CHAPTER – V

DISCUSSION

CHAPTER - 5
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5.1 INTRODUCTION

The present study was focused on the "Efficacy of Primary Health Centres for the promotion of community health in Kerala with special reference to Ernakulam district". The findings based on the analyses have been described in the previous chapter. This chapter is an attempt to carry out a discussion on the findings based on the available studies, the researcher's own experiences during the conduct of this research and on dialogues with subject experts in the same field. This discussion chapter is presented in the following order: present health care mechanism in the study area, manpower, infrastructure facilities and other supportive mechanism at the centre, services, profile of beneficiaries and their level of satisfaction at the s health care delivery mechanism operating from the Primary Health Centres.

5.2 PRESENT HEALTH CARE DELIVERY MECHANISM AT THE PRIMARY HEALTH CENTRES IN THE STUDY AREA.

The existing organizational structure of Primary Health Centres in the study area lacks uniformity in the distribution of Primary Health Centres in Kerala when evaluated on the basis of the nationally accepted Indian Public Health standards. This preposterous distribution of Primary Health Centres is apparent both in terms of their pattern, and location. As per the national schedule for health system, under each Community Health Centre atleast one Primary Health Centre is mandatory and it has to act as a referral unit for 5 to 6 sub centres. But in the study area, Block Primary Health Centres function parallel to Community Health Centres and even they can not equalize in terms of infrastructure or services. The Primary Health Centres function under these centres either as part timed mini PHCs or as full fledged 24 hour and 7 days functioning (24x7) PHCs. Even these 24 hour and 7 days functioning (24x7) PHCs do not offer services through out the day and seven days in a week as they are supposed to. Even the quality of the services provided by them is in no way superior to those available at the mini PHCs. A disparity is also found in the allocation of sub centres. The study shows that twenty nine per cent (28.57 per cent) of PHCs in

the study area have only less than 5 sub centres while 5 to 6 sub centres are the legal requirements according to the nationally set up standards for Primary Health Centres. As per the government norms, Primary Health Centres should be located in an easily accessible area. But the study has revealed that sixty seven per cent (67.1 per cent) of beneficiaries have to travel more than 8km to reach the nearest Primary Health Centre. Non accessibility of heath services is one of the important factors for the low utilization of the benefits offered by the Health Centres.

Some of the findings of earlier studies on Primary Health Centres fully concur with the results of the present study in terms of the observed trends of the distribution of the Primary Health Centres, and the reasons spotted for the short comings.

Dr. K K Arjunan et al (2004) in their report on "Standardization of medical institutions in the Kerala health service department" focused on the disparity on the number and distribution of various health care institutions in Kerala. According to him the health care institutions in Kerala are not distributed as per standard norms, but often the decisions on the distribution of the health care distribution are based on other socio-political and economic pressures/factors. There is gross disparity in the number of institutions across panchayats, municipalities, taluks

and across districts. There also exists no uniformity in service provision, bed strength and staff structure. Some institutions are too small and under-developed, whereas certain others of the same category are too unwieldy. Institutions of the same category often differ widely in quantity and quality of services provided.

According to the Fifteenth Human Development Report (1999), in India only 22 per cent of villages have a sub-centre based on the population criteria. According to Ajit K Dalal (2005), the existing extensive network of Public Health Centres falls far short both in terms of population coverage and the guidelines set out by the government. As the poor are the main users of primary health care facilities, the rich preferring to use private clinics and hospitals, the absence of public primary health care services means that many people either forego any medical care altogether or use too little too late or choose to seek expensive and unregulated care in the private sector.

National Family Health Survey II 1998-99 (NFHS II) indicated that in terms of population coverage, only 13 per cent of rural residents had access to a primary health centre, 33 per cent had access to a sub-centre, 9.6 per cent had access to a hospital and 28.3 per cent had access to a dispensary or clinic.

All these findings pinpointed towards one of the important problems of health care delivery that is the 'unequal distribution of Primary Health Centres' for providing Primary Health Care 'at the door steps of the community'. Primary Health Care is a package which is supposed to be distributed equally through the Primary Health Centre. The principle of equal distribution of such care (the first and important principle of Primary Health Care is to ensure the equitable distribution of health services to the communities irrespective of ones age, sex, area and social or political status) is not achieved due to socio, economic and political pressures/factors as it is seen/reflected in the nationally conducted surveys/studies. To put it briefly, the existing pattern of the health care delivery system does not ensure optimum health care to the rural population due to these incongruities in the geographical distribution of the health centres.

