CHAPTER - V

ANALYSIS AND INTERPRETATION

This chapter deals with analysis and interpretation of the study. The present chapter is divided into six parts according to the objectives of the study. The first part will intend to focus on the service delivery and administrative setup of NRHM, the second part will focus on the socio-economic conditions of patient visiting BPHC, the third part will be on nature and types services offered by BPHC, the fourth part will be on perceptions of patient about the services, the fifth part will deal with the role and intervention of grassroots actors like PRI, ANM and ASHA in governing BPHC and the sixth part will be on the challenges faced by the health personnel in governing BPHC.

5.1 Service Delivery Mechanism and Administrative Structure of NRHM:

The present study intends to understand the service delivery mechanism and administrative structure of NRHM. To understand the service delivery pattern and administrative setup the researcher has gone throughvarious documents of NRHM (Published by GOI), multiple literatures on health and has also made discussions with NRHM employees. These explorations and findings have helped to zero down understanding regarding service delivery mechanism and administrative structure of NRHM which is being discussed in the forthcoming segment below.

5.1.1NRHM: Aims and Objectives

The Government of India has taken a major initiative to address number of issues concerning health governance within the ambit of single programme that is National Rural Health Mission (Saxena, 2010). The Central government of the country under the Ministry of Health and Family Welfare launched NRHM in 2005. The mission recognises the importance of health as contributor of social and economic development and adopts the synergetic approach by relating health to the determinants of good health (NRHM, 2005). The aim of the Mission is to provide accessible, affordable, accountable, effective and reliable healthcare facilities in

ruralareas. It is operational in the whole country with special focus on 18 states these are eight Empowered Action Group (EAG) States namely Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Uttar Pradesh, Uttaranchal, Orissa and Rajasthan, North East States namely Assam, Arunachal Pradesh, Mizoram, Manipur, Meghalaya, Nagaland, Sikkim and Tripura including Himachal Pradesh and Jammu and Kashmir from the north (NRHM, 2005). It seeks to undertake architectural correction in the existing health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country. NRHM promotes integration, decentralisation and encouraging community participation in health programmes (11^{th} Five Year Plan, 2007-2011). NRHM operates as an omnibus broadband programme by integrating all vertical health programmes of the Department of Health and Family Welfare including RCH Programme and various diseases control programmes (MoHFW, 2010).

The Objectives of the Mission:

As per the Mission Document (2005), there are seven major objectives. These are mentioned below:

- To reduce child and maternal mortality
- To promote universal access to public services for food & nutrition, sanitation & hygiene and also promote universal access to public health care services with emphasis on services addressing Maternal & Child Health Care and universal immunization
- To Prevent and control communicable and non-communicable diseases including locally endemic diseases.
- To ensure access to integrated comprehensive primary health care.
- To stabilize Population growth, gender and demographic balance.
- To revitalize local health traditions & mainstream AYUSH.
- To promote healthy life styles.

The Mission Document of NRHM has outlined a plan of action in respect of each objective and set some time-bound goals for achieving effective improvements. These goals specifically take into account the Millennium Development Goals (MDGs) settled at the global level (Saxena, 2010). The Mission Document has further mentioned that under NRHM the State governments are required to enter into a Memorandum of Understanding (MoU) with Central government committing themselves to discharge their role as per the plan of action and ensure a minimum of 10% increase in the state budget for public health each year. The State governments in turn will receive additional funds, drugs and other materials used in the Public health care from Central government.

5.1.2 NRHM and its Strategies:

NRHM bridges the gap in Rural Health Care services through improved service delivery mechanism by introducing improved health infrastructure; augmentation of human resource and also envisages decentralization of programmes and effective utilization of resources. For the smooth delivery of services under NRHM, the Mission document has crafted both Core and supplementary strategies. The core strategies of the Mission include enhanced capacity of Panchayati Raj Institutions (PRIs) to manage public health services, strengthening and up-gradation of public health infrastructure like Sub-Centre, Primary Health Centre(PHC) and Community Health Centre (CHC) on the basis of Indian Public Health Standard(IPHS), provision of female health activist (ASHA), preparation of village health plan and Intersectoral district health plan, integration of vertical health and family welfare programmes, technical support to national , state and district health bodies, provision of monitoring and supervision of services,formulation of transparent policies for deployment and career development of health personnel, capacity building for preventive and promotive health care, promotion of Non-Government Organization(NGOs) to work in under-served areas. The supplementary strategies of the mission include; regulation of Private sector, Promotion of public-private partnerships, mainstreaming AYUSH, reorienting medical education and provision of social health insurance.

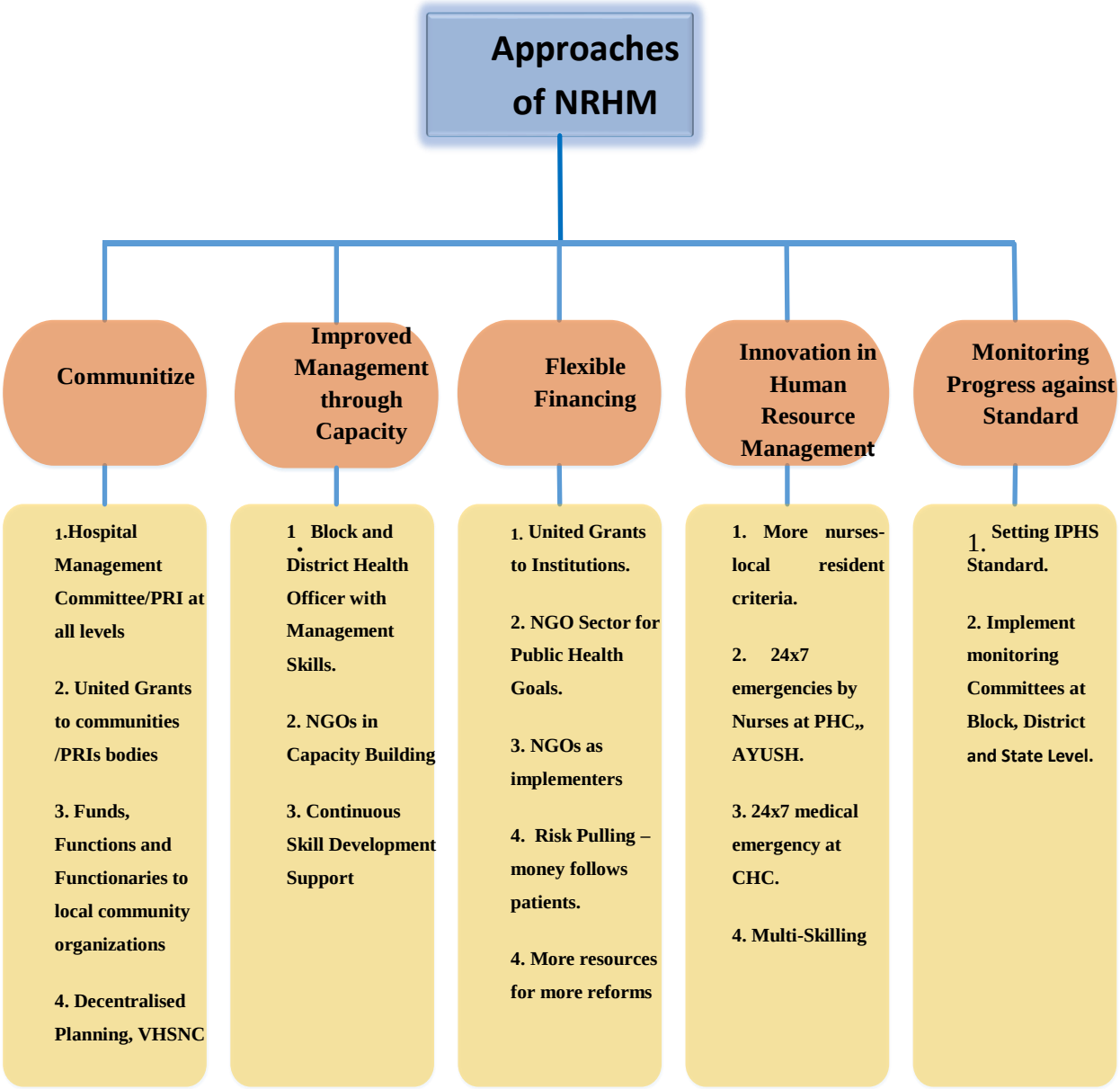


Figure 5.1: Approaches of NRHM

***Source**: NRHM, 2005(Mission Document)*

5.1.3 Approaches of NRHM:

From the figure 5.1, it is revealed that NRHM makes the public health delivery system more functional and accountable to people. It ensures proper human recourse management, community involvement, decentralization, continuous monitoring and evaluation against standards, convergence of health and related programmes from village level upwards, innovations and flexible financing and also interventions for improving the health indicators.

The major approaches of NRHM are discussed in the points below.

- ***Communitization:*** For ensuring better community participation different committees have been formed at various levels such as, Village Health Sanitation& Nutrition Committee (VHSNC) at village level, PRI at village/block level, Rogi Kalyan Samitis (RKS) at PHC and CHC level. Beside these, NRHM has introduced a provision of community health worker named as ASHA to act as a bridge between the professionals and the people.

- ***Flexible Financing:*** NRHM has subsumed all the Health and Family Welfare programs including RCH-II, National Disease Control Programs for Malaria, TB, Kala Azar, etc. Thus, the budget for NRHM consists of all these existing programs as well. The Mission envisages an additional budget of 30 percent over the existing Annual Budgetary Outlays every year to fulfill the mandate of the National Common Minimum Programme and also to raise the Outlays for Public Health from 0.9 percent of GDP to 2-3 percent of GDP. The outlay for NRHM accordingly is determined in the Annual Budgetary exercise. Further, the States are expected to raise their contributions to Public Health Budget by minimum 10 percent p.a. to support the Mission activities. Under NRHM the much needed funds are being provided to the districts to facilitate better functioning of health programme. The untied funds are also available under NRHM at various levels for smooth functioning of health service delivery.

- ***Monitoring and Evaluation under NRHM:*** Under NRHM, Health Management Information System (HMIS) has beendeveloped up to CHC level for assessing the progress and evaluate the outcome of interventions and decision making. Health care facilities like Sub-Centres, PHCs and CHCs used to report on their performance regularly to the people's bodies like Panchayats, RKS and District Health Mission (DHM). DHM also monitors compliance to Citizen's Charter at the CHC level. Beside these, Annual district reports, state reports and national reports are also need to be placed before the elected bodies at respective levels. External evaluation/social audits through professionals and NGOs and mid-course reviews and corrections are also mentioned in the program design.

- ***Improved Management through Capacity Building:*** Through continuous capacity development programme Management skills at block, district & state levels has been improved under NRHM. Post of District Health Managers has been created at district level and Block Programme Manager (BPM) at block level. NRHM has also included various NGOs in capacity building programme.

- ***Innovation in Human Recourse Management:*** NRHM has strengthened the existing manpower like nurses, Medical officerspecificallyat Sub-Centre, and PHC and CHC level to render quality services. Local residents from remote areas are trained and developed for providing basic health services. Multi skilling of health functionaries especially of doctors and paramedics is being carried out so that a person can carry out multiple tasks.

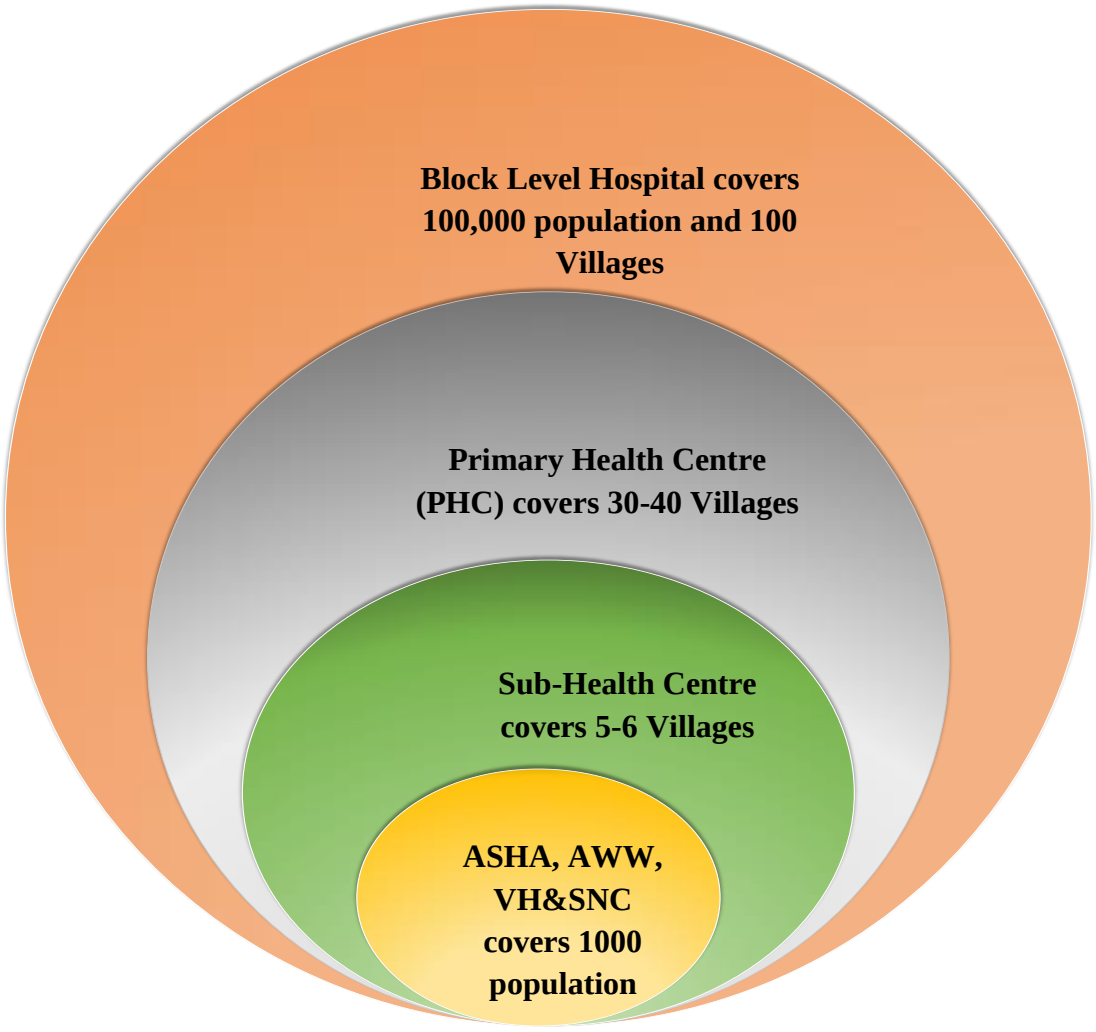


Figure 5.2: Service Delivery Pattern of NRHM

Source: *NRHM, 2005*

It is revealed from the figure 5.2 that from block to village, there are various kinds of services offered through different health setup. A patient can visit either of the centre as per their need and services offered there and there are provisions of referral from the Sub-Centre to PHC and from PHC to BPHC.

5.1.4 Service Delivery at Block Level:

Service Delivery is a process through which the services are offered to its beneficiaries as per the objectives of the scheme or programme. Here, NRHM as a Mission has its own service delivery mechanism for carrying out the services to the end users. At block level health care services are rendered through Block Primary Health Centre (BPHC) located at Block head quarter. The BPHC is a higher level institution in terms of available resources and coverage as compared to Primary Health Centres. As per Indian Public Health Standards (IPHS), BPHC covers a population of 100,000 and 100 villages. BPHCs are also the administrative headquarters for all PHCs and Subcenters in the designated area (health block). It is headed by a Sub Divisional Medical & Health Officer (SDMHO). As per the standards all BPHCs provide regular outpatient and inpatient services. Moreover, 24 hours emergency Services, referral services along with regular antenatal care is available at BPHCs. BPHC has provision of 24 hours delivery services for both normal and assisted deliveries. Beside these, immunization services through fixed immunisation day and family planning services such as tubectomy and vasectomy is provided by each BPHC as per the NRHM guidelines. The prime objective of creating BPHCs is to make modern healthcare services available to people in the rural areas so that they can obtain required treatment faster. However, for smooth running of administrative work each BPHC has Block Programme Manager, Block Community Mobilizer along with other support staffs.

5.1.5 Service Delivery at Cluster of Gram Panchayat Level:

At this level, health care services are rendered through Primary Health Centre (PHC). As per standards, PHC covers a population of 20,000 in hilly, tribal, or difficult areas and 30,000 populations in plain areas with 4-6 indoor/observation beds. It acts as a referral unit for 6 Sub-centres and refers out cases to BPHC/CHC and higher order public hospitals located at sub-district and district level. The nomenclature of a PHC varies from state to state that include additional PHCs/New PHCs/Mini-PHCs. As per

the norm, each PHC has one Medical officer, one AYUSH doctor, 3 staff nurse and other supporting staffs. 24 hours medical care is an important component of PHC and it provide both inpatient and outpatient services along with emergency care.

5.1.6 Service Delivery at Gram Panchayat Level:

From the figure 5.2 it is revealed that a Sub Centre is the most peripheral and first contact point between the primary health care system and the community. It is the lowest of a three level set up with referral linkage to the Primary Health Centre. As per the population norms, one Sub-centre is established for every 5000 population in plain areas and for every 3000 population in hilly/tribal/desert areas. As per the norm, each sub-centre is having 2 Auxiliary Nurse Midwives (ANMs) along with one Multi Purpose Health Worker. Immunization services through fixed immunization day are available at each Sub-Centre. Moreover, Mother and Child Health (MCH) care is an important component of each Sub-Centre.

5.1.7 Service Delivery at Village Level:

Community participation is recognised as a core strategy of NRHM. Through institutional provisions for community participation, NRHM seeks to decentralize the delivery of public health services which ultimately bring transparency and accountability in the service delivery process. NRHM envisaged active community participation by involving ASHA, Anganwadi Worker, and Panchayati Raj Institutions (PRIs) and other community members from diverse socio-economic strata at various levels of operations of the mission. According to the Mission Document, every village has Female Accredited Social Health Activists (ASHA), to act as an interface between community and public health system. ASHA facilitates preparation and implementation of the village health plan along with Anganwadi worker, ANM, functionaries of other departments and Self Help Group members under the leadership of Village Health Committee of the Panchayat. Under NRHM, one Village Health and Nutrition Day (VHND) will be organised in each Gram Sabha level per month in coordination with Village Health Sanitation and Nutrition Committee (VHSNC), Anganwadi worker, ANM and ASHA worker. On VHND ASHA, Anganwadi worker and panchayat members will mobilize community to bring pregnant women and children to the session site for availing services like antenatal care, immunization and counseling services from ASHA and ANM.

5.1.8 Administrative Setup of NRHM at National Level:

NRHM has its own administrative set up for managing the services it is offering.At national level, NRHM has a **Mission Steering Group (MSG)** headed by the Union Minister of Health and Family Welfare and an **Empowered Programme Committee (EPC)** headed by the Union Secretary for Health and Family Welfare. The MSG is empowered to approve financial norms in respect of all schemes and components which are the part of NRHM. The EPC have the flexibility to change financial norms approved by the MSG within a range of (+) 25 percent. The MSG and the EPC periodically monitor the progress of the Mission. NRHM has **Mission Directorate** at the centre for planning, implementation and monitoring of the mission activities and day-to-day administration. The Directorate is headed by a Mission Director.

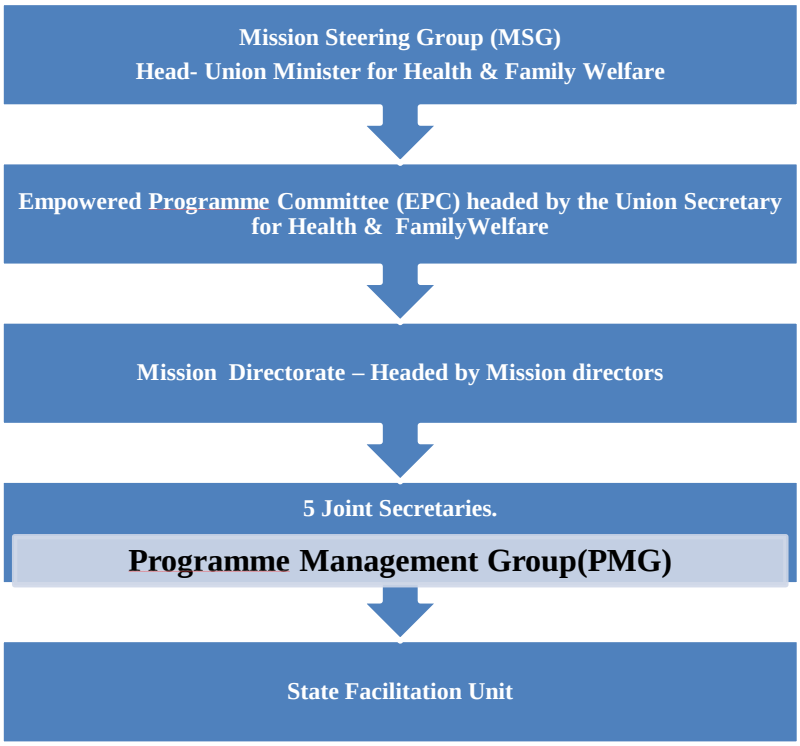


Figure 5.3: Governance Structure of NRHM at national Level

Source: *NRHM, 2005*

5.1.9 Administrative Setup of NRHM at State:

At state, NRHM functions under the overall guidance of **State Health Mission (SHM)**, headed by the Chief Minister and Co-Chaired by Minister of Health and Family Welfare (MoHFW), State government. SHM provide health system oversight as it monitors the progress in the implementation of NRHM. The main function of

SHM is carried out through the **State Health Society (SHS),** which is formed by integrating all the society setup for the implementation of various disease control programmes. **The Governing Body** of the Society, headed by Chief Secretary/Development Commissioner of the State, meets at least once in every six months. The Governing Body reviews the implementation of Annual Action Plan. **The Executive Committee** of the SHS, headed by Principal Secretary/Secretary, Health and Family Welfare meets at least once in every month. Executive Committee follows up the action on decision of Governing Body of SHS. The composition of SHS is shown in the table below.

Table 5.1 Composition of State Health Society

Composition	**Governing Body(SHS)**	**Executive Body(SHS)**
Chairperson	Chief Secretary	Secretary(H& FW)
Vice-Chair	Secretary (H&FW)	Director, Health & FW
Convener	Mission Director of State Health Mission	Mission Director
Members/ Joint Secretaries	**Members:** • Secretaries of Finances, Social Welfare, PHED, PR &RD, Hills, MAHUD. • Planning , GOI Representatives • Director of Health • Director of Family Welfare Services	**Joint Secretaries:** State Programme Managers/ Project Directors (Malaria officer, TB Officer, Leprosy Officer, Project Director RCH etc.) **Members:** • Secretaries of Social Welfare • PHED, PR & RD, Planning, Finance, MAHUD, Hills

**Source: NRHM, 2005*

The figure 5.3 indicates that the states can constitute **Programme Committees** for various National Programmes for more focused planning and review of each activity. The **State Programme Management Support Unit (SPMSU)** acts as the Secretariat to the SHM as well as the SHS and is headed by an Executive Director/Mission Director. The SPMSU have experts in the areas of human resources, Behaviour

Change Communication (BCC), Monitoring and Evaluation and other technical areas. The SPMSU provide the technical support to the SHM through its pool of skilled professionals like MBA, CA, MIS specialist and consultants for Reproductive and Child Health (RCH) and other National Disease Control Programmes.

5.1.10 Administrative Setup of NRHM at District

Under NRHM district becomes the core unit of planning, budgeting and implementation of the programme. All vertical Health and Family Welfare programmes at district level have already been merged into one common District Health Mission headed by the District Collector as the Co-Chair and Chief Medical Officer as the Mission Director.

The synoptic view of State and District Health Mission from top to bottom is presented in the figure below.

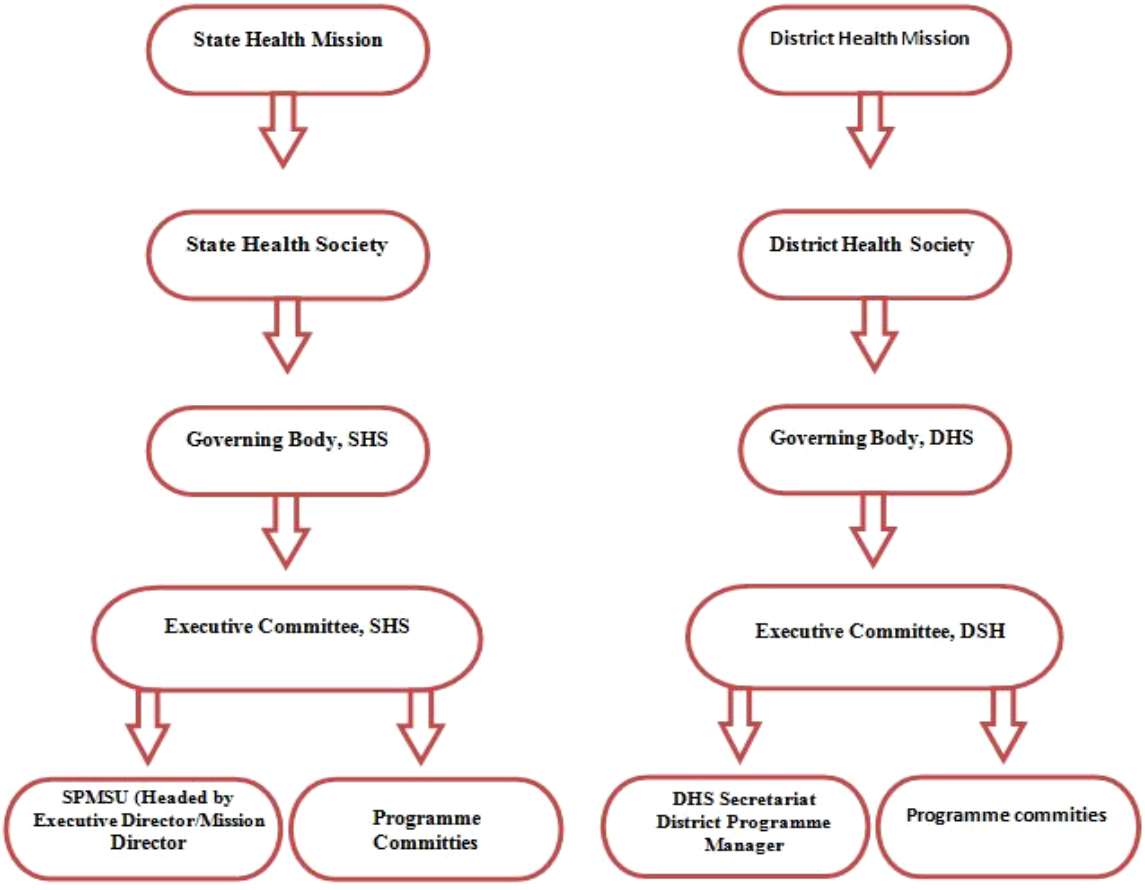


Figure 5.4: The Governance Structure of State and District Health Mission

Source: *NRHM, 2005*

From the figure 5.4, it is revealed that under NRHM every district has an integrated **District Health Society (DHS)** to support the DHM. The DHS is responsible for planning and managing all health and family welfare programmes in the district. The table (5.2) indicates that DHS has its two subparts i.e. Governing Body and Executive Committee. The main task of Governing Body is to ensure Inter-sectoral convergence and integrated planning. DHS is meant to provide the platform where the three arms of governance i.e. Zilla Parishad, District Health Administration and District Programme Managers of NRHM work together to decide on health issues of the district and delineate their mutual roles and responsibilities. In other words, the DHS is not an implementing agency rather it is a facilitating mechanism.

