SECTION-III

Analysis and Findings:

A: Location, Population Coverage and Years of Functioning of Urban Health Posts and Urban Family Welfare Centres

The Table 1 shows the number of urban family welfare centres (UFWCs)/urban health posts (UHPs) and the average population coverage of the facilities by state. In the country as a whole, total 1529 UFWCs/UHPs are currently functioning. On an average at the national level, each facility covers around 55376 urban population, specifically urban slum dwellers and urban poor.

It is interesting to note that around 64 percent of the total facilities are functioning in the state of Andhra Pradesh, Gujarat, Madhya Pradesh, Maharashtra, Tamil Nadu, and Uttar Pradesh. The facilities existing in different states vary in population coverage. Among major states, a facility in Bihar on an average caters the primary and RCH care needs of around 110 thousand urban poor. On the other hand, the average population covered by a facility in urban Rajasthan is around 5535 people. The average population coverage indicates workload on UFWCs/UHPs. Haryana, Punjab, Tamil Nadu, Andhra Pradesh, and West Bengal are at an advantageous position in the country, as the population coverage per facility is lower than the national level. Further, it is surprising to note that the size of average population coverage is unexpectedly high in case of newly constituted states viz; Chhattisgarh, Jharkhand, and Uttaranchal.
The distribution of urban family welfare centres and urban health posts by duration of functioning status reveals that around 53 percent facilities are working since last 30 and above years. Around 17 percent facilities have completed two decades in providing primary health care needs of urban poor. The rest are relatively younger by age, and among them mostly are urban health posts (see Figure 1).

![Figure 1: Distribution of UHPs / UFWCs by Duration of Functioning Status (in Years) of UHP's and UFWC's in India, 2004-05.](image)

**B: Basic Amenities and Transportation**

Table 2 reveals the distribution of urban family welfare centres/urban health posts by type of building. The table suggests that only 55 percent of the total facilities are having their own building which is provided by the government. Around one-fifth of facilities are attached to either hospital or urban health centres. The percentage of the total facilities functioning either in rented building or donated/ voluntary
society building is near about same. Moreover, it is important to note that one urban family welfare centre is being operated from the house of Public Health Nurse in Delhi.

The distribution of basic amenities with facilities and mode of transportation for workers to deliver the services generally adopted are shown in Table 3. It is to be noted that these information have been collected only from those facilities which are running in the government buildings. It is observed that the tap water supply is available with 82 percent of the total facilities. More than 90 percent facilities are electrified and having toilet facility as well within the premises of the building. Specifically, it is seen that around 45 percent facilities do not have any mode of transportation, and therefore, workers reach clients by walking to discharge health care services. Only four percent of facilities do have a car/jeep to do so. This seems to be quite low as most of the facilities cover a wider urban area.

C: Controlling Authorities, Manpower, Staffing and Training

It is always important to know the controlling authorities for existing facilities in the country. In this connection, it is observed that District Health Officers (DHOs)/Chief Health and Medical Officers (CHMOs)/Chief Medical Officers (CMOs)/Officials at Department of Family Welfare are the controlling authority for 60 percent facilities. Around 27 percent facilities are controlled by local bodies/municipal corporation or Block Medical Officers. The remaining 12 percent centres/posts are under the control of non-government organizations, trust, Civil Surgeon, Medical Officer, Medical Superintendents of Hospital, and principal RMPTC as a whole (Figure 2).

The distribution of respondents by their designations depicts that one-third among them were working as a full time medical officer
appointed at the facilities. Female health workers and public health nurses together added to 40 percent of the total respondents interviewed in this study. A large number of other non-paramedical personnel whose nomenclatures of designations vary state to state have also been interviewed (Figure 3).

It is well understood that the implementation of a programme or policy is difficult without adequate human resources availability. Specifically, in any health care system it is mandatory to have necessary skilled manpower to provide services in safe, effective and satisfactory manner. Therefore, each type of urban health posts/urban family welfare centres have a specified staffing pattern. A UFWC, which covers more than 50,000 urban poor, is supposed to have one medical officer, one public health nurse/lady health worker, two female multipurpose workers, one male multipurpose worker, and one clerk.

