CHAPTER V

ANALYSIS AND INTERPRETATION
OF QUALITATIVE DATA

5.1  Focus group discussion

5.2  In-depth Interview

5.3  Case studies

5.3  Summary
CHAPTER V

ANALYSIS AND INTERPRETATION OF QUALITATIVE DATA

Qualitative research is associated with naturalistic enquiries. Considering the nature of the study, the researcher used various approaches to collect data. In order to generate qualitative information, the investigator conducted focus group discussions with JPHNs, JHIs, ASHA and Anganwadi workers. In-depth interviews were also conducted with JPHNs, JHIs, supervisors and medical officers. Qualitative data has been presented in three sections.

5.1 Focus Group Discussions (FGDs)

5.2 In-depth interviews

5.3 Case studies

5.1 Focus Group Discussions

The investigator conducted four FGDs with JPHNs and four FGDs with JHIs separately in the four randomly selected primary health centres. Similarly, four sessions of FGDs were also conducted separately for the ASHA and Anganwadi workers of the same area. Discussions were held on six major areas as given below:
Areas of discussion

1. House Visits
2. Reproductive Child Health (RCH) services
3. Communicable disease control
4. Non-communicable disease management and prevention
5. Records and reports
6. Team work

Discussions were analyzed with the help of three experts from the field of public health and findings are presented in this section.

5.1.1 Group-Junior Public Health Nurses

Major findings

1. House visit

   As per the job description, JPHN and JHI should conduct house visits for all the houses in the assigned area in two months time. The morning hours are kept for field activities and during the afternoon hours, health workers should be available at the sub-centre. In order to have a proper coverage, the entire houses are divided into 40-day blocks. They have to plan it in such a way that the JPHN start from one end and JHI from the other end, so that one person visits half of the houses in that month and by the end of two months, both of them
visit all the houses of the area. They are expected to conduct 20 days house visits every month; accordingly they prepare an advance tour programme. But they are unable to conduct routine house visits as planned due to various reasons. The expressed difficulties are described below;

1.1 Increased population coverage: Most of them were having population coverage of about 5000 to 9000. National recommended ratio of one JPHN for 5000 population is not maintained in Kerala state, which affects the quality of services.

1.2 Utilization of JPHN’s service by Local Self Government (panchayat) for various kinds of enumeration works in the area. Health workers are directed to do such additional responsibilities and that affects the field activities.

“Recently we were assigned for the EMS housing scheme survey by the Panchayat and it took 2-3 months to complete the survey”, one JPHN.

1.3 Additional responsibilities entrusted by the health department, such as replacing JPHNs for staff nurse’s duties, also affect fieldwork.

“There is one post of a staff nurse in the mini primary health centre where I work and nobody is appointed to that post. JPHNs are posted in rotation, but we are not meant for that work”, one JPHN.
1.4 In-service training programmes, conference days and holidays are to be excluded to plan the field visits, leaving workers with only 12-15 days in a month. If any communicable disease occurs in the area, planned visits have to be cancelled and attention to be paid to the existing problem.

1.5 Inadequate staff position due to vacant posts: If one JPHN is transferred, or is on long leave, additional charge is given to the nearest area JPHN or divided between two persons. No substitute is posted when a JPHN is on supervisory training for six months or on maternity leave, additional charge is given to a person who is already overburdened.

“I have almost two sub-centre area to be covered. I can only concentrate on pregnant women and children. Think of the reports and records to be maintained at two places”, JPHN who has additional charge.

1.6 Transportation problems: Lack of public transportation to the assigned area affects the house visits. The health workers try to avoid the area which is far away and render service to the houses which are near the sub-centre. Health workers conducting field visits are entitled to avail Permanent Conveyance Allowance (PCA), which is only Rs. 70 per month for both JPHN and JHI.
“The money we spend on transportation highly surpasses the conveyance allowance we receive. It is high time that the government should take necessary steps to raise the PCA to a reasonable amount”, one JPHN.

2. Reproductive Child Health (RCH) services

2.1 Maternal health services: Most of the JPHNs who attended the FGDs opined that maternal services are getting its due importance. Pregnant women are identified and services are given through clinic visits or home visits. Now BPL families are provided with Janani Suraksha Yojana (JSY) fund through which a pregnant mother can avail Rs.1000 for the first two child births. People are aware of these services and ASHA motivates them to come to the sub-centre on antenatal clinic days. Most of the JPHNs agreed that inadequate supply of iron and folic acid tablet has affected the delivery of maternal health services.

2.2 Child health: Services to children below five years is an ongoing programme. Immunizations are given at the anganvadis and in the sub-centres once in a month. It is on a fixed date and mothers are informed about it. No such programmes are cancelled and there is good immunization coverage. All the PHCs do not have a vehicle; in such cases, a rented vehicle is used for outside programmes
2.3 Adolescent health: Services are rendered through schools and anganwadis to the adolescent group. Nutrition days are conducted once in a month for mothers and adolescent girls. There are practical difficulties in organizing these sessions in all the anganwadis every month.

2.4 School health: Programmes are planned in such a way that health checkups and vaccinations are conducted at least once in a year in all the schools of the respective area.

2.5 Family Planning: Most of the JPHNs believe that they are trying to provide family planning services in the best possible way they can. Laparoscopic sterilization camps are conducted periodically, and they distribute oral pills and condoms to the needy couples.