Table 5.2: Composition of District Health Society

Composition	Governing Body(DHS)	Executive Body(DHS)
Chairman	Deputy Commissioner	Chief Medical Officer(CMO)
Co-Chair	DDC cum CEO, Zilla Parishad	CMO/CDMO/CMHO/CS
Chief Executive officer	Chief Medical Officer/CDMO/Civil Surgeon	District Programme Manager/District RCH Officer
Members	District Programme Managers for Health & FW, District MO i/c AYUSH, District Programme Officer (WCD), District PMSU, District SW officer, All BDOs, All SDOs, CHC in-Charge, 2-4 Representatives of Medical Associations/MNGOs and Development Partners.	• Superintendent-District Hospital, • All District Programme Managers for Health & FW, District Programme Officer (WCD), Deputy Director of Tribal Development, All BDOs, Secretaries of Hospital Management Societies, Non- Official Members of Governing Body.

***Source**: NRHM, 2005*

The figure 5.4 indicates that DHS has **Secretariat** comprises of three full time persons namely District Programme Manager, Finance/Account Manager and Data

Assistant. DHS Secretariat facilitates the working of DHS as per the bye laws of society and it also facilitates preparation of District Logistic Plan for optimal utilisation of resources at each facility. District Programme Manager is the key player in setting up and operationalising DHS secretariat.

As discussed above, the administrative structure of NRHM is closely connected from central to district level. These structures have some similarities as well as differences. As per the Mission Document, at national level NRHM has Mission Steering Group and Mission Directorate. At state level, NRHM has State Health Mission and State Health Society. State Health Mission considers policy matters related to health and also review the progress in implementation of NRHM. However, ultimately under NRHM health services are reaching to the beneficiaries at the district level. At district level, there is District Health Mission and District Health Society. District Health Mission is Responsible for planning, implementing, monitoring and evaluating progress of Mission. It also provides leadership to village, Gram Panchayat, Cluster & Block level teams.

5.2 Socio- Economic Condition of Patients/Beneficiaries

Good health is universally recognised to be an integral element of development. The socio-economic development of any community has its direct impact on the health status of people living over there. There are numerous factors that directly and indirectly are linked with health status like hereditary factors, environmental factors, life style, adequate housing, basic sanitation and socio-economic conditions including income, education, availability and quality of health infrastructure (Park, 2013). This section represent socio-economic condition of 200 patients taking services from eight different BPHCs of Cachar district with the help of variables such as age, education, family consumption, family income, Individual income of patients, sanitation facility etc.

5.2.1 Age of the Respondent:

Age is an important factor in individual's life as men and women have different health requirements at different age. Age plays a key role in their physical growth, decision making in terms of educational aspects, carrier and marital aspects. For the

purpose of this study age of the respondents have been categorized into four groups, these are: 'Young', 'Mature', 'Middle' and 'Experienced Group'. 'Young Group' is consisting of 20-25 years; 'Mature Age Group' is consisting of 25-30 years, 30-35 years is considered as 'Middle Age Group' and above 35 years is termed as 'Experienced Group'. As discussed earlier in the present study the researcher has taken all the female married patients visiting BPHC from reproductive age group who has at least one child.

The figure below shows the distribution of Respondents as per their age.

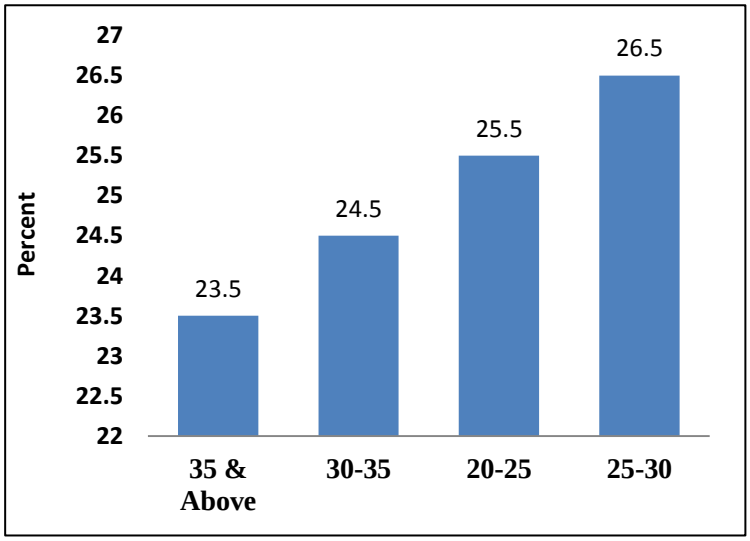


Figure 5.5: Age of the Respondents

From the figure 5.5, it is seen that 25.5 percent respondents are from young age group (20-25), 26.5 percent belong to mature category (25-30) , 24.5 percent are from middle age group (30-35) and 23.5 percent are from experienced group(35 years and above). The mean age of respondents is found to be 29 years.

In addition, during the present study it is observed that about half of the respondents (49%) got married before the age of eighteen years and three tenth (30%) respondents got married between the ages of 20-25 years. The data revealed that level of community awareness is low as high trends of marriage before completing the age of eighteen has adverse effect on women's health. However, the study also shows that 5 percent women were first time pregnant before the age of eighteen years which has its negative impact on maternal health.

5.2.2 Education Status of the Respondent:

Education is considered as the most important tool in bringing socio-economic transformation in society. It transforms human being from ignorance to enlightenment and a nation from underdevelopment to faster socio economic development. Low education levels are linked with poor health, more stress and lower self -confidence. Education is a great facilitator in the prevention of diseases and the promotion of health (Akram, 2014). In the present study the educational levels of the respondents are divided into four categories. These are: 'Illiterate', Education up to 5^{th} standard is considered as 'Education up to Primary Level', From 5^{th} to 7^{th} standard is considered as 'Education up to Upper Primary Level' and from 7^{th} to 10^{th} Standard & above is termed as 'Education up to High School and above' level.

The figure below depicts the educational status of respondents.

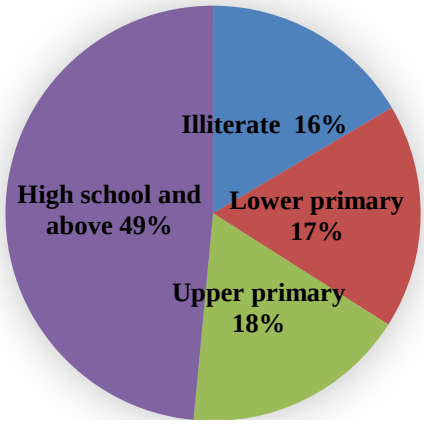


Figure 5.6: Distribution of Respondents on the basis of Education

The figure 5.6 indicates that less than one fifth of the respondents (16%) are illiterate, followed by almost equal proportion of respondents have education up to Lower primary (17%) and upper primary level (18%). From the figure is revealed that almost half of the respondents (49%) have education up to high school and above level. However, during the present study the researcher have observed that illiterate patients face problem in seeking treatment as they expressed that due to illiteracy they fail to understand the prescriptions and medicines advised by doctors and other paramedical staffs. In addition, the respondents have also expressed that they face problem in filling up different forms to avail the benefit under JSY as a result most of the time

they take help either from hospital staffs or from panchayat. However, as per NFHS (2005-2006) it is found that 65.46 percent women are literate in India; whereas, from the present study it is found that 84percent women are literate in India.

5.2.3 Religious Status:

Religion is defined as some beliefs and practices related to sacred things. The health of an individual can be affected by religious beliefs and prejudices. Some religious communities actively address moral and ethical issues. Some don't permit immunizations; others don't permit their members to be treated by physicians (Akram, 2014). In the present study, all the respondents are found to be belonging to three different religions, which are 'Hindu', 'Muslim' and 'Christian'.

The figure below shows the distribution of respondents according to their Religion.

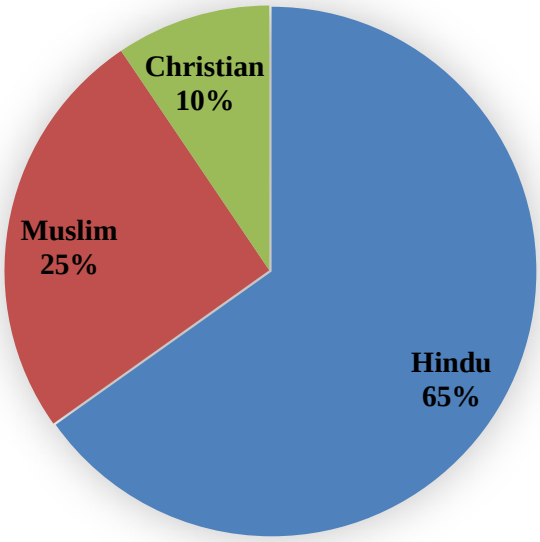


Figure 5.7: Distribution of Respondent on the basis of Religion

The above figure 5.7, shows that the overwhelming majority of respondents i.e. 65 percent are Hindus by religion; followed by one fourth of the respondents (25%) belong to Muslim and one tenth of the respondents (10%) belong to Christian religion. As per NFHS (2005-2006) in India 82 percent are from Hindu religion, 13 percent belong to Muslim religion and 3 percent belong to Christian religion. So, essence of the figure is that though the communities are having both Hindu and

Muslim population, but as patients Hindus are mainly taking the services from BPHC. However, essentially it can be said that Muslim women from reproductive age group are also taking the services from BPHC though limited in nature where the communities are dominated by Hindu population.

5.2.4 Caste Status:

Casteisa unique system in India.It is a hierarchical division of society. Caste status is ascribed as it can neither be changed nor be improved. Caste is a close system and it restricts social mobility (Rao, 1995). Caste is associated with some unique practices and taboos. Therefore, caste system has its direct and indirect impact on health.

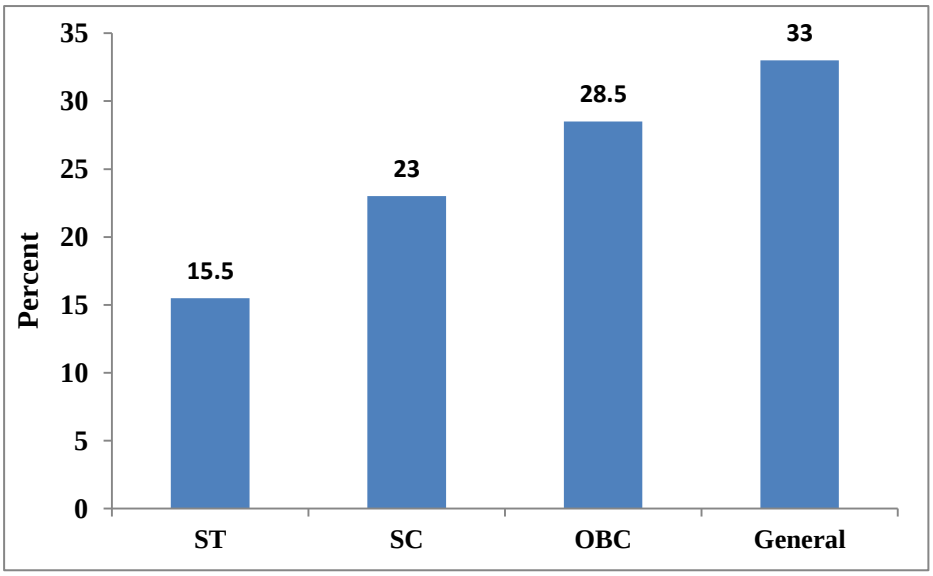


Figure 5.8: Distribution of Respondents on basis of Caste

The above figure 5.8, indicates that a substantial number of respondents i.e. 33 percent are from General category; followed by more than one -fourth respondents (28.5%) belong to other Backward Class (OBC), less than one –fourth respondents (23%) are from Schedule Caste (SC) and the remaining15.5 percent respondents belong to Schedule Tribes (ST) category. From NFHS (2005-2006) it is found that 23 percent belong to SC category, 15.5 percent belong to ST category, 28.5 percent belong to OBC category and 33 percent are from General category.

5.2.5 Family Position:

Family position plays an important role in individual's life as it determines individual's status in the family.

Table 5.3: Family Position of the Respondent

Family position	Frequency	Percentage
Head of the Family	5	2.5
Housewife	153	76.5
Daughter	6	3.0
Daughter in Law	36	18.0
Total	200	100

From the table 5.3, it is found that a very small portion i.e. 2.5 percent heads of households are women; while, majority of respondents i.e. 76.5 percent are house wife. However, as per NFHS (2005-2006) in India 14 percent heads of households are women. In addition, during the study it is observed that most of the respondents (60%) don't have any decision making power in family. Their husband or father in law used to take decision on behalf of them as a result they can't take decision related to their reproductive health that include space between child birth, preference of family planning method, preference place for delivery and frequency of antenatal care etc.

5.2.6 Types of Family:

The family is one of most important primary group in society. It is the most basic of all groupings. Family is the simplest and the most elementary form of society (Rao, 1995). The family is a small group consisting of father, mother, one or more children and sometimes near or distant relatives.

In the present study, the respondents are found to be either from nuclear family or from joint family. Where one couple i.e. husband-wife and their wards are living together is considered as nuclear family and where besides husband -wife and their wards, parents and other people are living together is considered as joint family. Extended family includes the nuclear family and any other kin with whom important relationships are maintained.

Table 5.4: Types of Family

Family	Frequency	Percentage
Nuclear	119	59.5
Joint	80	40.0
Extended	1	0.5
Total	200	100

The table 5.4 indicates that majority of respondents i.e. 59.5 percent are from nuclear family, while two fourth respondents (40%) are from joint family and very small portion of respondent (.5%) is from extended family. From the present study, it is found that respondents from nuclear family have expressed that they discuss their reproductive health problems with husbands; while in case of joint family respondents have reported that family members are not showing interest in women's health even at the time of pregnancy.

5.2.7 Family Size:

Size of the family plays an important role in individual's life. It is always felt that larger the family-size more secured is its members (Rao, 1995). In the present study, the families are classified into three groups according to their size. 'Small Size Family' is consisting upto four members, 'Middle Size Family' is consisting of four to seven members and 'Large Size Family' is consisting of seven and above members.

Table 5.5: Family Size of the Respondents

Family Size	Frequency	Percentage
Small Size	75	37.5
Middle Size	77	38.5
Large Size	48	24.0
Total	200	100

The table 5.5 shows that almost equal proportion of respondents i.e. 37.5 percent are from 'Small Size Family', 38.5 percent are from 'Middle Size Family'. The remaining one fourth respondents (24%) are from 'Large Size Family'. In the present

study, it is found that the average size of respondent's family is consisting of 5 members.

5.2.8 Family Income:

Income determines the economic status of a family. Income is an important factor in determining individual's access to information, education as well as health seeking behavior. Family income is one of the basic criteria to assess the standard of living of the family.

For the purpose of this study, family income of the respondents has been distributed as 'Low,' 'Average' and 'High' group respectively. Income up to 5000 is considered as 'Low', from 5001-10,000 is termed as 'Average' and above 10,000 is considered as 'High'.

Table 5.6: Family Income of the Respondents (Per Months)

Family income	Frequency	Percentage
Low	73	36.5
Average	62	31.0
High	65	32.5
Total	200	100

The table 5.6 indicates that more than one third respondent (36.5%) have expressed that their family income is 'Low'; closely followed by 32.5 percent expressed that their family income is 'High' and 31 percent have expressed that their family income is 'Average'.

The average family income of the respondent is found to be Rs 7,458 with a SD of 7127.351.

5.2.9 Individual Income:

Individual's income and social status are related with better health as higher incomes enable people to afford better housing, live in safer neighborhoods and increase the opportunity to engage in health promoting behaviours (Akram, 2014). In the present study, it is observed that small number of respondents i.e. 15.5 percent

areeconomically self-sustained. This proves the fact that despite of various efforts from government side the economic condition of rural women is not yet satisfactory which has adverse impact in their health aspects. As it is observed from the study that economically self-reliant women can take decision in their family matters as well as in their health aspects.

5.2.10 Number of Earning Members:

It is found from the table (5.7) that majority of respondents have only one earning member in their family; followed by less than one fifth respondents(18%) have two earning members in their family and very small portion of respondents i.e. 3 percent have three earning members and 1.5 percent have four earning members in the family. The average earning member in respondent's family is 1.

From the present study, it is revealed that most of the respondents are not from better economic condition.

Table 5.7: Number of Earning Members in the Family

Earning Members	Frequency	Percentage
One	155	77.5
Two	36	18.0
Three	6	3.0
Four & above	3	1.5
Total	200	100

5.2.11 Sources of Family Income

Sources of income depict the occupation in which the family members of respondents are engaged with. It helps to understand the economic security of the respondents.
The figure below depicts the sources of family income of the respondents.

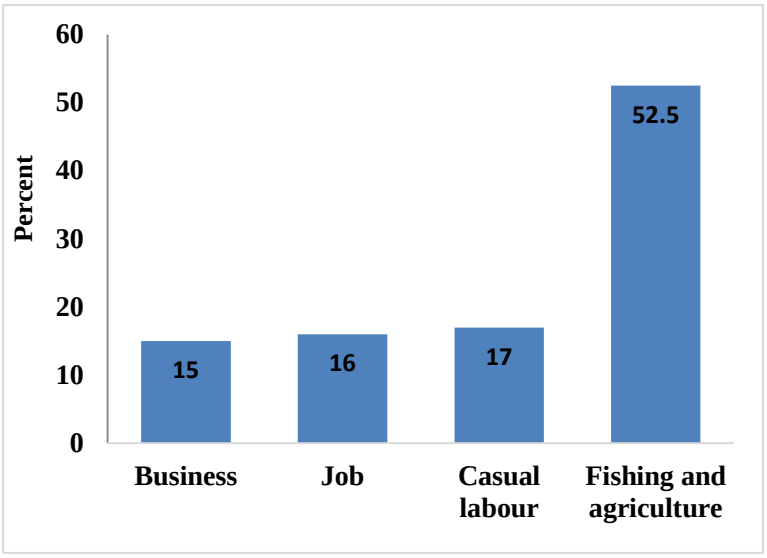


Figure 5.9: Sources of Family Income

Agriculture forms the backbone of the economy of Assam as it provides livelihood to more than 70 percent of its population (Census, 2011). But due to lack of sophisticated technology and ecological constraint still the agricultural productivity of Assam is far from satisfactory.

The above figure 5.9, shows that a considerable number of earning members from respondent's family i.e. 52.5 percent are engaged in agriculture and fishing activities; followed by less than one fifth respondents (17%) are earning their livelihood as casual labourers, almost equal proportion of family members i.e. 15 percent and 16 percent are engaged in business and job respectively. Beside these, it is observed from the present study that about one fifth respondents (19.5%) have expressed that they have been doing animal husbandry since long back.

From the above figure it is revealed the rural economy of Cachar district is still dominated by agriculture and allied activities.

5.2.12 Agricultural Land

For the purpose of present study respondents are classified into four categories according to their size of land holding. The respondents who have no land is considered as 'Land-Less', who have 1-5 bighas of land is termed as 'Small Size' land holders, 5-10 bighas of land is termed as 'Middle Size' and more than 10 bighas is termed as 'Big Size' land holders.

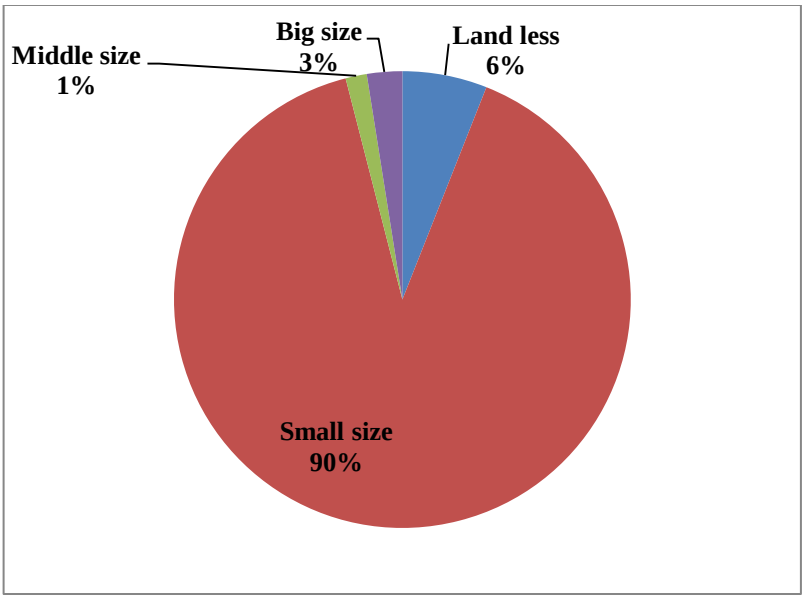


Figure 5.10: Availability of Agricultural Land

From the figure 5.10, it is found that less than one tenth of the respondents (6%) have expressed that they are 'Land Less'; followed by most of the respondents i.e. 90 percent are having 'Small Size of Land', while very small portion of respondents have expressed that they have 'Middle Size' and 'Big Size of Lands'. So, the above figure reveals that majority of the respondents are falling into category of 'Small Size of land'.

In addition, during the present study, it is observed that out of total respondents a significant number of respondents (73%) have reported that they have no additional house and shops. Whereas, around one tenth respondents (10.5%) have reported that they have additional house and less than one fifth respondents (16.5%) have reported that they have shop.

5.2.13 Accommodation:

In the present study, the accommodation pattern of respondents has been categorized into two parts —'Owned' and 'Rented House'. 'Owned House' refers to land and house belongs to respondent or any other member of her family and for which she no need to pay rent and 'Rented House' refers to where the respondents lived in other houses by paying rent.

Table 5.8: Family Income and Type of Accommodation

Family income	Type of Accommodation		
	Owned	**Rented**	**Total**
Low	67	6	73
	92%	8%	100%
Middle	62	0	62
	100%	0%	100%
High	65	0	65
	100%	0%	100%
Total	194	6	200
	97%	3%	100%

Looking at the cross table 5.8, it is observed that despite the variation in economic condition most of the respondents i.e. 97 percent are staying in their 'Owned House' while very small portion of respondents (3%) live in 'Rented House'. However, against the family income of the respondents it is found that less than one tenth of the respondents (8.2%) from low income group are residing in 'Rented Houses'.

5.2.14 Caste and Type of Houses:

For the purpose of present study the housing pattern of the respondents is categorized in to three groups comprising of 'Katcha', 'Semi-Pucca' and 'Pucca'. 'Katcha' means where no processed materials are used' 'Pucca' means constructions built fully with processed materials and 'Semi –Pucca' means where a part of the house is built with the processed materials.

From the figure 5.11, it is revealed that about one third of the respondents (33%) have 'Katcha' houses; closely followed by less than one third of the respondents (31.5%) have 'pucca' houses and more than one third of the respondents (35.5%) have 'Semi-pucca' houses. So it can be said that the housing status of the respondents are almost equal. As per NFHS (2005-2006) in India 46 percent people are living in Pucca houses.

However, considering their caste status it is found that the people from General and OBC category are living more in 'Katcha' houses i.e. 47 percent and 35.1 percent

respectively than the SCs and STs which is approximately 19.5 percent. Moreover, it is important to note that SCs and STs are getting support from Indira Abash Yojona (IAY) more than OBCs and General category.

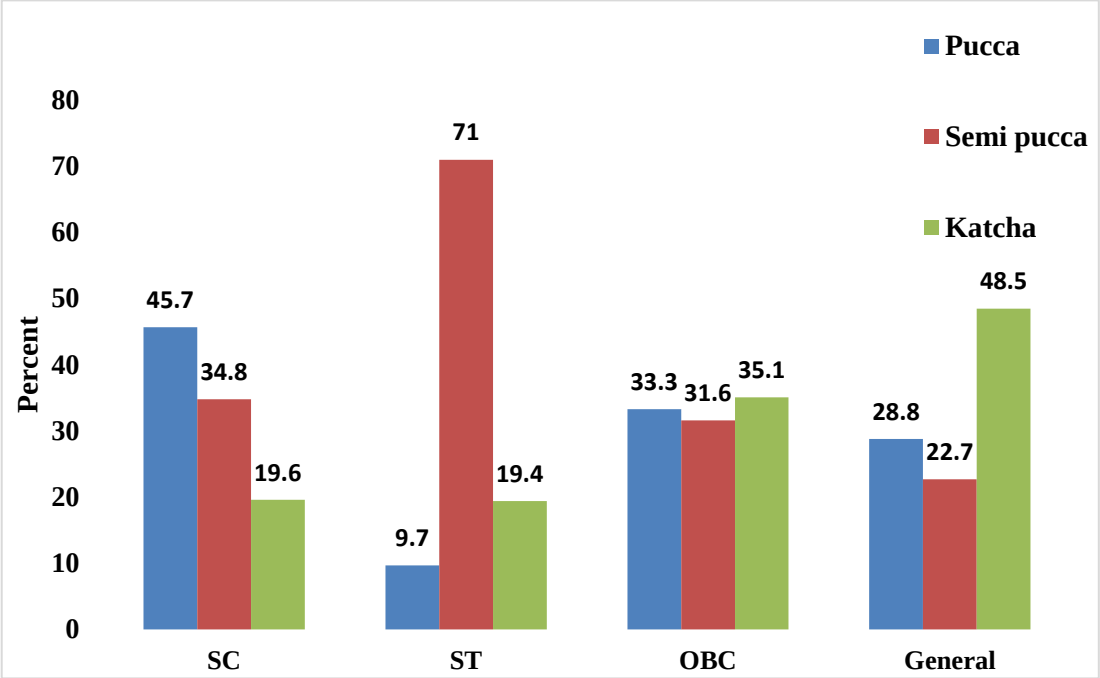


Figure 5.11: Caste and Type of Houses

5.2.15 Family Income and Type of Houses:

The figure 5.12 indicates that housing status of the respondents is almost equal. Considering the family income of the respondents it is found that low income group is having more number of 'Katcha' houses i.e. 63 percent in comparison to the high income group (10.8%). Again around one tenth respondents (11%) from low income group are having pucca houses; while, a significant portion of respondents (63.1%) from high income group are having 'Pucca' houses.

So it is revealed from the figure 5.12 that there is a positive relationship exists among the family income of the respondent and their housing status.

