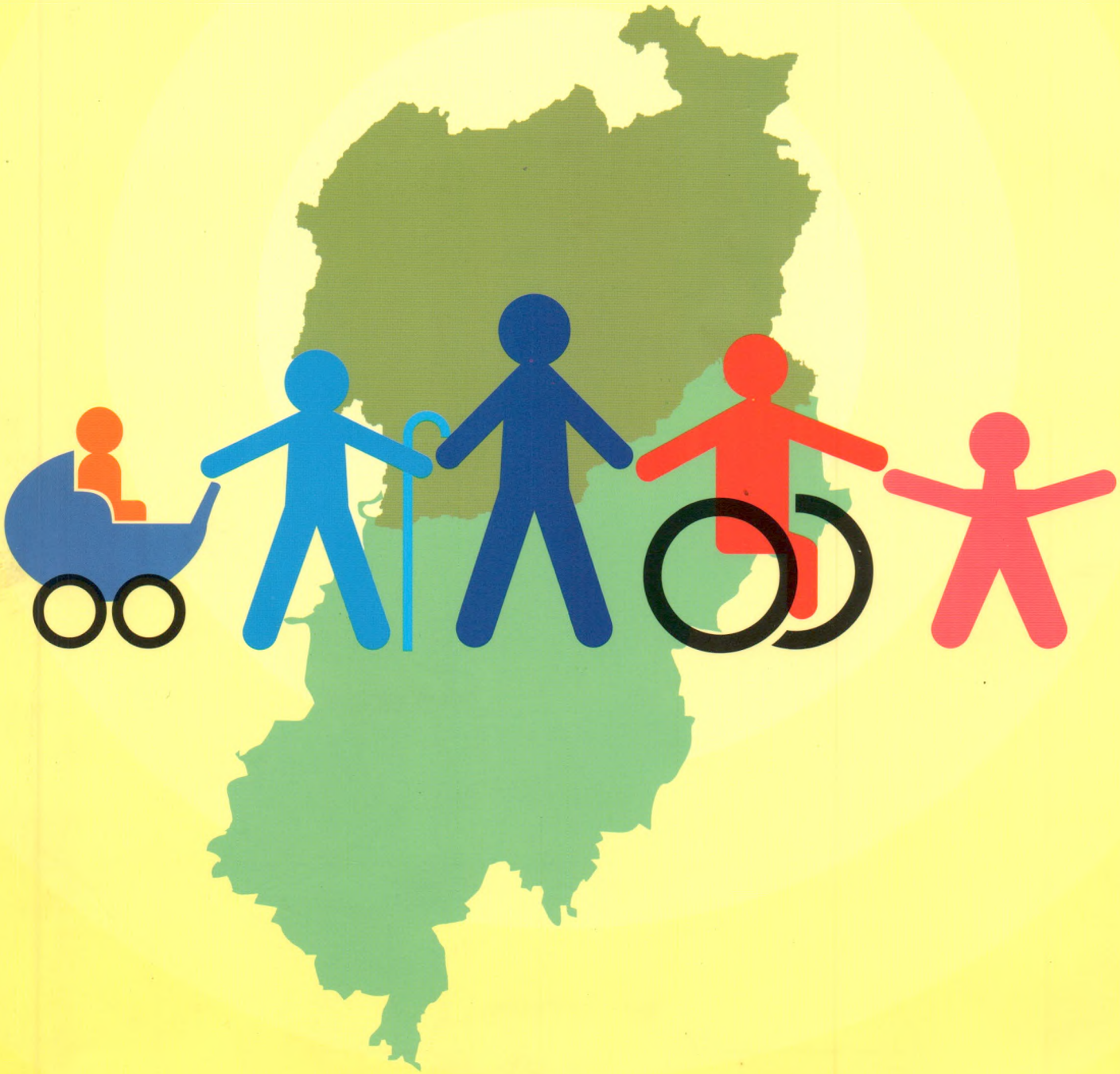
Issues and Challenges of Primary Health Care Facility

Perception of Service Providers and Beneficiaries in Balangir and Kalahandi Districts of Odisha



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Research Team
Uppali Mohanty
Mudhulika Sista
Christopher Deep

Inputs
Basanta Kumar Nayak
Subrata Satpathy

FOREWORD

Access to proper health care is a basic right of all the citizens and an important responsibility of the state. Health, being a state subject, holds significance and makes the state accountable in providing proper health care facilities to its people. In recent times, the state's overall budget size has increased manifold and a number of schemes / programme are being implemented. Despite increase in government spending on public health, dramatic change in indicators are yet to happen.

Keeping in view, this study is an attempt to understand the nuances of primary health care services provided at the grassroots and to gather the perceptions of the community regarding the services like access to health, infrastructure, human resource etc. This perception study revolved around the views and opinions of both the beneficiaries and the service providers on the issues at the selected districts. The report is expected to orchestrate an informed discussion and decision making at the appropriate level

Jagdananda
Co-Founder & Mentor

SECTION I

INTRODUCTION

1.1 Context Setting:

Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. "Health for All" means that resources for health are evenly distributed and that essential health is accessible to everyone. It means that health begins at home, in school, and at the workplace, and that people use better approaches for preventing illness and alleviating unavoidable disease and disability. It means that people recognise that ill-health is not inevitable and that they can shape their own lives and lives of their families, free from the avoidable burden of disease.

The agenda for Public Health in India includes the epidemiological transition, demographical transition, environmental changes and social determinants of health. Based on the principles outlined at Alma-Ata in 1978, there is an urgent call for revitalizing primary health care in order to meet these challenges. The role of the government in influencing population health is not limited within the health sector but also by various sectors outside the health systems. In India, the Constitution makes health the responsibility of the state governments, rather than the central federal government. It makes every state responsible for "raising the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". The National Health Policy was endorsed by the Parliament of India in 1983 and updated in 2002. The National Health Policy is being worked upon further in 2017 and a draft for public consultation has been released.

Odisha is one of the high priority states for India with visibly poor health indicators. The state reels with a high Maternal Mortality Ratio of 222 deaths per hundred thousand live births, which is much higher than the national average (SRS, 2014). In addition, the Infant Mortality Rate in the state is as high as 49 deaths per thousand live births, which again is much higher than the national average (SRS, 2014). In Odisha, the Department of Health and Family Welfare manages the public health care services and it has been taking various steps to improvise the health infrastructure and provide qualitative health care services to the people of the state.

1.2 About PHC:

The concept of Primary Health Centre (PHC) is not new to India. The Bhore Committee in 1946 gave the concept of 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. The health planners in India have visualized the PHC and its Sub-Centres (SCs) as the proper infrastructure to provide health services to the rural population. The Central Council of Health at its first meeting held in January 1953

had recommended the establishment of PHCs in community development blocks to provide comprehensive health care to the rural population. These centres were functioning as peripheral health service institutions with little or no community involvement. Increasingly, these centres came under criticism, as they were not able to provide adequate health coverage, partly, because they were poorly staffed and equipped, lacked basic amenities.

