I. Internship Report

1. Organization Profile

MINISTRY OF HEALTH &FAMILY WELFARE

The Ministry of Health & Family Welfare is instrumental and responsible for implementation of various programmes on a national scale in the areas of Health & Family Welfare, prevention and control of major communicable diseases and promotion of traditional and indigenous systems of medicines.Apart from these, the Ministry also assists States in preventing and controlling the spread of seasonal disease outbreaks and epidemics through technical assistance.

Ministry of Health & Family Welfare incurs expenditure either directly under Central Schemes or by way of grants–in–aids to the autonomous/ statutory bodies etc. and NGOs. In addition to the 100% centrally sponsored family welfare programme, the Ministry is implementing several World Bank assisted programmes for control of AIDS, Malaria, Leprosy, Tuberculosis and Blindness in designated areas. Besides, State Health Systems Development Projects with World Bank assistance
are under implementation in various states. The projects are implemented by the respective State Governments and the Department of Health & Family Welfare only facilitates the States in availing of external assistance. All these schemes aim at fulfilling the national commitment to improve access to Primary Health Care facilities keeping in view the needs of rural areas where the incidence of disease is high.

The Ministry of Health & Family Welfare comprises the following departments, each of which is headed by a Secretary to the Government of India:-

- Department of Health & Family Welfare
- Department of AYUSH.
- Department of Health Research
- Department of AIDS Control

Directorate General of Health Services (Dte.GHS) is an attached office of the Department of Health & Family Welfare and has subordinate offices spread all over the country. The DGHS

renders technical advice on all medical and public health matters and is involved in the implementation of various health schemes.

The Ministry of Health and Family Welfare is headed by Union Minister of Health and Family Welfare, Shri Ghulam Nabi Azad since 29th May 2009. He is assisted by the Ministers of State for Health and Family Welfare – Shri Dinesh Trivedi and Shri S Gandhiselvan.

VARIOUS NATIONAL HELATH PROGRAMS

- National Vector Borne Disease Control Programme (NVBDCP)
- National Filaria Control Programme
- National Leprosy Eradication Programme
- Revised National TB Control Programme
- National Programme for Control of Blindness
- National Iodine Deficiency Disorders Control Programme
- National Mental Health Programme
- National Aids Control Programme
- National Cancer Control Programme
- Universal Immuization Programme
- National Programme for Prevention and Control of Deafness
- Pilot Programme on Prevention and Control of Diabetes, CVD and Stroke
- National Tobacco Control Programme
- School Health Programme

NRHM

The Hon'ble Prime Minister launched the NRHM on 12 April, 2005 throughout the country with special focus on 18 states including Eight Empowered Action (EAG) states, the North Eastern states, Jammu & Kashmir and Himachal Pradesh.

The NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections. It also seeks to reduce the Maternal Mortality

Ratio(MMR)in the country from 407 to 100 per 1,00,000 live births, Infant Mortality Ratio(IMR) from 60 to 30 per 1000 live births and the Total Fertility Rate (TFR) from 3.0 to 2.1 within 7 year periods of NRHM.

The Vision of the Mission

- To provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.
- 18 special focus states are Arunachal Pradesh, Assam, Bihar, Chattissgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura,Uttaranchal and Uttar Pradesh.
- To raise public spending on health from 0.9% GDP to 2-3% of GDP, with improved arrangement for community financing and risk pooling.
- To undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country.
- To revitalize local health traditions and mainstream AYUSH into the public health system.
- Effective integration of health concerns through decentralized management at district, with determinants of health like sanitation and hygiene, nutrition, safe drinking water, gender and social concerns.
- Addresses inter State and inter district disparities.
- Time bound goals and report publicly on progress.
- To improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care.

II. GOALS, STRATEGIES AND OUTCOMES OF THE MISSION

The National Rural Health Mission (NRHM) has been launched with a view to bringing about dramatic improvement in the health system and the health status of the people, especially those who live in the rural areas of the country. The Mission seeks to provide universal access to

equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance. In this process, the Mission would help achieve goals set under the National Health Policy and the Millennium Development Goals. To achieve these goals NRHM will:

- Facilitate increased access and utilization of quality health services by all.
- Forge a partnership between the Central, state and the local governments.
- Set up a platform for involving the Panchayati Raj institutions and community in the management of primary health programmes and infrastructure.
- Provide an opportunity for promoting equity and social justice.
- Establish a mechanism to provide flexibility to the states and the community to promote local initiatives.
- Develop a framework for promoting inter-sectoral convergence for promotive and preventive health care.

The Objectives of the Mission

- Reduction in child and maternal mortality
- Universal access to public services for food and nutrition, sanitation and hygiene and
- universal access to public health care services with emphasis on services
- addressing women's and children's health and universal immunization
- Prevention and control of communicable and non-communicable diseases, including
- Locally endemic diseases.
- Access to integrated comprehensive primary health care.
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions & mainstream AYUSH.
- Promotion of healthy life styles.

NRHM has five main divisions

1 Program Planning and policy, NRHM I

2 NRHM II

3 FMG

4 Infrastructure Division, NRHM IV

5 NE Division, NRHM V

2. Department Profile

NRHM I, Planning and Policy Division

Work Allocation for NRHM I Division

1. Programme Implementation Plan under National Rural Health Mission-proposal appraisal. Under NRHM all State/UT Governments submit their requirements of funds for various activities for upgradation of rural health services in their States. The activities pertaining to NRHM flexipool are examined and coordination with all the other divisions of NRHM like FMG, Infrastructure, RCH, and other disease control departments for the comments and the approval of funds for various activities.

2. Records of Proceedings (ROP): Coordination of National Program Coordinating Committee (NPCC) meetings under NRHM of each state for the approval Program Implementation Plan (PIP), the activities pertaining to ROP are done in this division.

3. Activities pertaining to the formation of core activity sheet, like the funds allocation for the various activities comes under NRHM flexipool.

4. Monitoring of 235 High Focus Districts: The Division is coordinating the activities pertaining to monitoring of 235 high focus Non NE districts of India. Districts are allotted to different consultants of the division for the monitoring.

5. Indian Public Health Standards: Indian Public Health Standards (IPHS), which detail the specifications of standards to which these institutions would have to be raised to so that the citizen is confident of getting public health services in the hospital that can be measured to be of acceptable standards. Indian Public Health Standards (IPHS) for Community Health Centres, Primary Health Centres, and Sub-centres, have been prepared which lay down Standards not only for personnel and physical infrastructure, but also for delivery of services, and management.

6. Parliament Notices and Question. It is submitted that Parliament Session is normally for a period of five months which is spread out over the complete year. During the session, the work increases manifolds. It includes collection of material from all concerned, making letters, getting those issued, faxing, running /rushing to various sections for collecting material, giving soft copies to Parliament Section of the approved replies, tracking the questions. Although the work is equally distributed to all the dealing hands we have to work as a whole team.

7. . Other miscellaneous work which is marked Section from time to time.

3. Responsibilities allotted:

I was allotted the responsibilities:

1. Formation of ROP of the states like Bihar, Maharashtra and Jharkhand under this I was assigned to fill the monitarable indicators including the achievement s in the year 2009-10 and targets for the year 2010-11 of various indicators under NRHM and the preparation of summary of mission flexi pool budget(MFP) under PIP 2010-11.
2. I have done the compilation and analysis of all the activities and budget proposed under Inter Sectoral Convergence by all the states of India excluding North Eastern States.

3. Monitoring of High focus district: For monitoring 6 districts viz. Saran, Lakhisarai, Muzzafarpur, Nawada, Bhagalpur and Sheikhpura of Bihar has been allotted to me.
   Responsibilities under monitoring:
   - Development of Monitorable deliverables of assigned high focused districts.
   - Development of a quarterly monitoring plan to visit the allocated district with specific indicators. I have to visit health facilities like Subcentres, PHCs and Block CHC per month and track progress made due to their repeated monthly visits in health facilities in terms of infrastructure improvement, improvement in human resources and also attitude of care givers towards patients, civil society, and community health workers.
   - Interaction with ASHAs, VH&SC, PRIs, civil society groups to help measure civil society opinion to facilitate closer and harmonious interaction with the service providers.
   - We have to spend three days in one district and ensure quality improvement in the NRHM indicators given as framework and I have to submit a monitoring report to the MD NRHM of the State/ District CMO
   - Work as point person for the districts/ state and provide input in the review meeting of NRHM/Ministry
   - Support NRHM Division on planning process for preparation of Annual State Implementation Plans for the states as assigned.
   - Visits to the State/Districts for facilitating the District Health Action Plans to be integrated and collated with State Health Programme Implementation Plan.
   - Examining of State PIPs and provide comments based on NRHM Framework.
   - Compilation of physical progress reports on different identified indicators under NRHM to provide monitoring feedback and make suggestions for improvement.

