

**A QUALITATIVE STUDY OF FAMILY
PLANNING SERVICES AT THE
PRIMARY HEALTH CENTRE LEVEL IN
THE STATE OF KARNATAKA**

INDIA

Final Report

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Sub-contract No C194 110A

**INDIAN INSTITUTE OF MANAGEMENT, BANGALORE
&
THE POPULATION COUNCIL, NEW DELHI**

March, 1995

**A QUALITATIVE STUDY OF FAMILY PLANNING (WELFARE) SERVICES
AT THE PRIMARY HEALTH CENTRE (PHC) LEVEL IN THE STATE OF
KARNATAKA**

by

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Acknowledgements

The author is extremely grateful to Dr N S N Rao and Mr N S Sanath Kumar for their valuable assistance in moderating the discussions and for skillfully transcribing the audio recordings and translating these into English. Mr Sanath Kumar also collected data from the providers under the dynamics of contraceptive use study a part of which is included in this report. The author would also like to put on record the intelligent and hard work put in by Mr S Ramaswamy for data processing and analysis. But for the dedication of these persons, this report would not have been completed in such a short period.

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CHAPTER 1

INTRODUCTION

The Primary Health Centre (PHC) is a focal point for the delivery of comprehensive health and family welfare services to the rural population of India. These PHC's were established in 1952 as a part of community development programme (CDP). Its linkage with CDP was aimed at ensuring participation of the community and intersectoral coordination to bring about improvements in the health status of the people. The different manuals prepared for the operation of these PHC's contained a list of upto thirty functions which included everything from the provision of medical care to more than 100,000 population living in an area of 150-200 miles to conducting most advanced types of health education campaigns. These functions were broadly categorised as medical relief, control of communicable diseases, environmental sanitation, maternal & child health, family planning (welfare), school health, health education, and vital statistics (Dutt, 1965). Later addition in their activities and expansion of many vertical health programmes resulted in a substantial increase in staff numbers from 10-12, when initially started, to 40-50.

Although the PHC's have been in existence for more than four decades, they have not been very effective in achieving the objectives for which they were established. The utilisation of their services by the community has been rather poor. Several studies indicate that only 10 to 20 percent of the rural people utilise medical facilities provided by the PHC system (Johns Hopkins 1976, Chuttani et al 1976, Khan 1989). The utilisation of maternal and child health services has also been found to be very poor (Kanitkar & Sinha 1989, Ramachandran 1989, Bhatia 1993). The environmental education, health education, school health and vital statistics components of PHC services hardly receive any attention from the PHC staff (Parker et al, 1972, Chuttani et al 1976, Ghosh, 1992). The only function on which workers devote some time is family planning (welfare) which is primarily due to the enforcement of targets and availability of monetary incentives. But even the family planning services at the PHC level has been found to be poor (ICMR 1991).

Studies have also shown that awareness and use of PHC and sub-centre facilities is limited to the villages where these services are located. People living in the peripheral villages either are unaware of these services or find it difficult to reach them because of communication difficulties and distance. Image of PHC's has also been found to be poor. Even among a small proportion of villagers who have used these facilities, majority have shown dissatisfaction with the services, mainly because of non availability of medicines and rude and impersonal behaviour of the doctors (Chuttani et al 1973). Apart from doctors, the PHC system has a battery of health workers, both male and female, who are supposed to make domiciliary visits regularly in all the villages in their respective areas. A large proportion of the people in the rural areas have been found to be unaware of their existence (Chuttani et al 1973, Bhatia 1986).

In view of this the villagers patronise the traditional medicine practitioners. These practitioners are not, however, those who use traditional herbs, oils and incantations and having little or nothing to do with modern medicine. On the contrary they are increasingly using modern medicines (Neumann et al 1971, Bhatia et al 1975). These practitioners also provide family planning and abortion services to their clients (Neumann & Bhatia 1973, Bhatia 1973, Bhatia et al 1974). They are very popular among the rural people and their number is augmented every day. People willingly pay for their services rather than availing free services provided by the PHC system. One of the most important reasons for the existence of this phenomenon probably is the poor quality of services provided at the PHC Level. Several studies have attributed this to the problem of logistics and more importantly, personnel problems such as poor involvement and job satisfaction of peripheral workers.

CHAPTER 2

REVIEW OF RELEVANT STUDIES

An important empirical study in this direction is that conducted in several states of Uttar Pradesh. This study is a systematic organizational diagnosis of the family planning programme implementation at the primary health centre (PHC) and higher level organizational set up. Primary data was collected from the users of services in the rural areas, providers of services at the PHC level and personnel at higher administrative levels. The results of this study indicate that poor motivational levels of staff for rural work, lack of effort on the part of field staff and inadequacy of systems to induce work effort were mainly responsible for poor performance of PHC's. The study also found that user friendly strategies to fit in client needs could not be evolved due to weak linkages between different levels of health care administration (Mishra et al 1982)

In another study conducted in two taluks (sub-districts) of Karnataka, organisational aspects of family planning at PHC level were studied as a part of a broader investigation of 'organisational aspects of rural development'. The factors like coordination, communication and feedback between the field level staff and higher echelons of administration were found to be significant determinants of performance effectiveness. In addition, the factors like autonomy and participation of the field staff in the decision making process were found to be major contributors to the success of the family planning programme (Ray 1976)

The qualitative aspects of family planning and MCH inputs were recently examined in Gujarat by using focus group interview techniques. The study was conducted in four districts and selection of PHC's and sub-centres within these districts was based on couple protection rates and target achievement levels. The results of this study show that the poorly performing PHC's were badly maintained and lacked infrastructural facilities. A large number of female health workers in these PHC's were not residing at their respective headquarters even when the living quarters were provided. The follow up services were not very effective and the practice of charging the clients for the services provided was very common. The study found a positive association between the quality of inputs and the performance of PHC's within a district (Shariff and Visaria, 1991)

The relationship between the levels of job satisfaction and organisational problems was examined in a study conducted in five districts of India Population Project in Karnataka. The results of this study indicate that the job satisfaction level of workers was dependent on the frequency of interactions and guidance from the supervisory personnel (Narayana and Reddy 1980)

A study of auxiliary-nurse midwives (ANM's) at PHC's and staff nurses in rural hospitals in the state of Maharashtra indicated that the ANM's have a poor social image among the community and have to suffer many problems in their day to day working life. While studying the work priorities and preferences of ANM's, it was found that these functionaries have to employ extra measures for the purpose of achieving family planning targets. They take special care of the case's (client's) family, provide transport to the 'case' and the relatives, and give extra money to 'case'. The results of this study also reveal that about one-half of the respondent ANM's wanted their work to be more holistic than merely seeking target achievement for family planning which is the current practice (Jesani 1990)

A study conducted in different states of India investigated the level of job satisfaction among PHC personnel. The data in this study was collected through a mailed questionnaire from 22 PHC's. The results of this study showed that most respondents expressed dissatisfaction with regard to housing, educational facilities for their children and opportunities for career development. The study also revealed that respondents belonging to older age groups and males were relatively higher levels of satisfaction as compared to those of females and those of younger age groups. Further most of the employees showed discontentment with regard to promotions and professional growth. A large proportion of respondents were dissatisfied with the 'use of unreasonable pressure to achieve targets within the stipulated time', lack of 'freedom to make mistakes and learn from them', and 'equitable compensation for work' (Gupta, et al 1987)

Another study conducted in 22 PHC's across seven states of India looked at the relevant factors affecting family planning programme and their significant correlates and determinants. The data for the study was collected through a survey by using structured interview schedules. The conclusions emerging from this study are that the personnel were positively disposed to some aspects of environment such as mutual understanding and trust, information and communication flows, and sense of authority and responsibility, while their attitude was negative to several other aspects like promotional avenues, equitable compensation for work, learning opportunities and participatory decision making. The results of this study also indicated that PHC personnel were least satisfied with integration of family planning programme with anti-poverty programme and use of radio and TV, but were satisfied with the safety and use of contraceptives, and delivery of services (Alka Kalra 1987)

The job satisfaction aspects of primary health care personnel are reported in some other studies also (Paliwal and Sawhney 1982, Rastogi 1978, Satia 1976). One of the recent studies conducted in a southern state of India needs mention. The main objective of this study was to find out the perceptions and opinions of health and family welfare personnel of two PHC's in Kerala. These PHC's were selected on the basis of their performance and 88 personnel were interviewed. The results of the study show that there were variations in leadership qualities and style of the medical officers between the high and low performing PHC's, the former being more democratic in their outlook and emphasized the delegation of responsibilities to all officials for the achievement of organisational objectives. Further, the level of satisfaction of the employees in the better performing PHC was found to be relatively higher. The results of the multivariate analysis of the determinants of job satisfaction indicated that one's own confidence of getting a promotion was the single most important variable which accounted for variations in job satisfaction (Rajan & Varma 1991)

An evaluation of a pilot primary health care project in Punjab in 1979 revealed that there was overemphasis on clinical aspects and the preventive and promotive aspects were neglected. There was lack of community health orientation among the project personnel and they were not able to fully utilise their skills. The level of frustration among the staff was found to be very high. The time and energies of multipurpose workers were mainly wasted on data collection, compilation and maintenance rather than provision of direct services to the community (Bose and Desai 1983)

In another evaluative study the role of multipurpose workers (MPW) was assessed in the state of Gujarat. The results of this evaluation indicate that family planning and maternal and child health (MCH) activities were rated very high by the multipurpose workers and a very small proportion of MPW's perceived nutritional supplementation and record keeping as part of their duties. Further a large proportion of the workers felt that the level of their job satisfaction has decreased as a result of the implementation of MPW scheme (Gandotra and Patel 1983)

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CHAPTER 3

OBJECTIVES OF PRESENT REPORT, LOCATION OF STUDY, MATERIALS AND METHODS

The main objective of this study is to generate qualitative information on different aspects of the management of family planning services at the PHC level as perceived by the providers. An attempt has been made to analyse some job related aspects of junior health assistants (ANM's), senior health assistants (LHV's) and medical officers (MO's) of primary health centres (PHC's) in the state of Karnataka based on the analysis of primary data collected in several studies conducted under the direction of the author at the Indian Institute of Management Bangalore. These studies used a variety of interview, observational and focus group discussion techniques. Before discussing the methodologies and results of these studies, it is relevant to describe the organisational set up of health services in Karnataka.

ORGANISATIONAL SET UP OF HEALTH SERVICES IN KARNATAKA

According to the 1991 census Karnataka has a total population of 44.8 million which accounts for 5.3% of the total Indian population. The decennial (1981-91) growth rate of the state works out to be 20.7% as against All India average of 23.5%. With regard to health and family welfare programmes, the state maintains a progressive profile as compared to many other Indian states. In fact, it was in Karnataka that the nation's first family planning clinic was established in 1935. Health, according to the Constitution of India, is a state subject and the states have freedom to evolve their own pattern of health services suiting local conditions. However, most states follow the 'standard pattern' handed down to them by the Government of India, though with slight variations. Karnataka state is providing comprehensive health care services to its people by way of implementing various national and state health programmes of public health importance through its network of various health and medical institutions.

The Department of Health and Family Welfare Services provide the following health care services through (1) rural health component of minimum needs programme, (2) medical development programme, (3) MCH, family welfare and immunization programmes, (4) national malaria eradication and filaria control programmes, (5) national leprosy eradication programme, (6) national tuberculosis control programme, (7) national programme for control of blindness, (8) prevention and control of other communicable diseases like diarrhoeal diseases, kyassanur forest diseases, Japanese encephalitis etc., (9) school health programme, (10) nutrition programme- nutrition education and demonstration, (11) laboratory services and vaccine production units, (12) education and environmental sanitation, (13) health education and training programme, (14) curative services. The director of health and family welfare services is the head of the department and is responsible to provide health care services to the community by way of implementing various national and state health programmes. The director is assisted by one additional director (FW & MCH), eleven joint directors, one demographer and fourteen deputy directors. These officers act as technical advisors to the director. The director is also assisted by a chief accounts officer-cum-financial advisor and a chief administrative officer in all matters pertaining to finance, accounts and administration of the department.

At the divisional level, there are four divisional joint directors stationed at Bangalore, Belgaum, Gulbarga and Mysore. These divisional joint directors are assisted by two deputy

directors The divisional joint directors are responsible for supervision and effective implementation of various national and state programmes including family welfare programme and MCH services in the districts coming under their jurisdiction

At the district level, the district health and family welfare officers (DHFWO) are responsible for supervision, providing guidance, prompt and effective implementation of programmes through a network of medical and health care institutions in their respective districts The DHFWO's are assisted by district leprosy officers, district malaria officers, district tuberculosis officers, medical officers (FW & MCH), medical officers of district laboratories and regional assistant chemical examiners The district surgeons of the district hospitals located at district headquarters are responsible for providing curative and promotive services including referral services

At the sub-divisional level, the assistant district health and family welfare officers (ADHFW) are responsible for supervision and provision of guidance to medical officers of PHC's, PHU's and to the field staff for prompt and effective implementation of various programmes

At the primary health centre level, the medical officers of health are responsible for supervision and provision of guidance to the medical officers of PHU's and to the field staff coming under their jurisdiction The primary health centres provide all the basic health services and all the national health programmes are being implemented through PHC's As per the guidelines provided by the government of India there will be a PHC for every 30,000 population by the year 2000 AD

In Karnataka, there is a chain of institutions known as primary health units (PHU's) which also provide curative, preventive and promotive health services It is proposed to upgrade these institutions to PHC's in a phased manner by providing minimum additional inputs Each PHU covers approximately a population of 15 to 20 thousand

There is a sub-centre for every 5,000 population in plain areas and one sub-centre for every 3,000 population in hilly and tribal areas Each sub-centre is managed by one junior health assistant (female) and one junior health assistant(male)

MATERIALS AND METHODS

As indicated above, the findings contained in this report are based on the analysis of primary data from several studies conducted by the author The methods of data collection for each of these studies is given below

Dynamics of Contraceptive Use Study

The main objective of the study was to identify factors which influence contraceptive decision making and choice of method(s) by couples The study had three components (a) cross sectional, (b) anthropological, (c) providers In the cross sectional study component 4000 women in the reproductive age group and living in 80 villages and two districts of Karnataka were selected using stratified random sampling techniques and an effort was made to understand the socio-economic and demographic background of these women and find out their knowledge, attitudes and practice regarding contraception The anthropological study concentrated on gathering a mass of qualitative information which could not be elicited through cross sectional study which quantitative in nature This study was conducted in four villages, two each from two study districts Of these villages two were those where PHC headquarters were located and the other two villages had no

governmental health facilities whatsoever. In each of the selected villages a total of 12 households, which were earlier covered in the cross sectional study, were selected. In six of these households couples were using a contraceptive method at the time of cross sectional study and in the remaining six households no one was using any contraception. These households were regularly visited by a team of trained interviewers over a period of one month and required information was gathered with the help of detailed checklist. These interviewers were supervised by two experienced social anthropologists. The team stayed in the selected villages for the entire period of field work and established excellent rapport with the respondents in particular and community in general. In addition to the household members informal indepth discussions were carried out with the opinion leaders and different categories of functionaries from the development departments. The information collected was discussed by the team every evening and strategies to overcome problems in data gathering were worked out.

In the providers study all the 48 female health workers covering 80 villages selected for the cross sectional study were identified and contacted. Each of these workers was observed for a period of six working days and their activities were recorded intermittently at five minute intervals on a specially designed observation sheet. At the end of each day's observation, a resume of work done was prepared. At the end of the observation period, the observers prepared a detailed description of the work carried out by the worker and their interactions with the clients. Later all these health workers were interviewed at length with the help of a semi-structured interview schedule. In addition, male health workers, supervisors and medical officers of selected PHC's were also contacted and indepth interviews were conducted with them. The entire exercise was carried out by specifically trained and experienced interviewers under the supervision of a highly qualified and experienced social scientist. The same team was involved in all the three components of the study. This ensured their thorough understanding of the overall study design and objectives, as well as salient features of each component and linkages between them.

A Study of Time Utilisation of PHC Staff

This study was conducted in a PHC located at a distance of 9 kilometres from Chickballapur taluk (sub-district) of Kolar district in Karnataka. The PHC covers 70 villages with a total population of about 30,000. There are 7 sub-centres in the PHC and the maximum distance of a sub-centre headquarters from the PHC headquarters is 35 kilometres. Within the sub-centres the maximum distance from one village to another is 6 kilometres for five sub-centres and 9 kilometres for two sub-centres. The staff at the PHC comprise of three medical officers (MO incharge, lady medical officer and an ICDS medical officer), a pharmacist, a laboratory technician, a block health educator, two senior health assistants (male), a senior health assistant (female), a junior health assistant (male), 8 junior health assistants (female), three staff 'D' category (two attendants and a driver). The time utilisation of PHC staff was studied by work sampling and/or continuous observation techniques. The activities of the headquarters staff were observed by a trained and qualified researcher using work sampling techniques, while the grass root level workers were continuously observed by specially recruited graduate interviewers who were intensively trained for the job. The observers accompanied the workers on their field visits. The observations continued for a period of 45 working days.

Focus Group Discussions

A series of focus group discussions were organised in Bangalore and Kolar districts of Karnataka state. After seeking necessary approvals from appropriate health authorities, a list of medical officers (MO's), senior health assistants (LHV's) and junior health assistants

(ANM's) was obtained from the respective District Health and Family Welfare Officers. These lists were used for selecting personnel for focus groups. In each of the two districts- four focus groups- 2 for ANM's and one each for LHV's and MO's were assembled. A list of topics to be introduced in the group discussion was prepared. These topics were formed into a question route and thoroughly pretested on a few individual functionaries to ensure whether the wording of questions is appropriate, to determine whether the questions elicit discussion, and to identify questions that were not understood easily. The questions were finalised based on the results of pretests. The focus groups were led by the author and two moderators who have extensive experience of carrying out in-depth and anthropological investigations and are well conversant with different facets of health systems research. The focus groups discussions were held in the taluk(sub-district) hospital at Chickballapur, district Kolar and at the Population Centre, Bangalore. In each discussion there were approximately 10 participants. The discussions with ANM and LHV groups were conducted in the local language, while these were in English with MO's group. All the discussions were audio-recorded and later transcribed and translated into English. A content analysis was carried out to discover the implications of discussions for the research questions which were purported to be answered.

CHAPTER 4

RESULTS FROM DYNAMICS OF CONTRACEPTIVE USE STUDY

The study collected data on several aspects of contraceptive use dynamics, analysis provided here is based on part of the information gathered from the interviews with ANM's, LHV's and MO's, observation of ANM's, and respondents reports of interactions with the providers elicited during anthropological investigations

RESULTS OF INTERVIEWS WITH AUXILIARY-NURSE MIDWIVES(ANM'S)

Background characteristics

The background characteristics of the ANM's included in this study are given below in Table 1. Forty nine ANM's were interviewed using a semi structured interview schedule. The average reported age was 35 years and more than 80 percent were between 26 and 45 years. More than 80 percent of them had 10 years of schooling and a few older ANM's had only 8 or less years of schooling and some younger ones reported having studied upto 12th standard and beyond. More than three-fourths were married and majority had two or less living children. On an average the ANM's interviewed had been with the department for 12 years with a little more than half having been in service for more than 10 years. The average length of posting at any one place works out to be 4.3 years with more than 80 percent of them having a tenure of between 2-3 years.

TABLE 1
Selected background characteristics of ANMs

| | No | % |
|------------------|----------|-------|
| AGE | | |
| 21-25 | 4 | 8.2% |
| 26-35 | 26 | 53.1% |
| 36-45 | 14 | 28.6% |
| >45 | 5 | 10.2% |
| mean | 35.07 | |
| EDUCATION | | |
| PRIMARY | 1 | 2.0% |
| MIDDLE | 2 | 4.1% |
| HIGH SCHOOL | 40 | 81.6% |
| Higher Secondary | 6 | 12.2% |
| mean | 9.79 yrs | |

TABLE 1 (continued)
Selected background characteristics of ANMs

| | No | % |
|------------------------------|----|--------|
| EXPERIENCE/LENGTH OF SERVICE | | |
| < 3 yrs | 5 | 10 2% |
| 4-6 yrs | 6 | 12 2% |
| 7-10 yrs | 9 | 18 4% |
| 11-15yrs | 12 | 24 5% |
| >15yrs | 17 | 34 7% |
| Mean | 12 | 13 |
| MARITAL STATUS | | |
| Single | 6 | 12 2% |
| Married | 38 | 77 5% |
| Widowed | 5 | 10 2% |
| NO OF CHILDREN | | |
| 0 | 9 | 18 4% |
| 1 | 7 | 14 3% |
| 2 | 14 | 28 6% |
| 3 | 8 | 16 3% |
| >=4 | 4 | 8 2% |
| Unmarried & others | 7 | 14 3% |
| Mean | 1 | 81 |
| Average length of posting | | |
| <2 yrs | 2 | 4 1% |
| 2-3 yrs | 41 | 83 7% |
| 4-5 yrs | 5 | 10 2% |
| 6+ yrs | 1 | 2 0% |
| Mean | 4 | 27 |
| TOTAL | 49 | 100 0% |

Ranking of PHC functions by ANM's

The ANM's were asked to rank the eight PHC functions in order of their perceived importance. The ranking given by them was scored on a scale of 1 to 8, the function ranked first getting a score of 8 and that ranked last assigned a score of 1. The scores obtained by each function are: MCH(7.7), family planning(6.4), health education(5.2), control of communicable diseases(4.3), environmental sanitation (4.0), school health (3.1), medical relief(2.9) and vital statistics(2.7). The results are shown below in Table 2.