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

The Government of India's initiative to create and expand the presences of Primary Health Centres throughout the country is consistent with the eight elements of primary health care outlined in the Alma-Ata declaration. These are listed below:

- Provision of medical care
- Maternal-child health including family planning
- Safe water supply and basic sanitation
- Prevention and control of locally endemic diseases
- Collection and reporting of vital statistics
- Education about health
- National health programmes, as relevant
- Referral services
- Training of health guides, health workers, local dais and health assistants
- Basic laboratory workers

Thus, Primary Health Centre (PHCs), sometimes referred to as public health centres, are state-owned rural health care facilities in India. They are essentially single-physician clinics usually with facilities for minor surgeries too. They are part of the government-funded public health system in India and are the most basic units of this system. Presently there are 25,308 PHCs in India.

The state has been playing the role of a service provider in components focusing on infrastructure, preventive and promotive care, however, by and large this has been a uni-linear and monologue way of health care delivery. The perception of the people regarding the quality aspect of the health care delivery has been largely overlooked by the state. In a democratic set up it becomes crucial on the part of the state to understand and assess the actual needs and requirements of the target population for whom the health care services are provided. Instead, the people's perspectives, voices and opinions fail to get a required platform to put forth the existing needs before the administration. This widens the gap between the service providers and end –users and the expectations of the latter remain unreached to the former. The findings from the gap analysis across the constituencies in the two selected districts would provide a sound evidence base at the legislative space for a substantial debate on the issue. CYSD carried out this study in order to gain a deeper understanding by accumulating the perception and views of the people (end-users) and the service providers.

The purpose of CYSD as an organization was to act as an intermediary between the primary health care stakeholders at the grassroots level and the legislative arena. The intention was to provide substantial and profound evidence from the grassroots to the legislators for the latter to carry on a debate and discussion for the betterment of both the service providers and the beneficiaries. In order to provide such evidence, CYSD was thoroughly engaged in an in-depth and extensive field study comprising the PHCs of the selected constituencies.

SECTION II

METHODOLOGY

This section deals with the methodology that has been adopted in the study. The study has primarily focused on the views, opinions and overall perception of the service providers and the beneficiaries at the Primary Health Centres. The study is an in depth analysis of the various gaps and requirements at the primary health service and aims to provide the grassroots views of the existing scenario and the changes that are aspired from the service provider and beneficiary point of view.

2.1 Objectives:

- To assess the perception of the community in terms of their opinion, expectations and suggestion with regard to the health services provided to them at the PHCs.
- To ascertain the awareness levels on and availing of highly relevant health programs such as JSSK, JSY and Mamata
- To understand the issues and challenges faced by the service providers at the PHC level.

2.2 The Sample:

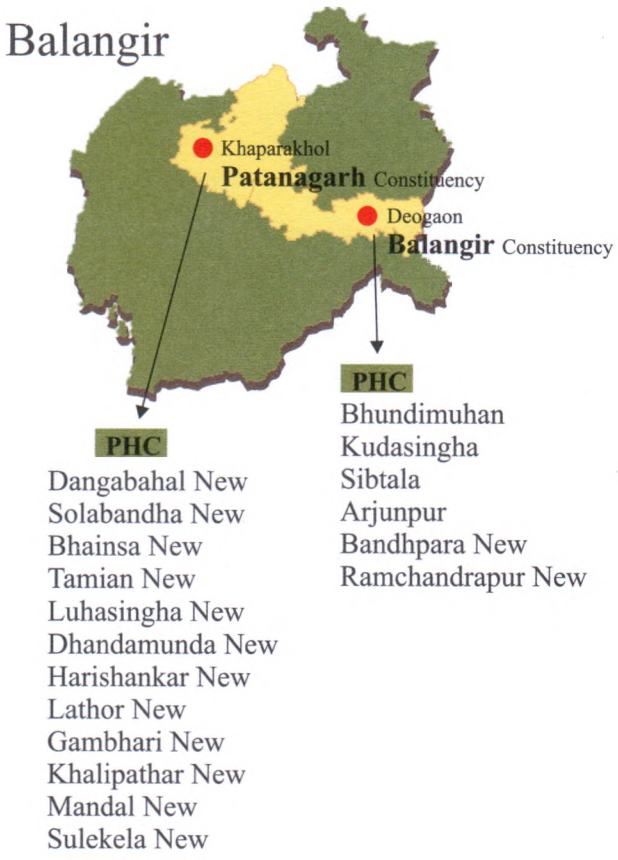
District	Constituency	PHC	Village
Bolangir	2	18	37
Kalahandi	2	19	38
Total	4	37	75

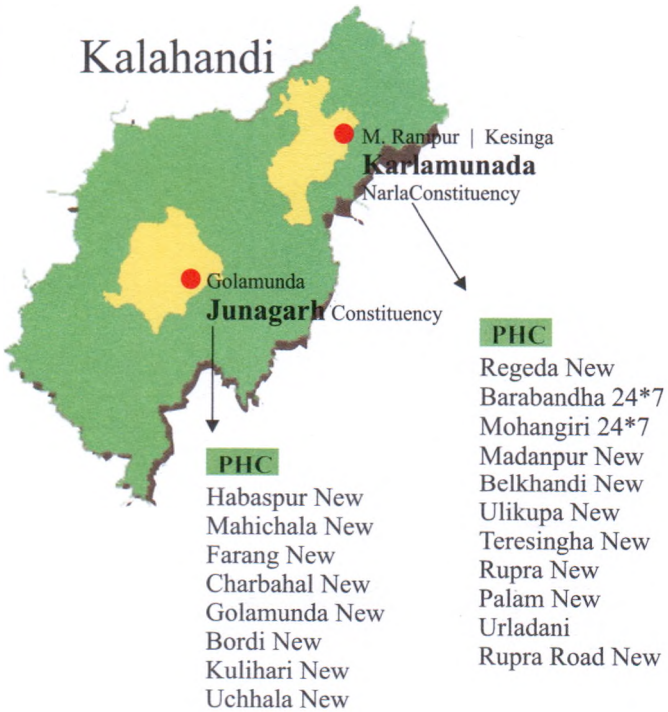
The overall universe of the study is Balangir and Patnagarh constituencies of Balangir district and Narla and Junagarh constituencies of Kalahandi district. In these four constituencies a total of 37 PHCs have been selected. The following table provides a detailed list of the PHCs that were selected for the study.

