

**Summer Training at
National Rural Health Mission (NRHM)
U.T. Chandigarh
(April 9 - June 1, 2012)**

Study to evaluate the performance of Civil Dispensaries in U.T Chandigarh

**By
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**Under the guidance of
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**Post Graduate Diploma in Hospital and Health Management
2011-2013**



**Institute of Health Management Research,
Jaipur
2012**

Certificate

This is to certify that Ms. Neha Bhalla from Institute of Health Management Research, Jaipur has undergone Summer Training at National Rural Health Mission, U.T., Chandigarh from 9th April, 2012 to 1st June, 2012.

The candidate herself carried out the project. Her approach to the study has been sincere, scientific and analytical. This summer training is partial fulfillment of the course requirement is recommended for the award of Post Graduate Diploma in Health and Hospital Management.

I wish her success in all her future endeavors.

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Memo No.: NRHM-UT/ 2192

Dated 26/6/12

TO WHOM IT MAY CONCERN

This is to certify that Ms. Neha Bhalla, PGDHHM, IIMR Jaipur underwent training in Public Health at National Rural Health Mission, U.T. Chandigarh w.e.f. 9th April, 2012 to 1st June, 2012.

She participated in the activities for the entitled project on "Impact of Health Department Chandigarh on Improving Status of Maternal and Child Health Through Evaluating Obstetric Patient Satisfaction, Assessing PHCs Based on IPHS and by Carrying Out Various IEC Activities" under National Rural Health Mission.

Her exposure in Public Health was very good. She aptly handled major responsibilities during her tenure with us and we found her to be hardworking and very productive.

She is a self motivated, duty bound and a highly committed team player with strong conceptual knowledge.

We at National Rural Health Mission, Chandigarh Administration wish her all success in her future endeavors.

19/6/12
Mission Director,
National Rural Health Mission,
Chandigarh Administration,
CHC, Sector 22, Chandigarh



नामी-दाती को ई पुरस्कार तो का दध समुपरा कोना

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Abbreviations

AIDS – Acquired Immuno Deficiency Syndrome

AIE – Alternate Innovative Education

ANM – Auxiliary Nurse Midwife

ARSH – Adolescent Reproductive and School Health

AYUSH – Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy

CA – Computer Assistant

CD – Civil Dispensary

CHC – Community Health Centre

DEO – Data Entry Operator

DH – District Hospital

DLHS – District Level Household & Facility Survey

ESI – Employee State Insurance

F.Y – Fiscal Year

GDP – Gross Domestic Product

GMSH – Government Multi Speciality Hospital

GOI – Government of India

HMIS – Health Management Information System

ICDS – Integrated Child Development Scheme

IDSP – Integrated Disease Surveillance Project

IEC – Information Education Communication

IFS - Indian Forest Service

IMNCI – Integrated Management of Neonatal and Childhood Illness

IMR – Infant Mortality Rate

IPHS – Indian Public Health Standards

IPS – Indian Police Service

IT – Information Technology

JSSK – Janani Shishu Suraksha Karyakram

JSY – Janani Suraksha Yojna

LHV – Lady Health Worker

MC – Municipal Corporation

MCH – Mother and Child Health

MCP – Mother and Child Protection

MMR – Maternal Mortality Ratio

MO – Medical Officer

MOH – Medical Officer of Health

MOHFW – Ministry of Health and Family Welfare

MPHW – Multipurpose Health Worker

MTP – Medical Termination Of Pregnancy

NBSU – New Born Sick Units

NCD – Non Communicable Diseases

NGO – Non Governmental Organization

NIDDCP – National Iodine Deficiency Disorders Control Programme

NLEP – National Leprosy Eradication Programme

NPCB – National Programme for Control of Blindness

NPCC – National Programme Coordination Committee

NPPCD – National Programme for Prevention and Control of Deafness

NRHM – National Rural Health Mission

NSSK – Navjat Shishu Suraksha Karyakram

NSV – No Scalpel Vasectomy

NVBDCP – National Vector Born Disease Control Programme

OA – Office Assistant

ORS – Oral Rehydration Solution

ORT – Oral Rehydration Therapy

PC & PNDT - Pre-conception and Pre-natal Diagnostic Techniques Act

PGIMER - Post Graduate Institute of Medical Education & Research

PH – Public Health

PHC – Primary Health Centre

PIP – Programme Implementation Plan

PPIUCD – Post Partum Intra Uterine Contraceptive Devices

QA – Quality Assurance

RCH – Reproduction and Child Health

RNTCP – Revised National Tuberculosis Control Programme

RTI – Reproductive Tract Infections

SDM – Sub Divisional Magistrate

SFM – State Finance Manager

SHP – School Health Programme

SRS – Sample Registration System

SSNP – Social Safety Net programme

STI – Sexually Transmitted Infections

SWD – Social Welfare Department

TBHV – Tuberculosis Health Visitor

TFR – Total Fertility Rate

UIP – Universal Immunization Programme

UT – Union Territory

VHSC – Village Health Sanitation Committee

WHO – World Health Organization

WIFS – Weekly Iron Folic acid Supplementation

National Rural Health Mission

U.T. Chandigarh



Overview

CHANDIGARH – City beautiful

Chandigarh is the first well planned modern city of India designed by the French Architect Le Corbusier. Chandigarh was constituted as a Union Territory on 1st November, 1966. It serves as the joint capital of both, Punjab and Haryana States. It is bounded on the North and West by Punjab and East and South by Haryana. Total area of the Union Territory is 114 Sq. Km.

Administrative Divisions:

Chandigarh is considered as one district administratively. It is divided in 3 Sub-divisions namely Central, East and South. A Sub Divisional Magistrate (SDM) heads each Sub-division. This city has a Municipal Corporation with 21 wards. A Mayor heads Municipal Corporation with 1 Senior Deputy Mayor & 1 Deputy Mayor assisting him/her. Each Municipal Corporation ward has an elected representative called Councilor. Municipal Corporation has the post of Medical Officer of Health (MOH) who looks after public health and environmental sanitation and is also Nodal Officer for Primary Health in the city. Urban slums are also under Municipal Corporation.

Demographic and Socio Economic Profile

The population of Chandigarh is 9,00,635 (Census 2001) and the projected population is 14,38,000(2011). Out of this 60% resides in the urban areas, 30% in urban slums and 10% in rural areas. Chandigarh has a decadal growth rate of 40.28% (Census 2001) against 21.54% for the country. Chandigarh has 22 villages (12 are under Chandigarh Administration and 10 villages are under the Municipal Corporation). There are 41 urban slums and colonies in the city.

Eyeing the summit:

According to National Urban Sanitation Policy which ranked the cities of India on Sanitation(2009-2010) **CHANDIGARH HAS BEEN RANKED FIRST AMONGST THE TOP 25 CITIES.**

Chandigarh has also been ranked first in Greenery and Plantation, Purity of Drinking Water, Efficiency of Garbage Disposal, Clean record, Cleanliness of public toilets, Participation of Municipality, Cleanliness on roads and Dustbin in public places by far in the country by ORG-AC Nielson in their recent survey.

We also top in:

- Human Development Index and Gender Development Index.
- Long healthy life and decent standard of living among the states of our country.
- Economic participation and decision making, it implies that Chandigarh's share in Administrative services or IPS and IFS is maximum and there is more enrolment in Medical and Engg. colleges.

Table 1: Distribution of Population of Chandigarh.