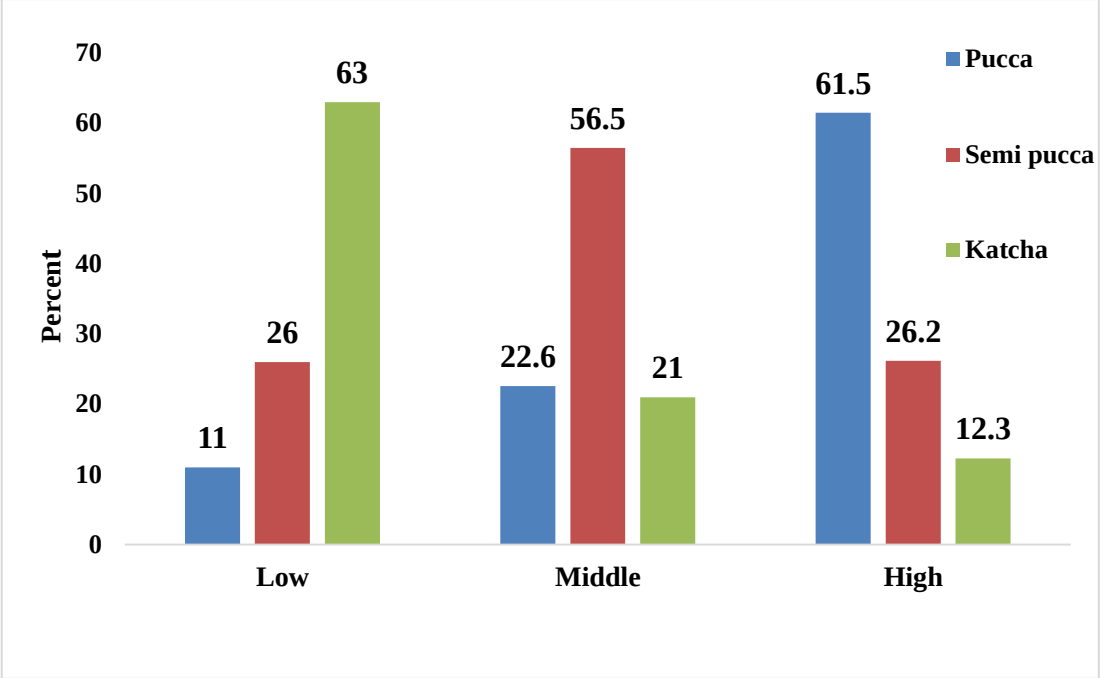


Figure 5.12: Family Income and Type of Houses

5.2.16: Fuel Use Pattern:

Fuel use pattern has its direct relationship with the health status of women and child in terms of premature mortality.

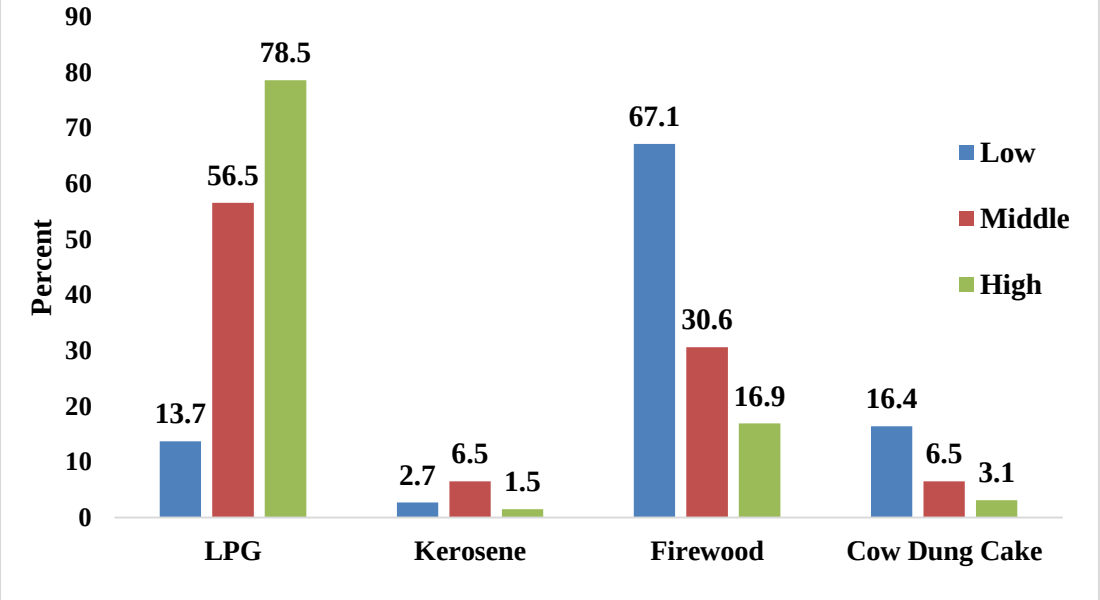


Figure 5.13: Family Income and Fuel Use Pattern

The figure 5.13 indicates that a high number of the respondents i.e. 48 percent use LPG for cooking; followed by around two fourth of the respondents (39.5%) use firewood, less than one tenth respondents use cow-dung cake and very small portion of respondents i.e. 3.5 percent use kerosene. It is observed that respondents from high income groups are using more LPG i.e. 78.5 percent in compare to the low income group i.e. 13.7 percent.

The above figure exhibits that there is a positive relationship existing among the family income of the respondents and the nature of fuel used by them for cooking.

5.2.17 Membership with SHG/Mahila Mandals:

Membership with SHG/Mahila Mandals is a vital factor as it helps individual to participate actively in the decision making process of family specifically in the field of health and education.

Table 5.9: Membership of Respondents with SHG/Mahila Mandals

Membership	Frequency	Percentage
Yes	96	48.0
No	104	52.0
Total	200	100

The table 5.9 indicates that an about half of the respondent (48%) have membership with SHG/Mahila Mandals; while, a significant portion of respondents i.e. 52 percent have expressed that they don't have any association with SHG/ Mahila Mandals, etc. In addition, during the study it is observed that beside SHGs most of the respondents are showing their interest to be associated with small microfinance units like Bandhan society. It has further observed that associating with the SHGs and other groups the women are getting a separate identity in the community which is respectful in nature.

5.2.18 Sources of Drinking Water:

The access to safe drinking water is a fundamental human need and therefore a basic human right (Kofi Annan, UN Secretary General). The provision of clean drinking water has been given priority in the Constitution of India. In the present study the sources of drinking water facility has been distributed into three categories. These

are: ‘Government Distributed Water Source’ means availability of piped water ; ‘Ground Water Sources’ means availability of water facility from well, bore well e.t.c. and ‘Open sources’ means availability of water from ponds, river, unprotected well, borehole, spring, surface water, etc.

The table below shows the sources of drinking water used by the respondents:

Table 5.10: Source of Drinking Water

Sources	Frequency	Percentage
Government Distributed water sources	48	24.0
Ground Water Sources	135	67.5
Open/Unprotected water Sources	17	8.5
Total	200	100

It is found from the table 5.10, that about one fourth of the respondents (24%) have expressed that they are using government distributed water sources; followed by majority of respondents i.e. 67.5 percent use ground water sources and less than one tenth of the respondents (8.5%) have reported that still they are using open sources for drinking purpose. As per NFHS (2005-2006) 28 percent rural people have piped water; whereas, in the present study it is found that only 24 percent have piped water facility. However, it is known from various sources that government distributed water through pipeline are better than other two sources as it is purified before distribution. Again ground water sources are better in nature than open sources like ponds/rivers etc.

The above table shows that most of the respondents are using ground water sources for drinking purposes as piped water facility is not reachable to most of the respondents.

5.2.19 Time Required in Fetching Water:

From the table 5.11, it is found that around one third of the respondents (34%) have expressed that upto 10 minutes time is required to fetch water from its source. Whereas, a significant proportion of respondents i.e. 62 percent have expressed that 10-20 minutes and very small portion of respondents i.e. 4 percent have reported that 20-30 minutes time is required to fetch water from its sources.

The table 5.11 inferred that a considerable number of respondents don't have lack of accessibility of water source near to their house. In addition, during this study, it is observed that majority of respondents i.e. 61.5 percent have expressed that adult women used to fetch water for the household which again have a worst impact on their health status.

Table 5.11: Time Required to Fetch Water

Time	Frequency	Percentage
Up to 10 minutes	68	34.0
10 - 20 minutes	124	62.0
20 -30 minutes	8	4.0
Total	200	100.0

5.2.20 Education and Methods of Water Purification:

From the figure 5.14, it is found that a considerable number of the respondents (43.5%) are using boiling as a method for purifying water before drinking ; followed by more than one fourth of the respondents (28%) are using other methods which includes using alum& bleach and staining the germ using cloths etc., while more than one tenth respondents (12.5%) have expressed that they are using filter and less than one tenth respondents (8.5%) have expressed that they are using electronic purifier to purify the water; while a very small portion of respondents i.e. 7percent have expressed that they are not treating water before drinking.

Considering the educational qualification there is no much difference noticed among the respondents about the methods administered by them for purification of water. Majority of the respondents from each educational level use boiling method for purification.

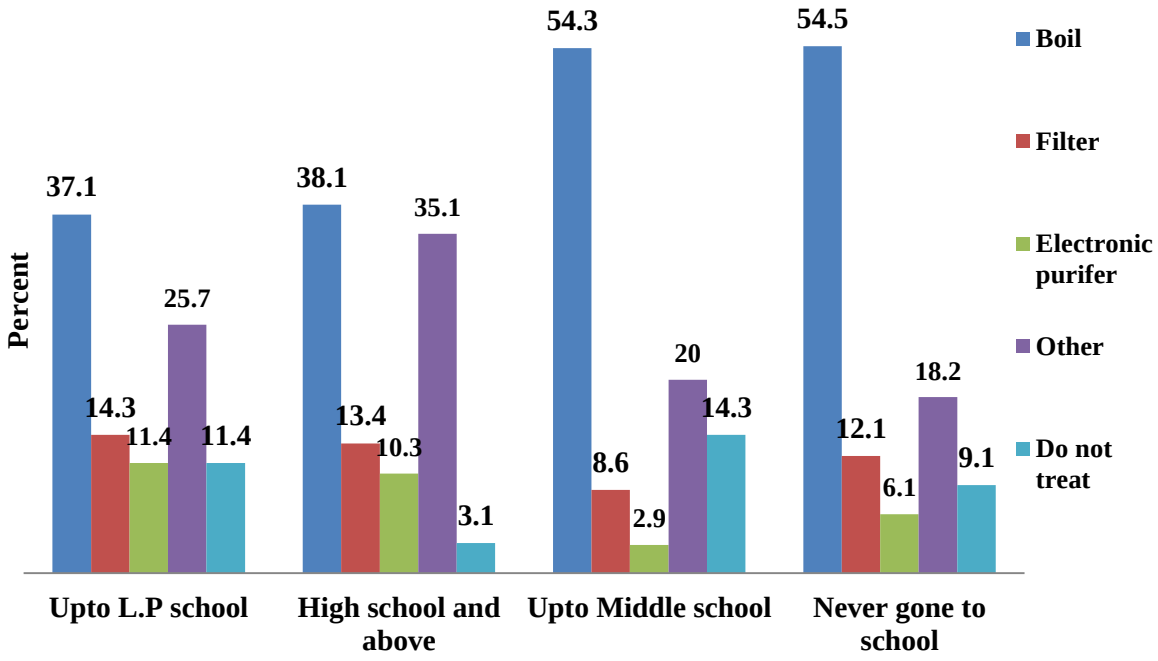


Figure 5.14: Education and Method Adopt for Water Purification

5.2.21 Caste and Method of Water Purification:

From the figure 5.15, it is found that respondents belong to ST, OBC and General categories are mostly using boiling method for purification of drinking water; whereas, a significant portion of respondents from Schedule Caste community i.e. 43.7 percent are using other method that include staining the germ using cloth and using alum/bleach etc. for water purification.

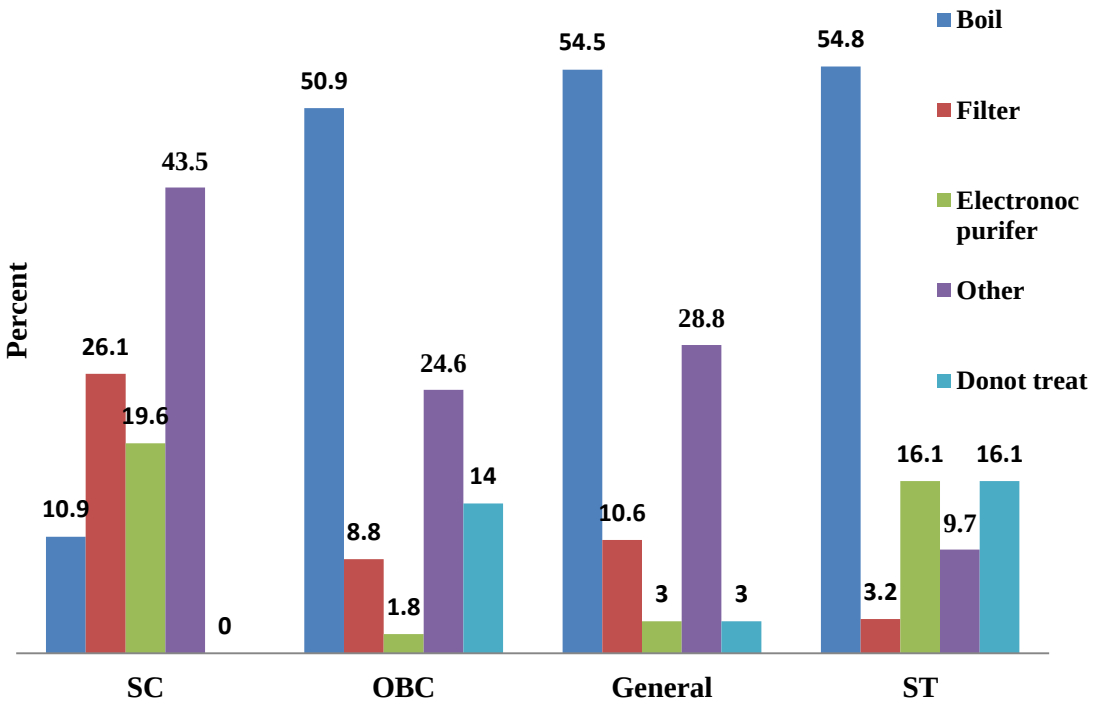


Figure 5.15: Caste and Method adopt for Water Purification

5.2.22 Family Income and Method of Water Purification:

Looking at the figure 5.16, it is seen that high income group has adopt any of the method for purification of water; while less than one fifth respondents (15.1%) from low income group and very small portion of respondents i.e. 4.8 percent from middle income group have expressed that they are not adopting any of the method for purification of water.

It is revealed from the figure 5.16, that there is certain level of impact on the income group towards the tendency of purification of water.

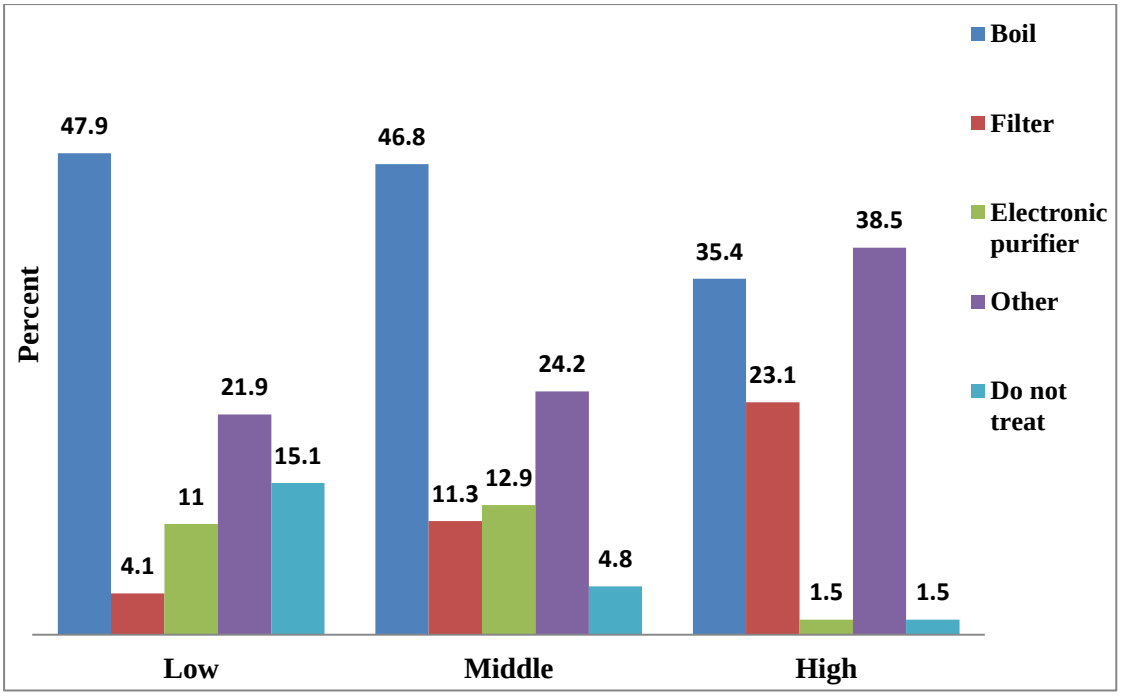


Figure 5.16: Family Income and Method adopt for Water Purification

5.2.23 Education and Sanitary Practices:

Sanitation refers to the provision of facilities and services for the safe disposal of human urine and feces. Inadequate sanitation is a major cause of disease and improving sanitation is known to have significant beneficial impact on health both in households and across communities (WHO, 2007).

From the figure 5.17, it is found that a significant portion of the respondents i.e. 51.5 percent use sanitary latrines, followed by equal proportion of respondents i.e. 21 percent use semi-sanitary and katcha latrines respectively. However, as per NFHS (2005-2006) it has found those 18 percent rural households have improved toilet facility; whereas, in case of present study it is found that 51.5 percent households are using improved toilet facilities. So, it can be said that the existing sanitary condition of the study area is far better than the country as a whole. The figure shows that less than one tenth of the respondents (6.5%) still practice open defecation. Considering the respondent's academic status it is found that majority of respondents i.e. 70 percent from high level education prefer sanitary latrines; whereas, among the illiterate a considerable number of respondents i.e. 42.4 percent use Katcha latrines. A significant portion of respondents i.e. 45.7 percent is having education up to primary

level use sanitary latrines and more than one third of the respondents i.e. 34.3 percent having education upto upper primary level use Semi-sanitary latrines.

The figure exhibits that there is a certain relationship existingamong the respondents about their preferences towards safe sanitary practices with their level of education. Furthermore, during the present study most of the respondents who are using semi-sanitary latrine have reported that they got latrine under Total Sanitation Programme and ASHA has facilitated them in availing such benefit.

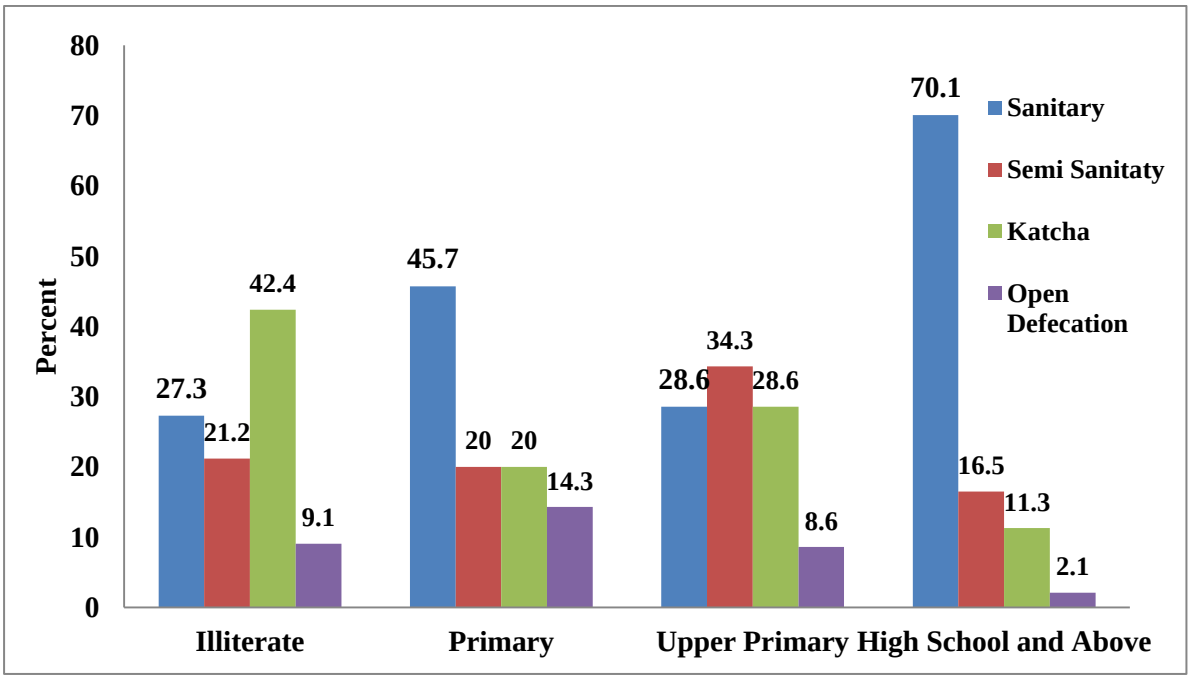


Figure 5.17: Educational and Type of Toilet/Latrine Use

5.2.24 Family Income and Sanitary Practices:

Looking at the figure 5.18, it is seen that the use of sanitary latrines are more as the income goes up i.e. 80 percent respondents from high income group use sanitary latrines. Further, it is observed that none of the respondents from higher income group practice open defecation. The figure exhibits that there is a positive relationship among the family income of the respondents and the type of latrines used by them.

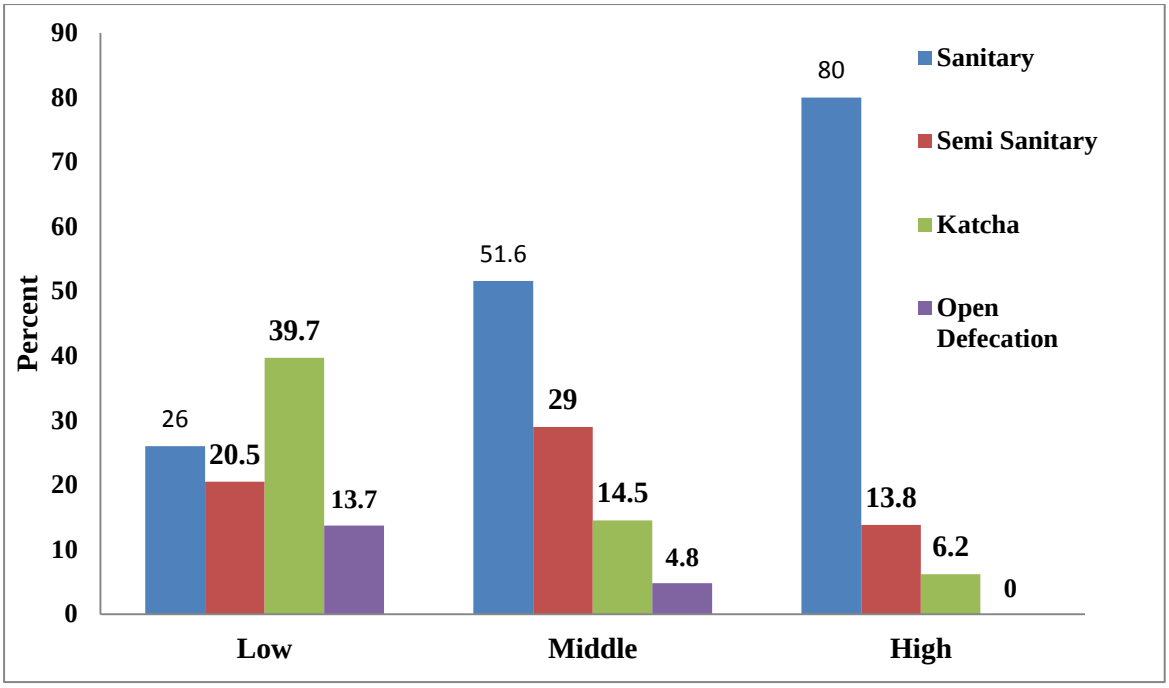


Figure 5.18: Family Income and Type of Toilet/Latrine Use

5.2.25 Religion and Sanitary Practices:

The figure (5.19) indicates that the use of sanitary latrines are more in case of the respondents belong to Christianity i.e. 73.7 percent ; followed by considerable number of respondents (54.6%) belong to Hindu religion and more than one third respondents (35.3%) from Muslim religion use sanitary latrines. However, it is further observed that none of the respondents from Christianity use Katcha latrine and practice open defecation. Considering the religious status of the respondents it can be said that Christian community is well advanced in comparison to Hindu and Muslim community in regard to their sanitary practice.

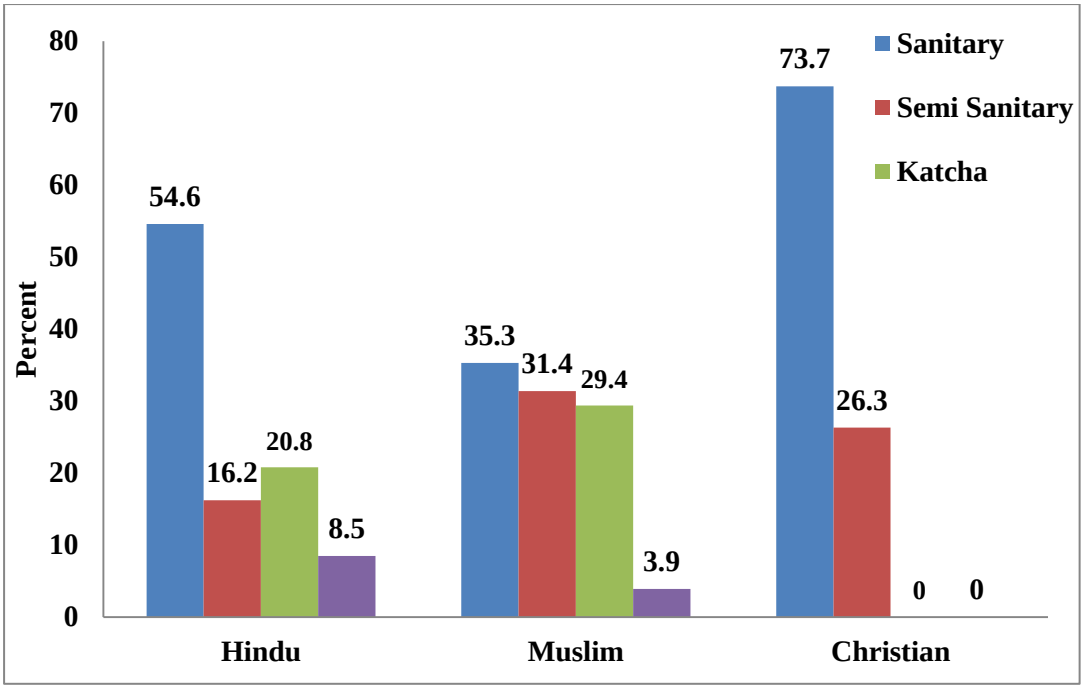


Figure 5.19: Religion and Type of Toilet/Latrine Use

5.2.26 Methods of Waste Disposal:

To prevent the spread of communicable diseases and preserve the environment it is essential to dispose the waste in a proper way.Improved waste disposal system affords many health benefits, both short term benefits of disease avoidance and the long term benefit of enhanced psychological and physical well-being.

The table below shows the methods used by the respondents for disposing the waste.

Table 5.12: Methods Used for Disposing the Waste

Methods used	Frequency	Percentage
Open bins within the compound	75	37.5
Open bins outside the compound	109	54.5
Burn the waste	13	6.5
No such method used	3	2.5
Total	200	100.0

Looking at the table 5.12, it is seen that a significant proportion of respondents i.e. 54.5 percent have expressed that they use open bins outside the compound for disposing the waste; followed by less than two forth respondents i.e. 37.5 percent

have expressed that they use open bins within the compound; However, one tenth respondents i.e. 6.5 percent have expressed that they burn the waste and very small portion of respondent i.e. 2.5 percent have expressed that they are not adopting any fixed method for waste disposal as based on their convenience they use to dispose the waste.