2.3 Methodology:

The study covered Primary Health-Care Center, sub centre, villages, and communities in the Balangir and Kalahandi districts of Odisha using the following tools:

- For 'Facility Mapping' of the PHCs, structured observation schedules with multiple choice options were filled up at 37 PHCs. In- depth interview of the service providers for obtaining their views and opinions on the existing issues and challenges were also taken.
- Exit interview of 50% of OPD patients visiting each PHC, (Average inflow of patients in PHCs being 20).The patients were selected on the basis of





convenience and snowball sampling methods. They were asked to share their satisfaction levels and experience at the PHCs. Total 370 patients (10 patients from each PHC) were covered in both the constituencies. An interview schedule comprising structured close ended questions was used as a tool for collecting data.

- Focus group discussions with the community helped in substantiating the evidence derived from facility mapping and exit interview. It was carried out in two ways:
  - General discussion on opinion and suggestion to different health services at PHC and
  - Discussion with selected beneficiary on JSSK & JSY.

A total of 8 FGDs were carried out in four constituencies highlighting on the perception of the community coming under the chosen constituency. Open ended FGD guide was followed for the discussion.

The grass root service providers (i.e. ASHA, ANM and AWW) were interviewed on various governmental schemes like JSSK, JSY and Mamata services. Here ASHA and ANM representing 20 percent of the sub-centers of the PHCs were selected (around 5 sub-centres under each PHC) and 5 percent of AWW under each PHC were covered. Hence, a total of 111 grassroot service providers were covered.

The report is comprised of both the qualitative and quantitative analysis. The qualitative analysis holds significance in such a perception study as it helps to dig deeper into the issues that seem not that significant at the surface level. The case studies and indepth interviews are a part of the qualitative data analysis. At the end of the report, a district profile has also been attached for a comparative overview of the district wise indicators.

2.4 Tools of Data Collection:

As discussed earlier, various schedules were formulated for eliciting response from both the beneficiaries and the service providers. The following is a detailed list:

No.	Type of Schedule	Number
1	Status check of PHCs	37
2	In-depth interview of MO and Pharmacist	37
3	Client Exit Interview	370
4	Focus Group Discussions (FGDs)	
4.1	FGD (General community) of PHC services	4
4.2	FGD Cumulative scaling (Specific Mothers) of the Facilities	4
6	ANM (JSSK)	37
7	ASHA (JSY)	37
8	Anganwadi Worker (Mamata)	37

2.5 Time Line for the Field Work:

	Number of days		
Types	Bolangir	Kalahandi	Total
Tool Design (Total 6 schedule)	0	0	8
Field Work	25	25	50
Scrutinizing	7	7	14
Transcription (12) and Data tabulation	10	10	20
Data Analysis and report writing	7	7	14

2.5.1 Bolangir:

Type	Number
Facility mapping of the PHCs	18
In-depth Interview	18
Exit interview	180
ASHA, ANM and Mamta for JSSK and JSY services	56
Focus Group Discussion (FGD) Specific and General health issues	4

2.5.2 Kalahandi:

Type	Number
Facility mapping of the PHCs	19
In-depth Interview	19
Exit interview	190
ASHA, ANM and Mamta for JSSK and JSY services	57
Focus Group Discussion (FGD) Specific and General health issues	4

The above two tables indicate a district wise breakup of the activities that were carried out for the study. In both the selected areas 23 days each were allotted to conduct the various schedules and other activities including FGDs.

SECTION III

FINDINGS AND ANALYSIS

PHCs: The Medical Haven for the Poor

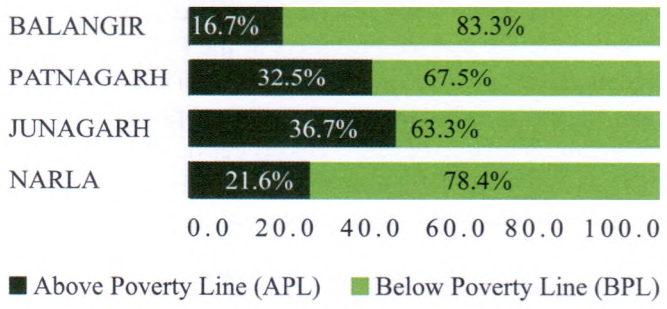
PHCs are the cornerstone and vital health care institutions in rural India. As health is a state subject, it is essential on its part to provide qualitative and reasonably inexpensive health care services to the poor people. This is because the poor cannot afford high medical expenses especially during critical cases. Similarly, it becomes difficult for the people staying in geographically inaccessible areas to commute to the urban areas to avail medical aid. Thus, these poor people are left with no other option than to rely on the PHCs. They are not only government-run but also available in close vicinity. Therefore, in such a scenario, the role and significance of PHCs becomes quite apparent and prominent in preventive and promotive health care in the rural hinterlands.

This section highlights various findings of the in-depth study that was conducted in PHCs of selected constituencies. The findings are correlated with the IPHS standards in order to carry out a gap analysis between the proposed and the actual.

3.1 Socio-economic profile of the respondents:

The study found that most of the respondents belong to the BPL category in Balangir (83.3%) and Narla (78.4%). These poor people who cannot afford high out of pocket expenditure in medical care are solely dependent on Government Health Care facilities system at the PHCS. Also the APL category people find it difficult to commute to the DHH in case of emergencies as they are far from their habitations. Therefore, PHCs need to be self sufficient and facilitative to both the categories of people due to inexpensive medical care and their availability in closer proximities.

Economic Category of Respondents



3.2 Human Resources:

3.2.1 Human Recourse availability at the PHCs:

As per IPHS standards, to ensure round the clock access to public health facilities, PHCs are expected to provide 24-hour service with basic Obstetric and Nursing facilities. Under NRHM, PHCs are being operationalized for providing 24*7 services in various phases by placing at least 3 Staff Nurses in these facilities. If the case load is there, operationalization of 24*7 PHC may be undertaken in a phase-wise manner according to availability of manpower. This is expected to increase the institutional deliveries which would help in reducing maternal mortality. PHCs with delivery load of more than 20 deliveries in a month, especially in large blocks where the CHC is over one hour of journey time away, may be upgraded to provide 24 hour emergency hospital care. This could be done by increasing the number of Medical Officers and other para - medical staff. For such PHCs, additional staff in the form of one MBBS doctor, one Staff Nurse and one sanitary worker cum watchman have been provided to take care of additional delivery case load.

