Summer Training at
CRY-Child Rights & You, Kolkata
(April 1–May 31, 2014)

Accessibility & Availability of Health Services

By
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Under the guidance of
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MBA- Hospital & Health Management (MBA-HM)
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CERTIFICATE

This is to certify that Mr. Melvin John Baxla has completed the summer training at **CRY-Child Rights & You, Kolkata** from 1.04.2014 to 31.05.2014 and has conducted the following project under my personal guidance and supervision. All the data related to the study is the first hand data collected by him.

Project – Accessibility and availability of health services in district Munger, Bihar

His approach to the project has been sincere, scientific and analytical. This work is partial fulfillment to the course requirements, recommended for the Post Graduate Diploma in Health and Hospital with specialization in Health Management.

I wish him all the success in future endeavors.

Colonel (Dr.) Ashok Kaushik
Dean (Academic & Students Affairs)
IIHMR, Jaipur

Prof. Barun Kanjilal
Professor
IIHMR, Jaipur

CHILD RIGHTS AND YOU

Ensuring lasting change
For children

30th May 2014

TO WHOM IT MAY CONCERN

This is to certify that **Mr. Melvin John Baxla** (Student of PGDHM, Institute of Health Management Research, Jaipur) was placed in **CRY-Child Rights and You, Kolkata** for internship program from 1st April 2014 to 30th May 2014.

In this tenure, he underwent basic orientation program entailing the organization's evolution, Vision, Mission, program approach and organizational structures, systems and processes and specially the functions of Development support unit in which he was placed. After the orientation program he undertook a study on **"Accessibility and availability of heaith services in Munger" Bihar.** During this study, he was stationed at Munger and closely worked with **Disha Vihar, development project partner of CRY**.

During his stay in **DISHA VIHAR**, he visited operational field & Health center, interacted with the stakeholders and collected data. He also took part in orientation to understand the Disha Vihar present interventions, area of operation, stakeholders, formal orientation on development notions and organizational structure.

In this stint of Internship period we found Melvin disciplined in his approach open to learning, proactive, and a pleasant personality to work with. His perspectives on rights based approach got enhanced through these internship programs.

We believe that this Internship experience has sharpened his overall understanding on child rights and hope he would remain an advocate of child rights.

We wish him all the Best for his future endeavors'!

(MOHUA CHATTERJEE)
General Manager – Development Support Unit

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Glossary

ANC	Ante Natal Care
AEFI	Adverse Event Following Immunization
AFP	Alpha-Fetoprotein Blood Test
AIDS	Acquired Immuno Deficiency Virus
ANM	Auxiliary Nurse Midwife
APHC	Additional Primary Health Centre
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
BCG	Bacillus Calmerre-Guerin
BPL	Below Poverty Line
DOTs	Directly Observed Treatment short-course
DPT	Diptheria, Pertussis and Tetanus
ER	Emergency Room
FGD	Focused Group Discussion
GOI	Government of India
HeP B	Hepatitis B
HIV	Human Immunodeficiency Virus
HR	Human Resource
IDSP	Integrated Disease Surveillance Project
IFA	Iron Folic Acid
IPHS	Indian Public Health Standards
IUCD	Intrauterine Contraceptive Device
IUD	Intrauterine Device
JSY	Janani Suraksha Scheme
LHV	Lady Health Visitor
MCH	Maternal and Child Health
MNH	Maternal and Neo-natal Healthcare
MO	Medical Officer
MTP	Medical Termination of Pregnancy
NCD	Non-communicable Disease
NFHS	National Family Health Survey
NRHM	National Rural Health Missiom
OCP	Oral Contraceptive Pills
OPD	Out-Patient Department
OPV	Oral Polio Vaccine

Glossary

OT	Operation Theatre
PHC	Primary Health Centre
PRI	Panchayati Raj Institutions
PRP	Platelet-rich Plasma
RCH	Reproductive and Child Health
RKS	Rogi Kalyan Samiti
RNTCP	Revised National Tuberculosis Control Programme
RTI	Right to Information
SC	Sub-Centre
SPIP	State Program Implementation Plan
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
TB	Tuberculosis
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Commitee

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ABSTRACT

The quality of healthcare in Munger is highly varied. In the urban areas of the district, healthcare is of adequate quality, somehow approaching and occasionally meeting fair standards. However, access to quality health care with medical facilities, health services or health education is limited or unavailable in most rural areas. It is surprising to observe urban medical practitioners or private practitioners being highly sought after by residents of rural areas as their services are more productive and more result oriented as compared to the Government ones in spite of the fact that the practitioners working in the formal public health care sector are more financially affordable and geographically accessible than the alternative. Government's initiative has provided much change as compared to the previous conditions by training thousands of volunteer village women who counsel families on the benefits of exclusive breastfeeding and provide other information vital to the survival of children and mothers who are pregnant or nursing. It is due to this factor that it has improved a lot in the health deliverance conditions as compared to what it was earlier.

INTRODUCTION

Munger has a fairly extensive network of public health facilities it remains grossly inadequate compared to the Government of India (GoI)/Government of Bihar (GoB) norms. Furthermore, even the existing facilities lack the basic minimum infrastructure needed for their optimal functioning. According to the information available, as per the district health plan, Munger has 9 PHCs covering a population of 1,359, 054, i.e. an average of one PHC for a population of 1, 51,006 as against the norm of 20,000 in hilly, tribal, or difficult areas and 30,000 populations in plain areas. (IPHS Guidelines, 2012). A similar situation prevails with regard to facilities at the Health Sub-Centre level, where the state has 155 Health SCs i.e. an average of one Health SC for a population of 8768 as against the norm of 5000 people in the plains and for 3000 in tribal and hilly areas. (IPHS Guidelines, 2012).