3. Communicable disease control: JPHNs agree that it is an important problem in the community but are unable to give much importance as they are already overloaded with maternal and child health services. JPHNs also take part in the control of communicable diseases.

“TB cases are increasing in the community and each case needs minimum six months follow-up, which is the ultimate responsibility of the health worker”, one JPHN.
Ward level fund is used for sanitation activities and the environmental sanitation has improved to a great extent. Panchayats should take necessary steps for the effective sanitation like waste disposal and provision of safe water supply in the area.

4. **Non-Communicable disease management:** JPHNs opined that lifestyle diseases and old age problems are increasing in the community and not much attention is paid to this area. They were asked to survey and to make a list of terminally ill patients as part of palliative programme. Morbidity pattern is changing and diseases like diabetes, hypertension, asthma, cancer etc. should get attention. They suggested that effective programmes should be planned to manage and control these diseases.

5. **Records and reports:**

5.1 Number of registers: One JPHN has to maintain more than 20 registers in a sub-centre, which is a laborious work.

5.2 Duplication of the writing work: Each health worker is supplied with a diary, which has to be maintained for three years. It does not have adequate space to write all the details of the house visits. Therefore, they are asked to carry a notebook while conducting house visits, record the information in this notebook and then transfer it to the diary; later, enter all the information in the
concerned registers. This is just one example of duplication of writing work.

5.3 Lack of sub-centre facilities: JPHNs are expected to be in the sub-centre during the afternoon hours to do the recordings. Most of the sub-centres do not have power supply and toilet facility; hence it is difficult to do this work at the centre.

5.4 Inadequate training in computer documentation: All the health details of the sub-centre area are to be entered in the computer, which is again the prime responsibility of JPHNs. They received only three days computer training, which is not sufficient.

5.5 NRHM accounts: All the JPHNs commented that they were already tired of the records, and the NRHM project increased the writing work further.

“We have to utilize the NRHM fund and maintain the accounts of ward level fund, sub-centre fund and the ASHA package. It is good to have funds, but handling money matter is a real headache”, one senior JPHN.
6. **Team work**

JPHN has to interact with various groups of health workers in their daily activities. Regarding the ASHA scheme, they think that ASHA workers are operating well in the field. Since ASHA do not have a fixed time schedule, it is difficult to monitor their work and JPHNs have to rely on the data they bring. ASHA only concentrates on those works, which bring them incentives. For example they may care for a BPL (Below Poverty Line) mother, but are likely to neglect the APL (Above Poverty Line) mother, as the JSY fund is for BPL mothers only.

When asked about the sharing of responsibilities with JHIs, most of them opined that they (JPHNs) are doing major part of the work. JPHNs complained that JHIs do not take up equal responsibilities, but in the staff conferences, supervisors always question the JPHNs, not the JHIs.

“Since we are all ladies, we do not react or protest. Authorities take advantage of it and make us to do the maximum work”, one senior JPHN

JPHNs were unhappy with the disparity in the training as well as the promotion criteria of both the groups of workers. JPHNs had to undergo six months training to be promoted to a supervisor, which is not applicable to JHI. Selection for this supervisory training is based on seniority, which usually happens after 15-20 years of service and then promotion scope is very much limited. Though JPHNs have their unions and these issues were
brought to the attention of the Government many a time, they could not bring fruitful results, as their union is not strong like the union of JHIs.

**Suggestions**

The following suggestions were derived from the discussions held with Junior Public Health Nurses

1. More JPHNs should be appointed and population coverage should be reduced to improve the quality of services.

2. JPHNs should not be assigned for any enumeration works, which are not directly related to health.

3. JPHNs should not be used to replace staff nurses.

4. Records need to be simplified and uniformity is maintained.

5. Clerical assistance should be provided to village level health workers for the maintenance of NRHM accounts.

6. Vehicle should be made available in all the primary health centres for effective supervision and conduct of outside programmes.

7. Construct Government buildings for sub-centres wherever it is lacking and strengthen the existing physical facilities.

8. Permanent conveyance allowance of village level health workers should be raised to a reasonable amount.

9. Maintain uniformity in training and promotion criteria of JPHN and JHI.
5.1.2 Group: Junior Health Inspectors

Summary of the group discussions conducted with JHI is given in this section.

Major findings

1. House visit

1.1 Inadequate staff strength: JHIs are expected to cover all the houses allotted to them with in two months time, which is never done. It is because most of them have population coverage ranging from 8000 to 12000.

1.2 Additional responsibilities: JHIs are assigned with additional responsibilities entrusted by Local Governments from time to time such as enumeration works, which are not directly related to health.

1.3 Additional charges: Most of the time JHIs are given additional charges in places where the post is vacant and they are unable to cover the entire houses.

1.4 Need based approach: Visit to all the houses by JPHN/JHI is not practical; on the other hand, it should be a need-based approach. Those families who actually require the services to be identified and visited by JHIs and JPHNs. Most of the JHIs opined that it is a waste of time going to all the houses, which is not actually required. The
olden concept of day block system is no longer essential as ASHA is operating in the field.

1.5 Lack of specific division of responsibilities between JPHN and JHI: Present system of doing everything together is not effective. Those who want to shirk their responsibilities, easily get a chance to do so.

1.6 Treatment of minor ailments: Village level health workers are not provided with specific standing orders to treat minor ailments.

“There is no point in just making house visits and giving health education; people need medicines and other services”, one senior JHI.