District	Balangir		Kalahandi		Total
Constituency	Patnagarh	Balangir	Narla	Junagarh	
MO (MBBS degree holders)	9	3	3	5	20
AYSUH Doctor	8	3	10	5	27
Nurse/Midwife	1	0	4	3	8
Pharmacist	12	6	10	8	36
Health Worker	7	5	6	9	24
Health Educator	0	0	0	0	0
Health Assistant	2	1	0	0	3
Clerks	0	0	0	0	1
Lab Technician	0	0	1	0	1
Driver	0	0	0	0	0
Sweeper	8	4	12	6	30
Any other	2	2	7	3	14
Total PHCs	12	6	11	8	37

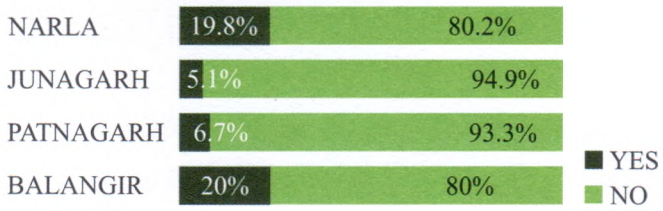
However, the study findings indicate that in only 52 percent (20 out of 37) of PHCs, there are Medical Officers holding MBBS degrees. This is one of the serious issues faced at the PHC level. As per the IPHS standards, it is clearly mentioned to have at least one MO having MBBS degree. The PHCs that don't have MOs (with MBBS) therein, the AYUSH doctors are acting as MO in-charge. The shortage of required number of doctors is a major cause of discontent among the people regarding the apathy and neglect of the government towards them. The FGDs revealed that people have a major complain regarding the unavailability of doctors and many even complained of paying money to the doctors in case of emergency. There are people who don't rely on the diagnosis of the AYUSH doctors and feel that an alternate doctor is required at their PHC.

The guidelines indicate that one AYUSH medical officer (desirable) has been provided for the people. As per the findings, AYUSH doctors are available in nearly 27 out of 37 PHCs (nearly 72 percent). On the other hand, the people's perception regarding the benefits of AYUSH was also quite apparent during the FGDs, as they thought these medicines have no side effects and thus, less harmful and effective at the same time.

Ailapada is a village that comes under the Palam PHC and is 8km away from the PHC. However, the villagers prefer to go to CHC Kesingha or DHH Bhawanipatna for treatment of any ailment due to unavailability of an MBBS doctor in Palam PHC. Thus, in spite of having a PHC at nearby vicinity, people are bound to pay higher transport cost (out of pocket expenditure) to travel to the CHC or DHH.

In case of pharmacist availability, the study found that in 36 PHCs, pharmacist was found, while in 1 PHC in Narla (Kalahandi) there was a shortage of pharmacist. Availability of laboratory technicians is extremely deplorable as only one PHC (it's a 24*7 PHC in Barabandha, Narla Constituency, Kalahandi district) out of 37 PHCs had one laboratory technician. Unavailability of laboratory technicians leads to unavailability of diagnostic services at the PHCs (though IPHS norms). This scenario is causing a lot of discontentment among the people as they have to pay an increased out of pocket expenditure for the various tests prescribed by the doctor. In addition, the service providers at the PHCs also feel that there is severe crunch of laboratory technicians causing a lack of interest among the people to undergo tests (thus delaying the diagnosis process). Therefore, the unavailability of **'Diagnostic Services'** is a major gap between the 'prescribed' on paper and the 'actual' at the ground.

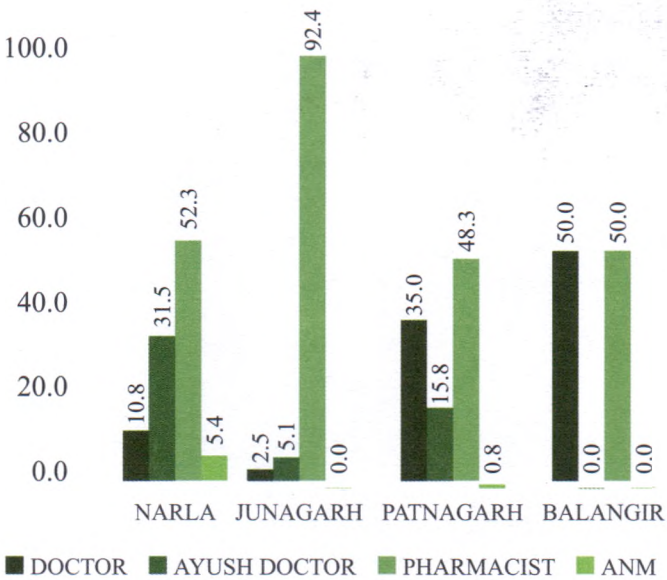
Patients who have frequented the PHCs



The above graph also indicates the same, as the patients who have frequented the PHCs have also felt disgusted due to unavailability of free diagnostic services. As a result of which their out of pocket expenditure escalates.

Sweepers at the PHC are a very important manpower as they are responsible for clean and hygienic surroundings of the premises. The study findings reveal that 30 out of 38 PHCs have sweepers. However, when correlated with the cleanliness aspect many people at the FGDs complained about poor and unhygienic surroundings of the PHCs. The PHCs which were found clean, the sweepers were self-motivated towards cleanliness. In few other PHCs, the sweepers were given a minimal incentive from the RKS funds.

3.2.2 Respondent Attended By:



The unavailability of doctors or 'doctor absenteeism' is a major challenge in the rural remote areas. The findings of the study (through client exit interviews) reveal that in none of the PHCs of the study areas, there is 100% availability of doctors. In Balangir constituency, only 50% of the respondent cases were attended by the doctors. The situation of doctor unavailability is worse in Junagarh constituency with only 2.5% cases and Narla constituency with only 10.8% cases attended by a doctor.

This reveals a sorry state of affairs of the doctors at the PHCs as against the IPHS standards mentioned wherein the availability of a doctor (holding an MBBS degree) falls under both 'essential' and 'desirable' category. The guidelines prescribe that Medical Officer should be available on call duty to manage emergencies and accommodation for at least one MO and 3 Staff Nurses will be provided. However, the accommodation (staff quarters) is another area that is highly neglected by the government.

3.2.3 Availability of Habitable Staff Quarters near PHC

Available staff quarters for Medical Officer					
District	Constituency	Yes	No	Habitable	Inhabitable
Balangir	Patnagarh	3	9	2	1
	Balangir	1	5	0	1
Kalanhandi	Narla	8	3	1	7
Junagarh		2	6	1	1

Though mentioned in the IPHS norms, the availability of staff quarters for the medical and para-medical staff near the PHC is very poor. Barring Narla constituency, the scenario is quite deplorable in other study areas. However, an analysis of the quarters at Narla constituency reveals that only 1 quarter out of 8 are in a habitable condition. This shows that though staff quarters are present near the PHCs, where doctors could easily stay, but those are in inhabitable condition i.e. there is lack of power supply, water, toilets etc. The in-depth interviews with the doctors and other medical staff indicated that even though quarters are available, they are not at in a habitable condition.

(Picture: Madanpur PHC)

This is one of the major reasons that doctors are unable to stay near the PHCs and thus, are unable to report at the PHC on time. An 'Observation Sheet' was prepared in the study that also indicates that though the PHCs remain open till 5pm every day, there are no doctors available after 2pm. This means that during the second half of the day, the pharmacist acts as the doctor (though he doesn't hold an MBBS degree) to treat the patients. Often, during the first half of the day, the patients can't frequently visit

the PHCs as they are busy in their respective work etc. In many cases also the PHC remains closed throughout the day. Therefore, the unavailability of staff quarters directly (or indirectly) paralyses the health care service delivery at the PHCs.