5.2.27 Hand Wash Habits:

Personal hygiene refers to the comprehensive cleaning of and caring for body. It is essential to maintain personal hygiene to combat and prevent diseases and illness. Washing hands can prevent the spread of germs from one person to another or from one part of body to another. It is observed from the study that most of the respondents i.e. 87.5 percent always use shop to wash hands after toilets; followed by about one tenth of the respondents (9.5%) have reported that sometimes they use shop while very small portion of respondents i.e. 2 percent have expressed that they had never use shop after using toilets. In addition, during the present study most of the respondents i.e. 81.5 percent have reported that after cooking they cover their food stuffs and a significant proportion of respondents i.e. 74.5 percent have reported that they use mosquito nets while sleeping.

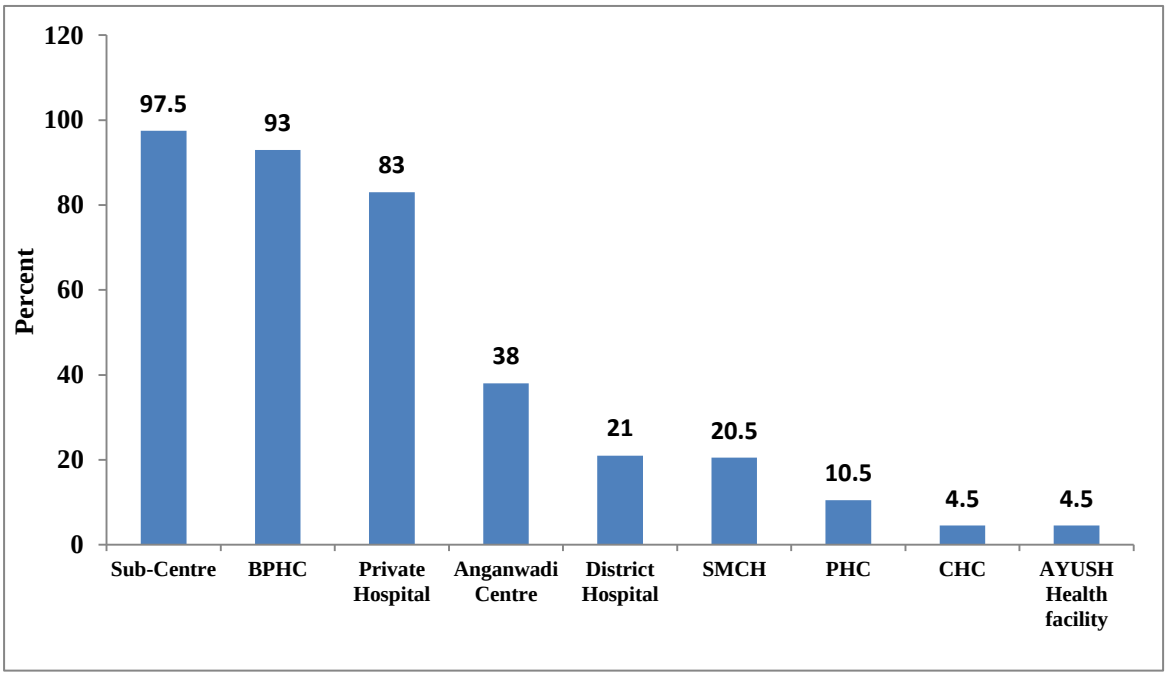
5.3 The Nature and Types of Services

In rural areas, people are mostly dependent on government services offered by SCs/PHCs/BPHCs /CHCs for meeting their health needs. In the present study the researcher has tried to explore that how BPHCs are providing health services to the people under its jurisdictions.Health services provided by BPHC under NRHM put focus on the delivery of those services which are physically available, affordable (economic accessibility), appropriate and acceptable. Health services can be inaccessible if providers do not acknowledge and respect cultural factors, physical barriers and economic barriers, or if the community is not aware of available services. Here, in this chapter the researcher analyse the service delivery system and gap in the delivery of services in field under NRHM.

5.3.1 Availability of Health Facilities:

Availability of health infrastructure is necessary condition to guarantee delivery of services specifically in rural areas. Availability of health facilities and their functional condition contribute to render smooth delivery of health care services.

The diagram below shows the availability of health facility of respondents in a range of 15 Km from their residence.



Multiple Responses Set

Figure 5.20: Availability of Health Facility within 15 Km

From the figure 5.20, it is found that Sub-Centres are mostly available within the 15 Km surroundings in almost all areas as 97.5 percent respondents have expressed this; closely followed by 93 percent respondents have expressed that BPHC is available within the range of 15 KM surrounding from their locality. Further, less than two fourth respondents (38%) expressed that health facilities are available at Anganwadi Centre within their locality, while about one fifth of the respondents have expressed that District Hospital and SMCH is available nearby their locality. In addition, the above figure depicts that a significant portion of respondents i.e. 83 percent have accessibility of privately managed clinics and hospitals in their surroundings.

The above figure reveals that the sub-centres and BPHCs are mostly providing the health care services to the respondents followed by ICDS as these are available in the nearby areas of the respondents.

5.3.2 Availability of Health Care Providers:

NRHM has introduced a number of grassroots health workers like ANM, ASHA and Anganwadi Workers for the promotion of Maternal and Child health.The table below shows the availability of health care providers by the respondents.

Table 5.13: Availability of Health Care Providers

Health Care Providers	Nos. of Response	Percent of Cases
Anganwadi Worker	54	27%
ASHA	180	90%
ANM	136	68%
Dai/ Traditional care givers/others	74	37%
Doctors/Pharmacist	19	10%
Total	463	232%

Multiple Responses Set (N-463)

Looking at the table 5.13 it is seen that in most of the cases there are two or three care givers who provide support to the respondents. Among them ASHA provides support to the patients in most of the cases i.e. 90 percent, followed by a considerable number of respondents (68%) have expressed that ANMs are available. However, availability of Anganwadi worker is expressed by more than one fifth respondents (27%). Beside these, it is seen from the table that Dai and other traditional care givers also provide support to the patients.

The study reveals that though after the launch of NRHM, trained government sponsored professionals are dealing the patient in most of the cases but there are traditional care givers still existing.

5.3.3 Accessibility of Health Facilities:

Access to health services is an important determinant in meeting the health care needs of people, especially those in rural areas. But access is not ensured even if the health

facilities are available and fully functional. The access to health care is constrained by road condition, transport facility and distance covered by the population in its jurisdiction.

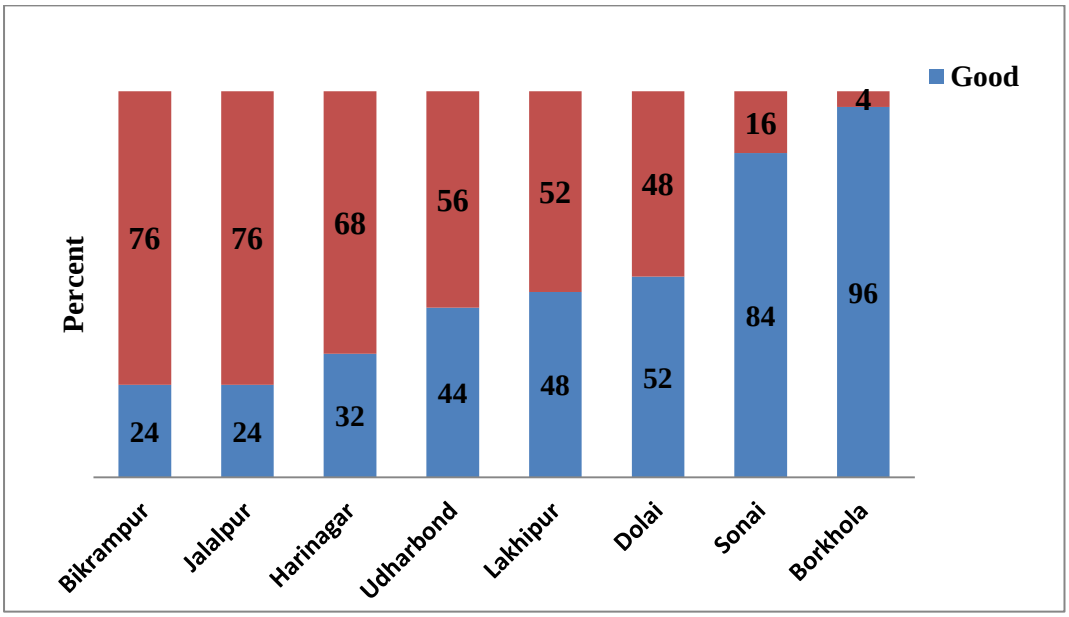


Figure 5.21: Road Condition towards Health Facilities

The above figure 5.21 depicts that almost equal proportion of respondents i.e. 50.5 percent have accessibility of health facility by good road condition and 49.5 percent respondents don't have accessibility to health facilities due to poor road condition.

Considering the accessibility of health facilities offered by different BPHCs of Cachar district, it is observed that Borkhola BPHC is well connected with the villages under its jurisdiction as majority of respondents i.e. 96 percent have reported this; followed by a significant portion of respondents i.e. 84 percent from Sonai Block have reported that they have accessibility of health facility by good road condition. Further, it is observed that there are blocks like Bikrampur, Jalalpur and Harinagar where the road connectivity is very poor as reported by the respondents.

The figure reveals that there are differences in accessibility of health services offered by BPHC as the road conditions are not so well connected with villages under its jurisdiction. In addition, during the present study respondents have reported that during rainy season they face more difficulty to visit the nearest health centre. So, it can be said that after the launch NRHM, till today around half of the respondents are not having accessibility to health facility by good road condition.

5.3.4 System of Medicine:

It is observed from the study that health care practices adopted by the respondents are mainly need based services which are accessible, affordable, and cost-effective and which provide satisfaction to the users.

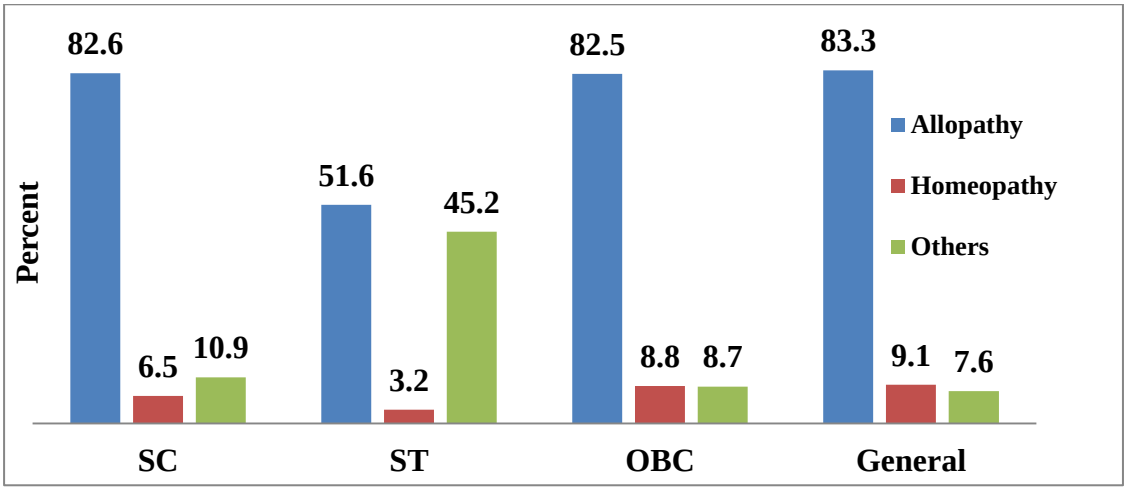


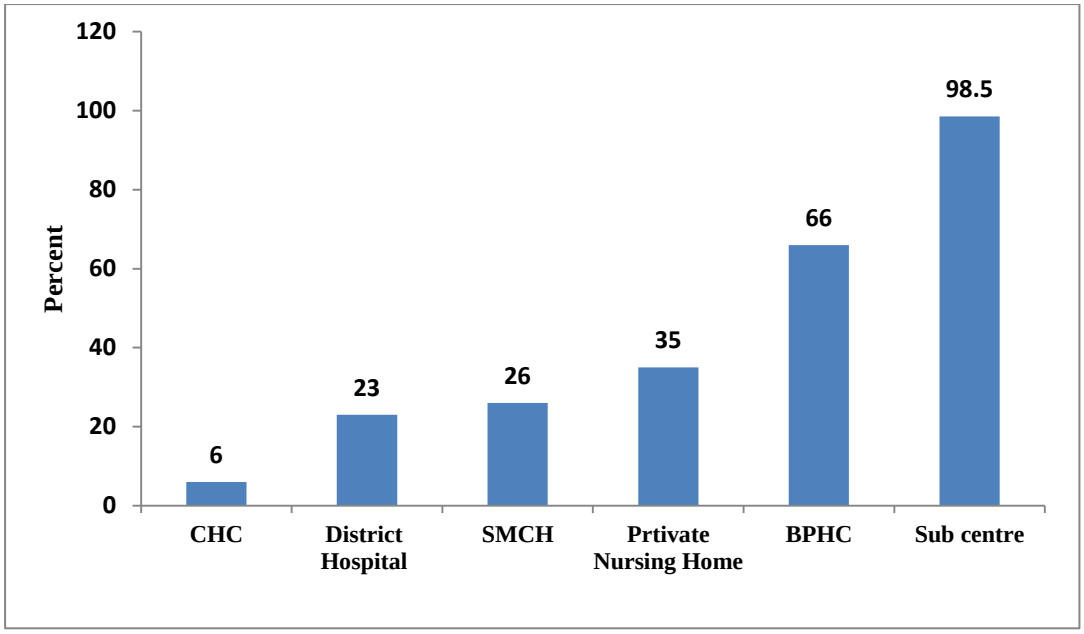
Figure 5.22: Caste and Preferable System of Medicine

The above figure (5.22) depicts that most of the respondents i.e. 77.5 percent prefer Allopathy for its quick response to cure disease and easy accessibility, followed by less than one fifth respondents (15%) prefer Ayurveda & Unani and very small portion of respondents i.e. 7.5 percent prefer Homeopathy. Similar result is found from the study conducted by Neelima & Reddy (2009). As the result of the study revealed that majority of people in rural Andhra Pradesh prefer allopathic medicines because of its quick response to cure diseases.

In comparison to the caste it is observed that respondents belong to SC, OBC and General categories have expressed that mostly they prefer the allopathic treatment due to its easy accessibility; (i.e. 80% & above in each case) whereas among STs more than two third respondent i.e. 45.2 percent prefer Ayurveda &Unani treatment as they believe that these types of treatment don't have any side effects.

5.3.5 Preferred Place for Treatment

From the present study it is observed that respondents have various responses regarding the choices of their first visit for treatment based on the types of diseases and accessibility of health facilities which also reflects their health seeking behaviour.



Multiple Response Set

Figure 5.23: Preferred Place for Treatment

From the figure 5.23, it is found that most of the respondents i.e. 98.5 percent have expressed that they prefer to visit Sub-Centre first for their treatment; followed by BPHC is preferred by a substantial number of respondents i.e. 66 percent, while more than one fifth respondents (26%) have expressed that they prefer to visit SMCH first as it provide better treatment and 23 percent respondents have expressed that they prefer to visit District Hospital first due to its easy accessibility. Even a considerable number of respondents have expressed that they prefer to visit private hospital for seeking treatment due to its proper infrastructure and quality care.

From the above figure it is revealed that sub-centre is the most common choice among the respondents for their treatment followed by BPHC.

5.3.6 Health Care Expenditure:

Health care expenditure is one of the major factors influencing health. For the purpose of this study, expenditure on health care spent by respondent's family has been categorized into 'Low,' 'Average' and 'High' group. Expenditure upto 500 is considered as 'Low', between 501-1000 is termed as 'Average' and expenditure above 1000 is considered as 'High'.

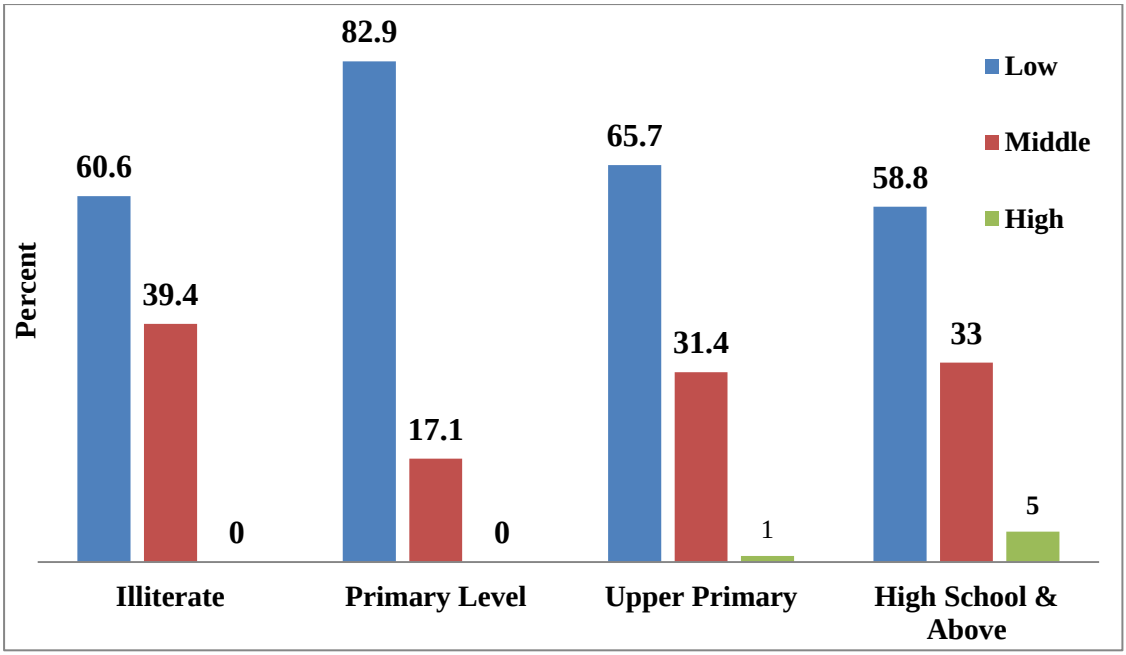


Figure 5.24: Education and Health Care Expenditure (Per month)

The figure 5.24 shows that majority of the respondents have reported that they spend 'low level' of expenditure on health care i.e. 64.5 percent; followed by less than one third respondents (31%) have expressed that they spend 'Average level' of expenditure and very small proportion of respondents i.e. 4.5 percent have reported they spend 'High' expenditure on heath care. However, all the respondents have expressed that household health care expenditure is related the purchase of medicine. The similar observation is also found from the study conducted by Sodani (1997).

Moreover, considering the respondent's academic qualification with the expenditure in health care it is observed that 8.2 percent respondents from highly educated group spend high expenditure on heath care.

5.3.7 Use of Telephone:

In the present study, the researcher has observed that telephonic services for health care are connected to ANM and ASHA in most of the cases. Even patients seek health related advice from doctors of BPHC over telephone.

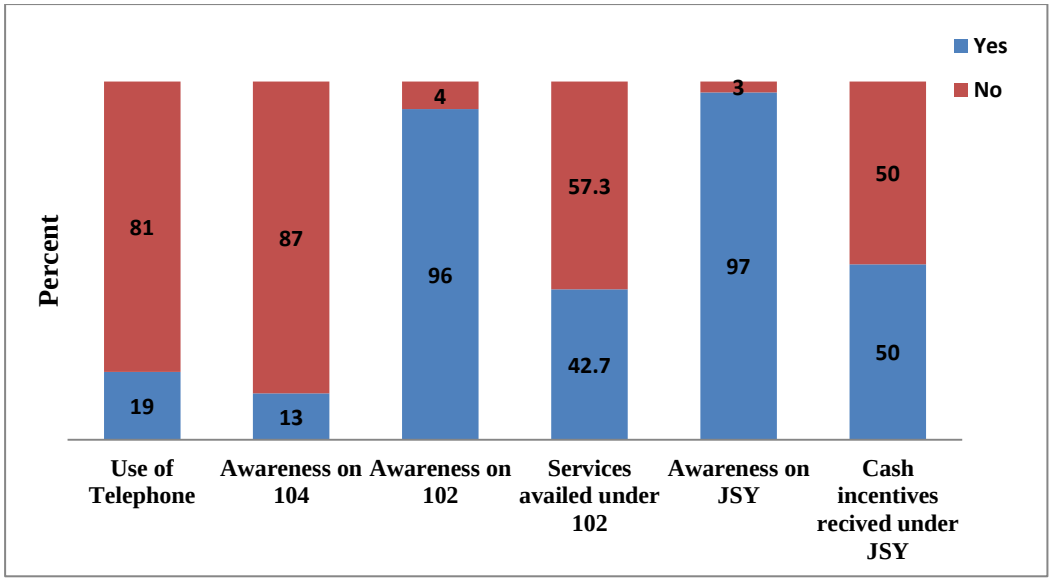


Figure 5.25 Awareness Level and Service Utilizations

From the figure 5.25, it is revealed that around onefifth respondents (19%) have reported that they use telephone to seek health advice from ANM, ASHA and Doctors depending upon the nature of health problem faced by them.

5.3.8 Awareness on 104 Services:

Government of Assam has launched Sarathi 104 as a one stop Health Information Helpline for resolving all health related issues of the citizens of Assam in a time bound manner. 104 Sarathi is a round-the-clock free of cost health contact center. It provides four key services: Medical advice using triage, Counseling services, directory information and complaint registry.

Looking at the figure 5.25, it is seen that most of the respondent's i.e.87 percent are not aware about the services of 104; while more than one tenth (13%) have expressed that they are aware about the 104 service.

In addition, during the present study it is found that out of the aware respondents, 50 percent have reported that they heard the term 104 first times from ASHA. Moreover, it is further observed that more than one fifth respondents i.e. 23 percent have sought help from 104 for seeking counseling service.

5.3.9 Awareness on 102 Services:

102 Ambulance service are meant for pregnant women & sick infants under Janani Shishu Suraksha Karyakram (JSSK). The 102 Ambulance Call Center facilitates calls to ambulances in emergency situations. The objective of 102 is to provide timely assured round the clock transportation services to pregnant women and sick infants at free of cost.

From the figure 5.25, it is seen that most of the respondents i.e. 96 percent have awareness on 102 mobile van services; while a very smallportion of respondents i.e. 4 percent have expressed that they are not aware about the services of 102.

5.3.10 Sources of Awareness on 102 Services:

The table below (5.14) depicts that a significant number of respondents i.e. 66.1 percent have received the information on the services of 102 from ASHA; followed by one fifth respondents (19.8%) received the information from friends and family member. Again, very small portion of respondents i.e. 3.5 percent have received the information from Auxiliary Nurse Midwives (ANM) and one tenth of the respondents have expressed that they received the information from TV and other media.

The table reveals that the ASHA is playing a major role in disseminating the information about 102 among the respondents.

Table 5.14: Sources of Information on 102 Services

Sources	Frequency	Percentage
Family member & friends	38	19.8
ASHA	127	66.1
ANM	6	3.1
TV & other media	19	9.9
Panchayat	2	1.0
Total	192	100

5.3.11 Receiver of 102 Services:

From the figure 5.25, it is found that out of the aware respondents more than two fourth (42.7 %) have received the services on 102 for pregnancy care. However, a substantial portion of respondents i.e. 57.3 percent expressed that they had never received the services due to the poor communication facility. However, most of the respondents have reported that due to poor road condition 102 vans failed to reach the community at right time.

5.3.12 Perception on 102 Service Deliveries:

From the table 5.15, it is found that out of the service receivers of 102, around two fourth respondents (41%) perceived that the services are fully satisfactory; followed by one fifth respondents perceived that services are moderately satisfactory and less than two fourth respondents (38.8%) perceived that 102 services are not satisfactory. It is observed that the services of 102 differ from block to block. Sometimes due to improper road connectivity such services affects, which leads dissatisfaction among the patients.

Table 5.15: Perception on 102 Service Delivery

Perception	Frequency	Percentage
Fully Satisfied	35	41.1
Moderately Satisfied	17	20.0
Not Satisfied	33	38.8
Total	85	100

5.3.13 Awareness on ASHA:

NRHM has provided a trained female community health activist termed as Accredited Social Health Activist (ASHA) to every village in the country. ASHAs are working as a bridge between the ANM and the village and they are accountable to the Panchayat (NRHM, 2005). They are playing a key role in the success of NRHM and to serve mother and child.

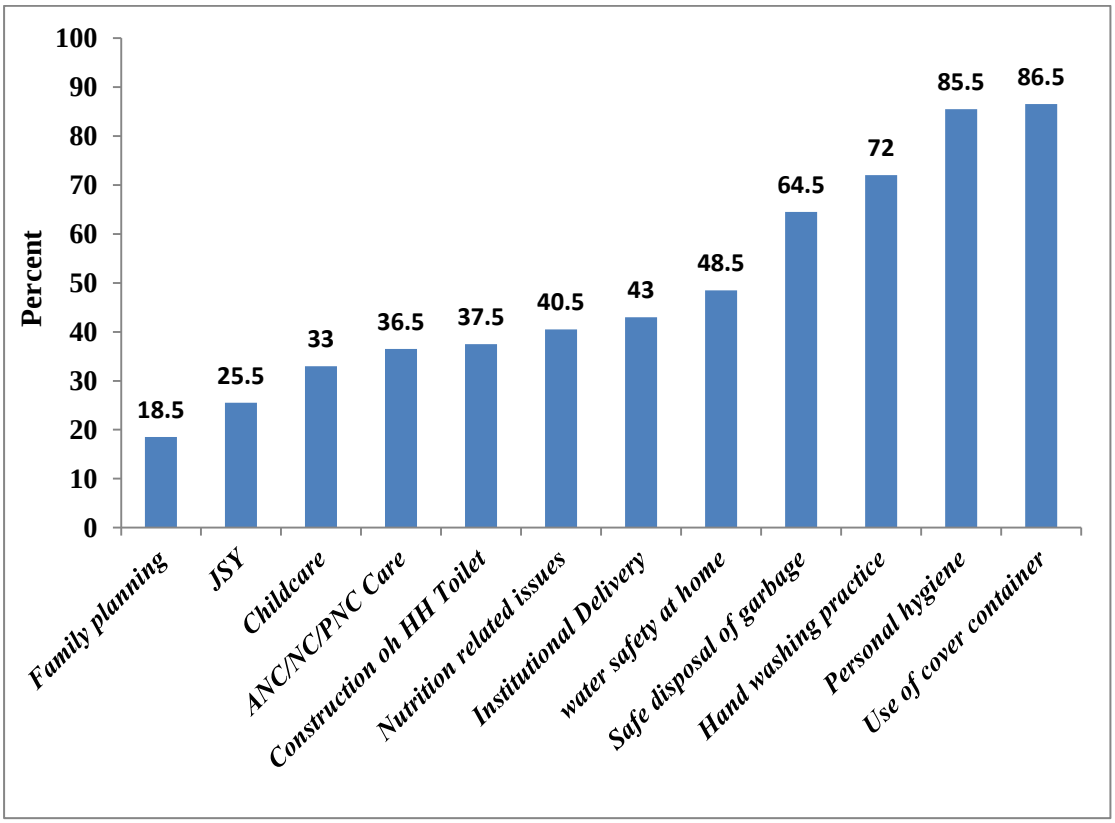
It is found from the present study that all the respondents aware about the term ASHA. However, it observed that though respondents have heard the term ASHA but in real sense all of them are not aware about their roles and responsibility prescribed

by NRHM. In addition, it is observed from the study that half of the respondents (50%) expressed that they are aware about the Kits of ASHA carrying while making home visit to their concerned village.