5.3 INFRASTRUCTURE FACILITIES, MANPOWER AND SERVICES

5.3.1 Infrastructure Facilities

Infrastructure facilities, Manpower and Services go hand in hand. As per the Indian Public Health Standards (2005), a Primary Health Centre should be well equipped with the necessary infrastructure, manpower and assured services. But the PHCs in the study area do not

have all the required infrastructure, manpower and adequate provision for services that enable a Primary Health Centre to function effectively true to the norms of Indian Public Health Standards.

The most conspicuous reason for the low utilization of government health care is lack of proper facilities, including the personnel which is turn, limits the utilization of the resources available (Nair 1998; Varartharajan et al.2002). According to Kutty (2000) availability of physical infrastructure is crucial for the staff to perform better. In many government health-care institutions, including the PHCs, the staffs present are underemployed due to lack of support facilities. This could arguably be due to the diminishing non-salary component in government health expenditure. K.R Thankappan et al(2005) in their study on "Current status of service delivery in the health and family welfare sector in Kerala with particular reference to reproductive and child health program" reveals that infrastructure facilities in many institutions were reported to be inadequate. A comprehensive study of nineteen villages by D. Banergee of Jawaharlal Nehru University, revealed that people all over the country are actively, seeking the help of the government health system but are totally frustrated with its response. From this it is clear that to ensure better services to the community, the

first thing to do is to ensure the essential infrastructure facilities and supportive manpower.

According to Ajit K Dalal(2005), the quality of health care services in India, provided by the public health system is extremely low almost along all the criteria on which quality can be judged – infrastructure, availability of drugs and equipment, regular presence of qualified medical personnel and treatment of patients. Instead of being supportive and palliative of people's health, it will not be remiss to say that the health system itself poses a hazard to its intended beneficiaries, especially the poor, who are often as reluctant to use public health services as the rich.

The Government PHCs are expected to render yeoman service to local community in and around such centres and they assume great significance since a large number of peoples from the poverty stricken and marginalized families are invariably approaching the centers for their health care. The selected PHCs in the study area fail to provide the expected service to the prevailing population. This was analyzed based on certain important parameters such as medical care at the Out Patient unit, emergency, referral services and In Patient services. However, it is noticed that the medical care rendered in the study area are not at all satisfactory as far as their services are concerned.

All the PHCs brought under the research study have an Out Patient Department (OPD). Though the government norms for Primary Health Centers for OPD services insist they should have separate facilities for the consultation and the examination of patients. But none of the PHCs in the study area have been found to have conformed to this stipulation. Indian public Health Standards demand 4 hour OPD service in the morning and 2 hour service in the afternoon and stipulate service to minimum 40 patients in a day. However, in the study area, only 42.85% of PHCs fulfil this requirement. In all the PHCs studied, medical care facility was available only from 9 am to 1 pm. None of them had an Out Patient clinic functioning in the after noon. Only about fourteen per cent (14.28per cent) had the 24 hour emergency facility and inpatient facility.

Although emergency services were available at all the PHCs in the district during the working time between 9am to 1pm except in fourteen per cent (14.28 per cent) of PHCs (Valakam) where 24hours emergency services were available, the majority of the beneficiaries were not fully satisfied with those services, owing to lack of adequate facilities and drugs. The emergency service delivery model, existing in the PHCs indicated that the present emergency services could only give first aid care to injuries and then the cases had to be referred to higher

levels of health care. The study also showed that there were no emergency services available for dog bite/snake bite or insect bite or such other conditions demanding urgent attention. Having a vehicle is an indispensable element in facilitating the referral of patients to other higher levels of health care in terms of transporting them. However, in the studied 7 PHCs, only fourteen per cent (14.28 per cent) of PHCs had the vehicle facility provided by the National Rural Health Mission (NRHM). It is interesting to note that the available vehicles were mainly for field work and not for transporting the referred patients to centres of higher care. Adequate and prompt referral services were not available at any of the PHCs studied in the area. None of the PHCs studied had specialist care available for stabilization of the patient or adequate staff support during transport. What is more, even ambulance services were not available at any of the PHCs under study for the transportation of patients for referral service. Immediate steps should be taken to ensure that all the PHCs are provided with ambulance facility.