   During the internship period I visited two district of Bihar Saran and Muzzafarpur allotted to me and I have submitted a tour visit report to the MD NRHM.

4. I was also involved in the mapping of health facilities of Jammu and Kashmir and Uttarakhand on the basis of difficult, most difficult and inaccessible area, under ID division (NRHM IV).

4. Learning in three months -

1. Developed a detailed learning about NRHM and its functioning
2. More aware of issues related to functioning and governance issues of implementation of a mission
3. Developed a detail idea about the formation of Program implementation plan of the states and formation of ROPs
4. Developed a detail idea about the funding of the NRHM under its various components to the states.
5. Visits to the districts helped to give detail idea about the working of health facilities like district hospital, referral hospital, PHCs and HSCs. During the visits the working of NRHM in the rural areas also gets cleared.
6. A better knowledge of Soft- excels.
7. Learned mapping of facilities

II. Dissertation Report

Assessment of public health infrastructure at district hospital, Jharkhand

CHAPTER 1: INTRODUCTION

Health status of population is one of the significant indicators of social and economic well being. Jharkhand, as one of the empowered action group state, continues to share a number of characteristics with other backward states of India such as high infant mortality, low immunization of children and expectant mothers, high mortality due to infectious and contagious diseases, high maternal mortality, and low institutional delivery. These coupled with poor accessibility and availability to health care facilities and high costs of treatment by households have made all achievements in health sector insignificant. Despite the National Rural Health Mission (NRHM) and Government's commitment to improve the availability of and access to quality health care by people, especially for those residing in rural area, the improvement in public health care services in the states has not shown marked improvement in public health indicators.

Like in most countries, the poor and marginalized have less access to health services, whether public or private. **The main barriers are physical, financial, social, political and informational**. **The predominant rural context with poor transportation facilities and lack of health infrastructures further aggravates low utilization of health care facilities and services. Poor provisioning, absence of accountability, lack of thrust on quality of services, weak linkages with wider determinants of health, unregulated non-governmental sector, has made health one of the primary reasons for families sinking into poverty and destitution.** Today, there are health centres and dispensaries but hardly any doctor or trained professional are present to attend to the patients.

The burden of treatment and care, thus generally falls on the Auxiliary Nurse Midwives (ANMs) who are also burdened with providing other health care services and programmes. The outcome is that the network of public health centres (PHCs) and sub centres (SCs) are not able to provide quality health care services to the entire population. Without strengthening the health system, it is not possible to provide health care services to common people. **The challenges are to make the public health system accountable, affordable and accessible by improved management**

of resources and community action. Health system is a set of inter-connected parts that must function together to be effective.

Improvements in one area cannot be achieved without contributions from the others.



Figure 1

This paper is an attempt to study the situation of health infrastructure at district hospital Jharkhand. Because Jharkhand is lagging behind in the performance in the field of health, this paper will provide an insight of the basic reason of low performance in the state which caters 65% of mineral wealth in the country itself.

1.1 OVERVIEW OF JHARKHAND HEALTH SITUATION:

1.1.1 Status of Health in Jharkhand

Despite the vision of 'Healthy Jharkhand - Happy Jharkhand' and commitment to ensure access to quality health care services to the last person, in the last household of the last village, Jharkhand is one of the under developed states in the country with regard to the health status of its people and provision of health services. Many factors contribute to the poor health status including poverty, poor infrastructure, and high morbidity. **Poverty associated communicable diseases like tuberculosis and malaria, along with maternal mortality and morbidity, comprise a major portion of the disease burden. Malaria is endemic with frequent epidemic outbreaks of Plasmodium falciparum malaria (about 50%).** Over 60,000 deaths occur every year due to tuberculosis. Prevalence of leprosy is 10 per 10,000. HIV/AIDS poses another rising threat and lifestyle diseases too are on the rise. The poor performance of state in most health indicators and service utilisation are evident form table given below.

Table 1

S. No.	Item	Jharkhand	India
1	Total population (Census 2001) (in millions)	26.9	1028.61
2	Decadal Growth (Census 2001) (%)	NA	21.54
3	Crude Birth Rate (SRS 2008)	25.8	22.8
4	Crude Death Rate (SRS 2008)	7.1	7.4
5	Total Fertility Rate (SRS 2007)	3.2	2.7
6	Infant Mortality Rate (SRS 2008)	46	53
7	Maternal Mortality Ratio (SRS 2004 - 2006)	312	254
8	Sex Ratio (Census 2001)	941	933
9	Population below Poverty line (%)	-	26.10
10	Schedule Caste population (in millions)	3.19	166.64
11	Schedule Tribe population (in millions)	7.09	84.33

12	Female Literacy Rate (Census 2001) (%)	38.9	53.7

The crude birth rate in the state is 26.2 per 1000 (SRS, 2007) [6] while the infant mortality rate is 49 (SRS 2007) [6] and 69 per 1000 live births (NFHS-3, 2005-06) [18]. 60 percent of infant deaths are neo-natal deaths. Only 52 percent children are fully immunised (as per CES, 2007 and 35% according to NFHS-3, 2005-06) [18]. 78 % of children are anaemic (NFHS-3, 2005-06) [18] and 59 % of children below three years of age are underweight.

Maternal mortality is high at 371 per 100,000 live births (SRS, 2003) [6]. 45 % women have reproductive health problems and 30% women complain of reproductive tract infections. 70% of women in Jharkhand are anaemic and about 30% of them are moderately to severely anaemic. According to state government figures, among all pregnant women, antenatal care was received by only 38% (whereas NFHS-3 shows 36%) [18], IFA consumption is 15% (NFHS-3)[18] and 50% received tetanus toxoid injection. Nearly 80% deliveries take place at home. Only 31% of all couples use any modern methods of family planning (NFHS-3) [18]. Permanent sterilisation, particularly female sterilisation dominates (23%) and total unmet need for family planning is as high as 24 %. Above statistics shows that in almost every health indicator, Jharkhand fares poorly.

1.1.2 Health services and Infrastructure

According to the state health MIS (as of 30th April 2008), there is a huge gap in the current availability and proposed numbers of health facilities in the state. The state has only 3958 sub-centres whereas the requirement is of 5057 health sub-centres. Interestingly, out 3958 sub-centres, only 1736 have their own building (RHS Bulletin 2007) [24]. For PHCs, the current availability is 330 while the proposed number was 1005. Table II and III shows the status of infrastructure and staffing of Public Health System in Jharkhand.

Table 2

Particulars	Required	In position	shortfall
Sub-centre	5057	3958	1099
Primary Health Centre	806	330	476

Community Health Centre	201	194	7
Multipurpose worker (Female)/ANM at Sub Centres & PHCs	4288	5011	-
Health Worker (Male) MPW(M) at Sub Centres	3958	1922	2036
Health Assistant (Female)/LHV at PHCs	330	-	-
Health Assistant (Male) at PHCs	330	660	-
Doctor at PHCs	330	330	0
Obstetricians & Gynaecologists at CHCs	194	30	164
Physicians at CHCs	194	0	194
Paediatricians at CHCs	194	0	194
Total specialists at CHCs	776	40	736
Radiographers	194	0	194
Pharmacist	524	348	176
Laboratory Technicians	524	381	143
Nurse/Midwife	1688	429	1259

(Source: Bulletin of Rural Health Statistics in India 2006. Infrastructure Division MoHFW/GoI)

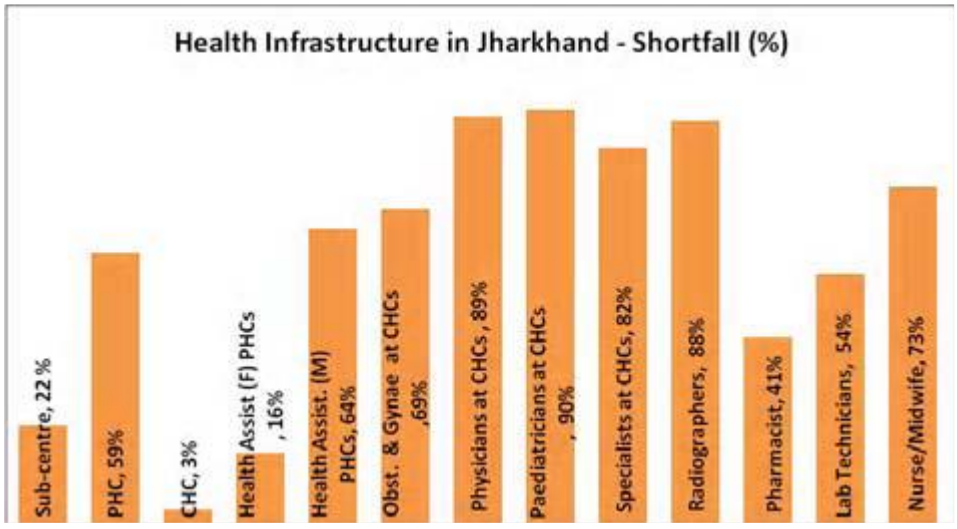


Figure 2

The other Health Institution in the State are detailed as under:

