Government Doctors	5	23	28
3	Indian System of Medicine	1	1	2
	Total	**19**	**35**	**54**

Patients

2.10 A minimum of 3 questionnaires was administered to patients in every hospital and clinic visited in the private sector. In all, a total of 112 exit proformas were administered to patients.

2.11 Break-up as per IP/OP: Equal representation was given to both the in-patients and out-patients in the sample as is shown in table 2.4.

Table 2.4: Break-up of IP/OP Patients

S.No.	Particulars	Number In urban Areas	Number In Rural Areas	Total Number
1	In-Patients (including Indian system of medicine)	46	10	56
2	Out-Patients	56		56
	Total	**102**	**10**	**112**

2.12 Classification as per Sex of patient:

Table 2.5: Sex wise Classification of Respondents

S.No.	Particulars	Number In-patients	Number Out-patients	Total Number
1	Males	33	38	71
2	Females	22	19	41
	Total	**55**	**57**	**112**

2.13 Classification as per Age of Patients:

Table 2.6: Age wise Classification of Respondents

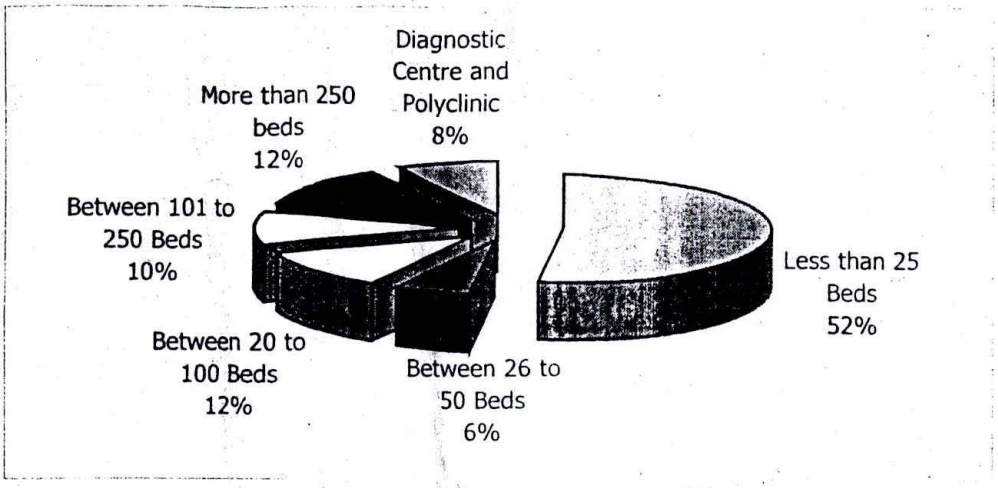
S.No.	Particulars	Number In-patients	Number Out-patients	Total Number
1	Less than 12 yrs		8	8
2	12 – 35 yrs	28	33	61
3	36 –50 yrs	13	12	25
4	Above 50 Yrs	14	4	18
	Total	**55**	**57**	**112**

2.20 Discussions with owners of certain hospitals, nursing homes, IMA members and hospital administrators were also held to get a feel of various qualitative parameters for setting up an accreditation body.

2.21 Break-up of respondents by number of beds, ownership, system of medicine and services provided is presented below

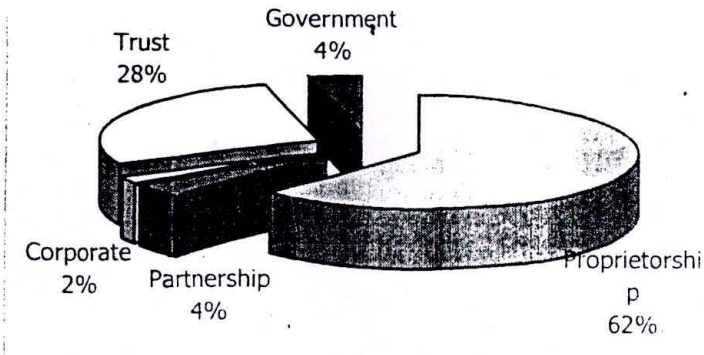
2.21.1 **Number of Beds:** Majority of respondents were nursing homes having less than 25 beds as is shown in exhibit 2.1

Exhibit 2.1: Classification as per Number of Beds



2.21.2 Ownership: Majority (62%) of the respondents had proprietorship concern as is shown in exhibit 2.2

Exhibit 2.2: Classification as per Form of Ownership



2.21.3 System of Medicine: Majority (88%) of them were allopathic graduates, 6% of them were from other disciplines and responses for other 6% were not available.

2.14 Classification as per Income of Patients:

Table 2.7: Classification of Respondents on Income

S.No.	Monthly Income	Number In-patients	Number Out-patients	Total Number
1	Upto 1000		3	3
2	Rs. 1000- Rs. 2000	4	3	7
3	Rs. 2000 – Rs. 3600	13	6	19
4	Rs. 3600 – Rs. 5000	11	12	23
5	Above Rs. 5000	18	12	30
	Total	**46**	**36**	**82**

Note : 30 respondents did not indicate family income

Coverage as per Spread

2.15 The respondents were mainly from the urban and rural areas of Bangalore, Belgaum, Kolar and Gulbarga.

2.16 Thus, to an extent possible, adequate effort was made to make the sample representative in terms of both categories of respondents and geographical distribution for the purpose of the study.

Primary Survey for Assessing Willingness for Accreditation

2.17 For assessing the willingness of private sector hospitals and practitioners for accreditation, a separate structured questionnaire (Annexure II) was mailed to 600 hospitals/nursing homes/Private Practitioners/Specialists through IMA and also through distribution at IMA sponsored seminars at Gulbarga, Belgaum and Kolar.

2.18 The break-up of responses received is shown in table 2.8. Though responses were received only from 36% of hospitals, the break-up of responses by number of beds, ownership, system of medicine and services (as has been detailed below) indicates that the sample was representative of the whole.

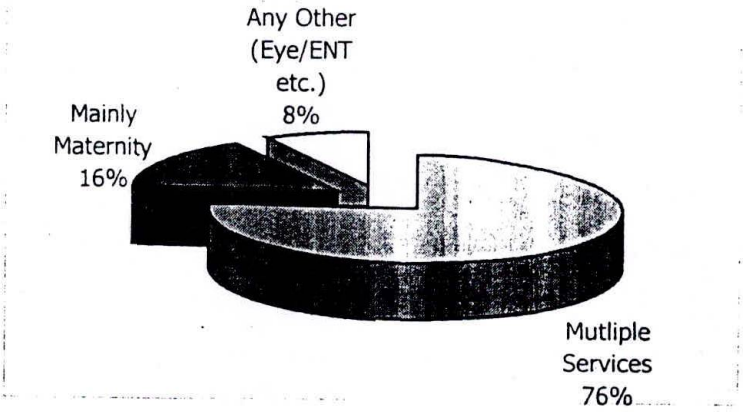
Table 2.8: Responses Received From Different Categories

	Proforma Sent	Responses Received	Percentage Responses Recd.
Number of Hospitals	500	180	36%
Number of Specialists	50	35	70%
Number of GP's	50	40	80%
Total	**600**	**255**	**42.5%**

2.19 The respondents were different stakeholders in hospital services. Though only 36% of responses were received from hospitals category, the responses were representative of the whole as could be seen from the break-up of total respondents presented below.

2.21.4 **Services Provided:** Majority were providers of multiple services and the break-up is presented in exhibit 2.3

Exhibit 2.3: Classification as per Services provided



3. Review of Quality and Level of Care

3.1 Quality of service provided in hospitals are usually determined by either of the following two methods

- Review of service offered such as effectiveness of treatment, hospital infection rates etc and facilities available (Equipment, Investigation, Staff etc)
- Review of patient's perception of the quality

3.2 This study has focused on review of level of care and quality in the private sector through exit patient perception of quality. This was conducted through a detailed patient survey, wherein around 102 exit proformas were administered to patients visiting Hospitals, Private clinics etc. In addition, around 10 patients from an alternate system of medicine namely Ayurvedic Medicine were covered. This chapter presents the findings of the survey on review of quality and level of care.

3.3 In order to retain the distinction between Allopathic medicine and the Indian system of medicine, for the purpose of review of patient perception, the observations from the patients of Ayurvedic hospital have been indicated separately.

Quality of Service

3.4 The quality of service offered by the private sector has been reviewed on the following parameters :

- Patient Expectation
- Repeat Visit / Recommendations
- Doctor – Patient communication
- Nursing care
- Ward Staff Support
- Support Services
- Administrative Support

Patient Expectation

3.5 Quality of care is perceived to be high, when the expectations of patients with respect to outcome of service is met.

3.6 Majority of the patients were of the view that their expectations of service were either fully met or have been met to a certain extent. None of the In-Patients (IP) were of the view that expectations have not been met. This holds true for the rural sector also. Around 3% of the out-patients(OP) were of the not satisfied with the treatment given.

3.7 Table 3.1 presents the response with regard to patient expectation.

Table 3.1: Patient Expectation Response

Expectation :	In-Patients	Out-Patients
Fully met	54%	49%
To some extent met	46%	48%
Not met	0%	3%
Total	**100%**	**100%**

3.8 In case of Indian Systems of medicine a majority of the patients were of the view that the patient expectation were met only to some extent.

Repeat Visits/Recommendations

3.9 Satisfaction of care and meeting of care expectations, is an indicator that the patient would visit the hospital for any subsequent illness as well as recommend the hospital to others.

3.10 This has also been reinforced in the survey where majority of respondents indicated that in the event of future illness they would like to visit the same hospital. Further, they would also either surely or may recommend the hospitals to others. This is true for both urban and rural hospitals.

3.11 Table 3.2 presents the response on repeat visits and recommendations

Table 3.2 : Response on Repeat Visits and Recommendations

Response	Repeat Visits	Recommend to others
Surely	54 %	42%
Maybe	43 %	56%
Not at all	3%	2%
Total	**100%**	**100%**

3.12 As part of the hospital survey findings, 70 % of the patients are repeat patients.40% of the patients went back for the same complaints and 60% for fresh complaints. This reinforces the response received from patients.

Doctor – Patient Communication

3.13 A Doctor's role is critical with respect to perception of the patient in regard to the quality of any hospital/clinic. Most patients visit the hospitals for consultation with specific doctors. The doctor's role is reviewed both in terms of technical capabilities as well as the comfort level the patient perceives with the doctor. As an average patient would not be able to judge the technical capabilities of the doctor, more often, on successful treatment, the confidence on the doctor's capabilities rise. The different factors reviewed in the exit proforma survey are:

- Communication on the illness and treatment process
- Sense of Comfort
- Opinion on treatment
- Doctor Behavior.

Communication on illness and treatment process.

3.14 Responses were elicited on whether adequate information was provided by the doctor about the illness and treatment meted out. It must be noted that extent for requisite information would vary from patient to patient. Around 84% of the patients were fully satisfied with the explanations given. In cases where the patients felt that adequate information about illness has not been provided, they were barely satisfied with the doctor's service. Thus, the survey indicated that communication played a key role in the overall satisfaction of the patient on the quality of services.

Sense of Comfort

3.15 The comfort level felt with the doctor plays a key role in removal of most apprehensions of patients. The patients were queried on whether they felt free to talk to the doctor regarding their concerns and worries. Majority of the patients were at a comfort level with regard to patient- doctor communication. In the rural areas, almost all patients with an exception or two, were very comfortable with the doctor communication.

Opinion on Treatment

3.16 Empirical studies have proven that a physician's task competence have a significant influence on patient decision on quality. Opinions on the doctor's competence are formed on recovery history of previous illness as well as patient's response to current treatment. The respondents were divided closely between 'good' and 'satisfactory' treatment. A small percentage (2%) was dissatisfied with the technical capabilities of the doctor.

