CHAPTER VI
Chapter VI
Reforms in Khurda and Sundergarh

Introduction:
As we have mentioned earlier that for this study we had selected two developed districts of Orissa, Sundergarh and Khurda, to look at the process and experience of health sector reforms. In this chapter we have also discussed about the socio-economic and demographic indicators of these two districts. Besides we have also presented a picture about the health care services structure in these districts. These two districts were selected on the basis of a ranking by National Commission on Population in terms of various socio economic and demographic indicators. Among the 30 districts of Orissa, Sundergarh was ranked 3rd, followed by Khurda at 4th. The first rank was of Cuttack with a composite index of 63.24 and 197 all India ranking followed by Jharsuguda at second rank with a composite index of 63.21 and all India ranking of 199.

Socio-economic and demographic indicators:
To improve the health status of a population, apart from the availability of better health care services, the socio-economic and the demographic indicators also play a crucial role. Therefore let us have a look at the socio-economic and demographic indicators of these two districts below. The table shows that in terms of decadal population growth rate Sundergarh was way ahead of Khurda with 161 in all India ranking. However in terms of percentage of birth order 3 and above Khurda was performing much better with 34.70 percent compared to Sundergarh with 44.00 percent. In terms of current users of family planning methods Khurda with 61.8 percent was way ahead than Sundergarh with only 49.20 percent. In terms of girls marrying below 18 years of age, Sundergarh with 17.00

356 National Commission on Population, District Wise Indicators, Government of India, 2001. The ranking of 569 district of India were conducted on a composite index and separately for each of the 12 indicators. These 12 indicators were, 1- Percentage of decadal population growth rate, 2- Percentage of births of order 3 and above, 3- Percentage of current user of family planning methods, 4- Percentage of girls marrying below 18 years of age, 5- Sex ratio, 6- Percentage of women receiving skilled attention during deliveries, 7- Percentage of children getting complete immunization, 8- Female literacy rate, 9- Percentage of villages not connected with pucca road (estimated), 10- Percentage coverage of safe drinking water and sanitation (estimated), 11- Percentage of Birth registered (estimated), 12- Percentage of Death registered (estimated).

357 Ibid.
358 Demographic indicators in terms of number of births and number of deaths each year etc.
percentage points was a better performing district compared to Khurda with 23.4 percentage points.

**Table: 6.1 Socio-economic and demographic indicators of two study districts**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Sundergarh</th>
<th>All India</th>
<th>Khurda</th>
<th>All India</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of decadal population growth rate</td>
<td>16.26</td>
<td>161</td>
<td>24.79</td>
<td>384</td>
</tr>
<tr>
<td>Percentage of births of order 3 and above</td>
<td>44.00</td>
<td>260</td>
<td>34.70</td>
<td>152</td>
</tr>
<tr>
<td>Percentage of current user of family planning methods</td>
<td>49.20</td>
<td>258</td>
<td>61.8</td>
<td>113</td>
</tr>
<tr>
<td>Percentage of girls marrying below 18 years of age</td>
<td>17.00</td>
<td>145</td>
<td>23.4</td>
<td>187</td>
</tr>
<tr>
<td>Sex ratio (Number of Females per 1000 males)</td>
<td>957</td>
<td>205</td>
<td>901</td>
<td>420</td>
</tr>
<tr>
<td>Percentage of women receiving skilled attention during deliveries</td>
<td>48.90</td>
<td>257</td>
<td>65.9</td>
<td>166</td>
</tr>
<tr>
<td>Percentage of children getting complete immunization</td>
<td>80.20</td>
<td>112</td>
<td>62.8</td>
<td>245</td>
</tr>
<tr>
<td>Female literacy rate</td>
<td>54.25</td>
<td>268</td>
<td>71.06</td>
<td>74</td>
</tr>
<tr>
<td>Percentage of villages not connected with pucca road (estimated)</td>
<td>81.71</td>
<td>547</td>
<td>75.18</td>
<td>530</td>
</tr>
<tr>
<td>Percentage coverage of safe drinking water and sanitation (estimated)</td>
<td>100.00</td>
<td>100</td>
<td>90.32</td>
<td>181</td>
</tr>
<tr>
<td>Percentage of Birth registered (estimated)</td>
<td>76.44</td>
<td>200</td>
<td>65.66</td>
<td>257</td>
</tr>
<tr>
<td>Percentage of Death registered (estimated)</td>
<td>62.37</td>
<td>187</td>
<td>39.11</td>
<td>327</td>
</tr>
<tr>
<td>Composite Index</td>
<td>62.37</td>
<td>209</td>
<td>61.09</td>
<td>223</td>
</tr>
</tbody>
</table>


The sex ratio of Sundergarh with 957 was much higher than Khurda with a sex ratio of 901. However, in terms of percentage of women receiving skilled attention during deliveries, Sundergarh with 48.90 percentage points was much below Khurda with 65.9 percent. On the other hand, in terms of percentage of children getting complete immunization, Sundergarh with 80.20 percent was much better performing than Khurda with 62.8 percentage of coverage. The indicators for female literacy rate show that Khurda with 71.6 percent was much better performing than Sundergarh with 54.25 percent.
In terms of percentage of villages not connected with pucca roads, Sundergarh with 81.71 percent was a low performer compared to Khurda with 75.18 percent. The figures for percentage coverage of safe drinking water and sanitation show that while Sundergarh had 100 percent coverage, Khurda had 90.32 percent of coverage. In terms of percentage registration of births and deaths, Sundergarh was way ahead of Khurda. Finally in terms of composite index, Sundergarh with 209th rank was ahead of Khurda, which had 223rd rank out of the 569 districts in India.

Now let us have a look at the health care services structure and experience of reforms in the two study districts of Sundergarh and Khurda. Here we would also be discussing about strengths and weaknesses in the health services in these districts.

**Sundergarh district: A profile**

The Sundergarh district was located in the northwestern part of Orissa, with a geographical area of 9712 square kilometers, which was 6.24 percent of the total land areas of Orissa. It had 17 community development blocks, 9 towns, 4 municipalities, 262 grampanchayats and 7 assembly constituencies. According to the 2001 census of India, it had a total population of 1829,000, which was 4.98 percent of Orissa’s total population. It had urban population constituting 34.38 percent of its total population, which was higher than all India average and a population density of 183 per square kilometer. Thus the population density shows that people were scarcely distributed. Further 7.54 percent of its population was scheduled castes and 43.63 percent of its population was scheduled tribes and it had a sex ratio of 957. Therefore maximum numbers of people were tribals in this district. While it had average literacy rate of 65.22 percent, among the scheduled castes the literacy rate was only 43.86 percent and among the scheduled tribes

---

359 Here it needs to be mentioned that we have not asked questions separately with regard to 'systemic changes' and 'health sector reforms' to our respondents at the district level. However in our analysis we have made a distinction.


361 The percentage of scheduled castes and scheduled tribes were based upon 1991 Census of India. All the 17 blocks of this district were tribal blocks.

362 The sex ratio or females per 1000 males was based on 2001 Census of India.
The literacy rate was 37.34 percent. Therefore while the scheduled tribes constituted the largest section of this districts total population, they were at the bottom in terms of literacy rate.

**Health care services structure in Sundergarh District:**

To understand the health care services structure is an important aspect to determine the implications of health sector reforms because if the structures of provisioning perform to an optimum level than different initiatives for health sector reforms would show positive results. Therefore let us first look at the health care services structure in Sundergarh district.

**Table: 6.2: Medical Institutions (allopacy) in Sundergarh District**

<table>
<thead>
<tr>
<th>Medical Institutions</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHH</td>
<td>2</td>
</tr>
<tr>
<td>SDH</td>
<td>2</td>
</tr>
<tr>
<td>UGPHCs</td>
<td>2</td>
</tr>
<tr>
<td>Area Hospitals (Other Hospitals)</td>
<td>3</td>
</tr>
<tr>
<td>CHC I</td>
<td>7</td>
</tr>
<tr>
<td>CHC II (Under OHSDP)</td>
<td>5</td>
</tr>
<tr>
<td>PHC</td>
<td>6</td>
</tr>
<tr>
<td>PHC (New)</td>
<td>54</td>
</tr>
<tr>
<td>Mobile Health Units</td>
<td>1</td>
</tr>
<tr>
<td>Total Medical Institutions</td>
<td>82</td>
</tr>
<tr>
<td>Sub Centres</td>
<td>345</td>
</tr>
<tr>
<td>No. of Beds</td>
<td>611</td>
</tr>
</tbody>
</table>

Note: DHH: District Head Quarter Hospital, SDH: Sub Divisional Hospital, UGPHC: Upgraded Primary Health Centre. Area Hospital- All these area hospitals were of 6-bedded institutions. In Orissa a PHC or a CHC I were headed by an MO, who was a Class II officer whereas a CHC II was headed by one Class I officer.

