AVAILABILITY AND ADEQUACY OF EMERGENCY MEDICAL SERVICES IN RURAL PRIMARY HEALTH CARE UNITS:

A STUDY OF THE NATIONAL CAPITAL REGION (NCR)

A Dissertation submitted to the Punjab University, Chandigarh for the award of Master of Philosophy in Social Sciences, in partial fulfilment of the requirements for the 45th Advanced Professional Programme in Public Administration (APPPA)

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CERTIFICATE

I have the pleasure to certify that Brig Desiraju Vivekanand has pursued his research work and prepared the present dissertation titled "Availability and Adequacy of Emergency Medical Services in Rural Primary Health Care Units: A Study of the National Capital Region (NCR)" under my guidance and supervision. The dissertation is the result of his own research and hard work. This is being submitted to the Panjab University, Chandigarh for the purpose of Master of Philosophy in Social Sciences in partial fulfilment of the requirement for the Advanced Professional Programme in Public Administration of the Indian Institute of Public Administration (IIPA), New Delhi.

I recommend that the dissertation of Brig Desiraju Vivekanand is worthy of consideration for the award of M.Phil. degree of Panjab University, Chandigarh.

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45th APPPA

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LIST OF ABBREVIATIONS

ACLS	Advanced Cardiovascular Life Support
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
ATLS	Advanced Trauma Life Support
AYUSH	Ayurveda,Unani,Siddha,Homeopathy
BLS	Basic Life Support
CHC	Community Health Centre
CHO	Community Health Officer
CMO	Chief Medical Officer
CPHC	Comprehensive Primary Health Care
DNB	Diplomate National Board
ED	Emergency Department
EMS	Emergency Medical Services
FGD	Focussed Group Discussion
FRU	First Referral Unit
HCP	Health Care Professional
HCW	Health Care Worker
HFA	Health For All

HWC	Health & Wellness Centre
HWC-SC	Health & Wellness Centre-Sub Centre
IDI	In Depth Interview
IPHS	Indian Public Health Standards
LIMC	Lower- and Middle-Income Countries
LHV	Lady Health Visitor
MCI	Medical Council of India
MLHP	Mid-Level Health Provider
MMU	Mobile Medical Unit
MoHFW	Ministry of Health & Family Welfare
MPW	Multi-Purpose Worker
NALS	Neonatal Advanced Life Support
NCD	Non-Communicable Disease
NCR	National Capital Region
NHM	National Health Mission
NMC	National Medical Commission
NRHM	National Rural Health Mission
OOPE	Out of Pocket Expenditure
PALS	Paediatric Advanced Life Support
PHC	Primary Health Centre/Primary Health Care

PMJAY	Pradhaan Mantri Jan Arogya Yojana
PPP	Public Private Partnership
PRI	Panchayati Raj Institute
RCH	Reproductive & Child Health
SDG	Sustainable Development Goals
SHG	Self Help Group
UHC	Universal Health Coverage
UNO	United Nations Organization
WHO	World Health Organization

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ABSTRACT

Introduction:

1. While India has made significant progress since Independence on the health front, the goal of Health For All (HFA) remains elusive. The lack of adequate health care facilities is especially stark in rural areas where close to 70% of India's population lives. Non availability of accessible and quality public health care services, compels the rural population to utilize private health care facilities, leading to increased out of pocket expenses, driving them further into poverty; especially during acute illnesses and emergencies.

2. Primary Health Care, defined as healthcare which is accessible, affordable, equitable, practical and acceptable to the community and with their participation, has been stated as the route to achieve Universal Health Coverage (UHC). Importance of Primary Healthcare has been stressed in the Alma Ata Declaration of 1978 to which India is a signatory. The Bhore Committee in 1946-48 strongly recommended the establishment of a tiered healthcare system in India with Primary Health Care Units forming the broad base. This system has been adopted by India since Independence, with one Primary Health Centre with dependent Sub centres for every 20-30,000 population and a graded structure through Community Health Centres, Sub-District and District Hospitals. The recently launched Ayushman Bharat scheme proposes the conversion of the Primary Health Centres into Health & Wellness Centres with an Expanded range of services.

3. Emergency Medical Services (EMS) at Primary Healthcare units has unfortunately been an ignored area of services. A medical or surgical emergency can occur at any time and if not dealt with at the earliest in an efficient manner, can lead to disability and death. Lack of EMS

at PHC level leads to overburdening of the secondary and tertiary facilities. Excessive focus on disease specific vertical national programmes has diverted focus from provision of efficient emergency services which is a horizontal connecting all vertical programmes, since medical emergencies cuts across the entire spectrum of disease and healthcare.

Objectives of the research

4. To assess the availability and adequacy of Emergency Medical Services at the PHC level with regard to infrastructure, manpower and training.

Research Methodology

5. In this descriptive Cross-Sectional Research Study with a mixed methods research approach i.e. both Quantitative and Qualitative for data collection and analysis, a total of seven Primary Health Centres in one district each of two States in the National Capital Region (NCR) viz. Uttar Pradesh (Gautam Buddh Nagar) and Haryana (Palwal) were assessed. Observations on the functioning of the PHCs were recorded as per standard checklists. Semi structured In depth interviews (IDI) with the MOs and Focussed Group Discussions (FGD) with the paramedical staff of the PHCs were held and content analysis done.

Findings and Conclusions:

6. The study revealed that Emergency services at the PHC level were grossly inadequate. PHCs did not have a dedicated Emergency Room which was well equipped and organized. MOs and paramedical staff had not undergone training in Cardiovascular and Trauma Life Support. The general tendency in dealing with emergencies was to administer elementary

first aid and transfer via ambulance to a higher facility at the earliest. Inpatient facility for admission and management of emergencies was underutilized. The PHCs were understaffed by almost 50%, doctors were not available 24/7, and the focus was on routine OPD care, specific disease control programmes and the various national health programmes especially Reproductive and Child Health (RCH) and Immunization. The PHCs in Haryana were better staffed and more clean than those in UP. The IDIs and FGDs with the doctors and paramedical staff revealed that the healthcare workers (HCW) were reasonably well motivated and satisfied with their job content. However, some of the MOs felt that a more fair and transparent system of rotation of postings and transfers was needed to avoid stagnation in rural areas. Infrastructure, patient amenities and general cleanliness of the PHC and its surroundings were in need of improvement.

Recommendations and Way Forward

7. Government and polity should be convinced that Primary Health Care is the path to adopt to achieve UHC. Strong political will and a massive, sustained increase in health care budget at all levels of governance is needed to improve infrastructure, logistics and manpower. Health should be shifted to the Concurrent list. Good governance and health administration in the district with increased role and accountability of the Panchayati Raj Institutions, along with more community participation is recommended.

8. The recommendations of the Bhore Committee should be revisited and a 50 bedded hospital made with some of the PHCs in each district with added human resources. Manpower shortages of HCW in rural areas should be addressed through mandatory 02 year rural postings, incentives of better salaries, facilities and working environment for the HCW

and his family, better workforce management, more rural focus in medical and nursing education, enhancing status and dignity of the doctors and staff working in Government PHCs.

9. The Government should sponsor and ensure that all the MOs and staff undergo mandatory training in Emergency Medicine. Emergency Department should form part of each PHC with separation from routine primary care and field work. All equipment needed to manage medical emergencies at the PHC should be authorized and provided. Dedicated and well-equipped ambulance services should be available with the PHCs.

10. There is a definite scope for Public Private Partnership of different models to improve Primary Health Care in rural India and up to 25% of PHCs can be run on PPP basis and results reviewed subsequently for effectiveness.

11. Provision of accessible, affordable, equitable, high quality Primary Health Care including timely Emergency Medical Services is the bounden duty of the Government. All stakeholders including the medical fraternity, the Community, the Media, Civil Society and other health related sectors of governance must coordinate and participate wholly to ensure the enhancement and success of India's Primary Health Care system which should include strong emergency medical services. This would reduce the economic burden of individuals, avoid expensive tertiary care treatment and improve the overall health of the population leading to better productivity and an economically prosperous nation.

CHAPTER 1

INTRODUCTION

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Introduction

1.1 Background

1.1.1 The Alma Ata Declaration of 1978 had stated that the goal of "Health for All" can be achieved most effectively through quality Primary Health Care. The World Health Organization in 1983 also endorsed the important role of Primary Health Care which is the first point of contact between the individual and the health system. **Primary health care** has been defined as health care which is practical, scientifically sound, socially acceptable, universally accessible to individuals and families in the community through their full participation, and at a cost which the community and the country can afford. In India the concept of Primary Health Care was expounded much earlier in 1948 by the Bhore Committee and the same has been followed with the establishment of a graded healthcare system beginning with Sub Centres at the village levels followed by Primary Health Centres (PHCs) at the next level and subsequently the Community or District Hospitals. The PHC is the first level where a Medical Officer is available. The Government in 2018 announced the **"Ayushman Bharat"** scheme with the idea of providing Comprehensive Primary Health Care (CPHC) through up-gradation of existing centres to Health and Wellness Centres. The **Primary Health and Wellness Centres** are mandated to provide an expanded range of services which span over preventive, promotive, curative, rehabilitative and palliative aspects of care. **Emergency Medical Services** are one of the listed expanded range of services.

1.1.2 Healthcare delivery to rural areas with easy access and provision of quality medical care at an affordable cost continues to remain elusive and a major challenge despite 74 years since Independence. The public health systems at the primary care level are underutilised or ineffective, leading to an increased burden on the Community and District hospitals. Even in rural areas there is a burgeoning **private health sector** which offers an alternative, albeit expensive. This is leading to major out of pocket expenditure even at primary care level, especially during acute illnesses. It is hoped that Comprehensive Primary Health Care will provide the necessary care, reduce mortality and morbidity at much lower costs and significantly reduce the need for secondary and tertiary care. (MoHFW, NHSRC Ayushman Bharat,2018) This will also be a step forward to achieve the Sustainable Development Goal SDG3 of Good Health and Wellbeing for all.

1.1.3 Emergency medical care is an important aspect of primary health care which involves the initial management of critical emergencies through first aid, resuscitation and stabilisation before further referral to a higher centre. In dealing with critical emergencies, e.g. acute coronary syndromes, strokes, poisonings, polytrauma, burns, acute respiratory distress, chokings etc. timely, prioritised and appropriate management is vital to save life and limb. This study focuses on this aspect of care at the Primary Health care level.