*In the PHCs with doctor irregularity, the Pharmacist was found to be taking up the entire responsibility. The villagers also shared that the PHC remains open at 9 am till 12 o'clock. The villagers are not much dependent on PHC instead they prefer going to CHC, SDH or DHH; due to lack of free medicines, unavailable of MBBS doctor, lack of facilities in PHC. There are no IPD services in the Dangbahal PHC or availability of medical staff at 24*7 round the clock. Village - Garjan, PHC - Bhundimuhan, Constituency - Balangir*

3.3 Availability of Infrastructure:

According to IPHS infrastructure guidelines, the PHC should be centrally located in an easily accessible area. The area chosen should have facilities for electricity, all weather road communication, adequate water supply and telephone. At a place, where a PHC is already located, another health centre/SC should not be established to avoid the wastage of human resources. PHC should be away from garbage collection, cattle shed, water logging area, etc. PHC shall have proper boundary wall and gate.

Services	Bolangir		Kalahandi	
	Bolangir	Patnagarh	Narla	Junagarh
PHC functioning 24*7	1	0	3	0
PHC with Power Backup	1	1	4	6
PHC having Sewage Facility	0	0	2	1
PHC without functional toilet	6	3	7	5
PHC Safe drinking water for consumption	0	5	5	7

Out of the total PHCs, 7 PHCs in Balangir i.e. PHCs at Arjunpur, Ramchandrapur, Kudasingha, Sibtala, Bhundimuhan, Kalipathar, Sulekela do not have electricity supply similarity 3 PHCs at Kalahandi i.e. PHCs at Belkhandi, Teresingha and Palam do not have electricity supply. Similarly, none of the PHCs in Bolangir constituency have safe drinking water provision; in other constituencies drinking water provision is also very poor. Out of 18 PHCs in Balangir, only 5 PHCs have drinking water facilities, while the same is relatively better in Kalahandi.

However, none of the PHCs in Balangir constituencies have power backup. 75% of PHCs in Junagarh and 36.4% PHCs in Narla have power backup; Kalahandi stays ahead of Balangir in having power backup. Sewerage facility is nil in both the constituencies of Balangir while, in Kalahandi, Narla fairs comparatively better than Junagarh. Though, in both these constituencies, the sewerage facility is less than 20%. Inspite of India's flagship programme, the Swachh Bharat Abhiyan which

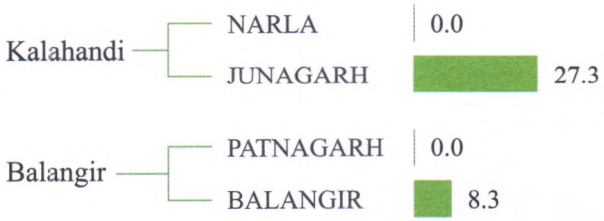
Deplorable and non-functional toilet at Madanpur PHC

aimed at providing toilets in rural areas for better hygiene, the study found that none of the constituencies have more than 70% functional toilets at their respective PHCs. In Patnagarh constituency, not even 50% of the PHCs have functional toilets.

3.4 Availability of 24 X 7 PHC (Maternal and Child Health)

IPHS guidelines promote institutional deliveries for the betterment of the mother and the new born as well as it provides 48 hours stay at the PHC post delivery. However, none of the PHCs at Junagarh (Kalahandi district) and Balangir (Balangir district) have any 24*7 PHC while 8.3% PHCs in Patnagarh (Balangir district) and 27.3% PHCs in Narla (Kalahandi district) have the same. The unavailability of 24*7 PHCs create a lot of problems for the people and many even are not aware about the significance of 48 hours stay at the PHC post delivery.

Availability of 24 X 7 PHC



The normal delivery women are not staying 48 hours at hospital as they had shared that there is lack of beds, and other unnecessary expenses at hospital. The hospital premises are very dirty and even did not get sufficient diet at hospital. During delivery time the hospital staff forcefully asked for money to make the delivery process. Eventually the beneficiaries paid to doctor, nurses, sweeper and medicine and other consumables too. Minimum 500 to 1500 rupees paid for normal delivery and 7000 rupees for C - section.
Village - Baijalpur, Sub center - Brundabahal

Subsequently, the study also found that very few PHCs at the study areas have labour rooms. This was also a major problem cited by the service providers like ASHA and ANM regarding the unavailability of labour room at the PHCs. While, institutional delivery is promoted on one hand, on the other hand the PHCs don't have labour rooms thus, creating a gap between prescribed and existing

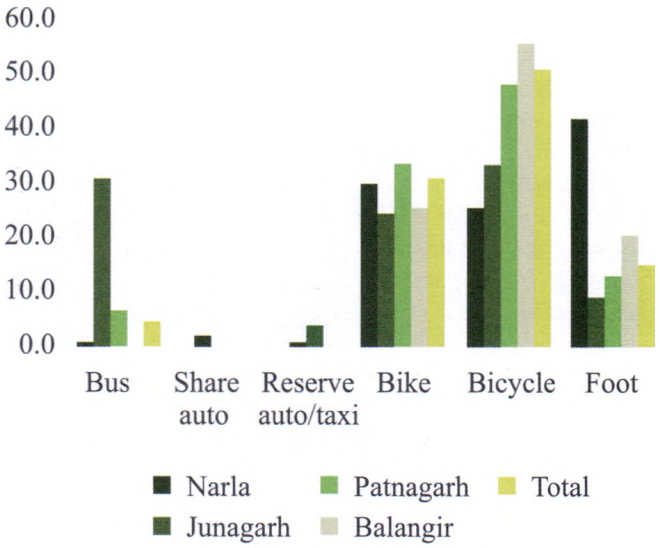
Availability of Labour room (in Nos)				
District	Constituency	Yes	No	Total
Balangir	Patnagarh	3	9	12
	Balangir	1	5	6
Kalanhandi	Narla	7	4	11
	Junagarh	4	4	8

reality. Functional labour rooms are a dire necessity at the PHCs as not only the beneficiaries but also the service providers feel so. Unavailability of functional labour rooms often leads to maternal and infant deaths during emergency situations. This is a major gap of what IPHS norms have prescribed and what really exists at a PHC. The demand from the people is to convert all the PHCs into 24*7 PHCs with functional labour rooms and IPD facilities, all for the safe and proper child delivery and the subsequent 48 hours care. Also, blood storage facilities need to be available at the PHCs to address any emergency situation during and after child birth.

3.5 Connectivity to the PHCs

Almost all the PHCs are connected by approachable roads. The graph indicates that bicycle and bike are the most preferred modes of transport of the people visiting the PHCs.