Therefore, Government should issue an order of standing instructions for health workers to treat minor ailments. Majority of JPHNs and JHIs expressed their agreement in opinion survey that there should be proper standing orders to treat minor ailments.

2. Reproductive Child Health Services

2.1 Maternal health services: JHIs think that it is mainly an area of JPHNs, but they convey the RCH information to JPHNs whenever they come across such cases during their field visits. According to Junior Health Inspectors, it should be again a need based approach. Those who do not use government facility and prefer to go to private hospital need not be attended.
2.2 Child health services: JHIs provide all support to JPHNs to organize immunization sessions in their area. They also take initiative in organizing school health programme. Lack of working vehicle is a problem pointed out by JHIs in order to organize outside programmes.

2.3 Family Planning Services: JPHNs and JHIs identify the target couples of their area and provide need-based services. Family planning is an area, which people would like to keep as a private matter.

3. **Communicable disease control**

Present control measures like well chlorination, source reduction activities, spraying etc. are effective to some extent. However, basic sanitation system should be strengthened; each panchayat should implement proper waste disposal system.

JHIs also raised the issue of lack of an analytical laboratory in the district, which is causing great inconveniences as they have to carry the water or food sample to the regional laboratory in Ernakulam or Pathanamthitta district. Communicable disease outbreaks are occurring in the district every year but no proper testing centres to confirm the diseases at an early stage. There are only four public health laboratories in the entire State.

JHIs opined that communicable disease outbreak can be minimized if strict laws are enforced; existing Public Health Acts are very weak when
it comes to true implementation. In Kerala two public health acts exist, the Travancore Cochin Public Health Act (1955), for the southern region and the Madras Public Health Act (1935) for the northern region. The proceedings of these Acts are not the same; hence a Unified Public Health Act is highly essential for enforcing health regulations. The State Government is trying to amend the existing public health acts, but not yet implemented.

4. Non-communicable disease management and control

Most of the JHIs opined that life-style diseases are not getting much attention. They suggested that special clinics for diseases like diabetes, hypertension, asthma etc. should be conducted every month at the sub-centre in the presence of a medical officer. People above 40 years can avail such services and it is an area, which should get attention.

5. Records and reports

5.1 Lack of physical facilities in sub-centres: JHI is expected to be present in the sub-centres during the afternoon hours and do the recordings. But most of the sub-centres function in a single room and do not have basic facilities. Male and female workers have to be accommodated in the limited space and moreover female worker do not feel safe and secure. Hence, JHIs avoid going to the sub-centre during the afternoon hours.
5.2 Lack of registers and report forms: junior health inspectors complained about the inadequate supply of registers.

“Government is not providing the required registers or report forms. We are asked to purchase them or photocopy the forms”, one female JHI.

5.3 Lack of uniformity in report forms: No specific forms are available for most of the reports. Forms are different in each primary health centres, some are handwritten and some are in printed form.

5.4 Complexity of the recording system: As new programmes are getting added to the existing programmes, the reporting becomes more complex. Now PHCs are computerized with one computer and internet system. All sub-centre information to be entered in computer and to be submitted in paper, which has doubled the work. Moreover, JPHNs and JHIs had not received adequate computer training and were facing difficulties.

5.5 NRHM project: Various accounts of the NRHM were fund to be maintained accurately which has again increased the clerical work load.

6. Team work

JHI interacts with ASHA, anganwadi workers and JPHNs and supervisors. Most of the JHIs believe that the ASHA scheme improved the services to the community. Anganwadi workers co-operate well
with the health related activities. According to JHI’s, there is no problem in co-ordinating the work with JPHNs, but they also agree that JHIs can easily escape when the responsibilities are not clearly divided. They are not happy with the existing promotion system.

“**JHIs do not undergo any supervisory training and promotion is based on service seniority. Such supervisors can not function effectively. Hence supervisory training is essential and selection should be based on a competitive test**”, one junior male JHI.

JHIs conduct ward level sanitation committee meetings and decide on the sanitation activities to be carried out. NRHM fund utilization and account maintenance is considered to be a major responsibility. Most of the male JHIs feel that it is good to have money so that they can do many activities for the community.

They also shared their views about the need of a Public Health Directorate in Kerala, through which only preventive sector will get due importance.

**Suggestions**

1. Appointment of JHIs, equal to the strength of JPHNs and population coverage should be reduced for better services.

2. Day block system of house visits to be shifted to a need based approach.
3. JHIs should be spared from additional responsibilities entrusted by the panchayat, which are not directly related to health.

4. There should be specific division of responsibilities between JPHNs and JHIs, rather than doing everything together.

5. Standing orders to treat minor ailments to be issued by Government of Kerala for village level health workers.

6. Strengthen the existing physical facilities of the sub-centres and construct new buildings, wherever it is required.

7. Equip all primary health centres with adequate manpower, medicines and vehicle.

8. Each district should have a well equipped public health laboratory with adequate facilities for microbiology and virology tests.

9. Unified Public Health Act to be amended at the earliest by giving more power to the health care workers.

10. Importance should be given to non-communicable disease management through monthly clinics at the sub-centre level.

11. Simplify the existing recording system and maintain uniformity in reporting system, supply adequate number of registers and report forms by the government.

12. Supervisory training for JHIs to be introduced as mandatory.
13. Public Health Directorate for preventive health sector to be established in Kerala.

