RAKSHAK FOUNDATION

Improvement of PHCs in India

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Preface

Platforms like Rakshak Foundation, a think-tank for policy research has so far and will continue to encourage and motivate the citizens of the country especially the youth to participate in social issues and design a full-scale sustainable model regarding the same. Currently, I am pursuing my bachelors in Aerospace Engineering from IIT Kanpur and consider myself privileged to be a part of Rakshak Foundation. The summer internship has given me an opportunity to be a part of the progress and functioning of this organization. It encourages the citizens particularly young students of leading institutes to participate in the issues which are vital to the nation's progress and embark upon a journey of social service they have never been before.

At present I'm working under the able guidance of my mentor Shri Rajeev Kapoor who has been really supportive and played an instrumental role in guiding me throughout the phase of the project. I hope this experience will sensitize me and hence awaken me to proactively act on the various burning issues in our country that needs immediate address. Therefore, I feel blessed to have got this opportunity to work with such great set of people in the direction of a noble cause.

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Acknowledgement

Before, I move on with the project I would like to acknowledge the support of many a people. First of all I would like to express immense amount of gratitude to my parents who always have stood by me morally and let me carry on with an internship not very mainstream for an IIT undergraduate. It is because of them only that it had been possible for me to take up this internship program.

Secondly I would like to thank Rakshak Foundation for giving me this opportunity to work on such project and providing me all the facilities for a fruitful research. Most importantly I would also like to thank my mentor, Shri Rajeev Kapoor, Principal Secretary, Vocational Education for being so supportive, helpful and resourceful throughout the term of this program. Besides, I would appreciate the support of my co-interns Upmanyu, Akansha and Jithin who provided with me relevant data as in law commission and Planning Commission reports regarding my Project.

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Contents

List of Tables/Graphs.....6

List of Figures.....7

Executive Summary.....8

1. Introduction 10

1.1 Background Information 10

1.2 Main Problems, their scope and impact on the society.....12

1.3 Goals and Objectives 16

2. Methodology.....18

2.1 Literature Search.....18

2.2 Field Visits: 21

2.2.1 Field study at PHC, Mehrauli: 21

2.2.2 Field study at PHC, Palam: 21

2.3 Surveys: 25

3. Meetings and Interviews 28

3.1 Meetings with others:.....29

3.1.1 Discussion details with the staff at PHC, Mehrauli 30

Dr. A.K. Jain: 30

Dr. Shyam:.....30

Miss Praveen Soyen: 30

3.1.2 Discussion Details with the staff at PHC, Palam: 31

Dr. Kiran Dambolkar:.....31

Dr. Shivani & Dr. Pritam: 31

3.2 Mentor discussion (1 in number):.....35

3.2.1 Outcomes of the discussion:.....35

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3.2.2 Objectives set after the mentor interaction: 35

4. Current NGO and Government Efforts 36

4.1 Historical background: 36

4.2 Why NGO's need to be introduced in the Health Systems strengthening: 38

5. Results and Discussions 40

5.1 Findings from the literature 40

5.2 Finding from the fields and impact on the theoretical focus of the project 45

5.2.1 Findings from the field studies: 45

5.3 Gap analysis 49

6. Recommendations, Scope and Strategy for Implementation 52

6.1 Recommendation & Scope 52

7. Conclusion: 63

8. References 65

9. Appendix A 67

9.1 Mentor Meeting and Interviews 67

9.1.2 Action Items before Next Discussion 67

9.1.3 References (People to meet, research report or papers to read) 68

10. Questionnaire (Only a part of it has been displayed) 68

10.1 Proforma for Facility Survey for PHC 68

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List of Tables/ Graphs:

1. Mismatch between the number of hospitals and the hospital bed.
2. 3-Tier distribution of Health-Care in India.
3. Details of personnel interacted
4. Health-Care Overview in India.
5. Pie-Chart denoting funds of health-care in India.
6. Services provided by the PHCs.
7. Information on Household members

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List of figures:

1. Snapshot of the Health facility Questionnaire
2. Snapshot of household survey
3. Picture of PHC, Palam
4. Target areas of Recommendation 1
5. Schematic representation of Recommendation 2
6. Target areas of Recommendation 3
7. Plan of action for Recommendation 4
8. Schematic diagram of Recommendation 5
9. Schematic diagram of Recommendation 6
10. Schematic diagram of Minor Recommendations.

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Executive Summary

Primary care can be defined as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." The quality of Primary Care is determined by the degree of comprehensiveness of i.e., the extent to which primary care practitioners provided a broader range of services rather than making referrals to specialists for those services and a family orientation, the degree to which services were provided to all family members by the same practitioner.

In India, Primary Health Centers have been instituted as a landmark for rural health services. It is a centre for a qualified doctor to address the health related issues of the villagers/ customers and come up with a curative, promotive and preventive suggestion aimed at positive well-being. Here, a typical PHC covers a population of 20,000 in hilly and tribal areas and caters to a population of 30,000 in plains. It acts as a unit of referral for the sub-centers (4-6 in number) and refer out cases to CHC (30 bedded hospital) in case of specialized treatment. Some of the major characteristics of PHCs are- first-contact care, person-focused care over time, comprehensive care, and coordinated care, as well as family orientation and community orientation.

Following are the features of Primary Health Centers (PHC) and can be summarized as -

1. Offers research-based health care reflecting national economic, political and socio- cultural characteristics
2. Addresses community needs through provision of promotive, preventive, curative and rehabilitative services
3. focuses on population health approaches, requires multi-sectorial cooperation and coordination in national and community development and promotes individual and community participation and self-reliance

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4. Supported by integrated, comprehensive and equitable health care systems
5. Provided by multi-disciplinary teams of health workers.

It has been observed that the stronger the country's primary care orientation (as measured by the same scoring system as in the earlier international comparison) was, the lower the rates were of all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from asthma and bronchitis, emphysema and pneumonia, cardiovascular disease, and heart disease.

Throughout the study, the most important factor that was focused at is 'Access to Care'. It primarily involves the process of finding a health center, getting an appointment with the MO and Referral to tertiary level health centers. Besides, addition of Primary Health Care (PHC) staff: Physicians, multipurpose health workers, physiotherapist and social workers forming a collaborative care team that offers integrated services is again a major area of focus. Moreover, it is highly recommended that an electronic repository of patient information is accessible regardless of where the patient is present for care and even innovative approaches that involve teams, alternative funding mechanisms and technology are needed to build a sustainable primary health care network that is accessible, available, appropriate and affordable.

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1. Introduction

1.1 Background Information

The term 'Primary Health Care' (PHC) gained widespread importance after the 1978 International Conference on Primary Health Care held by the World Health Organization (WHO) and UNICEF. Since that time, PHC has meant many different things to many different groups.

The Declaration of Alma-Ata is a ten point statement calling for:

'Urgent and effective national and international action to develop and implement primary health care throughout the world. '(WHO 1978).[1] The Declaration identifies health as a fundamental human right for which national governments and the international community should be solely responsible, citing inequalities in health between nations as a matter for the utmost concern.

In order to understand the development and the propagation of the philosophy of 'Primary Health Care' the Bhore Committee in 1946 defined PHC as ' A basic health unit to provide as close to the people as possible, an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care.'

Following that, in order to provide basic health-care services to the rural population PHCs were visualized as a cornerstone for its realization. On its first meeting in January 1953, the Central Council of Health was strongly in favor for the establishment of PHC system so as to provide comprehensive health care to the rural population. These centers initially functioned as peripheral health service institutions with minimal community involvement. Increasingly, these centers came under criticism, as they were not able to provide adequate health coverage, partly, because they were poorly staffed and equipped and lacked basic amenities.

In order to function properly any structure needs to trust its foundations. This

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is surely not the case with India's primary health centers. With lack of infrastructural facilities, missing essential drugs, absence of trained professionals, poor ailing villagers prefer to visit the distant city hospitals rather than next-door primary health centers. They visit the city hospitals at a stage when they are unable to bear the pain and in the process the complications of their disease also increase. They unnecessarily succumb to such diseases which could very well be treated at a very early stage. This mobility of villagers to cities also lead to spread of infectious diseases in cities. This increased patient load on the city hospitals lead to disruption in their smooth functioning, for example in delay of treatments of patients in need of more critical care. The Right to health care of every citizen of India rests on the foundations of a hierarchical system of healthcare promising to deliver quality care. The Primary Health Centers make up the bedrock of this foundation and hence need to play a pivotal role in shaping the future of a country of 670 million poor people. This project intends to research and analyze the present status of the PHCs in order to ensure more effective address of the recurrent issues which are often linked to their underperformance.

Currently, the Indian Public Health Standards (IPHS) for Primary Health Centers has been prepared keeping in view the resources available with respect to functional requirement for Primary Health Centre with minimum standards such as building, manpower, instruments, and equipment's', drugs and other facilities etc. The overall objective of IPHS for PHC is to provide health care that is quality oriented and sensitive to the needs of the community. These standards would help monitor and improve the functioning of the PHCs.

At present, the major stumbling blocks such as the inability to perform up to the expectation due to (i) non-availability of doctors at PHCs; (ii) even if posted, doctors do not stay at the PHC HQ; (iii) inadequate physical infrastructure and facilities; (iv) insufficient quantities of drugs; (v) lack of accountability to the public and lack of community participation; (vi) lack of set standards for monitoring quality care etc. These have been the major issues that need to be accounted so as to improvise the PHCs in India.

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1.2 Main Problems, their scope and impact on the society

As always it has been the curative services with the specialized physicians preferred over the family practitioners when it comes to health treatment. Public spending not only in India, but also in many of the industrialized nations has been oriented towards curative services rather than preventive and promotive health. In India, every year more than Rs. 100,000 crore is spent annually as household expenditure on health, which is more than 3 times the public expenditure in health sector. The private sector health care as it is unregulated; the health-care costs have been pushed to sky-rocketing values making it unaffordable for the rural poor. It is clear that maintaining the health system in its present form will become a major concern in India.

Persistent high-level of infant health disorders in the form of malnutrition, high levels of anemia among children and mother, inadequate safe drinking water throughout the year in many villages, unsatisfactory sanitation and waste disposal, besides various extraneous issues as in low age of marriage and at first child birth, lack of health awareness and education among the rural mass constitute some of the major problems of public health system in India. There is also a significant degree of correlation between the high levels of poverty and the environment degradation in the villages.

Thus, it is the need of the hour to deal with multiple health crises, ever increasing expectations of people and rising costs of health care. The problem of quality health care dissipation has to be met with utmost care and urgency. Given the scope and magnitude of the problem, it is no longer enough to be oriented only towards narrowly defined health care projects. The urgent need is to transform the public health system into an accountable, accessible and affordable system of quality services.

Six mechanisms, alone and in combination, may account for the beneficial impact of primary care on population health. They are-

1. Greater access to needed services,
2. Better quality of care,

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3. A greater focus on prevention,
4. Management of health problems in the initial stages,
5. Cumulative effect of the main primary care delivery characteristics, and
6. Role of primary care in reducing unnecessary and potentially harmful specialist care.