Table 2
Ranking of PHC functions by the ANMs

| PHC FUNCTIONS | Rank | | | | | | | | Average score |
|----------------------------------|------|----|----|----|---|----|----|----|---------------|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
| Medical relief | - | - | 5 | 3 | 5 | 10 | 12 | 8 | 2.95 |
| MCH | 39 | 5 | 4 | - | - | - | - | - | 7.73 |
| Family planning | 3 | 28 | 9 | 6 | 2 | 1 | - | - | 6.43 |
| Environmental sanitation | 1 | 2 | 6 | 12 | 8 | 10 | 6 | 4 | 4.00 |
| Health education | 6 | 8 | 12 | 4 | 8 | 4 | 4 | 2 | 5.21 |
| Control of communicable diseases | - | 3 | 9 | 13 | 9 | 8 | 5 | 2 | 4.33 |
| School health | - | 1 | 4 | 4 | 9 | 10 | 12 | 9 | 3.06 |
| Vital statistics | - | 2 | - | 7 | 8 | 5 | 9 | 17 | 2.73 |

Information was also solicited from ANM's about their perceived roles and responsibilities. Table 3 given below summarises their responses.

TABLE 3
Perception of ANMs about their roles and responsibilities

| | No | % |
|---|----|-------|
| PERCEIVED ROLE OF ANM | | |
| Identify pregnant women and children | 36 | 73 5% |
| Provide education on use of contraceptive methods | 36 | 73 5% |
| Visit each house and enquire about the health of family members | 23 | 46 9% |
| Provide education on environmental sanitation | 15 | 30 6% |
| Provide support to health team | 14 | 28 6% |
| Conduct deliveries | 10 | 20 4% |
| Provide education on nutrition | 9 | 18 4% |
| Provide education on immunization | 8 | 16 3% |
| Identify fever cases & take blood sample | 8 | 16 3% |
| Provide followup service | 7 | 14 3% |
| Register births & deaths | 7 | 14 3% |
| Provide education on child care | 7 | 14 3% |
| Provide medical relief | 6 | 12 2% |
| Provide school health services | 4 | 8 2% |
| Advise women to educate their children | 3 | 6 1% |
| Refer for medical checkup | 2 | 4 1% |
| Advise on contagious diseases | 2 | 4 1% |
| Distribute ORS packets | | |
| Motivate people to accept services | 1 | 2 0% |

An overwhelming majority of the respondents indicated that their major role is to visit each house and enquire about the health of family members, and provide education on use of contraceptive methods. A large number of other activities, indicated in the above table, were also mentioned by the respondents.

Work routines

On an average the ANMs were reported to be covering 6.6 villages. Approximately 40 percent covered between 4 to 6 villages, while about 30 percent each covered 3 or less and 7 or more villages. The details are given in Table 4 below.

TABLE 4
Number of villages covered by ANMs

| | No | % |
|-------------------------|------|-------|
| No. of villages covered | | |
| <=1 | 5 | 10 9% |
| 2-3 | 9 | 19 6% |
| 4-6 | 18 | 39 1% |
| 7-10 | 7 | 15 2% |
| >10 | 7 | 15 2% |
| Mean | 6.61 | |

The average distance to the farthest village from sub-centre headquarters is reported to be 12 kilometres and they are reported to be covering a distance of about 13 kilometres daily. The details are given in Table 5

Table 5
Average distance of villages covered and of farthest village from sub-centre headquarters

| Distance | Average of all villages | | Farthest village | |
|---------------|-------------------------|------|------------------|------|
| | No | % | No | % |
| 1-2 kms | 8 | 16.3 | 2 | 4.1 |
| 3-4 kms | 12 | 24.5 | 14 | 28.6 |
| 5-6 kms | 6 | 12.2 | 6 | 12.2 |
| 7-8 kms | 3 | 6.1 | 7 | 14.3 |
| 9-10 kms | 5 | 10.2 | 3 | 6.1 |
| >10 kms | 13 | 26.5 | 15 | 30.6 |
| DK/NA | 2 | 4.1 | 2 | 4.1 |
| Mean distance | 12 | 88 | 12 | 24 |

When asked where they spend most of the time, approximately one-fifth (20.4%) of the ANM's reported that they spent a major proportion of their time at the sub-centre village, and about three-fourths (73.4%) responded that most of their time is spent on field visits to the villages in their respective jurisdictions. A small proportion (6.1%) of the ANM's who were posted at PHC headquarters were reported to be spending most of their time at PHC. On an average they are reported to be contacting families either at the sub-centre or through domiciliary visits. The reported mode of transport for field work used by the respondents was walk only (67.3%), walk and bus (14.3%), bus only (14.3%), and other modes of transport (4.0%).

Based on the experience of previous one week the ANM's were asked to estimate the time they spent on various functions. The results indicate that on an average they spent 43 percent of their time on MCH including immunization, 30 percent on family planning, 13 percent on other PHC functions mostly malaria related work, and 14 percent on reports and other office work.

Interaction with clients

The interaction with the clients plays a pivotal role in the delivery of health and family welfare services and most often forms a critical component of the quality of service provided. However, efforts to measure this vital aspect can be described as perfunctory. Most often the methodologies employed to assess provider-client interactions are based on 'yes' or 'no' types of responses from the clients which result in diluted courtesy reactions and many a times misleading. In this study the ANM's were asked what methods they adopt to motivate couples to adopt family planning. Their responses are shown below in Table 6

Approximately half the ANM's interviewed indicated that they advise the women to use IUD for spacing, and explain the benefits of small family to couples. The other methods to motivate couples to adopt contraception mentioned by a large number of respondents are regular contacts with pregnant women, advise newly married couples to postpone pregnancy for two years, advise couples with male children to go in for sterilization, and provide education on adverse effects of having more children.

Table 6
Methods of motivation adopted by the ANMs

| | No | % |
|--|----|-------|
| Advise women to use IUD to space births | 26 | 53 1% |
| Explain benefits of small family | 25 | 51 0% |
| Regular contact with pregnant women | 21 | 42 9% |
| Regular contact with people | 19 | 38 8% |
| Advise those with two children to undergo sterilization | 18 | 36 7% |
| Advise couples with male children to go in for sterilization | 16 | 32 7% |
| Provide education on illeffects of having more children | 16 | 32 7% |
| Advise newly married couples to postpone pregnancy for two years | 6 | 12 2% |
| Inform about various incentives | 6 | 12 2% |
| Advise according to number of children couples have | 5 | 10 2% |
| Arrange group meetings and discuss on health programmes | 4 | 8 2% |
| Meet individually and discuss | 4 | 8 2% |
| Use AV aids and educate clients | 4 | 8 2% |
| Discuss with village elders on FP | 4 | 8 2% |
| Work more on MCH | 4 | 8 2% |
| Provide prompt service | 3 | 6 1% |
| Advise on environmental sanitation | 2 | 4 1% |
| Arrange to provide FP services whenever asked for | 2 | 4 1% |
| Request colleagues to advise my clients | 2 | 4 1% |
| Advise on nutrition | 2 | 4 1% |
| Make satisfied users recommend FP to others | 1 | 2 0% |
| Provide education on cleanliness | 1 | 2 0% |

As regards types of follow up services for sterilized clients and users of other methods of contraception, approximately half the ANM's indicated that they follow up the sterilized women to examine surgical wounds, administer medicine to relieve pain and refer complicated cases to doctor. The users of spacing methods are usually contacted to maintain regular contact. The responses of ANM's are shown in Table 7.

Table /
Follow up services provided by ANMs

| | No | % |
|--|----|-------|
| FOR STERILIZED CLIENTS | | |
| Examine surgical wounds | 32 | 65 3% |
| Administer medicine to relieve pain | 26 | 53 1% |
| Refer complicated cases to doctor | 25 | 51 0% |
| Maintain constant contact with the patient | 25 | 51 0% |
| Advise on bathing and hygiene | 15 | 30 6% |
| Advise on nutrition | 14 | 28 6% |
| Arrange transport for the patient | 1 | 2 0% |
| Advise on sexual intercourse | 1 | 2 0% |
| FOLLOW UP SERVICES FOR OTHER USER CLIENTS | | |
| Maintain regular contact | 25 | 51 0% |
| Refer complicated cases | 15 | 30 6% |
| Provide medical relief | 12 | 24 4% |
| Remove device in complicated cases | 11 | 22 4% |
| Ensure regular supply of contraceptives | 3 | 6 1% |
| Advise on proper use of device | 3 | 6 1% |
| Advise on nutrition | 1 | 2 0% |

Further based on the responses of the ANM's, those indicated their relation with the people as very cordial, cordial and formal works out to be 45, 47 and 8 percent respectively. When asked about their perception about the people's attitude towards them 37 percent indicated that this is very favourable, 47 % favourable and the remaining 14 percent reported it to be indifferent.

In addition to in-depth interviews with the ANM's, they were also observed by the researchers continuously for a period of six days and it was thus possible to record, among others, their interactions with the clients and other community members. During the observations it was found that most of the ANM's maintain cordial relationship with all the community members especially her direct clients including pregnant and lactating mothers, sterilized women and current and prospective users of spacing methods of contraception. The ANM's in order to gain the confidence of clients often engages in talks not pertaining to her work and shares with their clients and family members's personal problems, joys and sorrows.

In general, the ANM soon after her arrival in the village engages herself in informal chats with those passing by and exchanges pleasantries. The subject of discussion is anything from local agricultural situation, birth of a baby, illness or death of an important person, marriage, local politics or even national issues. The gossip lasts for a few minutes or more and then the worker begins visiting her clients. The social environment is generally quite informal facilitating free interaction. At the client's house, each worker employs her own methods of initiating conversation. During our observations we could see some workers involving in a good amount of horseplay with their clients, often cutting jokes while some begin their talks aggressively accusing the client either for not having followed her instructions to take tablets regularly or not heeding her advice to undergo sterilization. Being a government official the health worker commands a certain degree of respect in the villages covered. She is also an official with some power. Her endorsement is required to receive the benefits of maternity allowance, incentives for sterilization and similar other benefits. This is often used to her advantage when she commands clients to abide by her advice lest she would not help them.

get the benefits. However, recourse to such warnings is rarely resorted to even though the relationship of the health worker with her clients is more paternalistic and imposing in nature.

The mode of interaction of ANM's with their clients can best be observed from the following three cases.

Case 1

Mrs B, an ANM works at the PHC headquarters village. She appeared to be unhappy about this as she is instructed to report to her supervisors at PHC immediately after her field visits and is assigned additional work. The reasons for her unhappiness are that 'the other ANM's work till noon and are free afterwards, but I have to slog in the PHC and do work related to malaria programme- staining the blood slides- and perform other miscellaneous activities'. The houses covered by Mrs B are in a cluster. Most of her clients belong to immigrant families who had migrated from Andhra Pradesh and settled there about 10 years back. Mrs B normally concentrates on those households in which there are pregnant women and lactating mothers. With other households either she has casual contacts or no contacts at all. After arriving in the village, she briskly walks in the lanes and quietly marks the date of her visit on the stencils. If she sees somebody looking at her, she retorts 'what!' and moves on to the next house brandishing her pencil on the stencil on the wall. She looks at the researcher and says

"People here are very backward and illiterate. They cannot understand why we are doing all this. Can you see that house there? There is a woman whom I have to motivate for sterilization. She does not understand the value of small family and I have to break my head. But there is no way I can convince her. I have to spend a lot of time with such women. I have been visiting this village for a long time, so people know me as a good worker. They demand that I should attend all deliveries. But where is the time for all this. We have to meet family planning targets."

In an hour's time, Mrs B visited about seventy houses where her major work was marking on the stencil and simultaneously enquiring about health of 'everybody' without even entering the house. If somebody complained of health problems her stock reply was 'show to the doctor at the hospital(PHC). I don't have any medicines'. Now it was about 3 in the afternoon and Mrs B tells the researcher(observer) that she has to attend a function organised by a local group on nutrition of children. The researcher accompanies her to the function where the lady medical officer at PHC is seen giving a talk on child nutrition. The organisers thanked the women present at the function and told them to come in large numbers next time.

Case 2

Mrs V covers Agrhara sub centre coming under Chornur PHC of Bellary district. The village covered by her on the day of our observation is located at a distance of about 12 kilometres from the PHC headquarters. Before reaching the village Mrs V informed the researcher(observer) that

"The people in this village belong to Golla community which is totally against family planning programme. No amount of talk even by higher officials to convince them about family planning was of any use. It was therefore decided to provide them other health care services and after gaining the confidence of the people promote the use of contraceptive method. They are quite receptive to MCH services like immunization, antenatal care (TT and iron tablets) "

Upon reaching the village Mrs V visited a house where she met an expectant mother. After examining her, she told the woman about her six months pregnancy. She advised her to observe complete cleanliness and wear clean clothes. The woman was given iron tablets with instructions to take it every evening after food. In the meanwhile an old woman approached the ANM and told her that she has severe headache and fever. Mrs V examined her and immediately took a blood smear and gave chloroquin tablets and advised her to take all of them after dinner. She also observed that the old woman had dirty teeth and advised her to clean them everyday with a mixture of charcoal powder and salt. The ANM looked at the woman and said 'look how dirty they are'

Mrs V then moved on to another house closeby. She told the researcher(observer) that 'Here is a mother who was complaining about something, let us see how she is now'. The woman was sitting on a raised platform in front of her house. She appeared sick. Mrs V looked at her and enquired 'how is your pain now?'. The woman was suffering from pain in breast due to accumulation of excess milk. Mrs V examined the affected part and advised 'soak a clean cloth in hot water and press it against the part which pains. The milk will automatically flow. don't forget to nurse your baby. do not stop to feed your baby just because you have pain. if you leave it like that it will become hard and then I will not be able to do much. you may have to go to hospital where they may have to drain out pus. now take this'. She gave four chloroquin tablets and then took a blood smear of the patient.

In the next house Mrs V saw a woman with a small baby. She examined the baby and while enquiring about his health from the mother told her that 'you already have six children. Now you should stop. It is a very simple thing. You don't have to worry at all. I will be there. it will never pain. you will also get money and free medicines'. Mrs V was motivating this client to undergo 'needle operation' (laparoscopic sterilization). The woman smiled innocently but did not reply. Mrs V again repeated 'I am telling this for your own good. talk with your husband and others and let me know. I will meet you day after tomorrow. then tell me after all you and your children should be happy'. Thereafter Mrs V left the house.

She walked further in the village for while and later entered another house where she met a pregnant woman. The woman was examined by Mrs V. The woman who appeared very anaemic just whispered to Mrs V that she often get fits and is very scared. Mrs V advised her to get herself checked at the PHC hospital. She told her not to ignore this else she might have problems during delivery. The woman further added that 'I also get stomach pain on and off and I not have regular bowel movement'. Mrs V advised

'Drink some hot water daily before going to bed. Eat lots of green and other vegetables. You can do this also. boil some drumstick leaves and drink that water. you will have smooth motion'. The woman appeared satisfied with Mrs V's advice and said that she would do accordingly. Mrs V then moved out and on the way met a few persons who greeted her. Mrs V returned the greetings and enquiring about their welfare moved on. She then entered

a house where a woman had recently delivered. Pointing at the dai(TBA), who was present in the house at that time, the family members said that the baby was delivered by her. The mother told Mrs V that she had slight fever and headache. Mrs V asked the dai 'how did you cut the cord?' The dai who was chewing beetle leaf replied 'with a new blade of course'. Mrs V examined the mother and the newly born and advised her to eat lots of green vegetables. She also took a blood smear and gave her four chloroquine tablets advising her to take all of them together after food.

In the lane Mrs V met a woman who told her that she had missed her periods. Mrs V held the woman's hand for a few moments and told her that 'let us wait till next month then I will tell you' and moved on. Another middle-aged woman greeted Mrs V in the lane. Mrs V stopped and said 'how are you now let me see I will see you inside the house'. In the house Mrs V examined the woman and gave her a handful of iron and folic acid tablets and advised her to take nutritious food and left.

Case 3

Mrs S is a hefty, middle aged ANM working in Chornur PHC of Bellary district. Boisterous by nature, Mrs S is a compulsive talker who speaks on anything and everything she sees or hears. During the observations at the PHC village she was seen loudly greeting her friends and passers by with occasional bursts of laughter accompanied by hugs and mighty pats on the back of acquaintances. A cheerful person, Mrs V has already completed 21 years of service in the department. However, it was observed that Mrs S socialises with people belonging to higher socio-economic groups and ignores or neglects weaker sections of the society. She usually visited those households where there were pregnant women or lactating mothers. Even during these visits she did not examine the patients and mechanically distributed iron tablets. She often told the researcher(observer) that 'I have to talk to all and sundry in the village to get sterilization cases. I hate it. But what to do? I have to achieve my targets you see. Moreover, the male worker does not do any work at all. Added to this, there are no drugs. I have done LHV training two years ago but still I have not got the promotion. I always regret joining this department'. Mrs S entered a house in the village and enquired politely about the health of the woman. The client's husband was a tailor. Mrs S asked him 'can you stitch a clothe for me?' He replied with a smile 'first see your patient and give her medicine. I will stitch one for you'.

While walking in the lane Mrs S met a colleague Mrs J. Both of them talked for more than 15 minutes admiring about certain sarees. Then she entered the house of a PHC clerk and talked of her pending TA bill and requested him to process it fast. After about another 15 minutes proceeded toward the house of LHV. After entering her house, Mrs S told her 'Madam, I don't know whether I should go for field work today the festival is fast approaching people are busy cleaning their houses and we don't have a place to sit and moreover they do not feel like talking to us'. The LHV replied 'then do not go to the field today'. Mrs S looked at the researcher(observer) and said 'since you have come, I will go on duty though I am not very keen about it'. They left LHV's house and entered the village lane. On her way Mrs S entered the house of health inspector and chatted with him for a while on some personal problems. Thereafter she visited the house of a pregnant woman. The woman was not present in the house. Mrs S met the woman's mother-in-law and gave her iron tablets with instructions to pass them on to her daughter-in-law.

Then she moved into another house and met an IUD user. Mrs. S asked about her health and specifically enquired about any problem with the IUD. The client replied in the negative. The client offered coffee and Mrs. S chatted with her and others in the family for nearly 30 minutes and then left the house. On the way Mrs. S told the researcher (observer) that the client was her relation and does not allow her to go without having coffee. While walking on the main street of the village, Mrs. S visited a cloth shop. The shop owner told Mrs. S that he had pain in his legs. Mrs. S told him 'take Brufen, come to my house. I have relaxil ointment there which I will give you'. Again she chatted with him for about 10 minutes and left. While walking in the street she met several people who talked about general topics such as festival, cinema, TV and the like. After some time she entered a house of a newly married couple. Mrs. S enquired about their health and asked another woman in the house to get an IUD inserted. She told her that 'your child is already one year old. After your next period send a word to me, I will insert copper T. then what else?' She chatted with the woman for quite some time and then left for her home. She had completed her day's work.

Community Involvement

The ANMs were asked several questions about the methods they adopt to seek community involvement in the health and family welfare programmes, problems encountered in this regard and their suggestion to improve community participation for the effective management of the programmes. The results are shown below in Table 8.

Table 8
INVOLVEMENT OF COMMUNITY BY ANMs

| | No | % |
|--|----|-------|
| COMMUNITY INVOLVEMENT METHODS REPORTED BY THE RESPONDENTS | | |
| Seek support of village leaders | 33 | 67 3% |
| Visit houses and inform of the schedule | 18 | 36 7% |
| Personally bring people to venue where services are provided | 8 | 16 3% |
| Seek support from other functionaries | 7 | 14 3% |
| Provide prompt service | 5 | 10 2% |
| Arrange food/refreshment for those attending programmes or meetings | 4 | 8 2% |
| Provide more health education | 4 | 8 2% |
| Attend festivals and other functions in the village | 3 | 6 1% |
| PROBLEMS ENCOUNTERED IN COMMUNITY INVOLVEMENT BY THE HEALTH WORKER* | | |
| People avoid us in peak agricultural seasons | 24 | 49 0% |
| Labourers too tired to attend our programmes | 20 | 40 8% |
| Repeat visits absolutely needed for which there is not enough time | 7 | 14 3% |
| People avoid us if we talk about family planning | 6 | 12 2% |
| People avoid us due to lack of follow-up service | 5 | 10 2% |
| People are illiterate and superstitious | 4 | 8 2% |
| Elders do not allow youth to participate | 4 | 8 2% |
| Elders scold us of spoiling the minds of youth | 4 | 8 2% |
| None | 6 | 12 2% |

Table 8 (continued)
INVOLVEMENT OF COMMUNITY BY ANMs

| | No | % |
|---|----|-------|
| SUGGESTIONS TO IMPROVE COMMUNITY PARTICIPATION | | |
| Have regular contact with people | 23 | 46 9% |
| Maintain punctuality while conducting programmes | 17 | 34 7% |
| Involve more village leaders and functionaries | 15 | 30 6% |
| Arrange more film shows and dramas etc | 14 | 28 6% |
| Provide free medical treatment | 8 | 16 3% |
| Involve specialist doctors to provide treatment | 7 | 14 3% |
| More incentives needed | 4 | 8 2% |
| Provide food/refreshments to participants | 4 | 8 2% |

The most important method for community involvement mentioned by the respondents was to seek support of village leaders. The main problem encountered in community involvement was that during busy agricultural seasons the people have no time for any of the health and family welfare activities and hence avoid them. Further the weaker sections of the society who are mostly agricultural labourers are too tired after a day's hard work to participate in any of the programmes or meetings organised by them. The suggestions proffered by several respondents for improving community participation were regular contact with people, observance of punctuality in the conduct of programmes, involvement of more leaders and functionaries of other departments, and arranging more health educational programmes through film shows and dramas.