Table 3

Health Institution	Number
Medical College	3
District Hospitals	24
Referral Hospitals	-
City Family Welfare Centre	-
Rural Dispensaries	-
Ayurvedic Hospitals	1
Ayurvedic Dispensaries	122
Unani Hospitals	-
Unani Dispensaries	30
Homeopathic Hospitals	2
Homeopathic Dispensary	54

1.1.3 HEALTH DELIVERY SYSTEM IN JHARKHAND

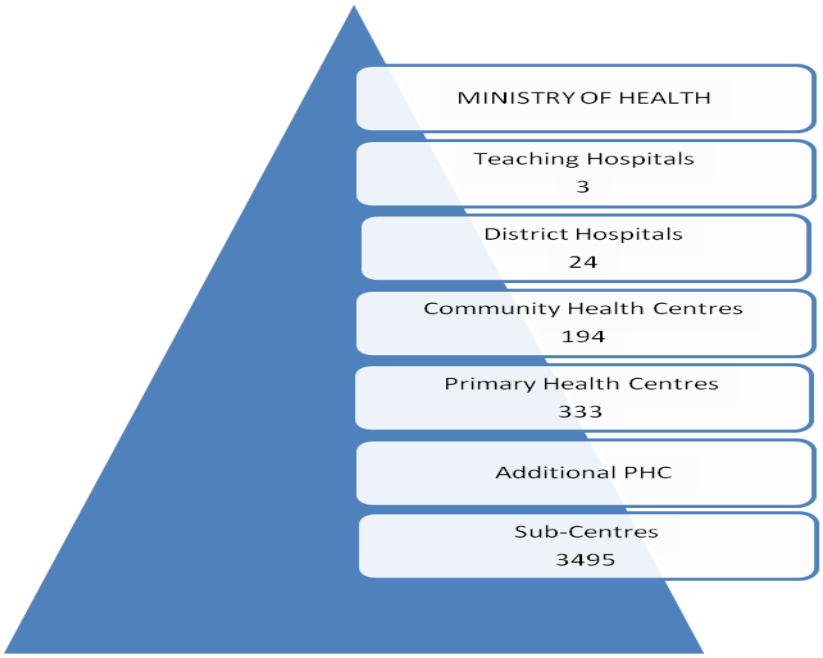


Figure 3

1.1.4 LITERATURE REVIEW:

Background:

India has one of the most extensive health infrastructures- a three-tier hierarchical referral system- for the provision of effective and efficient health services to the majority of its population. , only one tenth of the patients attending the secondary and tertiary level public health facilities were referred by someone. Most of the indirect patients had self referred themselves. The lack of infrastructure in the health care livery system is directly affecting this.

The health care system in India has expanded considerably over the last few decades but the quality of the services is not up to the mark due to various reasons. Hence standards are being introduced in order to improve the quality of services. A task group under the chairmanship of Director General of Health Services, Government of India was constituted to recommend the standards to be called as Indian Public Health Standards. IPHS are a set of standards envisaged to improve the quality of health care delivery in the country under the National Rural Health Mission.

Developing countries are currently struggling to achieve the Millennium Development Goal Five of reducing maternal mortality by three quarters between 1990 and 2015[2]. Many health systems are facing acute shortages of health workers needed to provide improved prenatal care, skilled birth attendance and emergency obstetric services - interventions crucial to reducing maternal death.

Fourth and fifth millennium development Goals (signed by 189 countries); demands reduction in infant and Maternal Mortality ratio respectively by 2015[2], which has not been possible even after so many years of safe motherhood interventions (initiated in 1987) in developing countries (WHO 1994). Although India has made slow progress in reducing maternal mortality, progress in Tamil Nadu has been rapid [15]. Similarly, the condition of Jharkhand too has not improved, even after interventions like child survival safe motherhood programme (CSSM) started in 1992 and Reproductive & Child health programme (RCH) started in 1996-97; still the infant mortality ratio and fertility rate shows a rising trend in comparison to India; where also the situation is not very comfortable. The fertility rate of Jharkhand has increased from 2.8 in 1998-99 to 3.3 in

2005-06[11]. This means increase in life time risk in women and only 5% Facilities give EmOC facility round the clock (Table-1), so more risk of maternal death.

The growing concern over the high mortality and morbidity, costs and organisation of the health services have focused the attention of Legislative, professional and public towards Quality of health care. Globally each year more than 585,000 million women die due to pregnancy and child birth related preventable causes (UNFPA 2004)[20]; of these deaths 99% occurs in developing countries and about 1% occurs in developed countries (WHO 2001) [3]. In India Maternal mortality ratio is 540/100,000 live births (WHO 2006)[1] and that of Jharkhand state is approximately 451/100,000 (same as in Bihar in 1997); (RGI,SRS,1997-98).This is very high compared to the international scenario like Sweden (8) , UK(11) , Greece(10),and even in neighbouring countries like Sri lanka (92), china(56) and Thailand (44)/100,000 , (WHO 2006)[1].

Similarly, global figure for Infant mortality is about 7.1 million deaths each year; of these deaths half die in the first 28 days after birth (neonatal period). Of the infants dying in the neonatal period about 75% die in the first week after birth (Lawn J.E, et al, 2005). In India, about 2.1 million child death occurs every year, which is the highest number in a single country). The national under five mortality rate of India is around 85/1000 live births (UNICEF 2006) [16] although there is wide variation between states. In Jharkhand state, the under five mortality rate is 69/1000 live births (NFHS-3 2005-06) [18].

Therefore, it's important to find what will reduce maternal and infant mortality in the population of Jharkhand.

This study focuses on quality assessment of services and facilities at district hospital. District hospital provides referral services and specialist services too. A literature search was done in pub-med, search engines like Google, Yahoo and visiting different 'international development' websites. Very few studies have been found in this regard. This type of study is needed to ensure regular quality assessment and improvement. This type of study provide monitoring and evaluation feedback.

References:

Table 4

Serial No	Name of Article	Author	Year of Publication	Place of Study
1	Leveraging human capital to reduce maternal mortality in India: enhanced public health system or public-private partnership?	Krupp K., Madhivanan P	2009	Public Health Research Institute, Yadavgiri, Mysore, India
2	Indian public health standards (IPHS) for community health centre.	Ministry of Health and Family Welfare, Government of India & Member Secretary, Task Group III NRHM.	2005 Jul-Sep	New Delhi
3	Innovations and challenges in reducing maternal mortality in Tamil Nadu, India.	Padmanaban P, Raman PS, Mavalankar DV.	2009 Apr	Tamil Nadu
4	Towards patient-centered health services in India--a scale to measure patient perceptions of quality	Rao KD, Peters DH, Bandeen-Roche K	2006 Dec	Uttar Pradesh in north India
5	Inter-state disparities in	Purohit BC	2004	15 major States

	health care and financial burden on the poor in India			in India
6	Morbidity profile of paediatric inpatients at a community health centre and a nearby [correction of nearby] district hospital in northern India.	Verma S, Rai SK, Kant S, Choudhury K	2007 Apr-Jun	Ballabgarh CHC and Badshah Khan (B.K.) hospital, Faridabad
7	Neonatal Survival 1 4 million neonatal deaths: When? Where? Why?	Joy E Lawn, Simon Cousens, Jelka Zupan, for the Lancet Neonatal Survival Steering Team	March 3, 2005	London Cape town
8	An action plan to assess the current situation of maternal & newborn care at government health facilities in Jharkhand	Kumar, Sudesh and Singh, Janet	2007	Jharkhand
9	Maternal health: a case study of Rajasthan	Iyengar SD, Iyengar K, Gupta V	2009 Apr	Rajasthan
10	Health infrastructure & immunization coverage in rural India	Ashlesha Datar, Arnab Mukherji& Neeraj Sood	January 2007	NFHS data from 26 major states of India

1.1.5 **Overview of Jharkhand:**

Jharkhand was carved out of Bihar State in 2000 (JISH, 2001) and is situated on the Eastern side of India. Jharkhand's bordering states are, Bihar to the north; Uttar Pradesh and Chhattisgarh to the west; Orissa to the south and west Bengal to the east. With Ranchi as its capital; Jharkhand has 22 districts, 33 subdivisions, 211 blocks and 32,620 villages (NFHS-2, 1998-99) [26]. A large area of Jharkhand (about 2.38 million sq. km) is covered by forests, rich in enormous amount of mineral resources; supplying one third of mineral resources of India, also large scales industries both private and public sector exists. 75% of the total tribal population of central India are mostly concentrated in Jharkhand, Madhya Pradesh and Orissa. Jharkhand's population consists of 24.8% schedule tribe and12.6% schedule caste.



