CHAPTER VI

ADMINISTRATION OF PRIMARY HEALTH CENTRES - A CASE STUDY
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There are many ways of achieving adequate primary health care. Normally the size, levels, functions, standards, staffing and economics of primary health care units vary according to local circumstances, the people's state of health and the level of the socio-economic development. Primary health care can be considered to have two sections: a macro-system and a micro-system. The former consists of such functions and areas as finances, national planning, organisation, manpower development and linkage with secondary and tertiary care. The latter comprises organisation for primary health care delivery units using appropriate health technology. Thus the primary health centre (PHC) is the nucleus institution which serves the central purpose of originating and disseminating all activities related to the delivery of primary health care.

The concept of the PHC as an institution to provide curative, preventive and promotive services can be traced to the report of the consultative council on medical and allied services in 1920 in England under the Chairmanship of Lord Dawson of Penn. Also, provision of rural health services through Rural Health Centres was recommended by the Health Interim Report on the Future of Medical and Allied Services, Ministry of Health, England and Wales, H.M. Stationary Office, London, 1920.
Organisation or the League of Nations. It defines the Rural Health Centre or the PHC as an institution for the promotion of health and welfare of the people in a given (rural) area, which seeks to achieve its purpose by grouping under one roof or co-ordinating in some other manner, under the direction of a Health Officer, all the health work of that area, together with such welfare and relief organisation as may be related to the general public health work.\(^2\)

The concept gathered momentum in socialist countries. The inter-governmental conference for Eastern countries, convened at Bandung, under the auspices of the 'League of Nations, recommended the integration of preventive and curative services and gave preference to curative services.\(^3\) The concept spread to other countries after the Second World War. In India, the Bhore Committee in 1946 recommended for the first time that a PHC should be set up to serve as the focal point for providing comprehensive curative and preventive health services in the rural areas.\(^4\) And the first PHC in Tamilnadu was established in 1948 in South Arcot District. The role and dimensions of the PHC began to develop along with the growth of the general socio-economic conditions and the health sector.


Eventually the PHC began to evolve into the most significant and relevant institutions in the rural areas to provide the much-needed medical care to the rural population and to enhance the general environmental conditions at the village level. The PHC was construed to be the most powerful and dynamic nucleus component of the public health system by virtue of its arduous responsibilities in terms of the upkeep of the physical quality of the individual and the sustained protection and improvement of the general conditions of the community as a whole. The PHC was supposed to constitute the optimum blend of the curative and preventive services.

The PHC, if properly staffed is supposed to provide the following principal services:

1. Treatment of simple diseases and short illnesses by out-patient care.

2. Initial treatment of serious illness pending referral to a bigger hospital.

3. After care, if required, of patients discharged from hospital.

4. Participation in immunisation and community health and nutrition programmes, including control schemes for communicable diseases by mass treatment for example, cholera, malaria, etc.
5. Maternal and child health work, including antenatal, delivery and post-natal care. 5

Unfortunately the general neglect of the 'preventive' aspects of the public health structure has made it possible for only a distinct minority of PHCs to be able to accomplish the objectives mentioned above. The major constraints are generally those of manpower and supplies, of drugs rather than buildings. Nevertheless the establishment of these nucleus units is imperative. At the time of their original conception, these centres represented a significant departure from the curative orientation of the existing hospitals and dispensaries. It was hoped that they would play an increasing role in raising the general standard of health of the rural population. The accent of work in the PHC was to be placed on improving standards of health rather than mere treatment of disease. The staff of the PHC was expected to spend as much time out of the centres as in them. Within the Centre the staff would provide the following services:

1. Simple out-patient care including examination, diagnosis and simple laboratory investigations.

2. Comprehensive maternal and child health services including ante-natal examinations, health education to mothers, delivery facilities and child clinics.

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3. The rural sanitarians and his staff would provide continuous services for health education of all kinds, but particularly in environmental hygiene.

4. A limited in-patient service for acute illness. Only a few beds would be provided for in-patient care as this was seen to be a minor function of the centre.