Following are some of the problems specific to Primary health care in India-

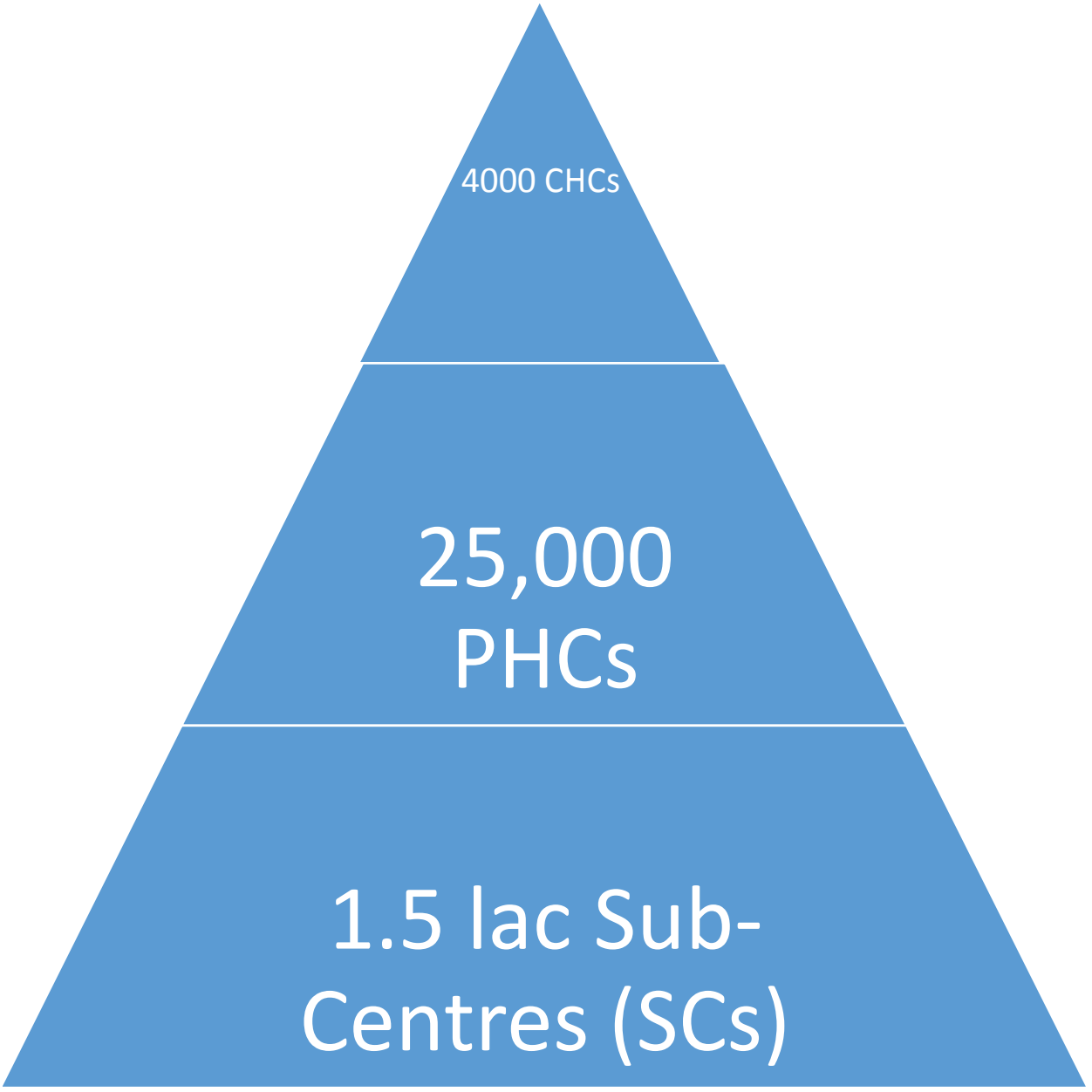
1. **Insufficiency of Hospital Beds:** There are around 12,000 hospitals having close to 5.7 lac beds in the country. Out of these approx. 7000 hospitals are in rural area with 1.5 lac beds and 5000 hospitals are in urban area with close to 5 lac beds. The disparity on the socio-economic front is clearly visible.



Graph 1: Mismatch between the number of hospitals and the hospital beds.

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2. **Insufficient number of Healthcare Centers:** There are close to 1.5 lac Sub Centers, around 25 thousand Primary Health Centers and 4 thousand odd Community Health Centers in India as on March 2009. (These figures are insufficient keeping in mind the model of 2005 National Commission on Macroeconomics and Health, which recommended a Sub-Centre for every 5,000 population, a Primary Health Centre for every 30,000 population and a Community Health Centre for every 1, 00,000 populations.)



Graph 2: 3-Tier distribution of Health-Care in India

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3. **Fewer number of Blood Banks:** Total number of blood banks in India is close to 2500 which is pretty dismal given the international standards. Besides, except for Assam, the states in North-eastern part of India are extremely low on availability of Blood Banks.

4. **Fewer Medical colleges in India:** With 300 odd medical colleges in India and close to 250 dental colleges it is very difficult to counter the dismal scenario of Primary Health in India. Moreover, Concentration of Health-Care in Metro cities and non-availability of urgently needed vaccines are some of the important areas that need to be focused upon.

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1.3 Goals and Objectives

Following is a brief description of the objectives that are supposed to be undertaken as per the task list assigned to us-

1. To study the structure of healthcare infrastructure in India. In this regard 'National Rural Health Mission- Meeting people's health needs in rural areas' a document with the intricate details of the program and realizing that the urgent need is to transform the public health system into an accountable, accessible and affordable system of quality services is to be read and analyzed. Once, the task of literature review is completed, the implementation problems observed from field visits are compared to the recommended guidelines mentioned in the document. Moreover, evaluating the accomplishments of Accredited Social Health Activists (ASHAs), Rogi Kalyan Samitis (RKSs) and Village Health and Sanitation committees (VHSc) is also an integral part of the project.

2. Visit PHCs of nearby villages and check for availability of doctors and nurses. This objective will be addressed in the further field visits to Kanpur, villages in Punjab and PHCs in West Bengal (Tentative) and to discuss with the authorities the medical facilities/ treatments the PHCs are capable of rendering and to study the distribution of essential drugs across the PHCs.

3. Meeting with the medical authorities and the local people and then conduct a survey on the quality of treatment received by them at the PHCs. To conduct both qualitative and quantitative interview of the key health personnel. A survey has been conducted with regard to the facilities available at the PHCs, its comparison with the IPHS for the PHCs in India and a Patient satisfaction questionnaire has also been framed.

4. Finding out the number of times patients had to be taken to city hospitals even for simple ailments and analyze whether it is due to unavailability of

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doctor or incompetent treatment. Moreover, study of the reasons for absence of trained doctors and nurses from the health-care centers.

5. Studying the funds allocated by the State government and the manner of its utilization. At present, I have dealt with those PHCs which are either under the Municipal Corporation and Govt. of India.

6. Comparing the quality of health care provided at the primary level with the rest of the world keeping in view the share of budget allocated to these centers. The medical infrastructure and the levels of implementation of the PHCs in almost all the continents are analyzed.

7. Suggestions regarding how doctors might respond to financial incentives, also suggest the need of people with good administrative skills to come forward and aid the working of these PHCs. Given the reluctance of doctors to work in rural areas, it is necessary to utilise most effectively the skills of the very few who are willing to do so by allocating one physician for every few PHCs.

8. To spread awareness about the importance of health education regarding family planning, sanitation and prevention of communicable diseases.

9. Suggestions regarding simple mechanism for the poor and many times illiterate people to register their complaints for non-availability of basic health services at the PHC which would be addressed in a time bound manner.

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2. Methodology

2.1 Literature Search

Following is the list of articles/journals referred to conduct an exhaustive research in the field of Primary Health-care

1. Literature review on the 'healthcare systems in European Union'. The report provides the health care policies in 15 EU member states. Health care systems arise out of specific political, historical, cultural and socio-economic traditions and the health-care system in the European countries is bound by that.

2. Barbara Starfield and James Macinko's [2] 'Contribution of Primary Care to Health and Health systems'. The analyses reflect upon shows that primary care is associated with a more equitable distribution of health in populations, a finding that holds in both cross-national and within-national studies.

3. Summary of the Report on 'Workforce Management Options & Infrastructure and Rationalization of PHCs'- Guidance to the ground realities of PHCs in India.

4. Literature review on Complaints and patient satisfaction: a comprehensive review of the literature. For the purposes of this report, patient complaints have only included complaints about quality of care rather than complaints about symptoms or side effects of drugs, treatment or illness.

5. A social commentary on the Primary Health system in Cuba. The foundation upon which Cuba's positive health outcomes are built is a primary care system that integrates public health and clinical medicine into a seamless continuum.

6. MOHFW document on the Indian Public Health Standards (IPHS)[3] for the Primary Health Centers (PHCs) in India. This document contains guidelines

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and standards for the efficient functioning of PHCs and the tasks of the technical and the non-technical staffs are well elaborated.

7. 'Primary Health Care and General Practice - A scoping report' [4] by Wendy Rogers and Bronwyn Veale. The basic philosophy behind the need of PHCs all over the world is underlined.

8. A case study on 'Interdisciplinary Primary Health Care: Finding the Answers– A Case Study Report'[5]. The basic problems related to condition of nurses and mid-wives, need for additional non-technical staff etc. were addressed but, the report was not vital in the Indian context.

9. Report of the health survey and development committee chaired by Sir Joseph Bhore. It is a document of 1940s and the factors responsible for the low level of ill health in India ex. the prevalence of malnutrition and under-nutrition among appreciable sections of the people, the serious inadequacy of existing provision for affording health protection to the community and a group of social causes consisting of poverty and unemployment, illiteracy etc.

10. A power point presentation on 'Paradigm shift in NRHM' [5] by Sundar Raman explicitly mentioning the objectives, hurdles and the progress of the NRHM with vital statistics.

11. A power-point presentation on 'Revitalizing health for all' [6]**.** It's a case study on the Primary health care model on Bangladesh with an emphasis on the historical model of Primary health system of Bangladesh and study the weakness and comprehensiveness of the present system.

12. Report on 'A compendium of primary care case studies- 38 case studies submitted by 29 countries across the 6 WHO regions ' [7] with primary stress on nursery and midwives.

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13. Literature review of the Health-care System in Singapore. Yu BAI, Chaoran SHI, Xiaoteng LI, & Feifei LIU.

14. Literature review- Towards realizing primary health care for the rural poor in Thailand: health policy in action. Mary J Ditton & Leigh Lehane .

15. Scaling up Primary Health Services in Rural India: Public Investment Requirements and Health Sector Reform - Case studies on Andhra Pradesh and Karnataka. Nirupam Bajpai, Ravindra H. Dholakia and Jeffrey D. Sachs.

16. Literature review on the Primary Health Care system in Costa-Rica. The country's health policies on the lines of equity and solidarity in the distribution of Public Health Services have been discussed. Its comparison with other Latin American countries on various health parameters like IMR, MMR, Life Expectancy reflects the positive aspects of Primary Health in the country.

17. A statistical and an analytical study of Health-care overview in India on the medical and non-medical infrastructure as well as the lack of a medically insured population. The various Govt. schemes like CGHS, ICDS, RSBY etc. were discussed with due stress on the implementation flaws.

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2.2 Field Visits:

In a span of 2 months after a detailed questionnaire pertaining to the field study, thorough analyses of literature and consultation with my mentor I conducted field visits to the Primary Health Centers in Mehrauli and the PHC, Palam in the 3rd and 4th week. Then, I was headed to PHC, Kanjhawala for my final PHC visit which was followed by meetings with ANMs in the M&CW Centers and household visits in Kanjhawala and slums in Bawana.

Highlighting the outcomes of the field-visits:

2.2.1 Field study at PHC, Mehrauli-

1. A detailed information of the structure, out-patient services, manpower, rehabilitation services etc. of PHC, Mehrauli was obtained. A qualitative idea of the structure and functioning of PHCs would assist in its comparison with the quantitative inputs available from various case-studies of Indian states and countries world-wide.

2. Working condition of ASHAs, ANMs, LHVs and implementation problems under the NRHM were observed/ analyzed. Mrs. Praveen Soyen guided me on the schedule of vaccination program under the NRHM scheme, the role of ASHAs in facilitating the ante-natal and post-natal care and sought for increasing the efficacy of ASHA workers by including more recruits and modifying the depressing wage structure.

3. Due to the lack of in-patient services and 24 hours health facilities many of the questions regarding physical infrastructure, primary management of surgeries, Pregnancy, fracture etc. remained unanswered.