Doctor Behaviour

3.17 Doctor's behaviour with the patient were reviewed in terms of whether the doctors were kind and helpul, indifferent or they needed improvement in the same. Around 14% of the respondents were of the view that there is a need to improve behaviour of doctors. This may be a response to behaviour of specific physicians and has been noted in a rural nursing home as well as in three other instances..

Overall Satisfaction

3.18 Majority of the patients were totally satisfied with the overall service provided by the doctors thereby, reflecting in the quality standards perceived by them. Table 3.3 provides the responses of the Doctor – Patient communication parameter.

Table 3.3 : Responses on Doctor Patient Communication Parameter

Response	Commu-nication	Comfort Level	Treatment Quality	Doctor Behaviour	Overall Satisfaction
Fully Satisfied	84%	78%	55%	81%	87%
Satisfied to some extent	12%	22%	43%	5%	11%
Not Satisfied	4%		2%	14%	2%

3.19 The exit proforma conducted on patients visiting the Ayurvedic Hospital indicated that majority of patients (~ 70%) were only satisfied to some extent with the

doctor's treatment. While ~80 % of the respondents felt that the communication between patient doctor could have been better, the responses were mixed with regard to the doctor behaviour (50 – 50 between Kind and Indifferent).

Nursing Care

3.20 Nursing care provided by the private sector was reviewed for in-patient care. High level of interaction between nurses and patient results in Nursing care being a key aspect in determining patient satisfaction thereby perception of quality. Nursing care determinants reviewed were :

- Support and kindness of nursing staff
- Perceived competence thereby quality of service
- Prompt answer to call

3.21 The majority of hospitals and nursing homes do not have nursing manuals. Missionary hospitals have standing orders for nurses for certain departments. Many of the hospitals are now planning to have manuals.

3.22 The survey revealed that most patients felt that the nurses were fairly friendly and courteous in the urban areas, while in rural hospitals it was predominantly found that patients felt that nurses need to improve their behaviour in terms of kindness and warmth. The feedback on quality of nursing care was equally distributed between 'good', 'satisfactory' and 'needs improvement'.

3.23 The major hospitals had trained and qualified nurses whereas the smaller hospitals and nursing homes have poorly trained nurses and not as per Nursing council norms.

3.24 Majority of the patients with the exception of the rural hospitals were of the view that the nurses responded promptly on patient. Table 3.4 presents the exit proforma findings on Nursing care offered in the private sector.

Table 3.4 : Responses to Nursing Care Offered in Private Sector

Responses	Nursing Staff Behaviour	Quality of Nursing Care
Good (Kind & Helpful)	58 %	32 %
Satisfactory (Indifferent)	12 %	32 %
Needs Improvement	30 %	36 %
Total	**100%**	**100%**

3.25 In the Ayurvedic hospital, the responses closely distributed across the three parameters i.e. 50 %, 30% and 20% respectively. Most in-patients were of the view that the nurses were indifferent and the quality of nursing care was only at a satisfactory level.

Ward Staff Support

3.26 Ward attendants are the key support staff assisting the quality care of the in-patients. Service in terms of promptness to calls and their behaviour with the patients reflect on the atmosphere of the hospital. Around 46% of the respondents

felt that these attendants were prompt in their service, while 38 % (predominantly rural) felt that they needed improvement.

Support Services

3.27 Hospitals are complex entities with multiple range of functions being conducted within. Though primarily clinical and para-medical care forms the key functions of the hospital, other areas such as Pharmacy, Housekeeping, Admissions and Food service play critical roles in ensuring quality care to the patient. Respondents were queried on the efficiency of these services and their satisfaction from them. The areas covered were :

- Medical Supply Procurement
- Quality of meals
- Housekeeping

Medical Supply Procurement

3.28 Easy availability of medical supplies in the medical/surgical shops located in the hospital is critical to the patient especially in emergency situations. While no respondent had any concern regarding availability, around 86% did not face any problems in procurement of medicine from these shops.

3.29 In the ayurvedic hospital, certain section of patients (60%) had difficulty in procuring medicines, in certain situations while the remaining 40% did not face any problems.

Quality of Meals

3.30 Provision of hygienic and good quality meals are a requisite for smooth recovery of the patient and also reflect on the quality of the hospital. However, it has been observed that unless made mandatory by the hospital, most patients do not avail of the hospital meal services. Further, the respondent's view on the quality would be highly individualistic and subjective to factors such as taste etc.

3.31 Around 62% of the in-patients (who availed of the facility) were satisfied with the meal quality and timely service while 38% felt that there is scope for improvement of meal service and quality.

3.32 All respondents of the Ayurvedic Hospital covered felt that there is a need to improve the quality and service of meals offered.

House-Keeping

3.33 Hospitals being at a high risk in terms of cross – infections, good housekeeping reflects on the overall quality care offered by hospitals. Housekeeping has been reviewed in the exit proformas in terms of cleanliness of wards, toilets etc as well as provision of linen and other supplies.

3.34 Responses on cleanliness of wards, toilets and bathrooms were highly hospital specific with certain hospitals rating very high (100 % satisfaction) and certain others quite low (75 % dissatisfaction). This is true for both rural as well as urban hospitals. On an overall basis, around 54% found that the toilets were clean.

3.35 With regard to linen supply, most of the rural respondents had used their own linen. This may be due to bad quality of linen supplied by hospitals or the hospitals do not provide for the same. The responses of other patients revealed an equal distribution between satisfactory and need of improvement parameters.

3.36 Majority of the in-patients felt that the facilities of sweeper, security and power were adequate.

3.37 Table 3.5 presents the responses on Housekeeping facilities of the hospitals.

Table 3.5 : Responses to Housekeeping Facilities

Responses	Cleaniness of ward, Toilets & Bathrooms	Quality of Linen
Satisfactory	54 %	51 %
Needs Improvement	46 %	49 %
Totally Dissatisfactory	0 %	0 %
Total	100%	100%

3.38 In the ayurvedic hospital, all patients felt that there was a distinct need for improvements of the cleanliness levels and the linen supply.

Administrative Support

3.39 Quick and simple administrative procedures facilitate in enhancing the comfort level of the patient with the hospital. The administrative support was reviewed in terms of the following :

- Admission & Billing Procedure
- Attitude of Reception staff
- Waiting time

Admission and Billing Procedure

3.40 Majority of the patients (76%) felt that the admission and billing procedure was simple with none of the view that it was very complicated. This is applicable to both the rural/ urban hospitals as well as the Ayurvedic Hospital.

Attitude of Reception Staff

3.41 Around 38 % of the respondents were of the view that the reception staff was courteous, prompt and answered their queries satisfactorily, while 57 % felt that there was a need for improvement in their attitude.

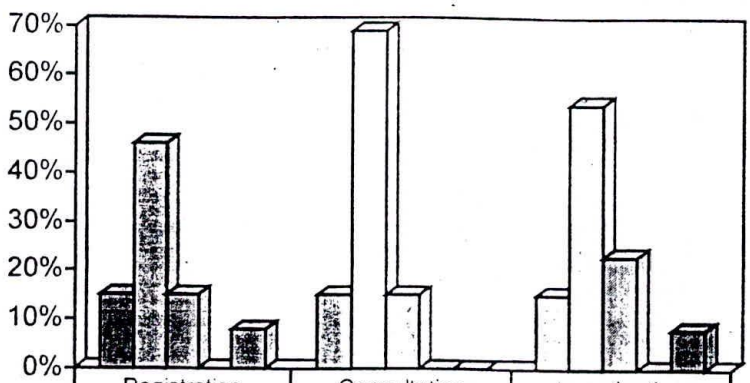
Waiting Time

3.42 Average waiting time was determined for the levels of enquiry/registration, doctor consultation and investigation. In all the three cases the majority of the respondents were of the view that the average waiting time was 30 – 45 minutes with 56 % feeling that though long, the waiting time was acceptable. 30 % of the

respondents were of the view that the overall waiting time was reasonable and within their expectations.

3.43 In the OPD, most of the waiting time (73%) was spent in waiting for doctor consultation. The average waiting time at each stage is presented in the Exhibit 3.1

Exhibit 3.1: Waiting Time



	Registration	Consultation	Investigation
Less than 30 min.	15%	15%	15%
30-45 min.	46%	69%	54%
45-60 min.	15%	15%	23%
60 - 120 min	0%	0%	0%
More than 120 min	8%	0%	8%

Level of Care

3.44 Level of care provided in the private sector was determined through the availability of services in the hospital and the perception of the patients of the same.

Services Availability

3.45 The various services available in the private sector can be summarised as under:

- Super speciality services are generally available in Corporate / Teaching hospitals
- The Trust and Missionary hospitals generally provide secondary level of care i.e. internal medicine, paediatrics, general surgery etc.
- Most of the nursing homes have only minimal services for emergency care.

3.46 With regard to investigation facilities the following observations have been made:

- Corporate / Teaching hospitals usually have facilities for all investigations
- Missionary / Trust hospitals offer secondary level of investigations
- Most nursing homes have only basic investigation services.

3.47 This has been confirmed in the exit proformas wherein most of the corporate / teaching hospitals had their own investigation facilities.

3.48 Facilities in terms of adequate water and power supply and the drainage facilities were found in all the hospitals covered. However, water purifier facilities were not available in the nursing homes.

3.49 While the private hospitals had adequate number of ambulances, the nursing homes did not have any. In terms of ward facilities, the nursing homes had only general wards and no ICU facilities while all the private hospitals covered had Emergency wards, general wards and ICU facilities. The nursing homes do not seem to follow any kind of standard protocols regimes.

3.50 The facilities available in the private sector are presented in Table 3.6

Table 3.6: Facilities Available in the Private Sector

Facilities	Private Hospitals (%)	Nursing Homes (%)
Emergency Ward	100	0
% Beds in General Ward	61	36
ICU	100	0
ICU Beds/Total Beds (%)	5-10%	0
Ambulance	67	0
No. of Ambulances (No.)	1-4	0
Overhead Water Tank	100	100
Water Purifier	100	0
Hot Water Facility	100	100
Generator	83	75
Elevator	83	0
Drainage Connection	100	100
Laundry	100	67
Space for Washing Patients Clothes	83	100
Declared Baby Friendly by Govt.	50	0

3.51 Majority of the private hospitals and nursing home laboratories are not standardised and none of them are participating in standardisation programme accreditated to the 'National Bard of Accreditation of Laboratories'.

3.52 There is thus an urgent need to set up minimum standards for hospitals and nursing homes of varying capacities and classified as primary, secondary and tertiary.

3.53 Currently, there are no permissions from any government authority required to set-up nursing homes. As a result, there has been a proliferation of poorly planned and ill-equipped nursing homes.