5.1.3 Group-Accredited Social Health Activists

Summary of the group discussions conducted with Accredited Social Health Activists of selected primary health centers is given in this section.

Major findings

1. **House visit:** They are expected to work for four days a week, visit all the assigned houses once in a month and provide necessary services.

   “Families expect a lot from us, such as checking blood pressure, urine sugar etc. for which we are not trained”, one ASHA.

2. **Reproductive Child Health (RCH) services:** All the pregnant women in the area are identified at an early stage and they are instructed to come to the centre on clinic days. ASHA helps the JPHN in organizing immunization sessions in the area; bring women and adolescent children for health awareness programmes.

   One worker pointed out that,  “We receive incentives for caring BPL mothers only, which should be made applicable for APL mothers also. The amount (Rs.200) is inadequate for the work we carry out”.
3. **Communicable disease control:** ASHA does well chlorination, conduct larval surveys, control mosquitoes by source reduction measures and provide health educations to people. They believe that there is a lot of improvement in the environmental sanitation. But they receive very little incentives for the sanitation activities like rupees two for a well chlorination, which should be raised to a reasonable amount.

4. **Non-communicable disease control:** It is an area to be taken care of, if they are taught to check blood pressure, urine sugar etc; and the instruments are provided, they are willing to do their best, and they think that they will be better accepted by people.

5. **Records and Reports:** They are provided with a diary and two registers, one register for the family survey information and another one for the RCH services. They completed the household survey and started entering the information in the registers.

6. **Team work:** ASHA co-operates well with the health team operating in the area. They did not report any problem with JPHNs or JHIs, or supervisors. They suggested that JPHNs/JHIs should be available in the sub-centre everyday so that people can come to the centre and receive services.
Most of them expressed happiness to work for the community, provided that a hike in incentives and monthly remuneration is granted to them.

**Suggestions:**

1. Adequate training should be provided to handle the life-style diseases in the community.

2. ASHA kit to be provided with sufficient medicines and implements.

3. JPHN and JHI should be available in the sub-centre every day

4. Provide monthly remuneration with a hike in incentives.

5. Local self government should take necessary steps to improve environmental sanitation.

**5.1.4 Group - Anganwadi teachers**

Focus group discussions were arranged with anganwadi teachers from the anganwadis of randomly selected primary health centre area; eight to ten teachers were present for each discussion.

Anganwadi workers are under Integrated Child Development Scheme (ICDS) and each anganwadi is covering a population of 1000, staffed with one teacher and a helper. Anganwadi teacher takes the responsibility of teaching pre-school children, looking after the health of mothers and children. Anganwadi helper cooks the food for the
beneficiaries and helps the teacher. They work on a fixed monthly honorarium.

**Major findings**

Summary of the group discussions conducted with anganwadi teachers is given in this section

1. **House visit:** Anganwadi workers are expected to survey all the houses of their area yearly and update the survey register. They have to be in the anganwadi from 9.30 am to 3.30 pm and do the field visits in the evening. They are instructed to visit five houses every day, identify the beneficiaries and provide need-based services. But in practice, regular house visits are not conducted, they convey the health related information to mothers whenever they come to the anganwadi for nutritional supplements.

2. **Reproductive Child Health services**

2.1 **Maternal health:** Anganwadi workers identify the pregnant women of their area and motivate them to come to the anganwadis. They get nutritional supplies in the form of “upumavu” or “aval” which they receive every day. This is applicable to lactating mothers and adolescent girls. They are expected to consume it in the anganwadi itself, but most of them take it home and share with other family
members. Each beneficiary’s weight is checked monthly and recorded in the respective registers.

2.2 **Child health:** Children up to six months get nutritional supplements in the name of “Amrutham”, which is a cereal distributed in the proportion of 100 gram per child per day. Mothers can get the packets and prepare it at home as directed by the workers. Children up to three years also get nutritional supplements; children above 3 years can be enrolled in anganwadi and get preschool training as well as high calorie diet. The village level health care workers arrange monthly health checkups and immunization programmes in all the anganwadis.

2.3 **Adolescent health:** Adolescent girls between the ages of 10 and 19 years get nutritional supplements from the angawadi. Periodic medical checkups are arranged for them and health awareness programmes are organized every month.

3. **Communicable disease control:** If any communicable disease is present in the area, anganwadi teachers communicate it to the health workers. Health awareness programmes to control communicable diseases are regularly conducted in anganwadis.
4. **Non-communicable disease management**: Anganwadi workers arrange health awareness programmes for the people of their area on different life-style diseases with the help of JPHN/JHI of their area.

5. **Records and Reports**: Anganwadi teacher is expected to maintain 21 registers and prepare monthly report of the activities carried out and submit it to their supervisor. They attend sectoral level and project level meetings, which is conducted every month.

6. **Team work**: Anganwadi teachers work as a team member with the health workers of their area. Anganwadi teachers are also members of ward level sanitation committee and their suggestions are given due importance. Anganwadi workers and health workers help each other in identifying the beneficiaries so that people get maximum benefit from the programmes.

“Through the introduction of ASHA scheme, we get great help in contacting beneficiaries. Mothers’ attendance increased remarkably and JPHN shows more interest to organize health awareness programmes”, one anganwadi teacher.