2.2.2 Field study at PHC, Palam-

1. Dr. Dambolkar, the CAMO of the PHC, Palam highlighted on the need for

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inclusion of multi-purpose health workers with a holistic focus on promotive, preventive and curative aspects of health care. The PHC, Palam as well as the 2 sub-centers under its administrative control lacked a substantial number of multi-purpose workers and relied more on health specialists and lab-technicians for specific chronic and non-chronic diseases.

2. Dr. Dambolkar also expressed his disappointment over the Management problems specific to PHC, Palam and also pointed the lackluster efforts from the side of Ministry of Health and Family Welfare, who reportedly have not visited the PHC even once in last 2 years.

3. Interacted with the interns from Lady Hardinge College who primarily deal with the OPD services, Immunization and Health Education of the public. It was highly satisfying to know that these interns organize daily talks on some of the health topics as in NRHM-How far has it benefitted the Public Care and precautions during Pregnancy, HIV, Anemia, TB etc.

4. Interacted with the lab-technicians there in the PHC. They were worried about the wage structure which was pretty dismal going by the salary structure in Private clinics. Besides, most of them worked on a contractual basis, thus they did not come under the direct purview of the PHC and a step-motherly treatment is supposedly faced by them.

2.2.3 Field study at PHC, Kanjhawala

Field visit to a Primary Health Center in Kanjhawala after consultation with the C.M.O. Of PHC, Palam Dr. Kiran Dambolkar. The PHC was primarily subdivided into 3 groups- Polyclinic, M&CW center and Mobile Van under the heads of 3 Medical Officer. Interacted with Mamta Rani and Kalpana, 2 of the staff nurses in the health-center and got an insight of the condition of nurses, ANMs, ASHAs.

1. The Primary Health Center at Kanjhawala has 3 major areas of jurisdiction- Polyclinic, M&CW facility and Mobile Van which are administered by MOs in each of these facilities. Interaction with the C.M.O. Dr. Om Prakash was brief

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with focus more on how effective are the health-care policies in the direction of prevention, promotive and rehabilitative health-care.

2. Mamta Rani, a staff nurse in the PHC discussed about the some of the general problems pertaining to the PHC and several nurse specific issues were also discussed. Discussion on the lines of insufficient availability of staff, redundancy in the recording of patients' information, unavailability of filtered water supply in the health center, unavailability of electricity backup was done. She also stressed on the need for introduction of a token fee (for ex. Re. 1) so that the health services provided are valued and due importance is given to better hygienic environment for living.

2.2.4. Field Study at M&CW center, Shahabad:

The ANMs in M&CW center, Shahabad Rajwanti Ma'am and Anu Ma'am informed about the working of the ANMs, ASHAs and discussed the implementation problems of various Government schemes like Janani Suraksha Yojana (JSY). The center was equipped with in-patient facilities for maternal care. The wage structure of ASHAs on the basis of the core and non-core activities, the analyses of the household survey reports conducted by the ASHAs and the minimum qualifications of ASHAs (depends on the region of operation) were highlighted by the ANMs. The ANMs stressed that the training of the male workers need to be more rigorous especially in Ante-natal care and periodic training in paramedics in treatment of minor ailments to bring down some of the extra burden of work from the female workers and the ASHAs.

Comparative analyses of the PHCs and the Maternal Centers visited:

In all 3 of the PHCs 4 Medical Officers were employed where the existing pattern as recommended by the Government is 3. Moreover, the number of lab technicians and specific departments as in AIDS control, DOTS centre etc. in Palam were more in Number. However, an exclusive center for mobile van was only present in Kanjhawala administered/managed by a Medical Officer.

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Moreover, both Palam and the Kanjhawala PHC had dental facility available as against PHC, Mehrauli. Besides, the PHC in Mehrauli did not institute a M&CW facility in the Centre in the PHC itself. All 3 of the PHCs lacked in-patient services which acted as a roadblock to the research, the M&CW center in Shahabad however had an in-patient unit catering to ante-natal, intra-natal and post-natal care. School related programs and the monitoring and supervision activities in PHC, Palam were organized at an active rate (as compared to other PHCs) with daily talks on major health related issues organized by the interns of Lady Hardinge Medical College, Delhi and regular monitoring by the Director, PHC, Najafgarh. Moreover, the infrastructure at PHC, Palam superseded that of Mehrauli and Kanjhawala in all counts. Lastly, services were offered for free in all the PHCs as well as the Maternal Center.

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2.3 Surveys:

2.3.1. Health facility Survey:

An objective questionnaire that addresses questions of:

1. Assured Services available that includes OPD services, Emergency Services, Referral Services and In-patient Services.
2. Average daily OPD attendance.
3. Treatment of specific cases-
    i. Surgery for cataract
    ii. Primary Management of wounds.
    iii. Primary Management of fracture
    iv. Primary Management of cases of poisoning/ snake, insect or scorpion bite.
4. MCH care that covers Ante-natal care, Intra-natal care, Post-natal care, Child care including immunization, Family Planning, MTP etc.
5. Other functions and services performed- Nutrition services, School Health programs, Promotion of safe water supply etc.
6. Monitoring and Supervision activities- Monitoring activities of ASHAs, Monitoring of National Health Programs, Visits of Medical Officer to all SCs at least once a month.
7. Manpower including MOs, Pharmacist, Nurse-Midwife, Health Worker, Health educator, Clerks, Drivers and other Class IV workers. Here, the existing pattern, recommended manpower and the Current availability of PHCs are noted.
8. Quality Control that addresses whether Citizen's Charter is functional/available or not? , Demanding a list of order notifying the members of Rogi Kalyan Samiti.
9. Furniture in the PHC that addresses availability of items like Examination Table, Delivery Table, Footstep, Bed side screen, Stool for patients etc.

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Household Survey:

To conduct a household survey a questionnaire was prepared addressing the following areas-

1. Medical facilities: Questions pertaining to the satisfaction of the villagers with the existing medical facilities in PHCs, Distance travelled to attain medical facilities, details of the Women Health Volunteers (WHVs) deployed in the village, Study of health services with the presence of Village Health Workers (VHWs).
2. Information on Household Amenities: It deals with electrification of households, sources of drinking water, purification of drinking water, Sewerage, Drainage and Road cleaning and water removing facility.
3. Information on Household members: Questions on Name, Relation with the head, Sex, Age, level of education, details of any major sickness, earnings per month, Cost of treatment per month etc.
4. Health Related information: Maternal Health dealing with number of deliveries performed in the household, whether the mother got ante-natal checkup or not, Details of the delivery i.e. attended by Dai/ Nurse/ Doctor? Child Health that deals with number of children surviving below 5 years, Whether the child receive immunization/ vaccination/Tika or not? Whether the children (below 5 yrs.) suffer from fever, malaria, respiratory disease or any other disease?

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Proforma for Facility Survey for PHC on IPHS

Identification :

Name of the State: _____
District:_____
Tehsil/Taluk/Block _____
Location Name of PHC:_____
Is the PHC providing 24 hours and 7 days delivery ? _____

Date of Data Collection
Day Month Year

_____ _____ _____
Name and Signature of the Person Collecting Data _____

1. Services

Sl No.		
1.1	**Population covered (in numbers)**	
1.2	**Assured Services available (Yes/No)**	
a.	OPD Services	
b.	Emergency Services (24 hours)	
c.	Referral Services	
d.	In-patient Services	
1.3		
a.	Number of beds available	
b.	Bed Occupancy Rate in the last 12 months (1- less than 40%; 2 - 40-60%; 3 - More than 60%)	
1.4	Average daily OPD attendance	
a.	Males	

Fig. 1: Snapshot of the Health facility Questionnaire

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D. Information on HH Members:

Sl. No	Questions	Member							
		1	2	3	4	5	6	7	8
1	Name								
2	Relation with Head of HH.								
3	Sex (M/F)								
4	Age (yrs.)								
5	Level of education.								
6	Enrolled in school? (Y/N)								
7	Gainfully employed (Y/N)								
8	Earnings per month. (Rs.)								
9	Hospitalisation last year (Y/N)								
10	Any major sickness last year								
11	How many days in the year for								

Fig. 2: Snapshot of household survey

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3. Meetings and Interviews



Fig. 3: Picture of PHC, Palam

3.1 Meetings with others:

Name	Designation	Institution	Contact details
Dr. A. K. Jain	CAMO	PHC, Mehrauli	01126641131
Dr. Shyam	Assistant MO	PHC, Mehrauli	9013956898
Praveen Soyen	Health Educator	PHC, Mehrauli	N.A.
Dr. Dambolkar	CAMO	PHC, Palam	9810779665
Dr. Shivani	Internee	PHC, Palam	N.A.
Dr. Pritam	Internee	PHC, Palam	9013836130
Dinesh Kumar	Lab Technician	PHC, Palam	N.A.
Arvind Yadav	Lab Technician	PHC, Palam	N.A.
Dr. Omprakash	RMS	PHC, Kanjhawala	N.A.
Mamta Rani	Staff Nurse	PHC, Kanjhawala	N.A.
Satbir Singh	Villager	Bawana	N.A.
Sona Devi	Villager	Bawana	N.A.
Sevakram	Villager	Kanjhawala	N.A.
Dayawati	Villager	Bawana	N.A.

Table 1: Details of personnel interacted

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3.1.1 Discussion details with the staff at PHC, Mehrauli

Dr. A.K. Jain:

As the head of the PHC, Dr. Jain permitted me to conduct a survey on the conditions of the PHC at Mehrauli. He was really supportive regarding answering the questionnaire prepared by me. We discussed at length on the Primary Health Care system in India. He suggested me to go through the Primary Health system in Bangladesh and some other Asian countries. Finally, he directed me to Dr. Shyam who answered to the 8 page long questionnaire that I prepared.

Dr. Shyam:

Shyam, a junior medical officer answered to the questions listed on the proforma prepared. He was very frank and came up with appropriate replies. As M&CW facility was not a part of the PHC he gave me the contact details of the medical officer of the M&CW center where I could get information regarding MCH care and family planning.

Some of the suggestions/ scope for improvement specific to PHC, Mehrauli were

1. Lab facilities were not up to the IPHS.
2. Some of the drugs are unavailable and the delay in getting these drugs have been one of the major roadblocks. Ex.- Anti-Malarial drug, Anti- Rabies vaccine, etc.
3. Emergency facilities and 24*7 availability of services is yet to be introduced.
4. It is expected that it gets converted to a polyclinic. Moreover, a 3 storeyed building is under construction; after its completion number of patients are expected to increase.

Praveen Soyen Ma'am:

She gave an overview of the structure of the M&CW facility, Mehrauli. The team structure was explained in detail to me.

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1. She provided me with the procedure of the selection of ASHAs and the training procedure for the workers.
2. The vaccination scheme for a period of 5 years was explained in detail and the way ASHA workers maintain a disciplined schedule for the patients (150 in number).
3. The implementation problems of NRHM were highlighted.

3.1.2 Discussion Details with the staff at PHC, Palam:

Dr. Kiran Dambolkar:

As the CAMO of the PHC he discussed the history of its foundation with me. The PHC at Palam is unique of its kind as it comes under the regulation of Govt. of India whereas most of the PHCs run under the State Govt. It was founded in 1957 with the objective of orienting the interns of Lady Hardinge Medical College i.e. initially it did not provide any form health services. Here, there are no multi-purpose health workers and specific center for various chronic and non-chronic diseases are instituted.

He even discussed the Management issues in the field of health care and considered it as the biggest stumbling block in the implementation of various health-related schemes. The PHC also has an Operation Theatre which is used only on camp basis.

Dr. Shivani & Dr. Pritam:

These doctors are interning under Dr. Dambolkar and currently handling the OPD services in the centre. These interns organize health talks with posters to reflect upon the health scenario in India. Some of the topics that they address are NRHM, Care and precautions during Pregnancy, HIV, Anaemia, TB etc. related information is also passed on to the aam junta.