The services to be conducted outside the health centres were to be even more significant in scope than the work done inside as follows:

1. Cover with supporting activity at five or six of the nearest dispensaries, working with the staff in each dispensary, teaching new techniques and training in standard methods as well as helping to organise immunisation and other community health programmes.

2. Spending time searching for infective diseases, examining local water supplies and being involved in discussions on improving health.

3. Involvement in disease surveys and collection of accurate statistics.
4. Building up a complete picture of the living conditions, customs, ideas, etc. of the people in area surrounding the health centre.

5. Helping to put into practice whole aspects of environmental sanitation. This requires constant support to villages so as to be able to work with the people in understanding the purposes behind a particular scheme.

6. Provide school health services in all the surrounding areas. This includes physical and laboratory examinations of apparently healthy school children. Immunisation schemes and health education should form a major part of such services.

7. Maintaining co-operation with other agencies that can be of help in health maintenance schemes, and also to assist these agencies in their own work when necessary.

It was thought that in the longer run the work of the health centres would change the thinking of the average person in regard to the prevention of disease as opposed to its cure and thus change the actual health conditions of the population surrounding the health centres.

Thus, the PHC is a multipurpose unit established at the peripheral level to render preventive and curative medical services to the community and to build up in course of time, the positive health of the community. The Manual of Operation for PHC's states that with the responsibilities devolving more and more on local authorities, the PHCs will have an increasing role to play as a technical adviser to those bodies and they would be looked upon as Public Health Institutions to study public health problems in rural areas in some detail to seek solution for the same, and to evaluate the programmes under way.  

It was envisaged that the PHC will co-ordinate its activities with that of the specialised services - such as water supply and drainage and work in close collaboration with such agencies at the Block level. Above all it was to work in close co-ordination with the Taluk and District Headquarters hospitals so that a satisfactory system of referral of patients from PHCs to these institutions for higher medical care can be evolved.

Above all the PHC is charged with the most arduous responsibility of activating and mobilising the local rural community to participate in the improvement of its health and its well-being.

environmental conditions. Thus the health unit, though primary in nature, plays a pivotal role in protecting and enhancing the health of the rural community.

In Tamilnadu, each primary health centre presently covers a population of 85,000 to one lakh, which is quite unwieldy, thereby affecting the efficiency of the centres and overtaxing the staff of the primary health centre. Tamilnadu is yet to achieve either the short term or the long term targets of population coverage as recommended by the Shore Committee in 1946. Further the staff pattern of the Primary Health Centre has remained relatively constant since the Shore Committee recommendations as indicated by the table below: 9

<table>
<thead>
<tr>
<th></th>
<th>1946</th>
<th>1982</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Officers</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Public Health Nurses</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Midwives</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Trained Dais</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Public Health Inspector</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Health Assistants</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Clerks</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Fitter Maistry</td>
<td>1</td>
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</tr>
<tr>
<td>Inferior Servants</td>
<td>15</td>
<td></td>
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</tbody>
</table>

In order to study these aspects and identify those problem areas in the working of a typical PHC, a case study was undertaken at the PHC at Elionur in Chingalpet District of Tamil Nadu.

Case study is one of the most important and authentic methodological tools of research, which involves the selecting of and isolating a single unit of a whole as a sample to analyse thoroughly and in detail. Most social issues involve a vast area or great number of subjects and variables which constitute the components of a given situation at a given time and place. The study or investigation of such issues in their totality may be deterred by constraints of time, resources and manpower.

The objective of the case-study method is to single out a particular area or a specific entity for the purpose of drawing inferences after careful scrutiny and applied as generalized facts with regard to the larger area of which it is a part. In short, it is the derivation of inferences from a micro-perspective to adduce generalisations in a macro sphere. The representative character of the isolated element which constitutes an integral and an intrinsic part of the larger fabric and the in-depth analysis of it from a multi-dimensional perspective validates the subsequent generalisations. Thus the features and
characteristics of the part is empirically decided as belonging to the whole. Thus the case-study facilitates the comprehension and examination of any phenomena of enormous proportions.