The main problem, which they face today, is that most of the anganwadis do not have proper buildings to function. Majority of the anganwadis are in rented buildings with limited facilities and receive only Rs. 200 per month from the Government as rent. Anytime they will be
asked to vacate the building and it is difficult to find a new place and this affects the services given to the community. They receive food materials in time, but storing facilities are inadequate. Play items for children are also not adequate. An anganwadi teacher receives a fixed monthly honorarium of Rs. 2080 and a helper receives Rs. 1500 per month, which they feel is grossly inadequate for the full time work they carry out.

**Suggestions**

1. Construct government buildings wherever it is lacking.

2. Provide adequate storing facilities for food materials.

3. Provide sufficient play items for children.

4. Permanent appointment of anganwadi workers in the government service with reasonable salary scale.

**5.2 In-depth interviews**

In-depth interviews were conducted with JPHNs, JHIs, supervisors and medical officers of the selected primary health centres. Recorded interviews were transcribed, analysed and organized under six themes as given below;

- RCH services
- Communicable disease control
- Non-communicable disease management and control
Records and reports

Primary health centre and sub-centre facilities

Supervision and team work

Major findings

The findings derived from the in-depth interviews are presented in this section.

5.2.1. RCH services: Village level health workers and their supervisors opined that RCH services are effective in the area. It is a team effort and all the health related workers actively participate in the RCH programme. Supervisors manage to arrange the vehicle and supervise the outreach immunization sessions. Target couples are identified and motivated for family planning methods. JPHNs play major role in rendering RCH services to the needy people of the area.

5.2.2. Communicable disease control: JHI takes care of the sanitation activities of markets, public eating places, cinema theatres etc. But the wards are equally divided among JPHN and JHI and they are responsible for the sanitation of the assigned wards. NRHM provides ward level sanitation fund and health workers with the approval of ward level sanitation committee, carry out various control measures. It is not very effective as there is no proper waste disposal system and safe water supply is lacking in the area. JHIs and their supervisors opined that the existing
public health act is weak in its true implementation and should be revised. Local governments should take steps to provide continuous safe water supply to the people of the area.

5.2.3. Non-communicable disease management and control: village level health workers and their supervisors admit that non-communicable diseases are not taken care off. This can be only done if the population coverage is limited to 3000. Physical facilities of sub-centres should be strengthened so that health workers can conduct daily clinics and people can avail the services from the health centre.

5.2.4 Records and reports: village level health workers and their supervisors commented that the clerical work is increasing day by day and consumes major part of their working time. Computer training provided to village level workers is very much inadequate and they find it difficult to process the data.

5.2.5 Primary health centre and sub-centre facilities: Village level health workers narrated their difficulties working with the limited facilities. JPHNs revealed their anxiety regarding their safety and security in the work place especially when the sub-centre is located in an isolated place. Mini primary health centres are functioning with one medical officer, one pharmacist and field staff. Mini PHCs do not have laboratory facilities and staff nurse is not appointed in most of the places. CHCs and BPHCs are not
adequately equipped in terms of manpower, medicines and vehicle. Vacancies of health workers and supervisors are not filled in time and inadequate staff strength affects the services.

5.2.6. Supervision and team work: supervisors opined that present supervision is not very effective as they have many constraints to conduct concurrent and consecutive supervision. Vacant supervisory posts, lack of working vehicle and high population coverage are some of the problems they face today. Medical officers appreciated the efforts of the JPHNs, but opined that the work of the JHIs needs to be improved. They opined that through effective supervision and co-ordinated activities, the health care services to the community can be improved to a great extent.

5.3. Selected Case Studies

In order to have a clear picture about the health care scenario at the village level, few selected case studies are presented in this section.

Case study-1

Name: A
Age: 24
Sex: Female
Education: B.Sc, JPHN training
Designation: JPHN
Work experience: Two years
The investigator fixed an appointment with the JPHN in her sub-centre, which is a tiny room with limited facilities. The purpose of the meeting was explained and assurance was made on confidentiality of the information.

JPHN is assigned in a low-lying area of Kottayam district in which majority of the houses are surrounded by water. She has to serve a total population of 5188 and 952 houses, spread over three wards. The sub-centre is a single room in a private building with no electricity; no safe water supply and lacking toilet facilities. It is located two kilometers away from the public transportation point. Since the houses are scattered, the JPHN has to walk several miles daily. She also has to take the ferry service to reach the two wards which is surrounded by water. She takes the help of ASHA to reach the field and render services. The people of her area are very co-operative and they appreciate her services.

When asked about the major responsibilities, she mentioned that it is RCH services and communicable disease control. Regarding house visits, she stated that though JPHNs are expected to cover all the assigned houses in two months time, it does not happen. So she mainly concentrates on pregnant mothers and under-five children. She believes that maternal and child health area is well covered. She is trying her best to motivate eligible couples for family planning measures.
She thinks that communicable disease control is mainly the job of JHIs, but she also takes part in such activities with the help of ASHA. “Lack of safe water supply is a problem of the area and people are frequently suffering from water borne diseases. People get pipe water only once or twice a week”, she said.

JPHN agrees that life-style diseases are increasing in the community and it is not getting its due importance. She arranges health awareness programmes in the anganwadis and schools. People of the area prefer to have JPHN available in the centre every day in order to provide necessary services. But most of the days she cannot return to the sub-centre due to the distance and lack of public transportation.