Figure 4

1.1.6 Demographic characteristics of Jharkhand:

Jharkhand is predominantly a rural state with 78 percent of its population living in 32,620 villages. Only 22 percent of its population lives in 43 urban settlements, comparatively less than the national average. Literacy difference between Jharkhand (58.6%) and India (67.6%) is moderate but great compared to tribal population (25.9%) and worse with tribal females (14.5%) of Jharkhand (NSSO 1991).

1.1.7 Concept of quality in Health Care:

In health, quality of care means 'the excellence' in reference to improvement in health status (Gilson, 1995). According to Donabedian, 2003[19], Quality has been defined as the extent to which application of medical science and technology is expected to achieve the most favorable balance between risks and benefits, were as Roemer and Montoya – Aguilar, 1988 agree that quality is a degree to which resources for health care or the services correspond to specified standards that are accepted to lead to desired results. The institute of Medicine, Washington DC defines Quality as "The extent to which health services for the individual and population increases the likelihood of desired health outcome and are consistent with the current professional Knowledge" (Institute of Medicine, 1990).

1.1.7 Why quality of health care is important?

The high level of mortality and morbidity in the field of mother and new born care, in spite of high coverage of the national program for their good health and care, has increased the concern for good quality client satisfaction care in the primary health care services (WHO, 1994). Quality has many dimensions that include availability of buildings, personnel and supplies, Technical competence of providers, and interpersonal contact between provider and the client; as identified by researchers and programme staff through experience and observation. A high percentage of pregnant women in developing countries still receive inadequate antenatal care and deliver at home due to cultural practices and the perceived poor quality of services partly motivate them

not to seek antenatal care and to deliver at home. For example, in women of St. Peters berg, Russia, it was identified that poor care in a previous pregnancy, long waits, frequent examinations, fear and dislike of visiting doctors as the main reasons for delay in seeking prenatal. On the other hand a study done in Cebu, Philippines showed that improved quality, as measured by - the availability of services and supplies, provider training, facility size, degree of crowding, price and distance increased the probability that all women used formal services.

Similarly, in Kenya certain reproductive healthcare facilities in low-resource settings perform better than others. The study examined the characteristics, behaviours and coping strategies of high performing reproductive healthcare facilities. These facilities were found to have characteristics like: knowledge and skills, infrastructure, equipment and supplies, leadership and management system and motivation. The high performing facilities also provided client and community focused services. Clients interviewed indicated that they choose to use the clinic not because it was the closest one to their homes or because they had no other options but, because they received what they came for (e.g. supplies, services) at a place that was clean and where the staff treated them with friendliness and respect. Waiting times were also acceptable and affordable to most clients. Client feedback was addressed on a regular basis, means that services continually shifted to meet community needs. Also high quality care apart from attracting more clients reduces per capita cost of services and ensures sustainability.

As in Bangladesh 'Women Health Coalition' attracts its clients by giving a wide range of services at one point. This helps the clients to avail many services in one visit. Moreover, the well trained paramedical staffs perform many examinations (pelvic examination, IUC insertion and menstrual regulation) rather than doctors doing it. Due to the high volume of clients the coalition is able to serve more people at a lower cost. Also by strengthening innovative decision making and problem solving capacity of mangers and providers, the quality and efficiency of healthcare delivery facility could be sustained. Thus quality and efficiency improvement of healthcare delivery facilities could bring desired outcome.

1.1.8 Determinant of Quality of care:

The measurable attributes of good quality health care varies with the level of assessment (Donabedian, 1988; Gilson, 1995). Measuring Quality is difficult so framework is developed that

enables the measurement of quality. Framework has two uses firstly they help to structure a situational analysis for knowing the quality of care provided in an institution. Secondly, it's a tool that helps to improve the quality of care by examining the activities in comparison to a set standard so that, changes could be made accordingly to bring care provided closer to the set standard. In literature search the following frameworks were found: (a) The Bruce framework (1990) [25] - has six fundamental elements of quality of care which focus on the interaction of client and service deliver point and less emphasis on the concept of access to the services to the woman and families (Bruce J 1990) [25]. This framework is more relevant to assess Family planning services. (b) Kwast framework suggests six major categories of quality care determinants for program development, which is a holistic approach to reduce maternal and neonatal morbidity and mortality and are linked to the outcomes (i.e. to improve the health of women throughout their life cycle). These determinants are political environment, financing, socio-cultural factors, health system, training & education, interaction and collaboration. (c) Hulton L.A, et al (2000) proposed a framework consisting of ten elements to assess quality of maternal health care. Six elements of which, stress on provision of care and the remaining four stresses on user's perception. (d) The US agency for international developments office of population and its partner agencies (2001), designed the maximizing access and quality initiatives (MAQ). These MAQ researchers developed a framework of 25 indicators to assess quality of care in clinical practice (Measure Evaluation, 2001). (e) Donabedian suggested an approach with three components (structure, process and outcome) for assessment of quality of care. In this approach the structure refer to the situation under which care is provided, which included firstly, human resources i.e. number, variety and qualification of professionals and support personnel. Secondly, material resources, such as facilities and equipments and thirdly, organizational characteristics such as the organization of medical and nursing staff, the presence of teaching & research functions, kinds of supervision and performance review, method if paying for care etc. The process means the activities that constitute health care - including both technical and interpersonal dimensions and principally capturing the content and method by which health providers deliver services to their patients. The outcome means changes (both desirable and undesirable) in individuals and population that can be attributed to health care, which includes firstly, changes in health status.

Secondly, changes in knowledge acquired by patient and family members that may influence future care. Thirdly, changes in behaviour of patients or family that may influence future health and fourthly, satisfaction of patients and their family member with the care received.

The modified model of Donabedian model which incorporates variable like infrastructure as part of the structure, Consumer's perception as part of outcome etc. can be made to fit to different circumstances.

1.1.9 How is quality of health care assessed?

While monitoring and evaluating quality of care a set standard and criteria is developed to assess quality of care. The standards are described as clear statements that specify the desired or achievable level of performance to be achieved and compared against actual performance. Whereas criteria are variable, that is indicators to determine whether set standards have been met (WHO, 1994).

There are many methods of assessing quality of care:

I. Facility base survey for the assessment of quality of services this tool has been applied in many developing countries as a method of monitoring and evaluating quality health care (Bryce et al, 1992, Garner et al, 1990).

II. Rapid assessment method for assessing maternal and child health services, including obstetric services had been applied by the WHO in many countries (WHO, 1995) [4]. It covers the availability of staff, supplies, instruments, records, interview staff and focus group discussion at the village level.

III. Patient flow analysis is a method for quality assessment developed by the centre for disease control in Atlanta, USA. This method has been applied in various countries like Africa, Asia and Latin America (WHO, 1991).

IV. Confidential enquires; verbal autopsies and audits are all other methods of assessing quality of care (Baker R 1995; Campbell S. M 2002).

CHAPTER 2: RESEARCH METHODOLOGY

2.1: Research Question:

What is the current situation of public health facility at SADAR HOSPITAL Giridih, Jharkhand?

2.2. **Aim, Objectives and Scope of the study:**

2.2.1 Aim: To assess the current situation of health care facilities at Giridih District hospital, Jharkhand.

2.2.2 Objective:

1. To assess the current health care facilities situation at Giridih Sadar Hospital, in terms of (a) Structure -

- Human resources (staff)
- Material resources (equipment, facilities &guidelines)

(b) Process

(c) Outcome

- Patient satisfaction

2. To identify the gaps in health care facilities compared to the Indian Public Health Standards (IPHS) set by the National Rural Health Mission.

3. To propose appropriate interventions to improve the quality of services in government health facilities.

2.2.3 Scope of the study: SADAR HOSPITAL GIRIDIH, Jharkhand

2.3 Methodology:

Descriptive method of research is adopted because it involves gathering data that describe events and then organizes, tabulates, depicts, and describes the data.

Data collection methods:

Survey

Interview

Observation

2.4 Assessment:

2.4.1 Site assessment:

This is the process of knowing the gap present between the desired facilities and the actual facilities. The tool used is IPHS facility survey template for 101-200 bedded district hospital.