*Source: Field Work, 2005.*

The table shows that, there were two district headquarter hospitals, two sub divisional hospitals, two UGPHCs or Upgraded Primary Health Centres in Hemgiri and Subdega blocks and both were block headquarter institutions. There were three area hospitals.

---

363 While the figures for average literacy rate of the district were from the 2001 Census of India, the figures for scheduled castes and scheduled tribes were from 1991 Census of India.
364 They were, in Bankibazar of Gurundia Block, Bilaimunda of Hemgiri Block and Surda of Nuangaon block.
The staff structure in CHC I institutions were, one MO in-charge, one assistant surgeon, three specialists (Gynec, Pediatrics and Orthopedic), one pharmacist and two staff nurse. However in Rajgrampur CHC I there were 8 staff nurses. The staff structure and bed strength in CHC II was same, as in CHC I, however under OHSDP the bed strength in Kuarmunda and Birmitrapur CHC II had been increased to 16 beds. All the CHC IIs' were under OHSDP. There were 6 block level Primary Health Centres, 54 PHC News and 345 Sub Centres\(^{367}\) in the district. In total there were 82 medical institutions and 611 public beds in the district. Among the Sub Centres only 154 had government buildings and the remaining 191 were supposed to be functioning in a rented building\(^{368}\). There was one mobile health unit in the Lephripa block.

According to the Orissa government norms there should be one CHC I or CHC II above 30,000 populations and below it a PHC New institution should be there. Under RCH II government of India was planning to introduce one sub centre per 1,000 populations as against the existing norm of 3,000 populations. However it was observed that in many places these institutions were covering population almost double than their mandatory requirements. At nowhere it was found that an institution was serving less number of populations than either the Orissa government norms or the all India norms.

**Vacancies in various posts:**
The existing manpower in different layers of health care services is a significant aspect of effective functioning of health care services structure. Therefore it was important to look at the then existing manpower in terms of different categories in Sundergarh district. The

---

\(^{365}\) They were in Rajgrampur, Sargipalli, Bargaon, Kutra, Bisra, Lahunipada and Koida and all these institutions were of the same block. Except in Rajgrampur all had Sub Centres and PHC News'. The earlier hospital in Rajgrampur had been converted to a 40-beded CHC I.

\(^{366}\) They were located in Mojhapara of Sadar block, Mangaspur of Tangarpali block, Kinjhirkela of Balisankara block, Kuarmunda of Kuarmunda block and Birmitrapur of Kuarmunda block.

\(^{367}\) For one Sub Centre building Rs 3 lakhs was provided along with 4-5 decimal areas. One Sub Centre building consisted of one - resident building with 2-bed rooms, one-latrine, one - bathroom and one - kitchen and two other rooms, one for office and another for delivery.

\(^{368}\) Interviews with ANMs made it clear that when the sub centres were in ‘rented’ buildings it meant it did not function at all!
table below gives a picture of different categories of posts in terms of sanctioned strength, in position and clear vacancy.

**Table: 6.3 Vacancies in various categories of posts in Sundergarh District**

<table>
<thead>
<tr>
<th>Posts</th>
<th>Sanctioned Strength</th>
<th>In Position</th>
<th>Clear Vacancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sr. Class I</td>
<td>11</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Jr. Class I</td>
<td>25</td>
<td>18</td>
<td>7</td>
</tr>
<tr>
<td>Class II Specialists</td>
<td>36</td>
<td>27</td>
<td>9</td>
</tr>
<tr>
<td>Asst. Surgeon</td>
<td>138</td>
<td>129</td>
<td>9</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>98</td>
<td>97</td>
<td>1</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>25</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>MPHW (M)</td>
<td>241</td>
<td>220</td>
<td>21</td>
</tr>
<tr>
<td>MPHW (F)</td>
<td>430</td>
<td>397</td>
<td>33</td>
</tr>
<tr>
<td>MPHS (M)</td>
<td>90</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>MPHS (F)</td>
<td>55</td>
<td>54</td>
<td>1</td>
</tr>
<tr>
<td>Radiographer</td>
<td>10</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Lab. Technician (Pathology)</td>
<td>29</td>
<td>29</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: MPHW (M): Multi Purpose Health Worker, Male, MPHW (F): Multi Purpose Health Worker, Female, MPHS: Multi Purpose Health Supervisor.

It shows that in terms of the Senior Class I posts, out of 11 sanctioned strength, 8 were in position and 3 posts were vacant. Similarly for the Junior Class I posts, out of the sanctioned strength of 25, 18 were in position and there were 7 vacancies. In Class II Specialists’ category, out of the sanctioned strength of 36, 27 were in position and 9 posts were vacant. In case of Assistant Surgeons, out of the sanctioned strength of 138, 129 were in position and 9 posts were vacant. However in case of Staff Nurse, only one post was vacant, out of the total sanctioned post of 98.

As we have mentioned earlier that the Senior Class I officers were heading CHC II institutions and hence if 3 posts were vacant in this category than it suggest that 3 of these institutions or such type of institutions were functioning without a head and as a result the smooth functioning of these institutions must have been difficult. The vacancies in the categories of Junior Class I, Class II Specialists and the Assistant Surgeons suggest that these posts were vacant in PHC and CHC level institutions and hence these required
immediate attention. Significantly in the category of Staff Nurse there was only one vacancy.

On the other hand there were no vacancies in the category of pharmacist. While there were 21 vacancies in case of health worker male, there were 33 vacancies in case of health worker female. In case of health supervisors, male, there was 50% vacancy and in case of health supervisors, female, only one post was vacant. In case of Radiographers there were 4 vacancies out of total sanctioned strength of 10 and finally there were no vacancies in the category of Lab Technicians.

Therefore the broader trends show that, while in the category of pharmacists all the positions were filled up, there were significant shortages in health worker, male and female. As these people are crucial for effective functioning of Sub Centres, their absence could make the people from different areas totally cut off from the nearby Primary Health Centres. Further there was serious crisis in the category of health supervisors, male, where out of 90 sanctioned posts, only 45 were filled up. The supervision work is an important aspect of implementation of various national programs at the block level and hence the shortage of male supervisors was a matter of serious concern. Similarly the shortage of Radiographers was a matter of concern for the district.

Medical Institutions (Indian Medicine and Homeopathy) in Sundergarh district:
Now let us have a look at the ISM and H institutions in Sundergarh district. The table below gives a picture of institutions under Ayurvedic and Homeopathic system in Sundergarh District.

<table>
<thead>
<tr>
<th>District</th>
<th>Ayurvedic System</th>
<th>Homeopathic System</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospitals Dispensary</td>
<td>Hospitals Dispensary</td>
</tr>
<tr>
<td>Sundargarh</td>
<td>0 32</td>
<td>1 22</td>
</tr>
</tbody>
</table>

It shows that under the Ayurvedic system the district had no hospitals and 32 dispensaries. In terms of Homeopathic system there was one hospital and 22 dispensaries.

369 Because in Orissa various posts of Staff Nurses have been vacant over the years.
There were no Unani hospitals or dispensaries in the district. Therefore under the ISM and H institutions it was mainly the dispensaries existed under the Ayurvedic and Homeopathic system in this district. Therefore it could be said that the allopathic system of medicine was the dominant system of health care that existed in the district.

**Block PHCs:**

As we have discussed in chapter II that two block level PHCs/CHCs were covered in the two selected districts of Orissa each. In this way, total four block PHCs were intensively studied. In Sundergarh district we have studied Kuarmunda CHC II and the Hatibari PHC for the purpose of our study.

**Kuarmunda CHC II:**

Now let us have a look at the Kuarmunda CHC II, which was functioning as a block level PHC. This was one of the two blocks selected for study. With a population of 92,427, it had 106 villages, 20 Gram Panchayats and 118 Anganwadi centres and it was divided into 4 sectors. It was located at a distance of 148 Kilometers from the district head quarters and the road connectivity was good. This CHC II existed nearby the bus stand of Kuarmunda town and nearby it there was one market area, one school and the police station. Rourkela the industrial town of western Orissa was only at a distance of 8 Kilometers from this CHC II. The referrals from here were sent to the Rourkela Government Hospital, Rourkela or to the sub divisional hospital, Panposh which was located at a distance of 5 kilometers.

This CHC II was a 16-beded institution and all these beds were functioning. In terms of manpower at the CHC II headquarter; there were three medical officers out of whom one was MO in- charge with orthopedics and gynic specialization, another MO was a gynecologist and the post of assistant surgeon was vacant for last one year. There was one pharmacist, 6 staff nurses and one lab technicians each for malaria and for pathology. In terms of infrastructure, water and electricity were available within its premises. The PHC headquarter building was well maintained and the Medical officers quarters were in good conditions.