Patient Perception on Services Availability

3.54 The patient perception on services availability was reviewed in terms of the following :

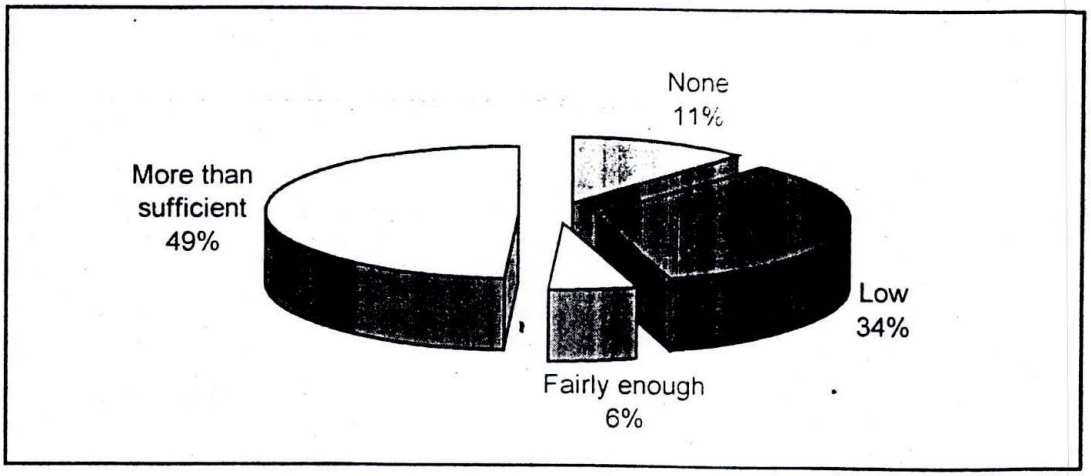
- Extent of investigations conducted
- OPD facilities such as
  - Physical Space
  - Drinking water
  - Seating arrangements
  - Fan & Ventilation
  - Toilet
- In-patient facilities such as water, power and security
- Equipment Availability

Extent of Investigations conducted

3.55 Investigations, normally conducted to confirm diagnosis, have become more or less a routine matter in most hospitals/nursing homes. The patient perception with regard to the extent of investigations conducted, elicited the response as indicated in exhibit 3.2

Exhibit 3.2: Patient Perception on Extent of Investigations Conducted

3.56 The most common investigation done for the in-patients was Blood (70%) and Radiological -X-Ray (62%), C.T Scan (12%) etc. A sample detailed exit proforma



was conducted for around 13 patients to determine investigations conducted against specific illness/symptoms. Table 3.7 presents a summary of the responses received.

Table 3.7: Illness Specific Investigations conducted

Illness/Symptom	Investigations
Hernia – Swelling in groin	Blood, Urine, CxR etc
Appendicitis	U.S Abdomen, Routine Blood and Urine
Lower Respiratory Liactxerfection, cough, expectoration, fever	Chest X-ray, PA view, Routine Blood and Urine analysis
Intestinal Perforation, Pain in abdomen, Fever	Urine, Blood, Chest X-ray
Amenorrhea in labour	US scanning of Abdomen
Congestive cardiac failure, breathlessness, cough and expectoration	Chest X-ray PA, Routine Blood and Urine
Pregnancy	Blood, Urine, USG, CxR
Acute Gastritis – Pain in abdomen	Endoscopy
Fever for evaluation	Blood, urine CxR etc

OPD Facilities

3.57 Availability of space has an important bearing on the level of care and quality of service. Majority (65%) of the respondents (specifically those visiting clinics) felt that there was a reasonably good space in the OPD while around 27 % (mostly constituting of hospital patients) felt that the OPDs were quite spacious.

3.58 The facilities in the OPD such as drinking water, seating arrangement, fan & ventilation and toilet were reviewed with the various patients to determine the extent of such facilities offered in the private sector. Majority of respondents were of the view that these facilities were fairly sufficient. Table 3.8 presents the responses with regard to the above.

Table 3.8 : Extent of OPD facilities

Response	Drinking water	Seating Arrangement	Fan and Ventilation	Toilet
Less	31%	21%	20%	26%
Fairly sufficient	53%	60%	64%	56%
More than sufficient	15%	18%	15%	17%

3.59 Majority of the patients (~80%) of the Ayurvedic hospitals found the OPD facilities to be less satisfactory.

In-Patient facilities

3.60 Majority of the patients felt that in-patient facility such as water, power and security were adequate.

Equipment Availability

3.61 The exit proformas addressed the query of to what extent the respondent felt that the hospital was well equipped. Around 41% of the respondents were not able to comment on the same while 35 % felt that the hospital was well equipped. However, this observation cannot be considered, as most patients are not qualified to judge the extent of equipment availability in the hospitals.

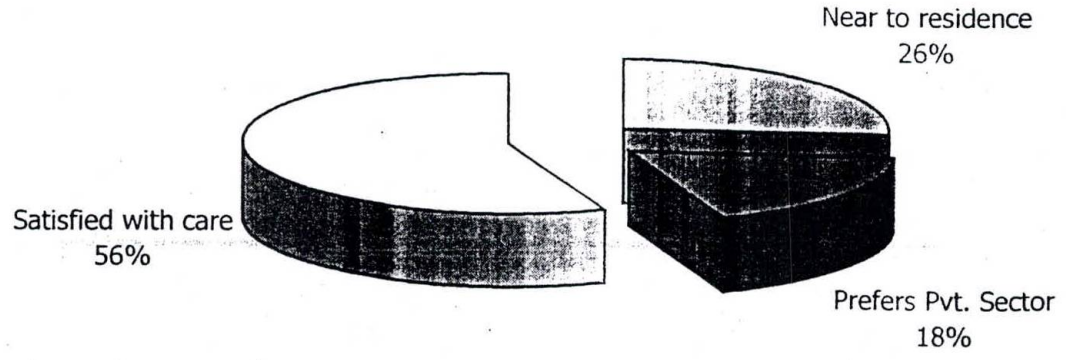
Comparative review of private sector with public sector (as perceived by the patients)

3.62 The exit proformas addressed the various reasons for visiting the private sector for treatment vis-à-vis the public sector.

3.63 Majority of the patients visited the private sector as they were either satisfied with the service or they distinctly preferred a private hospital over the government hospital. This is represented in Exhibit 3.3

3.64 Specific responses were elicited from a certain section of patients on their choice of

Exhibit 3.3: Reasons for Visiting Private Sector



hospital if both the private hospital as well as the government hospital were close to one another. All of the respondents preferred the private hospitals and the reasons for choice are :

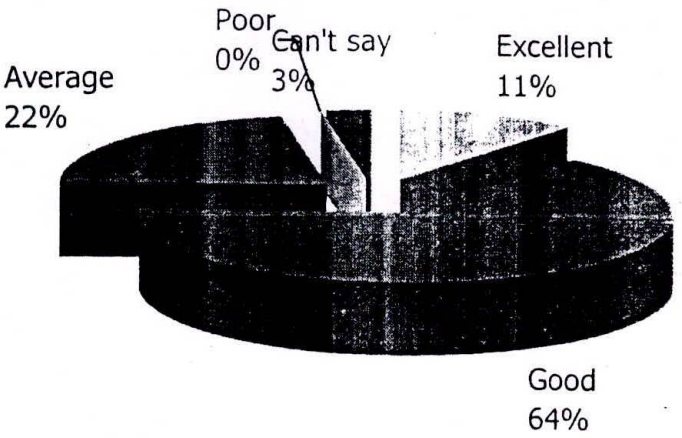
- Promptness of service
- Reliability
- Quality care
- Better services

Overall Rating of Private Sector (As perceived by the patients)

3.65 As discussed in the previous paragraphs, majority of the patients are quite satisfied with the quality of service and level of care offered by the Private sector hospitals/health care units. The overall rating of the private sector as perceived by the patients is depicted in the chart below :

3.66 The patients visiting ayurvedic hospital have rated the hospital to be average/poor.

Exhibit 3.4: Overall Private Health Care Centre Rating



4. Access to Health Care

4.1 This chapter presents the accessibility of health care services to poorer sections of the society both in terms of Physical and Social Access

Physical Access

4.2 Physical Access has been assessed by the following

- Availability of Hospitals
- Availability of beds in the districts
- Distribution of treatment of Out-patients and In-patients over source of treatment
- Physical distance traveled to reach hospital
- Means of transportation used to reach hospital

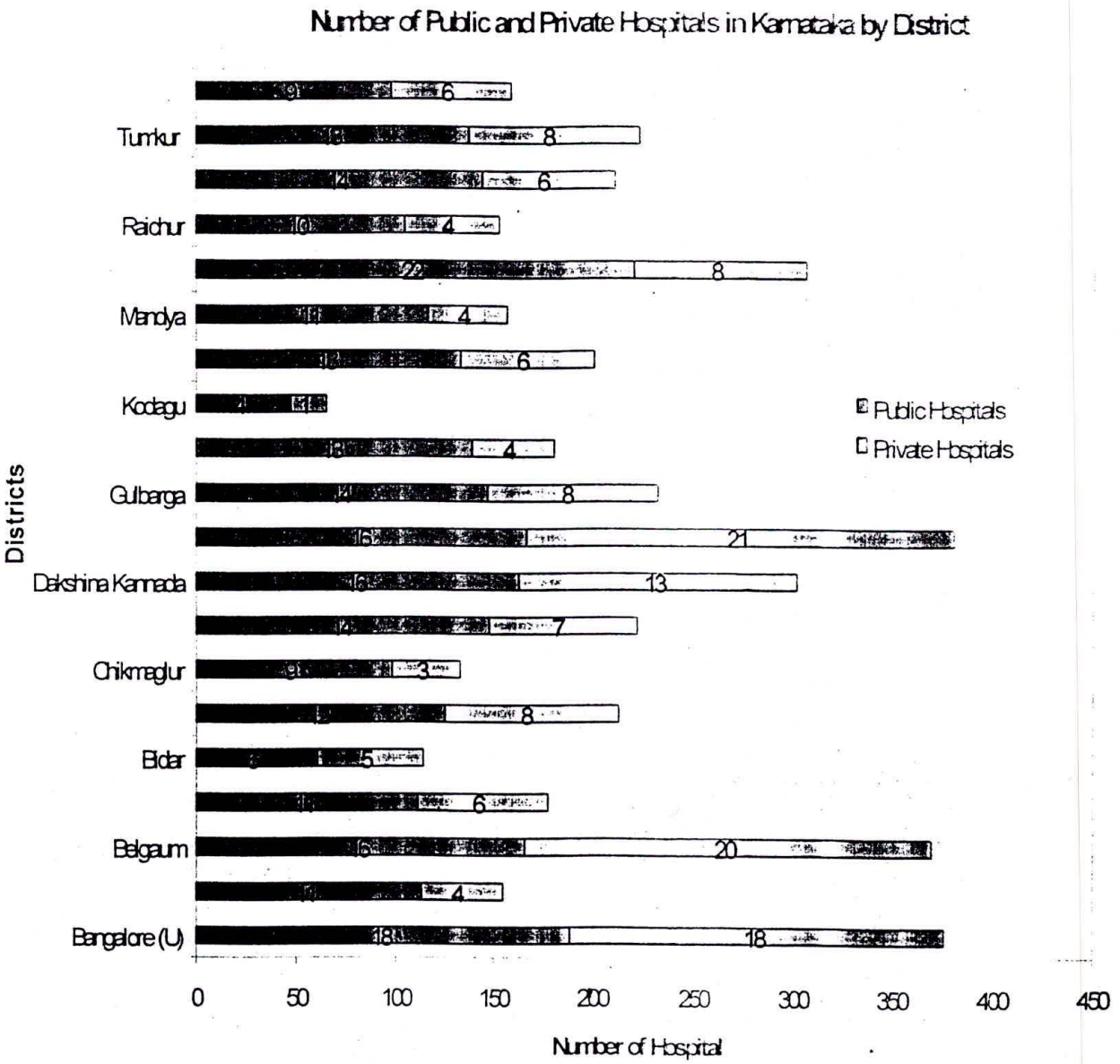
Availability of Hospitals

4.3 According to a survey conducted in 1995-96 by the Centre for Symbiosis of Technology, Environment and Management (STEM), Bangalore, there were in 1995-96, 2,624 public hospitals (hospitals, community health centres, primary health centres and primary health units) and 1709 private hospitals (clinics, nursing homes and hospitals).

4.4 Thus, the number of public health sector units is only slightly higher than that of private health institutions. In terms of number of patients treated also, the role of private health sector is increasing (this is presented below in section distribution of patients over sources of treatment).