	2011 Projected*	2010 Projected*	Census 2001
Total Population	14,38,000	13,68,000	9,00,635
Urban	8,60,600	8,20,800	7,01,390
Rural	1,46,000	1,36,800	92,120
Slum	4,31,400	4,10,400	1,07,125

Source: *www.censusindia.gov.in/Census.../Projected_Population/Projected_population

Table 2: Chandigarh at a glance

Parameters	Figures	
Population	Female	Male
Urban	358393 (91%)	450122 (88.8%)
Rural	35304 (9%)	56816 (11.2%)
Total population	393697 (43.7%)	506938 (56.3%)
Area (in sq. Km.)	114	
Decadal Population growth	+ 40.33%	
Overall Literacy Rate (%)	81.8	
Literacy Rate (%) among Males	85.6	
Literacy Rate (%) among Females	76.6	
Sex Ratio(0-6yrs)*	882	

Source: Census 2001

Goals of the Mission

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR).
- To improve access of rural people to equitable, affordable, accountable and effective primary health care.
- Revitalize local health traditions and mainstream AYUSH.
- Prevention and control of communicable and non-communicable diseases, including locally endemic disease.
- Universal access to public health services such as women's health, child health, water, sanitation & hygiene, immunization and nutrition.
- Population stabilization, gender and demographic balance.
- To raise public spending on health from 0.9% GDP to 2-3% of GDP
- Improve arrangement for Community financing , risk pooling and increase Community Ownership of Public Health
- To promote policies that strengthens public health management and service delivery in the Community.

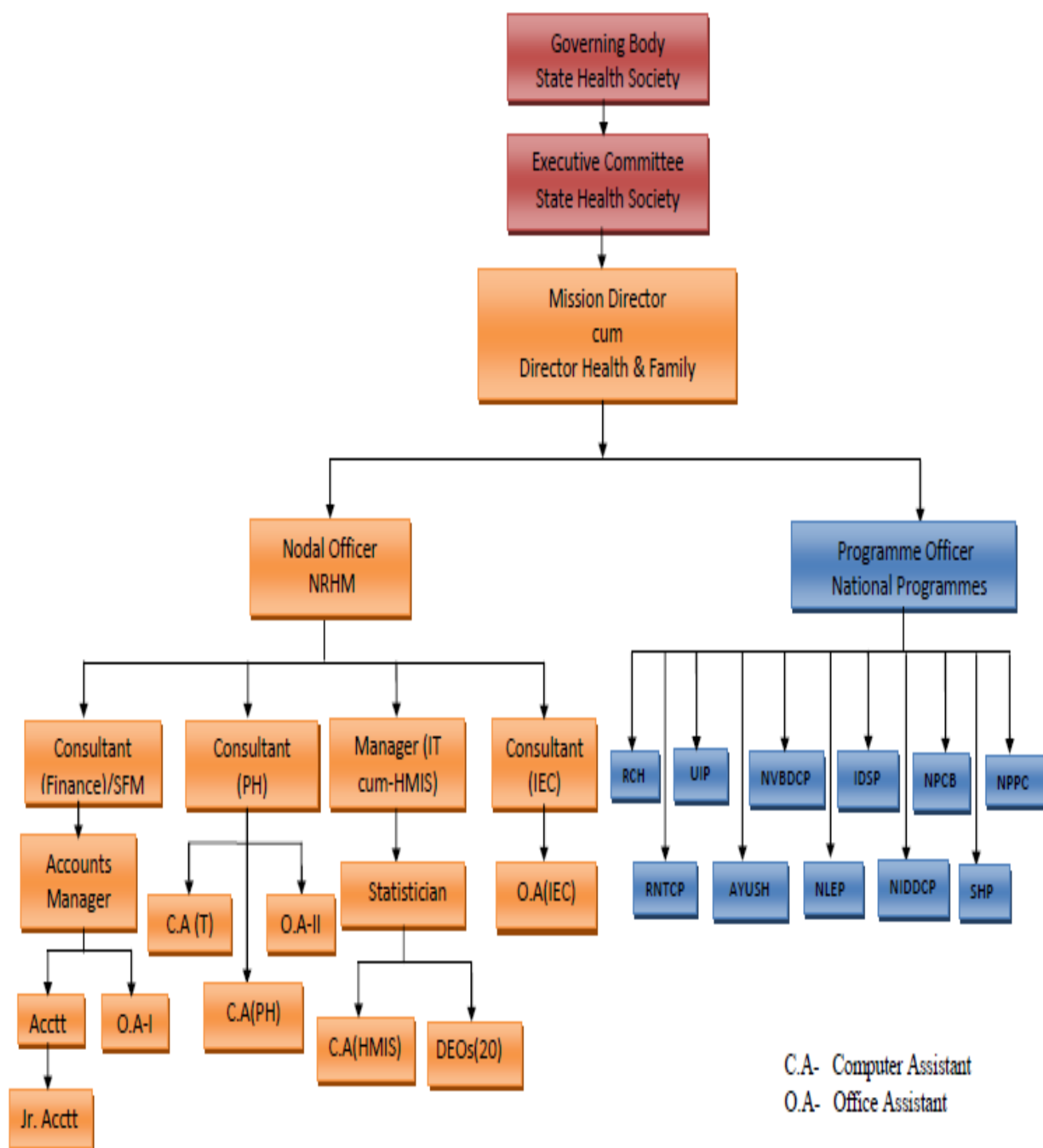
TABLE OF INDICATORS TO ASSESS THE PROGRESS

Indicators	Chandigarh Achievement	National Level Achievement
Crude Birth Rate		
SRS 2008	16.4	22.8
SRS 2009	15.9	22.5
Crude Death Rate		
SRS 2008	4.4	7.4
SRS 2009	3.9	7.3
Full Immunization (%) DLHS-3	73.0	54.1
Institutional Delivery (%) DLHS-3	74.0	47.0
Safe Delivery (%) DLHS-3	78.5	52.6
Total Unmet Need (%) DLHS-3	8.3	21.5
Health contribution to total GDP for the year 2008-09	1.72 %	

IMPACT INDICATORS	CHANDIGARH				INDIA
	2009-10	2008-09	2007-08	2006-07	2009-10
IMR*	25	28	27	23	50
MMR	NA	44***	38***	NA	254**
TFR	NA	2.1 [#]	NA	NA	2.7

Source: *SRS 2007, 08 & 09, 10, **MMR Bulletin 2009, ***Maternal death audit by PGIMER, Chandigarh;
#District Family Welfare Bureau retrieved on 30.12.2009, Chandigarh; NA-not available

ORGANOGRAM OF NRHM, CHANDIGARH, 2011 – 12



Innovations (2011-12)

PROJECT- FOUNDATION (Adoption of Villages).....

To strengthen the roots and to reinforce the cementing of the services being rendered to the beneficiary by various programmes, 'Project – Foundation' has been formulated and implemented in U.T. Chandigarh to achieve the motive of 'HEALTHY ROOTS FOR HEALTHY FRUITS' in all 22 villages of U.T, Chandigarh. The programmes implemented their activities in the adopted villages by way of conducting surveys, IEC activities, screening camps etc. First schedule of the adoption had been completed and the Programmes have moved on to the next schedule of adoption.

SWASTHYA MANCH (Intersectoral-Convergence).....

An activity by the name "SWASTHYA MANCH" has been implemented in all the 22 villages of U.T, Chandigarh since March 2010. The attempt is to utilize the platform provided during the celebration of Village Health & Nutrition Day on last Friday of every month for the overall development of the participants with regard to Health, Sanitation, Rural development and AIDS Control Society. After initial pitfalls and teething problems the venture has picked up very well. The participation of the Locals and Officials on same platform reflects the success of the initiative. The queries not dealt with are forwarded to the respective departments for the remedial purposes.

PROJECT- UDDHAR (For Slum Intervention).....

Existing five teams comprising of two ANMs, two MPHWS(M) along with a LHV to supervise them has been engaged to carry out house to house survey and immunization activities. They are armed with the motive to immunize each and every child especially the drop outs particularly in slums. They are accountable for the achievements of all the indicators of RCH amongst the beneficiaries residing in that slum thereby making an innovative effort to have a targeted approach in covering the dropouts. It has been initiated in five major slums. The generation of data as well as provision of services is authenticated by the report of coverage generated thereof and analyzed by District Immunization Officer.

