1. OBJECTIVES AND METHODOLOGY

INTRODUCTION.

1.1. The idea of developing Primary Health Centres (PHCs) as the focal point for providing comprehensive and preventive health service in the rural areas in India was first presented in a concrete form by the Health Survey and Development Committee of Government of India in 1946. However, due to various reasons, such as shortage of funds and of technical personnel, the establishment of PHCs could not be carried out until 1953. The Central Council of Health at its first meeting held in January 1953 accepted the provision of one PHC in each Community Development Block, as an essential part of the CD Project. Since then there has been a substantial momentum to this activity and by the end of 1977 as many as 5,353 PHCs in as many number of CD blocks are functioning in rural India.

1.2. The PHC forms the nucleus of the health activities in the area and is intended to provide integrated health care, both curative and preventive and to serve as a focus from which health services radiate into the area covered by the development block. It has been recognised that PHCs will naturally be able to offer only limited services and must therefore be supported by a series of appropriate higher level medical organisations.

1.3. The Committee recommended, as a short term programme, that a PHC should cover a population of 40,000.

1.4. There are currently 4 PHCs in the agency area of East Godavari district. One in each of the four blocks excluding Sankhavaram. Most of the tribal families of Sankhavaram Block use Rajavommmangi PHC, as their villages are geographically closer to the same.
However, administratively, these villages come under Sankhavaram PHC which is located in a non-tribal village. These four PHCs are in charge of 27 sub-centres spread over as many villages of the agency area.

1.5 In the ITDP sub-plan of East Godavari district with a view to provide adequate arrangement for referral services to the patients in the project area, two vehicles, one each at Rampachodavaram and Addateegala Block Headquarters, will be maintained. These will be primarily, used for transporting medical and para-medical personnel to the villages for immunisation camps and health education campaigns.

In addition, residential quarters for personnel employed in the four PHCs and for ANMs will be constructed.

This section presents the summarised views of the Medical Officers.

OBJECTIVES

1.6 The detailed objectives of the survey among medical officers of the PHCs have been to find out

i. the extent of usership of PHC by tribal population

ii. the limitations faced by medical staff in attending to the patients.

iii. the improvements and modifications desired for providing better service to the tribal population.
METHODOLOGY

1.7 Free unstructured discussion technique has been adopted for interviewing the medical officers of the PHCs. This technique has been felt to be more fruitful since in the structured questionnaire method the medical officer might rationalise his answers and hence the underlying motivational (or even demotivational) factors will not be brought out. The guidelines used for the free interview are presented in the appendix.

SAMPLE SPREAD

1.8 As stated earlier, the medical officers of all the four PHCs have been interviewed for the study.

PERIOD OF STUDY

1.9 The field work of interviewing the medical officers has been carried out during the second half of June, 1980.
II SURVEY FINDINGS

2.0 The table below compares the number of PHCs and rural population in all India, Andhra Pradesh and Agency area.

TABLE 2.1. NO. OF PHCS AND RURAL POPULATION.

<table>
<thead>
<tr>
<th>Sector</th>
<th>Total PHCs (at the end of 1977)</th>
<th>Rural Popn. (1000) (1971 Census)</th>
<th>Population served by a P H C</th>
</tr>
</thead>
<tbody>
<tr>
<td>All India-Rural</td>
<td>3,353</td>
<td>438,796</td>
<td>51,972</td>
</tr>
<tr>
<td>Andhra Pradesh-Rural</td>
<td>418</td>
<td>35,100</td>
<td>83,971</td>
</tr>
<tr>
<td>Agency Area of East Godavari District</td>
<td>4</td>
<td>151*</td>
<td>37,750</td>
</tr>
</tbody>
</table>

* including non-tribal population.

It can be seen that as compared to elsewhere in the country where a PHC on an average serves a population of about 82,000 in the agency area of East Godavari District the population served works out to only 37,750.

While this indicates that already a certain importance has been attached to the health care of the tribal population, such a set up is very necessary in view of the hilly terrain of the agency area.