4.5 The Exhibit 4.1 presents district-wise distribution of Public and Private Hospitals in Karnataka

Exhibit 4.1:



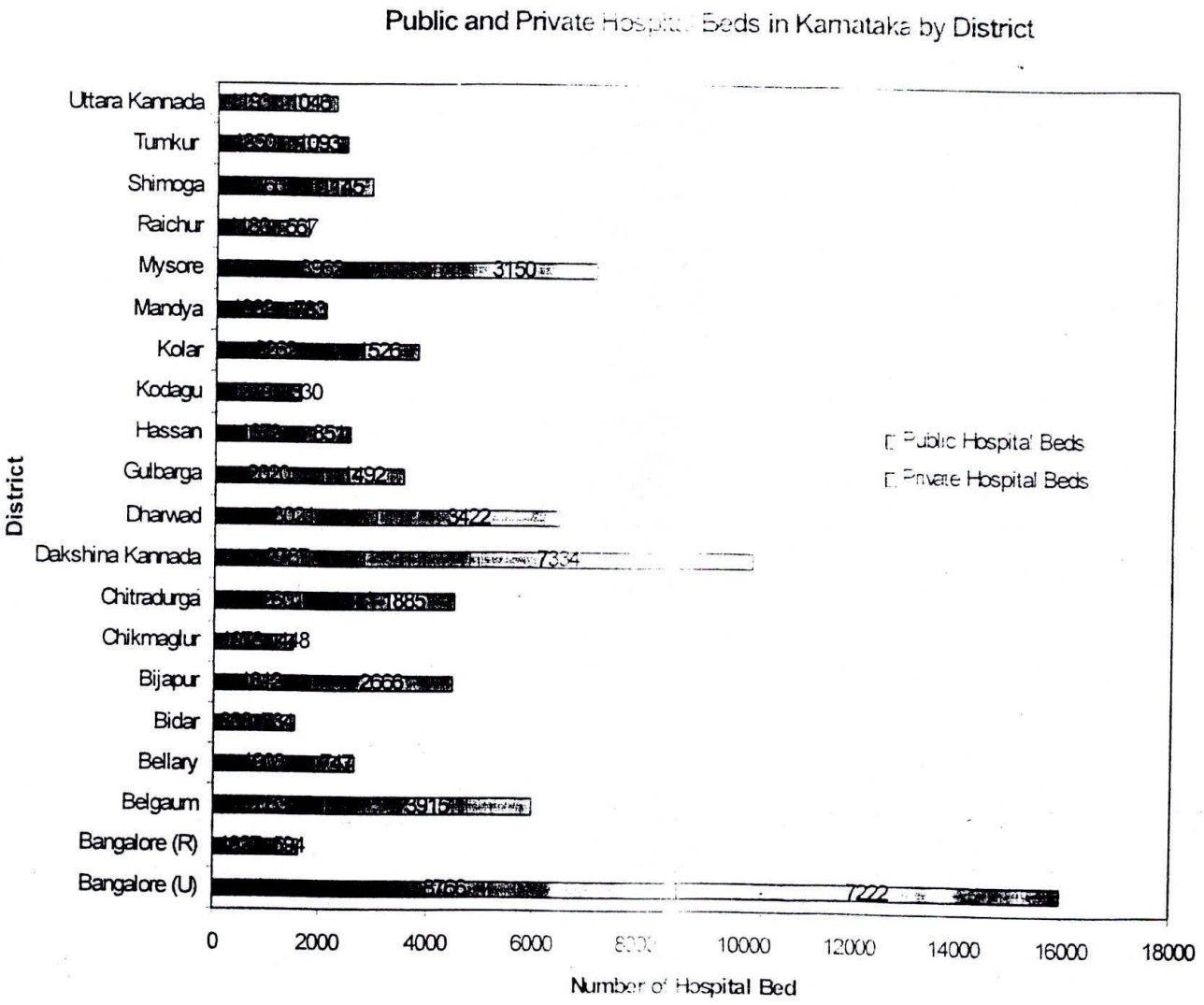
Source: Health Care Facilities in Non-Government Sector in Karnataka, STEM, 1996

Availability of Beds

4.6 The number of beds in the private sector in Karnataka is 40,900 compared to 43, 868 beds in public sector hospitals. A vast majority of private sector hospitals provide curative health care, while public sector hospitals promotive, preventive and curative services in rural areas and only curative services in urban areas. Thus, with the population of 44806468 (Census 1991), this translates into a mere 1.89 beds per thousand of population.

Exhibit 4.2:

Source: Health Care Facilities in Non-Gover... Karnataka ...



Bed Capacity at Ayurvedic Hospital

4.7 The Ayurvedic Hospital covered has a bed capacity of 325 beds in the general ward snd25 beds in the semi-private ward, with a n average occupancy rate of 30-40%

Distribution of Treatment of Out-Patients over Sources of treatment

4.8 Only 27% of the OPD patients in urban areas of Karnataka get their treatment at Public Hospital Centre. Majority of them (43.19%) gets their treatment from private doctors and 22% of them from private hospital in urban areas and similar trends are seen in rural areas. The details are in table 4.1

Table 4.1: Percentage Distribution of Out-patient treatment over Sources of Treatment

Type of Hospital	Urban %	Rural %
Public Hospital	[illegible]	25.72
Primary Health Centre	1.71	8.47
Public Dispensary	1.23	1.27
Private hospital	22.07	18.48
Nursing Home	1.01	1.16
Charitable Hospital	0.24	0.17
(ESI)Doctor	1.36	0.94
Private Doctor	43.19	41.51
Others	2.19	2.28
Total	100.00	100.00

Source:GoI, CSO, 42 round of National Sample Survey No. 364

Distribution of Treatment of In-Patients over Sources of treatment

4.9 There is almost equal distribution of In-patients treatment in public and Private sector in Karnataka Urban areas and whereas, in rural areas 60% get their treatment in public hospital and primary health centre and the balance 40% in private sector. The detailed break-up is presented in table 4.2

Table 4.2: Percentage Distribution of In-patient treatment over Sources of Treatment

Type of Hospital	Urban %	Rural %
Public Hospital	48.51	55.31
Primary Health Centre	0.39	2.71
Private hospital	40.49	32.94
Charitable Hospital run by Public Trust	1.26	2.59
Nursing Homes	9.06	5.62
Others	0.29	0.91
Total	**100.00**	**100.00**

Source:GoI, CSO, 42 round of National Sample Survey No. 364

Distance Traveled to Reach Hospital

4.10 One of the most important means of assessing physical access of healthcare services is to identify the distance traveled by patients to reach hospitals.

4.10.1 **Hospitals:** The primary survey reveals that more than 70% of OPD patients across categories use hospital within 10 kilometres of distance from their home. A very noticeable difference is that in Urban Government hospital as much as 60% of the patients come from a distance of more than 10 kms.

4.10.2 There is no particular noticeable difference in accessibility in urban and rural areas in private hospitals. This is because many patients in rural hospitals are also from neighboring villages. Table 4.3 gives details of the accessibility

Table 4.3: Physical Accessibility by Distance Traveled

Average Distance from Residence to Hospital	Percentage of Patients Visited										
	Corporate		Trust		Teaching		Missionary		N.H*	Govt.*	
	A	B	A	B	A	B	A	B	Avg.	A	B
	Urban	Urban	urban	Urban	Urban	Rural	Urban	Rural		Urban	Rural
< 3 km.	20	N.A	20	30	20	20	60	70	30	15	50
3-10 km.	50	N.A	55	30	60	60	20	20	50	25	30
>10 km	30	N.A	25	40	20	20	20	10	20	60	20

Source: Survey
*Only Representative cases of surveyed Govt Hospitals and Nursing Homes is presented.

4.10.3 **Practitioners:** A general trend that is visible is that more than 75% of the patients visiting General Physicians are from the radius of less than 3 kms from clinic and another 20-25% from 3 to 10 kms radius. In case of specialists the percentage of patients who came from the radius of 3 kms from clinic were in the range of 30-60% (with an average of 42%) and those from a radius of 3 to 10 kms was about 30-45%.

4.10.4 **Exit Proforma Findings**: The exit proforma survey reveals that a lot of patients (38%) travel even upto 10 km to reach the private hospital. However, around 53% of the patients reside within a radii of 5 km from the hospital.

4.10.5 In the Ayurvedic Hospital around 60% of the patients travel more than 10 kms to reach the hospital while 30% reside within the range of 3-10 kms.

Means of Transportation Used to Reach Hospital

4.11 Except in case of Corporate Hospitals, Majority (50-80%) of the patients visiting other hospitals reaches by walking or public transport. Use of public buses to reach hospitals is greatest in Government hospitals and teaching hospitals. Whereas in Missionary and teaching (in that order), hospitals patients walking to reach hospitals is also common.

Table 4.4: Means of transportation used by patients to reach hospital

Means of Transportation	Percentage of Patients Visited*					
	Corporate	Trust	Teaching	Missionary	N.H	Govt.
Own Vehicle	65	25	10	10	20	9
Bus	5	30	40	10	30	53
Auto/Taxi	29	25	10	10	20	17
Walk	1	20	40	70	30	21

Source: Survey
*Only Representative cases/cases in which information was provided is presented.

4.12 **Exit Proforma Findings:** Public transport (bus service, ... own two-wheeler vehicle are the common modes of transportation followed by the patients constituting 37% and 53 % respectively, of the total respondents.

4.13 In ayurvedic hospital, Majority of the patients (70%) use bus as the mode of transport to reach the hospital.

Social Access

4.14 The Social Access was examined from the view point of

- Sex-wise distribution of patients across hospitals
- Age-wise distribution of patients across hospitals
- Income group profile of patients
- Payments Category
- Treatment of Low income group patients at Hospitals
- Cost of treatment as perceived by patients

Sex-wise Distribution of Patients across Hospitals

4.15 No significant difference in treatment of male or female patients is noticed across categories of hospitals. However, except in case of missionary hospitals, the percentage of male patients treated is a little higher than female patients.

Table 4.5: Sex-wise classification of Patients Treated across Categories of Hospitals

Sex	Percentage of Patients Visited										
	Corporate		Trust		Teaching		Missionary		N.H	Govt. Avg.	
	A	B	A	B	A	B	A	B	Avg.	A	B
	Urban	Urban	Urban	Urban	Urban	Rural	Urban	Rural		Urban	Rural
Male	60	55	50	50	60	60	49	40	57	57	54
Female	40	45	50	50	40	40	51	60	43	43	46

Source: Survey

4.16 In the ayurvedic hospital, majority (80%) are male patients.

Age-wise Distribution of Patients across Hospitals

4.17 About 50% to 80% of the patients across categories of private hospitals are from the age group 12 years to 50 years. But there is no significant noticeable difference in access of patients of different age groups in rural or urban areas to treatment facilities in private sector vis-à-vis public sector.

Table 4.6: Age-wise classification of patients across categories of hospitals

Age Group Profile	Percentage of Total Patients Visited										
	Corporate		Trust		Teaching		Missionary		N.H	Govt.	
	A	B	A	B	A	B	A	B	Avg.	A	B
	Urban	Urban	Urban	Urban	Urban	Rural	Urban	Rural		Urban	Rural
<12 yrs	10	20	20	10	20	10	15	10	9	20	30
12-35 Yrs	40	20	20	40	30	10	44	10	26	20	20
36 -50 Yrs.	40	30	30	30	30	60	22	60	35	30	20
50 yrs.	10	30	30	20	20	20	19	20	30	30	30

Source: Survey

4.18 In the ayurvedic hospital, there is an equal distribution of patients (30%) across the age group other than less than 12 years, which constitutes 10% of the total patients.