Findings of the research study show that none of the studied PHCs have an Operation Theatre (OT), and labor room facility. Only fourteen per cent (14.28 per cent) of have laboratory facility, even though, Lab facility is one of the important factors in disease diagnosis. The NRHM has strongly recommended for this. If government succeeds

in ensuring this facility at Primary Health Centres as per the norms, it would be a mile stone in bringing medical care within the reach of common man. Besides, it will boost the credibility of the MCH programme as it is the medical care at the more than seventy one per cent (71.42 per cent)of Primary health Centres in the study area is limited only to Out Patient care only. K.R Thankappan (2005), in his study on "Current status of service delivery in the health and family welfare sector in Kerala with particular reference to reproductive and child health program", focused on the fact that PHCs were found to be functioning as Out Patient clinics only and the In Patient services (IP) were not provided. Unless IP facilities are provided in the Primary Health Center, the only government institution in a Panchayat with a medical officer, people will be pushed to private sector hospitals.

The inadequate infrastructure at the Primary Health Centre is one of the important factors which determine the quality of health care, provided through such centres. Inadequacy of infrastructure facilities such as Operation Theatre (OT), Labor room and laboratory adversely affect the Mother and Child Health care (MCH) including ante-natal care, intra-natal care, permanent family planning methods, and reproductive tract infections/sexually transmitted diseases and other general surgical procedures and even proper diagnosis of the ailment. So

the infrastructure and supportive facilities are decisive factors in the service delivery.

5.3.2 Manpower

Primary Health centre is the first contact point between village community and the medical officer. As per the Indian Public Health Standards, Primary Health Centres should be manned by 2 medical officers including one AYUSH (Ayurveda/ Unani/ Sidha/ Homeopathy) doctor and one lady doctor and supported by a 16 member staff including Para medical and field staff. None of the PHCs in the study area were found to follow this staff pattern. It was noticed that in the study area in more than seventy one per cent (71.42per cent) almost all the PHCs there was only one doctor, posted by the government and he had to shoulder the entire brunt of the work in the PHC. 28.57% of PHCs (Valakam and Kuttampuzha) had more than one doctor. Even there no AYUSH doctor had been appointed as required by the National Rural Health Mission (NRHM). In Kuttampuzha, one additional male allopathic doctor was found in the place of AYUSH doctor. No lady doctor functioned at this centre. In Valakam two allopathic lady doctors had been appointed in addition besides one male allopathic doctor. Indian Public Health Standards (IPHS) require that there should be two doctors, one AYUSH and one lady doctor at all the Primary Health

Centres. From all these it is clear that the PHCs do not have any uniformity in the availability of medical officers. It was a positive thing that 57.14% of Primary Health Centres of the total PHCs studied, had lady doctors in the medical staff. However, the regulations of NRHM have to be more strictly enforced to meet the health problems of the rural population promptly and efficiently. As regards the provision for staff nurse, only 28.14% of PHC have additional posts as per the Indian Public Health Standards. As per the demand of IPHS, one health educator has to be posted at PHC level. But none of the PHCs in the study area has as health educator and the responsibilities attached to these positions are carried out by the health inspectors in the area. The aim of health education is, to make the public know the causes for the outbreak of diseases and how best these could be prevented by taking prophylactic measures. In the absence of a trained and qualified health educator, it is impossible to impart health education in the proper way and to control endemic and epidemic diseases. This finding is quite pertinent in the context of the recent outbreak of endemic and epidemic diseases in Kerala, especially in the Ernakulum district.

Not all the PHCs studied had the post of male and female health inspector filled in. In 85.71 per cent of PHCs, Male Health Inspector (HI) and Lady Health Inspector (LHI) were available. In 14.28 per cent

of PHCs (Marady PHC) this post has not been filled. Valakam and Marady shared the post of male and female health inspectors three days each a week. These health inspectors were overburdened because they had to carry out between the responsibilities of all the sub centres of the two PHCs. Collection of Vital statistics is an important function of PHC. The responsibility was laid on the Junior Health Inspector (JI-male)/ Junior Public Health Nurse (JPHN-female).14.28 per cent of PHCs was found struggling for lack of adequate staff. All this reflected badly on the efficient functioning of the health care system.

Pervasive absenteeism of staff at the Primary Health Centres is the one of the important problems of health care services in India. According to Chaudhury et al, (2003), absenteeism among doctors was as high as 43 percent and among other health workers, 39 percent in government health care facilities across Indian states. A survey conducted by Banerjee (2003) in Udaipur in Rajasthan, found greater absenteeism in PHCs and CHCs than in sub-centres. These findings reveal the fact that there is no coordination among the staff at Primary Health Centres for meeting the emergency health needs or providing essential health care in promoting the health status of the community. Apart from the number of health centres providing Primary Health Care, the availability of Primary Health Care also depends on the number and

quality of the doctors, nurses and other medical personnel positioned in these centres. Staff shortage is the most acute problem faced by the public health system in India, especially in rural areas, as the medical personnel at large do not like to serve in rural and remote areas. As a result, many posts in sub-centres and PHCs in rural areas remain vacant. For example, in 1996, as many as 4,281 of 29,699 doctors sanctioned posts remained unfilled in rural health institutions (Misra et al., 2003).