Mode of transport to reach PHC



3.6 Physical Accessibility:

Almost all the PHCs are connected by approachable roads. The graph indicates that bicycle and bike are the most preferred modes of transport of the people visiting the PHCs.

All the PHCs in the study areas are within accessible reach to the people as all of them fall within 5 kms. Therefore, the average time taken to reach the PHC is not more than 21 minutes for the people. As the above table indicated that they prefer their own bikes and bicycles, to reach the PHCs. However, for pregnant women who are

	Constituency	Average Distance: Home to PHC (in Kms)	Average Time Taken to reach PHC (in minutes)
Kalahandi	Narla	3.34	22.97
	Junagarh	4.36	20.57
	Total	3.76	21.97
Balangir	Patnagarh	4.93	19.67
	Balangir	3.76	23.25
	Total	4.54	20.86

in utter labour pain, such transport could be fatal. In many cases, the ambulance was not found to be available or even did not reach on time.

3.7 Referral Transport:

IPHS norms mention that it is desirable that the PHC have ambulance facilities for transport of patients for timely and assured referral to functional FRUs in case of complications during pregnancy and child birth. This may be outsourced either through Govt/PPP model or linkages with Emergency Transport system should be in place. Even under Janani Sishu Suraksha Karyakram (JSSK), the pregnant women are entitled for free transport from home to health institutions, between facilities in case of referrals and drop back from institutions to home.

However, the status of referral transport vial 102/108 ambulance is in highly deteriorated condition and people have been grossly disappointed by the same. The government provision of 108/102 ambulance service

Availability of Functional Ambulance				
District	Constituency	Yes	No	Total
Balangir	Patnagarh	0	12	12
	Balangir	1	5	6
Kalanhandi	Narla	0	11	11
	Junagarh	1	7	8

could not reach at the last stage of pregnancy. Eventually people use private vehicle and go to district head quarter hospital which is very much expensive for them. The table clearly points out at the poor availability of functional ambulance at the study areas.

According to a patient (Tapaswini Dharua), during delivery time at hospital, beneficiaries have been facing financial constraints as they have to pay huge amount of money to the doctors and other staff. Apart from her personal expenses during delivery, she had to spend Rs 900 for hiring vehicle and Rs 1700 to the doctor and other staff.

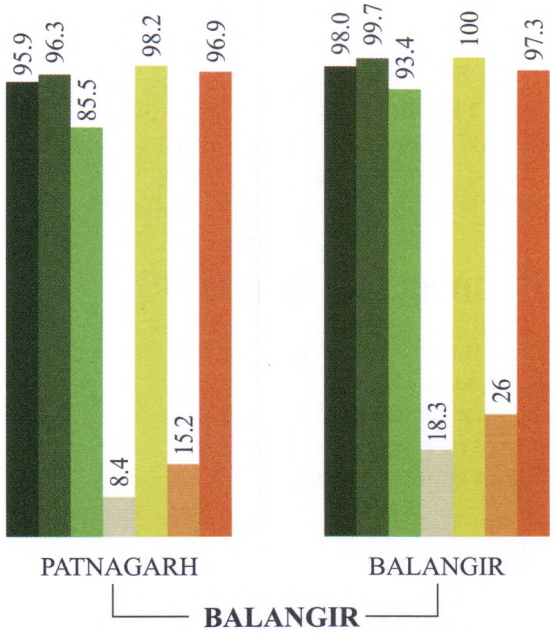
Case: Attractive Infrastructure- Poor Service Delivery: A Dichotomy

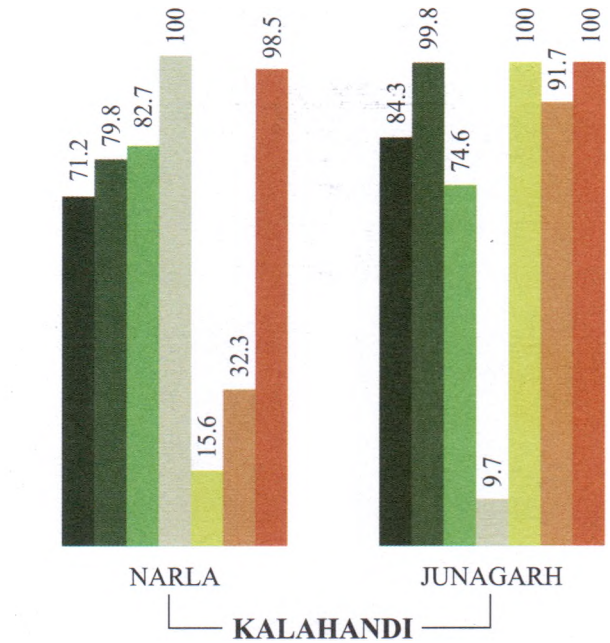
Village - Garjan
PHC - Bhundimuhan
Constituency - Balangir

In this primary health centre there is no staff quarter, only one hand pump and electric connection is available at the premises. An interesting thing is 108/102 ambulance had come only once to the village as of now. Most of the time, the customer service provider tells the beneficiary that they are going to the village but they do not turn up. Diagnostic facilities are not available in the PHC. So the village people do the test in nearest pathology which is very expensive and difficult for them to afford. The

referral transport is one of the major problems the severe patient gets into head quarter hospital with rented private vehicle, which is very expensive. The delivery patients are facing major problem while giving a big amount to the Doctor and Nurses at District hospital. Dwellers said that people wait one hour to meet Doctor and prescribe medicine and injection from outside which is very much expensive for the poor people.

3.8 Health outreach: Opinions of service providers and beneficiaries





The HMIS data analysis indicates that women staying in medical institutions after 48 hours of delivery are very poor in Patnagarh (15.2%), Balangir (25%) and Narla (32.3%), however, in Junagarh nearly 92% of the women stay for 48 hours after delivery. This is due to availability of CHCs and SDHs in closer proximity and the latter have well equipped labour rooms and wards that women find comfortable to stay in. The point to be highlighted here is the necessity of a well equipped 24*7 PHC that not only attracts women for institutional delivery but also provides the basic requirements of a habitable ward, post delivery. Many women are also not aware of the stay at the PHCs for 48 hours post delivery.

3.9 Availability of Medicines:

Issues related to medicine were not found in majority of the PHCs. The pharmacist mentioned that medicines never run out of stock for a longer period of time. In case any out of stock situation arises, then the stock is immediately refilled. The quality of the medicines, according to the pharmacist, is good. However, the FGDs revealed that people don't trust the quality of medicines as they think that government medicines are free and therefore, might be of poor quality. Though medicines are provided free of cost, as per government order, however, in Garjan village at Bhundimuhan PHC of Balangir district, people said that the doctor prescribes expensive medicines that they have to buy from outside.

3.10 Scheme based Analysis:

Janani Suraksha yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. This scheme integrates cash assistance with delivery and post-delivery care.