1.2 Statement of the Problem

1.2.1 Almost 70% of India's 1.3 billion population lives in rural areas with limited and poor access to healthcare facilities as compared to the urban population. Although the Government has a 3-tiered health care structure in place with Sub Centres, Primary health Centres and Community/District hospitals, there is an increased emphasis on Primary Health Care with 70%

of budgetary allocation to it in pursuit of Universal health Coverage. Studies however show that there is very poor utilisation of healthcare facilities at the primary level, an increased and often catastrophic out of pocket expenditure on healthcare. It is also seen that even in rural areas the private sector is the main health care provider for both outpatient and inpatient care.(MoHFW, NHSRC Ayushman Bharat, 2018)

1.2.2 Medical Emergencies can happen at any time, at any age, to any sex and at any place. It is a moment of crisis and panic for the patient and the family and often leads to tremendous expenditure. There is therefore a need for effective Emergency Medical Services at the primary health care level for immediate management to save life and limb. Lack of timely and appropriate management of critical emergencies (medical, surgical, trauma, paediatric, neonatal, obstetric etc) will lead to death and disability. Importance of the initial Golden Hour to resuscitate and stabilise patients before referral and transfer to a higher centre is well established but often ignored. (Advanced Trauma Life Support, 2016)

1.2.3 Emergency Medical Services have been included in the expanded range of medical services to be provided at the Primary Health and Wellness Centres. This requires Medical Officers and paramedical staff trained in Emergency Medicine along with necessary resuscitative equipment and drugs which may be lacking. Additionally, the PHC with its limited staff is expected to provide numerous services including Care during pregnancy and childbirth, Neonatal care, Childhood and adolescent care, Care of the elderly, Reproductive health care services, Management of communicable and Non communicable diseases, Care of the elderly, Mental health etc. The important aspect of Emergency Medical Care is likely to be ignored in this

process. Whether the private healthcare facilities in rural India have the wherewithal to handle emergencies adequately is also questionable.

1.2.4 An effective Emergency Medical System (EMS) at the primary healthcare level in rural areas is of utmost importance to save lives and limbs and reduce morbidity. All medical emergencies need to be first resuscitated and stabilised at the Primary health care level before transfer. The centres need to be fully ready to achieve this in terms of trained manpower, equipment, drugs and transportation. Transferring critical patients over long distances to the Community/District hospitals without stabilisation would be catastrophic.

1.2.5 There appears to be a lack of attention to this aspect of medical care both in practice as well as public health research. (Kobusingye 2005). There is therefore a need for an in-depth study into this important aspect of primary health care.

1.3 Research Objectives

1.3.1 This study will aim to assess the following parameters in both Government Primary Health and Wellness Centres as well as in the Rural Private Healthcare facilities:

i) To study the ***availability, capacity and training of the Medical Officers*** in Emergency Medicine for management of life and limb threatening emergencies.

ii) To study the ***availability, capacity and training of the Paramedical staff*** in handling emergencies and supporting the Medical Officers.

iii) To study the ***challenges and problems faced by Medical Officers and Paramedical Staff*** in rural areas with respect to Emergency Medical Care.

iv) To assess the ***existing Infrastructure available*** to manage emergencies (***Building, equipment, medicines and transport***)

v) To suggest ***remedial measures*** for improved emergency medical care in rural India.

1.4 Research Questions

1.4.1 Following are the Research Questions

i) Are the Government Primary Health and Wellness Centres in rural India capable of providing adequate Emergency Medical Care?

ii) What is the capacity of the Private Health Care Facilities in rural India to provide emergency medical care?

iii) Is there a need for further training of Medical Officers and Nursing Staff in Emergency medical care?

iv) Is there a case for mandatory and Government sponsored training of MOs in essential Emergency medicine courses/workshops like BLS (Basic Life Support), ALS (Advanced Life Support), ATLS (Advanced Trauma Life Support), PALS (Paediatric Life Support) and NALS (Neonatal advanced Life Support)?

v) Will Public Private Partnership be a feasible and win-win option to improve Emergency Medical Care in rural India?

1.5 Rationale or Justification

1.5.1 This study will look into the Emergency Medical Service (EMS) of both the Government (Public) healthcare system as well as the Private healthcare facilities at the Rural Primary healthcare level. It will provide information about the deficiencies in the existing systems, while also looking into the possible solutions for improvement. The study will provide useful inputs for the health administrators, policy planners and Medical Officers and Nursing staff to improve EMS at Primary Health facilities.

1.5.2 The aspect of emergency medical care at Primary Health Care level appears to be neglected and is not getting the attention it deserves. Primary Healthcare has tended to become focussed on disease specific or segments of population specific (e.g. Maternal, Neonatal etc) national programmes. While this has yielded good results, excessive emphasis on these verticals has taken away the focus on essential immediate emergency care services at the PHC. In fact, Emergency management is one horizontal which is common to all the various verticals, since emergencies can strike any subset of the population. This study can lead to an increased awareness of Emergency Medicine and its importance at the Primary Healthcare level.

1.5.3 An improvement in EMS care at Primary Health Care facilities will lead to overall reduction in referrals to higher levels of hospitals and thereby expected to lead to cost saving to the patient and the Government.

CHAPTER 2

REVIEW OF LITERATURE

CHAPTER 2

Review of Literature

2.1 Primary Healthcare in India: Current status and deficiencies

2.1.1 Gram Vaani (2013) in their essay on rural healthcare talks about the reality of the poor healthcare in rural India due to lack of qualified medical professionals, lack of quality infrastructure and basic medicines and facilities. The report says that in rural India, there are a limited number of Primary Health Centres of which 8% do not have doctors or medical staff, 39% do not have lab technicians and 18% do not have a pharmacist. Due to non-availability of facilities in the PHC, the rural population often turns to the local private health sector. This is often unregulated, informal and expensive. Gram Vaani has described the use of technology including certain simple mobile and IVR solutions and automations which can positively impact rural health care through information transfer and obtaining feedback. Some of the campaigns being conducted by Gram Vaani include Mobile Vaani, vSurvey, vInform and vAnswer for exchange of information between healthcare workers and experts.

2.1.2 May, Roth and Panda(2014) in their qualitative research study conducted in three rural districts of Uttar Pradesh and Bihar found that the first point of contact between the rural patient and a healthcare person is usually a Non degree holding allopathic practitioner because of his proximity, easy accessibility, belief systems and flexible payment options. The authors recommend that the Government should regulate, qualify

and integrate these practitioners into the existing public healthcare system. They suggest that this is the way forward for India to fill up the existing gaps in our rural healthcare. (May, Roth and Panda,2014)

2.1.3 Panagariya (2014) comments on the persistence of poor rural healthcare since decades of Independence despite the nation's economic growth. He states that only 13% of the rural population has access to primary health centres. To address the lack of medical talent in rural areas, he recommends the RURBAN initiative of Model Group Housing at Block level/PHC level for all Government employees with good facilities like schools, playgrounds, supermarket etc. The author recommends administrative reforms like combining the Medical, Health and Education departments into one supervised by a singular Principal Secretary. The author says that the single convergence link for primary, secondary and tertiary level health services should be the Director General Health Services (Panagariya,2014)

2.1.4 Chakraborty (2014) describes the continuing challenges of the rural healthcare sector and lists out lack of infrastructure, poor doctor-patient ratio, lack of insurance, affordability and lack of medicines as key problem areas which need addressing. (Chakraborty, 2014)

2.1.5 Sundararaman and Gupta (2011) studied the issue of the lack of skilled medical professionals in rural India partly due to their reluctance to work in such areas. Some of the suggestions by the authors to address this issue are monetary incentives, better workforce management for example rotational postings as in Tamil Nadu and Karnataka,

education, training and multi skilling and tasking and use of alternate service providers. (Sundararaman and Gupta, 2011)

2.1.6 Joseph Sharmila Mary (2020) mentioned that the doctor–population ratio of our country is only 1:1,457 as per the current population estimate of 1.35 billion, which is much lower than the WHO norm of 1:1,000. Due to lack of available trained doctors and medical professionals, the first point of contact in rural areas in India is usually an untrained practitioner. Many States e.g. Bihar have severe deficiencies in health human power to the tune of 40-70%. While deliberating about the possible solutions for the lack of trained doctors and healthcare personnel in rural areas, the author mentions about the introduction, in the NMC Bill 2019 of a new category, of "community health providers" (CHPs), to practise medicine at mid-level. These CHPs would have the right to prescribe specific medicines independently in primary and preventive healthcare; and to prescribe other medicines under the supervision of registered medical practitioners. The provision in the NMC bill for CHPs would give legislative backing to the concept of mid-level health providers (MLHPs) as envisaged in the Operational Guidelines for Comprehensive Primary Health Care at the Health and Wellness Centres (HWCs) under Ayushman Bharat. The MLHP, as indicated in these guidelines, is a community health officer (CHO)—with a BSc degree in community health or a nurse (GNM or BSc) or an Ayurveda practitioner. The guidelines further specify that the MLHPs would facilitate expanded range of services closer to the community, improve clinical management, enable follow-up of chronic diseases, and also help in dispensing medicines, early identification of complications, and undertaking basic diagnostic tests. The CHPs or the MLHPs along with ASHA (accredited social health activist) workers could function as

strong teams to perform field visits, ensure immunisation, detect early warning symptoms of routine diseases, detect non-communicable diseases in the early stages and provide antenatal check-ups in remote areas. The author mentions that studies done in Chhattisgarh State showed that 'Non-physician clinicians' offered a substantial improvement over 'no-physician' settings in rural healthcare facilities. Joseph stated that rural health practice has to be made more attractive for medical practitioners (with a special rural or primary healthcare allowance), to retain trained talent. (Joseph, 2020)

2.1.7 Perry and Rohde (2019) described the successful Jamkhed Comprehensive Rural Health Project in Maharashtra wherein the key elements of the Alma Ata Declaration of accessibility, community participation, equity and integration of services was incorporated to improve healthcare. The authors detail the contribution of the Aroles in training of Community Health workers and setting up of the Jamkhed International Institute for training of health professionals. (Perry and Rohde, 2019)

2.1.8 Sathyananda et al. (2018) attempted to review existing empirical literature on the subject of assessment of performance of the Primary Health Centres in developing countries. The selected 15 articles of literature were analysed and reviewed and compared with measures of WHO performance assessment framework. The authors found that the measures in the articles were limited in scope, restricted to protocols only and were not comprehensive enough. (Sathyananda et al, 2018)

2.1.9 Raman Kumar (2017), President of Association of Family Physicians of India, while reviewing performance of the 11th plan, in 2017 stated that despite progress, numerous goals were not achieved. There was a dire need for 'Infusing Life into Primary Care' and he made some comments and recommendations as under:Although Primary care medical specialty "**family medicine**" was a recognized post graduate qualification by the Medical Council of India (MCI), yet it had not been implemented in spirit despite repeated emphasis in the national health policies. Family medicine or general practice departments do not exist at medical colleges in India because MCI regulations do not mandate so. Primary health care practitioners, therefore, have no formal postgraduate training, no specialist accreditation, and no system at par for career progression compared to their hospital specialists. They have lower pay and worse working conditions than their hospital colleagues. Kumar felt that lack of appropriate training or qualification and full career progression was the major barrier to the availability of primary care doctors in the community.