The PHC (new) s’ were three and they were located in Raiboga, Andali Jambahal and Kadabhahal. These institutions were well connected through all weather roads. These were located near by market and school areas. However the infrastructures in all the three
institutions were in a very bad shape and in two of these institutions cleanliness was not maintained regularly. There were no water supply in these institutions but electricity supply was there only at Raiboga PHC (New).
**Table: 6.5 Kuarmunda CHC II: Suhergarh District**

Total population: 92,427.
Distance from the district headquarters: 148 Kilometers. Road connectivity was very good.
Location: Located nearby a bus stand, which was one of the busy routes for transport and communication in the district.
Number of Anganwadi centres: 118
Number of villages in the CHC area: 106
Number of Gram Panchayats: 20

Manpower at the CHC II headquarters: 3 medical officers out of which Gynic- 1, assistant surgeon- 1 and the other person was M/O in charge with O & G specialization. Out of these sanctioned 3 posts only 2 M/Os were there and another post was vacant for last one year.
Pharmacist- 1, Staff Nurse- 6, Lab Technicians- 1 each for malaria and for pathology.

Infrastructure: Water and electricity was available. The PHC headquarter building was well maintained and the MOs’ quarters were in good conditions.

Beds: 16

PHC (N): 3. They were at Raiboga, Andali Jambahal and Kadabahhal

Sub Centres: 22. There were 22 ANMs and 8 male workers present and 12 male workers were vacant. (Note: Each Sub Centre is supposed to have one ANM and one male worker). Many Sub Centres have been built in distant areas from villages due to lack of government land.

Sub Centres with no buildings: 10. Raiboga (3), Kadabahal (2), Kumjharia (2) and Kuarmunda (3). (The figures in the bracket suggest about the Sub Centres with no buildings in the respective four sectors).

Sectors: 4. Kuarmunda (6), Kumjharia (5), Kadabahal (5) and Raiboga (6). The figures in the bracket suggests about the number of Sub Centres.

Supervisors: 4. While in Kumjharia one male supervisor was there, the remaining sectors had one female supervisor each.

Indigenous medical practitioners: 107, according to an estimate by the CDMO’s office in the district in 2004.

Health status: Birth Rate- 19, Death Rate- 6, IMR- 35, MMR- 56, Sterilization achievement: 265 in October, November and January of 2004-05 out of the target 246. (Note: the term sterilization was synonymous with female sterilization).

*Source: Field Work, 2005.*

The mandatory manpower for each PHC (N) was Medical Officer- 1, Pharmacist- 1, ANM- 1, Sweeper- 2. In Raiboga and Kadabahal there were no Medical officers and
Pharmacists were heading these institutions. Even where the medical officers have been posted, it has been observed that they were absent. During field visit the Andali Jambahal institution was found to be closed.

There were 22 Sub Centres under this CHC II out of which 10 had no building of their own. Even where the sub centres had any buildings, the ANMs were not staying there. They were staying in the towns of Kuarmunda or Birmitrapur etc. While those sub centres, which had no government building, were supposed to function from a rented house, in reality these were not functioning at all. Due to lack of proper road connectivity, the ANMs were supposed to visit their field by walking. While all the 22 ANMs posts were filled up, the number of male workers post filled up was 8 only and the remaining 12 posts were vacant. The male workers rarely used to visit their field. As a result the work load on the ANMs used to be very high. Most of the ANMs interviewed were not aware about various national programmes. The group interviews with ANMs revealed that the focus of their activities was to achieve targets of female sterilization for each month under the RCH and the immunization program. In their visits to respective villages, the ANMs used to face abuses from the village males with regard to RCH and population control measures.

According to 2004 estimate there were 107 Indigenous medical practitioners in this block. In terms of health status in this block, birth rate was 19, death rate- 6, IMR- 35, MMR- 56; Sterilization achievement was 265 in October, November and January of 2004-05, out of the target 246.

Hatibari PHC: The table below gives a picture of Hatibari PHC. It was the second PHC in this district, which was studied for our purpose.

---

370 According to the senior officials in the state it was the pharmacist who in most of the cases was heading these institutions in Orissa.
371 By this CHC II.
Table: 6.6: *Hatibari PHC: Sundargarh District*

Distance from the district headquarters: 170 kilometers. Road connectivity was good.
Location: Located near the bus stand of Hatibari town.
The staff structure: Medical officers- 2, Pharmacists- 1, No staff nurse, Lab technicians: 1 for malaria and another for RNTCP, ANM- 1, Attendant- 4, Sweepers- 2, LHV (Lady Health Visitor) – 1, Statistical assistant- 1. Staff nurse post is vacant over the years.
Infrastructure: Water, Electricity was available in the PHC headquarter. The PHC headquarter buildings were well maintained and the quarters of the two medical officers were in good conditions.
Sectors: 3. They were at Hatibari (8), Nuagaon (8) and Sorda (10). One supervisor in each sector. While 3 lady supervisors were present, out of 3 sanctioned posts of male supervisors only one was present.
Beds: 6. All functioning.
Patients per day: 100 average.
PHC (N): 3. They were at Nuangaon, Sorada and Loaram. In Nuangaon the post of medical officer was vacant.
Sub Centres: 26. Only 8 had government buildings. For ANMs where government building was not there Rs 70 per month was given and for male workers 5% of their basic pay, which was 5% of Rs 3200, was provided. According to the ANMs this policy was quite discriminatory for them. In fact this was one of the main grievances of ANMs in all the four block PHCs in two districts that we studied.
ANM: 26+1 on deputation. One post vacant.
Male worker: out of sanctioned strength 16 only 8 were present.
Health Status: Birth Rate- 19, Death Rate- 6.62, IMR- 31, MMR- 53.05. (Note: all these figures were for the year 2004).
Epidemiological status: Malaria was endemic in this area followed by TB, Polio and Leprosy. Among the national programs RNTCP, Leprosy and Malaria were doing well in this PHC.
Note: Referrals from here were sent to RGH or Rourkela Government Hospital, Rourkela.

*Source: Field Work, 2005.*

The Hatibari PHC was catering to the population of 96,694 with 6 beds in total. It was located at a distance of 170 kilometers from the district headquarters and the road connectivity was good. This PHC existed nearby the bus stand of Hatibari town and was also closer to the market area. Besides one school and the police station were also nearby
it. Rourkela the industrial town of western Orissa was only at a distance of 25 Kilometers from this PHC. The referrals from here were sent to the Rourkela Government Hospital, Rourkela or to the sub divisional hospital, Panposh.

In terms of infrastructure, water and electricity were available within the PHC premises. The PHC headquarter buildings were well maintained and the quarters of the two medical officers were in good conditions.

The staff structure in the headquarter PHC was: Medical officers- 2, out of which one was MO in-charge. There was one Pharmacist, Lab technicians one each for malaria and another for RNTCP, one ANM, four Attendants, two Sweepers, Lady Health Visitor one and one Statistical assistant. There was no staff nurse present and the post was vacant over the years. In three sectors 3 lady supervisors were present and out of sanctioned post of 3 male supervisors only one was present. A new RCH building had come up in the PHC headquarter under World Bank funding with facilities like one operation room, one labor room, one duty room and two latrines and bathrooms each.

There were three PHC (N) institutions. They were in Nuangaon, Sorada and Loaram. In Nuangaon the post of medical officer was vacant. All these institutions were well connected through road and these were located nearby market and school areas. However the infrastructure in all the three cases was in a very bad shape and from outside these were also looking very dirty. During the field visit only the Nuangaon institution was open and the other two were closed. There was no water or electricity supply in these institutions, except for Nuangaon where electricity supply was there.

Out of total 23 Sub Centres only 8 had government buildings. However the ANMs mostly used to stay nearby Hatibari or Birmitrapur town.372 There was no water or electricity supply in 8 existing government sub centre buildings. Among the ANMs out of sanctioned posts of 26 one was vacant and in case of male workers out of 16 sanctioned

372 Located at a distance of 25 kilometers from Hatibari town and was famous for limestone mines in Western Orissa. Mostly the limestone and the dolomites were supplied from this town to Rourkela Steel Plant in Orissa, to Bhilai Steel Plant in Madhya Pradesh and to Durgapur Steel Plant in West Bengal.
strength only 8 were present. During group interviews with ANMs it was observed that they were not aware about various national programs and most of them rarely used to visit the fields. Discussing about their field challenges the ANMs were of the view that they had to face abuses from the villagers with regard to issues of RCH, HIV/AIDS and population control measures. The focus of ANMs activities were RCH and immunization programs and within RCH, to achieve targets of female sterilization for each month.

In terms of health status, birth rate was 19; death rate was 6.62, IMR- 31, MMR- 53.05 according to the figures for the year 2004. In terms of epidemiological status: Malaria was endemic in this area followed by TB, Polio and Leprosy. Among the national programs RNTCP, Leprosy and Malaria were doing well in this PHC. Referrals from here were sent to RGH or Rourkela Government Hospital, Rourkela.