Janansi Sishu Surakshya Karyakram (JSSK) launched on 1st of June of 2011 is an initiative to assure free services to all pregnant women and sick neonates accessing public health institutions. The scheme envisages free and cashless services to pregnant women including normal deliveries and caesarean section operations and also treatment of sick newborn (up to 30 days after birth) in all Government health institutions across State/UT. This initiative supplements the cash assistance given to pregnant women under the JSY and is aimed at mitigating the burden of out of pocket expenditure incurred by pregnant women and sick newborns.

Mamta Diwas: The main purpose of Safe Motherhood programme is to increase women's knowledge about pregnancy and early childhood care with the long-term goal of addressing malnutrition in the area. Antenatal check up (involves weight, Blood pressure, TT immunization, urine & blood test) of the pregnant women is conducted on this day and IFA tablets are distributed on the Mamta Divas. The main objective of this day is to reduce infant mortality and malnutrition among children through effective delivery of Health & Nutrition services on the same day and under the same roof. On the Mamta Diwas, a mother and child friendly environment is created at the anganwadi/Primary Health Centre.

1. *Accredited Social Health Activist (ASHA)*
2. *Auxiliary Nurse Mid Wife (ANM)*
3. *Angawadi Worker (AWW)*

ASHA and ANM are the health activist(s) in the community who will create awareness on health and its social determinants and mobilize the community towards

local health planning and increased utilization and accountability of the existing health services. The basic job of AWW is extremely important and needs to be carried out in the most efficient manner possible. They need to provide care for newborn babies and ensure that all children below the age of 6 are immunized. They are expected to provide antenatal care for pregnant women and ensuring that they are immunized against tetanus. In addition to this they provide post-natal care to nursing mothers.

These service providers put forth the various challenges they face at the ground level. Apart from the infrastructural and other issues that have already been highlighted earlier in the report, these health providers face other challenges like communication problem, excess field area and too much work load. They suggested that the operational area size should be reasonable and the job responsibilities should be properly mapped out. A major gap also remains that the ASHA are not getting incentive at the right time, thus creating lack of interest and motivation among them to carry out their regular functions. Similarly, the beneficiaries also complained that though MAMATA diwas is scheduled on a monthly basis, on the second Friday of the month. However it has not happening for the past four months as the service provider and ANM has remained absent. Due to this continuous absenteeism the beneficiaries have started losing trust on the ASHA workers, who take the responsibility of informing the beneficiaries staying far away **(Palam, PHC).**

However, the situation is not grim in other places, for instance, in Baijalpur village, at Brundabahal sub centre, the women were found to be satisfied and mentioned that The Village Health Nutrition Day (VHND) which is known as MAMATA Diwas has been regularly conducted on second Tuesday of every month. The duration of this event is three hours from 9 A.M to 12 P.M. The beneficiaries' pregnant women and lactating mothers and the service provider are present in this event. Before commencement of the programmes the ASHA informs all the beneficiaries to participate in MAMATA diwas and also makes them aware about the antenatal checkups.7 days after the birth, the ASHA comes to check the health of newborn child.

However, the women complained at times there is delay in enrolment with MAMATA scheme due to unavailability of MAMATA card and lengthy banking process.

Time take for mother to receive JSY incentive after institutional delivery

District	Constituency	Immediately	One Monthly	Quarterly	Half yearly	Yearly	More than year
Balangir	Patnagarh	0	2	4	3	2	0
	Balangir	0	1	5	1	0	0
Kalahandi	Narla	0	7	3	1	0	0
	Junagarh	0	4	2	2	0	0

Time take for ASHA to receive JSY incentive after institutional delivery

District	Constituency	Immediately	One Monthly	Quarterly	Half yearly	Yearly	More than year
Balangir	Patnagarh	0	1	4	5	1	0
	Balangir	0	1	5	1	0	0
Kalahandi	Narla	0	7	3	1	0	0
	Junagarh	0	4	2	2	0	0

In both the above tables, it is clearly mentioned that the JSY incentive is not provided to the Mother as well as the ASHA 'immediately'. It takes nearly a quarter and 6 months in most of the cases for the beneficiaries as well as the service provider to receive the incentive.

The delay in incentive, on one hand hampers the beneficiary as the poor woman would be waiting for the incentive to buy proper nutrition and other amenities for herself and the child. On the other hand, a delay in incentive to the service provider would create a lack of interest in their proper and effective carrying out of duty (thus, the beneficiary is affected both ways).

SECTION IV

SUMMARY OF FINDINGS/KEY DISCUSSION AREAS

Access to proper health care is a basic right of all the citizens and an important responsibility of the state. Health, being a state subject, holds significance and makes the state accountable in providing proper health care facilities to its people. In absence of a proper and efficient health care infrastructure, the state not only fails in delivering its commitments but also puts the lives of its citizens at stake. Though Odisha as a state has developed in the recent years, but a gross centre-periphery developmental dichotomy is visible. The urban areas have marched ahead leaving the rural areas in lurch. Health care facilities have still remained inaccessible to a large segment of population although it is mandatory on the part of the state to reach the last mile person.

Keeping in lieu with above statements, this present study was an attempt to understand the nuances of primary health care services provided at the grassroots and to gather the perceptions of the community regarding these services. This perception study revolved around the views and opinions of both the beneficiaries and the service providers at the selected constituencies and PHCs was considered as the cornerstone for reference. The study aimed to reveal the actual existing issues and challenges, related to health care, that the people in the remote areas are facing.

Infrastructure wise, functional buildings are available in Patnagarh (Balangir) and Narla (Kalahandi) blocks in comparison to other blocks. Unavailability of adequate functional buildings causes problems in imparting proper health care services to the patients. Also, as per the demand of the people, the PHCs need to be converted into 24 x 7 PHCs with IPD facilities. But in absence of a proper functional building these demands of the people could be seldom met. From the service provider's point of view too unavailability of functional buildings is also causing problems, for instance, VHND is not properly conducted, as per the ANMs, due to unavailability of functional buildings.

Staff quarters are also a major cause of worry revealed in the study. In absence of adequate and habitable staff quarters it wont be possible to put a check on doctor absenteeism and a 24*7 PHC won't function smoothly.
Provision of safe drinking water and power back up (important in case of power failure during emergencies) is also in a tepid condition at the PHCs.

One of the primary aspects of state's responsibility towards rural health care is provision of 'Free services' in order to ensure that the poor people are not devoid of getting proper medical attention and intervention. However, the study found that 'out of pocket expenditure' of the people is getting increased instead of getting alleviated. The unavailability of diagnostic services and referral transport is causing a lot of difficulties for the people. While in some instances people are bound to pay higher prices in getting their medical condition resolved, in other cases, many are often showing lack of interest due to lack of money (thus, turning again to traditional healing methods, or even quacks).