Income Group Profile of Patients Hospitals

4.19 The corporate hospitals had 60-90% of the patients from the upper middle income group and high-income group.

4.20 In case of trust hospitals, only 20% of the patients were from the lower middle and low income groups. 30-50% of the patients were from middle income groups (Rs. 3000-5000 p.m.).

4.21 Teaching hospitals had the maximum percentage (80-85%) of patients from the lower middle income and low-income groups.

4.22 Missionary hospital also had 60% of patients from lower middle and low-income groups. Both the missionary hospitals visited get a lot of donations and grants from India and abroad for charitable purposes and are hence able to provide free and concessional treatment to majority of patients who cannot afford the cost of treatment.

4.23 The nursing homes mainly cater to the middle income and upper middle income group, who form 75% of the total patients treated.

Table 4.7: Income Profile of patients across Hospitals

Income Groups	Percentage of Total Patients Visited										
	Corporate		Trust		Teaching		Missionary		N.H	Govt.	
	A	B	A	B	A	B	A	B	Avg.	A	B
	Urban	Urban	Urban	Urban	Urban	Rural	Urban	Rural		Urban	Rural
High Income Group (>Rs. 10000 p.m.)	40	20	10	20	---	5	N.A	10	12.5	5	5
Upper Middle Income Group (5000-10000 p.m.)	50	35	20	30	---	5	N.A	15	50	10	10
Middle Income Group (3000-5000 p.m.)	10	15	50	30	20	5	N.A	15	25	30	15
Lower Middle Income Group (Rs.600-3000 p.m)	---	10	20	10	70	80	N.A	30	7.5	25	20
Low Income Group (<600 p.m.)	---	5	---	10	10	5	N.A	30	5	30	50
Total	**100**	**100**	**100**	**100**	**100**	**100**	**N.A**	**100**	**100**	**100**	**100**

Source:Survey

4.24 Over 60% of the patients in the ayurvedic hospital are from the lower middle income and lower income group while only 10% of the patients are from the high income group.

Payment Category

4.25 Most of the patients in the corporate hospital are fully charged for consultancy, diagnostic tests and treatment. A very minimal percentage of them are provided concessions, usually in the range of 10 to 30%.

4.26 In hospitals run by trusts there was a mixed trend. A few of them, those run by religious communities, provide free treatment to about 20% of patients and about 50 to 60% of patients were provided treatment at concessional costs.

4.27 Teaching hospitals also provide free and concessional treatment to about 50% of the patients but the purpose of treating free/at concessional rates poor patients is to use them as clinical teaching cases for medical students.

4.28 Missionary Hospitals get substantial amount of their funding in the form of grants and donations from India and abroad for treating the poor patients. They are thus able to provide free and concessional treatment to majority (70%) of their patients.

4.29 Nursing homes usually run by individuals, cater to mainly middle class and upper middle class and usually charge in full for treatment. A very few of them are provided any form of free or concessional treatment.

Table 4.8: Payment Category of Patients across Hospitals

	Percentage of Total Patients Visited				
Payment Category (%)	**Corporate**	**Trust**	**Teaching**	**Missionary**	**N.H.**
Consultant					
Full Charges	100	30	50	0	90
Concessional Charges	0	70	30	0	10
Free	0	0	20	100	0
Diagnostic Tests					
Full Charges	90	30	50	20	70
Concessional Charges	10	60	30	30	20
Free	0	10	20	50	10
Treatment					
Full Charges	90	30	50	30	80
Concessional Charges	10	50	30	70	10
Free	0	20	20	0	10

Source: Survey

*Only Representative cases/cases in which information was provided is presented.

4.30 From our discussions with various doctors, patients, hospitals and diagnostic centres, there appears to be a widespread nexus between the various hospitals, nursing homes, diagnostic centres, specialists and family physicians in ordering unnecessary investigations, treatment in order to share the fees among themselves.

Treatment of Low income Group Patients

4.31 83% of the private hospitals and nursing homes charged low-income groups (income less than 600 p.m.). However, 75% of hospitals and nursing homes provided concessions in fees in treating these patients. The concessions ranged from 15% to near about 100%. 92% of the hospitals made referrals to other hospitals. Referrals were usually made for patients requiring super-speciality care. 25 percent of the hospitals always ordered investigations for patients and also charged interpretation fees. None of the hospitals had any follow-up procedure. 25% of them (both the corporate hospitals and a nursing home) considered it as a sole responsibility of Government to provide free treatment to the low-income group patients.

4.32 The ayurvedic hospital, being a government hospital, offered free treatment to their patients. None of the patients were corporate patients.

Cost of Treatment as Perceived by the patients

4.33 The cost of treatment as percieved by the patients were reviewed through the exit proformas wherein the patients were queried on the reasonability and affordability of the charges.

4.34 Majority of the OPD patients (~58%) were of the view that the charges were reasonable while around 30 % felt that they were a bit high. Similarly around 76 % of the in-patients felt that the charges were reasonable while around 19% felt that they were high.

4.35 Almost all the patients met the treatment charges on their own. A few of them borrowed funds from friends and relatives. A cross section of patients were queried on their affordability of these expenses and a majority of them (62%) felt that the medical care expenses constituted upto 5 % of their income. However, a sizable number (31%) also were of the view that the said expenses constituted more than 20 % of their income.

4.36 A sample exit survey was conducted covering patients visiting private health centres to determine the various chrages for treatment. Table 4.9 presents a summary of various charges incurred by the patients.

Table 4.9: Summary of Charges incurred by Patients

Private Health Centre	Consultation Charges	Diagnostic Tests	Treatment	Drugs
Teaching Hospital	250	750	3000	400
Nursing Home	150	400	800	300
Corporate Hospital	1000	3000	4000	1000
Nursing Home	500	500	400	200
Nursing Home	300	300	600	400
Nursing Home	4500	1200	5000	1500
Teaching Hosptial	450	250	1000	500
Teaching Hospital	600	450	1000	650

4.37 The Ayurvedic patients availed of free in-patient treatment at the hospital covered. Hence, while the in-patient charges were considered reasonable, most patients were of the view that external procurement of drugs is as expensive as the allopathic medicines.

5. Accreditation

5.1 This chapter presents the primary survey findings in regard to willingness of private sector for accreditation.

Accreditation

5.2 Accreditation is a professional and national recognition reserved for facilities that provide high quality of care (Lewis, 1984). It is the process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain pre-determined standards. Accreditation is usually granted for the purpose of assuring th public of the quality of institutions. The concept of accreditation exists in many countries. This is now also being applied to Health Care organizations.

Need for Accreditation

5.3 In Karnataka, and in rest of India as well, the private sector is more dominant than public sector. In fact about 70-80% of the total health care expenditure is from the private sector. With increase in demand for health care, the private sector has been growing at a very fast pace offering a wide range of facilities and services. The legal

regulations have not been effectively implemented to ensure a proper regulated growth.

5.4 There is also a wide variation in their range and quality of services provided. Presently there exists no appropriate mechanism of reliable information regarding quality of care. There also exists no adequate system of certification for the private organizations. There are no timely reviews undertaken to ensure that the standards are maintained.

5.5 Though, some private hospitals do carry out Medical Audit internally occasionally but do not share this information to the public or to the peer group. The performance data on these hospitals are termed "Confidential documents" by the concerned hospital management. Data for the hospitals under study was not available and also not forthcoming especially on the number of re-admissions, repeat operations, hospital acquired infection, blood utilisation, tissues removed etc. There are also cases of nursing homes which do not even maintain any medical records nor do they have any medical audit.

5.6 There is thus, an urgent need for an agency to set standards, ensure that the standards are met and maintained, and also provide information to public to judge the quality of care provided.

Willingness of Private Sector to Accreditation:

5.7 The following are the results of responses received from 255 respondents. The details of the respondents have been provided in chapter 2.

Need Felt for Accreditation Body

5.8 88% of the respondents felt that there was a need for an accreditation body which should lay down standards and grade hospitals. The break-up is presented in table 5.1

Table 5.1: Need felt for Accreditation Body

Need for Accreditation Body	88
No Need for Accreditation Body	8
Undecided	4

Role of Accreditation Body

5.9 Majority of respondents wanted the accreditation body to set standards, upgrade standards, assess hospitals for compliance of standards, certify quality and provide

education and information on best practices etc. Details of responses are presented in table 5.2.

Table 5.2: Role of Accreditation Body

Assess Hospitals for Compliance of Standards	86
Assist in Upgrading Standards	88
Assist in Certifying - Quality Assurance	88
Educative & Informative Role	78
Serve as Forum for Consumer Redressal	30
Take Punitive Action Against Hospitals	24

Aspects to be monitored by Accreditation Body

5.10 Majority of the respondents wanted accreditation body to monitor physical aspects, equipment, quality and number of personnel, type of treatment, follow-up of care, patient satisfaction. Only 42% favored monitoring of professional fees charged by doctors. The details are presented in table 5.3

Table 5.3: Aspects to be monitored by Accreditation Body

Physical Aspects	96
Equipment	95
Quality and Number of Personnel	95
Type of Treatment	88
Follow-up of Care	80
Patient Satisfaction	80
Professional Fees Charges	42

Benefits Envisaged

5.11 Majority of respondents felt that setting up an accreditation body would help in improving standards, aid in certifying quality and help in comparison of performance vis-à-vis other hospitals. About half of them felt that it would also serve as an useful marketing tool, regulate and manage competition among hospitals and create a level playing field among hospitals.

Table 5.4: Benefits Envisaged from Setting-up an Accreditation Body

Help in Improving Standards	88

Aid in Certifying- Quality Assurance	86
Comparison of Performance vis-a-vis other Hospitals	62
Useful Marketing Tool	52
Regulate & Manage Competition Among Hospitals	48
Create Level Playing Field Among Hospitals	46

5.12 We feel that an accreditation body would also help in

- Assisting organizations in improving their quality of care
- May be used to meet certain Medicare certification requirements
- Enhancing community confidence
- Providing a staff education tool
- Assisting organizations to fulfil state licensure requirements
- Enhancing access to managed care contracts
- Favorably influencing bonds rating and access to financial markets

Willingness to Participate in Accreditation Process

5.13 Majority (88%) of the respondents was willing to participate as soon as the Accreditation Body. They (92% of respondents) felt there was an urgent need for grading and classification of existing hospitals. They wanted that the body to initially give them an opportunity for self-evaluation and then finally assess compliance by way of an external assessment.

Organization of Accreditation Body

5.14 Independent, self-regulatory, non-profit body: In the discussions with respondents regarding the organization of the body, the respondents were of the view that the accreditation body should be an independent body without any Governmental/political interference. The body should have its own guidelines/code of governance i.e., it should be self-regulatory. It also has to be a non-profit body managed by professional experts.

5.14.1 The body should not bring an other sort of 'license raj'. It should have total transparency in its process of accreditation.

Responses of General Physicians/Specialists

5.15 94% of the respondents (General physicians and Specialists) felt that there was a need for accreditation body, while only 6% felt that there wasn't any need for such body. Majority (90%) was willing to participate as soon as it was set-up.

5.16 The accreditation body should be an external independent non-profit body without governmental interference.

5.17 The body's main role should be to lay down standards especially the minimum standards that are required to be fulfilled. It should mainly monitor the physical standards and process factors in case of General Physicians and specialists,

5.18 Majority (90%) was of the view that professional fees and charges should not be monitored.

Proposed Accreditation Body for Hospitals

5.19 We propose the framework of a workable accreditation body for hospitals. We would like to mention that this framework is by no means a blueprint but only the broad sketch of an idea. Various factors affecting the stakeholders as well as the existing social, political and economic ground realities need to be taken into account while implementing it. Much would depend on the involvement and initiative of the stakeholders. The accreditation system itself should be an outcome of discussions and debates on issues of concern among all the stakeholders. Collaboration, transparency between related parties and open communication are the hallmarks of the system whose framework we are proposing. Only then would it be meaningful and viable.