Orientation Training Camps (OTC's) for Community Leaders

Orientation training camps (OTC's) for community leaders are organised in the rural areas to educate them about the various health and family welfare programmes and seek their active participation for the effective implementation of these programmes. These camps are organised with great fanfare and refreshments are arranged for the participants. The ANM's were asked to indicate the objectives and usefulness of OTC's and give suggestions for making them more effective. Their responses are shown below in Table 9.

Majority of the respondents indicated that the main objective of OTC's is to arrange talks by doctors and specialists and exhibit films on health programmes. As regards usefulness of these OTC's a large number of ANM's said that the people have become more aware about the various programmes after their participation in OTC's. The main suggestions given by the respondents to make these camps more effective was to make them more interesting, use of more audio-visual aid and organisation of cultural programmes etc.

Table 9
Perceptions of ANMs about Orientation Training Camps (OTCs)

| | No | % |
|--|----|-------|
| PERCEIVED OBJECTIVES OF OTCs | | |
| Arrange talks by doctors/specialists on various topics | 29 | 59 2% |
| To arrange film shows on health programmes | 29 | 59 2% |
| To educate mothers on MCH and family planning | 22 | 44 9% |
| To educate people on various health schemes | 18 | 36 7% |
| To use charts/pictures while giving talks | 17 | 34 7% |
| To arrange food/refreshments for leaders | 15 | 30 6% |
| To arrange cultural programmes on health themes | 5 | 10 2% |
| Educate the community about different schemes | 2 | 4 1% |
| To organise exhibition on family planning | 2 | 4 1% |
| PERCEIVED USE AND EFFECT OF OTCs | | |
| People have become more aware of health and family planning programmes | 30 | 61 2% |
| Visual medium has good impact on the people | 16 | 32 7% |
| Groups of functionaries meeting people has been very effective | 12 | 24 5% |
| People are more convinced of the goals of various health schemes | 10 | 20 4% |
| OTCs have succeeded in educating the | | |
| People cooperate in MCH work | 7 | 14 3% |
| People now cooperate with us readily | 6 | 12 2% |
| Visits by doctors/specialists have a good impact | 5 | 10 2% |
| Frequent OTCs have a lasting impact on the community | 4 | 8 2% |
| OTCs are not effective at all | 4 | 8 2% |
| Detailed explanation of schemes in OTCs have increased utilization | 2 | 4 1% |
| OTCs have not served a useful purpose | 2 | 4 1% |
| OTCs help only knowledgeable persons | 1 | 2 0% |
| Community on hygiene and first aid | 1 | 2 0% |
| SUGGESTIONS TO IMPROVE OTCs* | | |
| Use more av aids and cultural programmes | 14 | 28 6% |
| OTCs should be conducted regularly at short intervals | 14 | 28 6% |
| Programmes should be made more interesting | 14 | 28 6% |
| Give more incentives to participants | 9 | 18 4% |
| Exhibit more films | 8 | 16 3% |
| OTCs should accompany prompt and quality service | 6 | 12 0% |
| Motivation to be done by workers in groups | 2 | 4 1% |
| Give gifts/momentos to leaders participating in OTCs | 1 | 2 0% |
| Involve other functionaries | 1 | 2 0% |

Basis of Target Setting

How are the targets assigned to the ANM's arrived at ? According to about three-fourths (73.5 %) of the respondents they are fixed according to population covered, about one-eighths indicated that these are arrived at on the basis of eligible couples, and another one-tenth (10.2 %) felt that both population and eligible couples are taken into consideration. The remaining 4.1 % provided no answer. Further a little more than half (55.1%) agreed with the method of target setting, while about two-fifths (38.8 %) of the respondents did not agree. The remaining 6.1 % said that there is no need for targets. Several respondents felt that targets are difficult to meet in predominantly Muslim and sparsely populated areas. These should therefore be fixed taking into account the local conditions.

Supervision

The respondents were asked several questions to know their attitudes, perceptions and opinions about the type of supervision and guidance they receive in their work. Their responses to different aspects of supervisory practices are shown below in Table 10.

Table 10
Perceptions and attitudes of ANMs towards their supervisors

| | No | % |
|--|----|-------|
| FREQUENCY OF MEETING IMMEDIATE SUPERVISOR | | |
| Almost daily | 3 | 6.1% |
| Once in a week | 35 | 71.4% |
| Once/twice a month | 9 | 18.4% |
| Rarely | 2 | 4.1% |
| PURPOSE OF CONTACT WITH THE SUPERVISOR | | |
| When official guidance is required | 25 | 51.0% |
| When referring family planning cases | 24 | 49.0% |
| To discuss regarding immunization | 18 | 36.7% |
| Maintenance of records and submission of reports | 15 | 30.6% |
| To seek help regarding motivating people | 7 | 14.3% |
| To procure drugs and equipments | 6 | 12.2% |
| To seek information and guidance about sterilization camps | 5 | 10.2% |
| When in need of transport | 2 | 4.1% |
| Work related to malaria programme | 1 | 2.0% |

Table 10 (continued)
Perceptions and attitudes of ANMs towards their supervisors

| | No | % |
|---|----|-------|
| PERCEPTION REGARDING SUPERVISOR'S UNDERSTANDING | | |
| Reasonably good | 26 | 53 1% |
| Very good | 3 | 6 1% |
| Good | 12 | 24 5% |
| Less aware | 1 | 2 0% |
| Not aware | 3 | 6 1% |
| Not concerned | 3 | 6 1% |
| DK/NA | 1 | 2 0% |
| SATISFACTION LEVEL REGARDING GUIDANCE FROM SUPERVISOR | | |
| Highly satisfied | 16 | 32 7% |
| Satisfied | 27 | 55 1% |
| Not satisfied | 6 | 12 2% |
| FREQUENCY OF COMMUNICATION WITH SUPERVISOR | | |
| Almost daily | 9 | 18 4% |
| Once/week | 18 | 36 7% |
| Less often | 14 | 28 6% |
| Rarely | 8 | 16 3% |
| PERCEPTIONS OF SUPERVISOR'S ATTITUDES TOWARDS WORK | | |
| Emphasis on efficiency | 33 | 67 3% |
| Emphasis on target achievement | 9 | 18 4% |
| Both target achievement and efficiency | 6 | 12 2% |
| Emphasis on humanitarian attitude | | |
| DK/NA | 1 | 2 0% |
| ADEQUACY OF SUPPORT FROM SENIORS | | |
| Quite adequate | 14 | 28 6% |
| Adequate | 28 | 57 1% |
| Inadequate | 3 | 6 1% |
| No support | 4 | 8 2% |
| RATING OF SUPERVISOR'S UNDERSTANDING OF FIELD PROBLEMS | | |
| High | 19 | 38 8% |
| Medium | 25 | 51 0% |
| Low | 5 | 10 2% |

Training

The number of respondents reported to have received short duration training of different types is given below in Table 11. A little more than two-fifths (42.8%) of the ANM's reported that they had received MPW training, and another 30.6% reported to have undergone general orientation. The number of those who received other than the above two types of training is very small. Further approximately one-fourth (24.5%) of the respondents indicated that they had not received any inservice training during their entire service with the department.

Table 11
TYPE OF TRAINING RECEIVED

| Type of training | No | % |
|-------------------------|----|------|
| MPW | 21 | 42.9 |
| General orientation | 15 | 30.6 |
| Immunization | 14 | 28.6 |
| Mental health | 8 | 16.3 |
| Guinea worm eradication | 5 | 10.2 |
| LHV | 5 | 10.2 |
| Mobile training | 5 | 10.2 |
| TB | 4 | 8.2 |
| ORT | 4 | 8.2 |
| IPP | 3 | 6.1 |
| Vital statistics | 3 | 6.1 |
| IUD insertion | 2 | 4.1 |
| FP | 2 | 4.1 |
| Leprosy | 2 | 4.1 |
| Antenatal care | 1 | 2.0 |
| MCH | 1 | 2.0 |
| IEC | 1 | 2.0 |
| ICDS | 1 | 2.0 |
| School health | 1 | 2.0 |
| No training received | 12 | 24.5 |

Note: Multiple response

The ANM's were asked about the type of training which would be most helpful and they would like to undergo immediately. The responses are shown below.

work
12

Table 12
Need for further training expressed by the ANM's

| TYPE OF TRAINING NEEDED | No |
|------------------------------|----|
| LHV training | 11 |
| Family planning motivation | |
| MCH | |
| To conduct OTCs | |
| Nutrition | |
| General nursing | |
| Health education | |
| Midwifery | |
| Office work | |
| Management of all programmes | 1 |
| MPW training | 1 |
| First aid | |

Level of concern with service conditions

The reported level of concern of ANM's with selected service conditions is indicated in table 13 given below

Table 13
Extent of concern of ANMs regarding selected working conditions

| Working conditions | Not bothered | | Sometimes bothered | | Always bothered | |
|-------------------------------------|--------------|-------|--------------------|-------|-----------------|-------|
| | No | % | No | % | No | % |
| Lack of adequate authority | 22 | 45.8% | 24 | 50.0% | 2 | 4.2% |
| Lack of promotional opportunities | 37 | 77.1% | 7 | 14.6% | 4 | 8.3% |
| Too much work to perform | 22 | 45.8% | 16 | 33.3% | 10 | 20.8% |
| Work interferes with family life | 18 | 38.3% | 17 | 36.2% | 12 | 25.5% |
| Lack of support from superiors | 36 | 73.5% | 7 | 14.3% | 6 | 12.2% |
| Inadequate living facilities | 21 | 42.9% | 11 | 22.4% | 17 | 34.7% |
| Problems of education of dependents | 30 | 62.5% | 8 | 16.7% | 10 | 20.8% |
| Illhealth of self/dependents | 28 | 57.1% | 10 | 20.4% | 11 | 22.4% |
| Inadequate training | 31 | 64.6% | 14 | 29.2% | 3 | 6.3% |
| Interference of local politicians | 37 | 77.1% | 9 | 18.8% | 2 | 4.2% |
| Lack of support from community | 33 | 67.3% | 12 | 24.5% | 4 | 8.2% |
| Inadequate salary/allowances | 40 | 83.3% | 3 | 6.3% | 5 | 10.4% |

Mean score

18.26

Median

18.00

Mode

14.00

* Mean score has been computed based on weights-

Not bothered= 1 Sometimes bothered=2 Always bothered=3

Several respondents indicated that they were always bothered about their living conditions, and personal and family problems which interfere with their job responsibilities

RESULTS OF INTERVIEWS WITH LADY HEALTH VISITORS (LHV'S)

Background characteristics

The background characteristics of 12 LHV's interviewed are given below

| | |
|-----------------------------------|-------------|
| Average age | 43 1 years |
| Average years of schooling | 9 9 years |
| Average length of service | 20 5 years |
| Average number of postings | 4 8 |
| Marital status | All married |
| Average number of living children | 3 0 |

Ranking of PHC functions by LHV's

The ranking of PHC functions by LHV's in order of their perceived importance is given below in table 14

Table 14
Ranking of various PHC functions by LHVs

| PHC functions | Ranking | | | | | | | | Score |
|----------------------------------|---------|------|------|------|------|------|------|------|-------|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
| Medical relief | - | 16 7 | 8 3 | - | - | 8 3 | 25 0 | 41 7 | 2 83 |
| MCH | 75 0 | 16 7 | - | - | 8 3 | - | - | - | 7 50 |
| Family planning | - | 50 0 | 25 0 | - | - | 8 3 | 8 3 | 8 3 | 5 50 |
| Environmental sanitation | - | 16 7 | 16 7 | 33 3 | 8 3 | 8 3 | 8 3 | 8 3 | 4 67 |
| Control of communicable diseases | 8 3 | - | 16 7 | 25 0 | 33 3 | 8 3 | 8 3 | - | 4 92 |
| School health | - | - | 25 0 | - | 33 3 | 25 0 | - | 16 7 | 3 75 |
| Health education | 16 7 | - | 8 3 | 33 3 | - | 16 7 | 25 0 | - | 5 45 |
| Vital statistics | - | - | - | 8 3 | 16 7 | 25 0 | 25 0 | 25 0 | 2 58 |

The ranking was scored in reverse order, function ranked 1 getting the highest score of 8 and that ranked 8 scored as 1. The overall score obtained indicate that the functions were ranked in this order: MCHH, family planning, control of communicable diseases, environmental sanitation, health education, school health, medical relief and vital statistics.

Perceptions of LHV's about various PHC programmes

The respondents were asked which of the programmes are most difficult and which ones are impossible in terms of their accomplishment. The responses are shown Table 15

Table 15
Perceptions of LHVs about various PHC programmes

| | No | % |
|----------------------------------|----|-------|
| MOST DIFFICULT PROGRAMMES | | |
| Medical relief | 1 | 8 3% |
| MCH | 1 | 8 3% |
| Family planning | 9 | 75 0% |
| Environmental sanitation | 1 | 8 3% |
| REASONS FOR DIFFICULTY | | |
| People are superstitious | 7 | 58 3% |
| Difficult to convince people | 6 | 50 0% |
| People are ignorant | 5 | 41 7% |
| Failure of equipments | 2 | 16 7% |
| People are uneducated | 1 | 8 3% |
| Lack of transportation | 1 | 8 3% |
| IMPOSSIBLE PROGRAMMES | | |
| None | 6 | 50 0% |
| Family planning | 4 | 33 3% |
| MCH | 1 | 8 3% |
| Environmental sanitation | 1 | 8 3% |
| REASONS FOR IMPOSSIBILITY | | |
| Unrealistic targets | 3 | 25 0% |
| Non-cooperation from people | 2 | 16 7% |
| Others | 2 | 16 7% |

Nine out of 12 LHV's indicated that the family planning programme is most difficult, and again achievement of targets in this programme was considered impossible by about one-third of the respondents. The reasons given for their opinions were mostly related to the ignorance and non cooperation from the people and unrealistic targets.

Attitudes of LHV's towards family planning targets and incentives

Two-thirds of the LHV's felt that targets are currently fixed based on population, while a majority of them were of the opinion that the ideal basis for target fixation should be number of eligible couples. One-fourths of those interviewed also indicated that lower targets should be fixed for resistant populations particularly in areas dominated by Muslims. Further eleven out of 12 LHV's considered targets necessary for effective implementation of the family planning programme, but a majority of them felt that the criteria for their fixation is not appropriate.

Three-fourths of the respondents indicated that incentives are necessary for motivating couples to adopt contraception, particularly irreversible methods and should be retained.

Interactions with the community

Eleven out of 12 LHV's interviewed mentioned that they mostly contact community members individually and only one respondent said that she arranges group meetings. During these interactions people often complain to them about lack of drugs/medicines and inadequate follow up of family planning cases. An overwhelming majority of those interviewed indicated that teachers, community leaders, anganwadi workers and dais are very helpful in their work.

Methods of Supervision

The LHV's interviewed reported that on an average they are supervising 1.5 male and 5.2 female workers. The percentage of workers reported to be excellent, very good, good, fair, poor works out to be 35.0, 18.8, 27.5, 12.5 and 6.2 respectively. As regards ability of the LHV's to supervise all the workers, a little more than half (58.3%) indicated that they are able to supervise all workers adequately, while the remaining 41.7% reported that it is difficult to supervise so many workers who are located at distant place. Furthermore they are occasionally assigned duties at the PHC which are very time consuming. The LHV's were also asked about the frequency of their contacts with the workers they supervise. The results indicate that 2 out of 12 LHV's were reported to be meeting their workers almost daily, 7 once in a week and 3 once or twice a month.

So far as methods of supervision are concerned, two-thirds of the respondents indicated that they accompany the workers for field work and demonstrate to them the appropriate techniques of implementing various programmes, 16.7% reported that they primarily depend on records for assessing the performance of their workers and spend considerable amount of time on scrutinizing various registers maintained by the workers. The remaining 16.7% mentioned that they make surprise checks to see if the workers are visiting the villages as per their fixed tour programme and also independently enquire from the people about the services provided by the workers.

On being asked what their approach to supervision is, 6 out of 12 LHV's reported that they listen to the work related as well as personal problems of the workers, try to find solution to them and guide the workers in all possible ways to improve the coverage and quality of services provided to the clients. Five of them stated that their aim is to see that workers achieve maximum output and no excuses are entertained, and the remaining 1 LHV indicated that her job is see that workers achieve the targets assigned to them and she is not bothered about anything else.

In order to ensure that the workers provide adequate followup care to their clients, 50% of the LHV's indicated that they check with the clients about the visits of workers and type of services provided by them, 25% reported that they personally observe the workers during their supervisory visits, 16.6% mentioned that they carry out surprise visits, and the remaining one respondent reported to be entirely relying on records of their workers to find out if they provide adequate followup care to their clients.

Information about the perception of the LHV's about the major deficiencies and problems of the workers supervised by them was also obtained. One-half of the respondents mentioned that their workers have no major deficiencies, one-fourths indicated that several of their workers are relatively new and have yet to learn their jobs, and the remaining one-fourths stated that most of their workers are irresponsible, dull headed and have poor health. The major problems perceived by the LHV's and number reporting them are: poor image of the

workers among the community because of overemphasis on family planning(2), family problems (4), lack of cooperation from the community(2), inadequate living conditions(5), frequent transfers(1), lack of facilities for education of children (2), heavy work load (1), lack of cooperation among colleagues(1), inadequate and late receipt of travelling allowance(3)

The LHV's were also asked about their relations with their health workers. Seventy five percent indicated that they are cordial and the remaining 25 % said they are very cordial

Support from Superiors

The number of LHV's reported to be meeting their superiors almost daily, once in a week and less often was found to be 5,4 and 3 respectively. Further 4 of them indicated that the support they receive from their superiors in their work is quite adequate, 5 stated it to be adequate, while 3 said that it is inadequate

Training

The LHV's are reported to have received the following short duration training

Table 16
TYPE OF TRAINING RECEIVED

| Type of training | No | % |
|---------------------|----|------|
| MPW | 10 | 83.3 |
| Leprosy | 6 | 50.0 |
| General orientation | 5 | 41.7 |
| General nursing | 5 | 41.7 |
| Family Planning | 5 | 41.7 |
| Immunization | 2 | 16.7 |
| Mobile training | 1 | 8.3 |
| ICDS | 1 | 8.3 |

Note Multiple response

Further only one LHV each expressed need for further training in general nursing, nutrition, emergency care, and use of audio-visual aids

Level of concern with service conditions

Eight out of 12 LHV's stated that they very much like their job, while the remaining 4 indicated that they just like it. The extent of their botheration with various service conditions is shown in Table 17. An overwhelming majority of respondents were bothered about heavy work load and stated that their job responsibilities interfere with their family life

Table 17
Perceived extent of concern of LHVs regarding selected working conditions

| | Not bothered | | Sometimes bothered | | Always bothered | |
|-----------------------------------|--------------|-------|--------------------|-------|-----------------|-------|
| | No | % | No | % | No | % |
| Lack of adequate authority | 8 | 66.7% | 2 | 16.7% | 2 | 16.7% |
| Lack of promotions | 9 | 75.0% | 2 | 16.7% | 1 | 8.3% |
| Too much work to perform | 3 | 25.0% | 5 | 41.7% | 4 | 33.3% |
| Conflicting orders | 8 | 66.7% | 3 | 25.0% | 1 | 8.3% |
| Inadequate training | 10 | 83.3% | 2 | 16.7% | - | - |
| Work interferes with family life | 4 | 33.3% | 4 | 33.3% | 4 | 33.3% |
| Lack of support from subordinates | 7 | 58.3% | 3 | 25.0% | 2 | 16.7% |
| Lack of support from officers | 7 | 58.3% | 4 | 33.3% | 1 | 8.3% |
| Political interference | 11 | 91.7% | 1 | 8.3% | - | - |
| Lack of support from people | 9 | 75.0% | 3 | 25.0% | - | - |
| Inadequate living facilities | 8 | 66.7% | 1 | 8.3% | 3 | 25.0% |
| Inadequate salary/allowances | 9 | 75.0% | 2 | 16.7% | 1 | 8.3% |
| Too much targets to achieve | 7 | 58.3% | 3 | 25.0% | 2 | 16.7% |

Mean

19.42

Median

19.50

Mode

17.00

*Mean scores have been computed on weights = Not bothered=1
 Sometimes bothered=2, Always bothered=3

RESULTS OF INTERVIEWS WITH MEDICAL OFFICERS(MOs)

Background Characteristics

Eight medical officers were interviewed, out of which six were males and two were females. The average age of the MO was 43 years and 7 were married and 1 was single. The average length of service in the department was reported to be 13 years and during this period they had on an average 4.8 postings. The average duration of posting at a particular place thus works out to be 2.5 years.