2.4.2 What to assess?

To evaluate the (a) availability of: (i) Human resources i.e. staff necessary for providing care services, (ii) Material resources i.e. Equipment, facilities & guidelines necessary for carrying out care work.

2.4.3 Process for conducting assessment:

(a) Meeting the staff

(b) Observing Clinical practices

(c) Review of records and reports

2.5 DATA ANALYSIS & INTERPRETATION

2.5.1DataCollection

Primary data: Primary data for the study was collected by conducting survey with the help of IPHS facility survey tool.

Secondary data: Secondary data was collected by using internet search engines like Google, yahoo.

2.5.2 Data analysis

Data collected in the hospital through IPHS template and questionnaires were entered in Microsoft excel sheet and category wise it was analyzed.

CHAPTER 3: RESULTS AND FINDINGS

3.1 Findings:-

3.1.1 Survey items:

A. STRUCTURE:

1. MEDICAL SERVICES/SPECIALITIES
2. PARA CLINICAL SERVICES
3. SUPPORT SERVICES
4. ADMINISTRATIVE SERVICES
5. MEDICAL PROCEDURE
6. SKIN PROCEDURE
7. PAEDIATRIC PROCEDURE
8. CARDIOLOGY PROCEDURE
9. MAN POWER DOCTORS
10. PARAMEDICAL STAFF
11. ADMINISTRATIVE STAFF
12. OT STAFF
13. BLOOD BANK STAFF
14. LAB TEST
15. CARDIAC INVESTIGATION
16. ENT & OPTHALMOLOGY INVESTIGATION
17. RADIOLOGICAL INVESTIGATION
18. ENDOSCOPY
19. DRUGS

B. PROCESS

C. OUTCOMES

-PATIENT SATISFACTION

- EMPLOYEE SATISFACTION

1. **SERVICES /SPECIALISTS:**

Table 5

Facilities	As per IPHS	Available	Not available
MEDICAL SERVICES/SPECIALITIES	14	11	3
PARA -CLINICAL SERVICES	8	7	1
SUPPORT SERVICES	20	5	15
ADMINISTRATIVE SERVICES	9	2	7

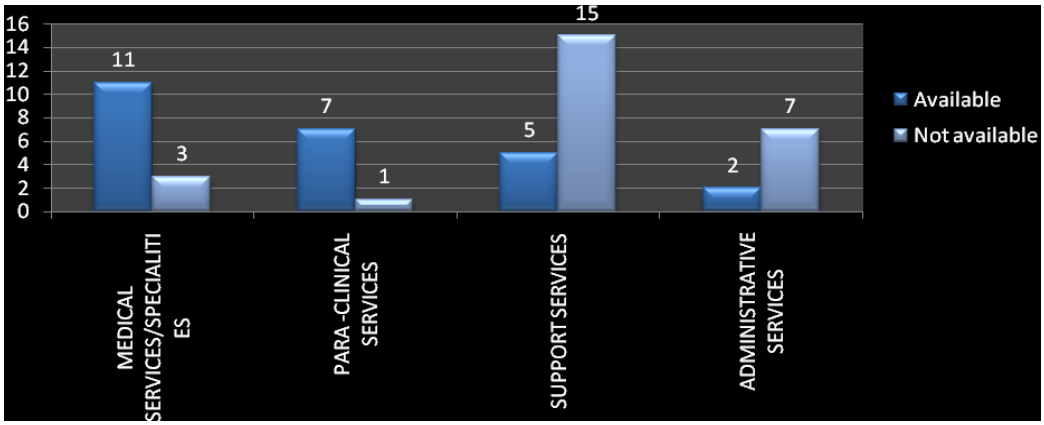


Figure 5

Discussion:

A survey result indicates 21% of medical services are not available against the standards.

In Para clinical service 13% of services were found not available. Support services are the back bone of all clinical services but in this the percentage of non availability is very high and it accounts to 75%. Hospital is managed by administration but at present hospital have only two administrative positions against the required 9. The result of survey in the field of process is very bad hospital is not following aseptic precaution in OT/ dressing room/ labour room. If this is the situation then how can people living in the last can think of getting quality of health care? This is the situation where resources come first and with priority and people believe it is apex body in

health care delivery system where they can approach easily. What will be the situation in remote area where modern facility can be reached easily?

2. PROCEDURES:

Table 6

Facilities	Available	Not available
MEDICAL PROCEDURE	12	13
SKIN PROCEDURE	O	5
PAEDIATRIC PROCEDURE	2	12
CARDIOLOGY PROCEDURE	1	7

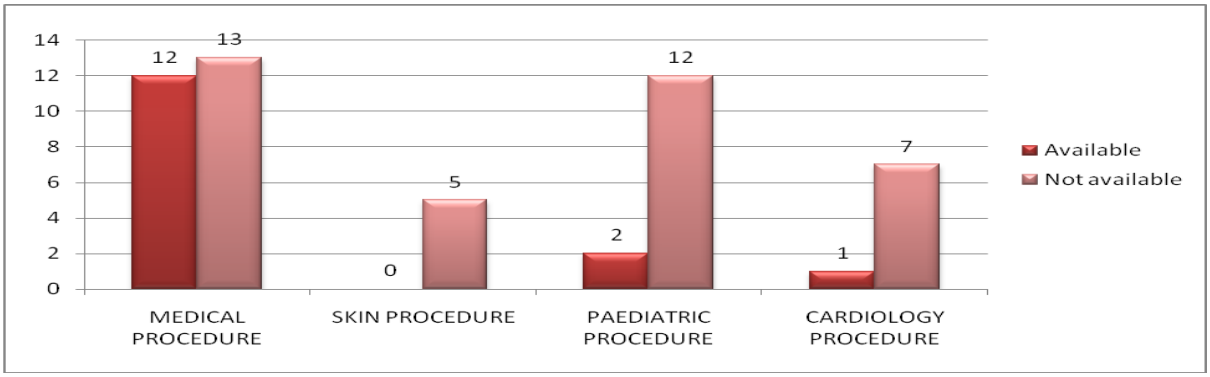


Figure 6

Discussion:

Among the standard medical procedure should present in 48% medical procedures were not available. Services in the field of skin procedures are completely absent.

Jharkhand is low performing state in the child health and mortality rate is very high but district hospital doesn't have enough facility in this field only 14% procedures were present for paediatric patients. Country is having burden of life style diseases and cardiac problem is among them but facility in this field is absent by 88%.

3. HUMAN RESOURCE:

Table 7

Facilities	Available	Not available
MAN POWER DOCTORS	20	14
PARAMEDICAL STAFF	91	62
ADMINISTRATIVE STAFF	10	7
OT STAFF	13	2
BLOOD BANK STAFF	5	4

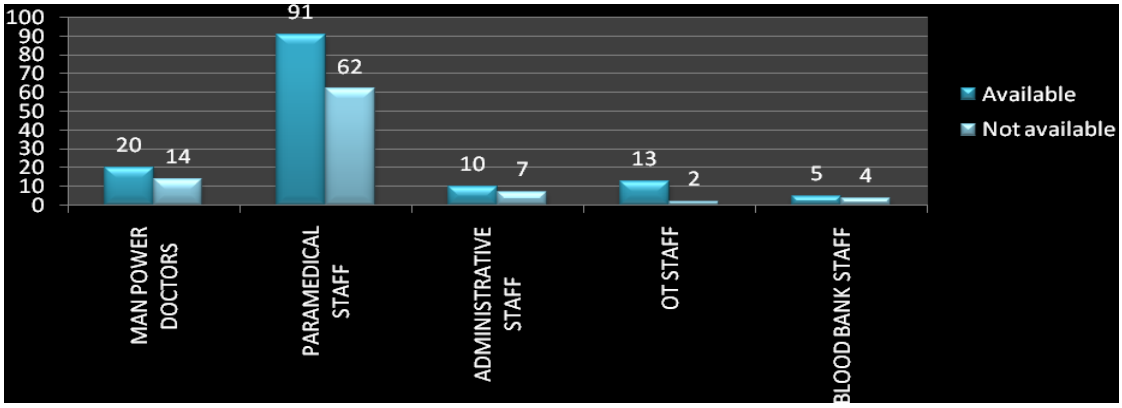


Figure 7

There is acute shortage of medical practitioner in the hospitals same situation has been found in district hospital too. Doctor's feels helpless without paramedic staffs, a huge gap have been found in the strength of paramedic staff. Against the sanctioned post of 17 administrative staff only 10 are available. OT requires good strength of manpower to manage its process but at district hospital only 2 staffs are available at present which is insufficient for proper management of OT. No standard procedures like fumigations and cleaning were done on regular basis. Blood bank which runs round the clock is also not having proper strengths for proper functioning.