The specific aims in conducting this study were —

i) to gain a first-hand overview of the functioning of a primary health centre from the organisational perspective;

ii) to identify the problems and bottlenecks, if any and their nature, in the optimal achievement of the primary health goals;

iii) to study the degree of community participation and the extent to which the PHC fulfils this aspect of primary health care; and

iv) to suggest remedial measures and an alternative strategy, if necessary.

The entire contingent of the staff of the PHC and the members of the community were interviewed with a structural interview schedules. The respondents were selected through simple random sampling from Alipur Village proper where the PHC is located and a village that is 7 km away from the PHC. The areas of activity evaluated were general out-patient and in-patient care
maternity and child care, environmental sanitation, specific communicable disease control and general unit organisation.

The Centre was selected mainly because of its unique location. It formed the only medical and health institution within the Block area with irregular and infrequent transport facilities. Alichur village is situated in the Munarthur Block of Sriperumbudur taluk in Chingleput District, 75 km from Madras City. Munarthur Block covers an area of 93.39 sq. km. with a population of 1.19 lakhs. It consists of 46 panchayats with 86 revenue villages and 26 hamlets. Alichur PHC covers 3,840 houses and 933 households with an average of 6 members in each family and functions with nine sub-centres. 10

80 per cent of the population of Alichur village is made up of agriculturists and cultivators, 12 per cent are industrial workers and the rest are involved in small trade or occupied in office in the cities. Hindus constitute the dominant majority. The major castes are naickers 45 per cent, granamis 22 per cent, archagars (temple priests) 4 per cent. The scheduled castes and scheduled tribes constitute 20 per cent. 11 Though the Brahmin strictly adhered to the traditional norms and religiously maintained the sanctity of the 'agrhrams', there was not much segregation nor prejudices based on communal feelings.

11. ibid.
About 52 per cent of the population is literate with males and females constituting 32 and 18 per cent respectively. The literacy rates for scheduled castes and scheduled tribes were 8 per cent. There were 57 elementary schools, 20 higher secondary schools and 5 high schools in the Block. About half of the villages in the Block consisted of population of 1000 to 5000 and about 13 per cent of the villages have a population of less than 500. The population density is 295 per sq.km. The vital rates available for the Block according to the sample registration are:

- Birth rate: 30.5
- Death rate: 12.21
- Infant mortality: 123.04 per 1000 live births

Environmental conditions were adversely affected due to lack of adequate drinking water supply. The Elichur village consisted of 3 wells and a pond. These were used for assorted purposes from bathing to washing the cattle. There was no proper water system and open air defection was quite common. There was not adequate drainage facilities. It was observed that the panchayat union staff regularly chlorinated all the sources of drinking water.

The Elichur Panchayat Union was formed in April 1959 and the Elichur PHC was established in December 1962. The Centre
was initially located in a maternity centre till regular
buildings were put up. The location of the PHC i. e. perhaps the
most significant factor in this regard. The Alichur PHC was
located at the southern most tip of the Kunrachur Block on its
south-western border. This violated one of the basic principles,
that the PHC should be located at the centre of the Block, at
least approximately. It was observed that this was a major
deterrent in effectively extending the health coverage of the
PHC throughout the Block. 83 per cent of the out-patients who
were attended to at the PHC were from the immediate vicinity of
Alichur village. Most villages in the cutlying areas of the
Block either solely depended on the auxiliary staff of the PHC,
the mobile unit or went to the taluk or district headquarters
hospitals at Kanchi or Chincheluput. The historical reasons for
the location of the PHC is a significant comment on the extent
of local influence playing a vital role in these establishments.
The PHC was initially functioning as a rural dispensary at
Vadukapattu, a village 6 kms away from Alichur. However, there
was no offer to denote or make available any land on the part
of the local residents to expand it to a PHC. A survey of the
Block revealed that this was at an extreme end of the Block and
therefore inconducive for the establishment of a PHC.
However, in 1960, an offer was made by a resident of Blichur village, one Mr. Manicka Mudaliar, to donate adequate land if the rural dispensary at Vadukapattu was transferred to Blichur as a PHC. This was the first offer made in Munrathur Block. Mr. Manicka Mudaliar possessed substantial landholdings both agricultural and non-agricultural in and around Blichur. He also wielded considerable political clout with the then Congress Ministry in the state. Mr. Mudaliar, however, was motivated more than mere philanthropic sentiments. He presciently realised that the location of a health centre would be a justifiable reason to increase the transport and communication facilities to the village, which would enhance the real estate value of his lands which were to be disposed.\(^1\)\(^2\) He succeeded in his manoeuvre and the centre was established in Blichur village.