Creation of a large number of distance and continuing education options for general practitioners in the private as well as the public sectors, would upgrade their skills to manage the majority of cases at local level, thus avoiding unnecessary referrals. He also recommended that specialized nursing and paramedical courses should be held,e.g. for Accredited Social Health Activists (ASHAs) to progress to become auxiliary nurse midwives.(Raman Kumar,2017)

2.1.10 Mohan P (2018) stated that Primary health care is healthcare provided to all, especially the most marginalised, with their participation and for their needs. If the primary healthcare system of a country is not functioning well, it is symptomatic of

problems in its democracy itself. Low priority and low budgets allocated to healthcare meant that poor people have no health facilities to go to when they fall ill. If there was one, it did not have a doctor, the drugs or the tests. So, they either do not seek care or seek care from poor quality but inexpensive sources, and fall into debt for meeting the resultant expenses. Healthcare designed for the people means facilities located within the communities they serve, and closer to where the more marginalised people live. These facilities should be equipped to deal with the needs of the community, and provide preventive, promotive and curative care. They should be staffed by a skilled team of providers that is empathetic to the people and their culture, and treats them with dignity. Mohan writes that Cuba has one of the most effective primary healthcare systems in the world, whose centrepiece is the community-based polyclinic, each of which serves a catchment area hosting between 30,000 and 60,000 people. The neighbourhood-based family doctor-and-nurse offices further extend care closer to the communities, one such office for 1,000-2,000 people. Prevention is the cornerstone of these services, complemented by community analysis and treatment. India has a large network of primary health centres (PHCs), each supposed to serve a population of 25,000. In many poor states, such as Madhya Pradesh, Bihar and Jharkhand, however, a PHC covers as many as 45,000, 49,000 and 76,000 people. In Rajasthan, the population is often so dispersed (especially in hilly areas in the south and in the desert in the west) that a family may need to travel 10-20 km to reach the nearest PHC. Even after one reaches the PHC, many of them are without a doctor. There is a shortfall of about 9,000 doctors in about 25,000 PHCs in the country, and about 2,000 of which don't have even a single doctor. In many others, a single doctor is posted for care round the clock, 365 days a year. Most

vacancies are in tribal and other similarly underserved areas. According to Mohan, the government has to finance and has to ensure the provision of primary health care, and not abdicate these responsibilities by privatising healthcare or relying on health insurance, such as with Ayushman Bharat. It has to urgently increase budgetary allocations to healthcare to at least 3-4% of GDP so that public expenditure on healthcare is at least 70% of total health expenditure. Such an increase will significantly improve availability of and access to high quality primary healthcare services for the most vulnerable communities. Mohan also asserted that there was a need for reorienting medical and nursing education towards the principles and practices of primary health care, including community participation. The government also has to invest in transforming the work culture of primary health systems so that the working staff felt valued. (Mohan,2018)

2.1.11 Roy, D (2019) in his article on the state of Primary Health Care in India said that while the government decision of transforming PHC centres into HWCs, followed by a National Health Protection Scheme at the secondary and tertiary level, is a step in the right direction, the transformation in the health scenario would require considerable administrative willingness and effort.

Over 68% of people in India are based in rural areas that face acute shortage of healthcare facilities. Healthcare workforce is far from being adequate, with a 1:921 doctor-patient ratio while the country is falling short of an estimated 1.94 million nurses. In terms of facilities, India has around 0.9 beds per thousand people. There are around 25,650 PHC centres across India, with 61% of them having only one doctor each and around 7.6% PHCs having none.

Roy emphasizes that, in this scenario, it was important that adequate steps be taken

so that the HWCs do not meet the same fate as that of the PHC centres. He stated that there were six pillars of health systems strengthening needed to build a robust healthcare system.

• Health governance: Investing in health governance to ensure that a transparent and accountable system is developed, which has multiple stakeholder participation for stronger health advocacy at various regional and community levels.

• Health information is the creation of evidence-based decision-making culture, furthered by various improved approaches and tools, and which ultimately support the strategic and incremental improvement of integrated health information systems. Demographic health surveys, civil registrations and vital statistics, and district health information systems are some of the tools used.

• Health finance. The institution of preferential public financing, increasing of public and private resources for shared goals, and incentivising private sector investment in health via philanthropy or shared value creation of public-private partnerships.

• A robust service delivery mechanism includes setting up of quality coordinated delivery of essential and evidence-based health services and developing and implementing cost-effective essential health services.

• Healthcare workforce. The creation of a strong human resource is essential for strengthening the health system. Conceiving and implementing effective models of imparting health education and ensuring skill training competence are important steps in the building of a strong health workforce.

• Supply chain strengthening is crucial for health systems as it ensures continuous

delivery of quality health commodities and products, such as medicines, equipment, etc. (Roy D,2019)

2.2 Role of Private Sector in Primary Health Care and Emergency Care

2.2.1 Salazar, Vora and De Costa (2016) in their cross sectional survey of obstetric care facilities in three districts of Gujarat found that Emergency obstetric care was dominated by the private healthcare sector and suggests that State led partnerships with the Private sector could be an important method to ensure that all women in the State receive emergency obstetric care.(Salazar, Vora and De Costa, 2016)

2.2.2 The World Health Organization, WHO in its handbook of May 2019 while elaborating on Primary Health Care, states that the **private sector** (both for-profit and not-for-profit) plays an important role in most of the world's health systems. The private sector provides a mix of goods and services including: direct provision of health services, medicines and medical products, financial products, training for the health workforce, information technology, infrastructure and support services (e.g. health facility management). As a result, most countries have "mixed health systems"—where a mix of public and private providers deliver health-related goods and services.

As per the handbook of the WHO, the 2030 agenda for SDGs served as an impetus to the health sector to involve the private sector to effectively contribute to the country's goals for Universal Health coverage. It was felt that the Private Sector had some obvious and possible advantages including Greater service capacity, Greater responsiveness, Better managerial expertise, Technology and innovation and Better Funding.

Listing out the various opportunities or options for the private sector in healthcare the WHO mentions Core segment (Clinical services, Laboratories and Medical products), Financial coverage and protection, Support services like Workforce management including training, Information Technology and Communication, Healthcare facility management and administration, Waste management including biomedical waste, Construction and Electromedical equipment manufacture, marketing and maintenance. The report however also mentions a word of caution in that there were potential problems too. The sector was very heterogeneous and would need to be regulated. Questions which should be asked before engaging with the Private sector in healthcare would include whether they were for profit or for non-profit? What are their social intentions? What is their record of social and ethical behaviour? And What is their capacity?

Fears of involving the private sector in public health include Danger of disruption of the market, Greed and lack of integrity, Not providing equity and accessibility of service to all, Weak or doubtful ethical behaviour.

Nevertheless, it was felt that it was not possible for the public sector to take on the burden of public health services completely on its own shoulders. There is a need to engage with the private sector, but in a regulated structure which is well steered, so that the benefits of their skills, resource and management accrue to the public health system while preventing negative behaviour and the nation can achieve its goals of Universal Health Coverage that is ‘Health for All’ (WHO Handbook,2019)

2.3 Panchayati Raj Institutions and Primary Health Care

2.3.1 Hooda (2016) in this study on effectiveness of the local government and community participation argues that health service delivery mechanisms can be made more effective through the participation of local governments and community in policy making, planning and services delivery. In order to evaluate their effectiveness, this study attempted to capture the degree of local agent's participation and extent of decentralization in health, and then measured their impact on health service access and health-seeking behaviour of rural households, controlling for socio-economic, demographic and political factors, such as reservation of women/minority groups in politics. This exercise was largely based on field survey data collected from 12 villages of Haryana. The results showed that the degree of community participation and women/minority groups' reservation in politics hardly matters for promoting equity in access to health care. This may be because the dominant class/caste/male captures most of the decentralization powers in Haryana. The study argued that the gains from decentralization can be enhanced by devolving more health-related functions, funds, management, regulation and policy making powers to local Panchayats and communities. (Hooda,2016)

2.3.2 Nanjunda (2020) in his article on Rural healthcare delivery in Karnataka has studied the role played by the various levels of the Panchayati Raj Institution. The author in his conclusion recommends much higher levels of engagement of the PRI in healthcare than what is existing. Additionally, the author recommends enhanced allocation of funds by the States to the PRI along with greater empowerment, autonomy and flexibility in spending by them on aspects of healthcare as per the needs on ground. This could be on training of doctors, staff or

upgradation of the facilities in the health centres. The author also advocates periodic orientation programmes for the PRI officials and representatives at various levels in matters relating to public health administration. The author emphasizes that decentralisation is a prerequisite for the success of any health-related programme. Bemoaning the unsatisfactory state of public health care in India especially in rural areas, which has led to many in the community to depend on the private sector healthcare facilities for their needs ,the author states that quality PRI engagement in healthcare is the way forward to build capacity and improve administration and service delivery. The author stresses that Quality PRI engagement is the only way to realise the Government's large-scale community health programmes impacting the marginalised and vulnerable sections of society. This necessitates capacity building to have skilled manpower and an administrative system that can address many complex issues pertaining to the local health care system. (Nanjunda,2020)

2.3.3 Kumar and Mishra (2016) conducted a qualitative research study in Hardoi district of Uttar Pradesh wherein through semi structured interviews from 89 respondents they studied the role of the Panchayati Raj Institutions (PRI) in the provisioning of primary healthcare in a decentralized health system. They found that certain challenges in this regard were the improper utilisation of service providers, influence of caste, coercive unethical work and lack of communication and coordination between the PRI leaders and the health workers. (Kumar and Mishra,2016)

2.3.4 The **Govt of Kerala** has started the **Mission Aardram** to improve Primary Health Care. Mission AARDRAM aims at creating "People Friendly" Health Delivery System in the state. The approach is need based and aims at treating every patient with 'dignity'. Through all

necessary investigation and intervention protocols it envisages transforming all Primary Health Centres into Family Health Centres as a first level Health delivery point. The Govt plans to make the Family Health Centres as health care delivery service institutions of Local Self Government (LSG) and make the LSGs responsible for their proper functioning and provision of infrastructure, manpower and supplies.