According to the 1988 ICMR study on Primary Health Care Services, only 15 per cent of the PHCs had the requisite number of health personnel. The shortage of lady health visitors (LHVs) was more acute; an LHV who was supposed to supervise four auxiliary nurse midwives (ANMs), had to supervise five to nineteen. The report added that 10 per cent of the PHCs did not have any record of pregnant women, and the majority had no facilities for the routine follow up of pregnant women with tetanus toxoid. Eleven per cent of PHCs were administering iron and folic acid to 60 per cent of the pregnant women. The majority of the PHCs had no facilities for the routine check up of pregnant women for weight, blood pressure and haemoglobin. Nor were birth weights recorded. All medicines especially antibiotics, were in short supply. Emergency equipment and life saving drugs such as as oxygen and steroids were not available in a large number of PHCs (Alok

Mukhopadhyay, 1992). However, the only solution to deal with is to ensure the regulations of NRHM in the provision of medical officers and other staffs at the PHCs to manage the health problems of rural population efficiently.

5.3.3 Services

5.3.3.1 MCH Including Family Planning Services

The selected PHCs in the study area have not been providing MCH services as against the express stipulation to do so. Antenatal care (ANC) is aimed at ensuring a healthy mother and a healthy child at the culmination of pregnancy and to prevent maternal and prenatal morbidity and mortality. In the study area PHCs did nothing but the registration of pregnant women, distribution of iron and folic acid tablets and totally ignored such vital services as regular check- ups and laboratory assistance. The study revealed that a complete package of services was not implemented. This meant that there was no continuity in the treatment throughout the pregnancy and its place as a temporary consultation unit for the pregnant women was being conveniently ignored. The government should intervene and ensure that the complete package of antenatal care services including laboratory facilities for the essential investigations is provided to all pregnant women, visiting the

PHC on all working days as per the guidelines of the National Rural Health Mission.

Intra natal facility was not available at any of the selected PHCs owing to the absence of operation theater and labor room facilities. Post natal care is crucial to the prevention of mortality and morbidity in both the mother and the new born. Unfortunately post natal care is a neglected component of maternal health services in the PHCs in the study area. None of the women received any form of post natal care from the PHCs. It has been found that most of the maternal and new born deaths took place during the post natal period from puerperal and new born sepsis respectively. So the provision for post natal care as part of maternal and child health services through primary health centres should be ensured without leniencies.

5.3.3.2 Family planning services

All the PHCs should provide round the clock counseling services for all the clients, desirous of availing of contraceptive services. They should have facilities for Intra Uterine Devices (IUD) insertion, provision of oral contraceptive pills, condoms, sterilization services and emergency contraceptive pills. The staff at a PHC should be trained in the various methods of contraception and should offer them to men and women wherever and whenever required. But the selected PHCs in the

study area had the provision only for condom distribution, oral pills and Intra uterine Devices (IUD) insertion. Sterilization services were not available at any of the PHCs studied. Provision for early and safe abortion service (MTP- Medical Termination of Pregnancy) was not available at any of the PHCs even though it is an important component of Mother and Child health (MCH) services. The infrastructure and skilled manpower for this service did not exist in any of the PHCs. No effective management of Reproductive Tract Infections/ Sexually Transmitted Infections (RTI/STI) was possible due to the lack of lab facilities. RTIs/STIs are the most wide-spread elements in reproductive morbidity and perinatal morbidity and mortality. Serious complications of RTI/STIs are Pelvic Inflammatory Disease (PID), preterm labor, miscarriages and still births, ectopic pregnancy, infertility and genital cancers. No effective service includes laboratory facilities for the management of RTI were not available at the Primary Health Centres studied. Availability of basic laboratory facilities will ease the process of making a diagnosis and prescribing the proper therapy. It is important to note that early diagnosis and treatment of RTI/STIs is an integral part of the chain of prevention of RTI/STIs. Laboratory services particularly related to pregnancy, new born care and post-natal management as back-up are absolutely necessary. These PHCs must have adequate space,

equipment, reagents and trained staff to carry out the required essential laboratory investigations. In the MCH package the child care component in terms of immunization is encouraging while the mother component totally is ignored by the Primary Health Centers. The School Health Programs scheduled only for once in a year including health check ups and immunization in all the PHCs studied in the area. So the performance of the selected PHCs was disappointing because only the partial ante natal care and child immunization service were available at the PHCs and it is obvious that none of the studied PHCs perform the task of MCH services adequately and efficiently and much emphasize has to be given on this important component of primary health care.