5.3.14: Discussions Held by ASHA

It is observed from the figure 5.26, that ASHAs are making discussions with the respondents mostly under three broad headings. These are: Sanitation and Hygiene; followed by Maternal and Child Health Care (including JSY, institutional delivery, ANC/PNC and child care) and discussions on Family Planning and other aspects.

The figure shows that frequency of advice given by ASHA in case of family planning, JSY and ANC is low in comparison to the advice given on sanitation and hygiene aspect. The study shows that much training is required to orient ASHA that for the improvement of overall health condition of women she need to put equal focus on each and every aspects of women's health including sanitation and hygiene, Maternal and Child health care and family planning aspects.



Multiple Responses Set

Figure 5.26: Discussions Held by the ASHA during Home Visit

5.3.15 Awareness on ANC:

NRHM has given importance on Antenatal Care (ANC). The ANC package include physical checks, checking position and growth of foetus, measuring blood pressure, weight check of pregnant women, giving IFA tablets and giving Tetanus Toxoid injection (TT) at periodic intervals during the time of pregnancy. At least three ANC are expected to complete the course of ANC to safeguard women from pregnancy related complications.

Table 5.16: Frequency of ANC

NOs of ANC	Frequency	Percentage
One ANC	50	25.0
Two ANC	62	31.0
Three ANC	40	20.0
No ANC	48	24.0
Total	200	100.0

It is found from the above table 5.16 that one fifth respondents (20%) have done full ANC; followed only one ANC is done by one fourth respondents (25%) and a substantial portion of respondents (31%) have done two ANC. However, the study shows that about one fifth respondents (24%) had never done any ANC. In addition, it is observed from the study that major ANC was done in II trimester this means 4 to 6 month pregnancy period. During the last trimester i.e. from 7 to 9 months doctors recommend regular checkups. Further, out of the respondents who have done ANC, it is found that 26.3 percent expressed that they have done regular checkups in last trimester. It is observed from the study that half of the respondents i.e. 50 percent approached to ANM for antenatal care and about one third respondents (32.8%) expressed that ASHA facilitated them to avail the checkups.

5.3.16 Consumption of IFA Tablets:

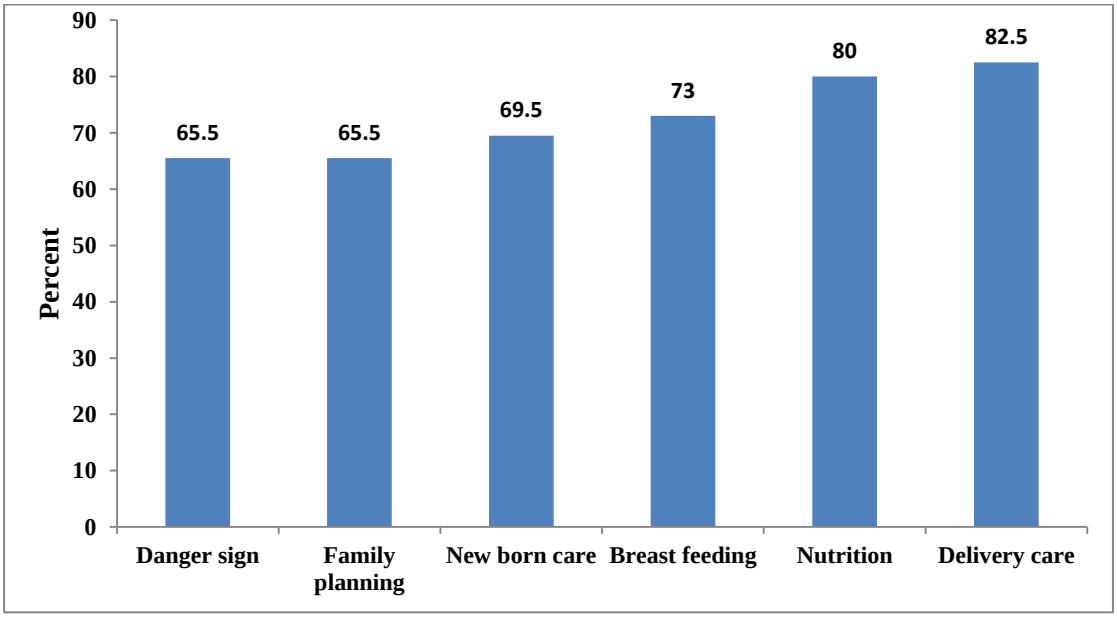
Consumption of Iron Folic Acid tablets is necessary for pregnant women as in India anemia among pregnant women is very common. It is observed from the present study that a significant number of women i.e. 60 percent have consumed IFA at the time of pregnancy and two fourth respondents have reported that they have never taken IFA due to various reasons including feeling of nausea after consumption and

lack of awareness about IFA. However, it is found from the study that among the respondents who have consumed IFA , one fifth have reported that there is irregular supply of IFA from sub centre as a result they are failed to consume full dose of IFA.

5.3.17 ASHA's Advice to the Respondents:

The respondents have given multiple responses about the advices/tips they received from ASHA/ ANM for having safe pregnancy and delivery.

The figure below shows the types of advice received by the respondents from ASHA and ANM during pregnancy.



Multiple Responses Set

Figure 5.27: Types of Advices Received during Pregnancy

From the figure 5.27, it is revealed that ASHAs have advised most of the important aspects (i.e. diet, danger sign of pregnancy, delivery care, breastfeeding, new born care and family planning method) which is essential to be observed by a pregnant mother. However, it is revealed from the above figure that ASHA and ANM are giving more focus on the discussion related to nutrition and delivery care in comparison to the discussion related to danger sign of pregnancy and family planning method.

5.3.18 Awareness on Village Health Sanitation and Nutrition Committee (VHSNC):

VHSNC is one of the key components of NRHM. The committee has been formed to take collective actions on issues related to health and its social determinants at the village level. The committee is envisaged to take leadership in providing a platform for improving health awareness and access of Community for health services, address specific local needs and serve as a mechanism for community based planning and monitoring (NRHM, 2005). Under NRHM, Village Health and Nutrition Day (VHND) will be organised in each Gram Sabha level per month in coordination with VHSNC, Anganwadi Worker, ANM and ASHA worker.

Table 5.17: Awareness on VHSNC

Block	Availability of VHSNC		Total
	Yes	No	
Bikrampur	24	1	25
	96%	4%	100%
Dolai	10	15	25
	40%	60%	100%
Jalalpur	24	1	25
	96%	4%	100%
Harinagar	9	16	25
	36%	64%	100%
Lakhipur	17	8	25
	68%	32%	100%
Udarbondh	11	14	25
	44%	56%	100%
Sonai	6	19	25
	24%	76%	100%
Borkhola	7	18	25
	28%	72%	100%
Total	108	92	200
	54%	46%	100%

The above table (5.17) shows that a considerable number of respondents (46%) are not aware about the term VHSNC. The table (5.16) depicts that there is a variation of responses regarding the functioning of VHSNC at different blocks. It varies from minimum 24 percent in Sonai to maximum 96 percent in Bikrampur and Jalalpur. In addition, it is also observed from the study that though respondents are visiting Anganwadi centre once in a month for giving vaccination to their child and sometimes for antenatal care but in reality they don't have proper information about the purpose of such visit in a particular day. Surprisingly, it is observed that a significant portion of respondents (45%) are not aware about fixed Village Health and Nutrition Day (VHND) to their concerned village.

5.3.19Awareness on Janani Suraksha Yojona (JSY):

JSYis a safe motherhood intervention launched in 2005 under the umbrella of NRHM.Its main objective is to reduce Maternal and Neonatal Mortality by promoting institutional delivery among poor pregnant women. It is a 100 percent centrally sponsored scheme under NRHM and it integrates cash assistance with delivery and post-delivery care to pregnant women and community health workers (NRHM, 2005).

From the figure 5.25, it is found that most of the respondents i.e. 97 percent have awareness on JSY. In addition, out of the aware respondents a significant portion i.e. 82.5 percent have expressed that they have received the information on JSY from ASHA; followed by an equal portion of respondents (8.3%) have expressed that they received the information from ANM and Panchayat members respectively. So it can be said that ASHA plays a very crucial role in disseminating the information about JSY to the women from reproductive age group.

5.3. 20 Cash Incentives Received under JSY:

From the figure 5.25, it is revealed that half (50%) of the respondents have expressed that they have received the cash incentives under JSY; while half of them have expressed that they have not yet received the cash incentives under JSY. Further, it is found that some of the respondents who have received the benefits expressed that ASHA/ANM facilitated them in availing such benefits; while others have expressed that after so many calls ASHA have not facilitated them in availing the benefit of JSY. There is a variation of responses from block to block regarding the help

provided by ASHA in availing the cash incentives under JSY. Moreover, it is observed from the study that most of the respondents expressed that the procedure of getting JSY card is too lengthy and sometimes complicated due to the submission of some documents. Surprisingly, it is observed from the study one fifth respondents who have received cash incentives under JSY have reported that they paid some amount of money to the staffs of BPHC for various medical reasons as a result respondents found them cheated as they do not get the full amount under JSY.

5.3. 21 Place of Delivery:

Though efforts are made by NRHM to promote Institutional deliveries for all children, but still there are preferences among the respondents which discussed and explained in tables below**.**

Table 5.18: Place of Last Delivery

Blocks	Place of delivery					
	At Home	District Hospital	BPHC	Private Hospital	SMCH	Total
Bikrampur	14	7	4	0	0	25
	56%	28%	16%	0%	0%	100%
Dolai	4	1	9	1	10	25
	16%	4%	36%	4%	40%	100%
Jalalpur	12	8	4	0	1	25
	48%	32%	16%	0%	4%	100%
Harinagar	2	1	22	0	0	25
	8%	4%	88%	0%	0%	100%
Lakhipur	0	2	23	0	0	25
	0%	8%	92%	0%	0%	100%
Udarbondh	3	0	22	0	0	25
	12%	0%	88%	0%	0%	100%
Sonai	2	8	9	5	1	25
	8%	32%	36%	20%	4%	100%
Borkhola	5	18	2	0	0	25
	20%	72%	8%	0%	0%	100%
Total	42	45	95	6	12	200
	21%	23%	48%	3%	6%	100%

It is found from the table 5.18, that about one fifth deliveries have been conducted at home; whereas, most of the deliveries (79 %) have been conducted at the institutional level that includes district hospital, BPHC, Pvt. Hospital and SMCH. However, it is further observed that a significant number of the respondents i.e. 47.5 percent have reported that they have conducted their last delivery at BPHC. However, as per NFHS (2005-2006) in India 72 percent deliveries have been conducted at home. So from the present study it can be said that, the condition has improved from earlier.

Considering the place of delivery with different blocks of Cachar district it is observed that most of the home deliveries are conducted at Bikrampur Block i.e. 52 percent; closely followed by Jalalpur 48 percent. This may be due the poor road condition and lack of availability of trained doctors. In other blocks it is found that majority of deliveries have been conducted at institutional level.

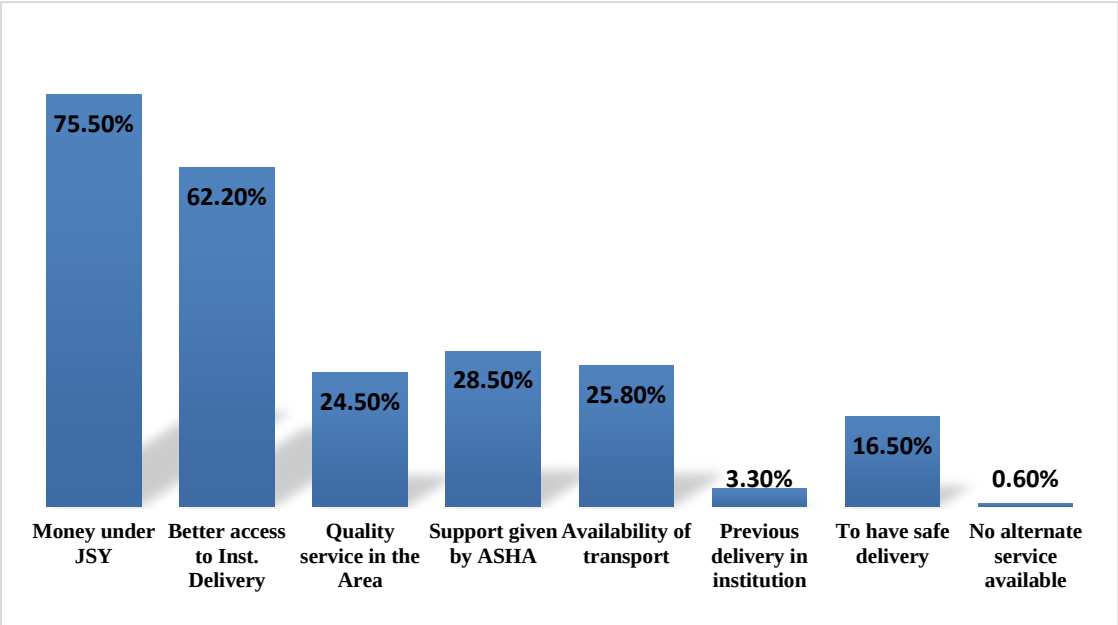
5.3.22 Types of Delivery:

From the present study it is observed that about one tenth respondents (9.5%) have reported that their last delivery was done at caesarean section, while most of the respondents i.e. 90.5 percent have reported that the type of their last delivery was normal.

However, the similar result was found as per the NFHS (2005-2006). As in that survey it was found that 9 percent of children born in India in the 5 year before the survey were delivered by caesarean section.

5.3.23 Reasons of Opting Institutional Delivery:

NRHM is committed towards the improvement of Maternal and Child Health through promoting institutional delivery. The figure below depicts the reason for opting institutional delivery by the respondents.



Multiple Responses Set

Figure 5.28: Reasons for Opting Institutional Delivery

The figure 5.28 reveals that JSY has created a good impact in increasing the institutional deliveries among the rural women as most of the respondents i.e. 75.5 percent have expressed that money under JSY is one of the reasons to have institutional delivery; followed by a considerable number of respondents (62.2%) have expressed that better access to institutional delivery is another reason to have institutional delivery. However, it is further observed that ASHAs have made the respondents aware about the safety involved in having institutional delivery as most of the respondents have expressed this.

5.3.24 Reasons for Home Delivery:

It is found from the present study that out of total respondents about one fifth deliveries (21%) have been taken place at home. The reasons expressed by the respondents for conducting deliveries at home are displayed in the figure below.

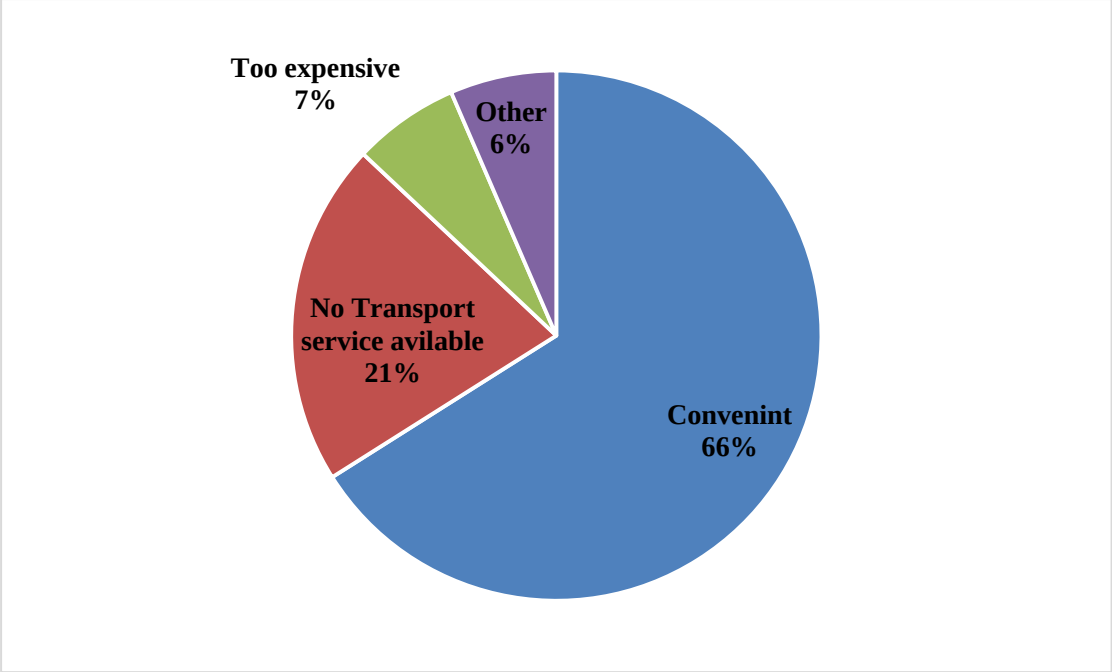


Figure 5.29: Reasons for Opting Home Delivery

From the figure 5.29, it is found that most of the respondents i.e. 66 percent have expressed that home delivery is convenient; followed by non-availability of transport facility is expressed by one fifth respondents (21%); while less than one tenth respondents (7%) expressed that institutional delivery is too expensive and a small portion of respondents (6%) have expressed due to some other reasons including religious beliefs and family pressure they preferred home visit.

5.3.25 Awareness on Nischoy Pregnancy Test Kit (NPTK):

NRHM has introduced NPTK which women can use for the early detection of pregnancy. It is available with all the ASHAs and these are meant to be distributed free of costs to the women from reproductive age group in the field by ASHAs.

It is observed from the present study that a majority of respondents i.e. 56 percent are not aware about NPTK; whereas, a substantial number of respondents (44%) have expressed that they are aware about NPTK. Further, most of the respondents who have awareness about NPTK reported that due to irregular supply most of the time ASHA failed to provide this kit to the respondents at the time of need.

5.3.26 Awareness on Immunization:

Universal Immunization Programme is a vaccination program launched by the Government of India in 1985. It became a part of Child Survival and Safe Motherhood Programme in 1992 and currently it is one of the important components under NRHM.

Table 5.19: Awareness on T T Immunization at Blocks

Block	Awareness on Immunization		Total
	Yes	No	
Bikrampur	20	5	25
	80%	20%	100%
Dolai	22	3	25
	88%	12%	100%
Jalalpur	19	6	25
	76%	24%	100%
Harinagar	14	11	25
	56%	44%	100%
Lakhipur	24	1	25
	96%	4%	100%
Udarbondh	25	0	25
	100%	0%	100%
Sonai	24	1	25
	96%	.4%	100%
Borkhola	24	1	25
	96%	4%	100%
Total	172	28	200
	86%	14%	100%

From the table 5.19, it is inferred that most of the respondents i.e. 86 percent have reported that they are aware about Tetanus immunization for pregnant mother. It is observed from the study that though respondents have awareness on vaccination but in reality they don't have proper information about the time of and dose of each vaccine so it happens that many a time they do not complete full dose of vaccine.

Considering the block wise awareness of respondents on TT immunization it is observed that a high majority of respondents i.e. 76 percent from each block have awareness on immunization except in case of Harinagar block it is 56 percent. Further observed that in case of Udarbondh block 100 percent respondents have awareness on immunization; followed by 96 percent in Sonai, Jalalpur and Borkhola block.

5.3.27 Education and Family Planning Method:

Family planning is a method that allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility. Family Planning is not confined to only birth control or contraception. It is important as a whole for the improvement of the family's economic condition and for better health of the mother and her children. Though India has launched Family Planning programme in the year 1952, but since 2005 it has become an important component of NRHM.

It is observed from the present study that a high majority of respondents i.e. 86 percent have awareness on one or more methods of contraception. As per NFHS (2005-2006) 98 percent Indian women are aware about one or more contraception. The table 5.20 indicates that almost equal proportion of respondents i.e. 42 percent prefer condom as family planning method; 40.5 percent prefer other methods that includes safe period & oral pills and a very small proportion of respondents i.e. 3.5 percent have opted female sterilization as family planning method. However, it is further found that less than one fifth respondents (14%) had never used any such methods of contraception due to lack of awareness.

Comparing the level of education of the respondents it is observed that no much difference found for the use of family planning methods. For the use of condom it varies from 34.3 percent to 45.4 percent and in case of other method it varies from 31.4 percent to 45.5 percent.

Table 5.20: Education and Preference of Family Planning Method

Education	Preference of Family Planning Method				Total
	Condom	Female Sterilization	Other	No Such Method Adopted	
Illiterate	12	2	15	4	33
	36.40%	6.10%	45.50%	12.10%	100.00%
Primary Level	16	2	11	6	35
	45.70%	5.70%	31.40%	17.10%	100.00%
Upper Primary	12	1	15	7	35
	34.30%	2.90%	42.90%	20.00%	100.00%
High school and above	44	2	40	11	97
	45.40%	2.10%	41.20%	11.30%	100.00%
Total	84	7	81	28	200
	42.00%	3.50%	40.50%	14.00%	100.00%

5.3.28 Religion and Family Planning Method:

From the table 5.21, it is found that about half of the respondents i.e. 48.5 percent from Hindu religion have expressed that they use condom as family planning method; followed by one third respondents (33.1%) have expressed that they use other method as family planning. Further, a considerable number of the respondents from Muslim and Christian religion have reported that they use other method as family planning i.e. Muslim 51 percent and Christian 63.2 percent respectively. It is also observed that almost one fifth respondents (20%) from Muslim religion have reported that they have never adopt any family planning method ; followed by more than one tenth (13.8%) among Hindus. On the other hand, it is observed that 100 percent Christians are using either of the method as family planning.

The table reveals that there is a positive relation exists among the religious status of the respondents and their preference for family planning method.

Table 5.21: Religion and Preference of Family Planning Method

Religion	Preference of Family Planning Method,				Total
	Condom	Female Sterilization	Other methods	No such method adopted	
Hindu	63	6	43	18	130
	48.5%	4.6%	33.1%	13.8%	100.0%
Muslim	14	1	26	10	51
	27.5%	2.0%	51.0%	19.6%	100.0%
Christian	7	0	12	0	19
	36.8%	.0%	63.2%	.0%	100.0%
Total	84	7	81	28	200
	42.0%	3.5%	40.5%	14.0%	100.0%

5.3.29 Caste and Family Planning Method:

Looking at the table 5.22, it is seen that highest number of STs i.e. 61.3 percent have expressed that they use condom as family planning method; followed by a considerable number of respondents (52.2%) belong to SCs category; a substantial portion of respondents (36.8%) from OBCs category and three tenth respondents (30.3%) from General categories use condom as family panning method. Even, about half of the respondents from General category have expressed that they use other method as family planning.

It is further observed that STs are 100 percent in using any of the family planning method; followed by one fifth respondents (19.6%) from SC category, less than one fifth (18.2%) from General category and more than one tenth (12.3%) respondents from OBC categories have expressed that they have never adopt any of the family planning method.

Table 5.22:Caste Status and Preference of Family Planning Method

Caste	Preference of family planning method				Total
	Condom	Female Sterilization	Other methods	No such method adopted	
SC	24	2	11	9	46
	52.2%	4.3%	23.9%	19.6%	100.0%
ST	19	0	12	0	31
	61.3%	.0%	38.7%	.0%	100.0%
OBC	21	3	26	7	57
	36.8%	5.3%	45.6%	12.3%	100.0%
General	20	2	32	12	66
	30.3%	3.0%	48.5%	18.2%	100.0%
Total	84	7	81	28	200
	42.0%	3.5%	40.5%	14.0%	100.0%

So from the above discussion it is reveals that 100 percent STs as well as Christians are using family planning method. So it can be said that STs as well as Christians are much well advance in this direction. In addition, during the present study it is observed that most of the respondents have shown hesitation while sharing their opinion regarding family planning method.

So from the above discussions it can be said that the use of contraception among the married women varies markedly by education, religion and caste. The similar result is also found from NFHS (2005-06).

5.4 Perception of Patients towards the Services

Perception, at this juncture, refers to the views, satisfaction and suggestions of beneficiaries towards the services offered by BPHC. Such issues are interpreted in the discussions below.

5.4.1 Reasons for visiting BPHC:

It is observed from the present study that there are three major reasons for which respondents prefer to visit BPHC. These are displayed in the figure below.

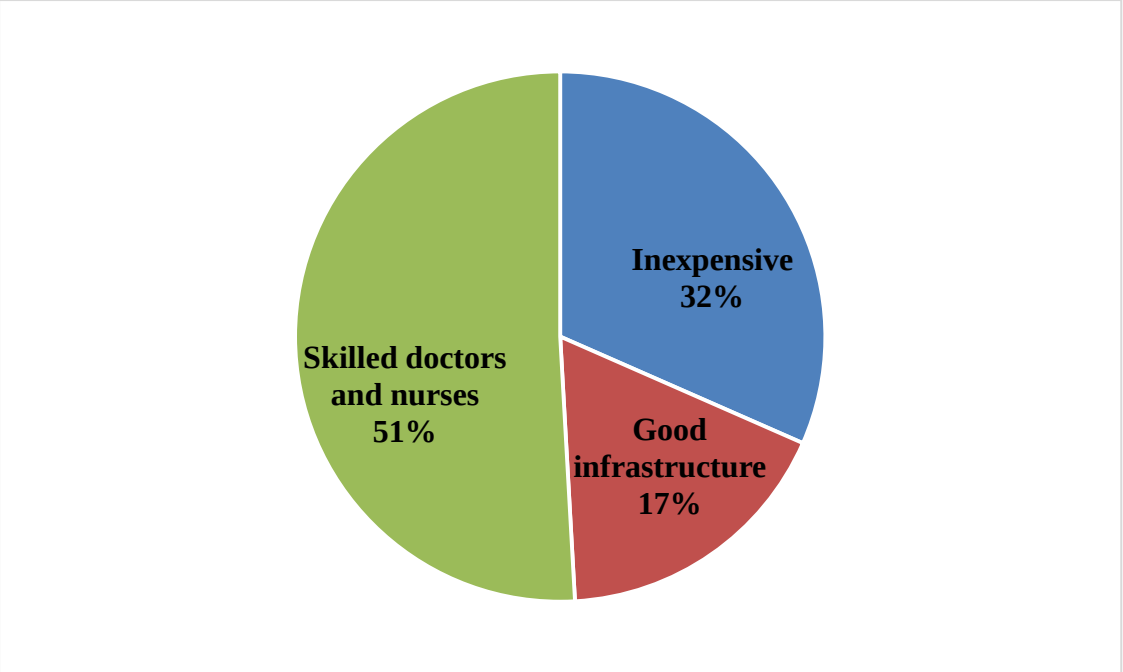


Figure 5.30: Reasons for Opting Services of BPHC

From the figure 5.30, it is found that a majority of respondents i.e. 51.4 percent have expressed that they visit BPHC for its inexpensive health care treatment; followed by a substantial number of respondents (31.9%) have expressed that availability of skilled doctors and nurses is one of the major reasons for seeking health care services from BPHC. Beside these, less than one fifth respondents (17.7%) have reported that due to the availability of good infrastructure they prefer to seek treatment from BPHC.

5.4.2 Sources of Information:

Looking at the figure 5.31, it is seen that a majority of respondents i.e. 54.5 percent have received the information about the services of BPHC from the ASHA; followed by more than one tenth respondents (13%) have received the information from ANM, about one fifth respondents (21%) have received the information from family members & relatives and about one tenth respondents (11.5%) have reported that they received the information from their neighbors.