Table 1 : Distribution of Sub-Centres in 4 blocks of Munger

S. No.	Block Name	Population	Sub-Centre's Required	Sub-Centre's Present	Sub-Centre's Gap
1	Sadar Munger	355412	28	23	5
2	Kharagpur	216645	48	26	22
3	Asargunj	71289	17	11	6
4	Tarapur	100947	23	17	6

(Source: Munger District Healthplan, 2012-2013; DLHS 3)

The Sub-Centres provides only consultation and immunization. Maternal and Child healthcare, which also includes family planning, has emerged as the main function of PHCs and SCs. Delivery procedures are to be taken care by the ANMs at the Type – B, SCs, however with unmatched equipments and low supplies and facilities, this is extremely regrettable to function. Only normal deliveries are conducted at the PHCs now with complicated cases being referred for further treatment.

[Type A, SC - This SC provides all recommended services except that the facility for conduction delivery is not available here.

Type B, SC - These Sub-Centres include centrally or better located Sub-centres with good connectivity to catchment areas. They have good physical infrastructure preferably with own buildings, adequate space, residential accommodation and labour room facilities. They already have good case load of deliveries from the catchment areas. There are no nearby higher level delivery facilities from this SC.] (IPHS Guidelines, 2012)

Roy and Prasad (1963) revealed in his studies the socio-medical aspects of OPD patient and further states that 73 percent patient had to wait at the OPD for more than 90 minutes before they are examined by the doctor. About 73 percent patients are dissatisfied by the doctor's attitude and 36 percent reported that there are shortages of staff. Around 58.3 percents are dissatisfied by sitting arrangements, toilet facilities and cleanliness.

Chahal (2003) identified in his study about PHCs that about 31 percent of the patients pointed that doctors were not empathetic and not commendable. The study reported that surgical equipments were of poor quality and the PHCs lacked in hygiene, cleanliness and maintenance. 57 percent of patients pointed out that they had never been asked about their grievances.

RESEARCH PROBLEM:

Utilization of health services is a complex behavioral phenomenon. The public health care system is inadequate in quality as well as in quantity. The growing demand for the quality health care and the absence of matching delivery mechanisms pose a great challenge. High absenteeism, low quality in clinical care, low satisfaction levels of quality care (clinical and with regards to courtesy and amenities) and rampant corruption plague the system. This has led to mistrust of the system, rapid increase in use of the treatment services provided by the private sector, high out of pocket expenditure that take a serious toll on families and quality of care. Empirical studies of preventive and curative services have often found that use of health services is related to the availability, quality and cost of services, as well as to social structure, health beliefs and personal characteristics of the users.

In the rural areas where the major chunk of population lives, the main source of health care is the government health centres that include PHCs and sub-centres, traditional healers, quacks and the private practitioners. The quality of government services in the rural areas has deteriorated to a great extent making these health centres dysfunctional due to lack of medicines and medical staff. 75 per cent of the health infrastructure and medical personnel in India are concentrated in the urban areas (Patil, et al, 2002). Extreme inequalities and disparities persist in terms of access to health care. This large disparity across India places the burden on the poor and especially women and children (the future of our nation).

RATIONALE OF STUDY

- *Precise facts plus information is essential to develop exact programming:*

Interventions such as community observing and encouraging women in accessing government services and awareness programs with community in ensuring children's right to health along with various programmes designed to engage with community based health workers like ASHA, ANM and AWW brings improvement in the health services overall. These types of interventions do impact in the health and treatment seeking behaviour among under privileged communities. But, to bring in long lasting changes in behaviour and practices with in community, the program needs to give more focus on the behavioural aspect and attitudinal change towards common perception and practices. To design such program, specific behaviour related data is required from both beneficiary and service provider's levels. This information would contribute in identifying the intervention areas, the areas which are needed to be looked at to bridge the gap of implementation and to bring lasting change in health status of community.

- *Explanations for insufficient operation of community based services necessitate profound investigation:*

Often the reasons for insufficient implementation are simplified as lack of commitment of health service providers, lack of supplies of medical materials, or community unaware and un-educated to understand importance of treatment seeking behaviour. From time to time it has been found that government system shows indifference to reach out to the people in remote areas. The health seeking behaviours also differs from one community to other. Some of the traditional beliefs and practices responsible are in not accepting government health facilities. The survey would attempt to go deeper and gather our some of the critical areas of concern in service delivery and service acceptance. The community health service providers often face serious problems in delivering services. Those areas need to be analysed.

- *Specific data would help making effective advocacy at various level:*

Advocacy at any level gets strengthen if it is backed by evidence. It is expected that empowered by the evidence, collected through the survey, partners and alliance would be able to advocate with government and elected representative towards bringing in positive changes in the lives of women and children. This would not merely have impact in operational areas but also may facilitate greater change at state level.