Strengths:

"As it is an undivided district government wing officers like DMO, DIO, DTO\textsuperscript{373}, ADMO Medical, DLO and SDMOs were assisting in performing all national programs. We have also got good infrastructure as compared to other divided districts\textsuperscript{374}. Significantly when we compare the two of our study block PHCs of Sundergarh with the other block PHCs of Khurda than it was quite clear that the block PHCs\textsuperscript{375} at Sundergarh had better infrastructure than Khurda.

Weaknesses:

"Shortage of doctors and paramedics, yet to be filled...as it is a tribal district the periphery institutions need to be filled up." Mentioning about the particular areas of concern he said, "Lahunipada, Nuangaon and Koida\textsuperscript{376} are the CHCs/PHCs of concern, where staffs are refusing to stay."

\textsuperscript{373} DMO refers to District Malaria officer, DIO refers to District Information Officer, DLO refers to District Leprosy Officer and DTO refers to District Tuberculosis Officer and SDMO refers to Sub Divisional Medical Officer.

\textsuperscript{374} It needs to be mentioned that before 1995 Orissa was having only 13 districts and later it was increased to 30 districts and the reason cited was that it would be administratively convenient. However there were districts like Sundergarh, which were not divided.

\textsuperscript{375} We need to mention here that in Sundergarh district we have taken Kuarmunda CHC II for our study, because this was the block headquarter institution.

\textsuperscript{376} These were three different blocks.
Constraints:

“As the sanction has to come from higher authority, new postings are less.\(^{377}\) For paramedics every month vacancy list is sent...first cleared by government and then only we can recruit on a contractual basis. Only in case of contractual doctors we can recruit without consulting higher authorities.” About infrastructure he said, “Except in medical colleges there are hardly any infrastructures in other places.” He further added that “but due to political pressure\(^{378}\) health centres are created, but nobody bothers as to how these will run without infrastructure.” He said that some politician wants to open a PHC New because he had promised in the election and hence they put pressure to open an institution without bothering as to how it would function.

Process and experience of reforms\(^{379}\):
Understanding the process and experience of health sector reforms at the district level was an important aspect to get a comprehensive view about the ongoing reform process in Orissa. However while the CDMOs were to some extent aware about some of the reform initiatives, the MO in-charge at the block headquarter PHCs had hardly any idea about these.\(^{380}\)

On the consultation process\(^{381}\):
Whether the CDMO was involved in consultation process before the reforms were initiated in the district? Responding to this query the CDMO said, "There was no such consultation held". That means reform elements were introduced with top-down

\(^{377}\) The CDMO was referring about the postings of paramedics in the district who were selected on a contractual basis.

\(^{378}\) This was a new dimension being mentioned by the CDMO about the lack of absence of staffs in PHC News.

\(^{379}\) For understanding the reform elements at the district level, we have not made a separate classification for the ‘reforms’ and ‘systemic’ changes. That is our questions to the respondents were not classified into these two categories. However for our own analysis we have used this distinction.

\(^{380}\) Even the CDMOs were not aware that the new initiatives by the state government were a reform initiative or not. While for the purpose of this study we have classified reforms and systemic changes in different categories, the state government in its vision document 2010 had mentioned in detail about the ‘reform’ initiatives taken by it. So here we were talking about the ignorance of CDMOs with respect to different health sector initiatives, which had been identified by the state government as reform elements.

\(^{381}\) The wider consultation process before initiating a reform element was important because the implementation and the sustainability of this reform element depends on the various levels of manpower located in different layers of health care services.
approach. This has implications for the successful implementation and the sustainability of the reform process.

User Charges:
In Sundergarh district user charges were collected at district HQ hospital, Sub divisional hospital Panposh, RGH Rourkela and in Bonai Sub Division hospital. These institutions were upgraded under Orissa Health Systems Development Project or OHSDP. User charges report was sent every month to World Bank funded OHSDP located at Bhubaneswar.

Responding to the question about his views on user charges the CDMO said, “It is a good scheme. A meeting is held every month called quality assurance meeting on the need assessment basis. There is a quality improvement group for quality assurance. Report is sent every month to OHSDP.” However it was difficult to collect the data with regard to user fees collected in the district for various years form the CDMO’s office. In fact this was also true in case of Khurda district.

On the creation of ZSS:
Responding to the question about amalgamation of different district societies, the CDMO observed, “The society fund is separate and functioning as earlier and user charges fund is separate. As collector is the head of Zilla Swastha Samiti, under one platform everything is discussed…coordination is good. Decision and implementation is quick due to the creation of ZSS.” The CDMO was of the opinion that the creation of ZSS had helped the district in responding to the emergency situations in a better way. For example if there was a sudden outbreak of malaria in the district and there were no funds for it than the money could be withdrawn from say TB account and later when the money for malaria comes, it could be transferred to the TB account. This was not possible earlier. Thus the amalgamation of district societies had helped in common pooling of resources. Besides the bureaucratic red tap had been reduced due to the creation of ZSS.
Training of medical interns:

“Generally in the two UGPHC\textsuperscript{382}s of Hemgiri and Subdega\textsuperscript{383} trainings are held for three months. Students are mostly from the Burla Medical College. During this training period students are given exposure to the national programs.” The CDMO was of the opinion that this present system was better than the earlier system when the students used to visit a nearby PHC with the guidance of a senior professor. However in that system most of the students used to neglect it and the professors also used to give them the required marks.

While the CDMO claimed that this new system was better than the earlier one but an interaction with one of the medical officers who was currently in-charge of a PHC and who had a nine years stint in one of these UGPHCs, suggested that during his stay only one intern had completed the three months course and ‘that too because she was from that area’. He was of the opinion that the CDMOs don’t put pressure on the interns and generally give them the certificate even though an intern has not attended the training for a single day.

Indigenous practitioners:

To the question as to whether ISP training was going on in this district, the CDMO said “The ISPs\textsuperscript{384} are in all blocks of the district for referrals to the primary level care. Training is yet to be provided. At present ISPs are being identified in each block.” Thus the CDMO was of the opinion that the ISPs were being identified in all the blocks of this district and would be involved in referrals to the nearest PHCs or CHCs. It needs to be mentioned here that Sundergarh has been identified by the state government as a tribal district and as such indigenous social practitioners must be there in large numbers. During the field visit to Kuarmunda CHC it was known that it had identified the total number of ISPs existing in Kuarmunda block.

\textsuperscript{382} Upgraded Primary Health Centres. These had built up in the 1980s with the help of funding from UK funding agency DFID.

\textsuperscript{383} These Upgraded Primary Health Centres were of 30-bedded institutions. There were in total two UGPHCs in the Sundergarh district.

\textsuperscript{384} Indigenous social practitioners. They have been thought to be included in the referral services to the nearby primary level care for complications in pregnancy and for malaria cases in a tribal district like Sundergarh.
Appointment of contractual doctors:

"If patients are not coming, doctors are negligent. Once you become a popular doctor in your area, programs will follow and you can control your staff, hence treatment is very important." The CDMO was talking about filling the vacant posts in PHC New's through contractual arrangement to a group of medical officer in-charge in some block PHCs in the district. Responding to this issue one medical officer in charge of a PHC said that only the retired old doctors were interested for these posts, as they don’t have to come regularly! While another medical officer said that at least let them join these posts. In the meeting it emerged that the ANMs were not keeping in touch with the population and they were also not involved in the national programs.

Petty maintenance of PHCs:

For the petty maintenance of PHC headquarters money had not come for the year 2005. However the CDMO was of the opinion that the scheme had been helpful for the PHCs. It was interesting to note here, what one of the MOs in our study PHC said with regard to this scheme. "Money under this head comes but it is not regular. In my knowledge this amount is being misutilised by the medical officer in-charge of a PHC in most of the

---

385 This was the opinion of the CDMO to his medical officers in the district as to how to get the participation of people in a block in various national programs. However this could also be possible that the CDMO made this comment to his officers because this researcher was present!

386 PHC New's were single doctor institutions in Orissa where only outpatient services were provided. Apart from a medical officer, one pharmacist, one ANM and a sweeper were supposed to be there. In needs to be mentioned here that in these institutions the first posting of a medical officer in the government service occurs. However it was in these posts that the doctors were most of the time absent. This was observed during first hand visit to all these PHC New's in the two districts chosen for study. It was the pharmacists who were present in all the cases and they were virtually running these institutions and in one case the PHC New was closed during the visit, whereas it was supposed to remain open. There were many aspects to this problem. From one medical officer's point of view, they find it very difficult to convince themselves to stay in a remote area after having spent their education in a city and they feel it as a punishment posting. Some other medical officers were of the view that in fact a pharmacist could effectively run these institutions and there was no need for a doctor and important thing was that in cases of complications they should refer the patients to the block PHCs in time. Off late the government of Orissa has planned to convert these single doctor institutions into PHC category, as it is the norm in other states in India and to convert the existing block level PHCs or CHCs as CHCs. At present in Orissa many block level headquarter institutions were either CHCs or PHCs. It was observed that at the PHC New level in the Sundergarh district the outdoor attendance was 10 to 15% a day and the CDMO observed that where there was less than 20% attendance, which suggested inefficiency of the MBBS doctor.