The interns also visit the sub-centres (Harijan basti & Pochampur) on Tuesday and Friday. Here, they provide OPD services, Immunization and Ante-natal Care. Emergency facilities and 24*7 availability of services is not introduced yet.

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Besides, I also interacted with 2 of the patients who visited the PHC. They filled the Patient Satisfaction Questionnaire. They were more or less satisfied with the behavior of the medical staffs and were in all praise for the infrastructure of the centre. However, they hesitated on some of the questions which were slightly personal questioning their health practices.

Discussion details with the staff at PHC, Kanjhawala

Mamta Rani (Staff Nurse):

We discussed about the nursing allowances, housing facility and the house-rent charged on them by the Municipal Corporation of Delhi (MCD) to the staff nurses. She felt that co-ordination between MCD and State administration needs to be improved and an effective chain of network needs to be brought in. They also discussed about the insufficient water-supply, unavailability of electricity backup. She also highlighted on the Staff to Patient ratio. In case of Private hospitals it is almost 1:5 whereas in the hospitals under MCD it is close to 1:50.

Besides, the proforma for facility survey for PHCs was filled whereby the Services available in terms of OPD services, emergency services, daily OPD attendance and the manpower available there in the PHC was also listed. Moreover, a health questionnaire on the grounds of Household Satisfaction was also made.

Discussion details with villagers/clients of Kanjhawala and Bawana:

Satbir Singh:

A 65 year old street laborer belongs to a slum in the town of Bawana. He is satisfied with the existing medical facilities near his locality. For health check-up he along with his family visit the dispensary in Pooth Khurd, around 1 km from his Residence. On a scale of 5, he rates the Govt. Health-care centers 4. He has never been to a Private hospital due to a poor economic background. In regard to the

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household amenities available, there is a provision of electricity almost all the days a week and the slum-dwellers have in general no complaints related to Electrification. Satbir and his family rely on Public hand pump for drinking and do not filter or boil the water before drinking. Satbir and many other people in his locality, due to the unavailability of exclusive latrine and toilet facility have to depend on open spaces for the same. Moreover, the drainage is an uncovered open path that acts as breeding ground for mosquitoes.

Sona devi:

A resident of the above-mentioned slum in Bawana was in full praise for a Pradhan named Pratap Dabas who founded the settlement for these people and provided the dwellers with free electricity and water-supply. She praised the proximate medical facilities as the Pooth Khurd dispensary, around 4 km from the slum which provided free, extensive medical care to her eldest grandson Himanshu in the initial years. He suffered from Pneumonia followed by inflammation of Thyroid and then developed certain physical deformities which still bothers the family but, they highly appreciate the primary, secondary and tertiary medical services available in the state.

Dayawati:

Besides the common issues raised and answered by the slum dwellers of Bawana, Dayawati insisted on a covered path for drainage as well as sewage. With flies and mosquitoes all around and the unhygienic environment unaddressed by the local administration, a depressing picture was painted by the dwellers there. In her family out of 3 deliveries performed (all of them attended by dai) 2 survived and 1 died at an age of infancy due to an unidentified disease which the other two siblings are also suffering from. Moreover, she also complained that the Anganwadi workers hardly come to the slum (not even once a month) to address the issues related to infants' health.

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Sevakram:

Met Sevakramji, drives for Asst. Commissioner, Labour Court, Ashok Vihar, Delhi and lives in the Kanjhawala village. His household is completely electrified with a 24*7 availability of electricity. Tanks located in the Ladpur Road act as a source of drinking water. The water is however not purified i.e. there is non-availability of filtered or boiled water. There is an exclusive facility for latrine and toilet in his household, however, in the surrounding areas the drains remain uncovered turning out to be breeding grounds for mosquitoes and flies. Regarding the health related information, in the field of maternal health, out of the 2 deliveries performed in the household 1 of the deliveries was attended by dai and the other

in a Government hospital. The mother did receive injection/vaccination but was bereft of any kind of ante-natal checkups. Considering the health status of infants, the younger kid suffered from pilia when he was six months old but, finally with the assistance of the medical officers from Kanjhawala dispensary his condition improved. The family members are unaware of any supplementary feeding program/ Anganwadi workers but, are highly motivated and enthusiastic about getting informed about various Government programs. He was not that satisfied with the medical facilities available in the proximity and feels that the medical officers need to be more sensitive and understanding towards the a resident talked about the household amenities available in terms of household electrification, sources of drinking water, availability of filter for water purification, sewerage and drainage facilities etc. The survey was also intended towards collecting information on house hold members, maternal health, Infants' and child healthcare and finally questions pertaining to Medical facilities available in the locality were addressed. The details of the discussion are mentioned in the field-visit report.

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3.2 Mentor discussion (1 in number):

3.2.1 Outcomes of the discussion:

1. The basic preventive and promotive role of PHCs was highlighted in the initial phase of our discussion.
2. Sir discussed about how NRHM has helped in improving the status and quality of the PHCs in India.
3. Sir suggested me to go through the Primary Health Care system in Bangladesh, Nepal and other neighboring countries which have made a steadfast progress in the field of Primary Health.
4. I was also guided on how to conduct the field study (Interaction with the villagers and the medical staff) in the PHCs in North and West Delhi.
5. We also discussed about the relevant questions pertaining to the RTI application that will be filed next week.

3.2.2 Objectives set after the mentor interaction:

1. A detailed qualitative analyses of the PHCs in Palam and Kanjhawala in Delhi.
2. A specific RTI application pertaining to the status of health care in the above mentioned PHCs focussing on the medical facilities (OPD and lab facilities) and the regularity of the medical and non-medical staff (A copy of the attendance register).
3. A plan to overview the Primary health care system in the top 10 healthiest countries of the world with key stress on European Union, US, Cuba and Costa- Rica.
4. A comparative analyses of the field studies in the PHCs in Palam and Kanjhawala in Delhi and derive relation between the standards of operation.

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4. Current NGO and Government Efforts

4.1 Historical background:

Government efforts in the direction of Primary Health Care:

Name of Scheme	Year of Enactment	Target	Objective	Means of Financing
ESIS: Employee's State Insurance Scheme	1948	Employees with income less than Rs 15000/month and dependents	To achieve universal health coverage	Financed by state government, employers and employees
CGHS:Cenral Government Health Scheme	1954	Government employees and families	To achieve universal health coverage	Financed by state government, employers and employees
ICDS: Integrated Child Development Services	1975	Malnutrition children under age 6	To improve nutrition and health status to children	The government, the United Nations Children's Fund (UNICEF) and the World Bank
RSBY: Rashtriya Swasthya Bima Yojana	2009	The poor below the poverty line	To provide affordable healthcare to the poor	Financed by Federal (75%) and State (25%) Government
NPHC National Programme for the Health Care of the Elderly	2011	Seniors	To provide the elderly an easy access to primary healthcare	Ministry of Health & Family Welfare

Table 2: Health-Care overview in India

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Since 1948, Indian Government has initiated various schemes in order to ensure health-care access to the middle and upper class as well as the poor and other special population. Some of them are addressed below:

It is obvious in the Indian scenario that a large gap in the provision of health services between the rural and urban areas exists and is mostly due to a lack of health-care resources and insufficient infrastructure in the rural areas. In regard to rural areas, significant measures have already been undertaken. To address the lack of availability of health services for the urban poor, Indian Government has launched the Urban Renewal Health Mission (URHM). Its principal mission is to ensure sufficient resources and to reduce health problems for the vulnerable poor sector residing in the urban fringes.

While the National Urban Health Mission has had some major success, India's biggest health-care concern of the health conditions in rural areas have not yet been addressed. The rural regions have less access to modern medical treatments and depend more on traditional treatment in the form of Unani and acupuncture. The rural population has significantly less financial capital and relies heavily on government funded medical facilities. To address the shortcomings of financial capital and lack of infrastructure National Rural Health Mission (NRHM) was launched in 2005 to improve the accessibility of health services in rural regions by adding more health-care facilities in these areas.

Besides, under NRHM Reproductive and Child Health Programme – II (RCH-II) and the Janani Suraksha Yojana (JSY) was launched. The launch of NRHM provided the state as well as Central Governments with a unique opportunity to carry requisite reforms in the health and family welfare sector. The reforms are seen as necessary for the restructuring of the health delivery system as well as developing better health financing mechanisms. It is imperative that the strengthening of health institutions like SHCS/PHCs/CHCs etc. Have positive consequences for all the health programmes with the assumption that a functioning public health system is in

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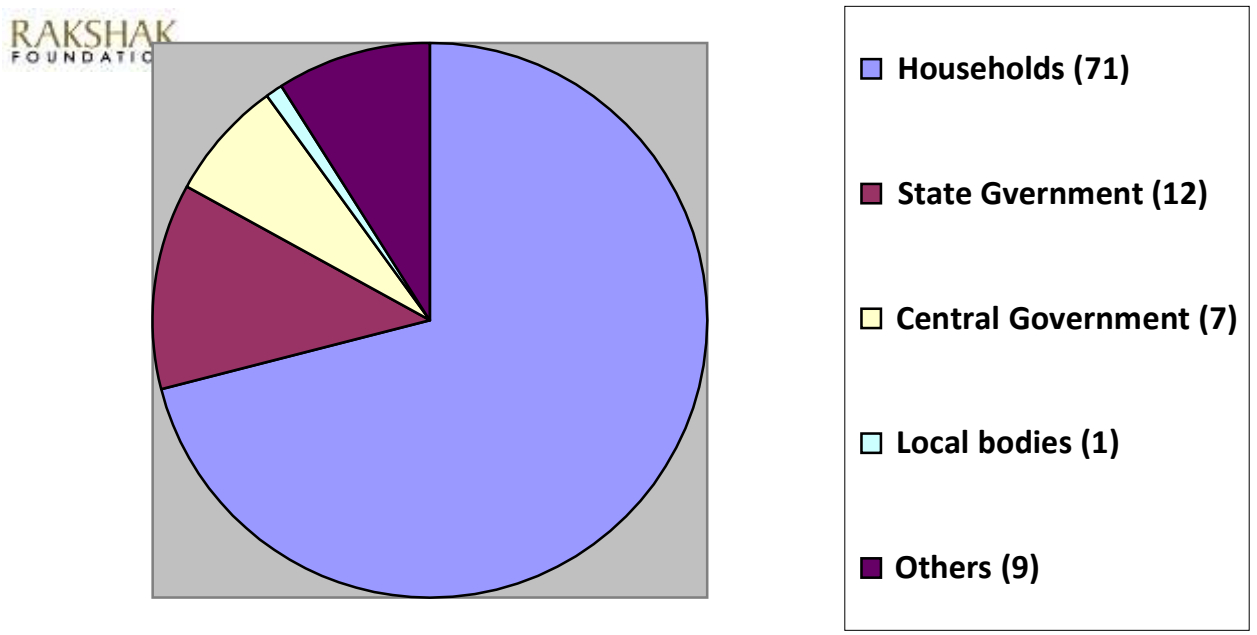
existence.

NRHM in partnership with non-governmental bodies through proper regulation and transparent systems of accreditation for quality health services at agreed costs and norms has provided substantial health-care facilities in the rural areas. Given the wide diversity in the quality and costs of non- governmental providers, NRHM emphasizes the need for partnerships based on provision of quality health services. Involvement of community groups in the process of partnerships will facilitate a more open and transparent relationship with the non -governmental sector.

4.2 Why NGO's need to be introduced in the Health Systems strengthening:

1. The hiring practices that the NGOs will engage in will ensure long-term health sustainability.
2. Employee compensation practices that strengthen the public sector will be enacted.
3. A human resource training and support system that is good for the countries where the work is conducted will be pledged.
4. The presence of NGO itself will minimize the NGO management burden for the ministries.
5. As the NGO's engage with communities they will support the ministries of health.