RESEARCH OBJECTIVES:

- To assess the provision of services by the community health workers and the health institutions in Munger

- To assess the satisfaction levels of health services by the health workers and health institutions among the community in Munger

- To come out with the recommendation for plan of action

METHODOLOGY:

Setting of the study/ Study area: *4 Blocks in District Munger, Bihar.*

Type of Study: Quantitative & Qualitative

Study Design: Descriptive, Cross-sectional

Medium of instruction: Hindi

Sample: 4 PHC (Sadar Munger, Kharagpur, Asarganj, Tarapur); 8 Sub-centres (Sitalpur, Hasanpur, Bibhay, Gangta, Chaurgao, Baijalpur, Chakhand, Rangram); 40 Exit Interviews of beneficiaries of the 4 PHCs & 20 women communities FGD.

SAMPLE SIZE:

An extensive survey over 4 PHC's, 8 Sub-centers, 10 Exit Interviews of the beneficiaries and 20 Focused Group Discussions on 20 women groups in four blocks was undertaken. Using a specific health institution guideline, questionnaire based on the experiences of the beneficiaries and a women-oriented questionnaire were determined. Local health-related behaviours and attitudes as well as communication with the ANM's & ASHA's were also focused upon.

TOOLS AND TECHNIQUES:

A checklist was prepared on the foundation of IPHS 2012, for the PHCs and the SCs based on the infrastructure, presence of equipment and supplies (in working conditions) and also the staff and personnel. A semi-structured questionnaire was used to target the beneficiaries of the PHCs and the village women community. The questions were about their experience with the practitioners, the staff and employees of the concerned health centre along with their satisfaction levels regarding their services. The FGD conducted was done among a group of women, and questions were asked about their perceptions, opinions, beliefs, and attitudes towards the service provided by the health institutions and health service workers. Questions are asked in such a manner of in an interactive group setting where the women were free to talk with other group members with a unanimous reply.

DATA COLLECTION & FINDINGS

As per the Government guidelines, the entrance area of the PHCs are to be equipped with barrier free access environment for easy access to non-ambulant (wheel-chair, stretcher), semi-ambulant, visually disabled and elderly persons. Ramp as per specification, Hand-railing, proper lightning etc. must be provided in the health facility and retrofitted in older one which lack the same; (NRHM, 2012). **Table 2** explains the conditions at the 4 PHCs. PHC Munger, certainly missed a major part on the physical attributes for the efficient functioning of services for health provision. Had there been a hand-railing at the Tarapur, PHC, it just would have made it much easier for the beneficiaries who are visually disabled and simply elderly persons. The Sadar Munger, PHC, had an enormous ditch precisely in front of their main entrance, for which the patients had to go round about and then enter the premises. This being a difficulty in the easy entry into the PHC poses to be a big hindrance.

Table 2: Infrastructure amenities of 4 PHCs in 4 blocks of Munger

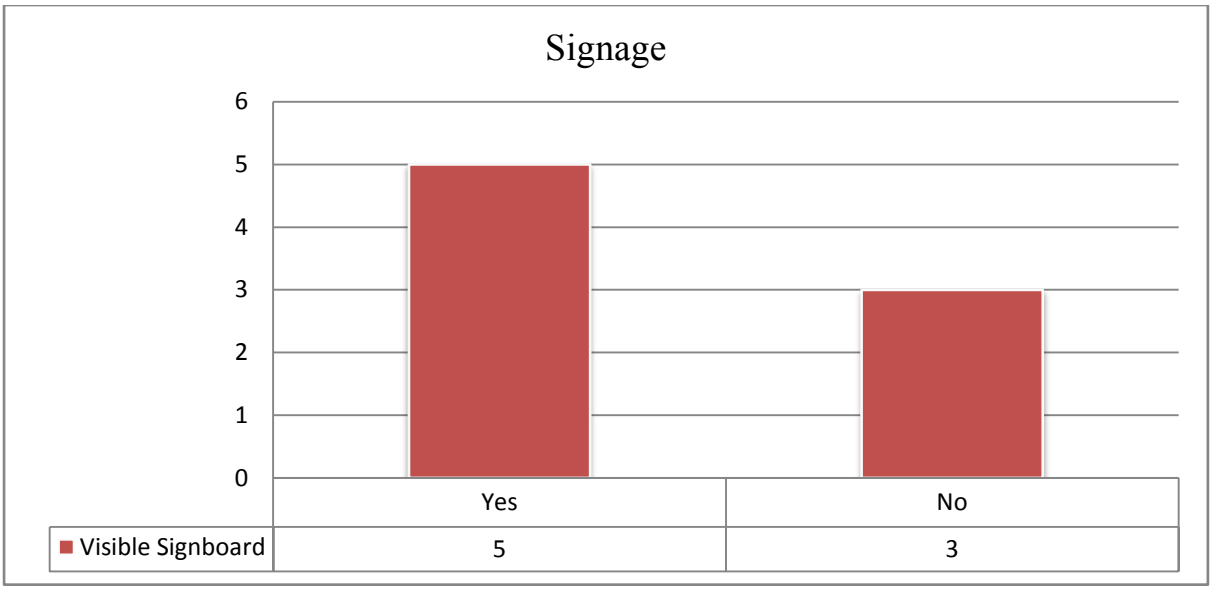
Particulars		Sadar Munger	Kharagpur	Asarganj	Tarapur
Entrance with barrier free access	Wheelchair	×	×	×	✓
	Stretcher	×	×	×	✓
	Ramps with railings	×	×	×	✓
Methods for disaster prevention	Fire Extinguisher	✓	✓	✓	✓
	Sand Bucket	×	×	×	✓
Situation at the waiting areas	Adequate Chairs	✓	×	×	×
	Separate lavatories	×	×	×	✓
	Safe drinking water	×	×	×	✓
Ward amenities	5.5 m*3.5 m; size	×	✓	✓	✓
	4-6 beds, male & female marked	×	×	✓	✓