4. INVESTIGATION AND DRUGS:

Table 8

Facilities	GAP	CURRENT AVAILABILITY

LAB TEST	55	26
CARDIAC INVESTIGATION	2	1
ENT & OPTHALMOLOGY	1	4
RADIOLOGICAL INVESTIGATION	5	2
ENDOSCOPY	9	0
DRUGS	322	70

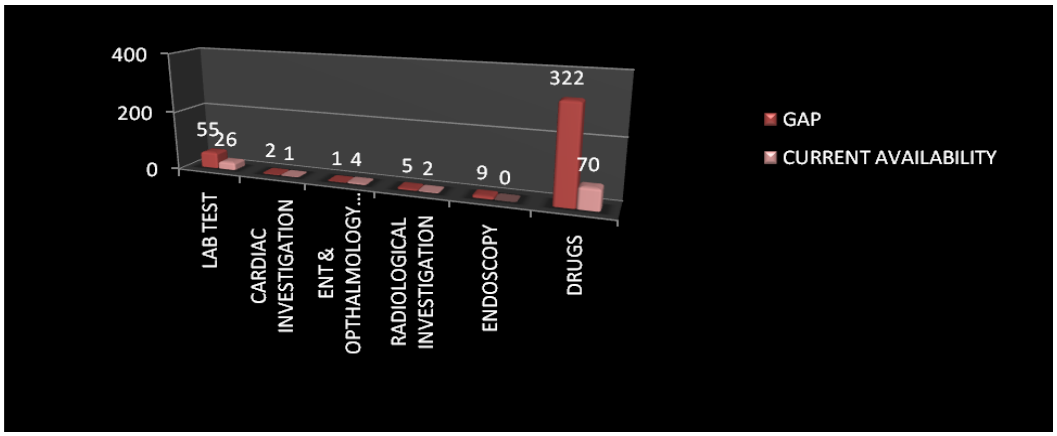


Figure 8

Discussion:

Lab investigation provides support in diagnosis but only 32% of total investigations are done here. In the cardiac investigation only one are present that also are non functional at present. In this area only 20% of investigations are absent, but the services are being provided due to absence of advance equipments. Only USG and X-RAY are done here among the set standards. All facilities in this field are unavailable**.**

There is wide gap in the availability of medicines only 18% of the standards are available. This is one of the basic reasons why patients don't want to go in the institutions. Patients has to buy the drugs from outside which is not as per quality of care and not affordable for the poor patient. Emergency facilities are not well equipped not even with basic emergency drugs like PAM, ATROPINE etc. How can a district hospital that is called to be specialist and referral hospital can't manage these things even when are committed to provide emergency health care. Poor patient for whom government is running a scheme JANANI SURAKSHA YOJNA with intention to provide financial assistance to mother how these types of system can be justified.

3.2 Process assessment: FMEA METHOD

Steps in the Process	Failure Mode	Failure Causes	Failure Effects	Severity	Actions to Reduce Occurrence of Failure
1. OPD					
Patient entry	Unaware Patient regarding the service and the location	Unavailability of display board and signage's	Delay in access to health services	HIGH	Display board & signage's should be displayed at appropriate place with all information
	Slip/ trip	Concrete stone has been fixed at the entrance	Patient may fall down or injure himself	HIGH	Remove the concrete stone from the entrance
	Transportation of patient	Non-availability of STRETCHER/ WHEEL CHAIR near the entrance -non availability of OPD attendant to attend non ambulatory patient	Patient has to be shifted with the help of relatives which may further aggravate their problem. Eg trauma patient, old patient	HIGH	Provision of wheel chair & stretcher near the entrance with porter round the clock
	Registration	Non- availability of adequate space at registration counter -improper functioning of registration counter.	It lead to crowd at registration counter and hinder the flow of patient in	MEDIUM	Provision of central registration counter in the hospital

			corridor		premises near the OPD
Patient arrives at consultant room	Unrestricted entry	Non-availability of OPD attendant in every consultants room	Increase waiting time. Crowding in the consultants room makes him uncomfortable and unable to concentrate properly and may take hasty decision.	HIGH	Deployment of OPD attendant/ trainee ANM in each consultant rooms.

	Examination	Non availability of basic instruments like BP apparatus, thermometer, weighing machine, curtain,	Improper diagnosis especially in paediatric clinic, general OPD -privacy of female patient during examination can't be maintained	HIGH	Provision and availability of required instrument in OPD with staff nurse/ ANM/attendant
	Waiting space and chair	Non-availability of benches outside the paediatric OPD,	Patient may fall down if he stands for long time	HIGH	Provision of bench outside the clinics

		EYE and ENT OPD	It hinders the flow of corridor as patient stand and make crowd outside the clinic.		
	Hand hygiene	Non availability of soap/ sanitizer in consultant room	Doctor may get infected or may transfer infection from one patient to other.	HIGH	Provision of soap/ sanitizer in the consultation room
Dispensary cum injection room	Non- availability of drugs -paediatric patient are not getting syp/suspension -emergency drugs are almost not available	Improper indent/requisition and uniformed about the stock in store room -	Patient does not get medicine which lead to purchase from outside	HIGH	-Daily stock taking at dispensary and store -Requisition for purchase of medicine should be made by doctors on monthly basis as they know better regarding trend of disease in particular season and patient they see. -Maintain a safety

					stock as per lead time to avoid unavailability.
	Improper display of drugs	Unavailability of PET drug storage box and labelling of box not done properly	Same colour and same sounding medicine can be given to different patient, which may cause adverse effect.	HIGH	Proper storage Proper labelling
	Drug delivery	Medicine given to patient in hand not in any envelop	Same colour medicine explained to take at different; as patient may not be able to identify the difference and take medicine simultaneously can produce adverse drug reaction.	HIGH	Drug should be distributed in envelop on which timing of intake should be noted as per patient understanding.
	BMW	Segregation and storage of BMW is not followed.	May cause harm to patient as well as staff.	HIGH	Provision of separate container to store used injection and

					cotton swab.
X-Ray	Unrestricted entry	Non availability of separate waiting space.	Make procedure room crowded	LOW	Provision of benches outside the procedure room for waiting patient.
	Privacy	Non availability of female attendant/ curtain/ separate change room.	Patient does not feel comfortable and may not cooperate.	MEDIUM	Provision of ANM and curtain.
	Reporting	Films given to patient without envelop.	It may hamper the quality of film	LOW	Provision of envelop for reporting
	Electricity	Back up of electricity has not been maintained.	Slip/trip of machine Procedure stops and patient has to wait for long.	MEDIUM	Can liaison with blood bank to maintain electricity.

ULTRASOUND	Electricity	Non availability of power back up	Slip/trip of machine and patient has to wait for long.	MEDIUM	Can liaison with blood bank to maintain electricity.
	Patient waiting space and seating facility.	Non availability of waiting chair outside the procedure room.	Patient seats on the floor/ stand outside the procedure	MEDIUM	Provision of benches outside of procedure room.

			room giving bad look and makes patient uncomfortable.		
	Maintenance	Improper handling of equipments	Slip/ trip of machine	LOW	Proper handling/ regular maintenance
Emergency	Service	Non availability of triage area/ separate emergency area	Same OPD act as emergency because of which emergency patient does not get much attention as they require.	HIGH	Identifying the area that can be built as and developed as emergency.
Pathology	Sample collection/ reporting	Non availability of reporting slip/ requisition slip in wards	Improper reporting and requisition	MEDIUM	Preparing a format and getting it printed
Operation theatre					

	Entry	Non availability of security guard at entrance/ restricted area signage	OT is most sensitive area in the hospital which requires specific aseptic precaution failure of which makes OT complex unsterile and unsafe for use.	HIGH	Door should be provided with auto close facility and proper display signage's regarding information should be displayed at the entrance.

	Sterilization	No proper record of sterilization is maintained.	Proper record and regular check create more accountability among employee failure of which makes them irresponsible and which would result in unsterilized OT which may cause infection.	HIGH	Regular record maintenance by OT assistance and cross check by surgeon.
	Emergency drugs and OT instruments	Irregular maintenance of drug and instrument	Unavailability of drugs/ instrument on time and may	High	Regular record maintenance by OT assistance and cross check

		register	hamper the procedures.		by surgeon.
	Pre-op room/ recovery room	There is no defined area within the hospital	Operated patient are more vulnerable than any other patient and catch infection faster than other	HIGH	There should be defined area near the OT complex.
IPD					
	Cleanliness	Cleanliness is not maintained round the clock, dust bin kept open in front of wards	It helps in spread of infection	HIGH	Duty roaster of housekeeping staff is prepared in such a manner that their presence can be assured round the clock. Dust bin with cap should be used instead of open bucket.