2.4 Emergency services and PHC

2.4.1 Yiadom,Wade,Williams et al(2018) in their article describe the importance and priority which Ghana has given to emergency care in Primary Health Care to address the ongoing shift in disease patterns as the population urbanizes, mobilizes and ages. Ghana has made significant investments in prehospital care, personnel training, healthcare resource provision, communications and new health facilities.

Traditionally, routine OPD based service and disease-specific services dominate healthcare systems. Access to emergency care is underemphasized and yet an essential horizontal component of basic health services. Healthcare personnel are traditionally adept at routine outpatient or in-patient ward management and find themselves ill equipped to handle genuine emergencies; be it their recognition, triage or management. Injuries have become a leading cause of mortality in children and young adults. Similarly, frequency of acute exacerbations of chronic diseases like cardiovascular, cerebrovascular and respiratory illnesses, and diabetes mellitus have increased needing prompt management at the Primary care level. Emergency care

for medical and surgical emergencies has been shown to lead to significant economic gains. The authors suggest that the model of increased emphasis on emergency medical care at Primary Health level may be a role model for other low and middle income countries (LMIC) too. (Yiadom,Wade,Williams et al, 2018)

2.4.2 Mohey and Saadoun (2017) in a cross-sectional study conducted in Alexandria, Egypt to assess the emergency services delivery in 16 randomly selected Primary Health Centres found many deficiencies. These deficiencies included lack of some essential equipment and drugs, lack of SOPs and guidelines and lack of training amongst the staff. The researchers found that there was a lack of belief and attitude amongst doctors and nurses towards the need for emergency management in Primary Health Care. The authors studied the infrastructure, processes and functioning, manpower, transportation facilities and patient satisfaction in the Primary Health Centres. They concluded that the overall emergency care services being provided was unsatisfactory and that there was a need for upgradation and improvement. They opined that high quality of emergency medical services at the Primary Care level would reduce the burden on the higher-level referral hospitals. (Mohey and Saadoun, 2017)

2.4.3 Singh, Doyle, Campbell and Murthy (2019) in their study assessed rural providers' perspectives on management and referrals of antenatal women with high obstetric risk, or with complications. They surveyed 147 health care providers in primary level public health care from poor and better performing districts from two states. They assessed their knowledge, attitudes and practices regarding obstetric care, referral decisions and pre-referral treatments provided for commonly occurring obstetric high-risk conditions and complications. Their results showed that the staff had suboptimal knowledge of, and practices for, screening common high-risk conditions

and assessing complications in pregnancy. Only 31% mentioned screening for at least 10 of the 16 common high-risk conditions and early complications of pregnancy. Only 35% (17/49) of the staff at Primary health centres, and 51% (18/35) at Community health centres, mentioned that they managed these conditions and, the remaining staff referred most of such cases early in pregnancy. The staff mentioned inability to manage childbirth of women with high-risk conditions and complications. There were large gaps in knowledge of emergency treatment for obstetric complications in pregnancy and pre-referral first-aid. The Staff generally were low on confidence and did not have adequate resources. Nurses had limited roles in decision making. Staff desired skill building, mentoring, moral support, and motivation from senior officers. The authors therefore concluded that the Indian health system should improve the provision of obstetric care by standardising services at each level of health care and increasing the focus on emergency treatment for complications, appropriate decision-making for referral, and improving referral communication and staff support. (Singh, Doyle, Campbell and Murthy,2019)

2.4.4 Ramanayake, Ranasingha and Lakmini (2014) in their review article on management of emergencies at Primary Care Level while emphasizing the importance of handling emergencies at the level of first contact, go into detail of the ideal location, layout and set up of the Primary Care Clinic. They also mention the essential drugs and equipment needed to be kept available at all times, the required training and knowledge of paramedical and medical staff, the common emergencies and their management and the need for practiced, efficient and timely transfer/referral procedures. Although the article is about Emergency management by GPs in their clinics, the same holds good for public Primary Health Centres too. (**Ramanayake**, Ranasingha and Lakmini, 2014)

2.4.5 Langabeer et al (2016) in their research, found that the integration of a telehealth-based initiative with patient navigation to a more appropriate care level, led to significant reduction in ambulance-enabled ED utilization. They found that the program resulted in a median 44-minute reduction in the unit back in service time (39 vs. 83 minutes) which was about 2.12 times more productive. They also observed a significant reduction in ED ambulance transports, from 74% to only 18%. These results came with little or no significant impact on clinical quality or patient satisfaction.They concluded that use of community paramedics, combined with telehealth and other mobile technology had the potential to improve overall emergency system capacity. (Langabeer et al, 2016)

2.4.6 Abu-Grain, Alsaad and El Kheir (2018) studied Primary Health Care physicians' practice and attitude related to Emergency Medical Service (EMS), the factors affecting it, and their learning needs in emergency medicine. The study revealed that 87.3% of physicians had a good diagnostic knowledge score while only 47.6% had a good patient management score. 63.5% of the physicians had a neutral attitude toward EMS. The most common reported emergencies encountered were bronchial asthma (86.51%), cut wounds (83.33%), and burns (76.19%). About 62% of participants reported that their greatest needs for further training were in cardiovascular and central nervous system emergency management, preferably by practical training in hospital emergency department (80%).(Abu-Grain, Alsaad and El Kheir, 2018)

2.4.7 Alsaad, Abu-Grain and El-Kheir (2017) performed a cross-sectional study with mixed research methods (quantitative and qualitative) in governmental PHC centres in Dammam, Eastern Province of Saudi Arabia, between September 2014 and January 2015. Using systematic random sampling technique, 13 out of 26 PHC centres were included in the study. The study

consisted of two main parts: The first involved the completion of an observational checklist to assess the availability and adequacy of human and nonhuman resources (workforce, emergency infrastructure, equipment, drugs and supporting facilities). The second part involved face-to-face interviews with nurses from the emergency room (ER) in the sampled centres. None of the centres had the emergency drugs such as methylergotamine, calcium chloride, and naloxone. Regarding ER equipment, none of the studied centres had cervical collars, mouth gags, or tracheostomy sets. Only one (7.6%) centre had a functioning fully equipped ambulance. Five (38.46%) centres were equipped with electrocardiogram and X-ray machines. The authors concluded that the Primary Health Care centres studied were deficient in infrastructure and supporting facilities. (Alsaad, Abu-Grain and El-Kheir, 2017)

2.4.8 Newgard et al (2016) studied 53 487 injured patients transported by EMS and performed a Rural vs Urban comparison and analysis. The Rural vs Urban sensitivity of field triage for identifying patients requiring early critical resources was 65.2% vs 80.5%. Also, only 29.4% of rural patients needing critical resources were initially transported to major trauma centres vs 88.7% of urban patients. 89.6% of rural deaths occurred within 24 hours compared with 64% of urban deaths. Rural regions had higher transfer rates (3.2% vs 2.7%) and longer transfer distances to travel. The authors thus concluded that most high-risk trauma patients injured in rural areas were cared for outside of major trauma centres and most rural trauma deaths occurred early, although overall mortality did not differ between regions. There was thus a need for improved timeliness and access to major trauma care among patients injured in rural regions. (Newgard et al, 2016)

2.4.9 Joshipura, Hyder and Rehmani (2004) in their article on the challenges and opportunities of Emergency Care in South Asia, found that one of the striking deficiencies in the health delivery structure was lack of focus on emergency care in primary health systems, which were ill-equipped to offer appropriate care in emergency situations resulting in a high burden of preventable deaths and disability. The authors explained that Emergency Medical Systems (EMS) encompass a wide spectrum from recognition of the emergency, access to the system, provision of pre-hospital care, through definitive hospital care. The burden of death and disability resulting from lack of appropriate emergency care is very high in low- and middle-income countries. In South Asia, health services in general, and emergency care in particular, have failed to attract priority, investments and efforts. The authors emphasize that integrating EMS with other health system components improves health care for the entire community, including children, the elderly, and other vulnerable groups with special needs. (Joshipura, Hyder and Rehmani , 2004)

2.4.10 Sancheti (2019) comments on the lack of proper emergency medical systems in rural India with limited awareness, information, training and infrastructure. The author emphasizes that an organized, coordinated EMS system with involvement of various Government departments like Health, Police and Fire along with private hospitals and the community is essential.(Sancheti,2019)

2.4.11 Kobusinghye, Hyder and Bishai 2006 in their chapter on Emergency medical services, describes in detail the importance of emergency care.

Emergency medical conditions occurs through a sudden and severe insult to the body or mind through injury, infection, obstetric complication, chemical or neurohormonal imbalance, or a

deterioration in a chronic condition which is serious enough to disrupt the body's normal physiology and functioning and poses a threat to life. The emergencies could be acute imbalances or exacerbations like diabetic coma, septicaemia, premature labour, asthmatic attack etc or an event like an acute myocardial infarction (heart attack), acute haemorrhage or trauma.

Emergency care is the care delivered within the first few hours after onset of this acute insult or injury. The earlier it is provided, the better will be the outcomes. There is a need for rapid assessment, timely and appropriate interventions, stabilization and safe transport to the nearest appropriate health facility so as to ensure survival, control morbidity and prevent disability. There are many misconceptions about Emergency Care especially in low income countries which lead to it being given low priority in the health sector. These include Equating emergency care with ambulance transport, Neglecting the role of the community, assuming that doctors are the only useful resources in acute situations, assuming that Emergency medical care is very expensive and requires high end technology as opposed to simple and effective strategies.

The author says that preparations made after a public emergency occurs often results in precipitate and hurried deployment of costly resources. What is needed instead is planned investment in emergency care which would be much more cost effective and efficient.

Emergency care can be at various levels, starting from Prehospital care, the first medical referral facility like the Primary Health Centre or a higher referral hospital. Even by just focussing on three areas: Obstetric, Coronary heart disease and Trauma, an effective Emergency Medical Service (EMS) could save hundreds of lives.