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Graph 3: A pie-chart denoting the funds for health-care in India

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5. Results and Discussions

5.1 Findings from the literature

Some of the important concepts which need attention in India is discussed below-

1. A report on the health care policies in 15 EU member states gave me insight on the health-care practices and infrastructure in Europe. Health care systems arise out of specific political, historical, cultural and socio-economic traditions. As a result, the organizational arrangements for health care differ considerably between Member States - as does the allocation of capital and human resources. The report reflects quite significantly on the quantity and the quality of life of the Europeans. But, cross-country comparisons are valid only within the limits of data availability and comparability.

2. Analyzed a report on Contribution of Primary Care to Health and Health systems by Barbara Starfield and James Macinko. The analyses reflects upon shows that primary care (in contrast to specialty care) is associated with a more equitable distribution of health in populations, a finding that holds in both cross-national and within-national studies. The means by which primary care improves health have been identified, thus suggesting ways to improve overall health and reduce differences in health across major population.

   Here, Reforms in Costa-Rica were also highlighted. These reforms included transferring the responsibility of providing health care facilities from the Health Ministry to the Costa Rican Social Security Fund (CCSS), expansion of Primary Care facilities and the reorganization of Primary Care to Integrated Primary Care Systems.

3. Read a report on the Primary Health system in Cuba. The foundation upon which Cuba's positive health outcomes are built is a primary care system that integrates public health and clinical medicine into a seamless continuum.

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The role of the practitioners, the integration of epidemiological categorization systems and tracking mechanisms into everyday patient interactions, the neighborhood clinics, and the community outreach aspects of primary care are what drive it towards further successes.

4. Read a MOHFW document on the Indian Public Health Standards (IPHS) for the Primary Health Centers (PHCs) in India. This document contains guidelines and standards for the efficient functioning of PHCs and the tasks of the technical and the non-technical staffs is well elaborated.

5. Thoroughly went through the article 'Primary Health Care and General Practice - A scoping report ' by Wendy Rogers and Bronwyn Veale. The basic philosophy behind the need of PHCs all over the world is underlined. Comprehensive Health Care, Selective Health Care, general practice and full-fledged medical check-up was studied in detail and the very minute differences in the approach of these medical facilities was observed.

6. Read a Report of the health survey and development committee chaired by Sir Joseph Bhore. It is a document of 1940s and the factors responsible for the low level of ill health in India ex. the prevalence of malnutrition and under- nutrition among appreciable sections of the people, the serious inadequacy of existing provision for affording health protection to the community and a group of social causes consisting of poverty and unemployment, illiteracy and ignorance of the hygienic mode of life and certain customs such as the purdah and early marriage are discussed.

7. Read a power point presentation on 'Paradigm shift in NRHM' by Sundar Raman explicitly mentioning the objectives, hurdles and the progress of the NRHM with vital statistics. The present status of the functioning of ASHAs, LHVs, ANMs and Ayush doctors have also been discussed.

8. Read a power-point presentation on 'Revitalizing health for all'. It's a case study on the Primary health care model on Bangladesh with an emphasis on the historical model of Primary health system of Bangladesh and study the

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weakness and comprehensiveness of the present system. Brief suggestions on the upcoming CPHC system is also provided.

9. On extensive study of the report on the Primary Health Care and the rural poor- Thailand, following are the learnings-

   In the above mentioned report there is a reflection of the strengths and weaknesses in the quality of the delivery of Primary Health Care in the rural sector of Thailand by a careful examination of 1 PCU. In Thailand, the PCU service providers had the knowledge of the way of life of their patients and their health problems, PCU programs comprising of Immunizations, ante and post-natal care were being conducted and the common infections and minor injuries were being treated. On the other hand, it was observed that inadequate resources were devoted to the problem recognition in the first place and health services were also poorly coordinated. As observed in India, because of inadequate training and supervision of PCU staff, PHC services are supplemented by the District Hospitals. PHC activity based on community participation was started in 1985, with a dedicated attention towards the following three items as main themes:

   (1) Training and supervision of Village Health Volunteers (VHV) and Village Health Communicators (VHC), and development of their activities.
   (2) Establishment and the proper functioning of Health Centers
   (3) Establishment and the operation of Drug Cooperative System (DCS).

   The PCU's have had problems because of shortage of rural medical practitioners and there have been challenges raised by the occurrence of recent epidemics, such as avian influenza, SARS and HIV/AIDS. The ultimate objective of the report was to provide the thai stakeholders, including senior provincial health officials and academicians to float in implementable strategies for improving the Primary Health Care system in Thailand.

   The major focus was on First-Contact Care, Comprehensiveness, Longitudinality and Co-ordination aspects of health-care. First-Contact Care

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was concerned on the Accessibility of the service and the extent of actual use of the service. Longitudinality basically deals with Person focused contact over time (involves the extent of provider- consumer contact for all but referred care). By Comprehensiveness, we refer to the following areas of concern- problem recognition; diagnosis of yearly review of PCU; management and assessment; health education etc. Finally, processing elements of performance, documentation of medicines and performance in regard to Co-ordination is one of the major aspects of health-care system in Thailand.

On analyzing First-Contact Care, Comprehensiveness, Longitudinality and Co-ordination in health-care, it seems inevitable that all of the parameters be incorporated into Indian health-care system.

10. A report on the Healthcare System in Singapore was analyzed . Following are the points to be highlighted-

    The early Primary Health Care, after Singapore's independence in 1965, began with a mass-inoculation program against the tropic epidemic diseases prevalent during that time. In order to provide convenience to the out-patient attendances, the government extended the network of hospitalization, including general hospitals, satellite out-patient dispensaries and maternal and child health clinics. Among the priority of public funding, Health-Care was ranked fifth.

    The philosophy of Singapore's health-care system is based on three pillars. Firstly, the country is aimed at building up a healthy population with preventive health-care and encouraging healthy lifestyles.

    Secondly, Singapore has focused on personal responsibility towards healthy living through the "3M" (Medisave, Medishield and Medifund) system. Thirdly, the government has to ensure that the supply side of the health-care services are controlled and the provision of heavy subsidies at the public health-care institutions is important.Highlighting on the "3M" system is a national medical insurance scheme through which memebrs build savings for their healthcare needs. Medishield, as a complementary plan to Medisave, is a catastrophic medical insurance that enables members to settle part of the expenses arising from prolonged hospitalization. Medifund is an endowment fund set up by Singapore.

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government to help citizens and PRs whose Medisave and Medishield are inadequate to pay the medical expenses.

An interesting comparision between the US and the Singapore healthcare system with a major highlight on the complicated format and a flawed health insurance system in the U.S. As against Singapore, in the US, not everyone has a health insurance, especially for someone who is not qualified for the government promoted insurance plans. Based on the lastest WHO report, Singapore achieves higher healthcare efficiency than the U.S. In the latest WHO health system ranking report, Singapore occupies the sixth position while U.S. with the largest proportion of GDP Ranks 37th. (WHO report). Moreover, the life-expectancy at birth for Singapore is 79 for males and 84 for females, 3 years longer than the average life expectancy of U.S. (1999). Singapore has stressed on the philosophy of health-care as personal responsibility and the proportion of Singapore Government funds oriented towards health-care is lesser than that of U.S.

11. A report on Scaling up Primary Health Services in Rural India: Public Investment Requirements and Health Sector Reform highlights the infrastructure availability in the Sub-Centers, Primary Health Centers and the Community Health Centers, availability of health-personnel in the health facilities and the health infrastructure particulars in Andhra Pradesh and Karnataka. Got an insight into the ideal health-care system and an estimate of the required health facilities in A.P. And Karnataka.

    Recommendations on the lines of entitled benefits to the BPL and the rural section of the society is highlighted. It adds that the public HFs can also charge regular (unsubsidized) fees from the patients and get their regular revenue for meeting most of their recurring and capital expenses. Moreover, the managers or service providers in public HFs would also find themselves directly accountable to the local population and can face a reward / punishment system. Stress on a need to carry out frequent supervision of

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lower level HFs in rural areas is made upon. There should be enough powers vested in the supervisory / monitoring authority to immediately punish the defaulters like absentee staff, indifference to replenish the stock of medical supplies, rude behavior with patients, etc.

5.2 Finding from the fields and impact on the theoretical focus of the project

Field visits have been completed in 3 Primary Health Centers in Delhi. The PHC at Mehrauli and Kanjhawala along with the M&CW center at Shahabad were governed by Municipal Corporation of Delhi (MCD) while the PHC, Palam is administered and governed by the Govt. Of India. Moreover, variation in OPD services, infrastructure, patients catered by the PHCs gave a wide viewpoint of the level of urban PHCs in India.

5.2.1 Findings from the field studies:

On the basis of the questionnaire prepared for the medical and non-medical staff as well as the patients following are some of the conclusions derived from the field visit to the PHCs -

1. In-patient services were lacking in both the PHCs. As per the Indian Public Health Standards (IPHS) the PHCs are supposed to have some in-patient services but, as informed by the CAMOs in the PHCs these days the CHCs are accountable for in-patient services rather than the PHC and there are hardly any PHC with in-patient facilities these days.

2. In all 3 of the PHCs close to 250 patients came for OPD services with 60% of them being females. The PHC at Mehrauli did not have any M&CW center and still could attract significant number of female population.

3. For tubectomy, vasectomy, other gynecological disorders like leucorrhoea, menstrual disorders, MTP etc. Patients are referred to other CHCs and hospitals

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in Delhi. Most of the services that are desired to be performed by the PHCs are referred to other centers.

5. All the medicines available at the PHC are provided free of charge.

6. Considering the laboratory services provided, anti-malarial vaccination and sputum test for TB is not conducted in the PHC, Mehrauli while, the blood examination for Anaemia, Sputum test as well as Anti-Malarial vaccines are available in the PHC at Palam. In PHC, Kanjhawala besides the conduction of Sputum test and the availability of anti-malarial vaccines, leprosy tests are also conducted (a unique facility in a PHC).

7. A public display mechanism, whereby a complaint/grievance can be registered is maintained in both the PHCs. Thus, the patients are aware of all the happenings in the Primary Health Center.

8. A PHC satisfaction questionnaire was filled by many of the patients in the PHC, Palam. The people rated the hygiene and cleanliness as 8 on a scale of 10. On an average, the patients visited the PHC twice in the last 6 months and were in general satisfied with the treatment by the doctors there.

9. The main reasons for dissatisfaction of the patients with the public facilities was unable to recover fully from the illness followed by non-availability of medicines. A people centred approach with better management of logistics and effective monitoring would improve the system.

10. The post of Lady Medical Officer (LMO) was non-existent in the PHC, Mehrauli. Luckily, the M&CW center was close to the PHC, hence it was not that big a setback.

11. An analysis of the data reveals that private alternatives are justifiably sought by the patients where existing public infrastructure is deemed inadequate.

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Filtered water-supply and electricity back-up for emergency cases was not available in the PHC, Kanjhawala and PHC, Mehrauli.

A household survey in 2 of the villages in North Delhi, Kanjhawala and Bawana was conducted to determine the health index of the people, to understand the various socio-economic parameters affecting the level of health and to understand people's perception of Primary health-care.

1. Quality of care plays a significant role in the choice of a health facility as is evident from the household survey findings. **85.71 %** (24 out of 28) of the people surveyed were satisfied with the medical facilities available. All the villagers/ slum-dwellers surveyed were dependent on Govt. PHCs for health-care benefits.

2. Out of the 6 households visited, all of them had electricity supply and the most common source of drinking water was hand pump. **71.42 %** of the people resorted to public hand-pumps for drinking water. Not a single household had water-purification (Filtration) facilities available.

3. **4 out of the 6** households surveyed had to depend on open space for toilet and latrine facilities. The slum visited in Bawana had a toilet and latrine facility made available for the public but, was not in a working condition.