- **Proposed strengthening:** Keeping in view the output and success achieved by the Mobile team it is proposed that this project may be strengthened not only for the component of Immunization and RCH but also for RNTCP and NVBDCP. The Male workers in the teams would be trained as well as

up dated regarding the job responsibility as Malaria worker and would be instructed to make a slide of fever case detected if any during the survey. They would also be sensitized on the component of RNTCP whereby the work performed by the TBHV would be carried out by them during their house to house visits in the slums.

- For the immunization component Last year only major pockets were tapped but observing the positive results achieved it is proposed that FOUR additional teams may be engaged to cover the smaller pockets of migrant settlements, nomads, construction sites, railway stations, bus stands, traffic signals, under bridges etc.... as well as for RNTCP and NVBDCP.

PROJECT – TINY-TOT

Strengthening of Health component of ICDS

There is significant convergence with the efforts of the Department of Women and Child and the Department of Health and Family Welfare, in nutrition, health and women's empowerment. At the initiation of the project in 2007, there were 369 Anganwaris. The Anganwaris are run by the Social Welfare Deptt. for the welfare of Pre School Children and for the care of pregnant, natal and lactating mothers thereof. For the effective functioning of the ICDS Scheme, the health component was being looked after by the Health Department with the help of two Medical Officers (ICDS). This was considered as inadequate. Therefore, 10 Ayush Doctors were appointed in December 2001 and the programme started running efficiently & consistently but due to the meager salary structure, three doctors left the project and the work is being carried out by seven doctors. The Anganwaris were then increased to 420 thereby increasing the load. Now, the Social Welfare Deptt. would be increasing the number of Anganwaris to 500. Therefore, it is difficult to manage the scope of work with the existing manpower and infrastructure. With existing staff the health checkup of each Anganwari can be repeated only after six to seven months thereby defeating the purpose of providing a complete and consolidated health care to the beneficiaries. In order to meet the objective of this strengthening of health component of ICDS in intention and spirit it is required to be strengthened with regard to additional manpower i.e doctors, para medical staff, medicines and vehicles under ICDS Scheme:

Name of Staff	No. of posts
Medical Officers	15
ANMs	15
Computer Asstt. / Clerk-cum Computer Operator	1
Statistician	1
Helper	2

At present the ICDS Scheme is running under the State Annual Plan and the expenditure is booked under 2210-Medical & Public Health, GMSH-16.

Since the ICDS scheme is covered under the inter-sectoral convergence with the Department of Social Welfare as such it is proposed that this scheme may be brought under the preview of National Rural Health Mission to achieve the target to IMR & MMR. **On the lines of School Health Programme the manpower requirement may be met through the NRHM and the cost of vehicles and other charges may however be continued to be borne through state budget.** This proposal is being placed to be incorporated in the Programme Implementation Plan(PIP) under Mission Flexi Pool – Head Additionalities for the F.Y 2011-12

For the year 2012-13, NRHM, Chandigarh has planned various strategies to achieve its objectives.

A. **STRATEGIES ADOPTED TO REDUCE MATERNAL DEATH(MMR)**

- Extensive Health talks to adolescents regarding the right age for marriage and delay of first pregnancy
- Detection of high risk pregnancy
- Implementation of JSSK, JSY& MCP Card.
- Micro birth planning- Improved perinatal care by ANMs,
- Improved Postnatal Care- Assured 48hrs stay in the hospital after delivery, strengthening of home visits by ANMs between 48hrs to 14 days of hospital delivery and within 24 hours of home delivery.
- Collaboration with SWD, NGOs, VHSCs.
- Health Talks with beneficiaries at the Community level and decision maker in the family.

B. **STRATEGIES ADOPTED TO REDUCE IMR**

- Provision for essential new Born Care (at Every delivery point)
 - ✓ Training in essential New Born Care (NSSK).
 - ✓ Home based New Born Care, peri natal care training.
- Expansion of services for care of sick new born at District Hospitals and NBSUs at CHC-22 and free referral transport under JSSK.

- Management of children with malnutrition, setting up of NRC, IYC at DH.
 - ✓ Infant and young Child feeding Practices and promotion of hand hygiene.
 - ✓ Micronutrient Supplementation.
- Management of Diarrheal Disease with ORS and zinc
- Management of Acute Respiratory Infections and treatment.
- Improving Immunization Coverage.
- Implementation of Mother & Child Tracking System.
- Integrated management of National and child hood illness (IMNCI) and Facility based IMNCI, Pre service IMNCI.
- Information regarding new born and sick new born care is being shared through MOHFW on regular basis.
- Formulation of Child Health Task Force Committee has been formulated.
- Health Talks with beneficiaries at the Community level and decision maker in the family.

C. **SAFE ABORTION**

- Strict implementation of MTP ACT has been done with enumeration of all MTP Centers (less than and more than two weeks)
- Linkage has been done with PC & PNDT Act The report are been analyzed on monthly basis for planning at future strategies.
- Trainings- All Tub,Vas /Minilap/C-Section/MTPs are being done by Gynae/Surgeon who are further assisted by Anesthetist. Till date no death has occurred due to complication of family planning procedure .For failure cases insurance services are being provided through ICICI Lombard Bank and the cases are regularly being discussed in the Quality assurance committee meetings.
- Health Talks with beneficiaries at the Community level and decision maker in the family.

D. **STRATEGIES ADOPTED TO REDUCE TFR**

- Quality family health survey, documentation for identification of target couples for permanent and spacing contraceptives.

- Assured family planning services at all health facilities especially on Mondays and Fridays.
- Promotion of PPIUCD for at least 50% of the couple delivering after first child at delivery point.
- Post partum sterilization for at least 15% of the patients undergoing 'C' section with at least two children and preferable all patients undergoing MTP with at least two living children.
- Promotion of perinatal care.
- Provision of Family planning counselor at District Hospital for counseling of ante natal and post natal couples.
- Promotion of male participation through NSVs.
- Training shall be finished for PPICUD, CUT 375 A before World Population Stabilization Fortnight.
- Trainings- All Tub, Vas/Minilap/C-Section/MTPs are being done by Gyne/Surgeon who are further assisted by Anesthetist. Till date no death has occurred due to complication of family planning procedure. For failure cases insurance services are being provided through ICICI Lombard Bank and the cases are regularly being discussed in the Quality assurance committee meetings.
- Health Talks with beneficiaries at the Community level and decision maker in the family.

E. STRATEGIES ADOPTED TO REDUCE CHILD SEX RATIO

- Medical audit of all the cases undergoing Ultra sound /genetic test and MTPs.
- Extensive health talks under ARSH Programme.
- Health talks with beneficiaries at the Community level and decision makers in the family
- Establishment of Gender equity cell/PCPNDT cell.
- Implementation of WIFS programme .
- Collaboration has been done with School health programme, SWDs, Education department.
- Extensive IEC in the colleges.
- Health Talks with beneficiaries at the Community level and decision maker in the family.

NEW INITIATIVES (2011-12)

❖ Integration of various health programmes for effective health care delivery

- **AYUSH- Exchange** : 3 Ayurvedic Medical officer, 3 Homoeopathic Medical officer, 1 Unani Medical officer and two Workshops have been organized on Mother & Child Development. Two exclusive AYUSH Health Melas have been held.
- **National Tobacco Control Programme:** Training workshop will be conducted for all Food and Drug Inspectors of Health Department, Police personals, School Teachers, Women self help groups, Municipal Corporation employees, Excise and Taxation and other civil societies will be sensitized. We are trying Tobacco trade under license if approved than awareness sensitization workshop will be held for Tobacco trade and enforces for the said law.
- **National Programme for Non Communicable Diseases:** Chandigarh is one of the pioneering states to have programme for control of non communicable diseases. A NCD cell has been made functional in the health department. The inter sectoral coordination committee under the chairmanship of Health Secretary will guide for policy issues and periodically review of the programme. Various cadres of health personnel (Doctors, Health Workers, Staff Nurses, Pharmacists and School Teachers will be periodically re-oriented regarding NCD its risk factor and its control. Budgetary requirement of manpower for further expansion of this programme is also being included in PIP 2011-12.
- **Under School Health Programme** integrated training/ capsule training will be provided to school health team and the school teachers to screen the school children for various diseases and treatment.
 - Medical Examination of 7000 children in AIE (Alternate Innovative Education) centres.
- **Under RNTCP** Chandigarh has always been achieving rather over shooting the target zone since the programme was launched in Jan. 2002. Various operational research (OR) projects have been undertaken by Zonal OR Committee established in PGIMER, Chandigarh. DOTS Plus Programmes is in the process of launching MDR TB during the current F. Y year and required training will be imparted to the doctors and paramedical staff.
- **Under Iodine Deficiency control Programme** all Gynecologist /Obst. And Pediatricians will be trained to screen ante natal mother and infants for hypo thyroidism to prevent mental retardation due to iodine deficiency. The external monitoring will be done by PGIMER, Sector 12, Chandigarh
- **NPPCD:** Screening of infants and poor school performers will be done for deafness.
- IEC Cell has been established in NRHM.