Emergency medical systems need to be a critical component of any National Health System especially in a LMIC (like India). There is a need for political will and funding. Universal

emergency care is consistent with the right to healthcare because by definition, emergency care is a matter of life and death. (Kobusingye OC, Hyder AA, Bishai D, et al. 2006**)**

2.4.12 Mony et al (2015) in their cross - sectional epidemiologic study in eight districts of Karnataka, to assess the availability of emergency neonatal care found that 80% of Government hospitals at district and sub- district levels did not have emergency neonatal care facilities. The authors stated that there was a definite need to improve emergency newborn care with special emphasis on equity. (Mony et al, 2015)

2.4.13 Kobusingye et al (2005) stresses on the importance and need for strengthening Emergency medical care systems in low and middle income countries, since emergencies occur everywhere and consume resources. They make a strong case for universal access to emergency care. The authors said that emergency care could make an important contribution to reduction in death and disability. The authors go on to state that effective pre hospital care, training of personnel, equipment, communication and transportation of patients are key areas that need to be focussed. They stressed that it was a misconception that emergency care was very expensive. They also state that emergency medical systems were a neglected area of research. (Kobusingye et al, 2005)

2.4.14 Lurie, Margolis and Rising (2013) studied the US Emergency Care System with focus on both daily needs for emergency medical care and the need and capacity to upsurge these services to meet with the requirements of disasters. They felt strongly that in addition to providing acute resuscitation and life and limb saving care, emergency care departments also provided the primary care physicians with support and was an important safety net for the

community. The authors suggest that a patient and community centred approach was essential to improve emergency medical care. (Lurie, Margolis and Rising,2013)

2.4.15 Razzak and Kellermann (2002) while debating the need for emergency medical care in developing countries, stated that provision of timely treatment during life threatening emergencies was not a priority for many health systems in developing nations. While reviewing the emergency medical care at various levels viz the Community, during transportation and at first contact and referral facilities the authors indicate the need to strengthen emergency medical care so as to improve health of populations and meeting expectations of the community. The authors stated that the obstacles to developing effective emergency medical care included a lack of structural models, lack of training, concerns about cost and sustainability. They stressed that a basic but effective level of emergency medical care was necessary to meet the perceived and actual needs of the community and also improved the overall health of the population. (Razzak and Kellermann, 2002)

2.4.16 Greenwood-Ericksen, M. B., Tipirneni, R., & Abir, M. (2017) state that residents of rural areas experience higher mortality rates for emergency and chronic conditions as compared to those living in urban areas. Laying stress on the importance of emergency medical services and care, the authors say that good emergency care serves a dual purpose of both handling acute care needs as well as providing an opportunity to assess and address societal needs of the community. The Emergency Department can serve as a tool and stepping stone for preventive medicine and chronic disease management. The researchers have proposed a model of an integrated Emergency Department (ED) along with the Primary Health Care Unit (PHC). This model as per them would be an ideal mix of providing emergency and acute care along with

routine primary and preventive health care. The physicians in the two areas can benefit from each other's expertise and the patients and the community get the dual benefit of all services under one roof. This would ensure not only emergency management but also subsequent follow up, investigations for the illness by the primary healthcare team; while simultaneously looking into societal needs like homelessness, substance abuse, neglect, malnutrition etc. The authors felt that this integrated model would avoid duplication of resources and thus reduce costs. (Greenwood-Ericksen, M. B., Tipirneni, R., & Abir, M, 2017)

2.4.17 MoHFW, NHSRC, Government of India in its Operational guidelines (2018) for Ayushman Bharat: Comprehensive Primary Health Care through Health and wellness Centres emphasizes the cardinal role of Primary Health Care in improving health outcomes, reducing mortality and morbidity at lower costs and reducing the need for secondary and tertiary care. Ayushman Bharat, the country's flagship health programme plans to convert existing health centres into Health and Wellness Centres with an expanded range of services. This includes the provision of Emergency Medical Services including for poisonings, trauma, burns, respiratory and cardiac emergencies, hemorrhage, choking, drowning etc. The Primary Health Centre is expected to resuscitate and stabilise such patients before referral. (MoHFW, NHSRC 2018)

2.5 Primary Health Care and Public Health Emergencies and Disasters

2.5.1 As per the **World Health Organization, WHO**, Primary Health Care has a major role to play in handling public health emergencies which it defines as "an event or imminent threat that produces or has the potential to produce a range of health consequences which requires coordinated action; e.g. epidemics, disasters (natural or manmade),violence, conflicts etc. The

current pandemic of Coronavirus COVID 19 is one such example. In these situations, Primary Health Care should be able to resist, absorb and accommodate such shocks in a timely and efficient manner. While routine healthcare would continue, Primary Health Care has a role in management of emergency cases, preventing disease outbreaks with public health measures including disease surveillance, communication, community engagement, immunization, early detection of disease and warning. It would need to ensure water safety and hygiene- sanitation through multisectoral coordination including engagement with the private sector.

The possible role of Primary Health Care is often ignored or unrepresented in disaster management plans and policies. The WHO states that there is a need to focus on providing adequate funding, infrastructure and supplies towards Primary Healthcare while also ensuring adequate healthcare manpower whose remuneration, comfort, conditions and protection is taken care of.

The WHO goes on to emphasize that a Strong Primary Healthcare System is a worldwide priority and should be placed at the heart of national and global health setups. (WHO Technical series, Brief on Health emergencies)

2.5.2 The deliberations during the Regional Meeting of **WHO in Dhaka in 2010** and their subsequent report emphasize that despite the challenges during an emergency, application of PHC principles was the best and most cost-effective strategy to ensure equitable access of populations to essential high quality health care. It would reduce vulnerabilities and enhance the resilience of the community to face the disaster.

Health system capability during any emergency is substantially dependent on the capacity of the first responders, community-based health workers and the functional health facilities. The PHC

approach in emergencies would integrate all the PHC principles into all activities that build the capacity of communities to prepare, respond and recover from emergencies thus building on their resilience. During disasters, maintaining the functionality of community-based care and the referral system and adapting to address new needs is critical. Ongoing pre-disaster initiatives to revitalize PHC can contribute to reducing the public health-related impact of emergencies.

The report clearly concludes that investing time and resources in emergency preparedness and response at community level; strengthening capacity of community health workers including volunteers as well as linking sub-national level government and nongovernmental organizations was critical for an effective response in an emergency and that this could be best achieved through community engagement and applied efficiently through the primary health care approach. (WHO report on PHC approach in emergencies)

2.5.3 Reddy, Srinath (2020) who is President Public Health Foundation of India, while writing about the country's preparedness to deal with the ongoing Coronavirus COVID 19 pandemic, wrote that for any outbreak investigation and epidemic containment, we need well-trained human resources at the primary care frontline. The health sub-centres and primary health centres, both rural and urban, must have staff who are not only trained for clinical care but also for early detection, outbreak investigation, counselling, basic tests, triage and referral, community health education and participation, citizen engagement and mobilisation for collective inter-sectoral action. The recommendation to strengthen primary health services has been around for long. The setting up of public health cadres was recommended by the High Level Expert Group (HLEG) on Universal Health Coverage in its 2011 report to the Planning Commission. The National

Health Policy also calls for public health management cadres to be established. Only Tamil Nadu and Odisha have such defined cadres now.

The fact that 80-85 per cent of the patients of COVID 19 will have milder forms of the illness, requiring home or hospital quarantine and less intensive supportive care, is ignored. Most patients will need to be treated, counselled and monitored in the primary and secondary care chain, ranging from the sub-centre to the district hospital, depending on the severity of the ailment.

Reddy also recollected the Gorakhpur encephalitis tragedy, which taught us that we should not depend only on a medical college to cater to the sick, but must strengthen district and primary care facilities. The HLEG also emphasised this need and the National Health Policy reiterates it. We should not lose sight of this in the clamour for more intensive care beds in urban tertiary care facilities. Our referral chains, for directional flow between primary and advanced care, must be systematically strengthened. That cannot happen with a weak public sector.

He emphasized that evidence suggests that countries with Universal Health Coverage (UHC) respond with efficiency and equity to health emergencies. The standout examples of a coherent and efficient response to the corona pandemic have been South Korea and Singapore. South Korea restricted COVID-19 mortality to less than 1 per cent. The United States, in contrast, is fumbling in deciding how to test and treat and at what cost, in its chaotic health insurance system. There is no doubt that countries which have adopted UHC and have a strong public sector component in healthcare delivery can provide an early, effective and organised response to any health emergency. A weak public sector and excessive dependence on the private sector can derail timely, effective and equitable responses in a national health emergency. (Reddy,2020)

CHAPTER 3

PRIMARY HEALTH CARE AND

HEALTH FOR ALL:

GLOBAL PERSPECTIVES

CHAPTER 3

Primary Health Care and Health For All: Global perspectives

3.1 Introduction

3.1.1 The importance of good health has been known to mankind since time immemorial. Disease, starvation, famine, epidemics have ravaged humanity all across the world since ancient times. In the modern world too, good health for all has been an elusive goal even in the rich countries and very much so in the low and middle income nations. There have been numerous attempts by International bodies like the United Nations Organization, UNO and the World Health Organization, WHO to get all the nations together as one, to address this vital issue and ensure Health for All.

3.2 The Alma Ata Declaration

3.2.1 The International Conference on Primary Health Care, meeting in Alma-Ata on 12 Sep 1978 expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world. The Conference defined “health” as a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity. They said that Health was a fundamental human right and that the attainment of the highest possible level of health was a most important world-wide social goal whose realization would require the combined and coordinated action of social, economic and health sectors.

3.2.2 The Conference stated that Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. They set a Target of Health for All by the year 2000. The health should be of a level that would permit them to lead a socially and economically productive life. The Alma Ata Conference emphasized that Primary health care was the key to attaining this target.

3.2.3 The Conference defined Primary health care as essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country could afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It said that Primary Health Care should form an integral part, both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It should be the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work. It would thus be the first element of a continuing health care process.

3.2.4 They defined certain **aspects of Primary health** care as under:

(i) Should reflect and be based upon the economic conditions and sociocultural and political characteristics of the country and its communities and their public health experience and research

(ii) Should address the main health problems in the community, providing promotive, preventive, curative and rehabilitative services

(iii) Should include health education, promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, family

planning and immunization against the major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries; and provision of essential drugs.

(iv) Should involve and coordinate with, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works and communications

(v) Would require and should promote maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources

(vi) Should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need.

(vii) Should rely and develop at local and referral levels, a team of health workers, including physicians, nurses, midwives, auxiliaries and community workers, as well as traditional practitioners as needed, suitably trained socially and technically to work smoothly and in a coordinated fashion to cater to the health needs of the community.

3.2.5 The Alma Ata Declaration expressed the need for all countries to adopt Primary Health Care as a National Policy and to exercise political will to mobilize the country's resources and available external resources rationally. (Alma Ata declaration,1978)

The Alma Ata Declaration Venue 1978

3.3 WHO and Primary Health Care

3.3.1 The World Health Organization avers that all people, everywhere, deserve the right care, right in their community. This is the fundamental premise of primary health care. Primary health care addresses the majority of a person's health needs throughout their lifetime. This includes physical, mental and social well-being and it is people-centred rather than disease-centred. Primary Health Care is a whole-of-society approach that includes health promotion, disease prevention, treatment, rehabilitation and palliative care. Primary health care is care for all at all ages. Primary Health Care is the best way to provide health care and services to everyone, everywhere and is the most efficient and effective way to achieve health for all. It can provide

90% of the health needs of a person throughout his or her lifetime. A primary health care approach includes three components:

- meeting people's health needs throughout their lives;
- addressing the broader determinants of health through multisectoral policy and action; and
- empowering individuals, families and communities to take charge of their own health.