**Organisation**

The staff contingent of the PHC consists of the general wing and family welfare wing. One Medical Officer including a woman Medical Officer was attached to each wing, along with a third Medical Officer. The senior-most Medical Officer was designated as Medical Officer-in-Charge and was given the charge of the overall administration of the PHC. The entire complement

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12. Interviews with former Panchayat Union leaders and perusal of the Panchayat records at the Block Development Office, Munrathur.
of the PHC staff were under his control, the staff could be generally classified into the preventive or the field staff and the institutional staff. The field staff consisted of the Health Inspector, Health Visitors, health workers, Vaccinators, auxiliary nurse midwives. These staff toured the sub-centres and the villages regularly. The laboratory assistant, store-keeper, public health nurse, pharmacist, cook-cum-waterman, junior assistant-cum-typist assisted the medical Officer at the PHC.\textsuperscript{13} The PHC also has a mobile unit wherein, the Medical Officers undertake tours of the villages everyday by taking turns especially to the remote corners of the block.

Acute shortage of auxiliary field staff was a major deficiency in the organisation of the PHC. This was more pronounced in the running of the sub-centres. 2 AHS and 5 Health Visitors had to cover 9 sub-centres each involving a walking distance of 6 to 8 km. One of the other factors found responsible for the inadequacies in the service was a lack of correspondence between the training of the staff and their actual work; trained personnel were performing routine tasks that could have been done by staff who were less qualified, while on the other hand some staff were expected to perform activities for which they were not properly trained. The Medical Officer at the Centre observed that this was partly due to the absence of well demarcated areas of responsibility of the rural health workers.

\textsuperscript{13} Vide Appendix XV for duties and responsibilities of the important staff of the PHC.
The curative and preventive responsibilities of the medical officers were also not properly and sufficiently programmed. The Medical Officer-in-Charge was burdened with the general administration of the PHC which included pay disbursements, drafting and consolidating reports coupled with the medical responsibilities which included attending the out-patient clinic at the PHC and undertaking tours with the mobile clinic. All the three medical officers, for all intents and purposes were completely involved in clinical services. This was, however, due to the heavy demand on the part of the patients. 83 percent of the respondents also stated that they expected only curative services from the medical officers.

The out-patient services were conducted at the centre in the morning and in the evening. The morning session started at 7.30 a.m. and was busier of the two sessions with about 200 to 250 patients attending the clinics. The evening session began at 3.30 p.m. and was attended by about 100 to 150 patients. Both the out-patient clinics were attended to by one male and one woman medical officers. The doctors observed that these services were too crowded, thereby preventing them from involving in any interaction with the patients, more than what was required to diagnose them and to prescribe the required drugs. It was also observed that no other staff member of the PHC was involved
in any sort of health advice or education to the patients who
visited the PHC either due to their non-availability or lack of
time. Each out-patient session lasted for an average of two to
three hours, thus occupying most of the time of the Medical
Officers in curative and clinical services.

However, 99 per cent of the patients interviewed at the
out-patient clinics expressed their fullest satisfaction with
the treatment and other clinical services provided by the Medical
Officers and the other institutional staff of the PHC.