Recommendations

The major problem in NRHM, Chandigarh is migratory population in the union territory. Although the manpower and the other resources are adequate enough to cater the population which belongs to the Union territory, despite of this, the U.T is facing a serious crunch of manpower and funds. This is because its public health facilities are being utilized by the people belonging from Punjab, Haryana, Himachal Pradesh etc. This migratory population also leads to under registration as well as faulty indicators for Immunization, infant mortality, maternal mortality, birth rate etc. One most astonishing fact about Chandigarh is that people here are so much aware and conscious about their health that they tend to visit tertiary health care centers, even though they may have to travel a long distance. This in turn has lead to the overcrowding of the tertiary level centers such as PGIMER, GMSH- 16, CHC- 22 etc. Another major problem faced by the U.T is the media. Any small issue or even a small mistake is highlighted and comes into the eyes of the media. Another issue is relating to the Anganwari, there are a number of Anganwari centers which are placed so close to each other such that the distance between two of them is hardly 500 meters. Therefore, the Anganwari workers find it difficult to register children into their respective centers as they cover a very small area. Also the people there are so conscious about their children's education that they prefer sending their children to Government schools or private schools because they have a perception that these centers do not provide any certificate so the education provided is not of good quality.

To overcome these, the following steps can be taken:

1. The primary health care services should be focused so that firstly the health care delivery system can be improved as well as the overcrowding of the secondary and tertiary healthcare centers can be reduced. This will help in improving the quality of the healthcare delivery system and will also facilitate to prevent the media from making issues in the newspapers.
2. The indicators for the U.T should be calculated after excluding the migratory population. This population should be screened and other schemes should be initiated to cater the needs of this population.
3. For the Anganwari
 - Certificate should be provided to the students so as to make their parents believe that their children are in right hands.
 - There should be separate classes for both local and migratory students as when they are in the same class, they hinder the learnings of others.
 - Some fun activities should be arranged for students which will help them learn better.

Health Network in U.T. Chandigarh



- District Hospital - 1
- CHCs - 2
- Polyclinic - 1
- Civil dispensaries - 26
- AYUSH dispensaries - 20
- Sub centres - 16

Other Hospitals :-

PGIMER
GMCH-32
ESI Ramdarbar
Police Hospital

Primary Health Care Centers

Sr. No.	Health Care Facility	Urban	Rural	Total
1.	Allopathic Dispensaries *	22	8	30
2.	AYUSH Dispensaries			
	Ayurvedic	8	1	9
	Homoeopathic	9	1	10
	Unani	1		1
3.	Sub-centres	-	17	17
4.	Alternative Medical Units	4	11	15
	Total	44**	38	82

Number of AYUSH Dispensaries Co-located with Allopathic Dispensaries=13

*Includes 3 unsanctioned and 3 of other departments

** It includes 4 in urban slums

Allopathic Dispensaries





CDs under MC

Urban CDs (16)

- HD, Indl. Area, Phase-I, (CITCO)
- HD-11, U.T.
- CD, U.T., Sectt., Sector-9
- CD, Labour Court Complex, Sector-17, Chandigarh
- CD, Modern Complex, Manimajra
- CD, Sector-42
- CD, Sector-40
- CD, Sector-38
- CD, Sector-35
- CD, Sector-33
- CD, Sector-26
- CD, Sector-23
- CD, Sector-20
- CD, Sector-19
- UD, Sector-26
- CD-CITCO

Rural CDs(4)

- CD-Hallomajra
- CD-Kajheri
- CD-Maloya
- CD-Dadumajra



CDs Chd. Admn.

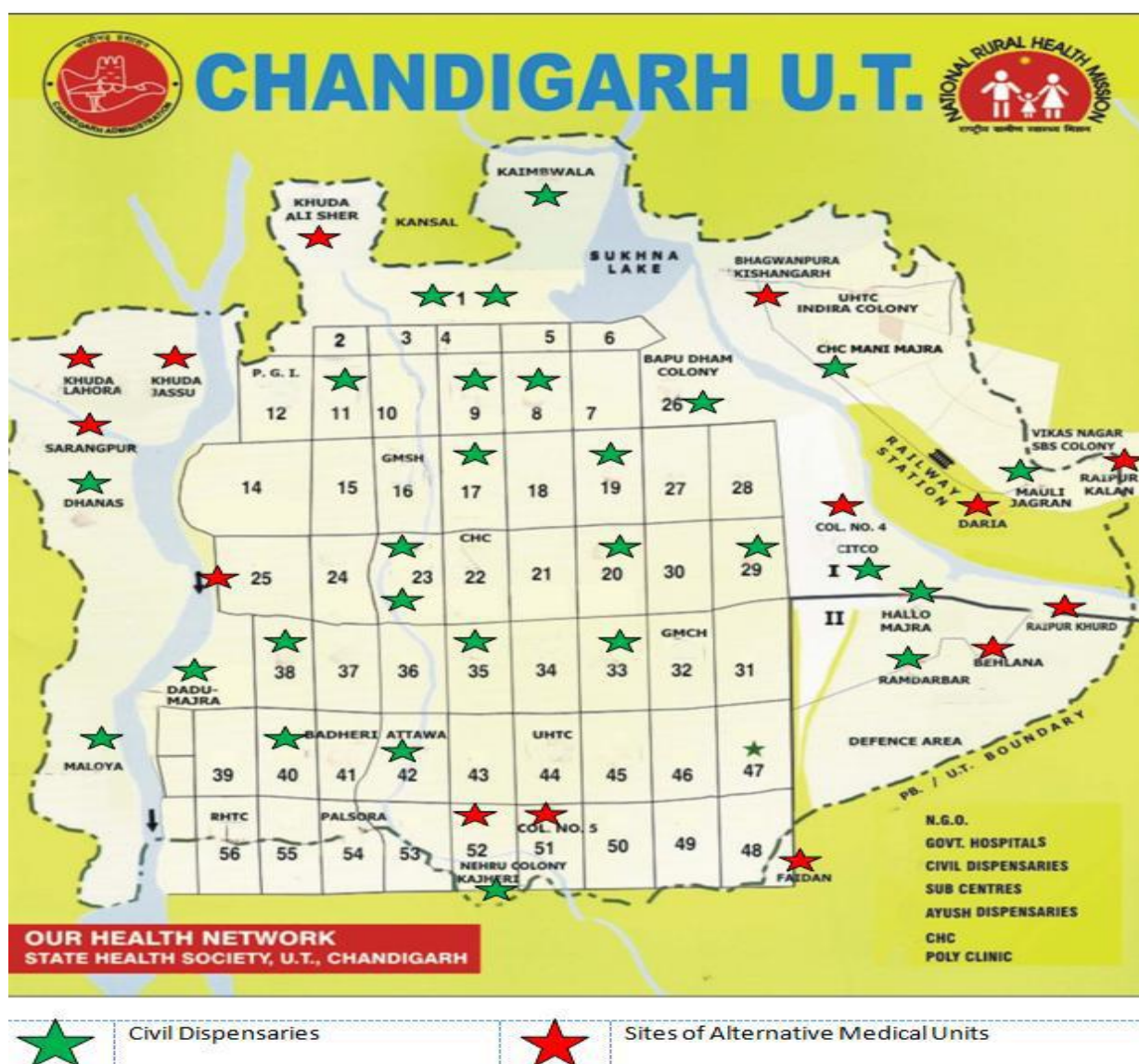
Urban CDs(4)