4. An open-path drainage system was observed in the locality of all the 6 households. These were the breeding ground for mosquitoes and flies and an eventual cause for many of the water-borne and air-borne diseases. **87.5%** (14 out of 16) of the deliveries were attended by Dai and in all such cases the mother did not get any ante-natal check-ups. None of the mothers die at the time of delivery. Only 1 out of the 16 children born died during the delivery, a total of 3 infants died before attaining the age of 1.

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5. The main reasons reported for dissatisfaction among the villagers with public health facilities were-
   - ✓ Insufficient recovery from illness, followed by
   - ✓ Non-availability of all the medicines.

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5.3 Gap analyses

After the conduction of qualitative analyses in 3 of the Primary Health Centers in India i.e. at Palam, Mehrauli and Kanjhawala, the critical analyses was narrowed down to quality of services provided by the staff, accessibility for the patients, availability of significant health services and health education, and lastly affordability; Since, most of the patients are provided OPD services for free, this is hardly matter of concern. The overall scene that comes out of the study is that, while most of the villagers manage to access necessary health-care, there is still avenues to improve so as to provide access to the basic health facilities. Mehrauli had a number of skilled and unskilled manpower providing health-care access to the poor villagers- a major area of concern while, in Palam though, the number of workers and medical staff was never an issue but, here there is a call for an increase in the number of multi-purpose workers. In Kanjhawala, the staff nurses act as multi-purpose workers but, work only as per the guidelines set by the RMS. Moreover, as highlighted by Dr. Dambolkar, Lack of management skills in the top rungs of the ladder, with significantly lesser number of meeting hours among the medical officers and the other stakeholders concerned for the implementation of various recommendations and schemes as proposed by the Government. Besides, adding to the dismal scene in PHC, Palam, as per the notice of the CAMO, the MOHFW has visited the PHC only twice in the preceding years of his juncture as the CAMO. Also, emergency care facilities and short duty hours (6-7 hours) for doctors in the government run Primary Health Centres, leads to low quality of treatment and hasty and careless primary diagnosis of patients. Due to a lack of awareness about various chronic and non-chronic diseases, physical and psychological problems, and medicines from doctors, patients are likely to lack knowledge about medicines and thus, they blindfolded rely on the heavy dosage medicines and the very essence of Primary health i.e. health education, prevention and person oriented treatment has completely lost the importance in the current scenario. It could be necessary for medical providers to explain usage of medicines and procedure of treatment so that the patients seek awareness. Both public and private hospitals are located within accessible distances. However, there are no such hospitals offering any X-ray, ECG

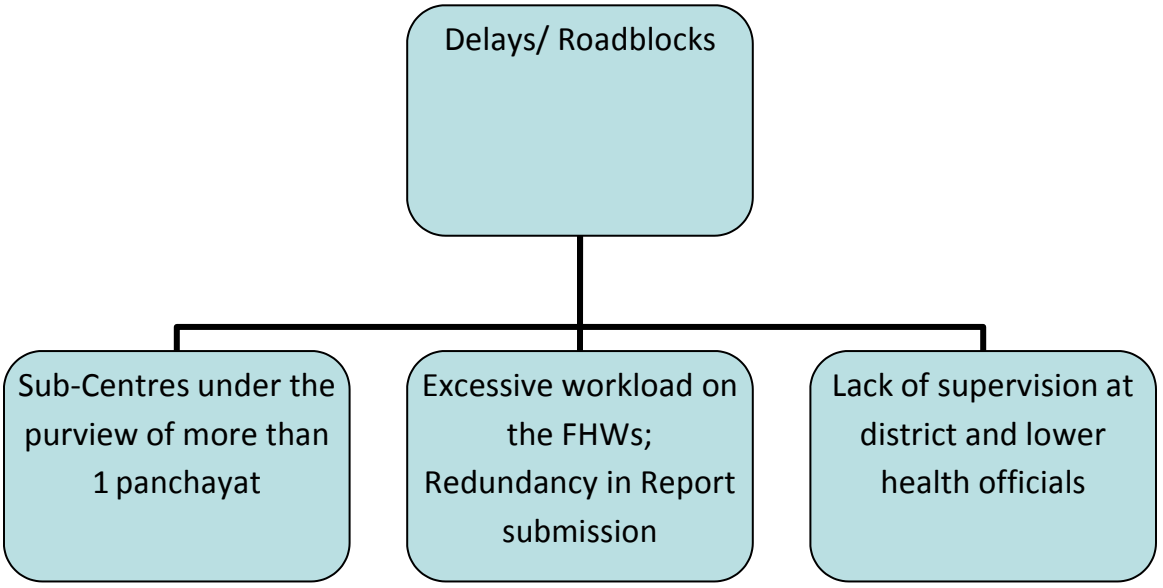
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scan, ultrasounds, other tests related to various chronic and non-chronic diseases. Generally, most of the villagers have to visit nearby towns in order to access these facilities. In case of child birth, there is a sense of urgency in regard to hospital beds, scans and ambulances etc. Accessibility would be even less of a concern for villagers if there were clinics or hospitals in the village that offered the above mentioned facilities.

Following are some of the roadblocks that the Primary Health Care system face in India -

1. Since one Sub Centre may come under the purview of more than 1 panchayat, they are supposed to be accountable to more than 1 panchayat head. These differences in demands from different panchayats make the entire system less productive. There is a strong case for synchronizing the area and population under a panchayat with that under one PHC or ward of an SC.
2. In MHW as per the norms is required to be involved in community visits, distribution of ORS, conduction of school health programmes etc. Often, it is observed that these activities are performed in alliance with FHMs and MHWs which further increase their workload. Moreover, they are also not provided with adequate remuneration.
3. One of the major stumbling block to the health-care system is the lack of supervision at the district and lower levels of health institutions. For an instance, the post of Counsellor, AIDS in the PHC, Palam was not been occupied and even the post of Block Health Educator has been abolished in some of the states.
4. Redundancy in submission of health reports to the MCD/ State Government. Moreover, most of the servers installed in the PHCs function effectively for only a limited time thus, causing delays and addition of workload for the Nurses/ANMs and other staff.
5. Considering the workload of MOs, as Mr. Dambolkar re-iterated the well known fact that more than 70% of MO's time is spent on Curative activities and thus he is able to spend around 10-20% of his time on promotional and preventive aspects of health care.

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Graph 4: Delays/ Roadblocks in the Indian Primary Health Care system

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6. Recommendations, Scope and Strategy for Implementation

6.1 Recommendation & Scope

The following recommendations/suggestions can be underlined for the improvement of primary health care services. With regard to the research work carried till now, following are the recommendations that can be suggested:

Foci of Concern:

If equivalent stress is given to the above mentioned parameters, a transformed Primary Health-care System in real terms will be achieved.

1. The addition to primary care staff: (physicians, nurses, nurse practitioners), of dieticians, mental health workers, occupational and physiotherapist and social workers forming the collaborative care team that offers integrated services;
2. Breaking down barriers to care for high needs patients, without regular access to primary care;
3. Developing a strong primary care work force by expanding education opportunities, and attracting and retaining providers in communities that need them;
4. Introduce nurse practitioner led quick care clinics.

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1. Access to care is one of the most discussed issues facing the Primary Health Care (PHC) system.

Access to Care is defined in 3 primary foci of concern-

1. Finding a health center
2. Getting an appointment with the MO/ doctor
3. Referral to DHs or other tertiary level health-centers

when needed for more highly specialized investigations or consultations.

Objectives:

1. Setting wait time standards based on the clinical judgment of experts;
2. Ensuring referrals are based on set criteria;
3. Standardized patient assessment and prioritization;
4. Ensuring the systems work effectively together, including centralized wait lists rather than multiple queue;
5. Wait time guarantees.

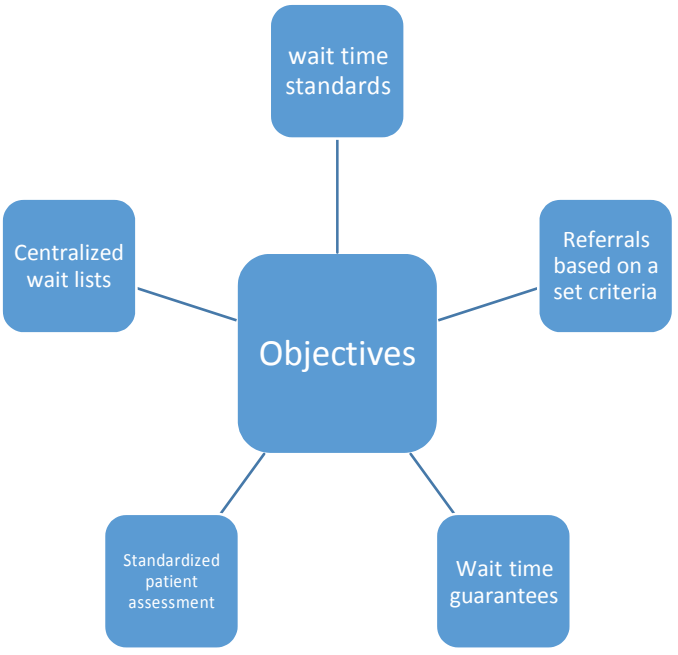


Fig. 4 Target areas of Recommendation 1

Methods of action/ Recommendations:

1. Adoption of a same day scheduling to ensure timely appointments with

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the patient's personal family physician, nurse practitioner and/or other appropriate members of the team;

2. The ability to access primary care outside of regular hours i.e outside the OPD timings;
3. Increase the number of walk-in clinics and provide access to basic services 24/7;
4. Improve coordination of referrals to other health care services, diagnostic services and tertiary services;
5. Improve referrals to primary care services by hospitals and emergency services; and
6. Increase funding and support for continuing care/home care spaces in the community.

2. **Timely Information** is a key enabler to support patients, families and providers to make decisions about care that is safe, and helps ensure coordination of care is effective, efficient and appropriate. It is highly recommended that the states deliver an electronic repository of patient information that is accessible regardless of where the patient is present for care.

The "One Patient-One Record" is a system that provides empowerment to the patients and will lead to earlier recognition of problems and more timely diagnosis resulting in faster and more effective treatment – thereby better overall health outcomes.

Electronic medical records form an information backbone for health-care workers and are fundamental to the ability of a team of health professionals to collaborate. This system will also empower healthcare workers by providing them with all the tools necessary to process, complete and view medical charts on a single workstation, without relying on multiple manuals or automated systems.

Moving to electronic medical records is an important step in order to improve quality and timeliness in healthcare delivery. Moving from paper to electronic

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records is essential to modernizing and transforming our healthcare system. We feel that continuity of information between and among healthcare providers correlate with improved quality of care, administrative processes and patient safety.

Recommendation on timely information-

a) System supports, including funding to support the transition from paper records be placed to enable every practice area to introduce and maintain the electronic medical record;

b) Electronic medical records are needed to facilitate day to day patient care, sharing of information in the referral-consultation process, teaching, carrying out practice-based research, and evaluating the effectiveness of care and services.