2.1 From the talk with MOs it is gathered that on an average 60 patients visit a PHC in a day; of these 65 percent or 40 in number are tribals. Recognising the fact that in the four villages where PHCs are located the tribals form only 37 percent of the total population, the higher proportion of tribals coming to PHC can be attributed to the following two reasons

i. the usership of PHC by nearby villages, where tribals will form a higher proportion and
11. the higher economic status of non-tribals that enable them to use paid services of a private medical practitioners.

2.2. In the opinion of MOs there has been a steady increase in the number of patients coming to PHC. As compared to a daily attendance of 42 per PHC in 1977, the figure has gone up to 56 in 1978 to 60 in 1979.

2.3. All the four MOs are of the opinion that most of the tribals report at an advanced stage of the disease. Besides being negligent about the distance of the village from the PHC also plays a major role in their coming at the advanced stage.

2.4. The MOs opined that a clear trend is seen in tribals coming out more enthusiastically in accepting the treatment and medicines.

2.5. The diseases commonly reported are diarrhoea, Dysentry, scabies and malaria. These are attributable to, in the opinion of MOs, to lack of protected water supply, mosquito menace and lack of personal hygienic conditions.

The solution for these as seen by MO is, besides controlling the extraneous condition, providing an intense health education through audio-visual media.

2.6. Each PHC has a sanctioned strength of eight staff members as given below:

One Medical Officer
Two Doctors
One Health Visitor (Lady)
One Auxiliary Nurse Midwife (ANM) (Lady)
Two Compounders
One Watchman
Besides these a few more ANMs and MPWs (Multipurpose Workers—Male and Female) and Dais are posted at different Villages under each PHC.

It is observed during the visit that in each PHC there has been some vacancies even though these could not be ascertained in detail.

2.7 The Medical Officers do not feel lack of sufficient manpower as a limitation for carrying out the duties of PHC. They only expressed a desire for posting a few more Health Visitors at the villages. This they felt would not only increase the effectiveness of their services to tribal families but also avoid the difficulty faced by the Lady Health Visitors in going from one village to another.

2.8 All of them bitterly complained about their inability to make even minimum visits to the villages. The petrol quota given to them is inadequate. Being medical personnel, they fell highly dissatisfied if they are unable to treat a patient due to lack of conveyance in reaching the patient in time.

2.9 They also complained about non-supply of the drugs and medicines they ask for. In this context, they quoted instances when they had to send the patients to the higher level hospitals due to lack of the desired medicines or drug with them. Some of them even took these instances as a personal insult.

In this connection, it may be recalled that the basic purpose of a PHC is of health care rather than of medical care. This aspect does not seem to have taken roots in the mental setup of the MO of a PHC. In view of this, it is strongly felt that an orientation programme for the MOs explaining the role of PHC will be of great help.
2.10 The other complaints voiced by the MOs have been more personal. They feel unhappy due to not having even certain basic facilities such as protected water supply, provision of furnished quarters and lack of good educational facilities for their children.

Removal of some of these limitations will go a long way in securing them full attention to their job.
III CONCLUSIONS

3.1 Based on the in-depth discussions with the MOs, the following is concluded:

i. In complete contrast to the attitude of the organisers of Ashram Schools, SNP Centres, Anganwadis and Teachers Depots, there exists a negative attitude among the medical officers of the PHCs with regard to their function and responsibility.

ii. It is amply clear that the medical officer is not at all committed to the function of a PHC. He does not seem to have understood the health care as the basic objective of a PHC. He overplays his inability to treat a diseased patient, he does not talk about his carrying out or otherwise of preventive measures such as immunisation programme and health education.

iii. They are also put by the lack of basic facilities for their families, a coming to live in these remote tribal areas.

iv. No proper statistical record is being maintained at the PHCs. Without such a record, it will become extremely difficult to assess the success/failure of the health care programmes carried out by the government now and again.

v. It has been observed that there exists a serious lack of co-ordination between PHC staff and the other officials in the tribal area.