The above figure exhibits that ASHA is playing an important role in disseminating information about the services of BPHC among the respondents

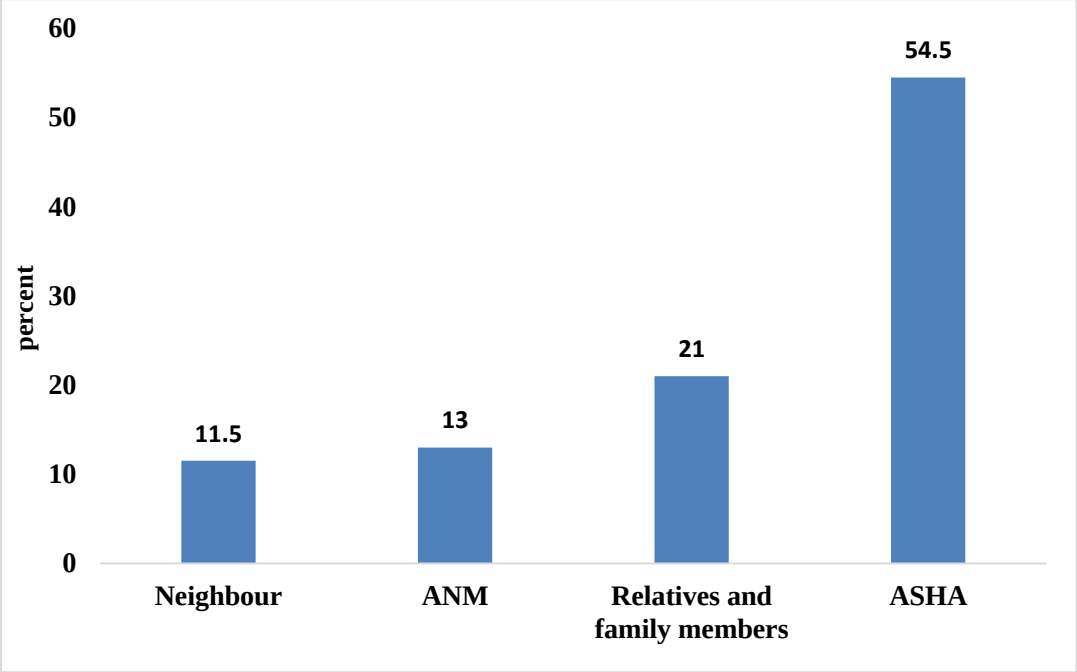


Figure5.31: Sources of Information on BPHC

.5.4.3 Mode of Transportation:

Availability of transport facility is one of the most important factors in determining the accessibility of health care facilities. However, the availability of transportation varies from block to block and also within a block depending upon the level of development.

Table 5.23: Mode of Transportation for BPHC

Block	Mode of Transportation					Total
	On foot	**Auto rickshaw**	**Bus**	**Truck**	**Other**	
Bikrampur	1	9	7	3	5	25
	4.0%	36.0%	28.0%	12.0%	20.0%	100.0%
Dalai	0	10	0	0	15	25
	.0%	40.0%	.0%	.0%	60.0%	100.0%
Jalalpur	1	8	7	3	6	25
	4.0%	32.0%	28.0%	12.0%	24.0%	100.0%
Harinagar	0	13	0	0	12	25
	.0%	52.0%	.0%	.0%	48.0%	100.0%
Lakhipur	0	21	0	0	4	25
	.0%	84.0%	.0%	.0%	16.0%	100.0%
Udarbondh	0	14	5	0	6	25
	.0%	56.0%	20.0%	.0%	24.0%	100.0%
Sonai	4	12	2	0	7	25
	16.0%	48.0%	8.0%	.0%	28.0%	100.0%
Borkhola	0	14	1	0	10	25
	.0%	56.0%	4.0%	.0%	40.0%	100.0%
Total	6	101	22	6	65	200
	3.0%	50.5%	11.0%	3.0%	32.5%	100.0%

The table 5.23 indicates that a significant portion of respondents i.e. 50.5 percent have reported that they depend on auto rickshaw plying on road to reach BPHC; followed by one third respondents (32.5%) have expressed that they prefer other modes including ambulance, private taxi e.t.c. Further, the above table depicts that there is a block wise variation from 32 percent to 84 percent on the use of auto rickshaw followed by other modes i.e. 32 percent to 60 percent.

It can be said from the above tables that on the basis of road condition and availability of vehicles respondents decide and use different modes of transportation to reach BPHC.

5.4.4 Travelling Time:

It is found from the table below (5.24) that a considerable number of respondent i.e. 47 percent expressed that more than 30 minutes time is require to reach BPHC from their residence.; followed by 31 percent have reported that they can reach at BPHC within the time of 15 minutes and 22 percent respondents have reported that they can reach at BPHC within 30 minutes from their residence. However, the time taken to reach the BPHC depends on distance, availability of public transport and road conditions.

Table 5.24 : Travelling Time to Reach BPHC (in minutes)

Block	Time to reach BPHC (in minutes)			
	1 - 15	Upto 30	More than 30	**Total**
Bikrampur	7	6	12	25
	28.0%	24.0%	48.0%	100.0%
Dolai	0	2	23	25
	.0%	8.0%	92.0%	100.0%
Jalalpur	7	6	12	25
	28.0%	24.0%	48.0%	100.0%
Harinagar	9	3	13	25
	36.0%	12.0%	52.0%	100.0%
Lakh pur	18	1	6	25
	72.0%	4.0%	24.0%	100.0%
Udarbondh	17	7	1	25
	68.0%	28.0%	4.0%	100.0%
Sonai	4	13	8	25
	16.0%	52.0%	32.0%	100.0%
Borkhola	0	6	19	25
	.0%	24.0%	76.0%	100.0%
Total	62	44	94	200
	31.0%	22.0%	47.0%	100.0%

5.4.5 Seating Arrangement:

It is found from the figure below (5.32) that more than two fourth respondents (43.5%) have perceived that seating arrangement is adequate, while a significant portion of respondents (56.5%) have perceived that seating arrangement is inadequate which leads dissatisfaction among the patients. Similar result is also found from the study conducted by Dey & Dutta (2012) as the study have also highlighted that there is no proper seating arrangement, cleanliness and toilet facilities at Silchar Medical College and Hospital which again leads to dissatisfaction among the patients.

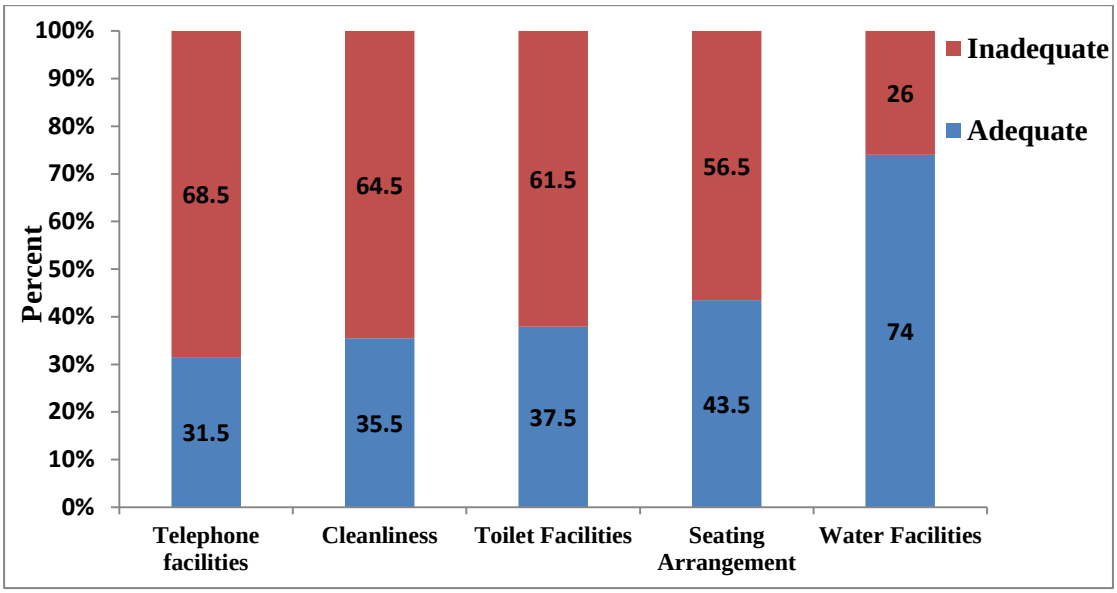


Figure 5.32: Perception on Facilities for patients at BPHC

5.4.6 Cleanliness:

The above figure (5.32) indicates that more than one third respondents (35.5%) have perceived that BPHC maintains cleanliness; whereas a high majority of respondents i.e. 64.5 percent have perceived that cleanliness is not properly maintained at BPHC. However, it is important to highlight here that respondents belongs to different Block have different opinion about cleanliness and availability of seating arrangement at the BPHCs of Cachar district.

5.4.7 Toilet Facilities:

From the figure 5.32, it is found that less than two fourth respondents (37.5%) have perceived that the toilet facilities are available and clean at BPHC, while a significant

number of respondents i.e. 61.5 percent have perceived that though toilet facilities are available butthese are not maintained properly. During the present study it is observed that most of respondents have reported that BPHCs are not having separate toilet which again create problems for the patients.

However, in the present study it is observed that respondents who come late at BPHC found the toilet dirty in comparison to those who come first.

5.4.8 Drinking Water Facilities:

It is found from the figure 5.32 that a majority of respondents i.e. 74 percent have expressed that there is an availability of drinking water atBPHC and around one fifth respondents (26%) have expressed that though drinking water facilities are available at BPHC but there is no continuous supply of drinking water. The similar result is found from the study conducted by Seetharamu (2004).

5.4.9 Telephone Facilities:

The figure (5.32) indicates that around one third respondents (31.5%) have expressed that the telephone facility is available within the premise of BPHC; while majority of respondents i.e. 68.5 percent have expressed that the telephone facility is not available at BPHC

5.4.10 Waiting Period:

The table below (5.25) indicates that most of the respondents i.e. 79.5 percent have expressed that they have to wait upto 30 minutes at BPHC to consult a doctor; while about one fifth of the respondents (20.5%) have expressed that they wait upto one hour to consult doctors at BPHC. However, similar result is found from the study conducted by Muhondwal et al (2008) shows that mainly the dissatisfaction persist among the patients due to long waiting times before receiving services.

Further, the table depicts in case of Borkhola block around half of the respondents (48%) have reported that they have to wait upto 1 hour to consult a doctor; followed by more than one fourth respondents (28%) from Bikrampur and Jalalpur have the same observation.The reason for such variation is lack of man power and huge work load as reported by both patients and doctors of BPHC. However during the present study it is observed that some of the respondents have reported that they have faced a

situation where after long time waiting they could fail to consult doctors at BPHC.

Table 5.25 : Waiting Period to Consult Doctors

Block	Waiting Period		Total
	Below 30 minutes	Upto 1 hour	
Bikrampur	18	7	25
	72.0%	28.0%	100.0%
Dolai	20	5	25
	80.0%	20.0%	100.0%
Jalalpur	18	7	25
	72.0%	28.0%	100.0%
Harinagar	20	5	25
	80.0%	20.0%	100.0%
Lakhipur	24	1	25
	96.0%	4.0%	100.0%
Udarbondh	24	1	25
	96.0%	4.0%	100.0%
Sonai	22	3	25
	88.0%	12.0%	100.0%
Borkhola	13	12	25
	52.0%	48.0%	100.0%
Total	159	41	200
	79.5%	20.5%	100.0%

5.4.11 Doctor's Extent of Attention:

From the table 5.26, it is found that more than one fourth respondents (26.5%) perceived that at BPHC doctors are always attentive as they listen carefully to the problems faced by patients at the time of treatment; while about one third respondents (34%) perceived that the doctors are sometimes attentive and a considerable portion of respondents (39.5%) expressed that at BPHC doctors are never attentive towards the patient. However, it is reveled from the table 5.26 that against the education qualification of the respondents no relations are coming out towards the doctors'

treatment meted to the patients. However, patients expect better and more care during their treatment.

It is observed from the present study that sometimes respondents fell hesitate to express their health problems specifically their reproductive health problem freely in front of maledoctors. Therefore, NRHM need to appoint both male and female doctors at each BPHC to deal with the reproductive health issues of women.

Table 5.26: Education and Doctor's Extent of Attention during Treatment

Education	Doctor's Extent of Attention			
	Always attentive	**Sometimes attentive**	**Never attentive**	**Total**
Just literate	10	9	14	33
	30.3%	27.3%	42.4%	100.0%
Primary	4	11	20	35
	11.4%	31.4%	57.1%	100.0%
Upper Primary	11	13	11	35
	31.4%	37.1%	31.4%	100.0%
High School & Above	28	35	34	97
	28.9%	36.1%	35.1%	100.0%
Total	53	68	79	200

5.4.12 Explanation of Treatment & Diseases:

Looking at the table 5.27, it is seen that one fourth respondents (24.5%) expressed that at BPHC doctors always explain the health problems faced by the patients; while more than one fourth respondents (28%) expressed that doctors sometimes explain health problems faced by the patients and a significant number of respondents i.e. 47.5 percent expressed that doctors never explain the health problems faced by the patients in a proper way.

In addition among the STs a high majority of respondents expressed that they had never got the opportunity from doctors to know their health issues properly. Further it is observed that 28.3 percent respondents from general category expressed that at

BPHC doctors always explain them about their diseases and treatment required to cure this problem.

The above table exhibits that patients are not found to be satisfactory to know their health status from doctors

Table 5.27: Caste and Explanation of Treatment & Diseases by Doctors

Caste	Explanation of Treatment & Diseases			Total
	Always	Sometimes	Never	
SC	11	20	15	46
	23.82%	43.50%	32.60%	100.00%
ST	0	7	24	31
	0.00%	22.60%	77.40%	100.00%
OBC	16	12	29	57
	28.10%	21.10%	50.90%	100.00%
General	22	17	27	66
	33.33%	25.80%	40.90%	100.00%
Total	49	56	95	200
	24.50%	28.00%	47.50%	100.00%

5.4.13 Treatment Time:

The figure 5.33 indicates that most of the respondents i.e. 61.5 percent have expressed that doctors provide 10 minutes time to attend the patient at BPHC; while more than one third respondents (35%) expressed that doctors provide 11 to 30 minutes time and a very small portion of respondents (3.5%) have expressed that doctors provide more than 30 minutes time to attend the Patient at BPHC.

It is observed from the study that doctors provide minimum 7-8 minutes time to maximum 30 minutes to treat a patient according to the needs of the patients

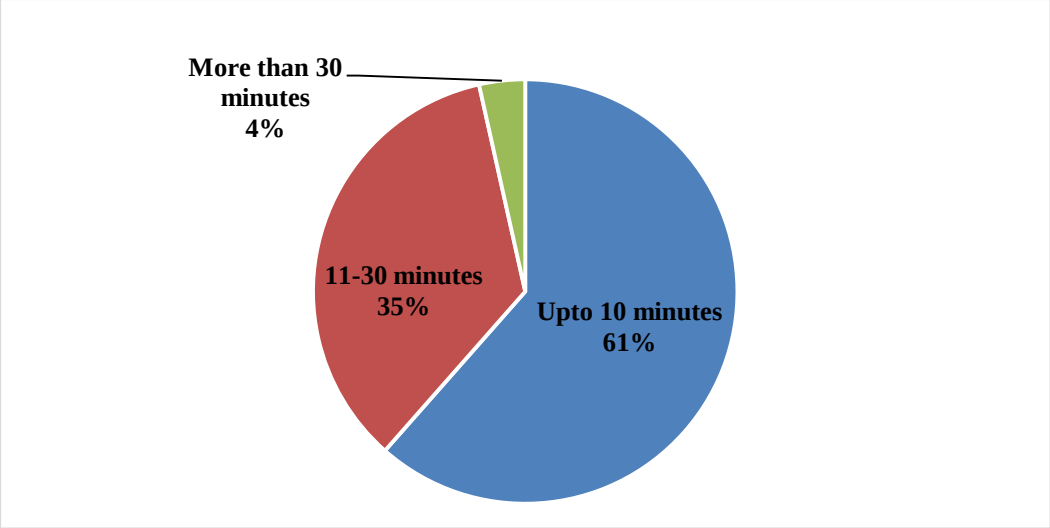


Figure 5.33: Treatment Time of Doctors

5.4.14 Conduct of Doctors:

Behaviour of service providers has greater impact on services. From the figure 5.34, it is found that most of the respondents (59%) have perceived that the conduct of the doctors is good during treatment hour at BPHC; followed by about one fifth respondents (21%) have perceived that the conduct of doctors at BPHC towards patient is poor and the remaining 20 percent perceived that the conduct of doctor is satisfactory at BPHC. Due to the poor conduct of doctors and other staffs of BPHC patients fail to connect themselves with such health facilities.

However, during present study it is observed that conduct of doctors depends upon their work load and it also vary from BPHC to BPHC. Therefore, NRHM need to take serious steps to reduce the work load of doctors so that they can provide better attention to the patient.

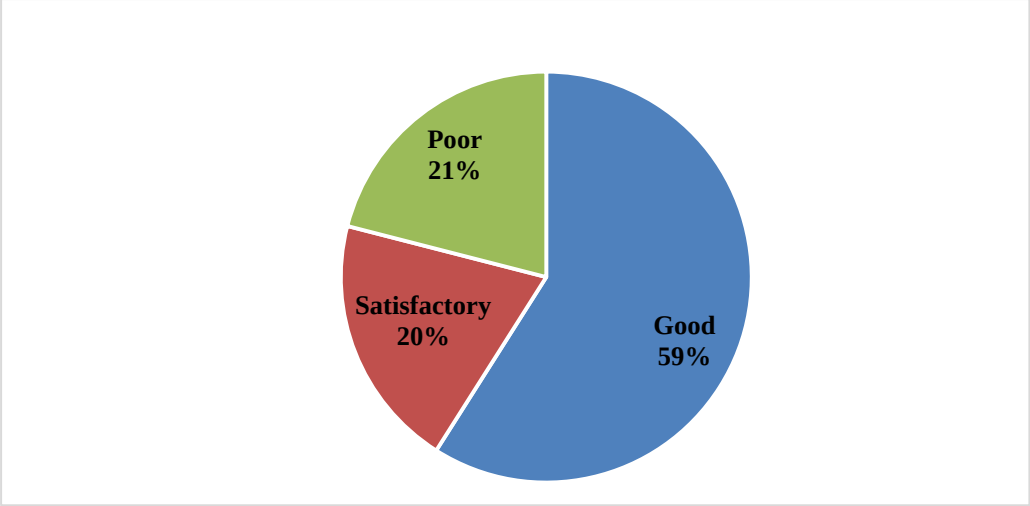


Figure 5.34: Conduct of Doctors during Treatment

5.4.15 Availability of Medicine:

The figure 5.35 shows that a high majority of respondents i.e. 63 percent have reported that there is an availability of medicine at BPHC; whereas, less than two fourth respondents (37.5 %) have reported that medicines are not available at BPHC. It is observed from the study that BPHC's are only having some basic medicines so it can't provide the medicine for acute illness. According to the doctors and other staffs, sometimes there are shortage of medicines also for one or two days and the patients visiting during that periods may not get all prescribed medicines but they can get it coming after two three days later.

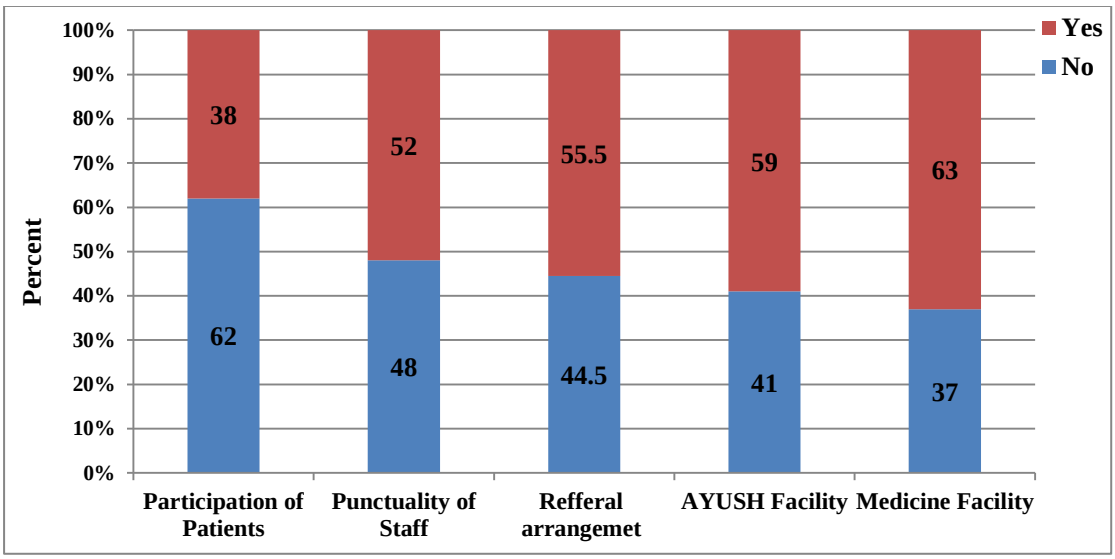


Figure 5.35: Resources Availability, Staff Arrangement and Referral Services for Patients

5.4.16 Referral Arrangement:

The referral arrangement implies that in serious cases, lower units should have facilities to transfer the patient to the higher level health unit without delay to save life (Saxena, 2010). The effective functioning of primary health care rests on the principle that if a patient cannot be treated with the available facilities at PHC, he/she should be immediately referred to the higher level health unit i.e. BPHC/CHC. If the illness is beyond the capability of CHC/BPHC to handle, the patients should be referred to the District Hospital.

From the figure 5.35, it is found that a substantial portion of respondents (44.5%) have expressed that BPHC's have referral arrangement; whereas, majority of respondents (55.5%) have expressed that BPHC's don't have proper referral arrangement. It is further observed that due to poor networking of BPHC with other health facilities (District hospital, SMCH etc.) most of the time during emergency patient faced difficulty in getting specialized care from district hospital and SMCH.

However, during the present study it is further observed that BPHC have failed to provide complete care to the women from reproductive age group. As during critical condition most of the times they either need to depend on District Hospital or SMCH.

5.4.17 Punctuality of BPHC staff:

The figure 5.35, shows that a significant portion of respondents (52%) have perceived that staffs are punctual in coming to BPHC; while around half of the respondents (48%) have perceived that staffs including doctors, Nurses and paramedical staffs are not regular in coming to BPHC.

During the study, the respondents have expressed that many a time they faced a situation when there is an absentia of doctors and other pera - medical staffs at BPHC which compel them to depend on private nursing home.

5.4.18 Availability of AYUSH:

Indigenous system of Medicine refers to the four different forms of health care practices. These are Ayurveda, Unani, Siddha and Homeopathy (AYUSH). In India, NRHM has given more emphasis in promoting AYUSH as one of its core objective lies on mainstreaming AYUSH.

The figure (5.35) shows that a considerable number of respondents i.e. 59 percent have expressed that AYUSH facility is available at BPHC; whereas, about two fourth respondents (41%) have expressed that they are not aware about the availability of such treatment at BPHC

5.4.19 Patient's Participation:

NRHM has introduced decentralized health system in India. It has adopted the synergetic approach to bring people's participation in health care aspects.

From the figure 5.35, it is found that less than two fourth respondents (38%) have expressed that they use to participate in the service delivery process offered by BPHC; while, majority of the respondents i.e. 62 percent have expressed that they have never participated in the activities of BPHC. It has been observed from the study that number of community awareness programme and activities conducted by BPHC as per the norm of NRHM are less for which the scope of participation of respondents are very limited.

5.4.20 Discrimination Faced:

In the present study, out of total respondents 63 percent have expressed that they faced some sort of discrimination while seeking treatment from BPHC. These are shown in the table below.

Table 5.28: Types of Discrimination faced by the Respondents

Types	Frequencies	Percentage
Economic status	66	52.3
Sex	6	4.8
Language& Religion	41	32.5
Other	13	10.3
Total	126	100

The table 5.28, indicates that majority of the respondents i.e. 52.3 percent have expressed that while seeking treatment from BPHC they face discrimination on the basis of economic status; followed by a substantial portion of respondents (32.5%) have expressed that they face the discrimination on the basis of language & religion, about one tenth portion respondents (10.3%) have expressed that they faced the

discrimination on other factors like appearance, education etc. and very small portion of respondents 4.8 percent face the discrimination on the basis of sex in availing the services of BPHC. The similar result is also found from the study conducted by Begum (1997).

5.4.21 Major Difficulties:

The table below(5.29) reveals that irrespective of Block most of the respondents i.e. 73.5 percent perceived distance as the main problem faced by them in seeking the services of BPHC; followed by more than one tenth respondents (11.5%) expressed that lack of quality care as the main problem; one tenth respondents expressed that cost is the main problem, a very small portion of respondents 3.5 percent have expressed that poor infrastructure as the main problem in availing the services of BPHC and 1.5 percent expressed that lack of trained health personnel as the main problem in availing the services of BPHC.

Table 5.29: Major Difficulties Faced by Respondents

Blocks	Types of problems					
	Cost	Distance/ Access	Lack of quality care	Unavailability of trained health personnel	Poor Infrastructure	Total
Bikrampur	1	19	5	0	0	25
	4.00%	76.00%	20.00%	0%	0%	100.00%
Dolai	5	16	3	1	0	25
	20.00%	64.00%	12.00%	4.00%	0%	100.00%
Jalalpur	0	16	3	1	0	25
	0%	80.00%	20.00%	0%	0%	100.00%
Harinagar	4	3	9	2	7	25
	16.00%	12.00%	36.00%	8.00%	28.00%	100.00%
Lakhipur	1	24	0	0	0	25
	4.00%	96.00%	0%	0%	0%	100.00%
Udarbondh	1	24	0	0	0	25
	4.00%	96.00%	0%	0%	0%	100.00%
Sonai	2	22	1	0	0	25
	8.00%	88.00%	4.00%	0%	0%	100.00%
Borkhola	6	19	0	0	0	25
	24.00%	76.00%	0%	0%	0%	100.00%
Total	20	147	23	3	7	200
	10.00%	73.50%	11.50%	1.50%	3.50%	100.00%

5.4.22 Block Wise Comparison

Block wise perception of the respondents/beneficiaries on four important criteria pertaining to the objective of the study have been displayed in the table below.