On the other side, a UHP that covers above 25,000 urban poor should have one medical officer, one public health nurse, three to four female multipurpose workers, three to four male multipurpose workers, and one clerk. Such a staffing pattern seems to be highly inadequate as more and more components under primary health care services and family welfare services have been added time to time since the onset of these centers/posts. In this regards, this report brought out a few hard facts. Further, it is unfortunate that the data suffer from the non-responses on this aspect. Nevertheless, the available data are enough to know the situation of sanctioned as well as positioned medical and para-medical personnel at enumerated facilities.

The Table 4 shows the distribution of medical and para-medical personnel by sex sanctioned to UHPs/UFWCs in India. It can be easily observed that at least one male medical officer was sanctioned to 21 percent facilities. In case of female the figures appear to be impressive as
at least one female medical officer was sanctioned to 72 percent facilities. For paramedical staff, only 34 percent facilities have got sanction to appoint a male public health nurse, and 83 percent for female public health nurse. The situation is quite poor in term of sanctioning a pharmacist at facilities. Though, a large number of facilities got a contractual female health worker sanctioned.

It is rather more important to know about the situation of existing manpower at the facilities. Table 5 provides the facts about the staff (medical and para-medical) working at the UFWCs/UHPs. Around 37 percent facilities are equipped with a male medical officer, and 66 percent facilities with a female medical officer.

The Table 6 gives more meaningful results, as 64 percent of 1039 facilities those reported about the current position of medical officer are equipped with either a male or a female medical officer. According to criterion all facilities should have at least one Public Health Nurse. However, this study reveals that about 13 percent facilities do not even have either a male or a female public health nurse. Further, only 216 facilities provide the information about positioning of pharmacists. Of those, 38 percent have managed to appoint a pharmacist. The data reveals that 930 facilities (out of 1516 those reported population coverage) should have one medical officer positioned as per the criterion laid down for the UHPs/UFWCs by the Ministry of Health and Family Welfare, Government of India. Therefore, around 29 percent facilities should recruit a male/female medical officer on urgent basis; otherwise, it would be difficult to deliver health care services as per the stipulated standard.

As the programmes change frequently, specially, after paradigm shift since 1994 ICPD, health facilities must have specialist to deal with a much critical situation at local level. Looking into this aspect, Table 7 was generated. It provides information about the percentage of facilities those
are having at least one health personnel trained in the specified training programmes.

The figures show that 90 percent facilities have the health personnel trained in one or the other aspects of basic and primary health care or reproductive and child health care. Despite that 79 percent facilities do have at least one trained personnel in the area of reproductive and child health care services. However, facilities are lacking in terms of having personnel who have undergone training programmes related to infant and child care i.e. Universal Immunization Programmes (33 percent), Control of Diarrhoeal Diseases/Oral Rehydration Therapy (21 percent), and Acute Respiratory Infections (20 percent). It would be appropriate to suggest that all the facilities spread over country should have at least one health personnel trained in the above areas of child health care. This may make radical changes in reducing high infant and child mortality. It is known that a significant proportion of deaths among children occurred due to delay and inaccessibility of services to treat diarrhoeal diseases, pneumonia and acute respiratory infections. This is well established that these diseases are more prevalent in congested, improper sanitation, poor ventilated, polluted, and unhygienic areas like urban slums. The concepts of child survival and safe motherhood (CSSM) and RCH are overlapping. Unfortunately, more than half facilities need trained personnel in area of the former one.

It is known from various research that the success of IUD popularity increases as the acceptors are followed up by family planning workers. Therefore, it is required to have personnel trained in the areas of IUD insertion. Only half of the facilities do have a trained staff in IUD insertion. As a whole, around two-third of the total facilities have at least one medical or para-medical staff trained in different areas like RTIs/STIs treatment, HIV/AIDS counseling, laparoscopic sterilization, NSV and ISM programmes etc.
D: Availability, Functioning and Adequacy of Equipments

It has been proven that scarcity in physical infrastructure and human resources is possible to mitigate with managerial skills. However, no service can be delivered unless facilities have appropriate tools, equipments, and supply of items in adequate quantity. In relation to it, Table 8 and Table 9 are prepared to study these factors. It can be observed from the Table 8 that only about two-third of the total facilities possess weighing machine (Infant), and of those around 13 percent are non-functional. It is surprising to see the figures for haemoglobinometer, which are not available with near about 61 percent facilities, and again some of them have been reported to be in nonworking condition. The importance of these two items is highly recognized as far as maternal and child care services are concerned. It is interesting to note that a slightly higher than one-third of the total facilities possess medicine chest, which is important to contain and preserve medicines of different kinds.