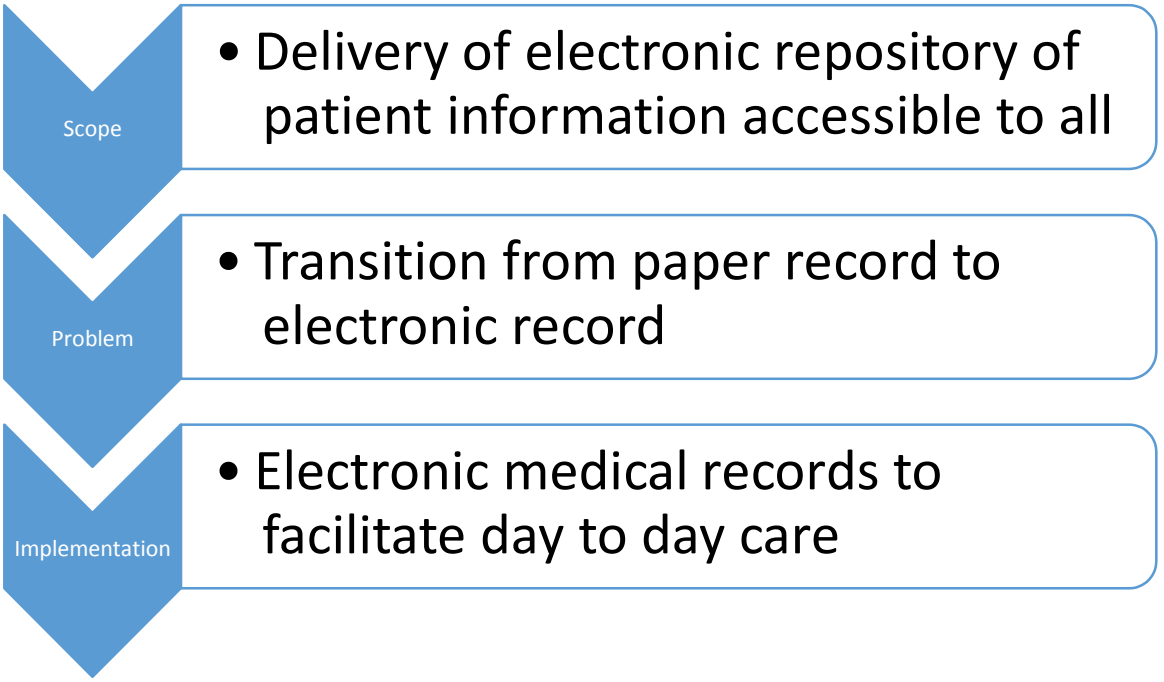


Fig. 5 Schematic diagram of implementation of Recommendation 2

3. Teams:

Innovative approaches that involve teams, alternative funding mechanisms and technology are needed to build a sustainable primary health care network that is accessible, available, appropriate and affordable.

Whenever individuals are brought together in teams, questions inevitably arise concerning the coordination of care and team leadership. Effective and efficient

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communication between all team members is essential; a single professional needs to be responsible for all clinical decisions and actions. This team leader Could be the physician, the nurse practitioner, the nurse manager, or even the nurse.

The issue of accountability pertaining to direction of care must also be considered. How will someone delegate and supervise medico-nursing acts? What about the issue of accountability and liability and patient understanding of the teams approach to care? Agreement must exist among the members of the team regarding their relationships, roles and responsibilities.

A policy and procedural framework that defines and describes the collaborative team functions is required. It is strongly believed that there is a need to ensure that human resources and nursing resources in particular, are used in a collaborative manner that maximizes their utilization and is in keeping with their applicable scope of practice. Clarity is needed as to what constitutes the team; how the team forms the relative value of onsite team versus virtual teams, governance and management of daily operations. But one important question remains: what exactly does this model mean for the role, number and practice for nurses?

There is an urgent need to setup a **Primary Health Care Team (PHCT)** to address health-related issues and propagate the philosophy of Primary Health Care in right spirits.

1. The Primary Health Team (PHCT) should include: family physicians, nurses practitioners, and nurses;
2. The PHCT should offer patients enhanced access and a broad scope of services carried out by teams or networks of providers; and
3. Team members should provide services that are only within their Professional scopes of practice and personally acquired Competencies.

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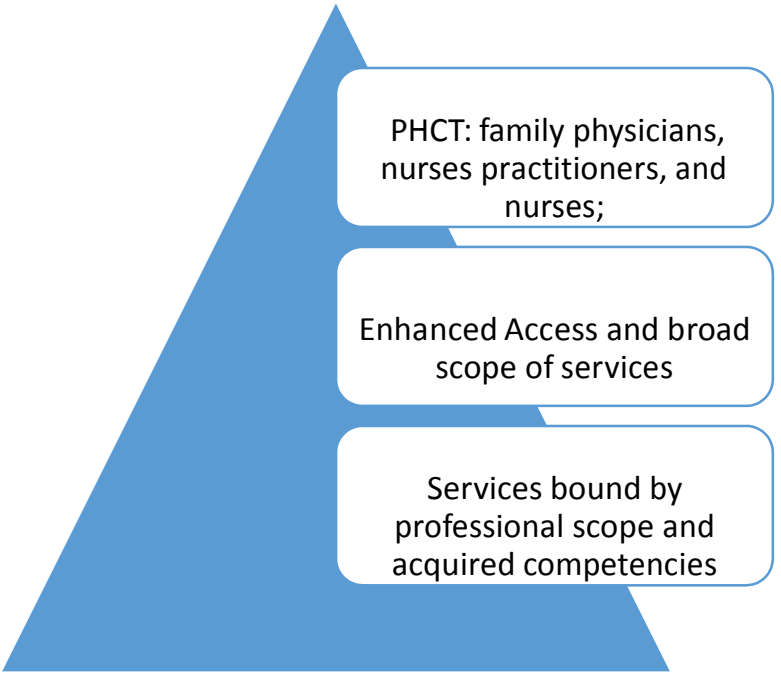


Fig. 6: Expectations from the Primary Health Care Team (PHCT)

4. Retrain male-workers

There is an urgency to retrain the male-workers to bring them to the fore of Multi-purpose health care system. With the ever increasing workload on the female workers regarding Reproductive and Child Health-Care, male workers who are exclusively posted for leprosy and malaria programs should be re-trained and given the additional responsibilities in the sub- centers. The posting of at least 1 FHW and 1 MHW should be the state and national policy in regard to the present scenario of health.

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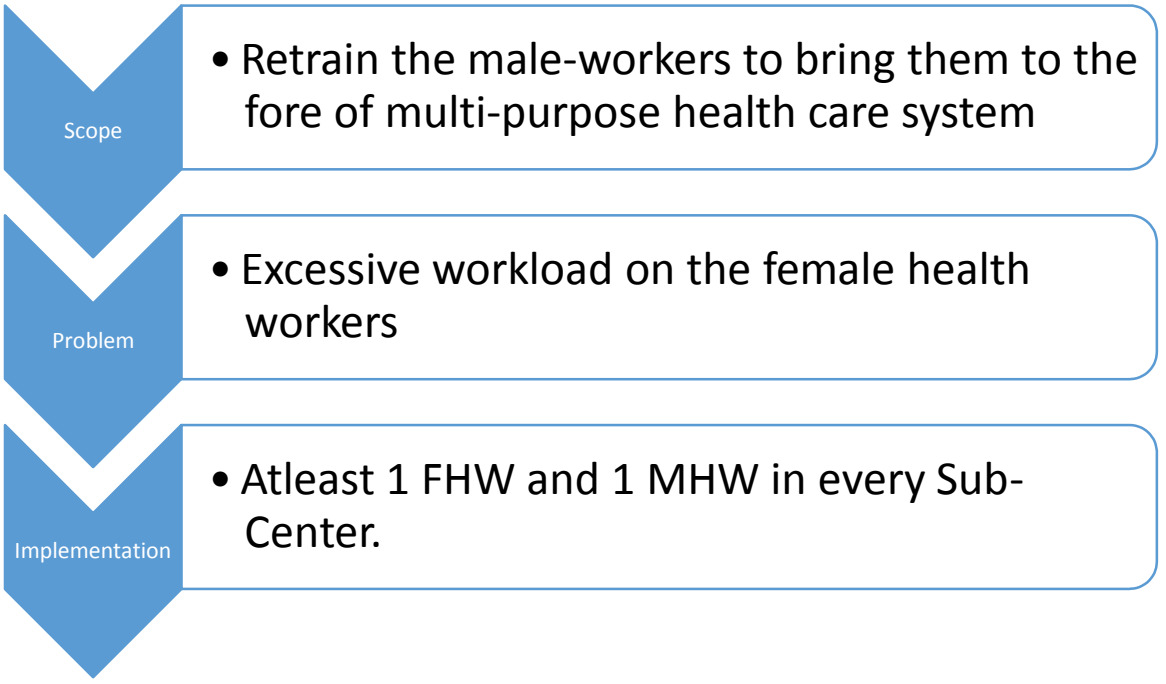


Fig7. Process of Implementation of Recommendation 4

5. Healthy Living

It is highly encouraged that the government promotes healthy living with substantial support on this initiative through a number of departments, programs and services. We believe that an increase in those programs will be necessary to meet the demands of a primary health care program that focuses on prevention and promotion.

Recommendations on healthy living:

a) Primary health care focus on wellness and work with individuals to improve health outcomes;

b) Care should always address health promotion and disease prevention.

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Fig8. Healthy living

6. 1 Panchayat- 1 Sub-Center

If a State finds it difficult to fill up vacant positions of Primary/specialized care in the PHCs, simple medical graduates should be recruited so that people get at least minimum services. Moreover, after realizing the workload of community-level workers in the grass-root level, it is earnestly recommended that the Sub-Centers come under a single panchayat for effective delivery of services and implementation of health programs. Similarly, the population coverage should be such that the Sub Centers are serviceable and accessible.

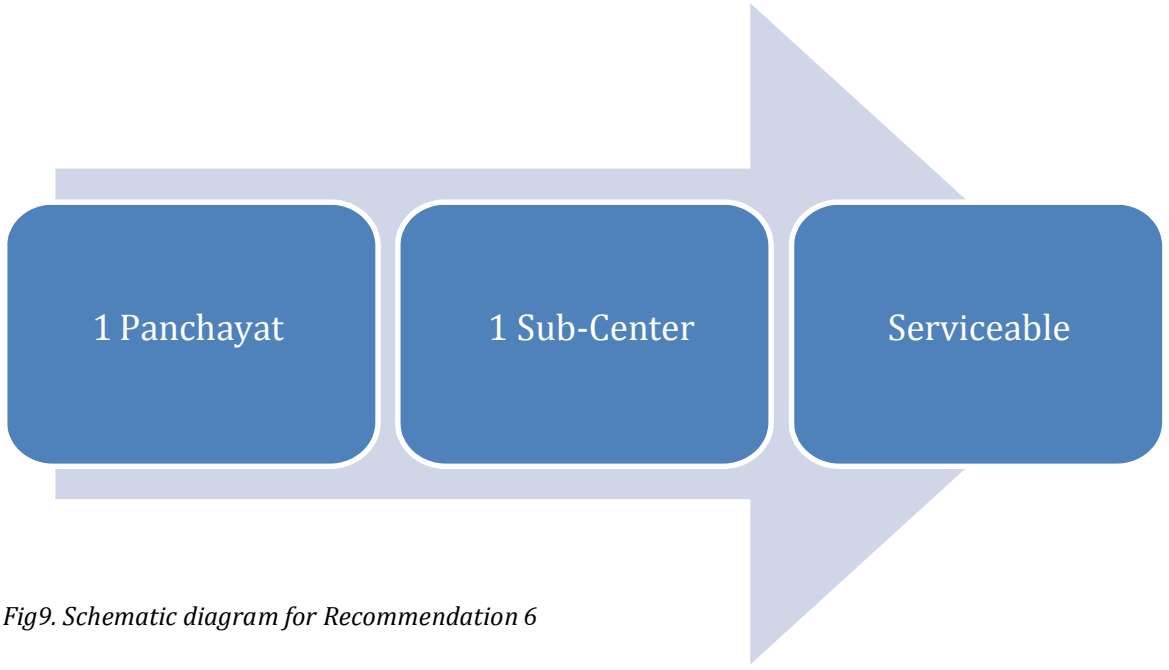


Fig9. Schematic diagram for Recommendation 6

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7. Lack of Training

The dearth of trained medical staff in Primary Care to act as role models reflects that a pool of primary care specialists must be incremental and should build/focus on places where excellence already exists. Development therefore needs to be heavily supported by the medical staff.

Scope: Establishment of small number of centers in the short run might meet the need of supply of high-quality trainers, researchers and teachers in primary care. In UK, medical schools are often visited to assess the training quality and any of the universities who failed to reach the standards set by the UK health care system, A strong consensus that both primary care service and primary care research is effective only when done with the collaboration with the hospital clinicians is widely accepted in UK.