Programmes

A vital sphere of activity in the functioning of the PHC
is the provision of preventive services. The on-going programmes
implemented at the Ghorah PHC included -

1. Family welfare
2. Maternal and Child Health services
3. School health
4. Control of communicable diseases (Malaria,
tuberculosis, Guinea worm control,
leprosy control) and
5. Health Education.
Again, the major deficiencies in the implementation of the programme were the lack of trained staff, transport, basic drugs and above all the right proactive strategy. The main thrust of the Family Planning scheme lies merely in performing tubectomy and vasectomy operations. There is a perceptible neglect of the effort to create a changed family view among the eligible couples. Even the distribution of contraceptives is almost non-existent and the emphasis is more on the incentive schemes for those who undergo the operations. This problem however is connected to the ANC services, for in a subsistence economy infant mortality has a direct bearing on the increase of pregnancies. The study analysed that only 23 per cent of the delivery cases were institutionally attended. Of the 75 per cent that were delivered at home, only 43 per cent were attended to by the PHC domiciliary staff. About 250 emergency maternity referrals had been made after the onset of labour. Some 90 per cent were found to be for conditions that might have been anticipated through ante-natal detection of risk factors. This despite the fact that maternity care was generally found to be one of the better elements in the rural health service.

Maternity care was a vital area that needed substantial toning up. Only 23 per cent of the delivery cases in the village took place at the PHC i.e. were institutionalised. Of the rest
43 per cent of the cases were attended to by the maternity assistants of the PHC. The rest were either unattended or resorted to local village assistance of traditional leaders who indulged in unscientific and unhygienic measures, thereby jeopardising the health of the mother and the child.

63 per cent of the respondent authors observed that they were not provided with continued ante-natal and post-natal care. This lack of interaction between the mothers and the field staff of the PHC was a major factor in the low percentage of institutionalised and recorded births.

The primary defect regarding most of the health programmes is that systematic and regular records along with the follow-up action have not been maintained properly. Except for the routine statistics which provide the number of cases immunised under each programme, there is no co-ordinated system of planning the programmes and the logistics based on these data. Further there is no clear relationship between the quality of care and the cost per patient contact or the overall assessment of the resource adequacy.

COMMUNITY PARTICIPATION

The major difficulty in achieving effectively the objectives of the primary health care programmes is the meagre involvement
of the community in the health care process. Primary health care must be accessible and acceptable to the people who need it. As the acceptance of many health measures may involve a change in living habits, the community itself must decide on the measures, help in carrying them out and evaluate their success. Basic health care can be given by ordinary people, provided they have adequate education, training, technical advice and supervision.

It follows that there must be a clearly defined relationship between the two components of frontline health care - the activities carried out by the government and those carried out by the people themselves. The relative contribution of each of the two partners to health care activity as a whole should be determined by the political and socio-economic situation in the given area.

It was observed that the four major factors which proved as obstacles to community participation of this kind in the Kichur village and in the Annurthur Block in general were -

1. Lack of adequate institutions of local self-government, a prerequisite to local involvement in health development in general.

2. Relatively rigid sectoral structure and clinical orientation of the Primary Health Centre.
3. Failure on the part of the staff of the PHC to establish intimate rapport with the village population, and

4. The system of beliefs in terms of religion, caste, superstition, etc. of the rural communities.

Contacts between the PHC and the local administration such as the Panchayat or the block development office were restricted to very limited areas. This was also because till 1980, the health assistants who were responsible for manning the sub-centres were paid out of the panchayat union funds, under the technical control of the PHC. But this arrangement was repealed when all the staff of the PHC was brought directly under the control of the Medical Officer.