3.3.2 By providing care *in* the community as well as care *through* the community, Primary Health Care addresses not only individual and family health needs, but also the broader issue of public health and the needs of defined populations. The principles of Primary Health Care were first outlined in the Declaration of Alma-Ata in 1978, a seminal milestone in global health. Forty years later, global leaders ratified the Declaration of Astana at the Global Conference on Primary Health Care which took place in **Astana, Kazakhstan** in October 2018. (WHO website, Primary Health Care)

3.4 The Astana Declaration

3.4.1 The Declaration of Astana on Primary Health Care and the associated Vision for Primary Health Care in the 21st century reinforces the commitment of all countries towards improving Primary Health Care as a means of achieving Universal Health Coverage and achieving health related Sustainable Development Goals (SDGs). It proposes a three-pronged approach:

i) Meeting people's health needs through comprehensive promotive, protective, preventive, curative, rehabilitative and palliative care throughout the life course

ii) Systematically addressing the broader determinants of health including social, economic and environmental factors, as well as individual characteristics and behaviour through evidence-informed policies and actions across all sectors

iii) Empowering individuals, families and communities to optimize their health as co-developers of policies that promote and protect health and as self -carers and caregivers

3.4.2 The Astana Declaration emphasized on the following aspects to improve Primary Health Care:

i. Political commitment and leadership
ii. Governance and policy frameworks
iii. Adequate funding and equitable allocation of resources
iv. Engagement of community and other stakeholders
v. Jointly define problems and solutions and prioritize actions
vi. Ensuring the delivery of high quality and safe health care services
vii. Engagement with private sector providers (Public Private Partnership)
viii. Primary Health Care workforce management
ix. Development of Physical infrastructure and appropriate medicines, products and technologies
x. Use of Digital technologies
xi. Fine tuning of Purchasing and payment systems
xii. Primary Health Care oriented research
xiii. Monitoring and evaluation of Primary Healthcare Services

Proceedings of the Astana Declaration,2018

3.5 Health for All, The Journey of Universal Health Coverage

3.5.1 The origins of Primary Health Care are usually associated with the Alma Ata declaration of 1978 which put health equity on the international political agenda for the first time. Primary health care also subsequently became a core concept of WHO's goal of Health for All. There were seven principles of Primary Health Care when it was first conceptualized:

i) Shape the Primary health care around the life patterns of the population

ii) Involvement of the population

iii) Maximum reliance on available community resources

iv) Integrated preventive, curative and promotive health services for the individual and community

v) Interventions to be done at the most peripheral practical level of healthcare services by trained workers

vi) Other echelons of services to support the periphery

vii) Primary Health Care to be integrated with other sectors of development of the community

3.5.2 Stampar, a fierce advocate of social medicine almost single handed developed the health system in Yugoslavia in the 1920s which was one of the finest of those times.

3.5.3 The Chinese Health System started developing in the 1930s

3.5.4 In 1937 the Bandung Conference was held in Indonesia which highlighted the need for Rural hygiene and intersectoral coordination for overall development of education facilities, economic development, and social development along with public health.

3.5.5 In 1946 the Bhore Committee in India did a very exhaustive study of the health conditions and requirements in India and made numerous recommendations including the establishment of Primary Health Care Centres

3.5.6 In 1969, the importance of a firm national policy providing healthcare for the underprivileged was stressed by Roemer, an eminent social scientist

3.5.7 Primary health care in the 1970s benefitted from the prevailing political climate of left wing and revolutionary movements which demanded an equitable distribution of resources. In the 1980s however, with Reagan and Thatcher at the helm and the increasing disenchantment

with communism, there were cuts in government spending on health programmes and increased spending on defence and the military.

3.5.8 In the ensuing years there was a growing debate between Selective Primary Health Care (SPHC) and Comprehensive Primary Health Care (CPHC). Many felt that CPHC was too idealistic and impractical and that Selective goals and targets of Primary Health Care were more feasible. This restricted interpretation of Primary Health Care became more popular in the 1980s. For example, the GOBI campaign of **G**rowth monitoring, **O**ral Rehydration, **B**reast feeding and **I**mmunization was a major area of thrust. Similarly, the EPI, Expanded Programme of Immunization was started by the WHO in 1974 covering six major killer diseases: Diphtheria, Pertussis, Tetanus, Poliomyelitis, Measles and Tuberculosis. Thus, although Primary Health Care could not fulfil the promise of 1978, its goals became a source of aspiration for health workers and instilled a sense of urgency.

3.5.9 However, the world is returning to and again embracing the idea of Comprehensive Primary Health Care. The Astana declaration of 2018 reinforced the maxims of the Alma Ata declaration and stressed on universal health coverage without any inequity. (Medcalf et al, 2015 and Walraven G,2019)

3.6 WHO and its concept of Primary Health Care

3.6.1 In recent decades, Primary Health Care has been neglected in many countries in favour of a disease-specific approach. This is often due to a combination of lack of political will, under investment, and common misperceptions of the role and benefits of Primary Health Care. It has, however, been proven that health systems with a Primary Health Care based foundation result in improved clinical outcomes, increased efficiency, better quality of care and enhanced patient

satisfaction.

3.6.2 All stakeholders – from government leaders to physicians to members of the public – need to be made aware of the role and benefits of Primary Health Care. Some common misperceptions include the notion that it only provides "basic" care, when, in fact, PHC provides essential care that can cover the majority of a person's health needs throughout their lives. Another misperception is that PHC is about maternal and child health – PHC is about health at all ages. PHC involves prevention, health promotion, treatment, rehabilitation, and palliation.

3.6.3 Another misperception is that PHC is "cheap" health care for the poor. Because PHC is based in the community, it is frequently the only health care available to poor or marginalized communities, who may not have access to a hospital. Because PHC focuses on the person rather than the disease, it is an approach that moves away from overspecialization. In PHC, the goal is to work through multidisciplinary teams with strong referral systems to secondary and tertiary care when needed.

3.6.4 It is a whole-of-society approach that seeks to address the broader determinants of health, such as community-level disease-prevention efforts, and to empower individuals, families and communities to get involved in their own health.

3.6.5 In 2018, world leaders committed to advancing PHC. However, moving from political commitment to reality will require efforts on the part of all stakeholders – governments, health care providers, civil society, and the public.

3.6.6 Primary health care is important because it is the foundation of a strong health system. It leads to more equitable health across the community and leads to greater patient and health worker satisfaction. Taking a PHC approach is about meeting the majority of people's health needs through services provided directly in the community where they live. A PHC approach

means working with multidisciplinary teams – doctors, nurses, caregivers, therapists, and others – to treat the person rather than the disease.

3.6.7 By providing health care services throughout a person's life, PHC allows people to develop long-term partnerships with their care providers. And it means that health care providers can address not only treatment needs, but also prevention, health promotion, rehabilitation and palliation services. (WHO and PHC)

3.7 Universal health coverage (UHC)

3.7.1 UHC means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. Currently, at least half of the people in the world do not receive the health services they need. About 100 million people are pushed into extreme poverty each year because of out-of-pocket spending on health.

3.7.2 To make health for all a reality, we need: individuals and communities who have access to high quality health services so that they take care of their own health and the health of their families; skilled health workers providing quality, people-centred care; and policy-makers committed to investing in universal health coverage.

3.7.3 Universal health coverage should be based on strong, people-centred primary health care. Good health systems are rooted in the communities they serve. They focus not only on

preventing and treating disease and illness, but also on helping to improve well-being and quality of life.

3.8 Assessing, measuring, improving PHC

3.8.1 Turning a political commitment into reality on the ground begins with a thorough, evidence-based understanding of the existing system. There are a number of tools available to carry out such an evaluation of the Primary health Care. In WHO's Eastern Mediterranean region, for example, existing indicators have been adapted to regional realities to create the PHCMI (Primary Health Care Measurement and Improvement) initiative, which enables countries in the region to evaluate existing health systems and approaches. PHCPI, the Primary Health Care Performance Initiative, through its Vital Signs Profiles, also provides a great deal of data to assist countries in evaluation and decision-making.

3.9 Health for All

3.9.1 "Health for all" means that health is to be brought within reach of everyone in a given country. And by "health" is meant a personal state of wellbeing, not just the availability of health services—a state of health that enables a person to lead a socially and economically productive life. "Health for all" implies the removal of the obstacles to health—that is to say, the elimination of malnutrition, ignorance, contaminated drinking-water, and unhygienic housing—quite as much as it does the solution of purely medical problems such as a lack of doctors, hospital beds, drugs and vaccines.

3.9.2 "Health for all" means that health should be regarded as an objective of economic development and not merely as one of the means of attaining it.

3.9.3 "Health for all" depends on continued progress in medical care and public health. The health services must be accessible to all through primary health care, in which basic medical help is available in every village, backed up by referral services to more specialized care. Immunization must similarly achieve universal coverage.

3.9.4 "Health for all" is thus a holistic concept calling for efforts in agriculture, industry, education, housing, and communications, just as much as in medicine and public health. Medical care alone cannot bring health to hungry people living in hovels. Health for such people requires a whole new way of life and fresh opportunities to provide themselves with a higher standard of living.

3.9.5 Health does not exist in isolation. It is influenced by a complex of environmental, social, and economic factors ultimately related to each other. The health of the poor is the result of a combination of unemployment , poverty, a low level of education, poor housing, poor sanitation, malnutrition, and lack of the will and initiative to make changes for the better. Thus, health management has to be considered along with such things as producing more or better food, improving irrigation, and marketing products.

3.9.6 Health and social awareness must go hand in hand, each reinforcing the other. This is what is known as community involvement. (Mahler, H 2016)

3.10 Alma Ata and beyond: Status of Primary Health Care

3.10.1 The 1960s and 1970s was, for many developing countries, an era of newly won independence from former colonial powers. This independence was accompanied by an enthusiasm to provide high-standard healthcare, education and other services for the people.

Governments moved to establish teaching hospitals and medical and nursing schools, often with the assistance of donor nations. These tertiary services consumed the largest portion of the country's healthcare budget, and were available mostly in urban areas, creating access problems for the predominantly rural societies.