The presence of the fire extinguisher was found at all the four PHCs. However, as the presence was particularly noted, the location of the same was observed to be far off from the reaches of the security guard in case or urgent emergency. On the other hand, there were no fire alarms to be found in any of the PHCs. All health staff should be trained and well conversant with disaster prevention and management aspects. Regular mock drill should be conducted. After each drill the efficacy of disaster plan, preparedness of hospital and competence of staff shall be evaluated followed by appropriate changes to make plan more robust. (IPHS, 2012) Unfortunately, none of the health centres were having a mock drill training event for their staff and employees.

Registration, assistance and enquiry counter facility are to be made available in all the clinics along with proper sitting arrangement, drinking water, ceiling fans and toilet facility separate for male and female. Main entrance, general waiting and subsidiary waiting spaces are required adjacent to each consultation and treatment room in all the clinics. (IPHS Guidelines, 2012) As per Table l, all the 4 PHCs were missing one factor or the other as per the Government stated guidelines. Absence of Enquiry help desks, improper seating arrangements (as required as per the load of the patients), drinking water (safe and hygienic), ceiling fans (on every floor and room) and toilet facilities (separate for both male and female) were present in only one of the 4 PHCs. Incompetence in delivering such privileges simply lets down the expectations of the beneficiaries even further.

Separate wards/areas should be earmarked for males and females with the necessary furniture. Cleaning of the wards, etc. should be carried out at regular intervals and at such times so as not to interfere with the work during peak hours and also during times of eating. Cleaning of the wards, Labour Room, OT, and toilets should be regularly monitored. (IPHS, 2012) As per **Table 2**, leaving apart Asarganj PHC and the PHC at Sadar Munger, the others were found to be having their ward conditions in such a manner that cross contamination was a bound possibility. With no bed side locker and stool for attendant, the patients would keep all their belongings and possessions on the bed mattress and the patient party would also sit on the bed itself. Few beds were even found to not having IV (Intravenous) stands.

Figure 1: Signage system in the Sub-centres



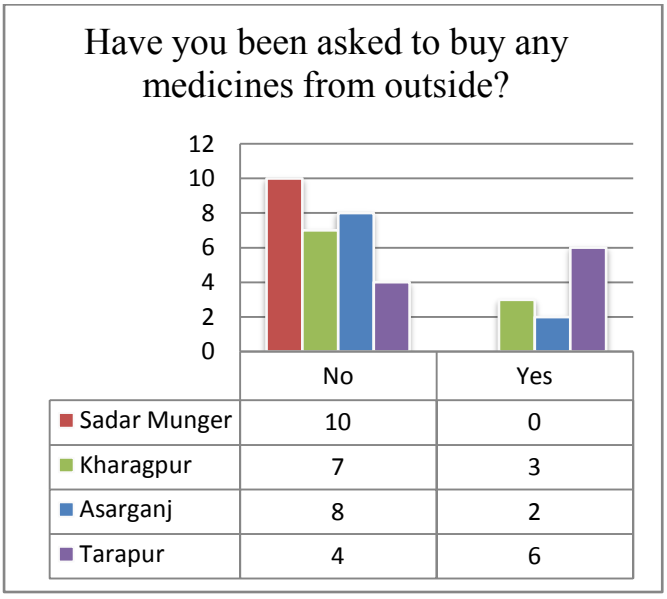
The main purpose of the signage and the signboards are to communicate and to convey information to the beneficiaries such that the receiver may make cognitive decisions based on the information provided. The signboard at few SCs did not display the necessary information like the name of the establishment or any other required information.

The writings and information were easily read from the signboard even from a distance. However whatever little information on the walls of the SCs were present, became plain withered as paints were all falling off. The signage boards for the directions were finely placed and it seemed that no beneficiary would have any problem in finding the SC.

Exit Interviews of the beneficiaries

The Union Health Ministry on 20 June 2013 launched the ambitious schemes called Free Drug Service and Free Diagnostics Service for providing free generic drugs at government health care centres to all patients coming to public sector facilities. (http://www.businessworld.in/news/finance/govt-launches-free-generic-drugs-scheme/947243/page-1.html)