Such an absence of interaction between the PHC and local authorities greatly affected the community participation in the health activities. This was accelerated when the Panchayat Union Councils were dissolved. Community participation was to a great extent the result of an interface between the PHC which is an executive unit at the local level and the panchayats which were the political and representative entities at that level.
such an inadequacy led to the erosion of local initiative to motivate or generate any public enthusiasm. 96 per cent of the respondents agreed that they were prepared and even felt the necessity for participating in the health process, but expressed strong inhibitions in that they lacked proper initiative and leadership. Presently the opportunity to provide that initiative rested only with the PHC field staff. No such initiative was forthcoming from the staff who acted more as surveillance agents amongst the community. There was no permanent or temporary health committee or committees found either at the Block level or at any of the village levels. Though the accent of the work in the health centre was to be placed on improving standards of health rather than treatment of disease.

While inadequate auxiliary health personnel is one reason for this, the more important factor concerned is the lack of a better assessment of the health climate of the area and directing the efforts of the health personnel accordingly, in keeping with a need-based plan of curative and preventive services. This is associated with the earlier mentioned problem of absence of adequate health information.

The available records of the PHC reveal that 80 per cent of all the activities of the health centre relate to only about 10 symptoms. It is remarkable that the four most prevalent
symptoms are the same everywhere throughout the area - coughs, fever, wounds and helminthiasis or worms. These represent more than half of the complaints encountered in the Ellichur PHC and in the field clinics as whole.

The following list shows the ten symptoms that are most frequent in the Kunrathur Block area and their percentage:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coughs</td>
<td>60%</td>
</tr>
<tr>
<td>Scabbes</td>
<td>53.2%</td>
</tr>
<tr>
<td>Proxja of unknown origin or common fevers</td>
<td>51%</td>
</tr>
<tr>
<td>Wounds and common injuries</td>
<td>46%</td>
</tr>
<tr>
<td>Helmi thilises</td>
<td>40%</td>
</tr>
<tr>
<td>Rheumatic pains</td>
<td>33%</td>
</tr>
<tr>
<td>bilaniasis</td>
<td>30%</td>
</tr>
<tr>
<td>Headache</td>
<td>27%</td>
</tr>
<tr>
<td>Pelvic pains</td>
<td>23%</td>
</tr>
</tbody>
</table>

Most of these conditions are preventible or require simple treatment and medicines. A correspondence of the disease pattern with the population feature proves that a proportionate distribution of the health staff in accordance with the specific needs...
of the area and the population density would facilitate the auxiliary and the medical staff to concentrate more time on the field and establish greater community contact instead of being confined more to the centre.

Another important set of factors was the inadequate support, technical supervision and referral facilities from the higher levels of health services such as taluk and district headquarters hospitals. Quite in contrary to the principles of primary health care, there was an obvious lack of integration between the PHC and other units of health services and other governmental agencies. A key factor in improving the efficiency of the field staff in implementing the programmes would be to plan the delivery of care of the field health services in terms of the geographic accessibility rather than in terms of the numbers of people per health unit or per health worker. Given the uneven distribution of the population, such ratios obscure the real problems of achieving effective population coverage. The population of the Block is distributed with 50 per cent of the villages comprising of a population of 1000 to 5000, 22 per cent with a population of 500 to 1000 and rest with a population of less than 500.  

directly associated with this issue is that of the supply of drugs and medicines to the PHC. A major problem in this area is that a uniform policy of drug distribution was followed throughout the state. This resulted in a surplus of a certain variety of drugs that were not required at the Centre and a shortage of those that were most in demand. The medical officer at the Aligarh PHC observed that a large quantity of hypertension drugs such as 'Methyl Dop' and 'Dejixin' were supplied in large quantities, while anti-biotics which were most required to treat the observed symptoms in the area were in perennial shortage. The medical Officer did not possess the discretionary authority to indent for only those drugs that were deemed necessary to meet the requirements of the PHC.

Financial constraints proved to be one of the major problems in efficiently administering the PHC. The general allocation for drugs is Rs. 12,000/- per month which proves to be grossly inadequate to meet the drug requirements of the area. The medical Officer is empowered to spend only upto Rs. 200/- from the PHC fund beyond which the sanction of the PHC is required.

Further the medical Officer was provided with a contingency amount of only Rs. 25/- per session. However, any expenditure incurred on emergencies by the medical Officer was reimbursed