- CD, Punjab & Haryana High Court
- CD, Maulijagan
- ESI Disp., Sector-29
- ESI Disp., Sector-23

Rural CDs(3)

- CD, Kaimbwala
- CD-Dhanas
- CD-Karsan

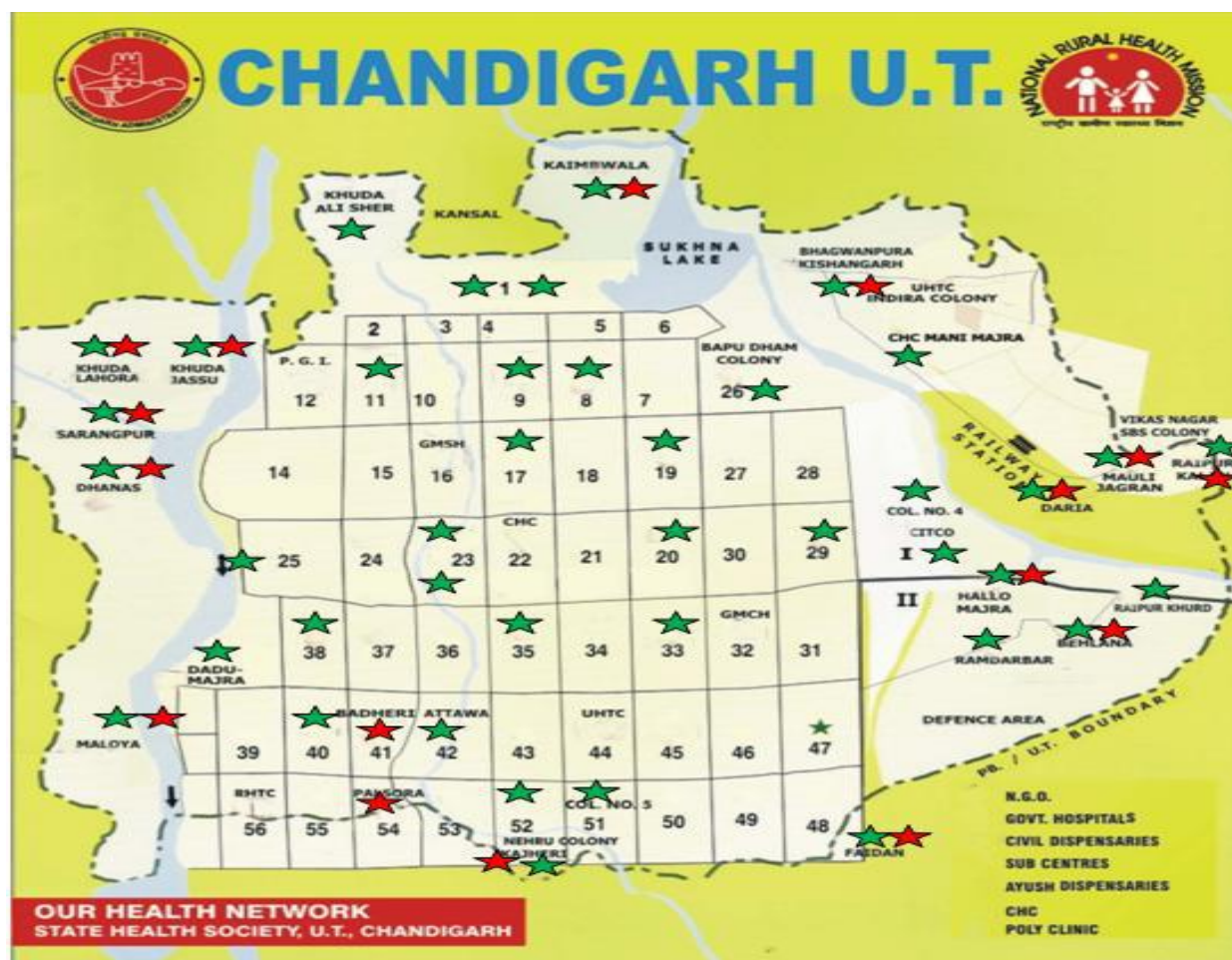
Alternative Medical Units



S. No.	Name of Village/Colony
1.	Janta Colony
2.	Village Faidan
3.	Colony No. 4
4.	Colony No. 5
5.	Village Daria
6.	* Village Makhan Majra
7.	Village Khuda Lahora
8.	Village Khuda Jassu

S. No.	Name of Village/Colony
9.	Village Kishangarh
10.	Village Khuda Ali Sher
11.	Village Raipur Khurd
12.	Village Behlana
13.	Village Raipur Kalan
14.	Sector-52
15.	Village Sarangpur

Sub-centers



★ Sub-centers (17)

Daria

Raipur Kalan

Mauli Village

Behlana

Hallomajra

Palora

Badheri

Kajheri

Maloya

★ Sub-centers (17)