Figure 2: Scenario of medicine provisions

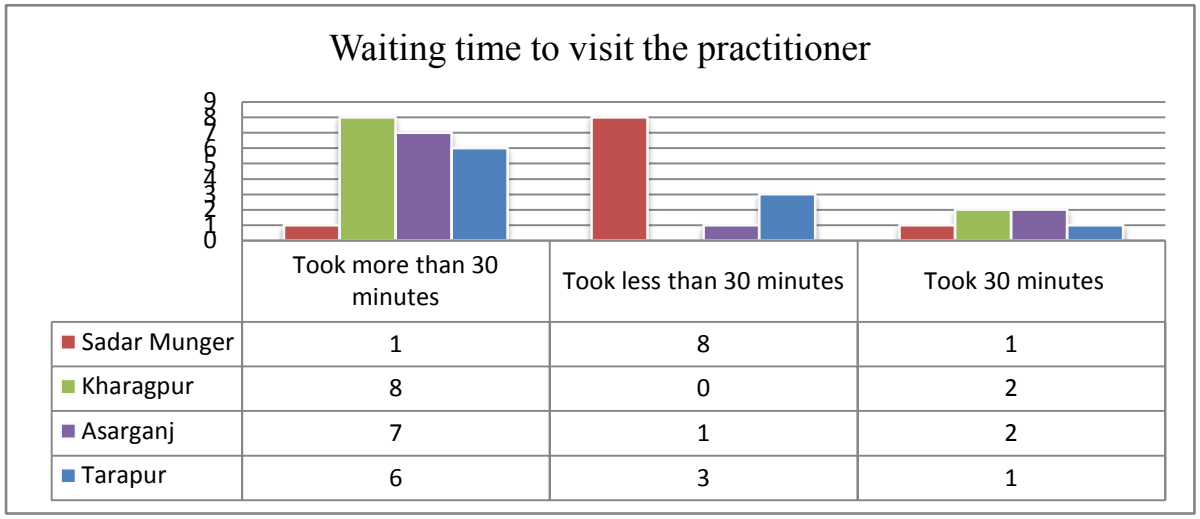


The schemes were launched under the National Health Mission. Under the scheme, public can avail free drugs and free diagnostics services at the government health centres and hospitals and would not have to buy medicines from outside. However the medicines were only limited to generic drugs and not private ones. The generic drugs included, Paracetamol, Azithromycin, IFA, B-Complex.

The Sadar Munger PHC only keeps drugs and medications for simple ailments and for injuries, such as that of dentistry, fever, cold and cough, etc. It does not keep complex medications for distribution. The patients who arrive to seek treatments for smaller ailments say that they never had the need to buy medicines from outside than this PHC. Beneficiaries visiting Tarapur PHC mentioned that they did receive free medicines, but a lot of times they had to buy injections from outside. There were few instances when they were also asked to buy drugs from outside pharmacies. However, according to them, the practitioner advised them to do this only when those drugs were not available in the PHC.

The waiting time in this concern is majorly due to the reason of long queues to visit the practitioner. As the PHC, Sadar Munger does not have many patients coming to visit the practitioners, it mostly remains vacant. The patient's do not require remaining in the long queues and hence don't take much time to visit the practitioner.

Figure 3: Waiting time for the beneficiaries



	Took more than 30 minutes	Took less than 30 minutes	Took 30 minutes
Sadar Munger	1	8	1
Kharagpur	8	0	2
Asarganj	7	1	2
Tarapur	6	3	1

However, as according to **Figure 2**, opposite is the case in Kharagpur, Asarganj and Tarapur. The PHCs are situated in more urban areas, bringing in more patients from different places, leading to prolonged waiting times. The second reason also being that they house better facilities than the smaller health centres along with the same free medicines. With limited doctors and large number of patients visiting, it results in longer queues and large waiting hours; thereby resulting in longer waiting durations.

Focused Group Interviews (women community)

A Village Health and Nutrition Day (VHND) or Health Day is observed every month in every village of the state to provide health care services to women, adolescents and children with discussions on health related issues like nutrition, personal hygiene; care during pregnancy, It is to be organized once every month at the AWC in the village and is seen to be as a platform for interfacing between the community and the health system.

Figure 4: VHND situation in the village

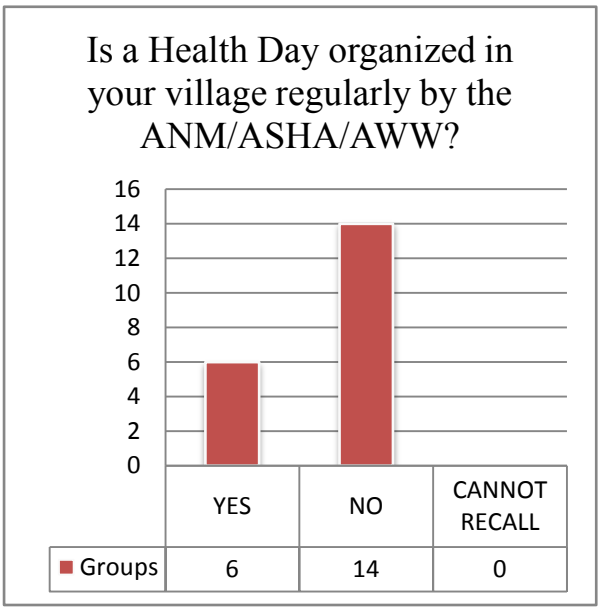
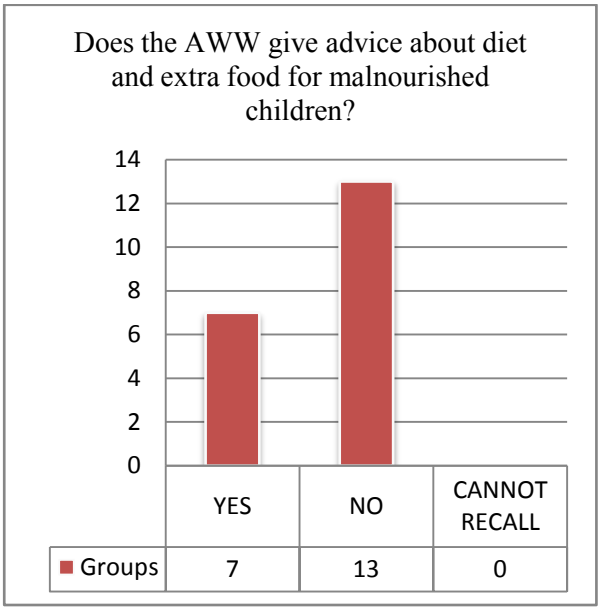


Figure 5: Information for diet for children



ANM/ ASHA of many areas along the region mostly limit their duties to no more than just immunization. The ANMs put no emphasis on health education, personal hygiene, education of children, dangers of sex selection, age at marriage, information on RTIs, STIs, HIV and AIDS, awareness of family planning, child nutrition, mother nutrition, hygiene or household sanitation. It is only in a few villages where some specific ANMs/ ASHAs consciously take measures to go ahead and actually execute their obligations up to the mark. This only explains their leniency towards other roles and responsibilities (**Figure 3**).