387 Here inferences have been made from the monthly coordination meeting held at the Sundergarh District in the month of March 2005 where apart from the senior officials of the district level, the medical officer in charge of all the block PHCs of Sundergarh district were also present.

388 This conversation happened in the chamber of the CDMO before the monthly coordination meeting was about to start.
cases..." Thus while the CDMO was not forthcoming on the actual working of this scheme, the medical officer in this PHC gave some good insights.

_Pancha byadhi Chikitsa Scheme:_
Responding to the Pancha Bhadhi Chikitsa Scheme, the CDMO said, "This is going on well...Innovative idea of the Orissa government. Quite helpful at the periphery level." Interacting with medical officers^389^ in the PHCs of this district it was known that because these diseases were very common among the population, therefore before the introduction of this scheme, they used to provide medicines for these diseases. However due to better drug supply after the new drugs policy they were able to provide the required medicines to the patients. However according to the MOs interviewed many of the patients were not aware about their rights^390^ under this scheme.

_New Drugs Policy:_
To the question as to whether there was any improvement in the supply and quality of drugs after the introduction of new drugs policy, the CDMO said, "Situation has improved than earlier." This was also the view of medical officers interviewed at different block PHCs.

_Mandatory pre-PG rural scheme:_
This scheme was operational in this district. However one MO was of the opinion that "By giving money to CDMOs, people are getting a certificate that they have done one year service in rural areas. But it is not happening in reality." This MO was of the opinion that rather than this mandatory one-year scheme, "After doing five-year service, one could go for in-service PG, where one would be getting regular salaries, promotion and the seniority would also be maintained." While the CDMO said that this scheme was functioning well, in reality it was not working.^391^

^389^ Interviews were also taken with medical officers attending the monthly coordination meeting in the district, apart from interviewing medical officers at block PHC headquarters in this district.
^390^ We have discussed in chapter V in detail about the rights of a patient under this scheme.
^391^ We have also discussed about this scheme in chapter III and chapter V.
Handing over PHCs\textsuperscript{392} to NGOs:

This scheme was applied in one district of Orissa on a pilot basis. However to know the opinion of the CDMO about this scheme, this issue was raised. Responding to this query the CDMO said, “NGOs in India have not gone to that extent to take up those responsibilities. In our district no such discussion\textsuperscript{393} has taken place.”

Improving health care services in periphery level institutions:

As the CDMO was dealing at the grass roots level and has had experience in this district for more than 20 years he was asked about the way out to improve the health care services in periphery level institutions. Responding to this question the CDMO was of the view that “It will take another 20-22 years for the staff to stay in periphery level institutions. The difference between a village and a town is roads, electricity, schools and latrine...until and unless these things are provided...apart from it literacy level has to improve along with economic status of the people. Orissa is a poor state.... Situation is improving... Compared to the time of independence now it is far better”. This observation was significant, as it has been noted that there was a kind of helplessness among the cadres and also the policy makers at the top level about addressing the issues of health care services at periphery level institutions. Therefore it was important to understand that the improvement of health care services was linked with the improvement in other aspects of life.

He further added, “At present we cannot provide remuneration to the MOs and other staffs for staying in difficult areas as Orissa is a poorer state”. He was giving a comparative picture of Indian Army having a policy of remuneration for those who opt for difficult areas. Therefore these were structural issues and would require a multi sectoral approach to effectively respond to the situation.

OHSDP institutions and staffs in Sundargarh District\textsuperscript{394}:

---

\textsuperscript{392} Here the PHCs refer to PHC (N), which were single doctor medical institutions in Orissa.

\textsuperscript{393} About the idea of handing over PHCs to NGOs.

\textsuperscript{394} See Annexure 1 in this chapter.
The figure shows that apart from the district hospital, sub divisional hospital and RGH hospital, Rourkela, five CHC II level institutions were selected under OHSDP. If one looks at the post of staff nurse, than it shows that all the positions created were of contractual nature. In fact this was the case in most of the posts for staff nurse created under OHSDP in 157 institutions in Orissa.

Khurda District: A profile

The Khurda district was located in the coastal part of Orissa, with a geographical area of 2813 square kilometers, which was 1.81 percent of the total land area of Orissa. It had 10 community development blocks, 7 towns, 3 municipalities, 168 grampanchayats and 6 assembly constituencies. According to the 2001 census of India, it had a total population of 1874,000, which was 5.10 percent of Orissa’s population. It had urban population constituting 42.93 percent of its total population which was much higher than all India average and population density of 666 per square kilometer. Further 10.93 percent of its population was scheduled castes and 4.10 percent of its population was scheduled tribes and it had a sex ratio of 901. Therefore scheduled castes were more in number than scheduled tribes in this district. While it had average literacy rate of 80.19 percent, among the scheduled castes the literacy rate was only 47.46 percent and among the scheduled tribes the literacy rate was 28.11 percent.

Health care services structure:

The table below mentions about the existing medical institutions in Khurda district.

---

396 The percentage of scheduled castes and scheduled tribes were based upon 1991 Census of India.
397 The sex ratio of females per 1000 males, was based on 2001 Census of India.
398 While the figures for average literacy rate of the district were from the 2001 Census of India, the figures for scheduled castes and scheduled tribes were from 1991 Census of India.
Table: 6.7 Medical Institutions (Allopathy) in Khurda District

<table>
<thead>
<tr>
<th>Medical Institutions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DHH</td>
<td>2</td>
</tr>
<tr>
<td>SDH</td>
<td>0</td>
</tr>
<tr>
<td>Other Hosp</td>
<td>8</td>
</tr>
<tr>
<td>CHC I</td>
<td>6</td>
</tr>
<tr>
<td>CHC II</td>
<td>1</td>
</tr>
<tr>
<td>PHC</td>
<td>5</td>
</tr>
<tr>
<td>PHC (N)</td>
<td>59</td>
</tr>
<tr>
<td>Total medical Institutions</td>
<td>81</td>
</tr>
<tr>
<td>Sub Centres</td>
<td>186</td>
</tr>
<tr>
<td>No. of Beds</td>
<td>715</td>
</tr>
</tbody>
</table>

Note: DHH- District Headquarter Hospital, SDH- Sub Divisional Hospital, CHC- Community Health centre includes upgraded PHCs, PHC- Primary Health Centre, MHU- Mobile Health Unit.

Source: Field Work, 2005.

The table shows that there were 2 District Headquarter Hospitals, one at Bhubaneswar and another at Khurda and 8 other hospitals in Khurda District. Thus there were 10 hospitals in total in this district. The CHC I institutions were 6 and the number of CHC II institutions was 1, Primary Health Centres were 5, PHC (N) institutions were 59 and 186 sub centres in total. Out of 186 sub centres only 90 had government building and the remaining 96 were supposed to be functioning on rented buildings. Therefore in total there were 81 medical institutions in the district with no sub divisional hospital or any mobile health unit. There were 715 public beds in total in the district.

Vacancies in various categories of posts:
Now let us have a look at the vacancies in various categories of posts in this district.

---

399 It needs to be mentioned here that in Orissa all the CHC II institutions were under OHS DP.
400 The structure of CHC, PHC and the PHC (New) and Sub Centre were same as they were at Sundergarh district.
401 This data was collected from the CDMO office, Khurda.
### Table: 6.8 Vacancies in various posts: Khurda District

<table>
<thead>
<tr>
<th>Posts</th>
<th>Sanctioned Strength</th>
<th>In Position</th>
<th>Clear Vacancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sr. Class I</td>
<td>8</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Jr. Class I</td>
<td>11</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Class II Specialists</td>
<td>63</td>
<td>61</td>
<td>2</td>
</tr>
<tr>
<td>Asst. Surgeon</td>
<td>128</td>
<td>123</td>
<td>5</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>119</td>
<td>115</td>
<td>4</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>96</td>
<td>94</td>
<td>2</td>
</tr>
<tr>
<td>MPHW (M)</td>
<td>186</td>
<td>142</td>
<td>44</td>
</tr>
<tr>
<td>MPHW (F)</td>
<td>239</td>
<td>239</td>
<td>0</td>
</tr>
<tr>
<td>MPHS (M)</td>
<td>73</td>
<td>39</td>
<td>34</td>
</tr>
<tr>
<td>MPHS (F)</td>
<td>27</td>
<td>22</td>
<td>5</td>
</tr>
<tr>
<td>Radiographer</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Lab. Technician (Pathology)</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: MPHW (M): Multi Purpose Health Worker, Male, MPHW (F): Multi Purpose Health Worker, Female, MPHS: Multi Purpose Health Supervisor.