Dhanas

Sarangpur

Khudda Lahora

Kaimbwala

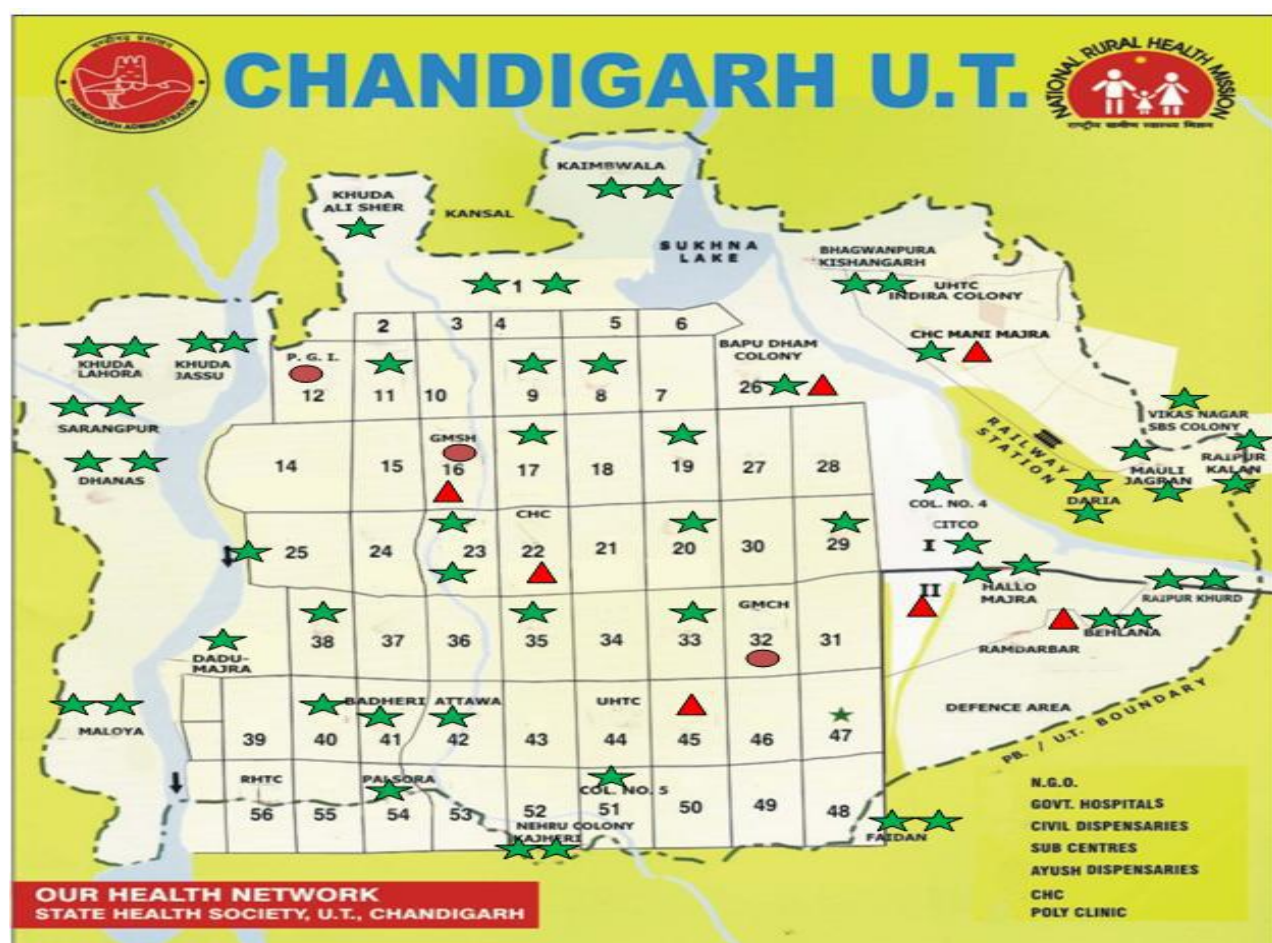
Raipur Khurd

Khudda Jassu

Kishangarh

Faidan

Secondary and Tertiary Care Health Centers



Secondary Care Health Centers

GMSH Sector-16

CHC-Manimajra

CHC-22

ESIC Ind. Area, PH:II, Ram Darbar

I.T.B.P.Behlana

Police Hospital-26

Poly Clinic-45

Tertiary Care health Centers

GMCH, Sector-32

PGIMER, Sector-12

Selective Tertiary

GMSH-16

***A Study to grade all the Civil
Dispensaries in U.T. Chandigarh and to
evaluate their performance***



IPHS
Indian Public Health Standard



National Rural Health Mission

Executive Summary

The study entitled “Study to grade all the Civil Dispensaries in U.T. Chandigarh and to evaluate their performance” was carried out with an objective to evaluate all the civil dispensaries and to find out the ones functioning well. This study mainly focused on the evaluation of the functioning of the 20 civil dispensaries located in urban, rural as well as slum areas of Chandigarh. It was conducted so as to observe the status of the health care services provided at the centers for the welfare of the community as well as establish standards so as to improve the quality of the health care delivery system.

The study included all the 20 civil dispensaries located in different areas in Chandigarh. IPHS norms were taken as standard for the grading of the public health facilities. The primary objective of the facility survey is to assess the existing situation of the health care facilities available in the government health care establishments at different levels in terms of infrastructure, staff, equipments and drugs. The Performa provided by IPHS was used as a tool for the collection of data. Infrastructure, manpower and availability of the equipments were taken as three main factors on the basis of which grades were given to each facility. The data was collected by means of an interview with the staff at the facility in order to get an overview of the problems being faced by the staff. This was further corroborated with observational evidence.

The study findings showed that 68.6 percent physical infrastructures are supported in Civil Dispensaries of Chandigarh against IPHS. On the other hand, Family welfare clinics, emergency room, and separate wards for males and females are yet to be set up. In the context of provision of MCH services, all services are provided equivalently to beneficiaries, although none of Civil Dispensary is providing MTP. On the other hand, only 25 percent have laboratory facilities. In context of manpower, Percentage of man power in Civil Dispensaries is 47.3 as laid by IPHS. It was also found that total requirement of staff at Civil Dispensaries is 300 and only 161 are in position, of which 20 are surplus in Pharmacist and Health worker, which reflects the shortage of more than 53 % staff. In context of equipment, overall availability of equipment at Civil Dispensary level was found to be 14.4 percent only. About 90 percent of equipment availability at the facility is still lacking. It was concluded that CD Maloya and CD Kajheri were performing better as compared to all the other facilities.

Introduction

All sector divisions of Chandigarh Union Territory region have undertaken for facility Survey to assess the availability of infrastructure, manpower, equipment and medicine at the health care facilities in the Primary Health Centres. The primary health care centres are known by the name of Civil Dispensaries in Chandigarh. The infrastructure, manpower, availability of equipments, provision of health care services is the same as that in case of a Primary Health Centre.

The establishment of primary health centres in India started as early as in 1952, and over the last five decades it has undergone several changes to meet the increasing demand for health care services. “The thrust has been on qualitative improvement in the health services through strengthening of physical facilities like provision of essential equipment, supply of essential drugs and consumables, construction of building and staff quarters, filling up of vacant posts of medical and paramedical staff and in-service training of staff.” In line with this, the Ministry of health and family welfare (MoHFW), Government of India (GoI) is implementing it under the NRHM umbrella.

Health Facility Survey basically offers assessment of the functioning of health facilities at all levels and focuses specifically on existing status and identified gaps in infrastructure, human resources, equipments and drugs. The rationale behind it was certainly the identification of the actual need and gaps in context with the health facilities and its determinants.

PHCs are the cornerstone of rural health services- a first port of call to a qualified doctor of the public sector in rural areas for the sick and those who directly report or referred from Sub-centres for curative, preventive and promotive health care. It acts as a referral unit for 6 sub-centres and refer out cases to Community Health Centres (CHCs-30 bedded hospital) and higher order public hospitals at sub-district and district hospitals. It has 4-6 indoor beds for patients.

PHCs are not spared from issues such as the inability to perform up to the expectation due to (i) non-availability of doctors at PHCs; (ii) even if posted, doctors do not stay at the PHC HQ; (iii) inadequate physical infrastructure and facilities; (iv) insufficient quantities of drugs; (v) lack of accountability to the public and lack of community participation; (vi) lack of set standards for monitoring quality care etc.

Standards are a means of describing the level of quality that health care organizations are expected to meet or aspire to. Key aim of these standards is to underpin the delivery of quality services which are fair and responsive to client's needs, which should be provided equitably and which deliver improvements in the

health and wellbeing of the population. Standards are the main driver for continuous improvements in quality. The performance of health care delivery organizations can be assessed against the set standards. In order to provide optimal level of quality health care, a set of standards are being recommended for Primary Health Centre to be called Indian Public Health Standards (IPHS) for PHCs.

Setting standards is a dynamic process. Currently the IPHS for Primary Health Centres has been prepared keeping in view the resources available with respect to functional requirement for PHCs with minimum standards such as building manpower, instruments, and equipments, drugs and other facilities etc.

The objectives of IPHS for PHCs are:

- i. To provide comprehensive primary health care to the community through the Primary Health Centres.
- ii. To achieve and maintain an acceptable standard of quality of care.
- iii. To make the services more responsive and sensitive to the needs of the community.

Minimum requirements at PHC for meeting the IPHS are:

- i. Medical care
- ii. Maternal and child health care
- iii. Family planning services
- iv. Training
- v. Basic laboratory services
- vi. Monitoring and supervision
- vii. Selected surgical procedures

Staffing Pattern in the PHC:

staff	existing	Recommended
Medical officer	1	3(at least 1 f)
Pharmacist	1	2
Nurse-midwife	1	5
Health workers(f)	1	1
Health educators	1	1
Health assistants	2	2
Clerks	2	2
Laboratory technician	1	2
Driver	1	Optional/vehicles may be outsourced
Class IV	4	4

Infrastructure refers to the basic support system in the form of ownership and condition of the building, and the basic facilities available within the building for the smooth functioning of the health care establishments. Some of the facilities included are supply of water, electricity, separate toilet with running water, furniture, number of beds for indoor patients, standby facility in the form of a generator, operation theatre, labour room, laboratory facility for testing blood, urine etc. is around 68.6 percent in facility wise.

Problem Statement

Health is a complex concept that involves much more than the absence of disease, a process that contributes to well-being and balance. Health is among the factors acting to conduct life and business in optimal conditions. Improving health sector performance should be a national priority due to the undeniable role that health plays in any society. Establishment of public sector performance is not an easy thing. Performance evaluation has as a fundamental goal to improve performance. Performance evaluation of public health organizations plays an important role in setting the direction in which to move a system of health care and public health policy making.