8. Referral system:

In the visit of the PHCs in Delhi it was realized that the patients were confused regarding the referral system and repetition of treatment was a major setback in the sector of primary health.

Scope: A clearly written referral manual must be made available in all health -care institutions and all referred patients should carry a referral card with the initial diagnostic features and treatment recorded in the referral card so as to avoid confusion.

9. Nurses Accommodation and Introduction of a token fee:

Convenient and standard residential accommodation need to be made available, for at least the key staff as a motivation for them to stay on so as to ensure the availability of services to the people. The mismatch between manpower and infrastructural facilities should be minimized so as to enhance efficiency as a whole.

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Moreover, It is recommended by Dr. Dambolkar that user fees be introduced in all the PHCs and higher level hospitals. The charges should be kept at a minimum as a token fee and should be different for different centers.

11. Lack of Supervision

The weakest link in the whole health-care network is the lack of supervision at the district and lower levels of health institutions. The supervision and monitoring system has been lagging behind and the entire system needs to be decentralized with the proper structuring of the supervisory staff and shift of power right from the CHCs to PHCs to the SCs.

A large number of positions of male and female health supervisors at the PHC level are vacant. The post of Block Health Educator (BHE) who basically performs education and communication activities and also plan field-related programmes has been abolished or phased out.

Recommendation: Since, supervision is one of the major components of primary health care, it is highly recommended that the strengthening is done at all levels.

Lack of mode of transportation as in unavailability of vehicles, Even the post of Block Health Educator (BHE) who performs education and communication activities and plans field- related programmes has been abolished (as in Rajasthan) or phased out. Lack of supervision seems to be Lack of supervision seems to be the most disturbing feature of the health sector. Since, supervision is one of the major components of primary health care, it is recommended that it be strengthened at all levels. It may also be noted that poor or ineffective supervision is also due to the non-availability of vehicles, which restricts access to larger areas by the PHC Medical Officers and the district-level Officers.

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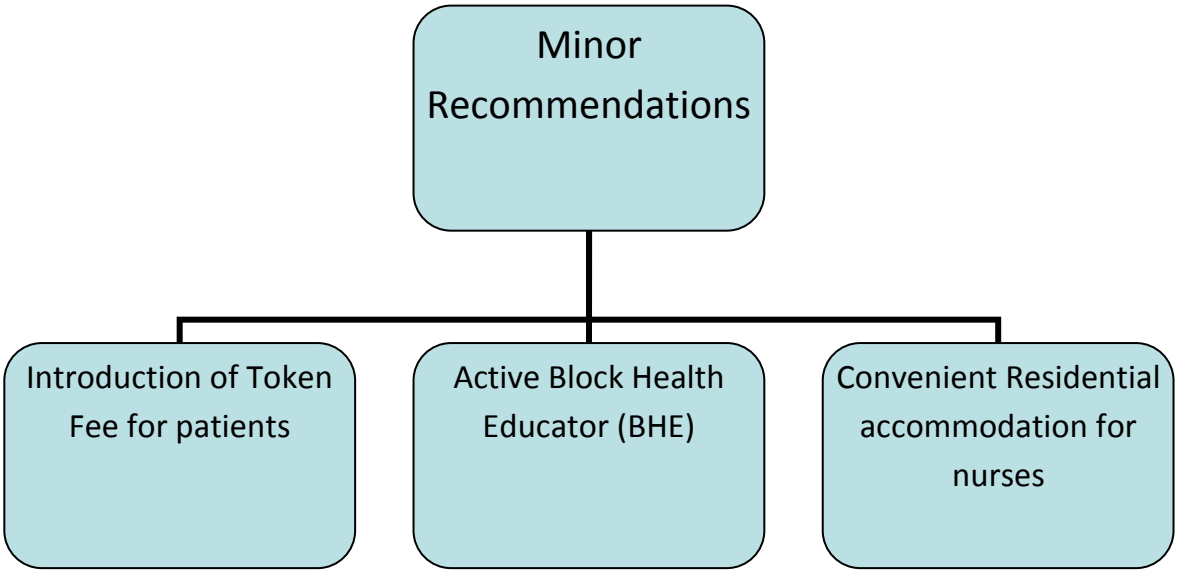


Fig9. Schematic diagram for Minor Recommendations

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7. Conclusion:

Now, it has been widely recognized that for improving the public health needs an ever-increasing stress needs to be given to Primary health, but in India there is a dearth of adequately trained doctors. The challenge of providing uniformly good care can be attained only by a multi-disciplinary team approach exploiting the skills of the staff with varied expert backgrounds and ensuring technological advances that enable even the people in remotest area to access health-care. The experience from doctors and other health personnel in India and abroad argue strongly for multidisciplinary teams and decentralized planning at the state and municipal levels supported by the national Ministry of Health. The evidence also suggests there will be efficiency as well as time gain from multi-skilling and the enhancement of role of medical and other non-medical staff.

Analyzing it this way, continuing economic growth will be accompanied by a growing public demand for primary care to be delivered with high quality at affordable cost. Now, what does affordable and accessible health-care reflect? In this regard, 3 things need to be considered with utmost priority- (1) effective prevention; (2) most care being delivered effectively outside hospitals using generic drugs; (3) access to hospital care to be prioritized according to need. The following objectives cannot be attained by hospital services alone, this cannot be delivered through a hospital led service alone—it needs a cadre of primary care specialist staff trained in evidence based care and working to quality assured standards.

An integrated and comprehensive approach can solve this problem where requirements of infrastructure can be determined district-wise on the basis of population so that an effectual infrastructure is established by the people at the ground level. A decentralized system would provide for a

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better administration and surveillance of local health problems, also emphases would be laid to long-term strengthening enhanced sustainability, finally this would result in saving public money as infrastructure solutions can be determined in a more cost-effective manner at the ground level.

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10. Scaling up Primary Health Services in Rural India: Public Investment Requirements and Health Sector Reform- Nirupam Bajpai, Ravindra H. Dholakia and Jeffrey D. Sachs .

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2. Contribution of Primary Care to Health Systems and Health - Barbara Starfield, Leiyu Shi and James Macinko- John Hopkins University.

3. Paper. Indian Public Health Standards (IPHS) For Primary Health Centres (March 2006)

4. A PowerPoint presentation on NRHM Paradigm Shift- Dr Sundar Raman. It highlights the Primary Health Care system in Bangladesh.

5. Primary Health Care and General Practice A scoping report- Wendy Rogers Bronwyn Veale (1968)

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9. Appendix A

9.1 Mentor Meeting and Interviews

Project ID: C151		
Intern Name	Asit A. Naik	
Date of Discussion	24th May, '13	
Time Duration	Start Time: **2:02 P.M.**	End Time: **2:31 P.M.**
Mentor Name	Shri Rajeev Kapoor	
Meeting Mode	Phone	
Meeting Venue	N.A.	

9.1.1 Discussion

1. The basic preventive and promotive role of PHCs was highlighted in the initial phase of our discussion.
2. Sir discussed about how NRHM has helped in improving the status and quality of the PHCs in India.
3. Sir suggested me to go through the Primary Health Care system in Bangladesh, Nepal and other neighboring countries which have made a steadfast progress in the field of Primary Health.
4. I was also guided on how to conduct the field study (Interaction with the villagers and the medical staff) in the PHCs in North and West Delhi.
5. We also discussed about the relevant questions pertaining to the RTI application that will be filed next week.

9.1.2 Action Items before Next Discussion

1. A detailed qualitative analyses of the PHCs in Palam and Kanjhawala in Delhi.
2. Filing an RTI application pertaining to the status of health care in the above mentioned PHCs.
3. Comparing the results obtained with specific quantitative case studies in

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India and the neighbouring countries.

4. Refer to research papers on the Primary Health system in the top 10 healthiest countries of the world.

9.1.3 References (People to meet, research report or papers to read)

1. Meeting with Poornima Singh Ma'am regarding the questionnaire for the field study.
2. A detailed field study in the PHCs in Palam and Kanjhawala in Delhi.
3. A qualitative analyses of the data acquired from the field visit and analyzing the results with the quantitative reports available.

10. Questionnaire (Only a part of it has been displayed)

10.1 Proforma for Facility Survey for PHC

Identification :

NameoftheState: Delhi

District:

Tehsil/Taluk/Block

Location Name of PHC: P HC, Mehrauli

Is the PHC providing 24 hours and 7 days delivery ? No (8 AM to 2 P M)

Date of Data Collection

Day	Month	Year
29	5	2013

Name and Signature of the Person Collecting Data Asit A. Naik

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Services

Sl No.		
1.1	**Population covered (in numbers)**	
1.2	**Assured Services available (Yes/No)**	
a.	OPD Services	Yes
b.	Emergency Services (24 hours)	Yes
c.	Referral Services	Yes
d.	In-patient Services	No
1.3		
a.	Number of beds available	No in-patient facility

	Bed Occupancy Rate in the last 12 months (1- less than 40%; 2 - 40-60%; 3 - More than	N.A.
1.4	Average daily OPD attendance	
a.	Males	180
b.	Females	120
1.5	**Treatment of specific cases (Yes / No)**	
a.	Is surgery for cataract done in the PHC?	No
b.	Is the primary management of wounds done at the PHC?	Yes
c.	Is the primary management of fracture done at the PHC?	Primary Treatment
d.	Are minor surgeries like draining of abscess done at the PHC?	Yes
e.	Is the primary management of cases of poisoning / snake, insect or scorpion bite done at the PHC?	Yes (P.T.)
f.	Is the primary management of fracture done at the PHC?	Yes
1.6	**MCH care including Family Planning**	

Table 3: Services provided by the PHCs

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10.2 Household Survey (only a part of the survey)

Village: _____Tehsil: _____District: _____

Head of HH: _____(M/F); Investigator: _____

Date: _____

A. 1 BPL Score _____; 2**.** Size of HH: _____

2**.** Land owned ____(Ha./Acre/____)

3**.** Caste: SC/ ST/ OBC/ Muslims/Others;

B.

1. No. of Animals/ Cattle: _____

Buffalo: ___; Cows: ____; Bullocks: ___; Goats & Sheep: ___; Donkey: ___;

Camel: _____; Poultry: ____

2. How far do you take them for grazing? ___km. 3. Who takes them? _____

C. Information on HH Amenities:

1. Is the HH electrified? Yes/ No.

2. Electricity available for_____days/week and ____hrs./ per day

3. Source of drinking water:

Winter: Tap/ Well/ Public Well/ Public Hand pump/ Pond/ Canal/ Other ( )

Summer: Tap/ Well/ Public Well/ Public Hand pump/ Pond/ Canal/ Other ( )

Monsoon: Tap/ Well/ Public Well/ Public Hand pump/ Pond/ Canal/ Other ( )

4. Distance to the source of drinking water: _____k.m. **5**. Who fetches drinking water? _____**6.** Do you filter water? Yes/ No

7. Do you boil the water? Yes/ No.

8. Facility for Latrine and Toilet: Exclusive/ Common/ Open space

9. Sewerage: Underground/ Covered path/ Open path/ No system

10. Drainage: Underground/ Covered path/ Open path/ No system

11. Road cleaning and waste removing facility: Yes/ No; ____times per week.

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D. Information on HH Members:

Sl. No	Questions	Member
1	Name	
2	Relation with Head of HH.	
3	Sex (M/F)	
4	Age (yrs.)	
5	Level of education.	
6	Enrolled in school? (Y/N)	
7	Gainfully employed (Y/N)	
8	Earnings per month. (Rs.)	
9	Hospitalisation last year (Y/N)	
10	Any major sickness last year	
11	How many days in the year for the sickness?	

Table 4: Information on Household members

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'Extent of freedom' nor the 'extent of equality' but
Rather the highest measure of participation."
- A.D. Benoist

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