Place of Residence

Four out of eight MO's were staying in the quarters provided to them at the PHC, and the remaining four were commuting daily from the nearby town. The mean distance from PHC to residence for those who were not staying at PHC headquarters was reported to be 18 kilometres.

Availability of Transport

Six of the MOs indicated that their PHC's have been sanctioned a jeep and in five of those PHC's the jeeps are in working order. Four of the MO's did not own any personal transport, while the remaining four had two wheelers.

Perceptions of MOs about job responsibilities

When asked about their job responsibilities, the MOs gave the following answers

Table 18
Perceptions of Medical Officer's about job
responsibilities

| Job responsibilities | No | % |
|------------------------------------|----|------|
| Administration & staff management | 6 | 75 0 |
| Implement all health programmes | 4 | 50 0 |
| Provide curative services | 3 | 37 5 |
| Provide preventive services | 3 | 37 5 |
| Organise meetings | 1 | 12 5 |
| Coordinate with Zila Parishad | 1 | 12 5 |
| To achieve family planning targets | 1 | 12 5 |
| To maintain vehicle | 1 | 12 5 |
| To make school visits | 1 | 12 5 |
| To maintain equipments | 1 | 12 5 |

(multiple responses)

Implementation of various programmes

Which are the most difficult programmes to implement ? To this question eight MO's mentioned family planning, two immunization, one each leprosy and malaria. When further asked about the problems with the implementation of family planning programme, four indicated that it is difficult to motivate couples to use contraception particularly those from the Muslim religion, 2 mentioned transport as a major bottleneck, one each indicated non-availability of drugs and non-cooperation from staff as major problems. The MO's were also asked about several administrative aspects which constrain them in the implementation of various PHC programmes. The results are shown below in Table 19. The major constraints mentioned by them were non-availability of drugs in adequate quantities, lack of support from the community, lack of motivation on the part of staff, and a shortage of manpower.

Table 19
Administrative constraints reported by MOs for effective
implementation of PHC programmes

| | Very constrained | Just constrained | Not constrained |
|--|---------------------|---------------------|--------------------|
| Coordination | 2 | 2 | 4 |
| Finance | 1 | 1 | 6 |
| Logistics | 1 | 1 | 6 |
| Communication | 1 | - | 7 |
| Equipment | 1 | 1 | 6 |
| Drugs | 5 | 2 | 1 |
| Manpower availability | 3 | - | 5 |
| Motivation of staff | 1 | 4 | 3 |
| Inter-staff relations | 1 | - | 7 |
| Inter-departmental relations | - | - | 8 |
| Training facilities | - | - | 8 |
| Community support | 2 | 5 | 1 |
| Cooperation of officers | - | 1 | 7 |
| No adequate powers to take action against erring staff members | - | 1 | 7 |

Supervision

Most the of MO's indicated that their work load is very heavy and they are not able to adequately supervise the entire PHC staff. On an average they reported to have made 12 visits to the PHC villages during a three month period. When in the village, they try to enlist the support of the community by meeting the leaders and by organising group meetings. They hardly have any time to hold clinics in the villages or check the records of workers. When asked whether they were willing to delegate responsibility for administrative work, seven out of 8 MO's responded in the negative.

Perceptions about major problems and deficiencies of staff

The major problems of the staff mentioned by the MO's and number of MO's mentioning them are inadequate living facilities(3), inadequate transport (3), security of female workers in the field (2), difficulties in motivating couples for family planning(2), insufficient salary and allowances(1), inadequate supply of drugs(1), inadequate supply of stationary, forms and registers. The major deficiencies of workers perceived by the MO's are low level of understanding(2), negligence(2), laxity in work(1), irregularity in work(1), lack of motivation(1).

Training

The number of MO's reported to have received different types of training was ICDS(6), leprosy (5), MPW (4), mental health(2), management (2), sterilization, general orientation, tuberculosis, UIP, medico-legal aspects (1 each). As regards their needs for further training, all the 8 MO's indicated that they need training in administration, one each expressed a desire to go in for leprosy, obstetrics and gynaecology training.

Extent of concern with various service conditions

The level of concern of MO's with various service conditions is shown in Table 20. Majority of the MO's were reported to be bothered with lack of promotional opportunities, inadequate supply of drugs and equipment, lack of support from the community, and political interference in their work.

Table 20
Extent of concern of MOs regarding selected working conditions

| Aspects of concern | Extent of concern (n=8) | | | | | | Mean score |
|-----------------------------------|-------------------------|------|--------------------|------|-----------------|------|------------|
| | Not bothered | | Sometimes bothered | | Always bothered | | |
| | No | ✓ | No | ✓ | No | ✓ | |
| Lack of adequate authority | 5 | 62 5 | 1 | 12 5 | 2 | 25 0 | 1.7 |
| Lack of promotional opportunity | 3 | 37 5 | 3 | 37 5 | 2 | 25 0 | 1.7 |
| Too much work to perform | 7 | 87 5 | 1 | 12 5 | - | - | 1.1 |
| Conflicting orders | 7 | 87 5 | 1 | 12 5 | - | - | 1.1 |
| Forced to do unwise things | 6 | 75 0 | 2 | 25 0 | - | - | 1.3 |
| Work interferes with family life | 4 | 50 0 | 2 | 25 0 | 2 | 25 0 | 1.8 |
| Political interference | 4 | 50 0 | 4 | 50 0 | - | - | 1.5 |
| Inadequate living facilities | 5 | 62 5 | 1 | 12 5 | 2 | 25 0 | 1.7 |
| Inadequate salary/allowances | 5 | 62 5 | 2 | 25 0 | 1 | 12 5 | 1.6 |
| Inadequate drugs and equipments | 2 | 25 0 | - | - | 6 | 75 0 | 2.5 |
| Inadequate staff | 5 | 62 5 | 2 | 25 0 | 1 | 12 5 | 1.6 |
| Inadequate cooperation from staff | 7 | 87 5 | 1 | 12 5 | - | - | 1.2 |
| Inadequate support from community | 3 | 37 5 | 3 | 37 5 | 2 | 25 0 | 1.7 |
| Mean | | | 20.43 | | | | |
| Median | | | 20.00 | | | | |
| Mode | | | 19.00 | | | | |

Mean scores have been computed on the basis of ranking of respondents with 1= Not bothered
2= Sometimes bothered 3= always bothered

CHAPTER 5

RESULTS FROM TIME UTILISATION STUDY

As indicated in Chapter 2 several PHC staff were observed over a period of approximately 45 days using work sampling/ continuous observation techniques to study their time utilisation patterns. The results of observations of ANMs(junior health assistant-female), LHVs(senior health assistant-female) and medical officers are discussed in this chapter.

Analysis of time utilization of ANMs

The observation started from the time ANM began her work and ended when she reported to have finished her day's work. Throughout this period a female observer accompanied her wherever she went. A total of 249 ANM days were observed and the average duration of observation for each ANM per day works out to be 247 minutes. Approximately two-thirds (65.2 %) of this time was spent on providing services, about one-fifths(19.0 %) on travel, and another about one-sixths (15.8 %) on personal work. The details are shown in Table 1.

Table 1
Time utilisation pattern of ANMs

| Activity | Average time spent/day/ANM (in minutes) | Percentage of of total time spent |
|--|---|-----------------------------------|
| Service/productive | 161 | 65.2 |
| Travel | 47 | 19.0 |
| personal | 39 | 15.8 |
| Average total time observed perform each ANM | 247 | 100.0 |
| Number of ANM days Observed | 249 days | |
| Number of ANMs observed | 7 | |

Out of the total productive time, a little more than one-fourth(28.0%) was spent on team or group activities. The two other PHC functions which accounted for a large proportion of total productive time were MCH (23.7 %) and family planning (22.4%). The other activities received very little attention of the ANM. The details of time spent on various functions / activities is presented in Table 2.

Table 2
Distribution of productive time spent by ANM
on various activities

| Activity | Average time spent per day (in minutes) | Percentage of total productive time per day |
|----------------------------------|---|---|
| MCH | 38 | 23 7 |
| Family planning | 36 | 22 4 |
| Nutrition | 2 | 1 2 |
| Immunisation | 7 | 4 3 |
| Vital statistics collection | 3 | 1 9 |
| Control of communicable diseases | 8 | 5 0 |
| Primary medical care | 3 | 1 9 |
| Team activity/ group meeting | 45 | 28 0 |
| Record maintenance | 6 | 3 7 |
| School visits | 1 | 0 6 |
| Interaction with TBA / VHG | 2 | 1 2 |
| Anganwadi visits | 3 | 1 9 |
| House visits (general) | 7 | 4 3 |
| Total | 161 | 100 0 |

Since considerable amount of time was spent on MCH and family planning, an attempt has been made to find out the time spent on various components/activities performed under these major functions. The analysis reveals that approximately one-third (31.3 %) of the total time on MCH function was devoted to PNC visits. The other major activities under this function were ANC registration (15.0%), deliveries conducted and/or supervised (14.0%), distribution of folic acid tablets (13.4%). As could be seen from Table 3 below, time spent on other components of MCH was limited.

Table 3
Distribution of time spent by ANM on various MCH activities

| Type of MCH activity | Average time spent/day (in minutes) | Percentage of total time on MCH |
|---------------------------------|-------------------------------------|---------------------------------|
| ANC registration | 5 7 | 15 0 |
| PNC registration | 2 6 | 6 8 |
| 0-1 registration | 1 3 | 3 4 |
| ANC visits | 1 0 | 2 6 |
| Delivery (conducted/supervised) | 5 3 | 14 0 |
| PNC visits | 11 9 | 31 3 |
| TT given | 2 2 | 5 8 |
| FS distribution | 5 1 | 13 4 |
| Talk | 2 8 | 7 4 |
| Recording | 0 1 | 0 3 |
| Total | 38 0 | 100 0 |

So far as time spent on various components of family planning is concerned, it is evident from Table 4 below that assistance in tubectomies accounted for more than two-fifths (44.7 %) of the total time spent on family planning. The other major activities under family planning function were registration of eligible couples and motivation on which 28.0 and 12.8 % of their time was devoted respectively. The time spent on other family planning activities was negligible.

Table 4
Distribution of time spent by ANMs on various family planning activities

| Type of FP activity | Average time spent/day (in minutes) | Percentage of total time on MCH |
|--|-------------------------------------|---------------------------------|
| Registration of eligible couples | 10 1 | 28 1 |
| Motivation | 4 6 | 12 8 |
| Group meeting | 3 0 | 8 3 |
| Distribution of oral pill/condom | 1 6 | 4 4 |
| IUD insertions | 0 3 | 0 8 |
| Assisting tubectomy | 16 1 | 44 7 |
| Follow up of IUD / tubectomy acceptors | 0 3 | 0 8 |
| Total | 36 0 | 100 0 |

Analysis of time utilisation of LHVs

Only one LHV was observed for 45 days and average time observed per day works out to be 236 minutes. Out of this a little more than two-fifths (67.8 %) was spent on productive activities, while about one-fifths (20.8 %) of time was spent on personal work or activities not related to her job responsibilities. The average daily time spent on travel was 27 minutes or 11.4 % of the total time observed. The details are shown in Table 5 below.

Table 5
Time utilisation pattern of LHVs

| Activity | Average time spent/day/ANM (in minutes) | Percentage of of total time spent |
|--|---|-----------------------------------|
| Service/productive | 160 | 67 8 |
| Travel | 27 | 11 4 |
| personal | 49 | 20 8 |
| Average total time observed perform each ANM | 236 | 100 0 |
| Number of ANM days Observed | 45 days | |
| Number of ANMs observed | 1 | |

The responsibilities of LHV are mainly to provide supervision and guidance to ANMs. On this activity the LHV observed spent on an average only 41 minutes daily or one-fourth (25.6%) of the total productive time. The other activity which took away lot of her time was maintenance of records and office work on which another about-fourth (27.5%) of the time was spent. The meetings at district headquarters, CSSM training, ICDS work were and interaction with workers were the other major activities which received some attention of the LHV. Table 6 given below gives details of the activities and time spent on them.

Table 6
Time utilisation of LHVs on various activities

| Activity | Average time spent per day (in minutes) | Percentage of total productive time per day |
|------------------------------------|---|---|
| Supervision | 41 | 25 6 |
| Record maintenance | 25 | 15 6 |
| Meeting at PHC | 2 | 1 3 |
| Meeting at Dist HQ | 15 | 9 4 |
| Health talks | 2 | 1 3 |
| Office work | 19 | 11 9 |
| Assisting MO | 3 | 1 9 |
| Interaction with workers | 11 | 6 9 |
| Interaction with community leaders | 1 | 0 6 |
| Participation in camps | 11 | 6 9 |
| CSSM training | 18 | 11 3 |
| ICDS work | 12 | 7 5 |
| Total | 160 | 100 0 |

The type of supervisory activities performed by LHV are shown in Table 7. About one-half of the total supervisory time was spent on supervising the immunization programme, and another 14.6% of the time was devoted supervising other maternal and child health activities. The LHV spent an average of 7 minutes daily in providing general supervision and guidance to workers and this accounts for about one-sixth (17.1%) of the total time spent on supervision.

Table 7
Type of supervising activities performed by LHVs

| Activity | Average time spent per day (in minutes) | Percentage of total productive time per day |
|----------------------------------|---|---|
| MCH | 6.0 | 14.6 |
| Family planning | 4.0 | 9.8 |
| Immunisation | 20.0 | 48.8 |
| Vital statistics | 0.8 | 2.0 |
| Control of communicable diseases | 0.7 | 1.7 |
| Primary medical care | 0.5 | 1.2 |
| General supervision & guidance | 7.0 | 17.1 |
| Anganwadi visits | 1.0 | 2.4 |
| House visits (general) | 1.0 | 2.4 |
| Total | 41.0 | 100.0 |

Analysis of time utilization by medical officers

The PHC included in the study was headed by a medical officer of health (MOH). There were two other medical officers at this PHC - an ICDS medical officer and a lady medical officer (LMO). The overall management of the PHC was the responsibility of MOH. During the absence of MOH, the ICDS medical officer looked after the work of PHC and in case both these MOs were absent, the responsibility for day to day working of the PHC was entrusted to LMO.

To assess the work pattern and the time utilization of these three medical officers, work sampling method was adopted. Work sampling was done for about 3 days a week or 25 days during the entire duration of the study. In all there were about 50 rounds of observation for each of the three medical officers. The activities they were found to be engaged in during these rounds are shown in Table 8.

Table 8
Time utilisation pattern of Medical Officers

| Activity | Type of medical officer | | |
|-----------------------------|-------------------------|-----|------|
| | Health | LMO | ICDS |
| Attending to patients | 18 | 15 | 18 |
| Interaction with MO | - | 1 | - |
| Interaction with Others | - | 2 | - |
| Away on official work | 22 | - | 1 |
| Personal work | 5 | - | 2 |
| Meeting at PHC | 1 | 1 | 1 |
| Administration | 2 | - | 1 |
| Conducting tubectomy at PHC | 2 | - | - |
| Rest | 3 | 17 | 17 |
| Not arrived | 14 | 4 | 3 |
| Just arrived | - | 1 | 1 |
| Absent/Leave | 4 | 8 | 6 |
| Others | 1 | 1 | - |
| Number of work sampling | 25 | 25 | 25 |
| Number of rounds | 50 | 50 | 50 |

The MOH in addition to being in-charge of the PHC included in the study was also looking after another PHC in the sub-district. He had therefore to spend considerable amount of time in travelling from one PHC to the other. He was trained in conducting tubectomies and was deputed by his superiors to several tubectomy camps in other PHCs to perform sterilization operations. Besides, he had also received CSSM training and was asked by his superiors to participate as an instructor for CSSM training for LHVs and ANMs conducted at the sub-district headquarters. He was therefore found to be absent on official duty in 44 % of the rounds, and was absent on personal work in another 10 % of the rounds. In 18 % of the rounds he was observed to be attending to patients. Thus he spent very little time on the management of the PHC which was one of his primary responsibilities. Each of the other two MOs were found to be spending one-third of their time on attending to out patients, and in more than one-third of the rounds they were observed to be idling away their time. The MOs also did not engage them in any activities related to overall administration or management of the PHC.

CHAPTER 6

RESULTS OF FOCUS GROUP DISCUSSIONS

This chapter describes the results of focus group discussions with junior health assistants-female (ANM's), senior health assistants-female (LHV's) and medical officers of PHC's (MO's). The discussions were focused on relevant management issues having an effect on the performance of these functionaries individually and the overall impact on the functioning of the primary health centres (PHC's).

Discussions with ANM's

As indicated in the earlier chapter discussions were conducted with four groups and in each group ten ANM's participated. The results of these discussions are summarised below according to the issues discussed.

Work Routines

The introduction of new pattern of PHC's, as per the recommendations of the government of India, limits the population coverage of a PHC to about 30,000. The PHC is further divided into several sub-centres. Each sub-centre is supposed to have one male and one female junior health assistant covering a population of about 5000. As per the perceptions of the ANM's, the households in the sub-centre area are to be equally divided between the male and female workers and each household visited at least once in a fortnight. There are no specific written job responsibilities of these workers. In general the manual of 'job responsibilities of Multipurpose staff' developed by the Ministry of Health and Family Welfare in 1986 is followed in the state without any modifications. This manual very clearly states that the male worker should visit each family in his area once in a fortnight. The manual is, however, less categorical about the female workers visits and indicates that she should 'limit her activities among 350-560 families, i.e., those households where there are cases for ante-natal and post-natal care and infants'. As per this manual, the female worker should 'at least make three post-natal visits for each delivery conducted in her area' in order to render advice regarding the care of the mother and the child. Further the manual prescribes that male workers should make a 'stencil' (inscription with certain entries) at the entrance (on the front wall) of every house they visit. The entry indicates the worker's visit with all the particulars like date and their signatures. 'Stencil' was a regular feature under the multipurpose scheme entrusted to the male workers. The main purpose of the 'stencil' work is to ensure worker's visit to all houses in their area as well as to enable their supervisors to locate and supervise the workers in the field.

An overwhelming majority of the ANM's who participated in the discussions very vehemently stated that most positions of male workers are vacant. Even in the sub-centres where the male worker is available, he does not share the responsibilities of ANM and consequently the ANM is forced to perform all these activities.

(1) Visit all households in the villages covered and sign on the 'stencil' mentioning there the date of visit.

- (2) Enquire about the health of all members of the household visited
- (3) Identify, register and follow pregnant women and distribute ferrous sulphate tablets and administer TT immunization, and provide antenatal advice on personal hygiene, nutrition among others Identify high risk pregnant women and refer them to the nearest referral centres and follow up these cases
- (4) Conduct and supervise domiciliary deliveries conducted by trained TBA's and refer complicated delivery cases
- (4) Follow post-natal cases and provide required care and services to the mother and the infant
- (5) Provide DPT, OPV, BCG, measles immunization to children according to advanced work schedule
- (6) Motivate couples to use contraception and provide all available family planning services including insertion of IUD's, distribution of oral pills and condoms and assist during family planning camps arranged at PHC and other designated locations
- (7) Follow sterilized women and users of other spacing methods and examine surgical wounds and provide appropriate treatment, examine IUD's in situ and medical relief for pain and discomfort reported Replenish supply of oral pills and condoms
- (8) Draw blood samples from each person reporting fever, and administer presumptive or radical treatment regimen for malaria a part of malaria surveillance programme
- (9) Provide treatment for minor ailments such as low fever, diarrhoea and dehydration and first aid for injury cases etc
- (10) Maintain records consisting of thirteen registers and enter details of all the work carried out such as immunization, family planning, collection of blood smears, receipt and distribution of drugs, household survey of total population, registration of infants, and identification of target couples
- (11) Attend regular monthly meetings at PHC headquarters, sector meetings and special meetings
- (12) Maintain regular contacts with all the link workers in the area which include, among others, trained birth attendants, anganwadi workers and village health guides
- (13) Maintain cordial relationship with the community served and strive to enlist their fullest cooperation in all health programmes being implemented
- (14) Organise mothers health clubs and other women groups and impart health education regularly by using educational aids This would also include arranging and participating in orientation training camps (OTC s) organised by the PHC staff

In order to carry out the above activities, the ANM's are guided by a fixed tour programme (FTP), also known as 'advance tour programme' This tour programme is fixed and not usually modified The programme is drawn up by higher level PHC officials taking into consideration

the number of villages covered by the worker and the official meetings she is expected to attend. The FTP is generally displayed at the sub-centre and copies are also kept at the PHC. These are made available to district level officials whenever required by them. The purpose of FTP is to ensure that all households falling under the jurisdiction of the worker are regularly and systematically covered. This also enables their respective supervisors to locate the workers and provide them required support and guidance. The adherence to FTP is considered as an important indicator of the performance of the worker. However, during the discussions the ANM's mentioned that it is difficult to strictly adhere to FTP due to a variety of reasons. The factors contributing to the disruption of the tour programme are attending to urgent calls to conduct domiciliary deliveries, accompanying family planning cases to PHC's, taluk hospitals and other health care institutions for the purposes of sterilization, fetching sterilization cases to family planning camps, assisting in the family planning camps the dates of which are generally notified in the monthly meetings, follow-up work in different villages, priority to the achievement of family planning targets, additional area allotment due to vacancies in other sub-centres, unscheduled meetings, deputation to training programmes, and other unforeseen situations. In addition, the FTP is also disrupted due to several other problems some of which are individual in nature while others reflect functional inadequacies.