World Health Organization has set an ultimate goal of primary health care is better health for all. In order to achieve this goal, there is a need for continuous monitoring of the healthcare system and making continuous improvements with an aim to achieve this goal. There are various problems in the healthcare delivery system in India; this can be broadly classified into problems of inequality, socio economic problems and unregulated growth of private sector. In order to overcome these, it is important to improve the quality of the healthcare delivery system so as to cater the needs of the growing population. This study was carried out with an objective to improve the quality of the primary health care delivery system in Chandigarh. There is a need to establish standards for the public health facilities for the betterment of the quality of the healthcare delivery system. Performance evaluation of public health organizations plays an important role in setting the direction in which to move a system of health care and public health policy making. In this situation, performance evaluation can be treated as "benchmarking".

Rationale

The years of neglect and the lack of a comprehensive system for addressing quality issues in the health sector are quite well known. The current structure of the health care delivery system in our country does not provide enough incentives for improvement in efficiency. Mechanisms used in other countries to produce greater efficiency, accountability, and more responsible governance in hospitals are not yet deployed in India.

The for-profit private sector accounts for a substantial proportion of health care in India (50% of inpatient care and 60-70% of outpatient care), but has received relatively less attention from the policy makers as compared to the public sector. Thus the private sector health care delivery system in India has remained largely fragmented and uncontrolled, and there is a clear evidence of serious quality of care deficiencies in their practices. In the present situation there is a need to establish bodies and systems to monitor clinical and non-clinical effectiveness of the services offered in the public facilities.

Patients are our primary customers. It is therefore important to measure their health care expectations and Strive to meet those expectations 100% of the time. When patient expectations are not reasonable, we must educate so that, over time, reasonable expectations are achieved.

Review of Literature

Evaluation Study on Functioning of Primary Health Centres (PHCs) Assisted under Social Safety

Net Programme (SSNP) - the study was conducted at the instance of the Planning Commission, by the Programme Evaluation Organisation to evaluate the functioning of Primary Health Centres (PHCs) assisted under Social Safety Net Programme (SSNP) and their effectiveness in facilitating institutional deliveries. For the study, 167 patients, 24 PHCs spread over six sample districts of three states were selected. In each selected village, the views of the knowledgeable persons were taken for preparation of qualitative notes on functioning of PHCs. The study showed that of the eight essential complementary facilities including the post of lady doctor, a maximum of six facilities were created in 3 PHCs followed by five facilities in 4 PHCs, four facilities in 1 PHC and two facilities in 4 PHCs. On an average, the population coverage by a programme assisted PHC is 68386 people and it is 57705 people by a non-assisted PHC against the prescribed norm of 20,000 to 30,000 people per PHC. More coverage of population and sub-centres by a PHC in large majority of the cases are indicative of the facts that adequate numbers of PHCs have not been established against their requirement. It was also observed that since the PHCs were not equipped with diagnostic facilities, the patients preferred to visit tertiary/district hospitals for treatment of their ailments. It was revealed that 54.88 per cent of beneficiaries belonging to assisted PHCs and 94.12 per cent belonging to non-assisted PHCs have incurred private expenditure on various items while seeking treatment in PHCs. It is interesting to note that a large majority of beneficiaries of the public health delivery system have expressed willingness to pay for the services if the quality of delivery improves.

Quality assessment of child care services in primary health care settings of Central Karnataka

(Davangere District) - This study was conducted to assess the quality of service in the delivery of child health care in a primary health care setting, to evaluate client satisfaction and to assess utilization of facilities by the community. The study revealed: 1. Immunization service: Identification of needed vaccine, preparation and care was average. Vaccination technique, documentation, EPI education, maintenance of cold chain and supplies were excellent. Client satisfaction was good. 2. Growth monitoring: It was excellent except for mother's education and outreach educational session 3. Acute respiratory tract infection care: History, physical examination, ARI education were poor. Classification, treatment and referral were excellent. Client satisfaction was good. 4. Diarrheal disease care: History taking was excellent. But examination, classification, treatment, ORT education were poor. Thus it was concluded that Mothers education was not stressed by service providers. Service providers' knowledge does not go with the quality of service rendered. Physical examination of the child was not good. Except for immunization other services were average.

Quality of Healthcare Services in Rural India: The User Perspective, J K Sharma and Ritu Narang –

This study was conducted to measure the perception of users availing rural healthcare services in India with a view to provide valuable information to the policy makers about the areas that need attention for improvement in quality of healthcare. The study examines the quality of primary healthcare services in rural areas in the state of Uttar Pradesh in India by using a 23-item scale. It was observed that ‘healthcare delivery’ and ‘financial and physical access to care’ significantly impacted the perception among men while among women it was ‘healthcare delivery’ and ‘health personnel conduct and drug availability.’ It was not merely the financial and physical access that was important but the manner of delivery, the availability of various facilities, and the interpersonal and diagnostic aspect of care as well that mattered to the people with enhanced economic earnings. However, it was surprising to observe that illiterates and those with less education did not consider financial and physical access to the centres important and were willing to travel great distances for treatment. It was also observed that the overall quality of healthcare services is perceived to be higher in primary health centres than in community health centres. Inadequate availability of doctors and medical equipments, poor clinical examination, and poor quality of drugs were the important drawbacks reported at community health centres. The inadequate availability of doctors for women was also reported at primary health centres.

Quality of primary health care in Saudi Arabia: a comprehensive review, Hanan AlAhmd, Martin

Roland - This study was conducted with an objective to get an overview of quality of primary care in Saudi Arabia, and identifies factors impeding the achievement of quality, with the aim of determining how the quality of Saudi primary care could be improved. This study revealed that Good access and effective care were reported for certain services including: immunization, maternal health care, and control of epidemic diseases. Poor access and effectiveness were reported for chronic disease management programs, prescribing patterns, health education, referral patterns, and some aspects of interpersonal care including those caused by language barriers. Several factors were identified as determining whether high-quality care was delivered. Thus it was concluded that there is substantial variation in the quality of Saudi primary care services. In order to improve quality, there is a need to improve the management and organization of primary care services. Professional development strategies are also needed to improve the knowledge and skills of staff.

OBJECTIVES

The primary objective of the facility survey is to assess the existing situation of the health care facilities available in the government health care establishments at different levels as well as to identify the gaps in terms of infrastructure, staff, equipments and drugs.

The main objectives of the facility survey are to assess:

- Percent of Infrastructure facilities as per the IPHS norms.
- To identify the gaps of manpower as per IPHS norms.
- Percentage availability of equipments as per IPHS norms.

METHODOLOGY

Study Population - All 20 Primary Health Centres are included in facility survey. The staff members present at the facility was interviewed for data collection.

Study Design – Cross – Sectional

Data Collection Tool – IPHS Performa for Primary Health Centers was used for data collection. It included questions for observation by the interviewer, open as well as close ended questions and a check list for verification of the facilities provided by the facility as well as its infrastructure.

Criterion for evaluating performance - The following critical input has been considered in this report:

- Infrastructure: Ownership of the building, water supply, electricity, Separate toilet, generator, vehicle, phone, laboratory, no. of beds, labour room, waste disposal and blood bank facility.
- Staff: All type of staff are considered as per IPHS norms.
- Equipment: IPHS list of equipment for different facilities are used.

By health services infrastructure, we mean the structures, functions and resources required to provide a range of health programmes and services-facilities, manpower, management, information, logistics, transport and supplies. It is through an appropriately organized infrastructure that health care programmes can be effectively implemented. The health system infrastructure needed for primary health care is comprised of the physical structures and the functional capacities needed to support all primary health care activities. This includes health services infrastructure such as facilities, including equipment; supplies and communications; health manpower, including education, training and supervision; planning, management and evaluation; financing; information systems, including health surveillance and programme monitoring; and possibly action-oriented research. It is the infrastructure which makes it possible to assess a population's health problems, to extend health care to communities and to people and groups with special needs, to ensure that manpower is deployed according to need, and to monitor the effectiveness of programmes.