As the AWWs primary focus is on poor and malnourished groups and it is necessary to provide supplementary nutrition to both children below the age of 6 as well as nursing and pregnant women. The Anganwadi Worker (AWW) under the ICDS is supposed to engage in organizing supplementary nutrition programme and other supportive activities. The AWWs provide outreach services to poor families in need of immunization, healthy food, clean water, clean toilets and a learning environment for infants, toddlers and pre-schoolers. They also provide similar services for expectant and nursing mothers. Anganwadis's responsibilities are to weigh each child every month, record the weight graphically on the growth card, to organise supplementary nutrition feeding for children (0-6 years) and expectant and nursing mothers by planning the menu based on locally available food and local recipes.

However, only 7 groups out of 20 women community groups in 20 different villages confirmed this characteristic of the AWWs role (**Figure 4**) as functional where she was diligent enough to find the children who are underfed and malnourished and provide them due health and nutritional education to children.

The ASHA (Accredited Social Health Activist) is a trained female community health activist, trained to work as an interface between the community and the public health system and are intended to serve as a key communication mechanism between the healthcare system and rural population with their errands including motivating women to give birth in hospitals, bringing children to immunization clinics, encouraging family planning, treating basic illness and injury with first aid, keeping demographic records, and improving village sanitation. They receive performance-based incentives for promoting universal immunization, referral an escort services for RCH and other healthcare programmes and construction of household toilets. The ASHAs responsibility is to counsel women on birth preparedness, importance of safe delivery, breast feeding and complimentary feeding, immunization, contraception.

With all of this being the few roles and responsibilities of the ASHA, unfortunately, only 6 out of 20 groups agreed that the ASHAs fully functioned as per their tasks (**Figure 5**). 13 women groups confirmed that the ASHA only looked after and assisted in immunization services to the ANM and performed as if that was the only undertaking they were assigned for. However, most women group did mention that, the ASHA barely educated them, regarding matters on health and hygiene, sanitation and cleanliness and also on nutrition related topics, neither for women nor the child.

Figure 6: Counseling by ASHAs

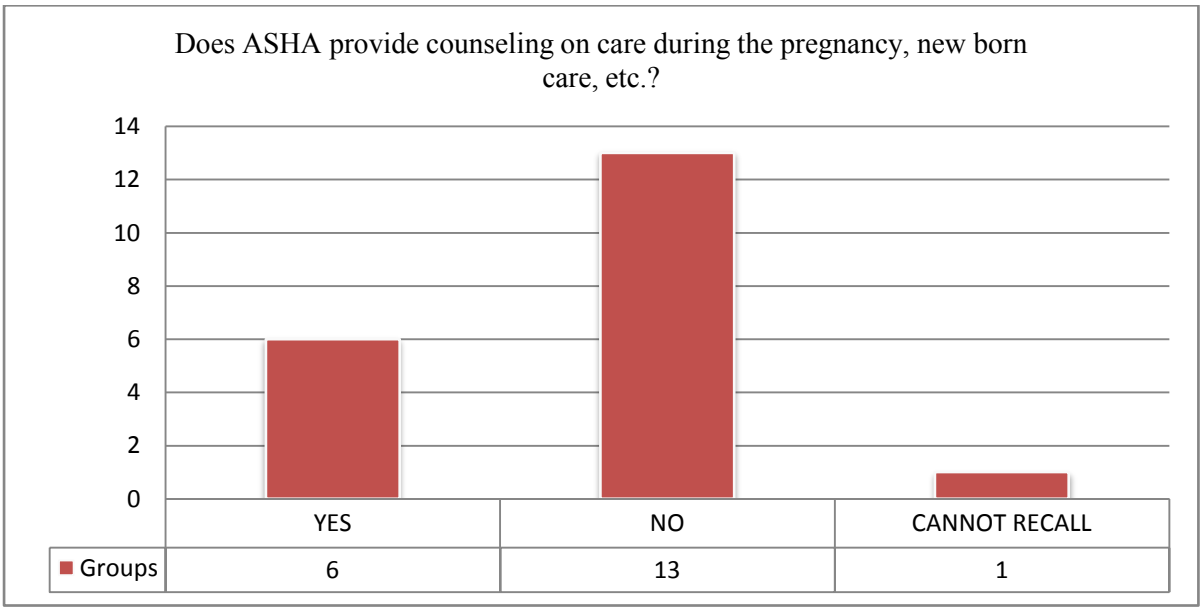
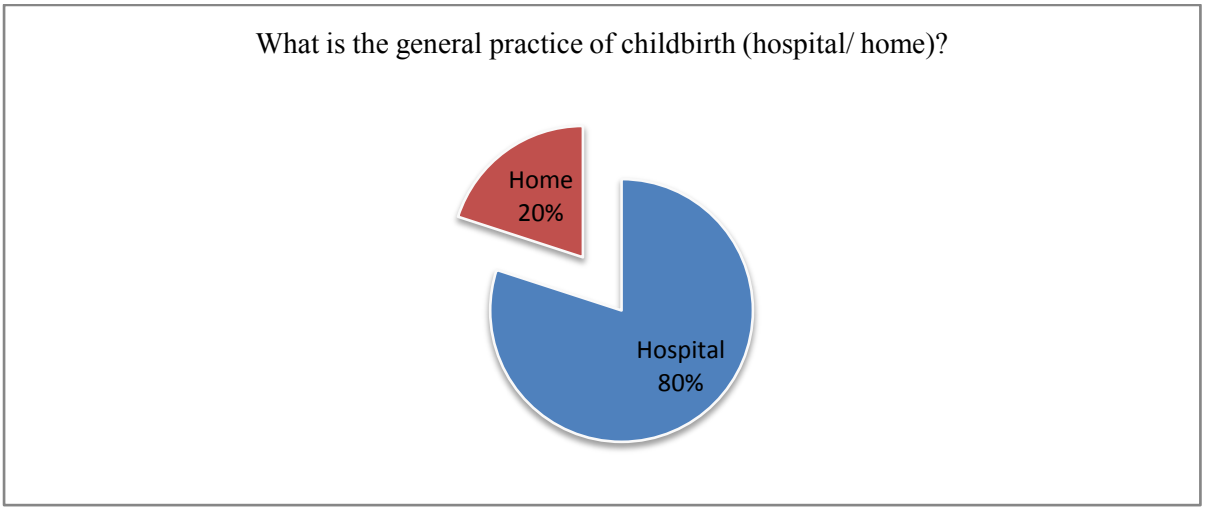