Regarding records and reports, new reports are getting added and too much of writing work. Since she has undergone six months computer training, it is easy for her to do the computer data entry. She carries the registers home and do the recordings at night. She feels that clerical work is taking major part of the time and utilization of NRHM fund is a real headache. JPHN complained that there is lack of clarity regarding the utilization of funds and no proper training was given regarding the maintenance of NRHM accounts. She is worried about the auditing, which is going to take place in the near future.
JPHN complained about the inadequate facilities of the sub-centre. “How can I sit in this tiny room and do the writing work without a fan”? she asked.

Since the sub-centre room is in a private building, she gets only Rs.50 from PHC to pay the rent and she is spending Rs.200 from her pocket to pay the total rent of Rs.250. The present room is too small to keep the necessary items. Though she can utilize the sub-centre fund Rs.10,000 to buy the furniture or other items, due to the lack of space she is unable to buy any items.

Regarding co-operation from the JHI, she was not willing to reveal much information. JHI comes to the area once in a while, and she does not want to make any comments about it. Both JPHN and JHI cannot be accommodated in such a small room and she feels that it is not safe. She hopes that the situation will change and there will be a better working atmosphere.

Case Study - 2

Name: B
Age: 54 Years
Sex: Female
Designation: Public health Nurse
Work experience: 22 years (JPHN-17 years, PHN-5 years)
An interview was fixed according to the convenience of the PHN. The investigator introduced herself and the purpose of the study was explained. She worked as JPHN for 17 years and underwent supervisory training in Thiruvananthapuram, and her first posting as PHN was in Idukki district. She served there for five years and got a transfer to her hometown. This mini PHC has a population of 28,000 with five sub-centres managed by a Medical Officer, one PHN, one HI, five JPHNs (one post vacant) and three JHIs. Additional charge of the vacant centre is given to the nearest sub-centre JPHN. The activities are carried out according to the programme schedule prepared by the supervisors and approved by the medical officer.

When asked about her duties and responsibilities, she mentioned that it is mainly the supervision of health care rendered to the community and preparing the consolidated reports. According to her the RCH services are well covered in the area. Communicable disease control is effective to some extent, but life-style diseases are not getting much importance. She pointed out that reports consume large part of the duty time, as they have to prepare various types of reports. Some are on a weekly basis and some are monthly reports. Reports are prepared in the format as per the directions of the Government and mainly to compare the targets and achievements.
Regarding the performance of sub-centre level workers, she feels that major part of the work is done by the JPHNs. Male JHIs do not take up responsibilities, whereas female JHIs co-operate well with JPHNs. It is better to have clear division of responsibilities between JPHN and JHI. She suggested that population coverage of JPHN and JHI should be limited for effective services. “Today health workers are overloaded with the clerical works such as preparing various reports, the incentive calculation for ASHA and maintaining the accounts”, she said.

When asked about the problems faced as a supervisor, she pointed that adequate staff should be available to cover the entire area. When additional responsibilities are given to any person, it will affect the total service. PHC do not have a vehicle to conduct the outreach immunization programmes, they have to hire an autorikshaw and Rs. 200 only is allowed for a programme. When it is a distant place, they find it difficult to run the programme with the limited amount. She further adds that only few people can be accommodated in an auto and there won’t be any place to carry the items necessary for the programme. Supervision cannot be carried out effectively due to the transportation problem.

Attendance of JPHNs and JHIs are maintained in the sub-centres. Supervisors are expected to visit the sub-centre, check the registers and verify the reports. When the immunization programmes are conducted at
the sub-centre, it is considered as a supervisory visit and necessary corrections are given. They face similar problems with the school health programme. Male workers manage with their own vehicles. She strongly suggests that working vehicle and driver should be made available in all the PHCs. Supervisors have to make a lot of telephone calls to conduct various programmes in the community and there is no provision for availing phone allowance from any fund. But JPHNs and JHIs can avail Rs. 300 per month as phone allowance from the ward level fund.

The PHN strongly suggests that there should be uniformity in the training, appointment and promotion of JPHN and JHI. Both JPHNs and JHIs are appointed in same salary scale, but JPHNs have to undergo six months training for the next promotion, which is not applicable to JHIs. She opined that supervisory training is required for both the groups of workers.

The PHN is at the verge of her retirement. It is sad that she got just one promotion in 22 years of service. She adds that her male counter partners get promotions earlier, which is highly demoralizing. She feels that supervisor training should be given with in 10 years of entry in service. At present it is based on seniority and usually after the age of 45 years, which is too late.
Another point is that vacancies at supervisory level posts such as MCH officer, District Public health nurse (DPHN), PHN tutor and Public Health Nursing Supervisor (PHNS) should be filled in time, so that eligible candidates can be promoted to the next higher post. Government should take necessary steps to solve this problem at least for the future generation, she concluded.

**Case Study- 3**

Name: C  
Age: 52 years  
Sex: Female  
Designation: Public Health Nursing Supervisor  
Work experience: 25 years (15 years as JPHN, eight years as PHN and 2 years as PHN supervisor)

She is working in the present primary health centre as PHN supervisor for the last two years. It has eight sub-centres with the posts of eight JPHNS and five JHIs. Out of the eight JPHN posts, three are vacant, as two got promotions and one left for training. Out of the five JHIs posts, two are vacant, as they are taken to the housekeeping department of medical college on working arrangement. These posts have been vacant for the last six months. When one JPHN goes for supervisory training, nobody is substituted and the nearest centre JPHN gets the additional charge and it affects the services to the community.
When asked about her responsibilities, it is mainly supervision of health care services delivered by JPHNs and preparing the reports. She thinks that maternal health is well covered even with the limited staff; antenatal clinics are conducted weekly. Immunization clinics are conducted as planned. Family planning services are not that effective. School health programmes are conducted in the schools of the area. But communicable diseases and life-style diseases are not taken care of properly. There is not much problem in co-ordination of the work between JPHN and JHI, but main problem is shortage of staff.