Objectives of the Accreditation Body:

5.20 The objectives of the Accreditation Body should be to

- Assess whether hospitals comply with standards and provide recognition to those that do.
- Upgrade standards in the light of a changing health care environment
- Assist hospitals to upgrade their standards
- Play an educative, consultative and informative role
- Act as a bridge between the various stakeholders and provide a platform for continued dialogue.

Constitution of The Body:

5.21 The establishment of such a body calls for representatives from the various stakeholders involved in health care delivery. This is necessary in order to make the system acceptable to all and to ensure its creditability from the start. The specific groups that we have identified are as follows:

- Representatives from the hospital owners
- Representatives from specialists' associations
- Representatives from professional associations
- Representatives from consumer organisations
- Representatives from Non Governmental Organisations (NGO)
- Representatives from the state government

5.22 We feel that once the system is functional, representatives from insurance companies, financial institutions as well as legal professionals could be included. This would further establish the creditability of the body.

Status and Structure:

5.23 We see the accreditation body as a non-profit, registered and autonomous entity. At a later stage, when the body has achieved stability and creditability, legislative support could be sought.

5.24 We visualize the body with a Governing Board at its helm. It would be a statutory entity entrusted with the responsibility of managing the body. It would be a final authority in decision making and an arbitrator of major issues. It would frame policies intended to develop the system and fulfil its stated objectives evolving a consensus would be the principle guiding all decisions. When serious differences of opinion occur, however, the majority would have to decide. The Governing Body would have to meet at least four times in a year.

5.25 The Board would comprise of nominees of representative associations and organisations as well as government and other stakeholders. In its composition, it should allow each of the stakeholders to be equally represented. This would prevent the Board from being monopolised – and overtaken – by dominant stakeholders. The composition of the Board could be changed every two years with

a fresh set of nominations. Totally, there would be 7 to 9 members. A Chairperson and a Secretary elected by this group would have tenures of two years each.

5.26 The composition of the Governing Board could be comprised of the following members, with one representative each from

- hospital owners' association
- medical association
- two specialists' associations
- the nurses' association
- consumer organisations
- NGOs
- state government

Functioning:

5.27 The main function of the body would be to assess whether hospitals comply with set standards, to assist them to upgrade their standards and to play an educative and informative role.

5.28 To carry out these functions in an efficient and effective manner, staff needs to be employed. The staff could work either full time or part time depending on the availability of finances. There would be a Director assisted in turn by four Assistant Directors in charge of handling specific aspects of functioning of the accreditation system. In other words, the four Assistant Directors would be individually responsible for the Assessment Division, the Educational Division, the Marketing and the Administration Division. The number of staff assigned to each division would be dependent on the nature of work. Each division would be responsible for the work in its own area.

5.29 This would be the constitution of the Executive Body. The Executive Body would be accountable and answerable to the Governing Board. It would be entrusted with the responsibility of implementing the decisions of the Governing Board.

Assessment division

5.30 This division would evaluate the compliance of hospitals. Two methods would be employed to assess compliance: self-evaluation by the participating hospital followed by an external assessment. Reconsideration of assessment findings would also be handled by this division but with a different team of assessors. Different assessment teams would assist this division. A team would consist of two post-graduate doctors, one health administrator and one health specialist. The assessors could work full time or part time, depending on the finances, but would need to undergo training in the method of assessment.

5.31 Standards with regard to physical aspects, equipment, qualification, number of personnel employed or attached, type of treatment and follow up of care would have to be assessed. The body should not only set minimum standards but also

periodically review the same, considering the changing environment and the existing ground realities in which the consumer and provider co-exist.

5.32 One area of prime concern that the accreditation body should include in their assessment is consumer satisfaction. It is necessary to develop a framework or guidelines to measure consumer satisfaction in a scientific manner. The fees charged by the hospitals needs to be examined and linked to the size of the hospital and the kind of services and facilities that are available. Most importantly, the needs of the provider and consumer need to be balanced. Initially, the accreditation body could start monitoring physical standards but then gradually move on to process and outcome standards. A handbook for hospital standards, depending on the size, kind of service and facility offered should be developed. This, in turn, would assist in the process of accreditation.

Educational division

5.33 The accreditation body would assist hospitals to upgrade standards. They would be aided in this by a group of experts from various concerned with hospital management. A participating hospital wanting to upgrade its standards could avail of the services of this committee. The focus would be on educating and providing information to the interested hospitals. Furthermore, it would hold regular workshops, training sessions and seminars in fulfillment of the objectives of the accreditation body. It would also assist in disclosing the assessment findings to the public at large. Disseminating the list of accredited hospitals could be one way of doing this. This information would be educative for the providers and informative for the user.

Marketing division

5.34 This division would lie at the interface of the accreditation body and society. Among other things, it would be involved in public relations, advertising, consumer education and creating awareness among the stakeholders.

Administration division

5.35 It would be responsible for general administration, which would encompass finances, human resources, operations, documentation and legalities

The Accreditation process

Pre-Survey

5.36 The hospital first submits and application to the accreditation body together with fees for survey.

5.37 The Assessment Division determines the appropriate standards for the participating hospitals.

5.38 The Assessment Division provides self-evaluation schedules, forms, scoring guidelines etc. to the hospital and collects them after they have been completed by the hospital.

5.39 The Assessment Division analyses the self-evaluation schedules and forms filled and returned by the participating hospital.

5.40 The Assessment Division co-ordinates the assessment schedule and procedure or protocols to be followed. This includes setting the survey dates, assigning an assessment team, the length of the assessment and setting the survey agenda with the hospital.

On-Site Survey

5.41 The assessment team gathers information by observing structures and processes in the hospital during visits to different units and departments, while on a tour of the building and by interviewing patients, the hospital owner or administrator, the clinical and support and, finally, by reviewing records and documents.

5.42 The team uses the information thus gathered to determine whether the hospital is complying with standards for various functions. These functions could be patient focused (for example, assessment of patients), organisation focused (for example, organisational performance improvement) or structure-and-function focused (for example, procurement of appropriate equipment and its maintenance)

5.43 The team identifies the areas of partial or non-compliance with standards.

5.44 The findings from the surveyors in the team are integrated into a single report.

5.45 The findings are reviewed and validated with the hospital owner or administrator.

Post-Survey

5.46 The self-evaluation of the hospital and the findings of the assessment team are validated by comparing them to the scoring guidelines.

5.47 The accreditation status and the appropriate recommendations are determined through a number of stages. These are :

5.48 The compliance findings are aggregated to generate an accreditation decision grid. This is essential as hospitals offer different kinds of facilities. Moreover, each facility would have an individual score of compliance to the set standards. If there is a high score in one facility and not in the other, the total average for that hospital would still be high. Would this then be truly reflective of the standard of that hospital? A decision grid would provide flexibility in determining the final score such that it would be as close to reality as possible.

5.49 The level of accreditation as minimum, optimum or excellent is determined. Also, whenever necessary, recommendations are made.

5.50 If indicated, the findings and final decision to be taken by the accreditation body is reviewed.

5.51 The Accreditation Report)|(containing the accreditation decision, accreditation decision grid and consultative recommendations) and the derived performance report (for public disclosure) are sent to the participating hospital.

5.52 Should a hospital challenge the accreditation findings or decision, an appeal may be sent to the assessment division.

Period of Assessment

5.53 The assessment could be done every two years.

Financing

5.54 During the initial period of three to five years, the accreditation body can depend on grants, but the long-term objective would be to attain self-sufficiency. Corporate houses, insurance groups and various associations could be approached for funds. The costs could also be reimbursed in part by the participating Hospital, which in turn could be used for developing the system. The constitutive elements of the system, namely the representative associations or organisations, could contribute to a corpus fund. Thereafter, other incentives could gradually be offered to the participating hospital to help expand the coverage of the accreditation body.

4 Participation ... tion in prev ntu

6. Public-Private Partnerships

6.1 This chapter presents the private sector participation in public health programs, need for health insurance for low-income group and scope and mechanisms for public-private partnerships.

Public Health Programs

6.2 The Government has taken certain steps to combat communicable, non-communicable and other major diseases which cause disability not only to improve the health status of India's population but also to prevent and control disabilities. For this purposes several National Health Programmes (NHP's) are carried out by State with Central assistance.

Current Private Sector Participation in NHP's

- **Hospitals**

6.3 **Awareness about NHP's:** All the hospitals and nursing homes visited were aware of National health programs being conducted from time to time by Government. However only 11% of them could right answers as to the exact number of such programs.

6.4 **Participation:** 55% of the hospitals and nursing homes visited indicated their participation in preventive programs. But their participation was more by way of self-organized camps for treatment of poor people or participation in camps organized by voluntary associations, IMA or pharmaceutical companies.

6.5 **Major Responsibility for Such Programs:** Almost all of them were of the view that major responsibility for such programs was of the Government and the private sector can only compliment the efforts of the Government by way of their participation in such programs.

6.6 **Envisaged Role in NHP's:** None of them were clear as to the role they can play in the success of NHP's. Most of them considered that they help by creating awareness by way of participation in such programs and health camps, and health education during OPD treatment.

6.7 **Government Initiatives:** Out of the hospitals and nursing homes visited, none of them had any Government functionary visiting them for such programs or DHS inviting them for CME/ training for these programs.

6.8 Government should encourage the private sector to adopt appropriate therapeutic norms and regimens recommended by national health programs and provide incentives to develop schemes to finance, train and integrate private providers in case finding, diagnostics and treatment for priority health programs that are of public health significance.

Need for Insurance Cover

6.9 Our primary survey reveals that currently 70-95% of patients (other than those getting free treatment) across categories of hospitals pay directly (i.e., on their own). The patients' availing insurance cover ranged from 0-4% across categories of hospitals.

6.10 The millions of individuals paying out of pocket have limited leverage in the private health care market. Moreover, the health insurance schemes in India are based on an indemnity basis i.e., benefits in the form of cash payments rather than services. An indemnity insurance contract usually defines the maximum amount that will be paid for services. In most cases, after the provider of service has billed the patient in the usual way, the insured person submits to the insurance company proof that he/she has paid the necessary bills. He/she is then reimbursed by the company for the amount of covered costs and makes up the difference him/herself. The indemnity type of contracts accelerates expenditure growth and over-servicing and also does not give enough leverage to influence the provider behavior. In contrast, the aggregation and application of purchasing power in large-scale pre-payment plans could have a powerful and positive influence on provider behavior particularly in private sector.

Current Government Mandated Insurance Schemes

6.11 India has two main systems of publicly mandated contributory health insurance – The Employees State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS) and other insurance policies are from Government owned GIC and its subsidiaries.

6.12 **ESIS:** ESIS was initiated in 1948 and became operational in 1952. It applies to non-seasonal factories using power and employing 10 or more persons, as well as to other establishments that do not use power but employ 20 or more people (several state governments have extended the scope). The employees covered under this scheme are those earning less than Rs. 6500 per month. Employers currently contribute to ESIS an amount equal to 4.75 percent of the wages payable to employees, while employees contribute 2.25 percent of their wages. Employees in the lowest wage group (i.e., who earn average daily wages of up to Rs. 15 per day) are not required to contribute their share with regard to such employees. State governments contribute a minimum of 12.5 percent of the total ESIS medical care in their respective states.