It is also seen that a large proportion of urban health posts/urban family welfare centres are having examination table, weighing machine (Adult), B.P. instrument, speculum, vaccine/day carrier. On the other hand, above 70 percent facilities have stove, pressure cooker and stethoscope available with them.

Table 9 provides the adequacy and availability of a few important medical instruments, medicines and other peripheral items used in health care system. It may be noted that only 54 percent facilities do have adequate number of needles for next one month. Though, the adequate numbers of disposable syringes for the next one month are available with 60 percent of the facilities. The situation is not very favourable in case of reagents, only 13 percent facilities do have adequate stock of reagent. The next critical item, ORS packets for next one month are not available in adequate number to more than 40 percent facilities.
The other less critical items, but important for programme monitoring and evaluation point of view, such as immunization cards, eligible couple register, MCH cards for a given period are not available in adequate amount to one-third of the total facilities. A positive feature has also been observed that around 81 percent facilities some or other kinds of register available in adequate number for the next one month.

**E: Performance of UHPs/UFWCs for Given Services and Attendees Turnover per OPD**

It is difficult and, more so, ambiguous to evaluate the performance of any health care system taking all the factors into account. Therefore, seven most crucial services in family planning, primary health care and reproductive and child health care have been incorporated to see the performance of UHPs/UFWCs in the last financial year. These services are given below:

1. Number of women received antenatal checkups
2. Number of women visited during postnatal period
3. Number of children treated for ARIs and Diarrhoea
4. Number of delivery conducted by PHN/MO at facility
5. Number of IUDs inserted by PHN/MO
6. Number of sterilization (male and female) conducted
7. Number of complicated cases referred

Table 10 provides average number of persons served per UHP/UFWC for selected services in each state. On average, a facility serves to 4515 individuals in the country as a whole. For the state of Maharashtra, the average is the maximum; about 8672 individuals per facility followed by the state of Madhya Pradesh, 7106 individuals per facility. It is to be mentioned that average number of persons who seek the selected services from UHPs/UFWCs is lower for all other major states than the national level average. The performance of facilities in the states
like Uttar Pradesh and Tamil Nadu is quite similar to the performance at
the national level. The states like Rajasthan, Haryana, Himachal Pradesh,
and Bihar are lagging behind as far as performance of facilities for
selected services in the last financial year is concerned. Nevertheless, the
performance of facilities can not be said poor as the average population
coverage is itself much lower than the other states.

In the national capital territory Delhi, on an average 5174 persons
received the selected health care services in the last financial year. Among
newly constituted states, Chattisgarh has done well and its each facility
provides above services to an average of 5429 urban poor. One should be
careful to interpret the results shown in the Table 10, as the figures may
be accurate due to improper maintenance of annual records at the
facilities.

The state and the national level figures of the average annual
attendees per facility are given for three consecutive financial years (Table
11). The table clearly reflects that around 35 percent facilities could not
provide information regarding attendances in OPD. The average of annual
attendees per OPD reveals an upward trend during 2000 to 2003 at the
national level. On an average, an OPD is attended by 33016 urban poor to
receive any kind of primary health care service in the country as a whole
in the financial year 2002-03.

The state level statistics show that the averages of annual attendees
per OPD in all three financial years are consistently high for Gujarat,
Himachal Pradesh, Tamil Nadu and Madhaya Pradesh. In that,
Rajasthan, New Delhi and Chhattisgarh are at moderate level. The
average is lower for Andhra Pradesh, Bihar, Jharkhand, Karnataka,
Maharashtra, and Punjab. It is to be noted that average annual attendees
per OPD is necessary but may not be sufficient to evaluate the
performance of facilities, because it does not capture the quality component.

**F: Suggestions to Improve UHPs/UFWCs Functioning**

In this study respondents were asked to give suggestions to improve their facilities in specific areas viz; supply of medicines, manpower, financial aspects, space or infrastructure, testing facilities, and publicity. The most frequent suggestion in each area has been presented in Table 12. It reveals that around 58 percent respondents want regular supply of medicines to improve their UHPs/UFWCs. Asking about the improvement in manpower, around half of the respondents express the requirement of paramedical personnel. Regarding financial aspects, around one-third suggested that admissible contingency/traveling allowances should increase.