*Source: Field Work, 2005.*

The table shows that in the category of senior class I, multipurpose health worker females and among the lab technicians all the posts were filled up. This was significant because the senior class I posts were mostly in CHC II institutions and this suggests that the first referral units in the district were well functioning. Similarly the multi purpose health worker females are a link between the community and the block PHC and hence when all the posts in this category were filled up, this suggests that the sub centres in the district must be functioning relatively well. The lab technicians are important for diagnosis of malaria and TB cases and their presence to a certain extent contributes enhancing the people's perception about access to effective health care in a health institution.

Similarly in the categories of junior class I, class II specialists, assistant surgeons, pharmacists, staff nurses and radiographers post, there were few shortages. However there were severe shortages in the posts of multipurpose health worker male and the multipurpose health supervisor male. Filling these two categories of posts was significant for effective functioning of sub centres and through these various national programs.
However another aspect of this problem was that even when the various categories of posts were filled up, in itself it was not enough for smooth functioning of various health institutions, because the staffs may not be willing to stay in the remote and difficult areas of the district.

**ISM and H institutions in Khurda District:**

The table below gives a picture of medical institutions under Indian System of Medicine and Homeopathy in Khurda District.

**Table: 6.9 ISM and H institutions in Khurda District**

<table>
<thead>
<tr>
<th>District</th>
<th>Ayurvedic System</th>
<th>Homeopathic System</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospitals</td>
<td>Dispensary</td>
</tr>
<tr>
<td>Khurda</td>
<td>1</td>
<td>18</td>
</tr>
</tbody>
</table>


The table shows that in Khurda district there was one hospital and 18 dispensaries under the Ayurvedic system and there was one hospital and 22 dispensaries under the Homeopathic Systems. There was no Unani dispensary. It needs to be mentioned here that out of total 5 Ayurvedic hospitals and out of total 4 Homeopathic hospitals in Orissa one each was present at Khurda district.

**Strengths and weaknesses in the health care services structure:**

Responding to the question about strengths and weaknesses in the health care services structure in the district the CDMO said, “In terms of vacant posts the post of MOs less. While all the PHCs should have three doctors we have only two. However the main problem is that the District Headquarter hospital has been upgraded from Sub Divisional District Hospital, but new doctors have not been employed.” He was also of the opinion that out of two hospitals, one at Bhusanpur and another at Odsing, these were manned by only one medical officer each. He further said, “In the district Head Quarter Hospital, the specialists’ posts like radiologist, FMT, Psychiatrist and pathology are vacant.”

---

402 The other four Ayurvedic hospitals were one each in Bargarh, Balangir, Ganjam and Puri district. See Health Statistic of Orissa, 2000-2001, Compiled by State Bureau of Health Intelligence, DHS, Orissa.

403 Similarly the other 3 Homeopathic hospitals in Orissa were one each in Ganjam, Sambalpur and in Sundergarh districts.
On the PHC (N)s in the district he said, "In most of the places pharmacists are running these institutions, in place of the medical officer." Therefore he was of the opinion that there should be two medical officers at these single doctor institutions, so that if one MO was absent than another could be available. The CDMO was also of the view that the basic facilities were also missing in these institutions. Another interesting aspect of these institutions in the district was that, "People were asked to select a plot where there would be one MO quarter, one pharmacist quarter and one dispensary quarter could be build up. This has not occurred. Most of the PHC (N)s has not been handed over to the government."

In terms of strength in the health care services structure in the district he said, "The allotted post for MOs were filled up...Medicines and instruments are adequate and all the block PHCs are in good condition." It needs to be mentioned here that during the visit to a nearby block PHC in this district, the medical officer in-charge said that the PHC building required repairing at many places and even his own quarter gets filled up with water in rainy season! However another question arises here and it was about the Orissa governments attempt to convert the existing PHC (N)s into block level PHCs and the existing PHCs and CHCs to CHCs according to the All India pattern. However if the conditions of the PHC (N)s were such that neither the required physical infrastructure nor the required manpower was available and even where there were posts, staffs refuse to be there, then in these circumstances would it be wise to change the designation of these institutions? Therefore would not it be feasible that the existing structures in the state were changed or renamed according to the requirements of the state, rather than changing to the All India pattern?

**Block PHCs:**

Two block level PHCs were studied intensively in Khurda district, they were Balakathi PHC and Mendhashala PHC.

**Balakathi PHC:**

The table below gives a picture of Balakathi PHC under Khurda district.
Established in 1982, it catered to the population of 1,09,000. The Balakathi PHC was located at a distance of 30 kilometers from the district headquarters and the road connectivity was very bad\textsuperscript{404}. This PHC existed nearby a market area of this block.

\textsuperscript{404} This was very significant because although this PHC existed only at a distance of 30 kilometers from the Capital of Orissa, more than half of the road was not all weather roads. Therefore we could say that if this...
Bhubaneswar the Capital of Orissa was at a distance of 30 kilometers from here. The referrals from here were sent to either the district headquarter hospital, Khurda or to the Capital Hospital, Bhubaneswar.

In terms of infrastructure, water and electricity were available within the PHC premises. However there were leakages at many places of the building roofs. Maintenance was poor. Even the quarter of the MO in-charge had leakages in the roof. It had only 6 beds and average outdoor patients per day were 200. There were three sectors under this block PHC. They were Pahala, Balakathi and Bhingarpur. The staff structure in this block headquarter PHC was, three medical officers in total, out of which one was MO in-charge, one was Gynic specialist and another one was pediatrics specialist. Besides there were one pharmacist, six supervisors, one lab technician, one Block Extention Educator or BEE for IEC activities in the block, one statistical assistant and one vital statistics clerk.

Among the 18 Sub Centres only 7 had government buildings and the rest 11 were supposed to be functioning in rented buildings. Due to lack of proper road connectivity, the ANMs had to visit their field villages by walking. However the ANMs mostly used to stay nearby Bhubaneswar and hence most of them were not visiting their fields regularly. On the other hand interviews with ANMs revealed that they had to face daily abuses from the villagers during their routine visits. The ANMs interviewed were ignorant about various national programs and many of them were of the opinion that their training was inadequate. The focus of ANMs activities were immunization and RCH programs and within RCH the focus was on population control measures through female sterilization.

There were three PHC (N) s, one each in Balianta, Pahala and Bhingarpur. These institutions were located in one corner of a village, with no proper road connectivity. There were no schools or any market nearby these PHC (New) s. There was no electricity

---

405 This was the observation of the supervisors in this block PHC.
or water supply in any of these PHC (New) s. The staff structure in these institutions was same. During the visit to these institutions it was observed that the medical officer in charge was absent and in one case even the pharmacist was not present. These institutions were located in the interior areas with no pucca road connectivity. In rainy seasons due to water logging these institutions almost get cut off from other areas. These institutions were urgently requiring some reparation. However cleanliness was maintained in all these three institutions.

*Mendhashala PHC:*

The table below gives a picture of Mendhashala PHC. Established in 1963, it catered to the population of 1,29,00 with an average outdoor patient load of 100 and with a capacity of 6 beds.
Table: 6.11 Mendhashala PHC (Khurda District)

Established: 1963  
Population: 1,29,000.  
Distance from the district headquarters: 45 Kilometers. However more than half of the distance was without pucca road.  
Infrastructure: Water and electricity was available. However the PHC headquarter building was not well maintained. The quarters of the Medical Officers had leakages in the roofs.  
Location: It was located nearby a village market.  
Manpower at HQ PHC: 
Medical Officer: 2, One M/o in charge and another Gynic specialist.  
Pharmacist: 1,  
Lab Technician: 1.  
ANM: 1, Block Extention Educator: 1.  
Statistical Assistant: 1.  
Ward Attendant: 1.  
Sweeper: 2.  
PHC (N): 4. They were at Chandaka, Itipur, Patia and Nuabandha.  
M/o- 4 present. Pharmacists- 4 present, ANMs- 4 present. Sweepers were present only in two PHC News.  
Sub Centres: 21. Out of which only 6 had government buildings.  
ANMs: Out of 21 sanctioned strength, 20 were present.  
Male worker: Out of 20 sanctioned strength, only 14 were present.  
Sectors: 5. Mendhasala (4), Chandaka (3), Kalaram (6), Putrapada (4) and Itipur (4). (Note: The figures in the bracket suggest the number of Sub Centres in each sector.  
Supervisors: 7. Out of which 4 were Lady Health Visitors or LHVs and 3 male supervisors. One supervisor for 4-6 Sub Centres.  
Beds: 6.  
Out door patients at Block HQ: approximately 100.  
Referrals: To the Khurda HQ hospital or to the Capital Hospital, Bhubaneswar.

Source: Field Work, 2005.

The Mendhashala PHC was located at a distance of 45 kilometers from the district headquarters. However, more than half of the distance from the district headquarters was without any pucca road. This PHC existed nearby a village market area of this block. There were no schools or police stations nearby this PHC. The referrals from here were
sent to either the district head quarter hospital, Khurda or to the Capital Hospital, Bhubaneswar.