As a supervisor she faces lots of problems. The PHC do not have a vehicle, she has to procure the vaccines from the District Office and run the field programmes. They hire an autorikshaw and somehow manage the immunization and school health programmes. Transportation problem affects the supervisory visits.

Out of the eight sub-centres, only two places have got accommodation facility that too is not utilized by the staff. According to her, this minimum facility is not sufficient for the present generation. They are not willing to stay in the sub-centres. In order to provide comprehensive and continuous services to the community, JPHN must stay in sub-centres. “The State Government should acquire the land for the sub-centre and construct building as per the Indian Public Health Standards”, she commented.
NRHM fund has helped to acquire equipment and furniture for the sub-centres and primary health centres. But it has added to the already piled up writing works. Nowadays JPHNS and JHIs are busy in maintaining the NRHM accounts. Supervisors also have to do a lot of clerical work. Preparing weekly and monthly reports is a real task, nearly 10-12 reports on various items are to be prepared and sent to district.”

Regarding the introduction of ASHA programme, she opined that it would help in improving the services only if they are closely supervised, which is not an easy task. There is no specific time frame work for ASHA and they work on honorarium basis. JPHNs and JHIs are some times forced to accept the data they receive from ASHA. Lack of proper monitoring system is a major drawback. Every new scheme will have its own advantages and disadvantages, she concluded.

**Case Study-4**

Name: D

Age: 29 years

Sex: Male

Education: MSc., Bed. JHI training

Designation: Junior Health Inspector

Work experience: Two years
The purpose of the interview was explained and consent was obtained. The JHI is assigned to a population of 9,810 with 1,950 houses. Regarding house visits, JHI commented “one person can not cover this much population in two months period”.

RCH activities get due importance in the programme, but JHI thinks that it is predominantly an area of JPHNs. The JHI co-operates well with JPHN in organizing immunization camps, school health clinics etc.

Regarding communicable disease control, the JHI follows up the cases in the community, collect water samples, chlorinate wells, and give health education. Water sample collection is a complicated procedure, which is done, when water borne diseases are reported in the area.

JHI has to collect water sample from the concerned area, take it to the medical college or to the regional laboratory in Ernakulam district and get the report when it is ready. According to him, these procedures should be made easier and each district should have a well equipped public health laboratory. Moreover there should be scientifically sound waste disposal system to control the occurrences of communicable diseases.

When asked about the non-communicable disease control, he agreed that it is an area which is neglected as health workers are already overloaded with too many other responsibilities. There are four wards under the JHI and the NRHM fund Rs. 40,000 (10,000 per ward) has to be
utilized effectively in consultation with the ward level committee and accounts are to be maintained separately.

Regarding cooperation between JPHN, he does not find any problem. The JPHNs of his area are very active and responsible. He owns a motorbike, so that he can reach the remote areas easily. He is quite happy with the motivation and encouragement from the part of supervisors, but suggested that more JHIIs should be posted for better services.

Case Study – 5

Name: E
Age: 48 years
Sex: Male
Designation: Health Inspector (HI)
Work experience: 13 years (8 years as JHI and 5 years as HI)

Prior appointment was fixed with the male JHI, working in the community health centre. When asked about the supervisory responsibilities, he mentioned that it is mainly the supervision of the health services provided to the community, managing public health issues and preparing reports.

Regarding the performance of JHIIs in the area, he said that they mainly concentrate on communicable disease control and solving public health issues. Maternal and child health services are mainly taken care of
by the JPHNs, but JHIs support them in conducting clinics. Life-style
diseases like hypertension, diabetes and asthma are increasing in the
community. Health workers arrange health awareness programmes in
anganwadis for the people of the area.

There are numerous other problems like improper waste disposal of
markets, hotels, shops causing epidemic outbreaks in the area. All these
problems cannot be solved by village level health workers.

“Whenever there is a public health issue, there will be too many
questions and enquiries from the higher level. All the public health
problems cannot be rectified by the village level health workers”, he
said.

Regarding the sharing of responsibilities between JPHN and JHI, he
feels that their work is well co-ordinated, but with lesser number of
workers, drastic changes wouldn’t happen. As a supervisor, he feels that
preparing various reports is a time consuming task. Along the monthly
consolidated report, nearly 15 additional reports have to be submitted. He
suggested that details of each programme should be compiled, as one
report and provision should be made to enter all the information as a
consolidated report. Now all the PHCs are computerized and JPHNs and
JHIs received only three days computer training, which is very inadequate.
He suggested that they should be given sufficient training and should be
made competent to feed the sub-centre level data in the desired format. This can be consolidated at the PHC level and concerned officials can avail it, instead of sending it separately to various sections.

The PHC’s vehicle is not in working condition; hence it is difficult to run the field programmes. To conduct immunization and school health programmes, they have to rent the vehicle. Since he owns a two-wheeler, it is quite easy for him to reach the remote places. From 13 years of experience, he feels that public health problems cannot be solved easily. Now migration of population from one place to other place is increasing mainly among the construction workers and it is difficult to keep track of them. Epidemic outbreaks are more frequent among these groups due to unhealthy living conditions. He further suggested that it is essential to have more co-ordinated efforts to improve the public health sector.