6.13 Though the scheme is extensive in its coverage, it has come under severe criticism. Ellis et al (1996) noted that "detailed patient surveys conducted in Gujarat found that more than half of all survey respondents covered by ESIS did not seek care from ESIS facilities for treatment". Another report by the center for Social Services, the Administrative Staff College of India (1996), was similarly critical, noting problems with "complex office procedures, abnormal delays in the settlement of cases and lack of specialists services, non-availability of ambulance vans, and low quality of medicines".

6.14 **CGHS:** The Central Government Health Scheme was introduced in 1954. It covers 16 major cities and a large proportion of Central Government employees. The central government heavily subsidizes the scheme. The employee's contribution ranges from Rs. 15 to Rs. 150 per month depending upon salaries. Treatment can be obtained at from more than 300 dispensaries, clinics, laboratories and dental units. The CGHS scheme has been criticized for slow reimbursement and incomplete coverage of private care.

Voluntary Private Insurance:

6.15 **GIC Schemes:** GIC's medical insurance consists of several levels of group and individual coverage, collectively known by the brand name Mediclaim. In general, Individual Mediclaim function on an indemnity basis, whereby the patient (or his employer on his/her behalf) pays the provider and is subsequently reimbursed. The individual Mediclaim has lengthy list of exclusions and does not cover "any existing disease or illness of chronic nature". The policyholders expect large out-of-pocket expenses in the event of a serious or chronic illness.

6.16 Group Mediclaim policies are available to any centrally administered group or corporate body of more than 50 persons and are also extended to dependants. Benefits are similar to to those contained in individual policies. Employees prefer group Mediclaim policies to the ESIS because the former offers a choice of providers. However, ESIS is mandatory for lower income employees and requires lower premium contributions from employers. Thus, emloyers prefer ESIS to group Mediclaim. They often use a combination of ESIS for those earning less than 6500 per month and group Mediclaim benefits for those earning more.

6.17 In late 1996, GIC introduced a low-premium scheme, Jana Arogya Bima, that requires payment of Rs. 70 to Rs. 140 p.a. depending upon subscriber, with a charge of Rs. 50 for each dependant child over the age of five. The low premiums makes the scheme attractive for rural middle class and some urban residents who fall outside the ESIS coverage. However, Jana Arogya Bima, payments are capped at Rs. 5000 per insured person per annum. This makes the beneficiaries to still rely on free care in public hospitals for any major illnesses.

Primary Survey Findings

6.18 In our primary survey, All the respondents (hospitals, nursing homes and private practitioners) replied in affirmative that there was a need for health insurance for poor people.

6.19 As regards affordability of premiums by the poor people, 47% of them felt that they would not be able to afford it, 13% of them were of the view that they would be able to afford it if they are sure of the benefits, and the rest 40% of them were 'not sure' as to affordability of premium.

6.20 All the respondents suggested group insurance. 7% of the respondents also suggested individual insurance policy. By group insurance here it is meant that insurance policy should be such that it provides for insurance cover for all the

members of family. However, none of them were clear as to nature of the policy and its functionality.

6.21 A sample exit survey was conducted to determine the extent of premium payable by the cross section of society. The premium affordable ranged from Rs. 300 per year (by the lower income group) to Rs. 500 per year (middle income group).

Public Private Partnerships

Need for Public Private Partnerships

6.22 Most of the state Governments in India are finding it difficult to expand their public facilities to cater to the growing health care needs of their population. The budgetary support to this sector is shrinking and currently most of it is used to finance the recurring expenditure like salaries of employees. As a result, the non-salary component has reduced dramatically. The areas affected most are the secondary and tertiary facilities and basic facilities in remote areas. Many state Governments are hence, exploring the options of promoting public-private partnerships (PPP's) in health sector.

6.23 The health needs of the community are changing fast. The number of deaths due to non-communicable diseases has increased and are likely to increase disproportionately in future. This health transition will place considerable demand on the Government to expand and upgrade their facilities in curative and tertiary areas to meet the health care requirements of population in coming years.

6.24 Recognizing the severity of financial crunch particularly in super speciality care, The Government of India in its national Health Policy of 1982 had recommended "...planned attention would also require to be devoted to the establishment of centres equipped to provide speciality and super speciality services, through a well dispersed network of centers, to ensure that the present and future requirements of specialist treatment are adequately available within the country".

6.25 Currently in Karnataka, about 50% of the in-patients and 60-70% of the out-patients get their treatment form the private sector. Given the role of the private sector in the state, there is a need to foster PPP's to influence the growth of private sector with public goals in mind.

Focus of PPP's

6.26 In general, the focus of public private collaborations has been on (Bhat, 1998)

- Developing Strategies to utilise untapped resources and strengths of private sector
- Enhance the capacity to meet growing health needs
- Reduce financial burden of Government expenditure in speciality and super speciality care
- Reduce regional and geographical disparity in health care provision and ensuring access
- Reaching to remote areas or targeting specific groups of population
- Improving efficiency through evolving new management structures.

Primary Survey Findings

6.27 All the respondents were willing to provide free or concessional treatment to low income group patients and take part in National Health Programs, if adequate support from Government was provided.

6.28 The support expected from Government was in terms of subsidies, grants, IT exemptions, and Schemes from Central and State Governments for free drugs and free vaccines. The table 6.1 provides the details

Table 6.1: Support Required from Government

Subsidies	80
Grants	67
IT Exemption	50
Central State Schemes for drugs & Free Vaccines	50

Scope for PPP's

6.29 From our literature survey and efforts of other state governments in this regard, we feel that the following areas could be explored for PPP's

6.29.1 **Clinical Service Tie-ups:** There could be tie-ups with regards to hiring out services of doctors, management of PHC's, tertiary and high-tech curative care etc. Some of the clinical service tie-ups efforts of other state Governments are listed below

- When West-Bengal was facing problems with regard to manning of primary health centres, it hired the services of private doctors on contract basis under the supervision of Panchayat Samities.
- In Gujarat SEWA-Rural was handed over the entire primary health care services in entire district by the State Government. The Government was to provide finance to entire PHC services in SEWA-Rural Project area. The SEWA Rural had the responsibility of managing the PHC's (including the freedom to recruit its own workers). SEWA-Rural was to fulfil the same targets which the government set for time to time.
- In Tamil Nadu Government took the initiative to invite industry to adopt a local PHC, health sub-center or district hospital. The industry was given responsibility of building, maintaining and equipping facility and the Government was to provide staff and medicine.

6.29.2 **Non-Clinical Areas of Tie-ups:** The areas of non-clinical tie-ups could be many like hiring out of ambulance facilities, Contracting out services of catering, laundry, security etc. The states of Maharashtra, TaminNadu, and West-Bengal have initiated such arrangements.

6.29.3 **Technology Tie-ups:** The technologies such as CT Scan, MRI are very expensive. The Government can subsidize the investment or provide other incentives like duty/tax exemptions and in return purchase the services for poor people.

6.29.4 **IEC Training:** Government can have tie-ups with private sector specialists for IEC training, CME, updates for conducting regular training programs.

Mechanism for Collaboration

6.30 **Joint Ventures:** In JV, Government's contribution can be in the form of cost of land and it can be treated as part of equity capital of the proposed organizations for providing speciality and super specialty care. The Government contribution can be in the range of 26% to 49%. In cases were cost of land is less than 26% of the total share capital, the government can contribute additional resources to meet the requirement. As a return on its equity capital, the facility should provide for free care to certain percentage of OPD and IPD 'poor' patients. Care needs to be exercised in choice of partner and clearly defining the 'poor' patients. Appropriate mechanisms needs to be put in place to check that the free care is offered to intended beneficiaries.

6.31 **Subsidizing Inputs/Providing Fiscal Benefits:** Another form of PPP could be in the form of Government providing inputs to private party at subsidized rates and/or fiscal exemptions. The Government of Rajasthan announced policy of providing land at subsidized rates and also included other fiscal benefits to institutions interested in setting up health facility. The quantum of facility depended upon whether the facility was to be set-up in rural or urban areas The fiscal incentives that were announced were

- Exemption from payment of sales tax on purchases of medical equipment, plant and machinery
- Exemption from payment of octroi on medical equipment, plants and machinery whether imported from abroad or other state.

The one other form of incentive could be providing finances from banks and other state financial institutions at subsidized rates.

6.32 **Contracting-out Services:** As has been stated earlier, there could PPP through contracting out services both in clinical and non-clinical areas. Some of them are

- Hiring services of doctors to man Primary health centres
- Hiring vehicles for ambulance purposes
- Contracting of services in the area of diet and catering, laundry, security, IEC programs etc.
- Contracting out high technology services like CT scan , MRI
- Contracting out maintenance of equipment and facilities

Precautions to be taken for a Successful PPP's

6.33 Before initiating PPP's the Government should come out with explicit policy document which should be publicly available.

6.34 The implementing agency with in the government need to be decided – whether it should the Directorate of Health or Urban development authority etc.

6.35 Before attempting a single window clearance, the committee in charge need to get all the clearances from departments concerned like (Department of Health and Family Welfare, Finance, Industry, Revenue etc.) to avoid delays and litigation after the process is initiated. Some of the clearances required may be

- Amendments in Land Revenue Act
- Exemption orders for offering Sales tax exemption etc
- Other clearances from urban development authority etc.

6.36 A detailed brochure containing information and guidelines on selection process, eligibility requirements, proposed form of participation etc need to be clearly stated and provided to all prospective bidders.

6.37 All the incentives and conditions need to be clearly stated to the prospective bidders for e.g., Incentives like subsidized rates at which land would be offered, the location need to identified, any fiscal exemptions and incentives etc. also need to be clearly finalized before the process is initiated and provided to all prospective bidders. Also, Conditions like making the facility operational in a specified time-frame, free care to poor, any price specifications need to be carefully detailed and finalized before the process is initiated.

6.38 Finally, public support for the process needs to be ensured to avoid any sort of litigation after the process is initiated.

6.39 MAPPING of the private sector is of utmost importance since there is no reliable data on the same.

Policy issues and policy measures for public private partnerships

Issues/ Concern	Unintended implications	policy measures
Expanding hightech super speciality services	Cost Quality Demand Inducement Unethical practices	• Protecting poor from catastrophic financial burden • Protecting and increasing government budgetary allocation to public sector • Development of monitoring mechanism and appropriate regulations • Rate regulation (change provider payment system) • Continuing medical education programmes
Geographic Distribution of Facilities	Equity Access to facilities	• Regulatory interventions such as • Licensing • Creating health map • Various types of incentives • Drawing definite plan where money should be spent • Remote area subsidy programs to allocate
Financing of New Investments	Cost Quality	• Creating specialised financial channels within the existing set-up of financial institutions to provide funds to private health care sector for financing their new investments in appropriate technologies after examining its cost effectiveness
Utilization Patterns	Equity: Access in terms of ability to meet cost	• Developing appropriate financial mechanisms • Protecting poor

7. Conclusions and Recommendations

Quality of Service

7.1 This study has focused on review of level of care and quality in the private sector through exit patient perception of quality. This was conducted through a detailed patient survey, wherein around 102 exit proformas were administered to patients visiting Hospitals, Private clinics etc. In addition, around 10 patients from an alternate system of medicine namely Ayurvedic Medicine were covered.

7.2 The quality of service offered by the private sector has been reviewed on the following parameters :

- Patient Expectation
- Repeat Visit / Recommendations
- Doctor – Patient communication
- Nursing care
- Ward Staff Support
- Support Services
- Administrative Support

7.3 Only 54% of Inpatients & 48% of outpatients were of the view that their expectations of service were fully met.

7.4 The above is reinforced with the fact that 54% of patients mentioned that they would surely revisit at the same hospital and only 42% mentioned they would recommend to others.

7.5 14% of the respondents were of the view that there is a need to improve behavior of Doctors.