During focus group discussions each of the participant ANM was prompted to mention their most pressing problem affecting adversely their work routines. Several of the problems mentioned were common to most ANM's and are discussed in the following paragraphs.

Residence

The most common problem mentioned by ANM's was inadequate or absence of living facility at the headquarters village. This has forced a large number of workers to stay away from their assigned PHC/sub-centre headquarters. They commute to their places of work from nearby towns by public transport which is often irregular, inconvenient, expensive and time consuming. In addition, a few ANM's also indicated that there are no buildings even for the sub-centres and these are located in single room rented accommodations which do not have any basic facilities such as sanitation, water and electricity. Those who are provided with quarters are also not satisfied with them because they lack basic facilities such as water, electricity, and toilet. The maintenance of these buildings was also reported to be extremely poor with several quarters leaking during the rainy season. This situation led many ANM's to abandon their quarters and rent accommodation in the nearby towns. A few workers also mentioned that they stay away from their headquarters villages because of absence of adequate facilities in those villages for the education of their children. The husband's place of work and difficulties of staying separately was also indicated as reason by a few for staying away from their headquarters. A typical day's work routine of an ANM who does not stay at her PHC headquarters illustrates how adversely this phenomenon affects her performance.

'I work as an ANM at a PHC which is located at a distance of 45 kilometres from the city where I stay. I have an eleven year old daughter who goes to a school near my place of residence. My husband works and lives in another town and only my daughter is staying with me. On that specified day I get up very early in the morning, did cooking, prepared my daughter for school, packed lunch for her and myself, and then left for work. I left house at 6.30 in the morning, walked to bus stand 2 kilometres away and boarded a private bus at 7.30. I disembarked from the bus at a roadside village and then took a matador van to PHC village which is 22 kilometres from the disembarkment.

point I reached the PHC at about 9 30 A M Thereafter, I collected the registers and medicines from the PHC and set out for one of the villages under my jurisdiction After walking about 4 kilometres, I reached the place of my work at about 10 15 AM In that village I visited two pregnant women and enquired about their health In another house I examined a child for measles In two other households condoms and oral pills were distributed It was 12 noon and after taking lunch, I left for another village at around 1 in the afternoon and walked about 1 kilometre to that village On reaching the village at about 1 30 P M , I visited the house of a recently sterilised woman and enquired about her health Then I entered the house of a pregnant woman and advised her about hygiene, nutrition, and rest I stayed in that village upto 2 30 PM and then returned to PHC by walking a distance of a little more than 3 kilometres At the PHC, I updated a few registers and made entries in my diary This work took about an hour At 4 30 PM I took bus for the town and reached home at about 7 PM'

During the discussion several ANM's indicated that since they stay away from their headquarters villages, they are not able to attend to deliveries which take place at odd hours Furthermore, their non-residence acts as a barrier in building confidence and establishing rapport with the community They are able to spend limited time in the villages covered by them and are not able to cover even the priority households

It was also found during discussions that the ANMs who stay at their respective headquarters provide better services such as attending to delivery calls as compared to those who stay at other places A worker who does not stay at the headquarters spends on an average, two hours on travelling from residence to place of work and Rs 100 per month approximately on transportation This obviously affects the coverage and quality of services

Transport

The ANM's are not provided any transport facility from the department to carry out the tasks assigned to them This was found to be a source of great dissatisfaction and disappointment for almost all the workers who participated in the focus group discussions Almost all of them indicated that they have to cover several villages which are scattered and in the absence of adequate transport facility, a good amount of time is spent on travel which to a considerable extent affects their work routine A serious problem encountered by the ANM's is that of carrying registers, equipments, drugs and other materials to the villages covered by them, particularly for immunization purposes Since many remote villages are not connected by public or private transport, they have to walk the distance carrying such heavy loads The need for an attendant who could assist them carry these materials to the villages was felt by all the workers Under the existing provisions, the ANM's are authorised to engage local help for this purpose on a monthly remuneration of Rs 50 per month This amount is considered to be too meagre to find anybody willing to provide such help As a consequence the ANM's have no alternative but to carry this load herself during her visits to the villages covered by her This problem is acutely felt during out-reach immunization programme for which the ANM has to carry several items such as vaccine career, vaccine bin, cooker, registers, drugs, and contraceptive devices

In some PHC's where there are vehicles in working condition, these are sometimes made available for immunization out-reach programme and this greatly facilitates the work. In the absence of transport facility and non-availability of attendant, several ANM's mentioned that many a times they are forced to reduce the frequency of their visits to remote villages or completely drop the inaccessible villages. In those cases, the remote villages receive insufficient attention from the workers. Furthermore the health workers usually walk to several of their villages or use public transport which are less frequent and often irregular. This constraint forces the ANM to plan her work routines based on the availability and timing of bus services or other means of transport. Many health workers indicated that they plan their immunization work schedule continuously for a week generally in the last week of the month during which period they carry out only immunization work and nothing else. Furthermore those ANM's who walk with such heavy loads get exhausted and are thus forced to cover only nearby villages. The remote villages thus do not receive adequate attention of the health worker. A case narrated by an ANM vividly illustrates the problem.

'I cover six villages with a total population of 3015. This population consists of 498 target couples, 138 eligible couples, 324 children in 1-4 years age group and 81 infants. The farthest village under my jurisdiction is at a distance of 12 kilometres from sub-centre headquarters and it takes about 30 minutes to reach that village by bus. I stay at the taluk town since there is no quarter at the sub-centre village and also it is difficult to rent suitable accommodation in the village. I leave house for work at 7 in the morning and catch the bus. If I miss that bus I have to wait for nearly two hours to get the next bus. I very much feel the need for financial help from the department to purchase a two wheeler. This would certainly be a great help in my work.'

Another ANM stated during discussions that

'I cover eleven villages having a total population of 6504. In this population there are 885 target couples, 421 eligible couples, 123 children in 0-1 age group and 442 children under five years. There is no male worker or BEE in the PHC and I have to shoulder their responsibilities too. It takes about 15 minutes by bus to reach the farthest roadside village and from there I have to walk to other villages falling in my area. I often get exhausted and am unable to complete the work assigned to me. Such heavy work load and absence of adequate transport facilities are adversely affecting my health and family relationships. I want to get out of this situation and am therefore trying for a transfer and seriously looking for a person who could help me in this.'

All the workers during discussions suggested that this problem would be eased to a large extent, if the department provides them two wheelers. This will help them work effectively and efficiently and will result in substantial improvement in the coverage and quality of care.

Link workers

For many of her activities the ANM seeks the assistance and cooperation of link workers who operate in the villages covered by the former. Most important of these workers are trained dais(TBA's), anganwadi (ICDS) workers and village health guides(VHG's). The trained dais often assist the ANM's in conducting deliveries and also inform the later about the pregnant women in the village. Several ANM's, especially those who commute to their work place from nearby towns, mentioned that trained dais located in remote villages carry out deliveries independently.

Anganwadi workers form another important group providing assistance to ANM's. In the areas covered by ICDS the anganwadi workers provide space for carrying out immunization work and assist the ANM's in bringing mothers and children to immunization venue. They also help in motivating couples for family planning, assist in the organization of women groups and arrange group meetings. The anganwadi workers, at times, also serve as depot holders for contraceptives and ANM's leave the supply of condoms and oral pills with them to be distributed to couples during ANM's absence from the village. Furthermore, anganwadi workers as a part of their work, maintain information relating to children covered by the anganwadi. The ANMs and anganwadi workers share this information and use it for updating their records. The ANMs also regularly meet the anganwadi workers in sector meetings every month. These meetings are attended by the PHC medical officer, concerned sector LHV, ANMs, child development programme officer (CDPO), Mukhysevikas and anganwadi workers. In these meetings ICDS activities are reviewed and the medical officer gives a talk on specific topic relevant to ICDS as well as PHC staff. Thus anganwadi workers and ANMs interact with each other on a regular basis. Besides trained dais and anganwadi workers, a few ANMs reported having contacts with VHGs who are supposed to provide basic health services in their respective villages. However, most ANMs indicated that VHG's are not of much help as they do not have regular contacts with ANMs. In addition, these VHGs are not available in the villages at the time of ANMs visits.

Supply of drugs

All the ANMs who participated in the group discussions reported acute scarcity of drugs. In fact, the ANMs mentioned inadequate supply of drugs as one of the most pressing problems faced by them and which results in dissatisfaction of clients and affects their other preventive, promotive and family planning motivational work. The budget for each sub-centre for drugs is presently Rs 5,000 per annum. In addition, the ANMs are also supposed to receive drugs required for treating sterilized women who are not able to reach the PHC or hospital for follow up treatment. The drugs supplied to ANMs are not as per the budget and are totally reported to be insufficient and much below their actual requirements. Further several ANMs indicated that they not only do not receive the required type of drugs in required quantity, but a large quantity of drugs which they don't actually need are dumped on them. Basic drugs such as paracetamol, and some analgesics which are needed most are either supplied much below the quantity required, or not supplied at all. Several participants repeatedly indicated that a huge quantity of FS tablets are supplied to them and they are compelled to distribute these tablets to the villagers for all ailments. The villagers have become aware of this practice and now refuse to accept these 'red' tablets and demand other drugs for their illnesses. Furthermore, most of the participants mentioned that a major proportion of drugs they receive are beyond their expiry date or are very close to the date of expiry. Many ANMs who receive these expired drugs continue to dispense them to their patients since no other drugs are available with them. It was further reported that the drug distribution system at the PHC is very informal. Whenever they need drugs they approach the medical officer at PHC who gives small quantities of drugs as per his whims and fancies.

The acute shortage of drugs is reported to have adversely affected the work routine and interactions with the people. An ANM, who represents the views of all those who participated, vehemently stated

'Whenever people see us, they demand medicines, preferably injections. If we say we do not have any, we are invariably accused of not providing good service to the people and they get angry with us. If we have adequate and timely supply of required drugs, it would greatly facilitate people's cooperation and this will also help us provide effective and efficient service to them. We spend a greater proportion of our time in the villages and several villagers come to us for treatment of minor ailments such as headache, cold, cough, fever and if we do not dispense drugs for these conditions they question the utility of being there. How can we enlist their cooperation in the implementation of various programmes?'

A large proportion of ANMs also indicated that in order to maintain good relations with the community, sometimes they buy drugs from the market by spending part of the money they receive from families for conducting deliveries. Summing up the views of several participants, an ANM indicated

'Just because we do not get drugs from the department, we cannot always tell our clients about our inability to treat them. After all we have to maintain cordial relationships with people in order to carry out our other tasks such as motivation for family planning, immunization. Thus, in order to satisfy the people and enlist their cooperation in other programmes for which targets have to be achieved, we have to provide the people drugs and other treatment required by them. The drugs provided by the department will not last even for a few months. So we have to buy drugs from private medical shops and dispense the same to our patients.'

Maintenance of records

The ANM maintains several registers pertaining to each of the activities performed by her. Some of these records are carried by the ANM during her field visits and are regularly updated. Presently the ANM maintains 13 such registers each pertaining to family planning, target population, immunization, collection of blood smears, births and deaths, drugs, equipments and several other activities. These records form the basis for assessing the performance of the ANM by her supervisors during their field visits and also in the monthly review conference. Many ANMs indicated their inability to carry these registers to the field because of heavy load and absence of adequate transport facilities and help. A large proportion of ANMs also mentioned that these registers are not properly designed and the space provided for making the necessary entries is not adequate. In addition, it was reported that several registers do not have enough pages and these get filled up soon. In order therefore to update the records they have invariably to buy additional stationery and the expenses incurred are not reimbursed by the department. The household survey is one such record which was often mentioned during the discussions. Besides these problems, the ANMs indicated that they have to spend a considerable amount of time in the maintenance of these records. As their work load is already very heavy and they have to spend a major part of the day on field visits, they have often to spend their evenings for updating the records. It was reported that on an average an ANM is spending about 45 minutes to 1 hour every day on record maintenance. Furthermore, many ANMs mentioned that some items of information are very complex and beyond their comprehension and in spite of the guidance provided by their supervisors they are unable to make proper and correct entries.

Monthly meetings and work review

All the ANM's are required to attend and participate in the monthly review meetings held at the PHC headquarters. These meetings are usually scheduled on the last or first working day of the month. A day prior to this meeting, all the ANMs update their records and prepare work reports and submit them to their respective supervisors (LHVs) for consolidation. On the day of the meeting, the ANMs reach the meeting venue in the morning and assist LHVs to make consolidated reports showing the overall performance of the worker. This takes considerable amount of time and actual review of each worker's performance begins at about 11 in the morning. The meeting is presided over by the medical officer of PHC, and a representative from the district health office also attends the meeting. Besides, all LHVs, male workers, health inspectors and BEE also attend the monthly PHC meetings. At the start of the meeting the MO(PHC) reads out important official communications received from higher authorities pertaining to various programmes, administration and makes various announcements.

After this each worker's performance is reviewed. Invariably the review begins with the worker reporting lowest performance. The consolidated report gives details of targets and achievement with respect to each programme. Most often the worker's performance is first assessed based on her achievement of family planning targets assigned to her, followed by her performance in other activities most importantly number of immunizations and blood smear collected. During the meeting the worker is asked to give reasons for her low performance and then appropriate actions are taken by the MO. The meeting usually continues upto 4 in the afternoon during which the performance of most of the workers is reviewed. After the review work is completed and necessary feedback and instructions are given to the workers, the dates for specific activities such as outreach immunization programme, sterilization camps and other activities to be taken up during the month are announced. The ANMs are also given instructions when they should collect vaccines and other materials from the PHC. In addition, any changes in the advanced tour programme of the ANM are discussed and affected during these meetings. After the meeting is over, the ANMs collect drugs and supply of contraceptives from the PHC. The salaries of workers are also disbursed on the meeting day.

In addition to the monthly review meeting at PHC, the ANMs also attend sector meetings every month. This meeting is attended by the PHC MO, sector LHV and also by ICDS functionaries such as CDPO, Mukhyasevika and anganwadi workers. In this meeting ICDS activities are reviewed and the MO gives a talk on a specific topic relevant to ICDS programme.

Several ANMs indicated during the discussions that while monthly review meetings are essential and serve an important purpose, the sector meetings are unnecessary and considerable amount of time is spent on them without any substantial benefit accruing to them.

Supervision

The ANMs are supervised by LHVs who are supposed to make regular field visits and observe the quantity and quality of services delivered by them. On an average an LHV supervises the work of 6 ANMs. The LHVs also accompany ANMs for outreach immunization programmes which are usually scheduled during the monthly meetings. Most of the ANMs mentioned that the LHVs visit them in the field twice or thrice a month. During these supervisory visits the LHV accompanies the ANM to the houses, helps and guides her in immunization work and IUD insertions. Sometimes the LHV also demonstrates to the ANM the correct method of IUD

insertion. She also checks the records maintained by ANM and points out the deficiencies and instructs her about the correct procedures of maintaining these records. The LHV also meets the people independently and enquires about the services provided by the ANM. The complaints, if any, of the people are listened to and the ANM is instructed to ensure that genuine needs of the people are met promptly. In addition to the interactions during field visits, the ANMs also contact the LHVs for different purposes such as

- (a) collecting vaccines and other materials,
- (b) submission of reports,
- (c) informing LHV about mahila mandal and other women groups arranging meetings and well baby clinics,
- (d) redressal of disputes between the ANM and the community

These contacts are also used by ANMs for seeking clarification and guidance from their supervisors for the implementation of various programmes and activities.

During the focus group discussions it was found that although the supervisory styles of LHVs vary considerably, almost all the ANMs perceived that the supervisory efforts of LHVs are mainly directed towards seeing that the ANMs achieve the targets assigned to them. Some of the ANMs mentioned that their supervisors are least bothered about their problems and quality of services. As a participant said

"The 'HV sister' does not bother about how I carry out my activities so long as I complete my targets. If I talk about any field problems with her, the stock reply is 'don't tell me all these. You are supposed to achieve these targets. Have you done this?' I am not interested about knowing how you do this, whom do you contact and the like. What I want are results. Just deliver them and I will never bother you. If you don't then I am not responsible for whatever happens."

While target achievement is by and large considered an important yardstick for assessing the performance of the health workers, a few ANMs also indicated that the LHVs also try in their own way to ensure that the health worker carries out her activities in an effective manner. During their field visits, the LHVs inspect the stencil markings on the walls to ensure that the worker has indeed visited the households. The LHVs also check the various records to find out the performance of ANMs and often warn them about the deficiencies. Some ANMs also revealed during discussions that whenever the LHVs visit them in the field, they help and guide them in their day to day activities. According to an ANM participant

'My supervisor visits me three times in a month. During each of these visits, she stays with me till evening and accompanies me to villages and provides help in immunization work and other activities. During her last two visits to my subcentre, she inserted three IUDs, helped me in door-to-door survey work, and also conducted a woman group meeting in which thirty women participated. My supervisor is quite cooperative and helps me in all activities. I have achieved about seventy five percent of my immunization targets and during her last visit she had talks with the remaining families and has motivated them to get their children immunized. I like the way she interacts with people. Whenever I commit any mistake she never points them out in front of people. She appreciates me whenever I do good work.'

Almost all the participants indicated that they hardly receive any guidance from the medical officers, except during the monthly meetings when they actually reprimand us for not achieving the targets. They hardly visit them in the field.

Interactions with community

The ANM being the main government health functionary at the peripheral level, is often approached by villagers, especially women and children, for meeting their health needs. She in turn has to seek active cooperation from the people in order to effectively accomplish the tasks assigned to her. Thus there is a mutually beneficial relationship between her and the community. In order to strengthen this relationship the ANMs adopt different strategies. During our discussions most of the ANMs mentioned that they know their clients personally and regularly visit them. These visits are more frequent in the households where there are pregnant women, lactating mothers and children. In other households the visits are relatively fewer primarily due to heavy load of work and contacts are often made when specifically requested for.

All the participants in the discussions however said that they try to have good relationship with their clients and others in the community. It was also mentioned that those belonging to weaker sections seek the services of ANM most, while higher socio-economic groups tend to go to nearby towns and seek care from private medical practitioners. The most common strategy adopted by the ANMs to enlist community involvement is to first gain the confidence of the village leaders such as pradhans (heads), mandal panchayat members and other important persons in the village. Further the ANMs also try to provide curative services to clients and dispense drugs for minor ailments. Sometimes they accompany the patients to PHC and ensure that they receive prompt care. This gesture is however shown in very rare cases of general ailments, though it is very common in family planning cases. Most ANMs indicated that due to inadequate supply of drugs they are not in a position to satisfy the demands of the villagers, and have to frequently face embarrassing situations. Those living at the subcentre headquarters mentioned that they do not have any privacy or free time as the village often disturb them even after they are finished with the day's work.

So far as the cooperation of the community in specific programmes such as family planning or immunization is concerned, our discussions revealed that most people now realise the importance of these programmes and willingly cooperate. Some of them come voluntarily to family planning and immunization camps. However, there is some resistance to family planning among certain sections of the community such as Muslims and scheduled castes. The ANMs now concentrate more on these sections and try to motivate them by making more frequent visits and asking satisfied clients and other opinion leaders to influence them to participate in the programmes. The ANMs find it particularly difficult to ensure active cooperation of the women by organising them and forming mahila mandals. The women apart from engaging in economic activities have several domestic chores to perform and find it difficult to attend the functions. A few families also refuse to immunize their children or pregnant women due to some superstitious beliefs and also due to fear that the child will get fever. Some women also believe that immunization would cause the same disease for which they are immunized. The ANMs also mentioned that it is difficult to convince couples without sons to undergo sterilization. Further it is difficult to motivate couples to use spacing methods either because of their unreliability of some methods and complaints of bleeding, white discharge, and low back pain for IUD. Though the ANMs provide symptomatic treatment for IUD complications and side effects and refer or accompany serious cases to PHC or sub-district hospital, there is general reluctance on the part of women to use IUD. Thus several ANMs find it difficult to achieve IUD targets.