Table 5.30: Block Wise Comparison of the Perceptions Beneficiaries

	Bikrampur	Dolai	Jalalpur	Harinagar	Lakhipur	Udarbondh	Sonai	Borkhola	Total
Health and Hygiene									
• **Availability of Piped water facility**	8(32%)	9(36%)	9(36%)	3(12%)	3(12%%)	4(16%)	6(24%)	6(24%)	48 (24%)
• **Improved Toilet Facility**	6(24%)	16(64%)	6(24%)	4(16%)	19(76%)	17(68%)	16(64%)	19(76%)	103 (51.5%)
• **Safe Waste disposal practice**	11(44%)	5(20%)	11(44%)	12(48%)	7(28%)	17(68%)	22(88%)	24(96%)	109 (54.5%)
• **Chronic Illness**	2(8%)	2(8%)	2(8%)	16(64%)	14(56%)	6(24%)	4(16%)	5(20%)	51 (25.5%)
Availability of Health Facilities									
• **Availability of Sub-Centre within 1 KM.**	5(20%)	25(100%)	5(20%)	22(88%)	5(20%)	12(48%)	8(32%)	18(72%)	100 (50%)
• **Accessibility of Health Care Facilities by road condition**	6(24%)	13(52%)	6(24%)	8(32%)	12(48%)	11(44%)	21(84%)	24(96%)	101 (50.5%)
Nature and Types of Services									
• **Awareness about 104 service**	0(0%)	7(35%)	0(0%)	0(0%)	6(24%)	2(8%)	9(36%)	19(76%)	43 (21.5%)
• **Awareness about 108 service**	22(88%)	24(96%)	22(88%)	25(100%)	25(100%)	25(100%)	24(96%)	25(100%)	192 (96%)
• **Drug kit Carried by ASHA**	12(48%)	18(72%)	10(40%)	8(32%)	16(64%)	12(48%)	10(40%)	14(56%)	100 (50%)

• **Availability of VHSN Committee**	24(96%)	10(40%)	24(96%)	9(36%)	17(68%)	11(44%)	6(24%)	7(28%)	%) 108 (54%)
• **JSY Awareness**	23(92%)	25(100%)	23(92%)	25(100%)	25(100%)	25(100%)	24(96%)	25(100%)	194 (97%)
• **Information on JSY through ASHA**	21(84%)	24(96%)	16(64%)	14(56%)	23(92%)	20(80%)	21(84%)	23(92%)	162 (81%)
• **Cash Received under JSY**	16(64%)	15(60%)	12(48%)	5(20%)	6(24%)	15(60%)	16(64%)	10(40%)	95 (47.5)
• **Immunisation**	20(80%)	22(88%)	19(76%)	14(56%)	24(96%)	25(100%)	24(96%)	24(96%)	172 (86%)
• **Insurance**	0(0%)	0(0%)	0(0%)	0(0%)	5((20%)	2(8%)	2(8%)	0(0%)	9 (4.5%)
Perception of Patients towards the Services									
• **Waiting period to consult Doctors(Below 30 Minutes)**	18(72%)	20(80%)	18(72%)	20(80%)	24(96%)	24(96%)	22(88%)	13(52%)	159 (79.5%)
• **Availability of Medicines**	22(88%)	21(84%)	21(88%)	4(16%)	6(24%)	11(44%)	16(64%)	25(100%)	126 (63%)
• **Clean Toilet facility**	11(44%)	10(40%)	11(44%)	14(56%)	4(16%)	7(28%)	12(48%)	6(24%)	75 (37.5%)
• **Adequate Seating Arrangement**	12(48%)	19(76%)	12(48%)	8(16%)	12(16%)	7(28%)	11(44%)	6(24%)	87 (43.5)
• **Proper Drinking Water Facilities**	18(72%)	25(100%)	18(72%)	19(76%)	19(76%)	20(80%)	17(68%)	12(48%)	148 (74%)
• **Cleanliness**	9(36%)	11(44%)	9(36%)	7(28%)	11(44%)	7(28%)	11(44%)	6(24%)	71 (35.5%)

For Total Respondents, N=200 (100%), In Block Wise Distribution, N=25 (100%)

In the above table 5.30, a comparison of the major issues is presented on which the block wise opinion have been sought from the beneficiaries. It has found that there are differences among the blocks on various issues where as in few cases the gap is limited. In case of Availability of Piped water facilities only 24 percent (48) are enjoying this facility and there is a gap among the blocks. Harinagar and Lakhipur blocks are with 12 percent, whereas Jalalpur and Dolai blocks are with 36 percent. A relation also found among the accessibility of piped water facilities and the rate of chronic illness. Both Harinagar and Lakhipur are found to be higher rate of chronic illness i.e., 64 percent and 56 percent respectively. In the matter of availability of Sub-centres within one kilometer surroundings, a wide gap found among the blocks. In Dolai, 100 percent people are getting access where as in Jalalpur and Bikrampur only 20percent are reported that BPHC is within one kilometer. Awareness related to 104 services are found to be very low (43, 21.5%) among the beneficiaries and there are very wide gap exists between the blocks (three blocks- Bikrampur, Jalalpur, Harinagar are nil where as 76 percent respondents are aware in Borkhola on the services of 104). In case of VHSN the result are appearing opposite. The respondents of two blocks i.e., Bikrampur and Jalalpur are highly aware (96%) but Borkhola found to be very low (28%) in this direction. The gap exists (Harinagar, 20%, to Bikrampur, 64%) on the information of Cash received under JSY. Availability of medicine is one the important criteria in NRHM; however, a wide gap also identified in the study between the blocks. Harinagar is appeared very low, only, 4 (16%) respondents have received medicines where as 88 percent respondents of Bikrampur and 100 percent of Borkhola have received medicines.

5.5 Role and Intervention of Grassroot Actors (PRI, ANM and ASHA)

NRHM has introduced the concept of decentralization of health care so it has given more emphases in the involvement of grassroots actors such as; PRI, ANM and ASHA in the delivery of health services specifically in rural areas. This section intends to explore the role played by Panchayat members, ANM and ASHA in governing BPHC.

5.5.1 Panchayati Raj Institution (PRI) and NRHM:

The 73rd constitutional Amendment Act, 1992 has recognised the importance of decentralized health care delivery systems operating through elected local governments. This initiative has empowered rural people to participate in the decision making process. This Act paved the way for the creation of statutory institutional structures at the village level –Gram Sabha (GS) and Gram Panchyat (GP) - basically aims at initiating a process of democratic decentralisation of governance and accelerating the socio-economic development of rural areas within a participatory framework (Ray, 2007). GP is empowered to manage heath and sanitation, including hospitals, Primary Health Centres and family welfare under the 11th Schedule of the Article243 ofIndian Constitution which has listed twenty nine functions of GP (GoI, 1992). The National Population Policy (2000) and National Health Policy (2002) emphasize decentralized planning (GoI, 2000) and involvement of PRI on the implementation of public health programmes (GoI 2002). To improve and uplift the condition of rural health services in India, the government have started a comprehensive national campaign and launched a programme called National Rural Health Mission on 12th April, 2005. Decentralization in health care is one of the important aspects of NRHM (NRHM, 2005).

The Mission envisaged the following roles for PRIs:

- The Mission involves panchayat for devolution of funds, functionaries and programmes on health.
- The District Health Mission (DHM) under NRHM is led by the Zillah Parishad. The DHM control, guide and manage all public health institutions in the district, Sub-Centres, PHCs and CHCs.
- ASHAs are selected by and be accountable to the Village Panchayat.
- The Village Health Committee of Panchayat prepare the Village Health Plan, and promote Intersectoral integration
- Each sub-centre has an Untied Fund for local action @ Rs. 10,000 per annum. This Fund is deposited in a joint Bank Account of the ANM & Sarpanch and operated by ANM, in consultation with the Village Health Committee.

- The Mission also states PRI's involvement in RKS for good hospital management.

- The Mission also makes Provision of strengthening the capacity of panchayat through proper training.

*(**Source:** NRHM, 2005)*

5.5.2 Role of Panchayat Leaders in the Delivery of Health Care Services:

Eight Gram Panchayat (GP) members i.e. one from each GP where Sub-Centres are located has been interacted for the purpose of the present study. They have been interviewed at different points of time as each GP are far away to one another. But the point of interaction was same. After having discussion with the G.P members the following observations have been identified.

- It is observed that majority of panchayat members (62.5%) are males and the remaining 37.5 percent are females. Further majority of the panchayat members (62.5%) belong to Hindu community, one fourth of them (25%) belong to Muslim community and the remaining 12.5 percent belong to Christian community. However, an equal number of panchayat members (37.5%) belong to SC and General Categories respectively. Again an equal number of members (12.5%) belong to SC and ST categories respectively. Regarding the educational qualification except one fifth panchayat members all others are having qualification up to HSLC or higher level. Almost all members except 12.5 percent have membership with civil society groups like local youth clubs, Mohila Madals, NGOs, and SHGs etc.

- It is observed that most of the PRI members i.e. 75 percent have admitted that NRHM has given a new opportunity for them to take an active part in improving the health and sanitation aspect of village. In addition, one fourth panchayat members (25%) have different opinion as according to them NRHM has failed to involve the PRI in the management of health aspect of the rural community and it has increased their work load.

- It is observed that except 12.5 percent all the sampled PRIs have reported that there is a regular availability of ANM in Sub-Centre (SC) which further

ensures timely services by Sub-Centre to the patients. However, 12.5 percent has pointed out that dissatisfaction prevails among the community regarding the services of ANM as during emergency most of the time she failed to provide services.

- Regarding the existence of Village Health Nutrition and Sanitation Committee (VHNSC) all the GP members have pointed out thatVHSNC is active in their village and it is beneficial to the villagers. Moreover, 12.5 percent has reported that the committee is beneficial as it has reduced the work load of panchayat leaders in terms of sanitation, public health and nutrition .The GP members have reported that they carefully follow all the guidelines received from the NRHM, regarding the selection of committee members. However, while the researcher has asked about the guidelines for the composition of VHSNC, none of the members could have able to answers properly. Out of the sample of G.P members, half of them have pointed out that they select the committee members at the time of Gram Sabha. However, one fourth GP members have pointed out that they generally prefer the committee members from their own political party to prevent the unnecessary conflicts.

- It is further observed majority of PRI members (75%) have pointed out that VHSNC organize health checkup camps and conduct awareness on health education programme for pregnant and lactating mother and the committee sensitize the villagers about the importance of sanitation. Further, 12.5 percent GP memberhas opined that the committee mainly works for supplementary nutrition purpose at the Anganwadi level and 25 percent G.P member has pointed out that some amount of funds from the VHSNC is also used to provide honorarium to ASHA.

- Majority of panchayat members (75%) have opined that they discuss the health issues in Gram Sanshad meetings. Potable water and sanitation seemed to be the most discussed issue; whileone fourth (25%) have reported that they discussed infant and child mortality matters in Gram Sanshad meeting.

- It is assessed from the study that half of the members have reported that ASHAs are working actively in the community, while rest half have reported

that ASHAs adopt unscrupulous means in utilizing the untied funds and most of the time they are not-cooperative. All the members have reported that regarding the selection of ASHAs they are not playing an active role as most of the ASHAs got selection on recommendation of ANM during the first phase of NRHM. Further, 12.5 percent GP member has opined that if ASHAs are belonging from different political party it leads to unnecessary conflict which ultimately hamper the villagers.

- From the study, it is observed that most of the panchayat members (62.5%) are aware about the benefits extended to women who were registered under JSY scheme and the remaining 37.5 percent have expressed that they don't have clear understanding related to JSY.

- The study also reveals that 37.5 percent are aware about the facilities available at BPHCs for referred patients. However, except 37.5percent others do not have any idea about the transportation facility available for referred cases. In addition, majority of the GP member (75%) have expressed that they are aware about the main purpose of 108 services whereas, only 25 percent are aware about services like 104 and 102.

- In connection with the difficulties faced by the GP in implementing program under NRHM, one fourth of them expressed dissatisfaction on non-availability of funds in time; less than two fourth (37.5%) have cited that due to the inadequate capacity building program most of the time they fail to understand different schemes launched under NRHM. However, 37.5 percent GP members have also felt that the existence of inadequate infrastructure in nearby health facilities like Sub-Centre and BPHCs is one of the major difficulties faced by GP in maintaining good health in the panchayat area.

- It is further observed that majority of (62.5%) panchayat members have expressed that more funds are required on a regular basis for the maintenance and effective functioning of activities under NRHM; While, 25 percent have expressed that arrangement of more training for ASHA and GP members are essential for bringing good governance under NRHM. However, 12.5 percent GP member has viewed that ASHA and panchayat leaders should meet

regularly and to discuss the difficulties faced by them in maintaining effectiveness under NRHM and this will also help them to minimise their internal conflicts.

Discussions:

In above, the understanding and perception of gram panchayat members on the process of the service delivery of NRHM has been described. It has found that majority of them are aware of the functional process of NRHM at the grass root level through Sub-centres, PHC and BPHC with the help of ANM and ASHA. However they are in need to be more aware regarding the contributory areas and responsibilities of PRIs as grass root village administration to the services offered by NRHM. They have only functional and limited understanding in this direction**.**

5.5.3 Auxiliary Nurse Midwives (ANM) in NRHM:

ANM is one of the key functionaries into the health management system. They work at field level and interact directly with the community, particularly for family planning, maternal and child health care aspects (Mavalankar et al, 2010). National Rural Health Mission (NRHM) has increased the roles and responsibilities of ANM. As per the NRHM guideline (2005) following responsibilities has been entrusted to ANM.

- ANM holds weekly/fortnightly meeting with ASHA and discuss the activities undertaken during the week/fortnight. She guides ASHA while they encountered any problem during the performance of their activity.

- Anganwadi Workers (AWWs) and ANMs acts as resource persons for the training of ASHA. She informs ASHA regarding date and time of outreach session and also guides her for bringing the beneficiary to the outreach session.

- ANM participates and guides in organizing health days in Anganwadi Centre. She helps ASHA in updating eligible couple register of the village concerned.

- ANM mobilizes ASHA in motivating the pregnant women for coming to sub-centre for initial checkups. She also helps ASHAs in bringing married couples to Sub- Centres for adopting family planning. She guides ASHA in motivating

pregnant women for taking full course of Iron and Folic Acid (IFA) tablets and tetanus toxoid injections etc.

- ANMs educate ASHA on the dangers sign of pregnancy and labour so that she can timely identify and help beneficiary in getting further treatment.

5.5.4 Intervention of ANM in the Delivery of Services:

Eight ANM i.e. one from each Sub-Centre has been interacted for the purpose of the present study. They have been interviewed at different points of time as SCs are far away to one another. But the point of interaction was same. After having discussion with the ANM the following observations have been identified.

Table 5.31: Profile of ANM

Age	**Percentage**
20-25	12.5
25-35	50.0
35 years & above	37.5
Marital Status	
Married	62.5
Unmarried	37.5
Educational Status	
Upto Matriculation	12.5
Matriculation & Above	87.5
Job Experience	
Upto 5 years	25.0
5-10 years	50.0
10 years& above	25.0

- It is found from the above table that half of the ANMs who are interviewed are within the age group of 25-35 years; while less than two fourth (37.5%) are from the age group 35 years & above and 12.5 percent ANM is below 25 years of age. By definition they all are female. Out of total respondents, most of them (62.5%) are married and rests are unmarried. Further, it is found that almost all the interviewed ANMs have education up to HS or higher level

along with the nursing degree. Regarding the job experience, one fourth (25%) ANM have job experienced of more than 10 years; while half of them have job experience of 5-10 years and the remaining 25 percent ANMs have experience of less than 5 years. In addition, in the present study it is found that half of the ANMs are Hindus by religion; while an equal number of ANMs (25%) are from Muslim and Christian Religion respectively.

- In the present study it is observed that most of the ANMs (75%) are not aware about the targets of NRHM; whereas rests 25 percent are aware about the targets of NRHM. Almost all the ANMs reported that NRHM has improved the Maternal and Child Health in rural areas; while 12.5 percent ANM has opined that it has increased the work load.

- A majority of ANMs i.e. 62.5 percent have reported that introduction of NRHM has increased the level of awareness on health and hygiene among the marginalized section of society and it has also increased their seeking health services. While rests of them felt that health seeking behaviour of rural people has not changed even after the launch of NRHM.

- A majority of ANM i.e. 62.5 percent perceive that ASHA have reduced the work load of ANM and they are mobilizing the community to avail health services; while 37.5 percent ANMs have expressed that due to the inadequate qualification ASHAs are incapable of bringing any change in the health sector. Moreover, most of the times they fail to maintain proper documentation which further increases the workload of ANM. Further, 12.5 percent ANM has reported that ASHAs are capable of bringing complicated cases to hospital in time.

- Majority of ANMs i.e. 75 percent have reported that they are involved in the selection of ASHA during the first phase of NRHM. However, one fourth (25%) of them have reported that ASHAs are selected by the Panchayat leaders and most of the time it is seen that political influence work while selecting ASHA.

- It is also observed from the study that half of the ANMs have reported that they had a monthly meeting with ASHAs and in that meeting they used to

have a discussion regarding the major health related issues of their respective area served; while 25 percent ANM have reported that ASHA meet them on weekly basis. However, one fourth (25%) ANMs have reported that ASHAs are not cooperative and they have lack of motivation towards their job.

- It is observed that half of the ANMs are fully aware about their roles and responsibility under NRHM. Further, 37.5 percent have reported that their main job responsibility is to conduct immunization programme with pregnant mother; while 12.5 percent of them has reported that their main job responsibility is related to make the rural women aware about the importance of adopting family planning method. In addition almost all the ANNMs have reported that for making women aware about the importance of adopting family planning methods they use IEC materials like leaflets /booklets e.t.c.

- It is observed from the present study that 37.5 percent ANMs have reported that they receive funds under NRHM on a regular basis, while rests of them have reported that the fund flow is not regular. Moreover, all ANMs interviewed for the purpose of this study reported to have joint account with panchayat. Further, most of the ANMs (62.5%) have reported that the annual maintenance funds and untied funds are spend on repair, renovation and purchasing of equipments, while one fourth ANMs have reported that they spend it for supply of electricity and water. However, 12.5 percent ANM have reported that the money is being spent on providing honorarium to the casual staffs like sweeper, helper etc.

- Most of the ANMs (75%) reported that Rogi kalyan Samiti (RKS) helps them in releasing of funds for beneficiaries and maintenance works; while 12.5 percent has expressed that RKS facilitate them to makes plan and the remaining 12.5 percent opined that RKS creates conflict among ANM and local panchayat leaders which ultimately hampers the effective functioning of sub-centre.

- It is observed that half of the ANMs said that some of the instruments are deficits in the sub centres as per Indian Public Health Standards (IPHS); whereas, others are not aware about the criteria of IPHS.

- Further, in the present study it is observed that only 12.5 percent ANM have reported that to live in ANM quarters. It is found from the study that half of the ANMs are staying outside the village where subcenters are located, whereas 37.5 percent ANMs live nearby the subcenters. It is further observed thathalf of the ANM have reported that sub centre don't provide quality quarter; while one fourth (25%) of them stated that non availability of water and power facility in the quarter is another reason for not staying at subcentres by the ANMs and the remaining 25 percent have reported that due to the lack of security they are not staying at sub-centre.

- It is observed that most of the ANM (87.5%) have expressed that JSY has increased the demand for institutional delivery after its implementation; while 12.5 percent of them has reported that JSY failed to bring any changes due to the delay in payment. Further, it is observed that all the ANMs interviewed for the purpose of this study are aware about the average amount to be paid to the beneficiaries for institutional deliveries. Regarding the average time of giving cash benefit to the patients under JSY, ANMs have different opinion. It is found that half of the ANMs have reported that it takes less than one week; and an equal number of ANMs (25%) have reported that it takes one to two weeks and more than two weeks respectively.

- All the sampled ANMs have reported that they received training on RCH related programmes after the introduction of NRHM. It is observed that less than two fourth (37.5%) ANM received training on neo-natal care; while one fourth (25) of them received training on sanitation and hospital waste management related matters and rest 25 percent opined that they have received training on family planning methods.

- Regarding the difficulties faced by ANM in governing the sub Centres half of them have reported that lack of coordination among the village panchayat leaders affects their work, while one fourth of them stated that lack of proper infrastructure and man power in sub centre were the main problem faced by them. However, rest 25 percent ANMs have reported that existence of power dynamics in the community have hampered the tempo of their work.

- It is also observed that most of the ANM (62.5%)have expressed that they need more training for the delivery of effective services, while one fourth ANMs felt that regular meeting with the panchayat leaders is essential for bringing transparency within the system. Further, 12.5 percent ANM said that NRHM need to adopt social auditing methods for monitoring the activities of Sub-centre.

Discussions:

From the above observations, it can be assessed that though ANMs are involved in the process of NRHM, but they are not fully aware about the entire NRHM programme as a whole. They concentrate only the roles and responsibilities assigned to them. Through various training under NRHM, ANMs got opportunity to upgrade their skills. It is further observed from the present study that ANMs attitudes are positive for the services offered by NRHM in the area of maternal and child health care. In addition, ANMs expressed their satisfaction in working under NRHM. However ANMs opined that they need more training on administration and management. ANMs work in collaboration with ASHAs in to their specific field area where sub-centres located. It is observed that though there should have proper cooperation and coordination among panchayats, ASHAs and ANMs for the smooth delivery of services to the patients but in reality it is not taking place in a proper way.

5.5.5 Accredited Social Health Activists (ASHA) andNRHM:

NRHM has introduced a female Accredited Social Health Activist (ASHA) chosen by and accountable to the panchayat –to act as the interface between the ANM and the village (Akram, 2014). As per NRHM guidelines, ASHA must be the resident of the village-women (married/widow/divorced) preferably in the age group of 25-45 years with formal education upto eight class, having communication skills and leadership qualities. The general norm of selection of ASHA is one for 1000 population (NRHM, 2005). As per NRHM guidelines the role and responsibilities of ASHA is discussed in the points below.

- ASHA takes steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation and

hygienic practices and need for timely utilization of health and family welfare services.

- She counsels women on birth preparedness, importance of safe delivery, breast –feeding and complementary feeding, immunization, contraception and prevention of common infections including reproductive tract infections / sexually transmitted infection and care of young child.

- ASHA mobilizes the community and facilitates them in accessing health and health related services available at the Anganwadi / Subcenters /Primary health centres, such as immunization, ante natal check-up, post natal check-up, supplementary nutrition, sanitation and other services being provided by government.

- She works with Village Health Sanitation and Nutrition Committee of the gram panchayat to develop a comprehensive village plan.

- ASHA arranges escort/accompany for pregnant women and children requiring treatment/admission to the nearest pre-identified health facility i.e. PHC/CHC/ First Referral Unit(FRU)

- ASHA provides primary medical care for the minor ailments such as diarrhoea, fevers and first aid for minor injuries. She is a provider of Directly Observed Treatment Short –Course (DOTS) under Revised National Tuberculosis Programme (RNTCP).

- ASHA acts as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), IFA tablet, disposable delivery kits, oral pills and condoms etc. She has given a drug kit from NRHM containing generic AYUSH and Allopathic formulations for common ailments.

- She informs about the births and deaths in her village and any unusual health problems / disease outbreaks in the community to the Sub-Centre / Primary Health Centre.

- She promotes the construction of household toilets under Total Sanitation Campaign.

5.5.6 Intervention of ASHA in the delivery of Services:

For the purpose of present study, thirty two numbers of ASHAs i.e. four from each Sub Centres have been interviewed at different points of time. After having interview with ASHA the following observations have been identified.

The table below shows the profile of ASHAs interviewed for the purpose of this study

Table 5.32: Profile of ASHA

Age	**Percentage**
Young(below 25 years)	15.6
Mature(25-35 years)	25.0
Experienced (35& above)	59.4
Total	100
Marital Status	
Married	78.1
Divorced/ Separated/Widowed	21.9
Total	100
Religion	
Hindu	53.1
Muslim	34.4
Christian	12.5
Total	100
Caste	
SC	25.0
ST	12.5
OBC	18.8
General	43.6
Total	100

5.5. 6(a) ASHA's Profile:

From the table 5.32, it is found that a significant number of ASHAs i.e. 59.4 percent are from the experienced age group. Most of the ASHAs i.e. 78.1 percent are married, whereas about one fifth ASHAs (21.9%) are either divorced / separated or widower.

Further the table indicates that more than half of the respondents are from Hindu Community i.e. 53.1 percent; followed by about one third ASHAs (34.4%) are from Muslim community and the remaining 12.5 percent are from Christian community.

Regarding the caste status, a considerable number of the respondents i.e. 43.6 percent are from General category; followed by one fourth (25%) are from Schedule Caste (SC) category, about one fifth (18.8%) are from Other Backward Caste (OBC) and the rest 12.5 percent are from Schedule Tribe (ST) category.

It is important to highlight that one of the eligibility criteria of ASHA is that she should be between 25 to 45 years and preferably married in the village. From the present study it is observed that 15.6 percent ASHA do not fulfill the criteria of becoming ASHA as they are from the age group of below 25 years. Moreover, out of the total respondent, 78.1 percent have reported that they are staying in the same village where they work; whereas, 31.2 percent have reported that they are staying in other villages.

5.5.6 (b) Education

In the present study, educational status of ASHA has been distributed into four categories. These are 'Just Literate', education upto 5^{th} standard is considered as 'Primary Level of Education', from 5^{th} to 7^{th} standard is considered education upto 'Upper Primary level' and from 7^{th} to 10^{th} standard and above is termed as 'High school and above' level of education.

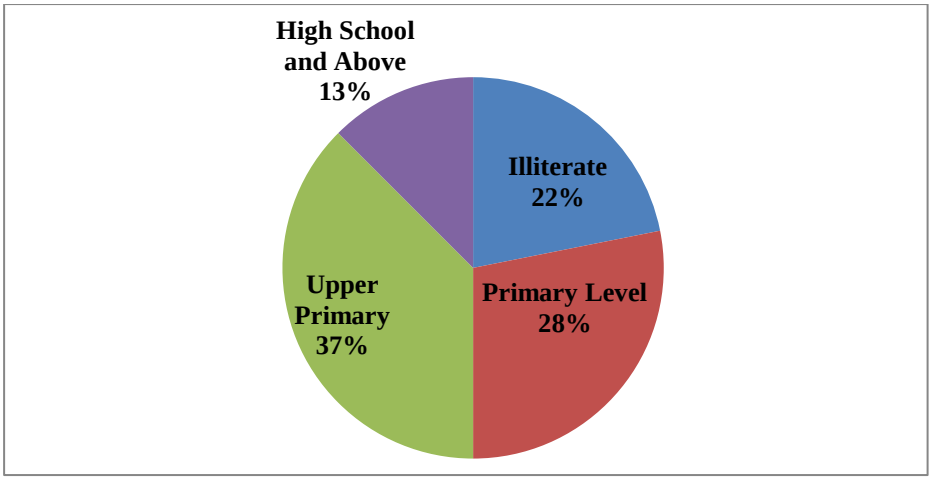


Figure 5.36: Educational Status of ASHA

The above figure 5.36 indicates that more than one fifth (22%) ASHAs are illiterate; followed by more than one fourth ASHAs (28%) have education upto primary level. Less than two fourth ASHAs (37%) have education upto upper primary level and a more than one tenth ASHAs (13%) have education upto high school and above level. Clubbing both the group i.e., illiterate and primary level of education it has come (22+28) to 50 percent who have formal education below eight standard.

The above figure exhibits that half of the respondents don't fulfill the eligibility criteria for ASHAs as they have studied below eight standards.

5.5. 6(c) Work Experience:

From the present study, it is observed that most of the ASHA i.e. 71.9 percent have more than 5 years of job experience, while more than one fourth ASHAs (28.1%) have less than five years of Job experience.

5.5.6. (d) Monthly Incentives of ASHA:

The figure 5.37 reveals that about one third ASHAs (31%) receive rupees less than 500 per month as incentives; followed by about one fifth (19%) ASHAs have reported that they receive between 500-1000 rupees per month as incentives; about one third ASHAs (34%) have reported that they receive rupees 1000-1500 per month and less than one fifth ASHAs (16%) have reported that they receive above 1500 rupees per month as incentives. However, during the study, it is observed that the

monthly incentives of ASHA is not fixed sometime it is more and sometimes it is less based on their activities covered.