7.6 The quality of Nursing care in private sector needs to improve although it is satisfactory in urban areas as compared to rural areas.

7.7 Many private nursing homes both in urban & rural areas, employed only "non qualified nurses" mainly ayahas given on the job training. Majority of the Nursing Homes especially did not have qualified trained Registered Nursing staff and followed staffing norms as per Nursing council norms.

7.8 Majority of the hospitals and nursing homes especially did not have administrative / nursing / standing orders , procedures manuals at all.

7.9 Majority felt that drugs were expensive (both allopathic or Ayurvedic) but were easily available.

7.10 Around 38% of respondents felt that the quality of meals provided needs to improve.

7.11 Only 54% felt that the house-keeping facilities (hygiene of hospital, clean toilets, clean linen etc.) were adequate. Majority of the nursing homes did not provide clean linen and patients had to use their own linen.

7.12 57% of respondents were of the view that the reception staff needs to improve their attitude.

7.13 The average length of stay was in the range of 7-10 days.

Level of Care

Services Availability

3.67 There is wide disparity in terms of services availability within same category of hospitals and among different categories of hospitals.

3.68 The various services available in the private sector can be summarised as under:

- Super speciality services are generally available in Corporate / Teaching hospitals
- The Trust and Missionary hospitals generally provide secondary level of care i.e. internal medicine, paediatrics, general surgery etc.
- Most of the nursing homes have only minimal services for emergency care.

3.69 With regard to investigation facilities the following observations have been made:

- Corporate / Teaching hospitals usually have facilities for all investigations
- Missionary / Trust hospitals offer secondary level of investigations
- Most nursing homes have only basic investigation services.

3.70 Facilities in terms of adequate water and power supply and the drainage facilities were found in all the hospitals covered. However, water purifier facilities were not available in the nursing homes.

7.14 While the private hospitals had adequate number of ambulances, the nursing homes did not have any. In terms of ward facilities, the nursing homes had only general wards and no ICU facilities while all the private hospitals covered had Emergency

wards, general wards and ICU facilities. The nursing homes do not seem to follow any kind of standard protocols regimes.

7.15 Most private Nursing homes have only basic investigation service facilities.

7.16 Majority of the private hospitals and nursing homes Laboratories are not standardized and none of them are participating in standardisation programme or accreditated to the "National Board of Accreditation of Laboratories".

7.17 The nursing homes do not have ambulances. Quick referral of serious cases is a major handicap.

7.18 Majority of the Nursing Homes does not have proper emergency wards/ ICU or equipment or manpower. At best they are suited to give 'first aid `. But they somehow manage to retain the patients in "ill equipped and ill planned" emergency rooms and ICU's.

7.19 The Nursing Homes are very poorly planned in terms of space planning and some of them are also located in remodeled residential houses and also located in residential areas.

7.20 There are no physical standards currently available for private hospitals. There is no proper space utilization since there are no norms.

7.21 There is a urgent need to set up minimum standards for hospitals of varying bed capacity and classified as primary, secondary and tertiary.

7.22 No permission is required to start a Nursing Home from any statutory body. As a result, there has been a proliferation of poorly planned ill-equipped nursing homes.

Patients Perception on Services Availability

3.71 The patient perception on services availability was reviewed in terms of the following :

- Extent of investigations conducted
- OPD facilities such as
  - Physical Space
  - Drinking water
  - Seating arrangements
  - Fan & Ventilation
  - Toilet
- In-patient facilities such as water, power and security
- Equipment Availability

7.23 49% of the patients were of the view that 'more than sufficient' investigations were made.

7.24 The most common investigation done for the in-patients was Blood (70%) and Radiological -X-Ray (62%), C.T Scan (12%) etc.

7.25 The facilities in the OPD were found to 'Fairly Sufficient' by majority of patients. However, in Ayurvedic Hospital the majority (80%) found OPD facilities to be 'less than satisfactory'.

7.26 Majority of the patients felt that in-patient facility such as water, power and security were adequate.

7.27 Most the patients could not comment on the adequacy of the equipment availability in hospitals.

7.28 Majority of the patients visited the private sector as they were either satisfied with the service or they distinctly preferred a private hospital over the government hospital for promptness of service, reliability, quality of care or better services.

7.29 The Ayurvedic hospital, in general, was overall rated by patients as 'average or poor'.

Physical Access

4.38 Physical Access has been assessed by the following

- Availability of Hospitals
- Availability of beds in the districts
- Distribution of treatment of Out-patients and In-patients over source of treatment
- Physical distance traveled to reach hospital
- Means of transportation used to reach hospital

7.30 There existed in 1995-96, 2624 public hospitals and 1709 private hospitals (STEM, 1996) and 43, 868 public hospital beds as compared to 40,900 private hospital beds. Thus, there are 1.89 beds per 1000 population

7.31 Only 27% of the OPD patients in urban areas of Karnataka get their treatment at Public Hospital Centre. Majority of them (43.19%) gets their treatment from private doctors and 22% of them from private hospital in urban areas and similar trends are seen in rural areas.

7.32 There is almost equal distribution of In-patients treatment in public and Private sector in Karnataka Urban areas and whereas, in rural areas 60% get their treatment in public hospital and primary health centre and the balance 40% in private sector.

7.33 The primary survey reveals that more than 70% of OPD patients across categories use hospital within 10 kilometres of distance from their home. A very noticeable

difference is that in Urban Government hospital as much as 60% of the patients come from a distance of more than 10 kms.

7.34 There is no particular noticeable difference in accessibility in urban and rural areas in private hospitals. This is because many patients in rural hospitals are also from neighboring villages.

7.35 More than 75% of the patients visiting General Physicians are from the radius of less than 3 kms from clinic and another 20-25% from 3 to 10 kms radius. In case of specialists the percentage of patients who came from the radius of 3 kms from clinic were in the range of 30-60% (with an average of 42%) and those from a radius of 3 to 10 kms was about 30-45%.

7.36 Except in case of Corporate Hospitals, Majority (50-80%) of the patients visiting other hospitals reaches by walking or public transport. Use of public buses to reach hospitals is greatest in Government hospitals and teaching hospitals. Whereas in Missionary and teaching (in that order) hospitals patients walking to reach hospitals is also common.

Social Access

4.39 The Social Access was examined from the view point of

- Sex-wise distribution of patients across hospitals
- Age-wise distribution of patients across hospitals
- Income group profile of patients
- Payments Category
- Treatment of Low income group patients at Hospitals
- Cost of treatment as perceived by patients

7.37 No significant difference in treatment of male or female patients is noticed across categories of hospitals.

7.38 About 50% to 80% of the patients across categories of private hospitals are from the age group 12 years to 50 years. But there is no significant noticeable difference in access of patients of different age groups in rural or urban areas to treatment facilities in private sector vis-à-vis public sector

7.39 Corporate Hospitals cater mainly to the upper middle and high-income group of people.

7.40 In Trust/ Missionary hospitals majority of the patients belong to the middle and lower income group. These hospitals give maximum concession to the poorer section.

7.41 Teaching hospitals had the maximum number of poor patients (probably due to MCI regulations)

7.42 Nursing Homes mainly cater to the middle income and upper group of people

7.43 Over 60% of the ayurvedic hospital are from the lower middle income and lower income group.

Payment Category

7.44 Most of the patients in the corporate hospital are fully charged for consultancy, diagnostic tests and treatment. A very minimal percentage of them are provided concessions, usually in the range of 10 to 30%.

7.45 In hospitals run by trusts there was a mixed trend. A few of them, those run by religious communities, provided free treatment to about 20% of patients and about 50 to 60% of patients were provided treatment at concessional costs.

7.46 Teaching hospitals also provide free and concessional treatment to about 50% of the patients but the purpose of treating free/at concessional rates poor patients is to use them as clinical teaching cases for medical students.

7.47 Missionary Hospitals get substantial amount of their funding in the form of grants and donations from India and abroad for treating the poor patients. They are thus able to provide free and concessional treatment to majority (70%) of their patients.

7.48 Nursing homes usually run by individuals cater to mainly middle class and upper middle class and usually charge in full for treatment. A very few of them are provided any form of free or concessional treatment.

7.49 83% of the private hospitals and nursing homes charged low-income groups (income less than 600 p.m.). However, 75% of hospitals and nursing homes provided concessions in fees in treating these patients. The concessions ranged from 15% to near about 100%. 92% of the hospitals made referrals to other hospitals. Referrals were usually made for patients requiring super-speciality care.

25 percent of the hospitals always ordered investigations for patients and also charged interpretation fees. None of the hospitals had any follow-up procedure. 25% of them (both the corporate hospitals and a nursing home) considered it as a sole responsibility of Government to provide free treatment to the low-income group patients.

7.50 There appears to be a widespread nexus between the various hospitals, nursing homes, diagnostic centres, specialists and family physicians in ordering unnecessary admissions, investigations, treatment in order to share the fees among themselves.

7.51 Majority of the OPD patients (~58%) were of the view that the charges were reasonable while around 30 % felt that they were a bit high. Similarly around 76 % of the in-patients felt that the charges were reasonable while around 19% felt that they were high.

7.52 Almost all the patients met the treatment charges on their own. A few of them borrowed funds from friends and relatives. A cross section of patients were queried on their affordability of these expenses and a majority of them (62%) felt that the medical care expenses constituted upto 5% of their income. However, a sizable number (31%) also were of the view that the said expenses constituted more than 20% of their income.

7.53 The Ayurvedic hospital patients availed of free in-patient treatment at the hospital covered. Hence, while the in-patient charges were considered reasonable, most patients were of the view that external procurement of drugs is as expensive as the allopathic medicines.

7.54 Presently there exists not adequate certification and standards of care (structure/Process/ outcome) in private health sector in Karnataka.

7.55 There is an urgent need to set up standards, ensure that standards are met and maintained. This information should be transparent and on website also. The public should be able to judge themselves the quality of care provided.

7.56 Some private hospitals do carry out Medical Audit internally occasionally but do not share this information to the public or to the peer group. The performance data on these hospitals are termed "Confidential documents" by the concerned hospital management.

7.57 The nursing homes do not maintain any medical records nor do they have any medical audit. Data for the hospitals under study was not available and also not forthcoming especially on the number of re-admissions, repeat operations, hospital acquired infection, blood utilisation, tissues removed etc.

7.58 All the respondents suggested group insurance. 7% of the respondents also suggested individual insurance policy. By group insurance here it is meant that insurance policy should be such that it provides for insurance cover for all the members of family. However, none of them were clear as to nature of the policy and its functionality.

References

1. Ramesh Bhat, 1998. *Public-Private Partnerships in Health Sector in India: Issues and Prospects*. August 1998.

2. C.David Naylor, et al, 1999. *A Fine Balance: Some Options for Private and Public Health Care in India*. Human Development Network

3. Centre for Social Services, Administrative Staff College of India. *Beneficiary Social Assessment for Karnataka, Secondary health Systems Expansion*. Hyderabad.

4. Rama V Baru, 1998. *Private Health Care in India: Social Characteristics and trends*. Sage Publications

5. Lipika Nanda. *Designing an Accreditation System for the Health Care Organizations in Andhra Pradesh*. Hospital Administration, Volume XXXVII, March/June 2000, Official Journal of Indian Hospital Association.

6. Suresh Balakrishnan and Anjana Iyer. *Bangalore Hospitals and the Urban Poor: A Report Card*. Public Affairs Centre, Bangalore

7. V.R. Muraleedharan, 1999. *Characteristics and Structure of the Private Hospital Sector in Urban India: A study of Madras City*. Partnerships for Health Reforms

8. Prof. A.K.Roy, *Patient Satisfaction Survey: A Tool for Total Quality Improvement.*

9. Others as specified.