An evaluation of the quality of family welfare services at the primary health centre level, carved out nationwide by ICMR (1991) recommends the urgent need to improve the performance in various aspects of Mother and Child Health (MCH) care. P.H Reddy's (1994) study on the quality of client provider interaction and family welfare services(MCH and FP programmes) in rural Karnataka and Kerala suggests that there is a need to allocate more funds to fill vacant posts, buy and supply adequate pre and post operative drugs, to conduct periodic re-service training programs for the medical, paramedical and non-medical personnel. It also stresses the fact that the existing

autocratic supervisory mode of action ought to be replaced by a supportive supervisory style.

5.3.3.3 Other services at the primary Health Centre:

In the field of nutrition, none of the PHCs in the study area could claim to have reached any where near the target in conducting nutrition classes for adolescent girls and pregnant and lactating mothers. Awareness on the requirements of nutrition is an important factor for the pregnant and lactating mothers to prevent nutritional deficiencies. The PHCs in the study area also failed to implement the provision for Safe Water Supply and Basic Sanitation Programme. The programme was aimed at providing safe water supply by ensuring that its sources were pure and uncontaminated and that waste disposal was regularly carried out by the beneficiaries of the PHC. This was supposed to be achieved by creating adequate awareness that would help reduce, even prevent the incidence of water borne and vector borne diseases in the area. The failure of this program was due to lack of adequate field staff and proper guidance to the community. Frequent report of water and vector borne diseases and out breaks of epidemics appearing in the media reflects the failure of this program. Diarrhoeal diseases, the primary cause of early childhood mortality, are linked to inadequate sewage disposal and lack of safe drinking water (The Prajnopaya Foundation, 2011). These

diseases can be attributed to poor sanitation and inadequate safe drinking water in India (US Library of Congress 2011).

As such, a Primary Health Centre is expected to and entrusted with the job to pay special attention to control these dreadful endemic diseases. But the recent picture of endemic diseases in Kerala reveals the unhygienic environmental conditions exist here. Shortage of field staff, lack of technical assistance and proper guidance are the main reasons for that. The performance of the PHCs can be largely improved if active participation of local community in the implementation of this program is secured through creative and sustaining measures.

Disease surveillance and Control of epidemics are an essential part of the functions of PHCs. The emerging and re-emerging communicable disease profile indicates the failure of this objective realization. Much remains to be done in this area. One of the important causes for this sad state of affairs is the high vector density in this region. Further more, the heavy influx of people from the north to this small state in search of jobs, especially of the construction labour creates formidable problems in the field of hygiene causing severe environmental pollution. since most of them come from endemic prone of areas like Bihar and Orissa, they carry the viruses with them and

become a source of transmission of diseases such as Malaria, Filaria, Dengue, Chikungunya and Japanese encephalitis. Dr. Jacob John, former head of the Virology division at the Vellore Medical College in Tamil Nadu and an acknowledged authority on virology in South India, pointed out, at a seminar on the threat of epidemics in the state conducted by the Malayala Manorama in Kottayam city, Kerala that many epidemics are staging a come back in Kerala. According to Dr Jacob John, lack of public action and the break- down of the public health care system are the main reasons for the re-emergence of epidemics in Kerala. N.P Chekutty's (Infochange, 2011) report on failure of Kerala's reputed public health care system reveals that one of the important reasons attributed to the return of many epidemics to Kerala is erosion of the grass root level public health care system that is Primary Health Centers. Pylore Krishnaier Rajagopalan, who was head of the Government Vector Control Research Centre in the southern city of Pondicherry between 1975 and 1990, blames policies that concentrate on the latest scientific techniques and not enough on basic controls. "Field work is almost dead," Rajagopalan says. "These mosquitoes are sun loving. How can a shade-loving, lab-bound, white-coated scientist control the mosquitoes through research? It may be the future but millions of people in India are suffering and dying now because we're

not doing the basics." An article titled “Understanding Government Failure in Public Health Services", published in the influential Economic and Political Weekly in October (2010) bewails that the system of public delivery of health services in India today is in crisis and points out that a high absenteeism, low quality in clinical care, low satisfaction with care and rampant corruption plague the system."

To Conclude:

The study on the “Efficacy of Primary Health Centers for the promotion of community health in Kerala with special reference to Ernakulam District” reveals the fact that the existing infrastructure facilities, manpower and services are inadequate to meet the primary health needs of the community and it has no valid role in the promotion of the health of people in the area of study.