Figure 7: Current practice of childbirth



On seeking response from 20-women community groups in different villages it was found out that 20% of the women in these 4 blocks still undergo home-based delivery. Many explain their reasons to be such as, the PHC is ‘’too far to travel’’ or especially when there is dearth of time to travel to the hospital or when no transport services are available, or simply when the PHC is situated far away.

Physical access is an important barrier as longer distances entail higher transportation and opportunity costs. The adverse effect of distance is stronger when combined with lack of transport, poor roads, and poor quality of care. In a recent study, distance may become irrelevant in a setting with high-quality health facilities and transport infrastructures. Some studies have shown that households are keen to travel longer distances for high-quality care (Collier et al 2002).

Table 3: Separate Payment to ASHA after institutional delivery

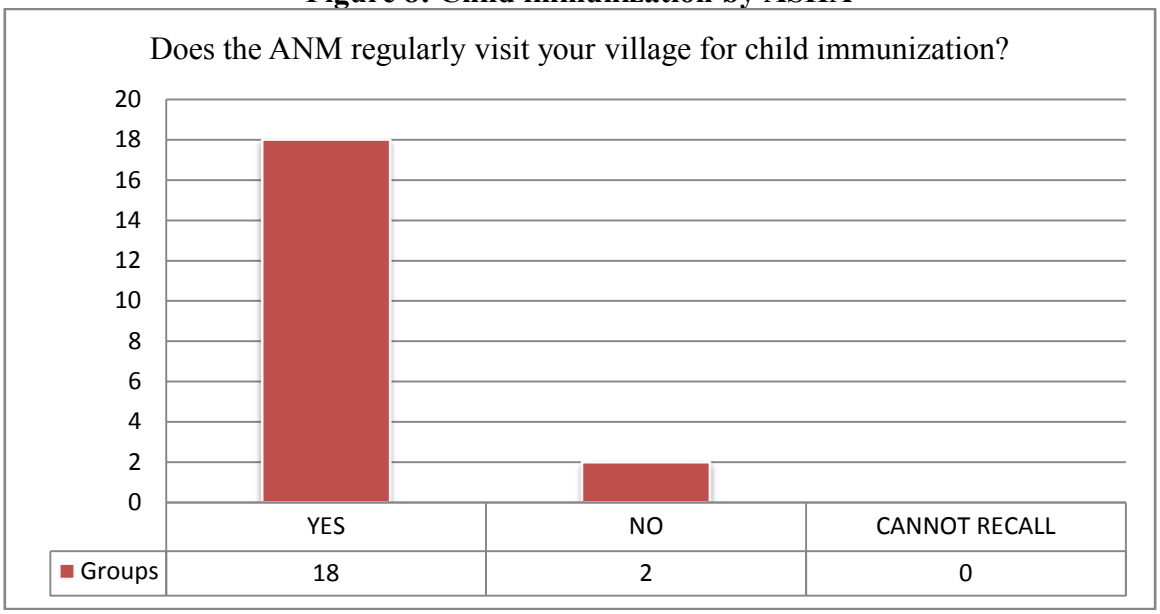
Replies by Women Group Communities	
YES	17
NO	3
CANNOT RECALL	0

As we observe, most (17 out of 20 groups) of the women community group confirmed and stated that the ASHA demanded money after they had accompanied the beneficiary to the health centre for delivery. There were moments when few family members would give money to the ASHA for her services out of content and joy. However, many mentioned that the ASHA has started strictly asking for money for her services and they had to reluctantly give her the money. A community group in Gangta mentioned that the ASHA threatened to not give them the birth certificate until unless they reward her with 200/-

Instances have also been noticed, as per the groups that the ASHAs would take 200/- out of the 1400/- (of the incentive) and give 1200/- to the beneficiary.