Prioritisation of work

When asked about the most important activities in their work routine, all the ANMs without exception mentioned MCH and family planning. This to a considerable extent reflects the prioritisation of work by ANM. All those who participated in the discussions reported to have either fully achieved their family planning and immunization targets or were close to their achievement. During our detailed discussions each of the ANM was prompted to narrate in detail her work routine on a normal day. On the basis of the details given by the ANMs it was found that activities of ANMs generally consisted of (a) follow up of pregnant women, distribution of FS tablets and administration of TT injection, (b) follow up of post natal cases to provide advice for the care of the mother and new born, (c) distribution of ORS packets to those suffering from diarrhoea, (d) follow up of sterilized women, examination and dressing of surgical wounds, and provision of advice on hygiene and nutrition, (e) follow up of users of spacing methods, distribution of condoms, oral pills, and establishing contact with IUD users, (f) identify fever cases, collect blood smears and provide presumptive treatment for malaria, and (g) conduct household surveys.

In addition to the above activities, the ANMs also reported that they attend to calls for delivery and this activity receives precedence over all other activities. The weekly immunization programme of the ANM is scheduled as per her advanced tour programme and specific outreach immunization work is carried out according to dates fixed by the LHV at the monthly review meeting at the PHC. On the immunization days, the ANM collects the vaccine from the PHC either personally or the same is brought to immunization venue by the LHV as decided on the meeting day. On reaching the village, the ANM meets the link worker and arranges for the venue of immunization. Most of the ANMs indicated that they are assisted by one of their ANM colleague who accompanies her on these days and carries out the immunization work, while the area ANM visits the houses and brings the mothers and children to the immunization venue. This assistance is mutual and the ANM in turn assists her colleague during immunization programme in the area covered by the latter. However, when the LHV visits the village, no other assistance is available to the ANM as task performed by ANM's colleague is now taken over by the LHV. Though the ANMs are supposed to plan one day in a week for immunization work, in the absence of any regular assistance, do not follow a set pattern for this activity. Most often, depending on the work routine of another colleague or visit of LHV, they devote an entire week every month exclusively for immunization and do not carry out any other activities on those days. It was brought out during the discussions that in a typical month, the ANM spends about five days on immunization work, four days on attending family planning camps, four to five days for attending meetings, collecting vaccines and other materials, and submission of reports and returns.

It was further reported that they do not receive any assistance from the male workers and have to look after their work of enquiring about fever cases and collection of blood smears.

Service conditions and job satisfaction

All the ANMs pointed out during discussions that salary, allowance and facilities provided to them are not commensurate with their activities. Most of the participants indicated that their work load is very heavy and unmanageable and they have often to concentrate on a few programmes where targets are assigned and other activities are neglected. Further the burden of achieving targets is mentally and physically stressful and affects the quality of services provided. Compounding this are several systemic inadequacies such as adequate and timely supply of drugs, absence of residential quarters at most of the sub-centre villages, poor

condition of quarters wherever they exist, lack of transport, and unsystematic demarcation of population and area covered by an ANM. No incentives are given to ANMs even when they have to look after an additional area or the work of a male worker who is either not posted in the sub-centre or does not do any work at all. Furthermore, there are insufficient promotional avenues and there is no system of time bound promotions. According to the existing rules the ANMs have to pass departmental examinations in accounts (lower and higher) in order to become eligible for promotion as LHV. Most ANMs feel that these examinations are not only irrelevant but are very difficult to pass. The participants also expressed their great disappointment with the official delays in the release of their allowances. All the ANMs, without exception, indicated that there is rampant corruption in the department and their TA bills, arrears and other claims are inordinately delayed unless they agree to pay a portion of their claims as 'speed money'. This affects their dedication and motivation to put in their best

It was also pointed out by almost all the ANMs that transport is the major bottleneck and their performance would considerably improve if some scheme is initiated by the department which would allow them to own a two-wheeler. They also felt a need for an attendant who could help them carry immunization and other materials to the outlying villages.

It was also revealed during the discussions that while some ANMs were apparently dissatisfied with their jobs, a few others were happy to be providing health care to the needy

people. The later group also at times felt frustrated due to several field problems and infrastructural constraints. A large proportion regretted having joined the health department as ANMs.

Discussions with LHVs

Focus group discussions were conducted with two groups of LHVs and in each group nine LHVs participated. The discussions were focused on several management issues and the results are summarised below.

Work routines

The LHV, officially designated as senior health assistant (female), is the key supervisory staff looking after the work of junior health assistant (female), also known as ANMs. There is a wide range in the number of personnel they supervise. While some supervise only about 3 ANMs, the others supervise as many as seventeen. They cover upto 100 villages with population ranging from 20,000 to 60,000. There were about 1357 PHCs in the state as of January 1995 and each PHC is supposed to have one LHV. However, in only 1020 PHCs the LHVs were posted and the remaining posts were vacant. Whenever the post of LHV is vacant, the LHV posted at the adjoining PHC is given additional responsibility and thus the area and population to be covered increases. In order to travel to the farthest village from the PHC, the LHV has to travel upto 25 kilometres and most LHVs cover these distances by bus, walk or private carriers.

The LHV is primarily responsible for supervising the work of ANMs, providing support to them, collecting and compiling monthly reports and integrating the PHC activities with those of ICDS programme. She prepares her tour programme every month after looking at the advanced tour programme of ANMs she supervises and keeping in mind the other activities in which she is

involved during the month. The MO PHC is rarely consulted while drawing the tour programme, but a copy of the tour programme so drawn is given to him/her. In view of limited time available to her for field visits, she often gives priority to those ANMs who are deficient in their work and to those areas where the progress of work is not satisfactory. She covers about 1 to 3 villages in a day on any out-reach visit day. Her monthly work routine normally consists of 4 immunization days at PHC headquarters, 5-6 meeting days at various places, 2 days for compilation of reports, 2 days for family planning camps and about 10 days for field visits to sub-centre area. This routine is often disrupted due to personal/ family reasons, camps or non-availability of transport.

During immunization days at the PHC, she is busy immunising children and pregnant women. Sometimes, she also arranges health education talks to groups of women attending such clinics. However during her visits to the villages, which are mostly concurrent with the visit of ANMs, she helps the ANM with immunization programme, visits anganwadi centres, and organises group meetings. However, if her visit to the village is not on a day when the ANM has arranged immunization, she generally checks the records to assess the performance of ANM. A few LHVs also indicated during the discussions that they make surprise visits to the villages to find out if the ANM actually visits the village and enquires from the villagers about the coverage and quality of services provided by her. These surprise visits, according to these LHVs, have considerably reduced absenteeism among ANMs and now they do visit villages indicated in their advanced tour programme, even though for a short while.

The major problem mentioned by the LHVs for not adhering to the work routine is the non-availability of transport. She may have to walk 10-15 kilometres on any field visit day. Most of the LHVs felt that their efficiency and effectiveness will considerably improve if they are provided with some vehicle, at least a two wheeler. It was found during the discussions that the LHVs and male supervisors draw their tour programmes independently and there is no coordination between the two.

Most of the LHVs are not aware of all the functions and activities of PHCs. They primarily concentrate on MCH and family planning programmes. There are no specific job descriptions for personnel available at PHC or even at the district headquarters. Our discussions with senior officials reveal that since there are frequent changes in the responsibilities of various health personnel, they have not been able to formulate specific job descriptions for various posts including LHV. The activities performed by the LHV are based on her own perception of the job.

Residence

Most of the LHVs indicated during the discussions that they are staying at the PHC headquarters either in the quarters provided by the government or rented houses. Those who stay in rented accommodation outnumber those who stay in the quarters. On an average they are reported to be paying a rent of Rs 200 per month. The problem of residing at their headquarters for LHVs is not as acute as those for ANMs, most of whom do not stay at their respective places of posting due to variety of reasons indicated in preceding paragraphs. Since PHCs are located in bigger villages with better facilities, most of the LHVs stay there.

Supervision

In order to provide supervision and support to ANMs, the LHVs make two types of visits to the field- concurrent and consecutive. In a concurrent visit the LHV accompanies the ANM

to the villages covered by her, while consecutive visits are surprise visits usually made after the ANM was scheduled to visit the village according to her advanced tour programme. It was reported during discussion that out of 10 supervisory visits, about two are surprise visits. During their visits to the villages the LHVs check the stencils on the wall, enquire from the community members about the visits of worker and her activities, enquire from the pregnant women and those recently delivered about the antenatal and post-natal services provided to them, check immunized children for marks, and scrutinize record and registers maintained by the ANM.

It was also revealed during discussions that more importance is given to coverage rather than quality of services provided. The assessment of the quantity of work performed by an ANM is usually made in terms of number of pregnant women registered (taking 3 per 1000 population in a month as norm), number of antenatal visits, and number of blood slides collected. The questions about the quality of MCH and other care are rarely asked. In fact, there is no mechanism to check whether the blood slides are actually collected from those reporting fever or others, and whether more than one slide is collected from the same person.

The concurrent visits are mostly for immunization purposes. During these visits, the LHV and the ANM work together and provide immunization, examine pregnant and recently delivered women, collect blood smears, insert IUDs and follow family planning cases. Sometimes the LHV also helps the ANM in motivating resistant couples.

On an average each LHV meets an ANM 3 to 4 times in a month either during field visits or during monthly meetings. All the LHVs felt that they are responsible for supervising only female workers and not the male workers. However, male supervisors like senior health assistant (male) and BEE often look into the work of female workers especially the one related to communicable disease control programmes.

The LHVs also supervise the activities of anganwadi (ICDS) workers whenever they visit villages where anganwadi centres are located. During these visits they particularly look at the cleanliness of the centre and cooking vessels, quality of food items prepared, and also examine the malnourished children. However, the LHVs have no administrative control over the anganwadi workers and report about the deficiencies observed to the ICDS supervisors.

All the LHVs who participated in the discussion reported that the MOs never accompany them on field visits. The complaints about the ANMs who in spite of repeated warnings do not show any improvement are lodged with the MO, who takes appropriate action which may be in the form of issuing written warnings or show-cause notice. The LHVs gave sufficiently large number of instances where the MOs had not acted on the reports of LHVs and have thus caused lot of embarrassment to the LHVs. They have also not shown any concern about the quality of services.

A number of suggestions were made by the LHVs to make the supervision more effective. Some of these suggestions are:

- (a) Improve the mobility of LHVs by providing transport facilities.
- (b) Reduce the number of ANMs to be supervised by an LHV to about four or a total population of 20,000.

- (c) Loans at subsidised interest rates may be provided to LHVs for the purchase of two wheelers
- (d) Avoid frequent transfers and ensure that an LHV stays in an area at least for 4 to 5 years
- (e) Provide incentives to good workers by instituting rewards and these rewards should be given on the recommendation of LHVs

Meetings

Each LHV has to attend 4-5 meetings in a month. The routine meetings which are held are as follows

- (a) Monthly conference on the first or second working day of the month at PHC headquarters
- (b) Meeting with the ANMs to collect reports a day previous to the conference day
- (c) ICDS workers meeting
- (d) Monthly meeting at the district health office
- (e) Sectoral meeting with ICDS officials

On the report collection days the LHV stays back at the PHC headquarters and the ANMs submit their reports. There may not be any formal meeting. On the monthly conference day all field workers along with the headquarters staff assemble at the PHC headquarters in the morning. The meeting usually starts at around 11 AM after the MO has completed his/her OPD work. The meeting is presided by MO and representative from the district health office also attends the meeting. The monthly progress of each worker is reviewed and discussed. It is mostly the LHV who is held responsible for any deficiencies in the work of ANMS. The contents of recent circulars and orders received from higher authorities are communicated to the staff. The meeting is adjourned at about 4 in the afternoon.

The ICDS meeting is attended by anganwadi workers, their supervisors and the concerned CDPO. The LHV and ANMs from the area also attend the meeting primarily to share information about various activities and bring about coordination in the implementation of common programmes. The MO PHC joins the meeting in the afternoon and gives a talk on a relevant health topic. This meeting is considered useful by the LHVs and facilitates cooperation among health and ICDS workers.

The monthly meeting at the district health office is usually held on the 4th day of the month and the supervisory personnel in the district participate in this meeting. The district health officer or in his absence a senior district programme officer presides over this meeting. In this meeting the LHVs present a report of activities in their respective areas and targets and achievements with respect to various programmes are reviewed. Most of the LHVs felt that even though this meeting is a big crowd, nevertheless it provides them an opportunity to discuss their problems with district level officials and during this meeting they interact with other LHVs in the district and discuss problems and strategies for effective implementation of various programmes.

In some areas sectoral level meetings are also held in which LHVS, ANMs and ICDS officials from the sector participate and exchange information and ideas. However, because of reorganisation of PHCs, which now cover a population of 30,000, these meetings are gradually being phased out.

Even though 4 to 5 days are spent every month on meetings, the LHVs who participated in group discussions felt that looking at the benefits they derive from these meetings they do not consider the time spent as unproductive or wasteful. Sometimes they get useful feedback about their work and activities which helps them in their endeavour to improve the coverage and quality of services. It was pointed out by many LHVs that these meetings could be made more useful if part of the day is used for imparting training to the participants in an organised manner. The guest faculty and specialists could be invited to deliver talks on topics relevant to their work. It was also suggested during discussions that the frequency of district level meeting could be reduced from once in a month to once in three months.

Records and reports

A new record maintenance system for the sub-centres has recently been introduced under which the ANMs have been provided with 13 registers of new type. The LHVs were given two days training by an official from the district health office who explained to them different items in these registers and how to fill them. This was only a class room training and there were no practice sessions or actual demonstration under field conditions to enter different types of information about the various programmes and activities.

The LHVs passed on these instructions to their respective ANMs. However, all the LHVs who participated in the discussions felt that they have not mentally reconciled to the new system of maintenance of records of various activities and are finding it difficult to switch over. They also mentioned that there is lot of duplication and several items of information of similar nature are to be entered in different registers. The space provided in the daily diary of ANM is totally insufficient record day to day activities in a systematic, consistent and coherent manner. The number of pages provided in some important registers such as TCR are grossly insufficient. Furthermore it was pointed out that because of their weight it is difficult to carry these registers in the field.

On her routine visits to the villages, LHVs scrutinize the records of ANMs and use them for tracing the beneficiaries or to verify the correctness of activities reported by the ANM. The maintenance of records by the ANMs, it was felt, is essential for assessing their performance, but this needs to be simplified.

Each ANM also submits monthly record of her activities to the LHV who in turn consolidates these reports and prepare a report for her area. The LHVs indicated that they have to spend one full day on this work. It was also pointed out during the discussions that the reports submitted by ANMs have several discrepancies due to insufficient understanding of the new reporting system and lack of practical training to fill in the forms correctly. Many LHVs felt that this is not a proper use of their time and they can engage themselves in more productive activities if some clerical assistance is provided to them for compilation and reconciliation of these reports.

Interaction with the community

The LHVs are usually not in close contact with the community as they visit a village once in three to four months. In the course of focus group discussions many LHVs indicated that during their routine visits to the villages they meet a few prominent members of the community such as village heads and panchayat members. In addition whenever there is a crisis situation they meet the village leaders to find solution to the problem. It was also pointed out by the participating LHVs that while in the village they visit a few houses to verify the activities recorded by ANM and thus come in contact with the community members. They also address some women groups especially in anganwadi centres. It was also reported by the LHVs that they address about 3-4 meetings in a month and those attending these meetings are mostly women and adolescent girls. Such meetings are usually preceded by immunization clinics.

Training

There are two categories of LHVs, one appointed directly and another promoted from ANMs cadres. Those selected from ANM cadres have to undergo six months training in the LHV training institution. There are four such institutions in the state of Karnataka each with an intake capacity of 30 candidates.

In addition to the basic training, all the LHVs reported that they have attended 7 days CSSM training and 10 days continuing education programmes. The CSSM training is conducted jointly for the LHVs and ANMs at the sub-district level hospital and in each programme 25-30 workers participate. The manuals used in this training are supplied by the government of India and the training is imparted by a core group consisting of MOs who are specifically trained for the purpose. The training is organised in a manner that one member of the core group acts as a facilitator to a group of 5 trainees. Several LHVs stated that this training has exposed them to new concepts of managing diseases like pneumonia, diarrhoea and high risk pregnancies. They are trying to put the knowledge gained to practical use in order to reduce infant and maternal mortality in their respective areas of operation.

The continuing education programme, which is conducted at the regional training centres, is of two weeks duration and is based on the modules developed by the government of India. There are five regional training centres in the state. The training is mostly didactic. All the LHVs were of the view that this training helps them recapitulate different aspects of their job which they learnt during their basic training as LHVs.

An area of major concern for almost all the LHVs was the accounts examination, a pass in which has been made mandatory by the government. They all feel that they do not have any training in accounts and it is beyond their competence to pass such an examination. It was suggested that suitable simplified module may be developed which will help them overcome this difficulty.

A few of the participating LHVs indicated that they would be interested in undergoing some advanced training especially in the area of community organisation and curative aspects of medical care.

Link workers

It was found during the discussions that the LHVs invariably contact the anganwadi workers and trained dais during their visits to the villages. It was pointed out the VHGs are frustrated and do not cooperate with them. These VHGs are sore that the supply of drugs to them has been discontinued. These link workers mostly assist in immunization programme and do not actively involve them family planning motivational activities. It was suggested that if trained dais are given some more incentives and are suitably trained in motivational strategies, they could be of great help in convincing couples to adopt family planning methods.

Cooperation and contacts with other departments

The only department with which the LHVs have good contact is the ICDS department. As indicated in the preceding paragraphs the LHVs participate in the ICDS monthly meetings and assist and guide the anganwadi workers in the organisation of immunization clinics, nutrition supplementation programmes and health education to mothers. Almost all the LHVs were of the opinion that cooperation between these two departments is mutually beneficial and needs to be further strengthened.

The LHVs also expressed that officials of the revenue department do not cooperate with them in their work and even to get the bills passed for various health programmes such as maternity allowance and TA bills, they have to bribe the concerned officials.

The cooperation from the panchayats at the village level was reported to be lacking. Most of the LHVs indicated that panchayat members rarely take part in the health activities organised in their villages. On the contrary they unnecessarily harass the workers and interfere in their work.

Family planning targets and incentives

(a) Targets

Each worker is assigned targets for different methods of contraception. The LHVs were not sure about the basis of fixation of these targets- whether it is total population or eligible couples in a sub centre area.

However, all the LHVs who participated in the discussions felt that targets are essential for good performance, as they keep the workers on their toes. The focus of every review meeting is the achievement of targets. The targets are fixed both for sterilization and spacing methods such as IUD, condoms and oral pills. In fact, 50 % of the total targets are now set aside for spacing methods. The achievement of targets for spacing methods is judged by the number of pieces of condoms or cycles of oral pills distributed and not on the basis of couple months protected. The workers often give an inflated account of their achievements and it is difficult to find out whether these contraceptives were actually distributed or used.

Almost all the LHVs indicated that the workers mainly concentrate on female sterilization. The couples, by and large, are also favourably disposed towards tubectomy and feel that they would have two children and then go in for sterilization. As such the achievements reported by the workers for spacing methods are mostly fake.

The major emphasis in the past was on female sterilization and no attempt was made by the workers to motivate males for vasectomy. However, in recent months directives are being issued from the department to bring in cases for vasectomy. The LHVs are therefore insisting that each ANM should at least motivate one person for vasectomy in a month.

The LHVs were also of the opinion that people now recognize the value of small families and voluntarily come forward for sterilization. They do not have to make strenuous efforts to motivate couples, as was done in the past. Their work to that extent has become easier. However, still there is a lot of resistance among the muslim community and it is difficult to motivate them for sterilization. The workers now concentrate their efforts on the muslim community, and some younger couples from the community have started using contraceptives without the knowledge of elders in the family. The weaker sections of the society, mostly belonging to scheduled castes, have now become less resistant towards family planning and it has become easier to motivate them.

The LHVs during discussions indicated that there is a lot of interest among women to limit the size of family and mentioned several instances where the wives are using IUD or even got sterilized without the knowledge of their husbands.

Most of the LHVs felt that targets should be fixed on the basis of remaining eligible couples and not on the basis of total population. In an area where most couples are already protected, it is difficult to meet targets.

(b) Incentives

Incentive money is paid to those undergoing sterilization. Even though there is no difficulty in getting this amount, several LHVs mentioned that a part of this money is taken away by hospital staff and balance by the husband. In fact, the woman undergoing sterilization does not get any money. There is no incentive for the workers but the work of those who motivate maximum number of couples is recognised by the publishing their names in the departmental newsletter 'Kutumba'.

(c) Camps

Tubectomy camps are generally held at sub-district or district hospitals. There are separate camps for conventional tubectomy and laparoscopic operations. There is a practice in the department that women who undergo laparoscopic operation are provided official transport from their villages to the place of operation and back. The villagers have become used to this facility and sometimes when the transport is not available it becomes very difficult to motivate the women to use public transport even when the ANM accompanies them.