**Case Study-6**

Name: F
Age: 52 years
Sex: Male
Designation: Health Supervisor (HS)
Work experience: 18 years (8 years as JHI, 6 years as HI and 4 years as HS)

An interview was conducted with the Health Supervisor at the Block Primary Health Centre (BPHC), the purpose of the interview was
explained. Block primary health centre encompasses a population of 75,000 with three mini PHCs attached. There are 15 JPHNs and 10 JHIs working in the area covering 15 sub-centres. Since the JHIs are not in equal number of JPHNs, most of the JHIs are given with one and a half sub-centre area. Hence they have to cover almost double the population of JPHNs; the services provided to the community are affected. At the supervisory level there are only two Health Inspectors and one Health Supervisor.

Regarding JHI’s contribution on RCH services, supervisor opined that JHIs are contributing their best by supporting the JPHNs of their area. The supervisor agreed that life-style diseases are not given proper care as health workers concentrate on communicable disease control and other public health issues. Regarding the inspection of hotels, he pointed out that existing Travancore Cochin Public Health Act is not giving enough power to the health workers to act up on any public health offences. It has to be revised in order to have better control over the public health issues.

JHIs prepare the reports as instructed to them and necessary corrections are given but the accuracy cannot be measured. Being a supervisor, the major part of his working time is spent on preparing reports. With the introduction of NRHM, clerical work has increased and no clerical assistance is provided to the supervisor. “Today health workers
are unable to function effectively as they are entrusted with multiple responsibilities. Each worker should have specific responsibilities, which can be counter checked”, he said.

The PHC has a jeep, which can accommodate only five people. In order to run the programmes at the sub-centres and schools, it is quite inadequate. He is happy that at least a vehicle is available for the PHC activities.

Case Study-7
Name: G
Age: 44 years
Sex: Female
Work experience: 15 years
Designation: Medical Officer in charge of Block PHC

The Medical Officer of the block PHC was contacted and a meeting was fixed. The purpose of the interview was explained and assurance was made on the confidentiality of information. The PHC serves a population of 87,412 and it has 14 sub-centres.

Regarding Reproductive Child Health (RCH) services, she was happy that the JPHNs are doing their work and providing health care services to mothers and children. According to the medical officer, family planning services are not that effective, especially from the part of JHIs.
Health workers are doing their best for the control of communicable diseases. However, it is a difficult task, as the existing sanitation system is not scientific. Source reduction activities alone are not going to control the diseases. Local government should implement proper waste disposal system. Public health problems can be controlled to some extent by enforcing strict laws.

Non-communicable diseases are increasing today, but are not getting the attention needed. According to the medical officer, primary health centres are not well equipped to meet the health needs of common man. All the PHCs should be equipped to conduct necessary investigations, and quality medicines should be made available.

Regarding records, it is a laborious work; somehow health workers are managing it. Records are very complex and it consumes major part of the working time. All the sub-centres do not have basic amenities and health workers find it very difficult to run the routine activities.

No vehicle is available for the primary health centre. They have to hire vehicles for the out-reach immunization sessions and school health programmes. A computer with internet facility is provided.

When asked about the team work she commented. “JPHNs are doing major part of the work. Since there is no specific division of
responsible, JHIs take advantage of it and it is very difficult to manage the male workers’.

Village level health workers are expected to go to the concerned area as per the advanced tour programme and mark their attendance in the sub-centre, which is counter checked during the supervisory visits. It is not easy to track each person and some people may take advantage of it, she added.

Regarding the performance of supervisors, medical officer stated that they are not adequate in number; two persons have to supervise 15 JPHNS. They also have to prepare a number of reports. When asked about her supervisory responsibilities, she pointed out that she is overburdened with administrative responsibilities and clinical responsibilities. Along with her, there are three other medical officers; one is on maternity leave, left with two to manage the peripheral programmes and the hospital. She has to attend the district level meetings, perform the administrative responsibilities, and manage the out-patient and in-patient section. She suggested that all the block PHCs should be upgraded to community health centres at par with the Indian Public Health Standards. She commented that present supervision is not effective and it has to be improved.

Suggestions

The following suggestions were derived from the in-depth interviews with JPHNs, JHIs, supervisors and medical officers;
1. JPHNs and JHIs should be posted in equal strength to improve the services rendered to the community.

2. Village level health workers should be assigned for health related activities only.

3. Physical facilities of the sub-centres should be strengthened.

4. There should be specific division of responsibilities between JPHN and JHI

5. One supervisor for four health workers should be made available to strengthen supervision.

6. Amend the existing public health acts and a unified public health act to be introduced in the State.

7. Each district should have a well equipped Public health laboratory.

8. All the block PHCs should be upgraded to CHCs at par with the Indian public health standards.

9. Uniformity in the reporting system and simplification of existing recording system is highly essential

10. Adequate computer training to all the health workers should be planned at the earliest.

11. Local self governments should take initiative steps in maintaining the sanitation of the area through community participation.
5.3 Summary

This chapter dealt with the analysis and interpretation of qualitative data. The investigator tried to generate qualitative information through focus group discussions and presented a summary of the discussions. Major findings of the in-depth interviews are also presented.

Selected case studies of the in-depth interviews conducted are also included to get a clear picture of the current scenario of primary health care delivery at the grass root level.