In term space or infrastructure requirement, the prominent suggestion of around half of the respondents was to provide a labor room and staff quarters to improve the functioning of their facilities. It is observed that only one-third respondents mentioned that the functioning of their centre/post can be improved by opening a laboratory for testing facilities. Around half of the total respondents require a public address system or IEC materials to do the publicity of ongoing health care programmes at their facilities.

**G: Opinion of Field Investigators about Cleanliness at UHPs/UFWCs**

In general, neat and tidy places attract every human being. The health care facilities are supposed to spread messages regarding the importance of public hygiene and sanitation in day to day life of urban poor. Therefore, it becomes rather more important to have a higher level of cleanliness in the facility premises and its surroundings. This will help to quarantine many infectious as well as respiratory diseases. Keeping
this in mind, this study evaluates the cleanliness in the facility buildings, premises, and its other departments. Three points scale has been used to assess the cleanliness; good, satisfactory and unsatisfactory.

Table 13 provides the opinion of investigators about the cleanliness of the different places of an UHP/UFWC in India. It may be reported that only 43 percent facility buildings and 35 percent facility premises maintained good cleanliness. Around half of the total facilities have doctor’s room in a good condition of cleanliness whereas 38 percent are able keep them with satisfactory level of cleanliness. The cleanliness of dispensing room of the facilities is more crucial. The study shows that around 38 percent dispensing rooms were cleaned nicely, and 47 percent were clean up to satisfactory level. The clean condition of laboratory can avoid the contamination of the collected sample and chemical agents available over there. The data reveals that around 41 percent laboratories were good cleaned and 46 percent were up to satisfactory level. It is also seen that the surroundings of only one-third of dispensaries is rated in a good condition of cleanliness. Though, around 48 percent dispensaries do have satisfactory level of clean surroundings, and remaining 19 percent were found to be with unsatisfactory level.

**H: Overall Grading of UHPs/UFWCs**

This study attempt to rank urban health posts or urban family welfare centres assigning equal score to some of the parameters considered under the availability of manpower, equipments in working condition, and regularity in supply of selected items (Table 14). Only those parameters have been chosen to grade a facility that assumed to be most essential in providing basic and primary health care, reproductive and child health care, and family planning services. The selected entities that have been used for the purpose are given below;
Manpower availability

Male Medical Officer, Female Medical Officer, Public Health Nurse (Male and Female), Female Health Worker (Male and Female), Contractual Female Health Worker (Female) Part Time Female Health Worker, Part Time Male Health Worker, Pharmacist (Male and Female) Grade D Employee

Availability of equipments in working condition

B.P. Instrument, Stethoscope, Haemoglobinometer, Speculum, Needles, Syringes

Regular and adequate supply of drugs, contraceptives and other items

ORS packets, Reagent strips, Lubricated Nirodh, IUD's, Reagent Strips for Urine test, IFA Tablet (Small/ Large), TT Injection, Vitamin A, Cotrimoxozole tablets and Disposable Delivery Kit, BCG, DPT, Measles Injections, and OPV drop.

The possession of each component listed above for manpower, equipments, and supply will give ‘1’ point to a facility, otherwise ‘0’ is assigned to it. A facility having total score less than 11 points is accredited as poor. Those earn total score between 11 and 19 points are accredited as below average. A total score between 20 to 24 points indicates a facility as of average grade. A facility with a total score of 25 and above is accredited as good.

Table 14 depicted that around one-third of the total facilities are accredited as good at the country level. Around one-fourth of the facilities are graded as below average. It is unfortunate that 99 facilities have been graded as poor, and most of these belong to Haryana, Maharashtra, and
Tamil Nadu. The average grade is earned by the rest 35 percent facilities of the country (see figure 4).

The state level grading of UHPs/UFWCs shows that Gujarat, Himachal Pradesh, Karnataka, Madhya Pradesh, Punjab, Rajasthan, West Bengal, Delhi and Chhattisgarh are doing well. Each one among these states is having two-thirds of their facilities accredited as either in average or good grade. On the contrary, Andhra Pradesh, Haryana, Tamil Nadu, Uttar Pradesh and Jharkhand seems to be lagging behind as a large percent (more than 45 percent) of facilities are falling under poor and below average grading. Among these states Haryana shows the poorest picture where 77 percent of the total facilities are accredited either as poor or below average. It is to be noted that the urban family welfare centre attached to Gousia Hospital Khanyar in district Srinagar earns zero score. The maximum 33 points have been earned by urban family welfare attached to Bagar Hospital in district Jodhpur of Rajasthan.