Such behaviour attitudes of the ASHA, simply brings a thought of doubt and distrust among the village residents in respect to ASHA and her services and may actually bring a situation once when the people would not want her services at all.

Figure 8: Child immunization by ASHA



The women community groups mentioned that the ANM takes a dynamic part in the immunization procedure. The scenario is that the ANM would let the village members know about the tentative date for immunization for their children and the beneficiaries' would go along with their children to the respective Sub-Centre to get their children immunized. However many groups did say ahead, that injections such as HeP B, Vit. A was not provided to their children. In fact many groups were not even aware that these vaccines were more than just necessary for their children's wellbeing.

The community groups in Gangta and Parhariya, contradicted to the question being asked and stated, that the women, themselves had to take their children to the PHCs to get their children immunized. The ANMs functioning in those areas would not inform the community people about the children's immunization services. Furthermore as per the women community in both the blocks, they were not provided with the concerned service for their children.

LIMITATIONS

1. Time Constraint
2. There was an immunization week declared on the first week of May, for which it was difficult to come across the ANMs at the Sub-Centres.
3. Requirement of an authorization letter at the Tarapur, PHC by the MO resulted in delays for data collection.

RECOMMENDATIONS

1. Strengthening of the Village Health Sanitation Committee on their roles and responsibilities.
2. Establish grievance receipt and redressal systems at Sub Centre and PHC.
3. Knowledge building of the community on the services offered from the Sub Centre for the pregnant, lactating mothers, children and the services from the PHC.
    a. Pooling of HR needs to be done, both in the health facilities of PHCs and the SCs. Only those personnel should be chosen who are determined and are strong-willed about their work and seek to perform their roles and responsibilities in the most efficient and effective manner possible.
    b. Undertaking of periodic assessment exercises of the facilities available as per government norms in the PHC & SC as per the IPHS norms and based on the findings, should develop phase wise improvement plans for Infrastructure, HR and Supplies.
    c. Orientation programmes to be held periodically on role clarity and skill enhancement of the health personnel.
4. Mapping of difficult areas and strengthen the ambulance service accordingly.
5. Ensure wide outreach of information on the toll free number for ambulance service within the community.
6. Adequate IEC process and awareness on government schemes to be organized for community.

CONCLUSION

"Universal health care in no country was achieved overnight," said Mr. Reddy. "In some case it has taken several decades; in some cases it has taken a century. But you have to begin somewhere."
K. Srinath Reddy, President, Public Health Foundation of India (PHFI)

Infrastructure forms a critical part of health service delivery in any country. Availability, accessibility, affordability, equity, efficiency and quality of MNH (Maternal and Neo-natal Healthcare) services highly depend on the distribution, functionality and quality of infrastructure. Most developing countries have invested substantially in developing health infrastructure in rural areas which provides a base for extending MNH services to the poor. Still, there is clear evidence that there are gaps and inadequacies in health infrastructure and its services.

It is evident from the study; all the types of health centres in the district are not adhering to the IPHS norms, and be it human resource, infrastructure or services. Some of the management staff is actually aware about IPHS, but they are not clear as how to make their facility centres according to the IPHS Guidelines. A coherent and sustainable plan that addresses the healthcare needs of the masses is strikingly absent. There are no national standards by which the physicians, nurses, pharmacists and hospitals are being trained. Guidelines and protocols for the management of disease, including the length of stay, are virtually non-existent in the health centres.

Public health is concerned with the health of the community as a whole. Its key goal is to reduce a population's exposure to disease. Many public health professionals argue for a greater expansion of government's role in the public health system. Then again there's this account where there appears to be widespread dissatisfaction, unhappiness and frustration amongst public about the healthcare they are getting even in the larger city hospitals. There is an intrinsic lack of trust in the health service delivering personnel. This trust deficit between the patients/public on one side and the community health workers/ health institutions on the other side appears to be causing a significant negative effect on the recovery and well-being of patients and the quality of care as a whole. The gap needs to be bridged and all sides need to take steps to make sure that there is a coherent approach that leads to better patient care and satisfaction at an affordable cost. The first step in this direction is to go back to basics and remind ourselves of the roles and responsibilities of each group.

REFERENCES

- Indian Public Health Standards (IPHS)-Guidelines for Primary Health Centres; Revised 2012
- Indian Public Health Standards (IPHS)-Guidelines for Primary Health Centres; Revised 2012
- An analysis of the primary health care system in India with focus on reproductive health care services by Amlan Majumder & V. Upadhyay
- Review of the Present Health Status of India, Emerging Health Problems and Their Solutions by M.C. Kapilashrami; 2000
- Monthly Village Health Nutrition Day- Guidelines For AWWs/ASHAs/ANMs/PRIs, Feb, 07
- Building the Infrastructure to Reach and Care for the Poor: Trends, Obstacles and Strategies to overcome them- D. Mavalankar, K. Ramani, A. Patel, P. Sankar
- Health workforce in India: assessment of availability, production and distribution
- http://shodhganga.inflibnet.ac.in/bitstream/10603/4259/16/16_chapter%208.pdf (26th May, 2014)
- http://heapro.oxfordjournals.org/content/18/4/327.full