The LHVs and ANMs spend full day at the camp. The ANMs also spend the day previous to the camp in motivating and preparing the couples, and on the day of the camp they have to be present there to perform duties entrusted to them. The sterilized cases are usually followed up by the ANMs and the LHVs during their routine rounds to the villages visit the houses of those women who report complications.

Referrals

The LHVs play a negligible role so far as referrals are concerned. Most high risk pregnancies referred by the ANMS go to sub-district(taluk) or private hospitals for delivery. Furthermore only higher socio-economic group comply to the advise given by the ANMs and those who cannot afford the cost of delivery in a hospital ignore the advise and even repeated warnings of the ANM. The LHVs also indicated that PHCs do not have adequate facilities to handle complicated delivery cases.

General suggestions of LHVs

- (a) Limit the number of ANMs to be supervised by an LHV to four
- (b) Improve the supply of essential items such as kerosene to ANMs
- (c) Arrange prompt payment of TA/DA of staff, in order to avoid payment of 'speed money' by the workers
- (d) Ensure timely provision of essential drugs to ANMs in adequate quantities
- (e) Replace male workers and supervisors with female workers supervisors
- (f) Improve the quality of monthly meetings by introducing structured training programmes
- (g) Remove the mandatory provision of passing accounts examination by the workers
- (h) Absolve the LHVs with long duration of service from field postings and place them at training institutions as tutors
- (i) Introduce parity in the pay scales of directly recruited LHVs promoted from ANMs cadres. Presently the ANMs promoted as LHVs get only one advanced increment in the ANM scale
- (j) Provide transport to LHVs for field work or arrange loans on low rates of interest and easy repayment terms to enable them to own two-wheelers
- (k) Reduce record maintenance work of LHVs by providing clerical assistance to them
- (l) Provide attendants to ANMs to facilitate carrying of immunization materials and records to outlying villages
- (m) Avoid frequent transfers of LHVs. They should be retained at one place for at least 4-5 years to show better performance

Discussion with medical officers(MOs)

Focus group discussions were conducted with two groups of MOs of PHCs, one from Kolar and one from Bangalore districts. In each group eight MOs participated. The issues discussed with these groups and gist of discussions are given below.

Work routine

Most of the MOs said that they spend a greater proportion of their time at the PHC seeing the patients and attending to other administrative work. Although they are supposed to visit every sub-centre at least once a week, these visits are very infrequent due to a variety of reasons which will be later elaborated in this section. Each of the MO participating in the discussions was prompted to describe a typical day in his/her working life. An MO who was asked to describe his work routine on a specific day stated

'I live in a rented house in the PHC village itself. On that day I reached my clinic at about 8.30 am. Immediately after entering the PHC, I inspected the cleanliness of the premises. Then I checked the attendance register and put my signature. Then I enquire from the staff nurse and the health inspector about any mail. There was not any on that day. It was nearing 10 am and there were already several patients waiting outside the OPD. I began seeing the patients and this went on upto 1 in the afternoon. During these three hours I saw about 45 patients. Most of the patients had minor problems and there was only one case of severe diarrhoea. The patient looked dehydrated and I put him on IV fluids. I went home for lunch at about 1 PM and returned at about 2 PM. Immediately thereafter I went to the local school accompanied by the headquarters ANM and examined about 70 children studying in 6th and 7th standard. While I was examining the children, the ANM took height and weight of children. I found four cases of dental carries and one case of rheumatoid heart condition. Other children were found to be normal. I discussed the health of the children with the teacher and advised him to collect medicine for dental caries from the PHC and give it to children. I completed this work at about 4 PM and then returned to PHC. Again at PHC I attended to some patients. I finished seeing outdoor patients at about 5 PM. Then I took the round of the maternity section where two pregnant women were admitted for delivery and examined them. I returned to my residence at about 5.30 PM. At about 10.30 PM I was informed by the nurse that a woman was having labour pains and was about to deliver. I went to the PHC and delivered the woman and returned to my residence at midnight.'

Almost all the MOs indicated that the work load at the PHC is so heavy that they hardly find any time to visit the villages. Those not living at the PHC headquarters or not having any kind of transport found it extremely difficult to make any outreach visits.

Residence

Several MOs during the course of discussions indicated that although they have strict instructions from their superiors to stay at the headquarters, they are unable to do so due to lack of adequate living facilities. It was also pointed out that most of the PHC villages do not have good schools for their children and for the sake of the future of their children they are forced to take up residence in the nearby towns. Further it was also indicated by many MOs who participated in the discussions that quarters, wherever they exist, do not have even basic facilities such as water, adequate sanitation, electricity and are unliveable. They have no other alternative but to rent houses in the taluk or district towns by paying high rents and commute daily to the PHC headquarters. In the words of a lady MO

'I am posted to a remote PHC located at a distance of 76 kilometres from the city of Bangalore where I stay. The PHC does not have any quarters and there are no suitable houses available in the village for rent. I usually leave home at about 6.30 in the morning and take train for the taluk(sub district) town which is at a distance of 60 kilometres. Thereafter I board a bus and cover a distance of 26 kilometres to my PHC headquarters. It takes about two and a half hours to reach my work place. This PHC does not have a jeep and I do not have any other transport facility to visit villages covered by the PHC. The PHC covers about 40 villages and the farthest village is located at a distance of about 15 kilometres from PHC headquarters. Thus it is very rarely that I step out of the PHC village. On a few occasions I had requested my health inspector to take me to some nearby villages on his personal two-wheeler so that I can show a few outreach visits in my records. The patient load at the PHC is very low and most people from the outlying villages either go to taluk headquarters or to private practitioners practising in the roadside villages. I spend about two to three hours at the PHC and leave for home in the afternoon immediately after lunch'

Since a majority of the MOs do not stay at their headquarters, they spend considerable time in commuting and this adversely affects their work routines. They are able to spend very little time at the PHC and rarely make outreach visits. Another participant put it candidly

'I can not make visits to villages since I do not have any transport and spend lot of time in travelling from my residence to PHC. To be frank, I have not visited any village covered by my PHC for the past two years.'

Staff position

The delivery of health and family welfare services at the PHC is further affected by several vacant positions of staff. Almost all the MOs mentioned that it is very difficult to provide adequate coverage and improve the quality of services without full complement of sanctioned staff. Even otherwise the field workers have to provide a wide range of services to the population and already are overburdened. The non filling of vacant positions worsens the situation. According to one MO

'I cover a population of 38000 spread out in 80 villages. There are 8 subcentres under the PHC. Though all the ANM positions are filled, there is not even a single male worker in the entire PHC area. The position of LHV is also vacant for quite some time. The senior health inspector is entrusted with the responsibility of supervising the work of ANMs, but since I also do not stay at the PHC, he is more interested in practising like a 'doctor' mainly in the PHC village rather than providing supervision and guidance to ANMs. Thus the ANMs are left on their own and hardly receive any support in their work'

All the MOs indicated that they have made several personal as well as written requests to the higher authorities for filling the vacant positions but to no effect. The other phenomenon which was repeatedly mentioned by the participants was that of 'punitive' or 'stop gap' postings due to political interference. The personnel posted in this fashion are hardly motivated to do any work and in fact are a bad influence on those who are performing satisfactorily. The effect of this was vividly described by an MO who stated

' I have been posted to the present PHC recently. My predecessor had lot of problems with the people and with the interference from the health minister he was transferred to another PHC. I hear that he is idling away his time there and is not doing anything worthwhile. The clerk at the PHC who is supposed to assist me in administrative work has been sent here by the directorate on 'punishment' transfer. He does not listen to me and behaves insultingly with all other staff members. The LHV too is on a 'punishment' transfer. She stays in Bangalore and neither comes to the PHC regularly nor visits the sub-centres. These persons are with the department for several years and not amenable to any discipline. What can I do in this situation?'

Another participant observed

'I cover a population of 37,000. In my PHC, the post of pharmacist is lying vacant for the past 2 years, BHE for one year, three male workers posts are vacant for a long time and there is no laboratory technician for quite some time. I take the assistance of headquarters ANM to dispense medicines and do other office work. The blood slides are sent to taluk hospital for examination. This disrupts the work routines.'

Whenever there is a vacancy at the sub-centre, the ANM from the adjoining centre has to cover that area. This adversely affects her performance. Further the vacancy of an LHV makes the situation worse since the work of all ANMs in the PHC remain unsupervised. This problem was considered to be very serious by most participant MOs.

Supply of drugs and equipment

Almost all the MOs who participated in the discussions mentioned several problems with the supply of drugs and this according to them has undermined their credibility and seriously affected the functioning of the PHCs and sub-centres.

It was pointed out that the drugs are rarely supplied as per their indents which are based on the morbidity pattern in their respective areas. The drugs which are not needed are dumped on them while the life saving and essential drugs are supplied very irregularly and in quantities which are much below their actual requirements. Furthermore, on several occasions they receive vaccines and drugs which have either lost their potency or are very close to the date of expiry. The quality of drugs supplied was also reported to be very poor since these are purchased from not so well reputed local pharmaceutical companies for extraneous considerations. Although on paper each PHC has a budget of Rs 30,000 for drugs, this remains only on paper and actual supply is made based on availability, first come first served basis and on the whims and fancies of superior officers. During the discussions one of the participant MOs stated that

' My PHC has an annual budget of Rs 30,000 for drugs. We normally prepare an indent for the required drugs based on the disease statistics of PHC area and send it to the district office. The government medical stores (GMS) is supposed to supply part of the drugs indented, while the balance is to be supplied by the district health authorities. But we hardly get the drugs indented. The reasons for this are never explained to us. Irrespective of what we indicate in the indent, unnecessary drugs are dumped on us and we find it difficult to use them. In several cases one drug is supplied and the drug complimentary to it is supplied

for example penicillin is supplied but not the distilled water ampules. Many a times we have to destroy the medicines after their expiry date. Never during my ten years service I have received drugs as per my requirements given in the indent. Moreover we have to pay Rs 200 to Rs 300 as bribe to ensure that whatever drugs are supplied are properly packed. If we do not pay, a proportion of drugs will be pilfered before reaching the PHC. The drugs are also of sub-standard quality and we do not get essential life saving drugs at all. Regarding the drug situation, less said the better.'

It was also indicated by many participants that they do not get cleaning agents such as phenyl required for keeping the PHC premises clean. In addition, the equipments required for effective performance of their functions are not supplied. There is also no money available for repairing several items of equipment lying idle due to minor defects. According to one participant

'Sometime back I had to attend to an abnormal delivery. The woman had breach presentation. We did not have the correct scissors to attempt episiotomy. There was not even a single phial of methargin which is used to arrest bleeding. There were no IV fluids either and there was no nursing or any other kind of assistance available to me. I had to attend to the case singlehandedly. The PHC is in a remote area and the taluk hospital also does not have any facilities to handle such cases. I conducted the delivery with the resources available to me and luckily everything went on well. If something had happened, I would have been blamed.'

Similar views about the drug supply situation were expressed by the ANMs and LHVs and these are discussed in the preceding paragraphs.

Supervision

The methods and strategies used by the MOs for supervising their staff were discussed in detail by the group. It was found that MOs have different mechanisms for overseeing the work of their subordinates. However, it was very evident from the discussions that MOs rarely visit the sub-centres and outlying villages. They enumerated several reasons for their inability to undertake such visits on a regular basis. Firstly, the MOs reported that they have to spend a major part of their day at the PHC OPD seeing the patients for minor ailments as well as for emergencies. This is a perceived need of the people and if they fail to discharge their curative responsibilities complaints are lodged against them and political pressures are brought in for their transfer. The villagers, according to them, are least bothered about other preventive and promotive services. They have also to attend to post-mortem, medico legal cases and general administrative work. This leaves them with very little time for outreach visits. Secondly, many PHCs do not have official jeeps. Wherever the vehicles are available in working condition, these are shared by many PHCs for immunization and family planning work. The problems related to adequate supervision of staff were vividly described by an MO. To quote him

'I cover a population of about 32000. We do not have any official transport at our PHC. In addition to being incharge of my PHC, I am drawing and disbursing officer(DDO) of four more PHCs, which were part of my PHC before implementation of the new scheme of having a PHC for 30000 population. However, due to administrative anomalies, I continue to be DDO for these PHCs also. I have to thus spend considerable amount of time on administrative work relating to the PHCs which are not under my jurisdiction now and for which I

have no other responsibility whatsoever. At my PHC also, I spend lot of time on attending to patients, post mortem and medico-legal cases. I am therefore not able to follow the advanced tour programme of visiting the sub-centres and other villages under the jurisdiction of PHC. The unavailability of official transport also makes these visits difficult or rather impossible. I can review the work of my staff only at the monthly conference which is held at the PHC on the last working day of every month. During these meetings I discuss the performance of each worker in terms of targets assigned and achieved, and give appropriate instructions. I mostly leave the general supervision of ANMs to LHVs who are asked to report to me on a regular basis about the problem workers and those who lag behind in their work. In cases where there are serious complaints about a worker from the community, I try to visit the village and enquire from the villagers about the problems and then take action to remedy the situation. This however happens only once in a while. Whenever there special programmes such as well baby clinics or group talks are arranged at the sub-centres or other villages, I normally ask other supervisors such as LHV, BEE, senior health inspector to deputise me. Let me be frank. It is just not possible for me to visit the villages without adequate transport facility. I know that supervision work suffers due to this. But what can I do?’

It was very clear from the discussions that the MOs are not able to supervise all the PHC staff and concentrate their efforts only on those who are not able to achieve their targets.

Although an overwhelming majority were not making field visits, there were also a few reported exceptions. Some of them indicated that they use their personal two-wheelers to visit some sub-centres closer to PHC. According to one MO

‘My PHC covers a total population of 26000 with 9 sub-centres. Almost all the ANMs stay in Bangalore and commute daily to their work places. There is no vehicle in our PHC. So I use my personal scooter to visit villages. I concentrate my visits to only three sub-centres while the remaining sub-centres are looked after by another MO who is incharge of a primary health unit (PHU) which also falls within the jurisdiction of my PHC. During my visits to sub-centres, I hold clinics, issue maternity certificate, and if time permits check the records of the ANM and meet village leaders to enquire about her work.’

Another lady participant indicated that she spends about four days in a month to supervise the workers in the field. According to her

‘I normally make surprise visits. During my visits I find that about half the ANMs in my PHC do not make visits as per their advanced tour programme. When I visit the village I usually contact the women in the household and enquire about the worker. I check the stencils on the wall. I also visit a few pregnant women and ask them about antenatal check up by ANM. Whenever I receive complaints, I personally warn the concerned worker, and in some rare cases where the worker continues to be insolent I report to ADHO.

All the MOs, without exception, indicated that it is difficult to extract any work from the male workers. If they ask them about their activities, they misbehave with them and bring in political pressure. Since they have only a nuisance value, they leave them alone. The discussions also revealed that although majority of the ANMs are sincere in their work, the

lack of close supervision by MOs which was stated to be due to reasons 'beyond their control' makes some of them lethargic and they visit the outlying villages only for short periods say an hour, to meet their tour requirements

So far as supervision of MOs by their superiors is concerned, it was indicated during discussions that although the ADHO and DHO are supposed to visit the PHCs on a regular basis, such visits are very rare. They visit the PHC areas only during emergent situations such as epidemics or enquiry into specific cases of deaths like maternal deaths. By and large the performance of the PHCs is assessed during monthly meetings at the district headquarters.

Meetings

The MOs attend five to six meetings in a month as part of their official responsibilities. These are (a) monthly conference at the PHC headquarters, (b) monthly medical officers conference at the district headquarters, (c) block level ICDS meeting at taluk headquarters, (d) block level meeting with the ADHO at taluk headquarters, and (e) monthly sectoral meeting at the ICDS headquarters. In addition to the above meetings, some MOs indicated that they arrange fortnightly meetings of the PHC staff to review the progress of work. A few MOs also attend the development programme officers meetings at the taluk headquarters. This meeting organised by the civil administration department is attended by the officers of all development departments to review the progress of developmental progress and discuss strategies for effective coordination.

What happens at the monthly PHC conference has already been described in the preceding paragraphs. This meeting was considered to be very important by all the MOs.

The monthly MOs conference is held at the district headquarters and it is attended by all the MO PHCs of the district. In this meeting the progress of each PHC is individually reviewed by the DHFWO and other district level programme officers. The meeting lasts for about three to four hours. The participants in our discussions indicated that while reviewing the progress, priority is given to family planning, particularly achievement of sterilization targets. The review of other programmes is only cursory and is completed only in a fraction of the total time devoted for the meeting. The MOs are rarely given an opportunity or adequate time to present their problems. After the review relevant instructions, circulars and other communications are either distributed to the participants or read out by the district level officials. This meeting was also considered to be important by the MOs.

The main objective of the monthly ICDS meeting is to review and coordinate the common programmes. This meeting is attended by CDPO, MOs of PHCs, Mukhyasevikas and LHVs. In this meeting different aspects of ICDS activities are discussed and the dates of visits by MOs to anganwadi centres are scheduled. Several MOs indicated that they visit the anganwadis only when the transport is arranged by the CDPO.

The monthly sectoral meeting is held primarily to review the work of anganwadi worker and expose them the latest information on child health and related aspects. In this meeting MO PHC, CDPO, LHV, Mukhysevika, ANMs and anganwadi workers participate. At the beginning of the meeting, the work of anganwadi workers is reviewed based on the reports submitted by them and instructions are issued to improve the coverage and quality of care. Thereafter the MO PHC delivers a talk relevant to child care aspects. This is also an occasion for the anganwadi workers and ANMs to exchange views about common activities.

In addition to the above meetings, the MO PHC also attend a meeting convened by the ADHO who is stationed at the taluk(sub district) level. In this meeting, the MOs discuss administrative problems which are local in nature and amenable to solution at the taluk level. This meeting was considered to be unnecessary by several MOs and they wanted it to be discontinued.

Interaction with community

As indicated in the preceding sections the MOs rarely visit the villages covered by the PHC and hence have relatively less personal contact with the community. The main contact of the MOs with the community members is through the patients who visit them at the PHC and this contact is for a very short period and superficial. The MOs in the OPD are eager to dispose off the patients as quickly as possible and not inclined to listen to the problems of community members. The reasons indicated for this were lack of time and multifarious responsibilities of MOs. However, it was also indicated that they have to spend considerable time with him if some influential person visits the PHC. The MOs during discussions also indicated that people's expectations from the PHCs are rising, and they often complain about shortage of drugs, absence of staff and lack of concern, non availability of MOs and other health personnel during emergencies. Since they are not able to satisfy the needs of the community, this often results in confrontations, which sometimes take a serious turn in the areas where the people have become politically conscious of their rights.

Posting of specialists to PHCs

Several MOs who participated in our discussions had post-graduate qualifications in surgery, paediatrics, chest diseases, EAT, medicine, ophthalmology, obstetrics/gynaecology, or anaesthesia. These specialists were posted to PHCs and PHUs where facilities to practice their specialisations do not exist at all. While the specialists positions at community health centres and taluk hospitals remain vacant, a large number of specialists are posted to lower level institutions. A lady MO having specialised qualification in obstetric and gynaecology mentioned during the discussions

'I am posted to a remote PHC where there are not facilities whatsoever for conducting even normal deliveries. I can never handle obstetric emergencies here. The daily OPD attendance is about 80 and majority of them are women and children. However, for most the gynaecological problems and obstetric complications, women go to taluk headquarters and consult a private gynaecologist/obstetrician. Ironically when I am rotting at the remote PHC, the taluk hospital does not have a qualified gynaecologist. In the absence of any facilities I have not been able to handle any complicated deliveries. Further my PHC is not well connected to all the villagers in my jurisdiction. The people therefore prefer to private doctors at the taluk headquarters'

Another participant who is an anaesthesiologist indicated that since he is working for over ten years in different PHCs, he has lost touch with his area of specialisation. Despite existence of vacancies for anaesthetists in several hospitals in the state he had not been posted there. A similar account was given by another participant who is an EAT specialist. Most of participants said that the main reason for this anomaly is corruption and nepotism. Specialists who can pull strings with politicians and influential persons are posted to major hospitals in the cities and towns while others have to waste their talents and expertise at PHCs and PHUs.

Service conditions and job satisfaction

Most of the MOs appeared to be totally frustrated and dissatisfied with their service conditions. Many of them of the view that in view of abysmal conditions prevailing in the PHCs they are not able deliver the services in an effective and efficient manner. Corruption, favouritism, lack of concern for people, and lopsided policies of the government, and lack of administrative procedures were mentioned as reasons for poor coverage and quality of services provided by PHCs. One of the participants said

‘There is corruption at all levels in our department. We have to bribe at each and every stage, from clerk to higher officers, to get our salary and other claims passed. We are not supplied with stationary and registers and have purchase them locally spending from our own pockets. The expenditures incurred by us are never reimbursed’

Most of the participants mentioned that if the administrative procedures are streamlined, much of the problems could be solved. They suggested that there should be a separate cadre of administrative medical officers to which only those trained in administration/management should be inducted. All promotions to senior level administrative positions at the taluk, district, divisional and state level should be from this cadre only.