I: Socio-economic Status of Beneficiaries and Utilization of Services

The quality of care can be studied in client’s perspective or provider’s perspective or mix of the two. In recent literature, the mixed is documented as more appropriate in various settings (Bruce, 1992). In view of this, a total of 3858 respondents were interviewed, randomly, soon after they received services at the facilities. Although, it was planned to conduct two exit interviews from each facility, but some of the population research centres have conducted upto three interviews per facility. Therefore, it was an additional advantage to append the extra interviews conducted with beneficiaries. The table 10 depicts the distribution of beneficiaries, who were urban poor, by gender, age, education and occupation. It reveals that around 86 percent beneficiaries were female. In
general, around three-fourths of the total beneficiaries age between 19 and 34 years, which is a prime age band for childbearing.

It is to be noted that a majority of beneficiaries were literate, and about 18 percent of them attained more than ten years of schooling. A large proportion of beneficiaries have reported their occupation as household chores. This may include both paid, unpaid household maid, and largely women who are looking after household chores. On the other side, around 36 percent beneficiaries are having occupation other than the categories specified over here. The percentage of beneficiaries in labourers category, which was expected to be higher in urban slums, was only nine.

Table 2 shows service utilization pattern of urban poor for primary health and reproductive and child health care services available at urban health posts and urban family welfare centres. For female beneficiaries, it is found that 29 percent of them visited the facilities for antenatal checkups and 28 percent came to get immunization or vaccination services for their children. As expected, the utilization of family planning services among female beneficiaries is slightly higher than male beneficiaries. More often women or men, who are in childbearing age, are utilizing the services, as they require primary and RCH care during family building process. Again, among younger beneficiaries, the percentages of antenatal checkups and immunization or vaccination receivers are high. The utilization of immunization and vaccination among beneficiaries above age 30 is found to be higher. It indicates that they must have brought their children to avail these services. Analysing utilization by education, there is no specified trend has emerged. It means that services available at UHPs/UFWCs are accessible to all urban poor irrespective of their educational background.
The occupational structure may be taken as an indirect measure of household level or individual level income. However, it is not always relevant in all the settings as household sole earner, more often males in India, are likely to be at the workplace. Therefore, to get meaningful results, all beneficiaries are divided into two categories; household chores and others. It seems that beneficiaries (30 percent) who involved in household chores are more often go to the facilities receiving immunization and vaccination care for their children. On the contrary, the beneficiaries from other kinds of occupations are more in percentage to receive family planning services and antenatal care, around 19 percent and 29 percent respectively. No background characteristics do make any significant difference in receiving ORS and other health care services from the facilities available in urban slums.

**J: Quality of Care at UHPs and UFWCs: A Clients’ Perspective**

This study also focuses on the quality of care provided at the facilities. It includes client’s satisfaction, waiting time in receiving services, behaviour of doctor and health worker. It also envisages on accessibility of facility, follow-up services in terms of home visit by health workers in the last one month, and frequency of health workers’ visits to the community. The data from beneficiary survey reveals that most of the respondents got services within half an hour, and more so, around one-fourth received services within no time. And the majority of the beneficiaries reported that behaviour of doctor and health worker was good while providing services. Quality of care in terms of accessibility of health facilities, around 56 percent beneficiaries responded that it was convenient, and 30 percent reported very convenient too.

In general, around 63 percent beneficiaries reported that health workers visited to their home or community at least once during the last one month preceding the survey date. But, the strong interventions are
required where there was no home or community visit by health worker during the same reference period. It may be seen that around one-fourth of the total beneficiaries said that no health worker visited their community or home during the last one month. It may be inferred that quality of care towards follow-up services needs an improvement. Seeking responses on frequency of health workers’ visits, quality of care component at the facilities has a few positive features too, as 22 percent beneficiaries reported that health workers visited their home or community daily or weekly basis (Figure below).

![Pie Chart](image-url)

**Figure 4: Frequency of Home/Community Visited by Health Worker**