3.10.2 Primary Health Care envisaged universal coverage of basic services such as education on methods of preventing and controlling prevailing health problems; promotion of food security and proper nutrition; adequate safe water supply and basic sanitation; maternal and child health, including family planning; vaccination; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs. The emphasis changed from the larger hospital to that of community-based delivery of services with a balance of cost-effective preventive and curative programs. The approach was intersectoral, involving agriculture extension officers, schoolteachers, women's groups, youth groups and ministers of religion, etc. The community, through its leaders, was to be involved in the planning and implementation of its own healthcare services through community Primary Health Committees.

3.10.3 National governments throughout the world adopted Primary Health Care as their official blueprint for total population coverage with essential services. Goals and targets were set for Achieving Health For All by the Year 2000 which include:

i) at least 5% of gross national product should be spent on health;
ii) at least 90% of children should have a weight for age that corresponds to the reference values

iii) safe water should be available in the home or within 15 minutes' walking distance, and adequate sanitary facilities should be available in the home or immediate vicinity;

iv) people should have access to trained personnel for attending pregnancy and childbirth

v) child care should be available up to at least one year of age.

3.10.4 In the initial stages, nurses and health extension officers were trained to work in community health centres, which covered the population. They were given balanced training in clinical and preventive PHC interventions. Village health workers were trained in a limited number of skills to fill any gaps. Community representatives, through Village Primary Health Care Committees, were supposed to have a central role in planning and overseeing their healthcare services. Adequate supervision to ensure service quality, essential drugs, vaccines and equipment, especially at the most peripheral levels, was envisaged.

Almost as soon as the Alma-Ata Conference was over, Primary Health Care came under attack. Politicians and aid experts from developed countries could not accept the core Primary Health Care principle that communities in developing countries would have responsibility for planning and implementing their own healthcare services. A new concept of "Selective Primary Health Care" (SPHC) advocated providing only PHC interventions that contributed most to reducing child (< 5 years) mortality in developing countries. The advocates of SPHC argued that comprehensive PHC was too idealistic, expensive and unachievable in its goals of achieving total population coverage. By focusing on growth monitoring, oral rehydration solutions, breastfeeding and immunisation, greater gains in reducing infant mortality rates could be achieved at reduced cost. In effect, SPHC took the decision-making power and control central to PHC away from the communities and delivered it to foreign consultants. These technical experts,

often employed by the funding agencies, were subject to the policies of their agencies, not the communities. SPHC thus reintroduced vertical programs at the cost of comprehensive PHC.

3.11 Reasons for poor success of PHC and Failure to achieve HFA by 2000

3.11.1 The reasons for poor success of the PHC and failure to achieve HFA in time include:

i) Many ordinary people felt PHC was a cheap form of healthcare and, if they were able to, they bypassed this level to attend secondary and tertiary centres because of a lack of staff and essential medicines at the PHC level.

ii) Civil war, natural disasters and, more recently, HIV affected the ability of PHC to maintain comprehensive services, especially in many sub-Saharan countries.

iii) Political commitment was not sustained after the initial euphoria of Alma-Ata. In many cases PHC became a jargon term used as a slogan, and little else. Politicians saw PHC as a way to reduce expenditure in health and lacked the political will to ensure that services were equitably shared and distributed. Most healthcare resources continue to be directed to the large urban-based hospitals.

iv) Issues of governance and corruption in the use of resources. Vertical, definable, time-limited programs that could be changed every few years suited both donor agencies and governments. (Hall & Taylor,2003)

CHAPTER 4

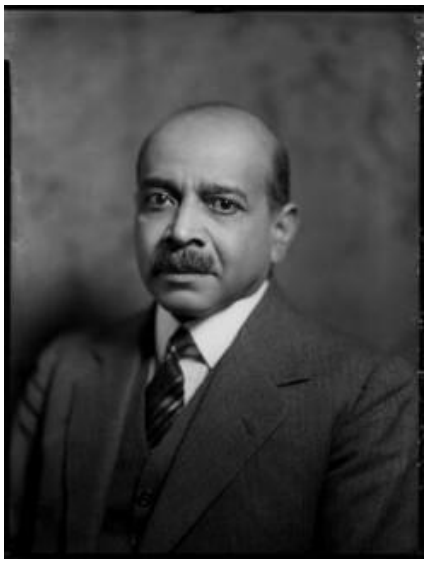
PRIMARY HEALTH CARE IN INDIA

CHAPTER 4

Primary Health Care in India

4.1 Origins and Progress of PHC Through the Years

4.1.1 One of the first steps towards establishing Primary Health Care in India was taken in British India when the **Bhore Committee** was set up by the Government of India in 1943. It was a health survey taken by a development committee to assess the health condition of India. The development committee worked under Sir Joseph William Bhore, who acted as the chairman of the committee. The committee consisted of pioneers in the healthcare field who met frequently for two years and submitted their report in 1946. This was, and remains one of the most exhaustive studies of the state of health, healthcare and associated sectors in India.



(Sir Joseph William Bhore KCSI KCIE CBE (1878 – 15 August 1960) was an Indian civil servant and diwan of the Cochin State. He is best remembered for his chairmanship of the Health Survey and Development Committee that charted a course for public health investments and infrastructure in India.)

4.1.2 In its final report in 1946, the Committee noted thus: "If it were possible to evaluate the loss, which this country annually suffers through the avoidable waste of valuable human material and the lowering of human efficiency through malnutrition and preventable morbidity, we feel that the result would be so startling that the whole country would be aroused and would not rest until a radical change had been brought about". Based on the recommendations, the Government of India established the first Primary Health Centres in 1952.

Salient findings of the Bhore Committee report:

4.1.3 The term health implies more than an absence of sickness in the individual and indicates a state of harmonious functioning of the body and mind in relation to his physical and social environment, so as to enable him to enjoy life to the fullest possible extent and to reach his maximum level of productive capacity.

4.1.4 The survey found and reported startlingly low levels of health in India, with very high infant mortality rate, overall mortality rates and one of the lowest life expectancies in the world at that time. The main causes of the low level of health in India were listed out as lack of an environment conducive to healthful living including poor sanitation, malnutrition, lack of health protection, both curative and preventive, lack of general education and health education.

4.1.5 The survey found that the quantity and quality of hospitals across India was very low, with inadequate staff. There was also a marked urban bias with scarce facilities in rural India. The

report also noted the tendency for doctors to concentrate in urban areas. For instance, in Bengal, the ratio of doctors to the population was found to be three and a half times more in urban areas than in rural areas. Since at that time about 90 percent of the total population lived in villages, this disparity was too important and was hence emphasized.

Insufficient number of hospitals and dispensaries available for providing medical relief to the people with unsatisfactory quality of the service rendered by these institutions.

4.1.6 In addition, the medical officers in charge of many dispensaries had for long periods, been out of touch with modern medical practice without an opportunity to work in bigger hospitals. Other defects included unsatisfactory conditions in regard to the design of, and accommodation in, medical institutions, considerable overcrowding in the wards and grave insufficiency of the nursing staff.

4.1.7 The Survey reported on the serious difficulties which the poorer classes faced in securing medical aid at public hospitals and dispensaries due to distances and unsympathetic attitude of healthcare staff.

4.1.8 Lack of medical staff of all categories; doctors, nurses, midwives, sanitary inspectors, compounders etc.

4.1.9 Rural dispensaries too were, in many cases, functioning quite unsatisfactorily. The buildings, in which they are housed, were often inadequate. A single doctor, struggling with the help of a compounder, had to deal with hundreds of patients. The average time devoted to a dispensary patient was as short as three-quarters to one minute. The supply of drugs and dressings was also insufficient to meet the needs of the patients. Arrangements for patients to wait for their turn for examination were poor.

4.1.10 Thus, the Bhore Committee concluded that the existing organizations for curative

and preventive health work in India were altogether inadequate for the tasks with which they are confronted.

Recommendations of the Bhore Committee

4.1.11 The Bhore Committee strongly felt that a nation's health, using the term to signify that positive state of well-being in which mind and body are able to function to their fullest capacity, was the most potent single factor in determining the character and extent of its development and progress. Expenditure of money and effort on improving the nation's health was a gilt-edged investment which would yield rich dividends.

4.1.12 In formulating plans for a national health service the Bhore committee felt that the following objectives should be achieved: —

a. The services should make adequate provision for the medical care of the individual in the curative and preventive fields and for the active promotion of positive health
b. These services should be placed as close to the people as possible, in order to ensure their maximum use by the community which they are meant to serve
c. The health organization should provide for the widest possible basis of co- operation between the health personnel and the people
d. In order to promote the development of the health program on sound lines the support of the medical and ancillary

professions, such as those of dentists, pharmacists and nurses, was essential.

e. In view of the complexity of modern medical practice, "group practice", was recommended including various specialists.

f. Special provision for certain sections of the population, *e.g.*, mothers, children, the mentally deficient etc.

g. No individual should fail to secure adequate medical care, curative and preventive, because of inability to pay for it

4.1.13 The Report emphasized that, closer the health service could be brought into contact with the people whom it serves, the fuller would be the benefit it could confer on the community. They suggested therefore a series of appropriate healthcare organizations in an ascending scale of available manpower, facilities and technical efficiency with the lowest ones in the scale as close to the community as possible

4.1.14 The district health scheme they suggested would consist of three types of organization in an ascending scale of efficiency from the point of view of staffing and equipment. At the periphery will be the primary unit, the smallest of these three types. A certain number of these primary units will be brought under a secondary unit, which will perform the dual function of providing a more efficient type of health service at its headquarters and of supervising the work of these primary units. The third level would be at the District Headquarters which would also provide overall supervision, coordination and administration. The Bhore Committee recommended that the population covered by each primary unit should be in the neighborhood of ten to twenty thousand.

4.1.15 The Three Million Plan

A figure of three million was taken to represent a district. Each district would consist of 150 primary units, each having, on an average, a population of 20,000. About 30 of these primary units could suitably be included in a secondary unit so that the district would have five such units. The strength of staff and hospital accommodation that were recommended for the Primary Unit is as below:

THE LONG-TERM PROGRAMME

	Controlling medical officers	Other medical officers	Non-medical staff	Hospital
Primary unit	1	5	78	75 beds
Secondary unit	1	139	358	650
headquarters	1	238	1,398	beds
District				2,500
headquarters				beds

4.1.17 The Primary Unit

The Committee recommended that both preventive and curative health work should proceed hand in hand. Each unit would have six medical officers, six public health nurses and a 75-bed hospital and all these could be utilized for organizing a combined curative and preventive health service in the area. Each primary unit would

be linked in the chain of the community's health services with the help of ambulance units controlled by a secondary unit that would facilitate the rapid removal of cases requiring urgent treatment either from places within the area of each primary unit to its own hospital or from primary unit hospitals, to the larger institution at the headquarters of the secondary unit. Telephonic connection between the headquarters and individual primary units would also be desirable in order to promote promptness and efficiency in the administration of medical aid. Of the six doctors one would be the controlling officer who, in addition to his duties of supervision over the whole staff in the area, would also be the administrative head of the hospital of the remaining five medical men.