Apart from the beneficiary's perception regarding the health care facilities, the service providers too showed displeasure in many aspects. The doctors showed discontent regarding unavailability of staff quarters leading to daily commuting to the PHCs (few of them which are in remote and inaccessible areas).
Keeping the above mentioned issues in view, its mandatory on the part of the state to atleast follow the IPHS norms properly and also incorporate the suggestions of the people in the policy making. Access to proper health care is a right of the individual and the responsibility of the state. However, the policies and programmes meant for the people need to be inclusive, participatory and people-centric. The state must listen, discuss and include the views, opinions and perceptions of the target population while formulating its policies and not make the latter a close door bureaucratic exercise. This study, therefore, concludes with the following key grey areas that need further and urgent attention:

1) 24 x 7 PHCs with IPD facilities
2) Access to safe drinking water
3) Clean, hygienic and safe surroundings at PHC with proper sewerage facilities
4) Habitable staff quarters for the medical and paramedical staff
5) Provision of diagnostic services and referral transport to curb out of pocket expenditure of the poor people.
6) Timely disbursement of incentives under various schemes to the beneficiaries as well as service providers.
7) Robust and effective grievance redressal mechanism

CHALLENGES AND SUGGESTIONS BY GRASSROOTS SERVICE PROVIDERS

	Challenges	Suggestions
ANM	1. Communication with regard to road, transport to reach the last mile beneficiary 2. Unavailability of habitable ANM quarter at Sub-center. 3. Misunderstanding with the community people regarding job responsibility. 4. Large area like 15 villages has been covered by an ANM. 5. Unavailability of Health workers 6. Code numbers of Mamata beneficiaries officially delay. 7. VHND is supposed to be conducted at Anganwadi center but in most of the areas buildings are unavailable. 8. Multiple task at a time like immunization, frequently home visit, VHND, sector meeting, etc.	1. Need of an approachable road 2. Habitat ANM quarter at sub center 3. Required male health worker. 4. Reduce the coverage areas as per practical convenience. 5. Increase the number of beds at PHCs and curtains for maintaining privacy of the pregnant women 6. Provision of ICDS buildings to conduct VHND
ASHA	1. Non-availability of ambulance 2. Frequent home visit for ANC, PNC and immunization. 3. Insufficient malaria kit and pregnancy kit. 4. Delay in both JSY beneficiaries' incentive and ASHA incentive. 5. Error in Mother Child Protection (MCP) card and account name. 6. Unavailability of waiting room and diet facility during delivery time. 7. Lack of Co-ordination among AWW and ASHA. 8. Most of the pregnant woman prefer home delivery.	1. Ensure ambulance services at right time to the pregnant women. 2. Requirement of an associate male worker during delivery period at night. 3. Sufficient malaria kit and pregnancy kit. 4. Ensure the availability of waiting room at delivery point and provide food allowance to the ASHA. 5. Ensure fixed salary.
AWW	1. Pending timely update of opened zero account in Anaganwadi center. 2. Delay in registration and lack of staff 3. Untimely submission of Pass book, Voter ID and data entry issue leads to over payment. 4. Frequently home visit for pass book 5. Lack of official concern for timely disbursement of installments	1. Habitat ICDS building 2. Requirement of an associate staff 3. Flexible banking process

DATA MATRIX ON KEY INDICATORS

	Bolangir			Kalahandi		
	Bolangir	Patanagarh	Total	Narla	Junagarh	Total
Functional Building	6	11	17	11	6	17
Approachable road	6	12	19	11	8	19
Availability of water supply	4	11	15	11	8	19
Safe drinking water for consumption	0	5	5	5	7	12
Availability of power supply	1	10	11	8	8	16
Availability of power back up	1	1	0	4	6	10
Availability of Sewarage facility	0	0	0	2	1	3
Availability of functional toilet	3	6	9	7	5	12
Availability of Labor room	1	3	4	7	4	11
Availability of Functional ambulance	1	0	1	0	1	1
Grievance reddressal system in place	0	0	0	0	2	2
Registered Rogi Kalyan Samittee	5	11	16	9	6	15
Habitable staff quarters for Medical Officers	2	0	2	9	2	11
Habitable staff quarters for Para-medical staff	2	1	3	6	1	7
Deliveries conducted in the PHC	1	1	2	5	4	9
PHC have a essential drug list	3	9	12	11	8	19
Available of medical Officer	5	10	15	3	4	7

DISTRICT HEALTH PROFILE

Key Indicators	Balangir	Kalahandi	Odisha
Health Care Infrastructure	226 (SC), 44 (PHC), 15 (CHC), 2(SDH), 1 (DH)	242 (SC), 45 (PHC), 16 (CHC), 1 (SDH), 1 (DH)	6688 (SC), 1305 (PHC), 377 (CHC), 27 (SDH), 32 (DH)
Infant Mortality Rate (per 1000 person)	97	54	49
Maternal Mortality rate (per 100,000 person)	234	245	222
Doctors availability		139 (MBBS), 87 (AYUSH)	
Paramedical staff availability		762	
Ambulance availability		32	
Bed availability in Public health institutions		555	
Mothers who had full antenatal care (%)	34.4	13.7	23.1
Institutional births (%)	87.1	74.5	85.4
Average out of pocket expenditure per delivery in public health facility (Rs)	4,989	5,133	4,225
Children age 12-23 months fully immunized (BCG, measles, and 3 doses each of polio and DTP (%)	93	88.2	78.6
Children age 9-59 months who received a vitamin A dose in last 6 months (%)	49.9	78.1	69.1
Children under 5 years who are underweight (weight-for-age) (%)	44.7	39.7	34.4
Children age 6-59 months who are anaemic (%)	67.3	67.2	44.6
Pregnant women age 15-49 years who are anaemic (%)	59.5	73.7	47.6

Source: SRS-2016, NFHS-4, NHM

List of Abbreviations

ANC – Antenatal Care
ANM - Auxiliary Nurse Midwife
APL – Above Poverty Line
ASHA - Accredited Social Health Activist
AWW – Anganwadi Worker
BPL – Below Poverty Line
CHC – Community Health Centre
DHH – District Headquarter Hospital
FGD – Focus Group Discussion
ICDS – Integrated Child Development Services
IPD – In Patient Department
IPHS – Indian Public Health Standard
JSSK – Janani Shishu Suraksha Karyakram
JSY – Janani Suraksha Yojna
MO – Medical Officer
MBBS – Bachelor of Medicine, Bachelor of Surgery
MCP – Mother and Child Protection
OPD – Out Patient Department
PHC – Primary Health Centre
PNC – Post natal Care
SC – Sub Centre
SDH – Sub Division Hospital
VHND – Village Health Nutrition Day

An initiative of:

Centre for Youth and Social Development

E-1, Institutional Area, Gangadhar Meher Marg,
PO. RRL, Bhubaneswar - 751 013, Odisha, India
Tel: +91 674 2300983, 2301725
e-mail: cysd@cysd.org / info@cysd.org
www.cysd.org