A questionnaire to diagnose management problems of the MOs was administered to them. There were 22 questions with six point scale. The analysis of filled in questionnaires reveals that most of the MOs lack capabilities in planning, supervision, direction, organisation, and evaluation.

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

Primary health centres (PHCs) are the focal points for the delivery of integrated health, including family planning (welfare), services to the rural population of India. Studies have shown that these PHCs are not very effective in the achievement of objectives for which they were established. A large number of factors have contributed to the ineffectiveness and inefficiency of these health care institutions. A systematic identification of these factors and formulation of implementable strategies is a prerequisite for bringing about an improvement in the functioning of PHCs which would facilitate achievement of the goal of 'Health for All by 2000 AD'. The health care is a labour intensive industry and the coverage and quality of care provided, to a large extent, depends on the technical competence and motivational level of the providers which in turn is determined by a variety of factors, including the skill with which this important resource is managed.

The main objective of this study, which was jointly sponsored by the World Bank and the Population Council, is to generate qualitative information on different aspects of the management of family planning services at the PHC level as perceived by the providers. An attempt has been made to analyse some job related aspects of junior health assistants (ANMs), senior health assistants (LHVs) and medical officers (MOs) of PHCs in a southern state of Karnataka based on the analysis of primary data collected in several studies conducted under the direction of the author at the Indian Institute of Management Bangalore. These studies used a variety of interview, observational and focus group discussion techniques. The main conclusions from these studies which are presented in different chapters of this report are summarised here. There is however a need to be cautious in interpreting these results since different methodologies have been used to obtain information on similar aspects. The account given by the health personnel in the individual interviews is generally biased and exaggerated. The information obtained through observations, and focus group discussions appears to be much closer to reality.

Work routines

There is no systematic and organised method of planning work by different categories of staff. There are no written job descriptions given to staff and their responsibilities change from time to time depending upon the exigencies of work. Most staff members have their own perceptions of the tasks they are expected to perform. Although advance tour programmes exist on paper, these are rarely followed. Several factors such as non-residence at the headquarters, non availability of transport, unscheduled meetings, pressure to achieve family planning targets, 'fetching' and accompanying family planning 'cases' to camps, non cooperation from the male workers, assignment of additional areas due to vacancies, lack of proper supervision and guidance etc. often cause disruption in the advanced tour programme of ANMs. The LHVs are not able to adhere to their tour programme and discharge their supervisory responsibilities due to non availability of transport and inability to cover long distances on foot, particularly by those above 40 years of age, pressure of office work and meetings. The MOs rarely visit the sub-centres or other villages in their respective areas due to non-availability of official transport and lack of interest in non-clinical work.

The results from the time utilisation study indicate that the ANMs and LHVs spend about 3 hours daily on various activities which mostly centre around family planning and MCH. The MOs spend about one-third of their time in clinical work and for the remaining duration they are either absent or idle away their time.

Residence

The directives from the health department stipulate that the staff should stay at their respective sub-centre, PHU and PHC headquarters. A majority of the ANMs and MOs, however, do not stay at their headquarters villages and commute long distances to their respective places of work from nearby towns where they take up residence. This consumes a lot of their time and energy and adversely affects their work performance. Their absence from the headquarters deprives the people of round the clock care particularly during emergencies and deliveries. This inhibits the building of confidence and rapport with the people which is so essential for successful implementation of various programmes. The main reasons given for not residing at the headquarters are the non-availability and poor condition of government quarters, inability to rent suitable accommodation in the villages and lack of schooling facilities for their children.

Link workers

The link workers whose assistance is often sought by the health staff are TBAs, anganwadi workers and VHGs. These workers help the staff in a variety of ways. While the interactions with the anganwadi workers and TBAs is reported to be regular, the VHGs are not of much help.

Supply of drugs and equipment

The inadequate and irregular supply of drugs and equipment was the most important reason mentioned by all the categories of staff included in this study which hampers their functioning and undermines their credibility among the people.

Maintenance of records

The ANMs and LHVs reported that they spend considerable amount of time on the maintenance of records. They have not yet reconciled to the health management information system which has recently been introduced. They found this system not only unintelligible but deficient in many respects. In much of their village work, the ANMs use intuitive judgements and records are rarely used for planning various activities. These records are mainly used by them for preparing reports to be submitted to LHV every month. These records are examined by the supervisory personnel primarily to see the progress of the workers towards the achievement of family planning targets.

Meetings

The staff have to participate in several meetings every month which consume a considerable amount of their time. These meetings aim at reviewing the work of individual functionaries at various levels. But the discussions in these meetings are mostly concentrated on the achievement of family planning targets and strategies to improve the performance in this particular area. The other functions of the PHC receive very little mention or attention. The staff found some of these meetings useful and wanted other meetings either to be scrapped or conducted less frequently.

Supervision

The supervision was found to be very lax. The visits by the LHVs to sub-centre and other villages were not only inadequate, the time during these visits was either spent on immunizing the children or in checking the ANM records. The guidance and support provided to the ANMs by their supervisors was reported to be negligible. The MOs hardly made any field visits and mostly depended on the reports presented on the meeting days to know the progress and performance of workers. The laxity in supervision often encouraged the workers either to skip the visits to the outlying villages or spend very little time there. There were however a few exceptions to this general pattern.

Interactions with the community

The interaction of the ANMs with the community was relatively better as compared to the LHVs and MOs whose visits to the villages were less frequent. Further the ANMs who stayed at their headquarters had a better rapport with their clients than those staying away. The inadequate availability of drugs and overemphasis on family planning, particularly sterilization, appeared to be undermining the credibility of staff with the community. The only contact most of the MOs had with the community was through the OPD clinics which was hardly enough to establish any kind of rapport and to know their felt needs and reactions to the various programmes. The OTCs, which were conducted earlier, provided some opportunity for senior staff and MOs to come in contact with the community leaders and other influential persons, but this activity is now almost dropped because the funds available for OTCs were considered to be insufficient.

Service conditions and job satisfaction

All categories of staff appeared to be frustrated with their service conditions due to lack of promotional opportunities, frequent transfers, non availability of liveable official quarters, political interference, corruption and nepotism. The LHVs were unhappy with differentials in pay scales of direct recruitee and promotee LHVs. The frustration among the MOs, particularly the specialists, was quite apparent during the discussions.

Recommendations

The findings presented in this report have several policy implications for the delivery of primary health care, including family planning(welfare), services at the PHC level. A few recommendations emanating from these studies and which are given below, could possibly help in improving the efficiency and effectiveness of the rural health care system.

- 1 Most of the PHCs and sub-centres do not have adequate space and are operating from the old dilapidated PHU and dispensary buildings. The construction of PHC and sub-centre buildings should be properly planned taking into accounts the needs of the people, type of services to be provided and future expansion plans. The location of these buildings should be decided taking into account the convenience of the people and safety and security of the staff, particularly ANMs at the sub-centres.

- 2 All staff posted at the PHC or subcentres should be provided with suitable residential accommodation with all the amenities such as water, sanitation and electricity. After this has been ensured, it should be made mandatory for the staff to stay at their respective headquarters and this should be strictly enforced by taking stringent action against those who

do not stay at their respective headquarters

3 There should be regular maintenance and upkeep of the buildings. The PHC and sub-centre premises should be kept spotlessly clean to create a demonstration effect on the people about environmental sanitation.

4 The PHCs should be properly equipped to provide facilities for conducting sterilization, MTP and deliveries. The proper and timely maintenance of the equipment should also be ensured.

5 The indents for drugs should be carefully prepared by the MOs taking into account the patient load and morbidity pattern in the area. The higher authorities should ensure regular and timely supply of these drugs as per the requirements. There is a need to improve the quality of drugs and the drugs supplied should not be close to the expiry date.

6 All the PHCs should be provided with jeeps in good working conditions with sufficient budgetary provisions for POL, repairs and maintenance.

7 In order to improve the mobility of the staff, two-wheelers should be arranged for them on hire-purchase basis. A provision should be made for adequate allowances to the staff for meeting the running and maintenance cost of these vehicles.

8 The tour programmes of the staff should be drawn in consultation with them and should be strictly adhered to. Any deviations from these programmes should be immediately reported to the higher authorities along with reasons and copy of this be placed in the personal file of the official concerned. If such deviations are frequent, these should be viewed seriously warranting disciplinary action against the erring officials.

9 The frequency of supervisory visits by the LHVs and MOs to the sub-centre areas be increased. These visits should be used not merely for checking records, but more time should be devoted for providing support, guidance and training to the ANMs. There should also be regular contacts by the supervisory staff with the community during these visits. The contacts with the community will be strengthened and credibility of the ANM will considerably improve if the supervisors visiting the villages conduct clinics for patients referred by the ANMs. The MOs and LHVs should also make surprise visits to the villages to get feedback from the community about the performance of workers. They should also check stencils to ensure that the workers visit the household as per their tour plans.

10 The patients referred by the ANM to the PHC should be properly attended to. The ANMs should keep a record of the patients so referred, type of treatment received and follow up services provided.

11 The emphasis should shift from sterilization to spacing methods and the ANMs should be given proper training for inserting the IUDs. There should be proper and regular followup of users of spacing methods.

12 The fixation of targets, as felt by most of the functionaries who participated in the study, should be decentralised and be based on local conditions.

13 The planning and implementation of programmes should be decentralised at the PHC level. The MO of PHC should be vested with adequate powers to prepare budgets, allocate resources between different activities and work out methods and strategies for implementation of various programmes. This could be done in consultation with the district authorities who should provide all encouragement, support and guidance to MOs in their managerial functions. Similar operational autonomy should be given to the ANMs to plan programmes for their respective areas in consultation with LHVs and MOs. Since these officials are in direct contact with the community, they get feedback and information about the felt needs of the people and their reactions to various programmes. This could facilitate continuous review and adjustment of plans and implementational strategies.

14 The modern management methods and concepts should be applied in the operation of PHCs. A concerted effort should be made to improve the motivational and job satisfaction levels of the staff.

15 The performance appraisal of the workers should be based on their performance on several activities and not merely on the basis of achievement of sterilization targets. While appraising the performance of a worker quality of work should also be taken into account for which suitable indicators of quality should be developed.

16 The promotional opportunities for ANMs and LHVs should be improved. The direct recruitment to LHV positions should be stopped and the differentials in the pay scale of those recruited directly and those promoted from ANM cadre should be removed.

17 The male workers should be phased out and their work be distributed among the ANMs. The population to be covered by ANM should be reduced to 3000 and she should be made responsible for all the health and family planning activities.

18 The school health activities should receive more importance from MOs. The current visits of the MOs to schools and examination of children is limited to the PHC or closeby villages and is perfunctory.

19 There should be proper policy to post the specialists where adequate facilities exist to use their expertise. Their talents should not be wasted by posting them to places where adequate facilities are not available.

20 There should be separate cadre of medical administrative/ management services. All positions starting from the administrative medical officer of CHC and above should be filled by persons having post graduate qualifications in management. All promotions to the higher administrative positions upto the Director of health services should be made only from this cadre. Suitable training programmes should be developed for training doctors in management. Until such long duration training programmes are developed all the medical officers should undergo short duration training in health management at the state or other national level institutions.

21 There should be a proper training for the workers to familiarise them with the new health management information system. These training programmes should develop capabilities among the ANMs to use the information collected for planning and implementing various activities at the subcentre level. Similar training programmes should be organised for senior level functionaries.

APPENDIX

FAMILY WELFARE PROGRAMME - INSTITUTIONS BY DISTRICT
AS ON 31 3 1994

| Sl No | Districts | UFWC | PPC | PHC | RFWC | Sub-Centres | F W Centres | MTP Centres |
|-------|------------------|------|-----|------|------|-------------|-------------|-------------|
| 1 | Bangalore (U) | 35 | 5 | 28 | 7 | 134 | 95 | 40 |
| 2 | Bangalore (R) | - | 3 | 56 | 12 | 276 | 180 | 16 |
| 3 | Chitradurga | 1 | 5 | 71 | 13 | 441 | 79 | 20 |
| 4 | Kolar | 2 | 5 | 69 | 15 | 359 | 173 | 23 |
| 5 | Shimoga | 2 | 6 | 63 | 10 | 365 | 232 | 16 |
| 6 | Tumkur | 1 | 4 | 79 | 16 | 404 | 208 | 21 |
| 7 | Belgaum | 5 | 8 | 109 | 21 | 578 | 250 | 12 |
| 8 | Bijapur | 2 | 6 | 85 | 21 | 426 | 178 | 8 |
| 9 | Dharwad | 11 | 6 | 86 | 24 | 571 | 163 | 25 |
| 10 | Uttara Kannada | 3 | 3 | 53 | 11 | 302 | 125 | 21 |
| 11 | Bellary | 2 | 3 | 47 | 12 | 240 | 170 | 6 |
| 12 | Bidar | - | 4 | 36 | 9 | 217 | 82 | 39 |
| 13 | Gulbarga | 5 | 7 | 86 | 17 | 467 | 162 | 70 |
| 14 | Raichur | 1 | 7 | 69 | 15 | 349 | 118 | 16 |
| 15 | Chickmagalur | 1 | 5 | 41 | 8 | 328 | 63 | 8 |
| 16 | Dakshina Kannada | 6 | 5 | 111 | 17 | 692 | 296 | 27 |
| 17 | Hassan | 1 | 6 | 66 | 11 | 450 | 105 | 23 |
| 18 | Kadaguu | - | 3 | 27 | 3 | 158 | 91 | 11 |
| 19 | Mandya | 1 | 5 | 57 | 9 | 364 | 123 | 14 |
| 20 | Mysore | 8 | 7 | 118 | 18 | 672 | 361 | 54 |
| Total | | 87 | 103 | 1357 | 269 | 7793 | 3254 | 471 |

APPENDIX

STATEMENT SHOWING DISTRICT-WISE THE NUMBER OF
HEALTH INSTITUTIONS IN KARNATAKA

| Sl No | Districts | Dist Hospl No of beds | Taluk level Hospl | | Below Taluk level | |
|----------|---------------------|--------------------------------|--------------------------|------------------------------|--------------------------|-------------------------------|
| | | | 100 beds and above | Between 30 and 50 beds | 100 beds and above | Between 30 and 50 above |
| 1 | Bangalore (U) | - | - | 1 | 1 | 1 |
| 2 | Bangalore (R) | - | 2 | 6 | - | 1 |
| 3 | Chitradurga | 405 | 2 | 6 | - | 4 |
| 4 | Kolar | 260 | 2 | 9 | 1 | 1 |
| 5 | Shimoga | 429 | 1 | 7 | - | 1 |
| 6 | Tumkur | 325 | 1 | 8 | - | 1 |
| 7 | Belgaum | 740 | - | 9 | - | 4 |
| 8 | Bijapur | 316 | 1 | 9 | - | 5 |
| 9 | Dharwad | 170 | 1 | 14 | - | 5 |
| 10 | Uttara Kannada | 250 | - | 10 | - | 1 |
| 11 | Bellary | 512 | 1 | 5 | - | 1 |
| 12 | Bidar | 283 | 1 | 3 | - | 1 |
| 13 | Gulbarga | 700 | 1 | 8 | - | 8 |
| 14 | Raichur | 250 | - | 7 | - | 5 |
| 15 | Chickmagalur | 279 | 1 | 4 | - | 1 |
| 16 | Dakshina Kannada | 925 | 3 | 4 | - | 5 |
| 17 | Hassan | 344 | 3 | 4 | - | 6 |
| 18 | Kadaguu | 410 | 2 | - | - | 6 |
| 19 | Mandya | 398 | - | 6 | - | 2 |
| 20 | Mysore | 1450 | - | 8 | - | 5 |
| | | | 21 | 128 | 2 | 64 |

APPENDIX

HEALTH AND FAMILY WELFARE DIRECTORATE - KARNATAKA
STAFF POSITION AS ON 01 01 1995

| Sl No | Category of staff | Sanctioned | In position | Vacant |
|----------|------------------------------------|------------|-------------|--------|
| 1 | Health Officer Class I (Sr) | 54 | 38 | 16 |
| 2 | Surgeons | 74 | 46 | 28 |
| 3 | Health Officer Class I (Jr) | 439 | 328 | 111 |
| 4 | Health Officer cum Asst Surgeon | 3818 | 3405 | 413 |
| 5 | Sr Health Assistant (Male) | 1221 | 971 | 250 |
| 6 | Health Supervisor | 76 | 70 | 6 |
| 7 | Sr Non-Medical Supervisor | 184 | 176 | 8 |
| 8 | Jr Health Assistant (Male) | 5644 | 4853 | 791 |
| 9 | Para Medical worker | 1231 | 709 | 522 |
| 10 | L H V | 1269 | 1020 | 249 |
| 11 | A N M | 9137 | 8875 | 262 |
| 12 | B E E | 726 | 284 | 442 |
| 13 | Jr Lab Technician | 1627 | 1007 | 620 |
| 14 | Sr Lab Technician | 303 | 259 | 48 |
| 15 | X-Ray Technician | 249 | 238 | 11 |
| 16 | Radiographer | 42 | 34 | 8 |
| 17 | Sr Pharmacist | 443 | 404 | 39 |
| 18 | Jr Pharmacist | 2039 | 1622 | 427 |
| 19 | Staff Nurse | 4233 | 4010 | 223 |
| 20 | Sr Staff Nurse | 600 | 450 | 150 |
| 21 | Driver | 1053 | 928 | 125 |

Staffing pattern including Recurring and Non-recurring Expenditure for sanction of Primary Health Centres under Minimum Needs Programme

| Sl No | Name of the Post | No of Posts | Total Average pay per Annum |
|-------|--|-------------|-----------------------------|
| | | | Rs |
| 1 | Medical Officer (Assistant Surgeon-cum-Health Officer Gr II) | 1 | 40,608 |
| 2 | Pharmacist | 1 | 21,204 |
| 3 | Health Worker Female | 3 | 37,464 |
| 4 | Block Health Educator | 1 | 26,340 |
| 5 | Health Assistant Female | 1 | 18,732 |
| 6 | Staff Nurse | 1 | 26,340 |
| 7 | Junior Laboratory Technician | 1 | 21,204 |
| 8 | First Division Clerk | 1 | 21,204 |
| 9 | Driver | 1 | 17,724 |
| 10 | Class 'D' | 3 | 25,896 |
| | | 14 | 2,56,716 |

Recurring Per Annum

| | Rs |
|---|----------|
| 1 Staff Salary | 2,56,716 |
| 2 Drugs | 50,000 |
| 3 Drugs for 3 sub-centres @ Rs 5,000/- each | 15,000 |
| 4 Contingencies (including Electricity) | 6,000 |
| 5 P O L | 15,000 |
| | 3,42,716 |

Non-Recurring

| | Rs |
|-------------------------|----------|
| 1 Equipment & Furniture | 50,000 |
| 2 Vehicle | 2,00,000 |
| | 2,50,000 |

Building

| | |
|--|----------|
| Construction of PHC Building with staff Quarters | 9,00,000 |
|--|----------|

GRAND TOTAL

| | |
|---------------|---------------|
| Recurring | Rs 3 42 lakhs |
| Non-Recurring | 2 50 lakhs |
| | |
| Total | 5 92 lakhs |
| | |
| Building | Rs 9 00 lakhs |

NOTE This does not include the existing facilities in terms of staff and Equipment in which case proportionate deduction have to be carried out The revised estimate is applicable for the New Primary Health Centres to be started from 1995-96

APPENDIX

Staffing pattern and expenditure both Recurring and Non-recurring for Up-gradation of each Primary Health Centres/Taluk level Hospitals to that of 30 bed General Hospital

Government Order No HFW 480 CGM 80, Bangalore dt 25 11 1980

| S1 No | Name of the Post | No of Post |
|----------|---------------------------------|------------|
| 1 | Health Officer-cum-Asst Surgeon | 3 |
| 2 | Asst Dental Surgeon | 1 |
| 3 | X-Ray Technician | 1 |
| 4 | X-Ray Attender | 1 |
| 5 | Jr Laboratory Technician | 1 |
| 6 | Laboratory Attender | 1 |
| 7 | Pharmacists | 2 |
| 8 | Aux Nurse Midwives | 2 |
| 9 | Staff Nurse | 3 |
| 10 | Class-IV | 4 |
| 11 | Helpers | 10 |
| 12 | Cook | 2 |
| 13 | Dhobi | 1 |
| 14 | Office Superintendent | 1 |
| 15 | First Division Clerk | 1 |
| 16 | Second Division Clerk | 3 |
| 17 | Typist Gr II | 1 |

RECURRING PER ANNUM

- 1 Staff
- 2 Diet
- 3 Bedding and Linen
- 4 Drugs
- 5 Contingency

NON-RECURRING

- 1 Equipment and Apparatus
- 2 Dental Unit
- 3 X-Ray Unit
- 4 Building Cost (approximate)