In context of manpower, comprehensive health care relies on adequate numbers and distribution of trained physicians, nurses, allied health professions, community health workers and others working as a health team and supported at the local and referral levels. India's health workforce is made up of a range of health workers who offer health-care services in different specialties of medicine (panel 2). The workforce includes many informal medical practitioners, generally called registered medical practitioners, such as traditional birth attendants (known locally as dais), herbalists, snake-bite curers, and bone setters. For most

of the population, especially the poor, registered medical practitioners are often the first point of contact for treatment.

Availability of essential equipments is necessary to provide basic laboratory tests with an objective to avoid overcrowding of secondary and tertiary healthcare centres and at the same time to reduce the direct as well as indirect costs incurred by the patients in visiting the secondary or tertiary healthcare centres.

Results

INFRASTRUCTURE : Table 1 presents the percentage of PHCs with selected infrastructure facilities much as own building, toilet facility, continuous supply of tap water, electricity, labour room, laboratory, telephone, functional vehicle and beds for in-patients in each state. In the region 20 PHCs reported, 95 percent are functioning in government building in good conditions, but only 65 percent have separate toilet, 65 percent have regular tap water supply and 55 percent of the PHCs continuous power supply, while 30% have a labour room.

- 68.6 percent physical infrastructures supported in PHCs of Chandigarh against IPHS.
- Only 11 PHC have regular electricity supply with no power cuts, also no power back-up mechanism present at all PHCS.
- Separate toilets are 65 percent, while cleanliness ranges from poor to fair only.
- Family welfare clinics, emergency room, and separate wards for males and females are yet to be set up.
- In the context of provision of MCH services, all services are provided equivalently to beneficiaries, although none of PHC is providing MTP. The availability of laboratory in PHC to test blood and urine of the women seeking antenatal cure as well as for the diagnosis of RTI/STI among men and women is critical. Out of the 20 PHCs surveyed only 25 percent have laboratory facilities.
- For communication purposes, especially as the PHCs are supposed to refer the complicated cases to higher health facilities, the telephone facility in PHC is very important, but it is a scare facility in a PHC. Only 5% PHCs have a telephone connection.

TABLE 1

Physical Infrastructure	Existing pattern	Recommended	Total number recommended in 20 PHC	Current Status at PHC	Identified Gaps
Government building for PHC	1	1	20	19	1
Prominent Display Boards	1	1	20	19	1
Registration Counter	1	1	20	20	0
Water supply piped	1	1	20	13	7
Pharmacy for drug dispensing & storage	1	1	20	20	0
Separate Public utilities for males	1	1	20	13	7

& females					
Suggestion/ Complaintbox1	1	1	20	14	15
Family welfare clinic	1	1	20	20	0
Waiting room	1	1	20	19	1
Emergency room	1	1	20	6	14
Separate Wards for males & females	1	1	20	1	16
Number of beds	4-6 beds	4-6 beds	80-120 beds	0	80-120 beds
Labor room	1	1	20	0	20

MAN POWER: The availability of Medical Officer (MO) is the essential part of PHC, as it is the first interface place of patient's interaction with doctor. Percentage of man power in PHCs against laid by IPHS is 47.3. At least 2 doctors, of which 1 maybe from AYUSH.

- 62.5 percent of manpower is available as per all PHCs considered.
- The health assistants (Female) also known as ANM's has a key role to play in the implementation of RCH programme at grass root level. 6 ANM's are looking after the work of 16 Sub Centres. There is a gap of 34 ANM's as per IPHS norms.
- Total requirement of staff at PHC's is 300 and only 161 staff are in position, of which 20 are surplus in Pharmacist and Health worker, which reflects the shortage of more than 53 % staff.
- There is, specially, a shortage of MO (15), Nurse (36), health assistant (34), clerks (39) and class IV (46).
- As shown in Table 2.

TABLE 2

Personnel	Existing pattern	Recommended	Total number recommended in 20 PHCs	Current STAFF at PHCs	Identified Gaps
Medical Officer	1	2 (one may be from AYUSH and one other Medical Officer preferably a Lady Doctor)	40	25	15
Pharmacist	1	1	20	31	-11

Nurse - Midwife (Staff Nurse)	1	3 (for 24 hour PHCs; 2 may be contractual))	60	24	36
Health Worker (Female)	1	1	20	29	-9
Health Educator	1	1	20	4	16
Health Assistant (One male and One female)	2	2	40	6	34
Clerks	2	2	40	1	39
Laboratory Technician	1	1	20	7	13
Driver	1	Optional; vehicles may be out-sourced		0	
Class VI	4	4	80	34	46

EQUIPMENT: In the context of provision of services of institutional deliveries, the availability of equipment in PHCs is essential. Over all availability of equipment at PHC level was found only 14.4 percent only. ABOUT 90 percent of equipment availability at PHCs is still lacking.

As shown in Table 3.

TABLE 3

Equipments	Existing pattern	Recommended	Total number recommended in 20 PHC	Current Status at PHC	Identified Gaps
DEEP FRIZER	1	1	20	2	18
I.L.R	1	1	20	3	17
BP APPRATUS	1	1	20	2	18
STATHOSCOPE	1	1	20	2	18
NEEDLE CUTTER	1	1	20	2	18
OXYGEN CYLINDER	1	1	20	1	19
Wheel chair	1	1	20	1	19
Stretcher / Trolley	1	1	20	5	15
Oxygen Trolley	1	1	20	8	12

Discussion

The study revealed that the PHCs were lacking in the basic physical infrastructure as per the norms laid by IPHS. It was observed that the PHCs in Chandigarh were supported by only 68.6% of the physical infrastructure. Although, separate toilets for both the sexes were available at 65% of the centers but the cleanliness ranged from poor to fair. The PHCs were found to be lacking Family welfare clinics, Emergency rooms and separate wards for males and females. Even the availability of labor room was 30%. Power back up mechanism was also lacking at all the facilities. It was observed that there was no provision of MTP services in context with MCH. Basic laboratory facilities were also lacking as only 25% of the centers were equipped with the laboratory facilities. The most critical factor, referral services were very poor at the centers which accounted for the main reason for the overcrowding of the Government hospital – sector 16, Community Health Center – sector 22 and PGIMER.

In context of human resources, the study revealed that the PHCs were also facing shortage of manpower which hindered the delivery of quality healthcare to the patients. It was observed that the PHCs were supported with only 47.3% manpower as per the norms of IPHS. Thereby, suffering a shortage of 52.7% manpower. It was also observed that the PHCs suffered a shortage of 34 ANMs as per IPHS which hinders the effective implementation of RCH program at grass root level. Total requirement of staff at PHC's is 300 and only 161 staff are in position, of which 20 are surplus in Pharmacist and Health worker, which reflects the shortage of more than 53 % staff.

The study also revealed the fact that the PHCs were facing a shortage of equipments. The PHCs were found to be equipped with only 14.4% of the essential equipments as against the IPHS norms.

Thus, it was concluded that among all the PHCs functioning in Chandigarh, CD- Malloya and CD- Khajeri were performing better as compared to others. Therefore, there is a need to take certain important steps to improve the quality of primary healthcare services provided by these centres.

Recommendations

1. The first step should be to benchmark the 2 best performing centres i.e. CD- Malloya and CD- Khajeri, so that other centres can be motivated to perform better with the existing resources.
2. The next important step should be to improve the referral services. The PHCs should be provided with all the basic equipments and drug supplies and above all a telephone so as to cope up with the emergency cases and referral cases. This will help reduce the overcrowding of the tertiary and secondary healthcare centres, thereby, improving the quality of healthcare delivery system.
3. The centres should be supported with labour rooms so as to promote the institutional deliveries which will further help reduce the maternal mortality as well as infant mortality rate.
4. The centres should be provided with the basic equipments like stethoscope, wheel chair, BP apparatus etc.

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