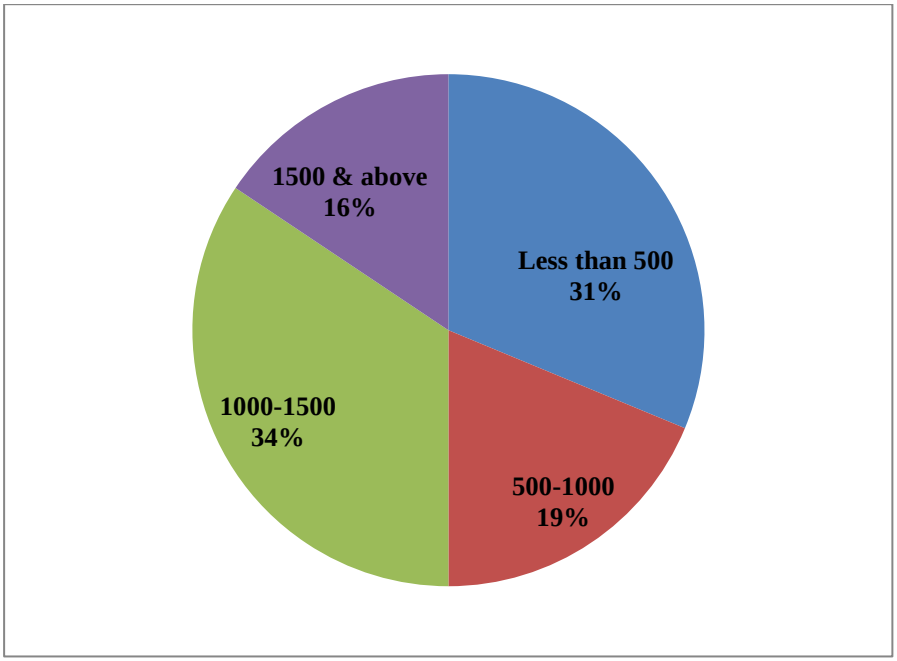


Figure 5.37: Monthly Incentives of ASHA

5.5.6 (e) Reason for Becoming an ASHA:

There are various reasons behind women entering into the profession of ASHA. The reasons are one or more. The table below depicts the reasons expressed by ASHA.

Table 5.33: Reason for Becoming an ASHA

Reasons	Frequency	Percentage of cases
Earning money	21	65.60%
Serving/helping the community	13	40.60%
Reducing population growth	9	28.10%
To remove misconceptions	7	21.90%
To Promote Mother and Child Health	5	15.60%
Total	55	171.80%

Multiple Responses Set

From the above table (5.33) it is inferred that earning money is the foremost reason behind the women entering into the profession of ASHA as 65.5 percent have expressed this; followed by two fourth (40%) respondents expressed that serving/helping the community as one of the reason, 28.1 percent have expressed that

reducing the population growth as one of the reason; while about one fifth respondents (21.9%) have expressed that removing misconceptions and the remaining 15.6 percent have expressed that promotion of Mother and Child Health is one of the major reason motivate them to become ASHA.

From the above table it is revealed that earning money is one of the foremost causes expressed by the rural women for becoming ASHA and there are also some other social causes which motivates them for this work. However, during the present study ASHA have expressed that despite of no fixed salary they want to continue their work as an ASHA as it has given a new identity to them which ultimately increase their status and dignity in the community.

5.5.6 (f) ASHA's Selection Method

The figure 5.38, shows that most of the ASHA i.e. 60 percent got selection through the recommendation of ANM; followed by one fourth (25%) ASHA have reported that they got selection on recommendation of PRI; about one tenth (9 %) have reported that they got selection on recommendation of Anganwadi Worker and a small portion of ASHA (6%) have mentioned that they were selected on recommendation of Village Health committee.

It is important to highlight here that though as per the NRHM norm, ASHA should be selected on the recommendation of PRI but during the first phase of NRHM most of the ASHA were selected on the recommendation ANM considering their previous work experience as village Dai.

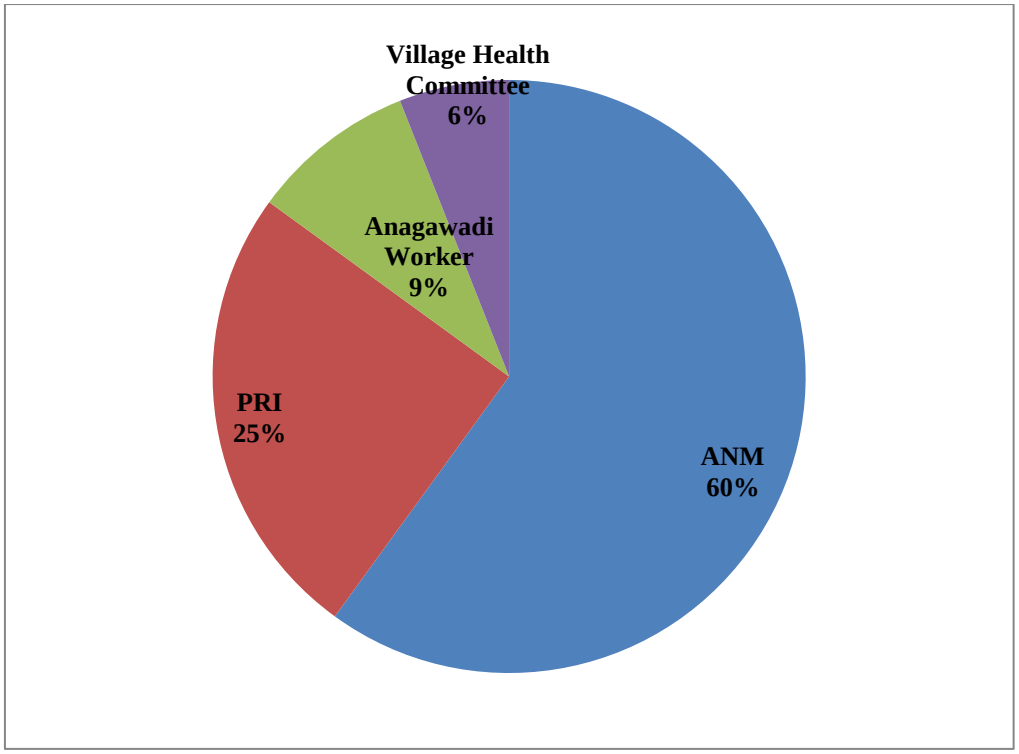


Figure 5.38: ASHA's Selection Method

5.5.6 (g) Training Participation:

From the present study, it is found that most of the ASHA i.e. 93.8 percent have attended training programme under NRHM; whereas, a small portion of respondents (6.2%) have reported that they have not yet participated in any training programme under NRHM. However, a significant number of ASHA i.e. 63 percent have reported that they have received the training on other hall including different NGOs; followed by one fourth ASHA have received the training on PHC and about one tenth (12%) have received the training either at BPHC or at CHC. During the study, it is found that two fourth (40.6%) ASHA have expressed dissatisfaction with the training programme conducted under NRHM; followed by less than two fourth ASHA (37.5%) expressed satisfaction with the training programmes and about one fifth (21.9%) ASHA have expressed that they were moderately satisfied with the training programme.

However, it is important to highlight that almost all the ASHA have expressed that the logistic arrangement at the place of training was not proper such as food arrangement, water facilities, proper bed, toilet facilities etc. But they have

appreciated the teaching quality of trainers and their method of imparting knowledge as good and useful.

5.5.6 (h) ASHA's Responsibility:

ASHA have expressed that there are set of responsibilities in connection with Mother and Child Health (MCH), from immunization to delivery of child. Here they have enlisted their choices which are multiple in natures.

Table 5.34: Responsibilities as an ASHA

Responsibilities	Frequency	Percentage of cases
Help in immunization programme	29	90.60%
Accompanying delivery Cases	28	87.50%
Create awareness on health & hygiene	30	93.80%
Encourage women for institutional delivery	31	96.90%
Organize village health day	22	68.80%
Family planning	24	75.00%
Formulate village Health Plan	11	34.40%
Provide basic curative care	12	37.50%
Total	187	550.10%

(Multiple Responses Set)

The above table (5.34) indicates that according to ASHA's prioritization it is found that 90.6 percent ASHAs have reported that they help in immunization programme; followed by accompanying delivery cases have been reported by 87.5 percent ASHA; creating awareness on health and hygiene is reported by 93.8 percent ASHA; 96.9 percent have reported that they encourage women for institutional delivery ; organize village health day have been reported by 68.8 percent ASHA; 75 percent have reported that they encourage village women from reproductive age group for the adoption of family planning method; 34.4 percent have reported that they formulate village health plan and 37.5 percent have reported that they provide basic curative services to the rural people.

5.5.6 (i) Networking of ASHA:

Under NRHM, there is a close network of ASHA with other stake holders to carry out their duties smoothly. The table below has shown the networking of ASHA with different stakeholders.

Table 5.35: Networking of ASHA with other Stakeholders

Networking	Responses	Percentage of cases
ASHA supervisor	28	87.50%
Anganwadi Worker	11	34.40%
ANM	16	50.00%
BPHC staffs	10	31.20%
PRI	2	6.20%
Total	67	209.30%

(Multiple Responses Set)

It is observed from the study that ASHA's have multiple responses regarding network with other stakeholders for rendering their services. As presented in the table 5.35, most of the ASHAs (87.5%) have expressed that they maintain network with ASHA supervisor; followed by 50 percent have expressed that they maintain network with ANM, 34.4 percent maintain network with Anganwadi worker, 31.2 percent have expressed that they used to maintain network with BPHC staffs and the rest 6.2 percent expressed that they have good network with Panchayat members for better delivery of their services.

5.5.6 (j) Priority towards ASHA:

The table 5.36 indicates that about one fifth ASHAs (18.8%) have expressed that they always receive the priority by hospital staffs when they accompany the patient; followed by half of the ASHAs have reported that sometimes they receive the priority and about one third ASHAs (31.3%) have expressed that they never receive any priority by hospital staffs when they accompany the patients.

It is important to highlight that most of ASHAs have mentioned that though from BPHC they receive some priority due to their frequent visit and accessibility. But in case of referral from BPHC to District hospital/ SMCH ASHAs never receive priority rather some of them have negative experience in this direction.

Table 5.36: Priority Given by Hospital Staffs

Priority	Frequency	Percentage
Always	6	18.8
Most of the Times	16	50.0
Never	10	31.3
Total	32	100

5.5.6 (k) ASHA's Knowledge on Antenatal Care:

From the table 5.37, it is found that a substantial number of ASHAs i.e. 59.4 percent have knowledge related to TT injections, a very high majority i.e. 90.6 percent are aware about the number of antenatal checkup required during pregnancy; followed by 78.1 percent have knowledge related to breast feedings, 65.6 percent have correctly know about the use of Iron Folic Tablets (IFA). However, it is further observed that more than one fourth i.e. 28 percent ASHAs are correct in their knowledge related to diarrhoea treatment of a child and about one third ASHAs (34.4%) know the minimum birth weight of a child.

The table reveals that ASHA's have a moderate level of knowledge on ANC, which need to be taken care to improve their knowledge during training programme as these are very essential.

Table 5.37: Knowledge of ASHA about Ante Natal Care

Knowledge	Know	Don't Know	Total
Pregnant Women should take two TT injections	19(59.4%)	13(40.6%)	32(100%)
women should undergo a minimum of three ante natal checkups during pregnancy	29(90.6%)	3(9.4%)	32(100%)
Recommended to exclusively breastfeed child for three months	25(78.1%)	7(21.9%)	32(100%)
women should consume a minimum of 100 IFA tablets during pregnancy	21(65.6%)	11(34.4%)	32(100%)
During diarrhea a child should be given increased quantity of fluids	9(28.1%	23(71.9%)	32(100%)
The minimum birth weight of the new born child should be 2500 grams	11(34.4%)	21(65.6%)	32(100%)

5.5.6 (l) ASHA's Knowledge on Pregnancy related Complications:

The table (5.38) reveals that ASHA have knowledge related to the complications faced by women during pregnancy. The table shows that a very high majority of ASHA i.e. 87.5 percent are aware on abdominal pain; followed by swelling of hands and feet are expressed by 68.9 percent. Even a significant number of ASHA i.e. 62.5 percent have correct knowledge that no movement of foetus is another complications face by a pregnant mother; anemia is expressed by 59.4 percent and vomiting is expressed by 53.1 percent; whereas about one third ASHA (34.4%) are aware on body convulsion and less than one fifth ASHA (15.6%) are aware on high fever face by women during pregnancy.

Table 5.38: Knowledge ASHA on Pregnancy related Complications

Types of complications	Know	Don't Know	Total
Swelling of hands and feet	22(68.9%)	10(31.2%)	32(100%)
Vomiting	17(53.1%)	15(46.9%)	32(100%)
Anemia	19(59.4%)	13(40.6%)	32(100%)
Convulsion	11(34.4%)	21(65.6%)	32(100%)
High Fever	5(15.6%)	27(84.4%)	32(100%)
Abdominal pain	28(87.5%)	4(12.5%)	32(100%)
No movement of fetus	20(62.5%)	12(37.5%)	32(100%)

5.5.6 (m) ASHA's Knowledge on Vaccination:

The table below (5.39) indicates that all the ASHA have foremost basic knowledge on BCG vaccine; followed by 65.6 percent ASHA have knowledge on DPT and 59.4 percent on TT. However, it is further observed that Booster dose; OPV and Measles are reported by very less number of ASHA.

The above table exhibits that ASHA have low level of knowledge on vaccine given to the mother and child for immunization. So it should be taken care to improve their knowledge through training programme as these are essential.

Table 5.39: ASHA's Knowledge on Vaccination for New Born

Knowledge	Know	Don't Know	Total
BCG	32(100%)	0%.	100.00%
DPT	21(65.6%)	11(34.4%)	32(100%)
TT	19(59.4%)	13(40.6%)	32(1000%)
OPV	11(34.4%)	21(65.6%)	32(100%)
Measles	11(34.4%)	21(65.6%)	32(100%)
Booster dose	9(28.1%)	23(71.9%)	32(100%)

5.5.6 (n) ASHA's Action:

As presented in the table 5.40, it is found that majority of ASHA i.e. 43.8 percent have reported that on recognition of any danger sign by pregnant mother ASHA prefer to take her to BPHC; followed by one fifth ASHA (21.9%) have reported that they prefer to take them to Sub-Centre. Even CHC is reported by about one tenth ASHA (9.4%) and SMCH/District Hospital is reported by more than one tenth ASHA (12.5%). However, 12.5 percent ASHA have reported that they prefer to take the pregnant mothers on private hospital if family demands during emergency as they believe that private hospitals have easy accessibility and better care.

Table 5.40: Action of ASHA on Detection of Sign of Complications

Actions	Frequency	Percentage
Take her to Sub- centre	7	21.9
Immediately take her to BPHC	14	43.8
Take her to functional CHC/FRU	3	9.4
Refer her to SMCH/ District hospital	4	12.5
Refer her to private hospitals	4	12.5
Total	32	100

5.5.6 (o) Sources of Information:

ASHA acts as a liaison between the government health care institution and poor pregnant women. ASHA played a vital role in promoting and propagating JSY. During the present study it is observed that all the ASHA have knowledge on JSY.

Table 5.41: Sources of Information on JSY

Sources	Frequency	Percentage
ASHA Supervisor	8	25.0
ANM	10	31.3
BPHC	7	21.9
During Training	5	15.6
Village Panchayat Leader	2	6.25
Total	32	100

The table 5.41 shows that ASHA have received the information about JSY from different sources, among them a substantial number of ASHA (31.3 %) have reported that they came to know about JSY first time from ANM; followed by one fourth ASHA (25%) have reported that they received the information on JSY from ASHA supervisor; about one fifth (21.9%) ASHA have received the information from BPHC staffs; less than one fifth (15.6%) ASHA have expressed that they came to know about JSY at the time of training programme and a very small proportion of respondents i.e. 6.25 percent have reported that they received the information about JSY from Panchayats.

The above table reveals that ASHA Supervisor and ANM are playing an active role in disseminating the information on JSY to ASHA.

5.5.6(p) ASHA's Perception on JSY:

The table 5.42 indicates that all the ASHAs have perceived JSY as a means for the promotion of institutional delivery, while 31.2 percent have perceived that JSY is implemented for the benefit of mother and new born child; 34.4 percent ASHAs perceived that JSY helps in stabilizing the population growth; 25 percent ASHAs perceived that it is useful for the registration of birth and death and even a high majority of ASHAs i.e. 93.8 percent perceived that the beneficiaries received cash incentives under this scheme.

However, during the study it is observed that a significant portion of ASHA (56.25%) have expressed dissatisfaction with JSY as they perceived that the JSY procedure is too cumbersome and lengthy. In addition, some of them have experienced a situation

when panchayat members and hospital staffs also want their share from the cash received by the beneficiaries which create problem for ASHA in rendering services.

Table 5.42: Perception of ASHA on JSY

Perception	Responses	Percentage of cases
Promotion of institutional delivery	32	100.00%
Proper care of mother and new born	10	31.20%
Population stabilization	11	34.40%
Registration of birth/ death	8	25.00%
Get cash incentives	30	93.80%
Total	91	284.40%

Multiple Responses Set

5.5.6 (q) Facilitation of JSY Cases:

From the table 5.43, it is found that a significant number of ASHA have reported that they facilitated upto 5 cases of JSY during last six months; while more than one fourth (28.1%) ASHA have reported that they have facilitated 5-10 cases and the remaining 12.5 percent have reported that they have facilitated 10 cases and above during last six months.

Table 5.43: Number of JSY Cases Facilitated by ASHA in every Six Months

Number of Cases	Frequency	Percentage
Upto 5 cases	19	59.4
5-10 cases	9	28.1
10 Cases & above	4	12.5
Total	32	100

5.5.6 (r) Village Health Day:

As per the NRHM guideline ASHA need to organize one village health day per month in the community. The table below has shown the number of VHD organize by ASHA in last one year.

Table 5.44: Number of Village Health and Nutrition Day (VHND) Organised per Year

Number of VHND	Frequency	Percentage
Up to 5 days	18	56.3
5-10 days	9	28.1
10 days & above	5	15.6
Total	32	100

The above table (5.44) shows that most of the ASHAs i.e. 56.3 percent have reported that they have organised upto 5 VHND in last one year; followed by more than one fifth ASHA (28.1%) have organised 5-10 VHND in last one year and less than one fifth (15.6%) have reported that they have organised 10 and above VHND during last one year.

The above table reveals that a high majority of ASHAs are not able to conduct VHD meeting as per NRHM norms due to more area coverage which in turn increases their work load in the delivery of services to the community as per the NRHM norms.

5.5.6 (s) Place Recommended by ASHA:

Considering the availability and accessibility of health facility and affordability of patients ASHA recommends the place of delivery. The table below depicts the place of delivery recommended by ASHA.

Table 5.45: Place Recommended by ASHA for Delivery

Places	Frequency	Percentage
BPHC/CHC	22	68.8
District Hospital	4	12.5
SMCH	2	6.3
Private Nursing Home	4	12.5
Total	32	100

From the table 5.45, it is found that a high majority of ASHA i.e. 68.8 percent recommends pregnant women to visit BPHC; followed by an equal portion of ASHAs (12.5%) recommends pregnant women to visit District hospital for delivery respectively and the remaining 6.3 percent expressed they recommend pregnant women to visit SMCH for delivery.

During the present study, it is observed that considering the patients physical condition sometimes ASHAs recommend their patients to visit private nursing home if family can bear the cost as they expressed that private nursing home provide quick and quality services to the patients at the time of emergency.

However, in the present study it is observed by the researcher that a significant number of ASHAs representing from different Blocks of Cachar district have reported that in SMCH and district hospital they used to get ill treatment from the health care providers including doctors and nurses. So, except critical condition they avoid to visit these health facilities.

5.5.6 (t) Drug Kits Issued to ASHA:

As per guideline, NRHM should issue Drug kits to each ASHA to provide basic medicines to the people. From the present study, it is revealed that most of the ASHA i.e. 75 percent have reported that they have received the drug kits; whereas, one fourth ASHAs (25%) have reported that they have not yet received any drug kits from NRHM. However, all the ASHAs who received the drug kits have reported that there is an irregular supply of drug from NRHM.

5.5.6(u) Job Satisfaction:

From the present study, it is observed that a high majority of ASHA i.e. 71.9 percent have expressed dissatisfaction with their jobs due to less incentive; whereas 28.1 percent have expressed satisfaction with their job as this job has given them recognition in the community.

5.5.6 (v) Difficulties Faced by ASHA

In course of discharging the duties the ASHAs may have some difficulties to be faced. The table below has explained some of the difficulties faced by ASHAs.

Table 5.46:Types of Difficulties Faced by ASHA

Difficulties	Frequency	Percentage
Funds not available in time	5	15.6
Adequate training is not provided	3	9.4
Delayed supplied of drugs	6	18.8
Behaviour of health personnel is not good	4	12.5
Lack of support from Panchayats	14	43.8
Total	32	100

The above table (5.46) shows that a high majority of ASHAs i.e. 43.8 percent have reported that Panchayats are not co-operative which create problem for ASHAs in discharging their duties properly in the village; followed by about one fifth (18.8%) ASHAs have expressed that delayed supply of drugs as one of the major problem; less than one fifth ASHAs (15.6%) have expressed that they face the problem of irregular disburse of funds; more than one tenth ASHAs (12.5%) have expressed improper behavior of health personnel and about one tenth ASHAs (9.4%) have expressed that absence of adequate training is another major problem faced by ASHA in the delivery of services under NRHM.

5.5.6 (w) Support Required

From the table 5.47, it is revealed that majority of ASHA i.e. 75 percent have expressed that they should be paid a fixed remuneration; followed by less than one fifth ASHAs (15.6%) have expressed that funds should be disbursed regularly so that they can organize the VHND timely and about one tenth ASHAs (9.4%) have expressed that more training is required to be arranged for ASHAs for the smooth delivery of services.

Table 5.47: Support Required by ASHA

Supports	Frequency	Percentage
More training to be arranged	3	9.4.
ASHA should be paid fixed remuneration	24	75.0
Funds should be released regularly	5	15.6
Total	32	100

5.6 The problems and Challenges Faced by BPHCs

To understand the existing problems of service delivery through BPHC, the researcher has interacted with eight Block Programme Manager (BPM) i.e. one from each BPHC and eight Sub-Divisional Medical and Health officer (SDMHO) for the purpose of this study through interview schedule. The problems as came out from the discussion have been mentioned in points below:

- ***Infrastructural Facilities:***

  It is found that all the BPHCs in Cachar district are functioning in government buildings. However, 62.5 percent BPM have reported that BPHC building is insufficient to cater to the needs of the people; while, 37.5 percent have mentioned that BPHC have sufficient accommodation. In addition, it is observed that most of the BPHC's are not having generators and telephone facilities. However, 25 percent BPM have reported that BPHC's are not having separate consultancy rooms for AYUSH. Further, it is found that only 12.5 percent BPM expressed that BPHC's have proper waste disposal system. Most of the BPM i.e. 75 percent have mentioned that lack of availability of canteen facility for in patients and medical shops are the major problem faced by BPHC which create hurdles during emergency. They have further added that none of the BPHC has any linkages with blood bank which again hamper their work during emergency.

- ***Public Health facilities:***

  From the study, it is observed that 87.5 percent BPM have mentioned that BPHC's have public health facilities, like toilet arrangement, piped water supply and electricity, while 12.5 percent BPM has mentioned that there is no regular water supply facility in the BPHC. In addition, most of the BPM i.e. 67.5 percent have mentioned that though they have these facilities within the premises of BPHC, but these are not being maintained properly. However, 75 percent BPM have mentioned that BPHC's are not having separate toilets for male and female which create problem in maintaining proper cleanliness.

- ***Residential Accommodation:***

Lack of availability of residential accommodation in remote rural areas is creating problem for BPHC's staffs to stay and work in such areas. In the present study, it is found that the residential accommodation of doctors has been provided in all the BPHCs, but there is a shortage of quarters. However, all the BPM have mentioned that there is a shortage of quarters for GNM and other Para-medical staffs.

- ***Medicines:***

The regular supply of medicines is inadequate in most of the BPHCs as cited by the BPM. The stock of medicines is inadequate due to the lack of proper storage facility.

- ***Laboratory facilities:***

For efficient discharge of curative functions, the BPHCs must possess sufficient laboratory facilities. From the study, it is found that though all the BPHCs of Cachar district have laboratory facility but these laboratories are not having sufficient equipments.

- ***Manpower:***

It is found from the study that all the BPHCs are having one SDMHO. All the BPHCs are having lab technicians, GNM, pharmacist and accountant. However, 75 percent BPM have mentioned that due to the non-availability of cleaning staff and driver, they need to hire contractual housekeeping staffs from the funds of RKS.

- ***Work Load:***

In the present study it is observed that most of the SDMHO have opined that approximately per day they are treating more than 80 patients including patients from both Out Patient Department (OPD) and Indoor Patient Department (IPD). Further, 75 percent SDMHO have mentioned that though they have shifting duty as per the norm, but due to the lack of man power they need to work more. As a result of this high work load they fail to maintain direct linkages with the nearby

communities. Moreover, 75 percent SDMHO have reported that NRHM has increased the work load of BPHC specially the documentation work. However rest 25 percent SDMHO have mentioned that though NRHM has introduced decentralisation of work to improve grass root governance, but in reality the Panchayats are failed to participate actively in the smooth delivery of health services in to their locality.

- ***Poor Co-ordination with other health care facilities:***

All the BPM and SDMHO have reported that there is a poor linkage of BPHC with other health care facilities like, District hospital and Silchar Medical College & Hospital (SMCH).

- ***Lack of Counseling Facilities:***

It is found that 37.5 percent SDMHO have opined that in BPHC counseling facility is not being provided to the patients as a result of this most of the time patients fail to cope up with the situation.

- ***Sources and frequency of funds:***

All the BPHCs are getting funds directly from district. However, 37.5 percent BPM have reported that there is a delay in getting funds from district which hamper their work.

- ***Status of Rogi Kalyan Semite:***

RKS (Patient Welfare Society) is a registered society, acts as a group of trustees for the hospital to manage its affairs. It consists of the members from local NGOs, local elected representatives and officials from hospital/ CHC/ PHCs. In Cachar district all BPM have mentioned that they have registered RKS in BPHC. As per the frequency of RKS meeting, all the sampled BPM have reported that they meet once in a month. However, 62.5 percent BPM have pointed out that local elected representatives are not actively participating in RKS meeting. Further, 37.5 percent have reported that RKS is not addressing the grievances of patients; while 25 percent have pointed out that there is no suggestion box in the hospital. Most of the BPM i.e. 75 percent have reported that they are utilizing the RKS funds for

the maintenance, renovation and buying equipments, while rest 25 percent BPM have mentioned that they are utilizing the RKS funds for hiring contractual staff.

- ***Management Skills:***

Almost all the BPM have mentioned that though NRHM has improved the health status of rural people specifically women and child to certain extent, but still it have to walk a long distance to reach its goal. In addition, half of the BPM have mentioned that lack of administrative skill on the part of BPHC staffs is one of the major problems in governing BPHC under NRHM. However, 25 percent BPM have cited that ineffective communication flow between higher authorities of BPHC to the field level worker is another problem faced by the BPM in governing BPHC

- ***Miscellaneous:***

All the SDMHO have reported that mostly women from reproductive age group are the frequent users of BPHC services. These women are facing the problem of anemia, Low blood pressure, iron deficiency and diarrheal disease due poverty, early marriage, and absence of family support and lack of awareness. Beside these, 25 percent BPM have mentioned that recruitment of less qualified ASHA as per norm diminish the working efficiency which ultimately create problem in governing BPHC. All the SDMHO have said that though JSY act as a revolutionary step to increase institutional delivery in rural areas but in reality the JSY procedure is too cumbersome so that most of the time rural women are deprived to avail the benefit under JSY. In addition, 25 percent sampled BPM have mentioned that lack of participation of elected representatives hamper the tempo of their work. Further, it is observed from the opinion of the BPM that there are complexities in area demarcation for BPHC under NRHM for which patients as well as health care providers of BPHC face difficulties in governing BPHC.