	Patient care	Vital data of	Improper	HIGH	Staff nurse should

		patient like pulse, BP, temperature are not maintained on their BHT	diagnosis		be directed to follow instruction of physician and collect all data required
	Numbering of beds	Beds in the wards is not numbered properly	Identification of patient will be difficult	HIGH	Numbering of beds in proper manner.
	Security	Non availability of security personnel in IPD	Patient relatives seats on patient cot and chew tobacco there only, a fine particle of tobacco dust can be fatal for new born baby.	HIGH	Posting of security personnel in wards at least in day time to restrict the entry of more than one attendant in wards.
Labour room					
	Maintenance	Non maintenance of equipment which are essential to reduce neo-natal mortality.	Can become fatal for new born child who require acute aid of those equipments. -simple equipment like incubator/warmer is non functional which are essential to treat	HIGH	Regular maintenance

			neonatal jaundice		
	Cleanliness	Irresponsible behaviour of safai karmchari	Can delay in availability of table and make patient restless.	HIGH	Making them more accountable toward their responsibilities.
	BMW	Lack of system of segregating BMW & disposing as they require	Spread infection in environment	HIGH	Develop the system of collection and destroying BMW.
	Waiting space/ waiting chair	Unavailability of waiting chair outside the labour room in corridor	Patient relative's stands in front of labour room hinder the traffic.	MEDIUM	Provision of chair in the lobby.

Failure Mode: What could go wrong?

Failure Causes: Why would the failure happen?

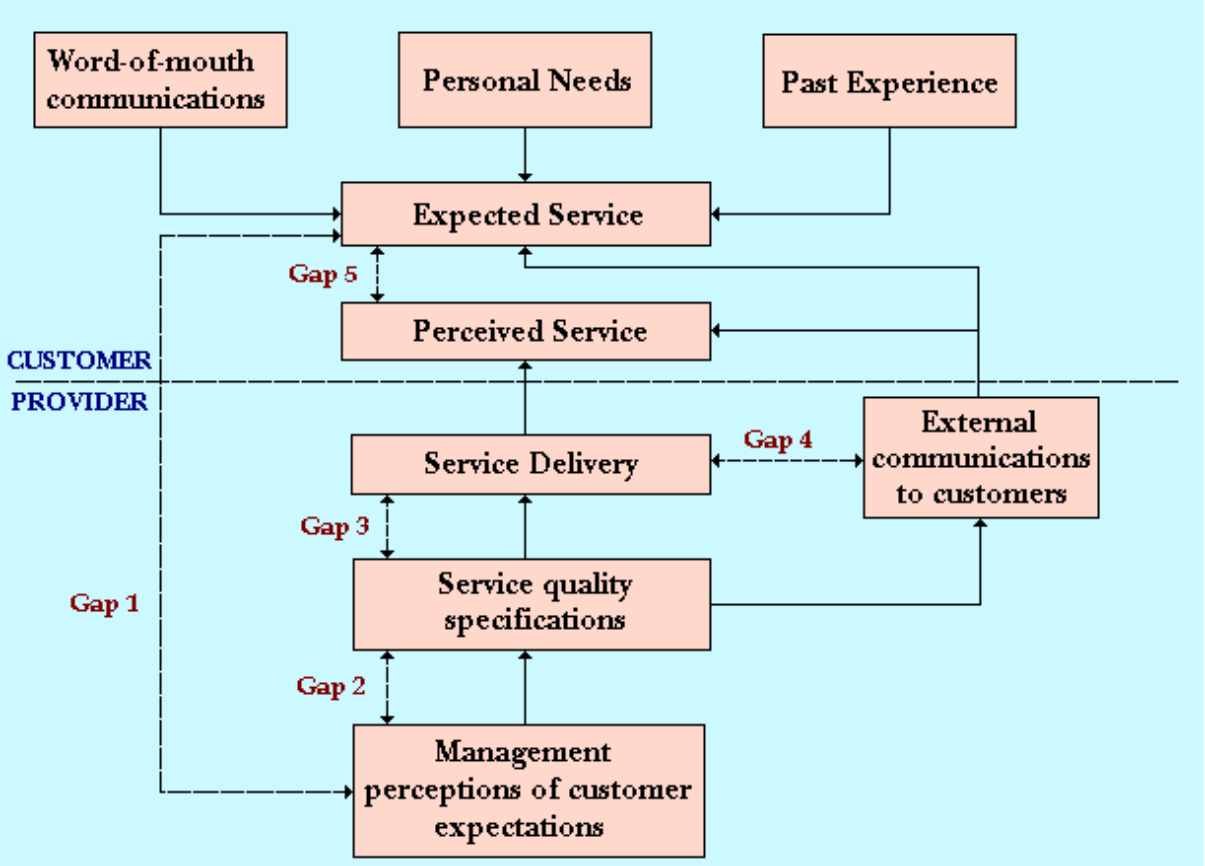
Failure Effects: What would be the consequences of failure?

Severity: HIGH: directly affecting patient safety

MEDIUM: indirectly affecting patient

LOW: somehow affect patient

3.3 Analysis of results as per The Service Quality Model:



[Parasuraman, Zeithaml and Berry 1985]

The Gaps in the Model

– **Gap 1: Customer Expectations - Management Perceptions Gap**

– **Gap 2: Management Perceptions - Service Quality Specifications Gap**

– **Gap 3: Service Quality Specifications - Service Delivery Gap**

– **Gap 4: Service Delivery - External Communications Gap**

– **Gap 5: Expected Service - Perceived Service Gap (or the Service Performance Gap**

Gap 1: Customer Expectations – Management Perceptions

Gap

Key factors:

- **Inadequate use of the Information available:**

Giridih has very low literacy rate and people always get involved in fights among themselves which give immediate need to emergency care for traumatised patients. But the hospital doesn't have independent emergency department.

- **Lack of interaction between management and customers:**

Top management of the hospital never try to interact with patient regarding their expectations and the quality of service they are getting.

- **Insufficient communication between employee and managers:**

Employee and managers should have free communication system so that manager could get the information about the problem they are actually facing and their requirements. This system is totally absent in the hospital and being a service sector this is most important way to keep updating their organization. Employees have the direct contact with service delivery agents like doctors/ paramedics and the service recipients. They understand better about requirements to improve service delivery.

- **One way communication between top management and personnel:**

Top managers don't like to have two way interaction because of which actual problem remains the same.

Gap 2: Management Perceptions - Service Quality

Specifications Gap

Key factors

- **Inadequate management commitment to service quality:**

Managements don't feel committed to deliver quality services to the customers and they never take any review of the quality of service they deliver eg rusted instruments being used in OT.

- **Absence of formal process for setting service quality goals:**

As they are not committed toward delivering quality service so they never try to set any goals to improve and monitor service quality.

- **Perception of feasibility -that customer expectation cannot be met:**

This is the major problem in the hospital managements have the strong feeling that customer expectation can't be met within the resources. Although resources are not being utilized properly hospital has untied funds to cater the contingency expenditures but those funds remain unutilized at the end of the financial year.

Gap 3: Service Quality Specifications - Service Delivery

Gap

Key factors

- **Lack of teamwork**

  There is total absence of the concept of team work. Everyone feels that he is not designated to do this job. Eg managing a critical patient might need second opinion but attending physician never get much help of others as others feel that the patient was not admitted during my duty.

- **Poor employee-job fit**

  Store keeper is handling the inventory management who has not got any formal training on inventory management.

- **Poor technology -job fit**

  OT is handled by a compounder who does not know about the handling of OT instruments. Staff nurse doesn't know about the functioning of warmer in the delivery unit.

- **Role conflict / Role ambiguity among contact employees:**

  This is the major problem among the class IV employees their roles and responsibilities have not been communicated properly.

Gap 4: Service Delivery - External Communications

Gap

KEY FACTOR:

- **Inadequate communication of the quality of services they provide.**

Services which are available in the hospital are not advertised or communicated to local public. This the main factor behind low utilization of the services.

Some time there is huge difference between the quality of service they deliver and customer hears about the service. This happens because improper communication.

Gap 5: Expected Service - Perceived Service Gap (or the

Service Performance Gap

- This gap is directly related to everyone's perception of service quality. Customers expect certain things from the government hospital like free service, availability of medicines etc. But at present the availability of medicines is not adequate for the treatment of all ailments and range of medicines for all age groups are not available.