In terms of infrastructure, water and electricity were available within the PHC premises. However the PHC headquarter building was not well maintained. The quarters of the Medical Officers had leakages in the roofs. The staff structure in this PHC was two medical officers out of which one was gynic specialist and another was MO in-charge. Besides there was one pharmacist, one lab technician, one Block Extention Educator, one statistician, one ANM but no staff nurse.

There were four PHC (N) s in this block, located in Chandaka, Itipur, Patia and Nuabandha. Among the staffs in these institutions two sweeper posts were vacant in two PHC (N) s. From this one could understand as to how difficult it would have been to run these institutions. Again among these four institutions medical officers were absent; in three of them during field visit and in the remaining one it was closed at a time when it should have remained open. Besides these institutions were located in the interiors of this block with no pucca road connectivity and these were located in one corner of a village. There were no schools or market near by these institutions. There was no electricity or water supply in these institutions. The buildings were in a dilapidated condition.

Out of 21 sub centres only 6 had government buildings. This suggested the gravity of the situation at these periphery level institutions. One sub centre covered 6,000 to 7,000 populations but some sub centres also covered population of 4,500. On an average one sub centre covered around 6-7 villages. As there was hardly any pucca road connectivity, the ANMs had to visit their villages by walking. Whether a sub centre had a building or not, it was alleged by the MO in-charge that most of the ANMs were staying near Bhubaneswar and would visit the fields occasionally. Among the ANMs out of 21 sanctioned posts 20 were present and among the male workers out of 20 sanctioned posts only 14 were present. About the male workers it was said that while the ANMs occasionally do visit their allotted villages, the male workers hardly ever visit the fields. Out of seven supervisors, 4 were lady health visitors and the rest three were male. Here
also the ANMs were found to be ignorant about various national programmes. Interacting with ANMs it was clear that two national programs, they focused were immunization and RCH. Within the RCH the focus was on population control measures through female sterilization.

Process and experience of reforms:
Now let us have a look at the process and experience of health sector reforms at Khurda district. As we have mentioned earlier that while we held interviews with the medical officers’ in-charge at block headquarter PHCs with regard to health sector reforms, it was observed that they had no idea about these reform initiatives and they could only talk about their institutions. Hence it was only the CDMOs in these two districts who could give their views on some of the reform initiatives. At the same time CDMOs were not aware that a certain health initiative by the state government was a reform initiative or not. They were only aware about different schemes.406

On consultation process about reforms:
Whether in the initiatives for introducing reforms in the health sector he was consulted by the senior officials in the state? Responding to this question the CDMO said, “There was no consultation at the CDMO level.”407 Therefore here also the CDMO was not consulted prior to the initiation of health sector reforms.

OHSDP Institutions:
To the question, what were the institutions funded by OHSDP in the district, the CDMO said, “They have helped in the construction of three CHCs and the District Head Quarter Hospital.” Therefore out of 7 hospitals to be constructed in the district under OHSDP, the

406 This was very significant observation because for the successful implementation of the reform initiatives it was important that at all the levels of health care services structure the staffs were aware about various reform initiatives so that a collective effort could be made toward some concrete results.

407 It was significant because what the CDMO said was that it was not about a single CDMO only, but at the CDMO levels itself there was no consultation about the reforms in the health sector. The same was also the case about consultation at the block level medical officers who act as a direct interface with the community. However it was quite surprising that the senior officials in the state when interviewed were of the opinion that the consultation process involved officials at all levels in the state, including some ANMs! On the other hand one senior official was of the opinion that it was not necessary to have opinion from all these levels as the senior technical level directors themselves have come from same experience over the years through postings at various places. But the question arises that by not involving the rank and file would it be possible for effective implementation of the reform initiatives in the state?
User Charges:
What were the institutions in the district where user charges were introduced? Responding to this the CDMO said, “Only in the district hospital user charges has been introduced. The services like routine urine check up, ECG, Ultra Sound, and the paying beds have been introduced.” On deciding the cost of user charges he said, “The cost of user charges is passed in the ZSS meeting, which is less than market price.” And how the below poverty line people were exempted from user fees, to this question he said, “Near about 40 percent of the user charges are not collected and the direct beneficiaries are the BPL card holders. And the doctor treating a patient certifies him/her as a BPL category.”

But how far the collection of user charges help in day to day recurrent expenditure of the institution? Is it sufficient enough? Responding to this question, the CDMO said, “Near about 70 to 80 percent of the regular expenditure was collected from user charges.” On his opinion about the concept of user charges he said, “User charges should be enhanced. Some charges for outdoor patients should also be there. It should continue.”

Petty maintenance of buildings:
On the question about availability of funds under the petty maintenance scheme where Rs 10,000 per annum was provided to the medical officer in-charge at the block PHC, the CDMO said, “Money comes from the DHS without CDMO’s interference to the MO at

---

408 This was the observation by the CDMO during interview. The construction work for the district headquarter hospital was still going on during the field visit.
409 However interacting with health officials at various levels they accepted that in practice it was really very difficult to exempt the poor from paying for user fees. This was even the opinion of some medical officers in the Capital Hospital, Bhubaneswar.
410 It needs to be mentioned here that most of the interviewees at different levels in the state were in favor of introducing user fees at different levels of health services structure. Even the medical officer in-charge of the block PHCs were of the opinion that the introduction of user charges would not only help in improving the services available, it would also help in generating resources for regular maintenance of these institutions.
CHC/PHC level and hence can not say anything.” However, interacting with medical officers at block PHCs it was told that the fund under this scheme was not regular.

*New Drugs Policy:*
Due to the introduction of new drugs policy, was there any change in the supply of drugs in this district? Answering to this question the CDMO said, “The supply is good, timely and adequate.” Interestingly he added, “The quality was same, however it was earlier difficult to procure drugs locally for CDMOs.”

*District Cadre for Paramedics:*
The CDMO was of the opinion that even though the paramedics were converted to district cadres, the situation has not improved in this district. He said, “About 70 to 80 male worker posts were vacant in the district.” This was a matter of serious concern and this would also affect the work of the ANMs as work load would increase on them. This in turn would affect the effective implementation of various national programs in the district.

*Mandatory Pre PG Rural Scheme:*
The CDMO said that this scheme was not applicable in this district as the remote and the inaccessible areas were less compared to other districts.

*Handing over PHCs to NGOs:*
This scheme was also not implemented in this district. It needs to be mentioned that this scheme was introduced in a block PHC of one district in Orissa on a pilot basis. However the CDMO was opposed to any idea of handing over PHCs in remote areas to NGOs. Because according to him it was the structural issues which were required to be addressed in these remote institutions and hence as long as these issues remain unaddressed, even the NGOs would face similar type of problems which currently the government staffs faced.

411 About the quality of drugs, even the medical officers at the block PHCs were of the opinion that it had improved.
On the creation of ZSS:
On the creation of ZSS in this district the CDMO was of the opinion that, "As resources are in one point, common pooling of resources has helped to meet any emergency situation." Because funds could be transferred from one head to another, under emergency circumstances and later this could be repaid when the money in this head comes. This has given a lot of flexibility to the COMOs, which was earlier not possible.

Involving Traditional practitioners:
On necessity to involve traditional practitioners in referrals, the CDMO was of the opinion that, "Traditional practitioners can do IEC activities... You cannot stop them. Why not regularize them, so that we can have control over them. Now they are functioning anyway... At present no referrals by traditional practitioners occur." This was an important observation by the COMO because interaction with other senior officials in the state brought to the fore the view that traditional practitioners were going to stay because they have a greater hold over the community and people rely on them, as in times of need these traditional practitioners were always available in contrast to the government appointed medical officers. Therefore innovative strategies should be thought out about involving them to improve the health care services structure in remote and hilly areas.

Training of medical interns:
On the question about whether medical internship training scheme was going on in Khurda district, the CDMO said, "The Banapur CHC was selected and students have successfully got trained. They spent 7 days in the district Head Quarter Hospital and the rest of their time in the periphery institution." It needs to be mentioned here that the Banapur CHC was having problem because medical officers were unwilling to stay there and hence provisions were made for contractual doctors. So the question arises how in these circumstances the medical interns could get any first hand experience?
Difficult areas in the district:

About the difficult areas in the district the CDMO said that the “Niladri Prasad area which comes under Banapur CHC in Khurda district is very inaccessible and recently we have appointed one contractual doctor there.”412

Structural Constraints and Health Sector Reforms:

The vacancy of staff positions in these two districts show that there were severe shortages of male supervisors, multipurpose health worker male and most of the sub centres in these two districts had no government buildings. Besides, the ANMs were not regularly visiting their fields. And the sub centres even where there were government buildings ANMs refused to stay. In case of male workers they rarely visited the fields. Therefore a suggestion was given about appointing another female assistant to the ANMs. For the ANMs where government building was not there, Rs 70 per month was given and for male workers 5% of their basic pay, which was Rs 160, was provided. According to the ANMs this policy was quite discriminatory for them. In fact this was one of the main grievances of ANMs in all the four block PHCs in two districts that we studied. In the entire four block PHCs the ANMs were of the view that they had to face regular abuses from the village males. Further there was inadequate training of ANMs and as a result most of the ANMs interviewed were not aware about various national programs and about the treatment procedures. Besides, the group interviews with ANMs revealed that their focus was mostly on achieving the targets of female sterilization for each month under RCH and to conduct immunization programs. All these structural issues had a strong bearing on the effective functioning of various sub centres and through them various national programs.