3.4 OUTCOMES: PATIENT SATISFACTION SURVEY

Outpatient Satisfaction Survey (OPD Sample- 40 Patients)

Table 9

S. No.	Attribute	Poor	Fair	Good	Very Good	Excellent	No Comments
1	**Availability of sufficient information at registration/admission counter**	0.00	75.00	25.00	0.00	0.00	0.00
2	**Waiting time at Registration/Admission counter**	0.00	0.00	0.00	75.00	25.00	0.00
3	**Behaviour and attitude of staff at the registration/admission counter**	0.00	0.00	70.00	30.00	0.00	0.00
4	**Cleanliness of OPD, Bathrooms & Toilets**	0.00	76.00	24.00	0.00	0.00	0.00
5	**Attitude and communication of doctors**	0.00	9.00	85.00	6.00	0.00	0.00
6	**Time spent for examination of patient and counselling**	0.00	47.00	53.00	0.00	0.00	0.00
7	**Attitude and communication of Lab Assistants**	0.00	40.00	57.00	0.00	0.00	3.00
8	**Promptness at Medicine counter**	0.00	45.00	30.00	12.50	12.50	0.00
9	**Quality and number of information display boards**	30.00	40.00	15.00	15.00	0.00	0.00
10	**Your overall satisfaction during the visit to the hospital**	20.00	75.00	5.00	0.00	0.00	0.00
	Total Satisfaction	5.55%	40.7%	36.40%	13.85%	3.75%	0.30%



Figure 9

Inpatient Department Satisfaction Survey (IPD Sample- 40 Patients)

Table 10

S. No.	Attribute	Poor	Fair	Good	Very Good	Excellent	No Comments
1	Availability of sufficient information at registration/admission counter	17.50	30.00	25.00	20.00	7.50	0.00
2	Waiting time at Registration/Admission counter	0.00	0.00	0.00	75.00	25.00	0.00
3	Behaviour and attitude of staff at the registration/admission counter	0.00	0.00	50.00	30.00	20.00	0.00
4	Your feelings on discharge process	20.00	20.00	27.50	15.00	17.50	0.00
5	Cleanliness of the ward	17.50	20.00	60.00	2.5	0.00	0.00
6	Cleanliness of Bathrooms & Toilets	75.00	12.5	12.5	0.00	0.00	0.00
7	Cleanliness of Bed Sheets/ pillow covers etc.	7.5	17.50	50.00	17.5	7.5	0.00
8	Cleanliness of surroundings and campus drains	0.00	15.00	75.00	10.00	0.00	0.00
9	Regularity of Doctor's attention	0.00	0.00	75.00	25.00	0.00	0.00

10	Attitude and communication of doctors	0.00	25.00	50.00	25.00	0.00	0.00
11	Time spent for examination of patient and counselling	0.00	75.00	20.00	5.00	0.00	0.00
12	Promptness in response by nurses in the ward	0.00	0.00	5.00	75.00	20.00	0.00
13	Round the clock availability of Nurses in the ward	0.00	0.00	20.00	70.00	10.00	0.00
14	Attitude and communication of Nurses	0.00	30.00	38.00	10.00	22.00	0.00
15	Availability of Ward-Boys/ Girls in the ward	0.00	30.00	30.00	20.00	20.00	0.00
16	Attitude and promptness of Ward boys/girls	35.00	35.00	26.00	0.00	04.00	0.00
17	Attitude & communication of other staff of hospital	7.00	30.00	45.00	08.00	0.00	0.00
18	Your perception of Doctor's knowledge	0.00	0.00	7.5	17.5	75.00	0.00
19	Timeliness of supply of diet	0.00	7.5	20.00	0.00	72.5	0.00
20	Your overall satisfaction during the treatment	0.00	7.5	12.5	80.00	0.00	0.00
	Total Satisfaction	8.97%	17.75%	32.45%	25.27%	15.05%	0.00%

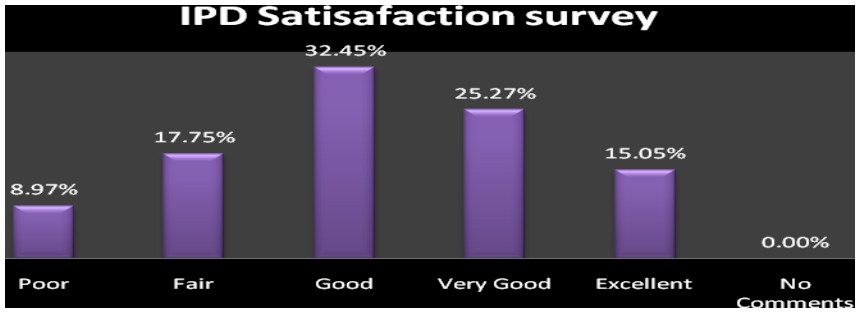


Figure 10

Employee Satisfaction Survey (All in Percentage for 25 employees)

Table 11

S. No.	Attribute	Poor	Fair	Good	Very Good	Excellent	No Comment*
1	**Distribution of workload of Hospital Employees**	75.00	20.00	5.00	0.00	0.00	0.00
2	**Clarity of roles and responsibilities**	0.00	60.00	20.00	10.00	10.00	0.00
3	**Opportunity to show individual capabilities**	50.00	10.00	0.00	0.00	40.00	10.00
4	**Housing facilities available for employees**	60.00	25.00	15.00	0.00	0.00	0.00
5	**Coordination and cooperation of your co-workers in discharging your duty**	0.00	75.00	15.00	10.00	0.00	0.00
6	**Building, Infrastructure of Hospital**	0.00	0.00	75.00	6.67	25.00	0.00
7	**Availability of Basic office /working equipment/ tools**	60.00	40.00	0.00	0.00	0.00	0.00
8	**Maintenance of the hospital equipments**	75.00	25.00	0.00	0.00	0.00	0.00
9	**Availability of**	90.00	10.00	0.00	0.00	0.00	0.00

	AC/Refrigeration facility in your workplace						
10	**Appreciation/ recognition for your good work**	50.00	40.00	0.00	0.00	0.00	10.00
11	**Motivation level of employees**	0.00	75.00	0.00	0.00	0.00	25.00
12	**Hospital leadership system**	80.00	20.00	0.00	0.00	0.00	0.00
13	**Evaluation system for annual appraisal (CR) and promotion**	90.00	0.00	0.00	0.00	0.00	10.00
14	**Opportunities for training & skill development**	40.00	20.00	0.00	0.00	40.00	0.00
15	**Opportunities of use of computer**	55.00	15.00	10.00	5.00	0.00	5.00
16	**The existing grievance management system in the hospital**	60.00	10.00	20.00	0.00	0.00	10.00
17	**Opportunities for expressing opinion/views on work related topic**	75.00	20.00	05.00	0.00	0.00	0.00
18	**Decision making by hospital in-charge**	75.00	20.00	05.00	0.00	0.00	0.00
	Total Satisfaction	**51.94%**	**26.94%**	**9.44%**	**1.76%**	**6.39%**	**3.9%**

- *All figures are in percentage*



Figure 11

CHAPTER 4. CONCLUSION AND RECOMMENDATION:

The overall health status of facilities at district hospital is very poor. The reasons for the poor health facility status are not hard to find with the results. Major factor hindering access to quality health services are lack of or non existing inter-sectoral linkages between different stake holders. This phenomenon is also found between different Government Departments. Here the role of panchayati raj institutions and civil society organisations becomes pertinent as one of the important stakeholder. Existence of services in terms of structure will never ensure its utilization to fullest unless and until there is proper channel between different stake-holders which can link people to these services. It requires concerted public action to establish an accountable and affordable public health system, in partnership with nongovernmental providers. It requires participation of democratic institutions (Panchayats, user groups, Rogi Kalyan Samitis, women's groups, NGOs) in health delivery from public and non-governmental providers. Such health sector reforms require higher order of management of resources.

Even though much of the responsibility for efficient working of the public health system lies upon the government, the people also need to assert their rights. To address the issues related to quality health care services, capacity building of health service providers, accountability and use of right to information for improving the quality of health care services are very critical factors. It is a challenge to the PRI and civil society institutions to make a difference in improving the access to primary health care services and contribute in ensuring access and utilization of services in their area.

4.1 To improve the services of the hospital, author recommends following strategies to be implied in every field:

Table 12

Area	Strategies
Structure	• Stream line the process of purchasing medicines and take corrective action to utilize untied funds fully and properly so that material could not get

	out of the stock any time. • Regular maintenance of the equipments. • Regular training of all medical/ paramedical staffs • Restructuring the various department as per the standards to maintain quality • Maintain adequate staff at every point of service. • Increase the accountability of the staff by proper monitoring by involving local bodies
Process	• Improves the service delivery process • Regular collection of feedback from service recipients' • Regular process audits
Outcomes	• Take corrective action against the feedback collected • Inform the service recipients about the services well