The shortage of male supervisors was hampering in the supervision work for the ANMs. Besides the existing supervisors interviewed were of the opinion that as they were not provided any travel allowance for field visits, they had to visit their fields by bi-cycle. As a result most of them used to visit their fields very rarely. However there were

412 Giving a very harsh opinion on the contractual doctors at periphery level institutions in Orissa one senior officials in the state observed, “All the contractual doctors have their own NGOs where most of the time they spend rather than being in their posts.”
suggestions by the medical officers for establishing the post of Lady Health Visitors so that they could interact well with the ANMs and so that the supervision work could be possible.

At the level of PHC (New) institutions\textsuperscript{413} it was observed that in most of the cases the medical officers were absent and in their place the pharmacists were heading these institutions. Therefore it was suggested that at these institutions pharmacists were enough to operate daily activities. Another suggestion was that instead of one medical officer two medical officers could be appointed in these institutions, so that if one was absent than other would be available. However, this was not a feasible solution because the medical officers were not absent because of work load, rather they were resentful about being posted in a remote and difficult area. However interestingly the government of Orissa was planning to convert these PHC (New) s into block headquarter PHCs according to the all India pattern. Therefore it seems that this was totally contrary to the ground reality. Thus we could say that the reforms have not made an effort to address these structural issues.

Similarly while the district cadre for paramedics’ scheme had been introduced, in reality nothing has changed. The idea was that an ANM should live closer to the community and hence they should not be transferred frequently. The medical officers’ in-charge at the block headquarter PHCs were very unhappy about their current postings because there was no promotion policy or rather the transfer and postings policy was very arbitrary in nature. This has created a sense of helplessness among them.

Besides the infrastructure from block PHC level downwards were in a dilapidated condition. While the block headquarters PHCs were requiring urgent repairing at many places, in most of the PHC (New) institutions there were no water and electricity supply. There was no all weather road connectivity to these institutions and in rainy seasons many of them used to be cut off from their block headquarter PHCs. One of the CDMOs was of the opinion that due to political pressures the PHC (New) institutions were being

\textsuperscript{413} These were single doctor headed medical institutions.
created in Orissa. However these politicians never looked that how in a remote place such an institution would function or where the funding would come from to provide for water, electricity or maintenance costs or how could various staffs be motivated to stay in such places.

The sub centers were at worst condition among these three levels of institutions. Those few sub centres where there was a government building, mostly it was used by stray cattles! Further, from the block headquarter PHCs to various PHC (New) s and to sub centres, in most of the places, there were no pucca or all weather roads. As a result supervision work was difficult, the medical officers at PHC (New) s were refusing to stay and the ANMs had to cover their field villages by walking.

Conclusion:
Our analysis of the health sector reform process in the two districts of Sundergarh and Khurda showed that there were no consultations held with the CDMOs with regard to health sector reforms. This was a significant lapse in the implementation of health sector reforms because if the officials at the district level were not consulted at the beginning they would feel left out of the process and would not give their commitment to the various reform initiatives.

Similarly it was observed that the medical officers’ in-charge at the block PHCs were not even aware that different reforms were being carried out by the state government. However the most surprising thing was that even the CDMOs were not aware that some of the health sector initiatives by the state government were reform initiatives. This was primarily due to two reasons, one was that there was definitional confusion and another was that there was no effort at the level of health directorate to make the CDMOs aware about various reform initiatives in health sector. As a result various reform initiatives were being carried out at the district level as any other routine activities. Therefore it was

---

414 Because any new initiative in the 1990s by the state government had been termed as a reform initiative by the ‘Orissa Vision Document 2010’.
415 This was the observation of one senior official in the health department of government of Orissa.
important that the CDMOs were to be involved for achieving the expected outcomes of the reforms.

Broadly at the district level we could say that three elements of reforms were introduced, according to our definition of health sector reforms. These were, introducing the scheme of contractual doctors, introducing user fees at district health quarter hospitals and sub divisional hospitals under the OHSDP project and identifying indigenous medical practitioners. While there have been no discussion about handing over PHCs to NGOs in these two districts, still we have presented the opinion of two CDMOs in these districts about this reform element.

At the block level it was observed that contractual doctors have been appointed in the two of our study districts. Only the retired doctors were applying for these posts knowing that they won’t have to visit these institutions regularly. This reform initiative did not address the structural constraints a medical officer faces in working in a remote and difficult area, for there was no effort or no discussion about making the transfers and postings policy transparent in case of the medical officers. Therefore this initiative was also not working in reality.

In case of user fees while the CDMOs were very enthusiastic that this had helped the health institutions in meeting their miscellaneous expenditures. They were of the opinion that earlier due to this lack of money they were helpless in repairing minor faults in different diagnostic equipments or for petty maintenance in district headquarter hospitals. At the same it was also agreed that the poor were not getting exempted from paying user charges. However the real matter of concern was that there was no effort at the district levels to ensure that the poor were exempted from paying user fees. Interestingly even the medical officers’ in-charge at block PHCs were in favor of introduction of user fees at block headquarters PHCs for certain services. According to one of them if the poor could spend their money on drinks why not pay for their health care services?

There were efforts to identify the indigenous medical practitioners in Sundergarh district so that they could be involved in referrals to nearby PHCs specifically with matters
related to pregnancy related complications and in cases of fever, which was most likely to be malaria.\textsuperscript{416}

About the scheme of handing over PHCs in remote areas to NGOs both the CDMOs were opposed to the idea. Particularly they were not favorable to the idea of involving NGOs in operation of PHC (New) institutions. Interestingly during the field visit it was observed that the state government was identifying NGOs through the mother NGO scheme to hand over these PHC (New) institutions in remote and difficult areas. This suggests that before implementing this scheme, concerned CDMOs were not consulted.

Various systemic changes introduced in these two districts were: mandatory pre-PG rural scheme, training of medical interns at CHCs under the guidance of CDMOs, the new drugs policy, Pancha Byadhi Chikitsa scheme, petty maintenance of PHC health quarter buildings and creation of ZSS.

The mandatory pre PG rural scheme and the training of medical interns at CHCs under the guidance of CDMOs have also failed in these two districts because of lack of a transparent transfers and posting policy and apathy of senior officials toward the public health aspects. This was also due to the fact that even the CDMOs had their own private clinics where they used to spend their evening hours.

The new drugs policy on the other hand has ensured the availability of quality drugs at various levels of district health institutions and this has also increased the drug use by patients at these various levels in our two study districts. However it was observed that while medicines for Pancha Bhyadhi Chikitsa scheme were available at different health institutions, people were not aware about their rights under this scheme.

For the petty maintenance of PHC headquarter buildings money was not coming regularly to the block PHCs. There were also allegations of misuse of funds under this scheme by the medical officer in-charge in the block headquarter PHCs.

\textsuperscript{416} As Sundergarh was an endemic district in terms malaria, in western part of Orissa.
On the other hand the creation of ZSS had helped in better coordination of district funds and the amalgamation of different societies had helped in its effective functioning under the supervision of district collector.
Annexure 1:

**OHSDP Institutions in Sudergarh District:**
- District Headquarter Hospital.
- Sub Divisional Hospital Bonai.
- Rourkela Government Hospital or RGH.
- Mohapara CHC II.
- Mangaspur CHC II.
- Kinjhirkela CHC II.
- Kuarmunda CHC II.
- Birmitrapur CHC II.

Note: 10 bedded wards in each CHC II with 1- for delivery room, 1- for minor operation, 1- for waste management.

**New Staffs under OHSDP in Sundergarh District:**
- RGH Rourkela: Assistant Surgeon- 5, Dental Surgeon- 1, and Staff Nurse- 9, Assistant Matron- 1, Lab Technician- 1, Technical Store Keeper- 2, Radiographer- 2.
- Bonai Sub Divisional Hospital: Assistant Surgeon- 2, Anesthesia Specialist (Class II)- 1, Staff Nurse- 5 (contractual).
- Kinjhirkela CHC II: Specialist O&G- 1, Staff Nurse- 5 (contractual).
- Mangaspur CHC II: Specialist O and G- 1, Staff Nurse- 5 (contractual).
- Birmitrapur CHC II: Specialist O& G- 1, Staff Nurse- 5 (Contractual).
- Kuarmunda CHC II: Specialist O& G- 1, Staff Nurse- 5 (Contractual).
- District Headquarter Hospital: Matron- 1, Assistant Matron- 1, Lab Technician- 1.

Note: The posts of staff nurse in most of the OHSDP supported institutions were contractual in nature.