Over and above the hospital nursing staff there would be six public health nurses for rural health work, these being qualified nurses with training in midwifery. Of these four may be put on to preventive work in the homes of the people. Each nurse so engaged should be able to deal with the health of school children; the welfare of mothers and children, tuberculosis work and other activities in the houses within her area of jurisdiction. The remaining two public health nurses and two medical officers will be available for the organization and carrying out curative treatment in the homes of the people.

In their view at least two or possibly three of the six medical officers provided in each primary unit should be women. One of them will be employed in the hospital on the gynecological and obstetrical side. Another will be required for domiciliary duties and a third could be utilized to supplement the work of the other two in the hospital and outside.

Excluding the hospital staff the remaining members of the primary unit organization would consist of midwives, sanitary inspectors, health assistants, a fitter misery and some inferior servants.

Creation of a class of health worker known as 'Health Assistant', was conceived by the Committee to assist the doctors, both on the curative as well as on the preventive side and assist the Rural Medical Officer of Health in running his dispensary who would also attend to such matters as purification of water supplies, the checking of vital statistics by house to house canvassing, minor anti-malaria works, the spray killing of mosquitoes and other similar duties.

4.1.18 Staffing of the 75 bedded hospital:

One 75 bedded hospital with each Primary health Unit, with staff as under:

Controlling Officer: 01

Medical Officers :06

Public Health Nurses: 06

Midwives: 06

Sanitary Inspectors: 02

Health assistants: 02

Mistry: 02

Servants: 10

For the 75 bedded hospital:

20 Nurses including Matron, Theatre nurses, ward sisters and Staff nurses

Social workers : 03

Ward attendants: 08

Compounders: 03

Cooks : 03

Kitchen servants: 03

Sweepers: 08

Mistry: 01

Mali: 01

Short Term Programme

4.1.19 In the Short Term the Committee recommended that a start should be made with five primary units in each district. Each of these would cater to a population of 40,000 in place of the much smaller and more fully staffed and equipped unit serving a population of 10,000 to 20,000 recommended for the long-term programme. In place of a 75-bed hospital for each primary unit they suggested that, during the first five years of the short-term programme, one 30- bed hospital should be established to serve four primary units The Committee recommended that in the short term, the primary unit composition could be as given below:—

Medical officers	2
Public Health Nurses	4
Nurse	1

Mid wives	4
Trained *dais*	4
Public Health inspectors	2
Health assistants	2
Pharmacist.	1
Clerks	2
Fitter Mistry	1
Inferior servants	15

4.2 Subsequent Committees and Reports

4.2.1 The Bhore Committee report was subsequently followed up by various programmes and committees as under:

1953: National Malaria Eradication Programme

1962: Mudaliar Committee to assess progress made on Bhore committee. Found that Primary Health Centres were still unsatisfactory and understaffed. Suggested that each PHC should not cover more than 40000 population. Constitution of an All India Health Service

1963: Chadah committee for malaria eradication

1965: Mukherjee Committee for Family Planning

1967: Jungalwallah Committee suggested integration of all health services and programmes under a single Director

1973: Kartar Singh Committee suggested that each PHC should cater to 50000 population and have 16 sub centres each manned by a Multipurpose worker male and female

1975: Shrivastav Committee for creation of a pool of paramedicals and their training

1978: The Alma Ata Declaration

1983: National Health Policy

1986: Bajaj Committee on paramedical training, vocationalisation of education

2002: National Health Policy

2005: National Rural Health Mission

2013: National Urban Health Mission

2013: The Rural and Urban Health Missions were combined into one National Health Mission, NHM

2018: Launch of Ayushman Bharat

4.3 Present status and organization of Primary Health Care in India

4.3.1 The Primary Health Care Infrastructure in India is a three tier system with Sub Centre, Primary Health Centre (PHC) and Community Health Centre (CHC) being the three pillars of Primary Health Care System.

i) **Sub Centre:** Most peripheral contact point between Primary Health Care System and Community

ii) **Primary Health Centre (PHC):** A Referral Unit for 6 Sub Centres
iii) **Community Health Centre (CHC):** A Referral Unit for 4 PHCs

The three tier infrastructure is based on the following population norms:

Centre	Population Norms	
	Plain Area	Hilly/Tribal/Difficult Area
Sub Centre	5000	3000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

Sub Centres (SCs)

4.3.2 The Sub Centre is the most peripheral and first contact point between the primary health care system and the community. Sub Centres are assigned tasks relating to interpersonal communication in order to bring about behavioural change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhoea control and control of communicable diseases programmes.

Each Sub Centre is required to be manned by at least one auxiliary nurse midwife (ANM) / female health worker and one male health worker. Under the National Rural Health Mission (NRHM), there is a provision for one additional second ANM on contract basis. One lady health visitor (LHV) is entrusted with the task of supervision of six Sub Centres. Government of India bears the salary of ANM and LHV while the salary of the Male Health Worker is borne by the State governments.

4.3.3 Primary Health Centre (PHC)

PHC is the first contact point between the village community and the medical officer.

The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The PHCs are established and maintained by the State governments under the Minimum Needs Programme (MNP)/ Basic Minimum Services (BMS) Programme.

As per minimum requirement, a PHC is to be manned by a medical officer supported by 14 paramedical and other staff. Under NRHM, there is a provision for two additional staff nurses at PHCs on contract basis. It acts as a referral unit for 6 Sub Centres and has 4-6 beds for patients. The activities of PHC involve curative, preventive, promotive and family welfare services.

4.3.4 Community Health Centres (CHCs)

CHCs are being established and maintained by the State government under the MNP/BMS programme. As per minimum norms, a CHC is required to be manned by four medical specialists i.e. surgeon, physician, gynaecologist and paediatrician supported by 21 paramedical and other staff. It has 30 in-door beds with one OT, X-ray, labour room and laboratory facilities. It serves as a referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations.

4.3.5 First Referral Units (FRUs)

An existing facility (District Hospital, Sub-divisional Hospital, Community Health Centre etc.) can be declared a fully operational First Referral Unit (FRU) only if it is equipped to provide round-the-clock services for emergency obstetric and New Born Care, in addition to all emergencies that any hospital is required to provide. It should

be noted that there are three critical determinants of a facility being declared as a FRU:

i) Emergency Obstetric Care including surgical interventions like caesarean sections;

ii) new-born care; and

iii) blood storage facility on a 24-hour basis.

(NHM website, Vikaspedia)

4.4 National Rural Health Mission

4.4.1 The National Rural Health Mission (NRHM) was launched on 12th April 2005, to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. Under the NRHM, the Empowered Action Group (EAG) States as well as North Eastern States, Jammu and Kashmir and Himachal Pradesh have been given special focus. The thrust of the mission is on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. NRHM focuses on Reproductive, Maternal, New-born, Child Health and Adolescent (RMNCH+A) Services. Moreover, the linking of community and facility-based care and strengthening referrals between various levels of health care system to create a continuous care pathway is also to be focussed.

4.4.2 Strategies of the NRHM

Core Strategies

i) Train and enhance capacity of Panchayat Raj Institutions (PRIs) to own, control and

manage public health services.

ii) Promote access to improved healthcare at household level through the female health activist (ASHA).

iii) Health Plan for each village through Village Health Committee of the Panchayat.

iv) Strengthening sub - centre through an untied fund to enable local planning and action and more Multi-Purpose Workers (MPWs).

v) Strengthening existing PHCs and CHCs, and provision of 30- 50 bedded

vi) CHC per lakh population for improved curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards).

vii) Preparation and Implementation of an inter - sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation & hygiene and nutrition.

viii) Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels.

ix) Technical Support to National, State and District Health Missions, for Public Health Management.

x) Strengthening capacities for data collection, assessment and review for evidence-based planning, monitoring and supervision.

xi) Formulation of transparent policies for deployment and career development of Human Resources for health.

xii) Developing capacities for preventive health care at all levels for promoting healthy lifestyles, reduction in consumption of tobacco and alcohol etc.

xiii) Promoting the non-profit sector particularly in under-served areas.

4.4.3 Supplementary Strategies

i) Regulation of the Private Sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost.

ii) Promotion of Public Private Partnerships for achieving public health goals.

iii) Mainstreaming AYUSH – revitalizing local health traditions.

iv) Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics.

v) Effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

4.5 Importance of PHC in India

4.5.1 There is global evidence that Primary Health Care is critical to improving health outcomes. It has an important role in the primary and secondary prevention of several disease conditions, including non-communicable diseases. The provision of Comprehensive Primary Health Care reduces morbidity and mortality at much lower costs and significantly reduces the need for secondary and tertiary care. For primary health care to be comprehensive, it needs to span preventive, promotive, curative, rehabilitative and palliative aspects of care. Primary Health Care goes beyond first contact care, and is expected to mediate a two-way referral support to higher-level facilities (from first level care providers through specialist care and back) and ensure follow up support for individual and population health interventions.

4.5.2 In India, the need for and emphasis on strengthening Primary Health Care was

first articulated in the Bhore Committee Report 1946 and subsequently in the First and Second National Health Policy statements (1983 and 2002). India is also a signatory to the Alma Ata declaration for Health for All in 1978. The Twelfth Five Year Plan Identified Universal Health Coverage as a key goal and based on the recommendations of the High- Level Expert Group Report on UHC had called for 70% budgetary allocation to Primary Health Care in pursuit of UHC for India.

4.5.3 The National Health Policy, 2017 recommended strengthening the delivery of Primary Health Care, through establishment of "Health and Wellness Centres" as the platform to deliver Comprehensive Primary Health Care and called for a commitment of two thirds of the health budget to primary health care.

4.6 Ayushman Bharat

4.6.1 Ayushman Bharat is one of the present Government's flagship schemes. It is a Health Scheme with two pillars. Ayushman Bharat (AB) is an attempt to move from a selective approach to health care to deliver a comprehensive range of services spanning preventive, promotive, curative, rehabilitative and palliative care. It has two components which are complementary to each other. Under its first component, 1,50,000 Health & Wellness Centres (HWCs) will be created to deliver Comprehensive Primary Health Care that is universal and free to users, with a focus on wellness and the delivery of an expanded range of services closer to the community. The second component is the Pradhan Mantri Jan Arogya Yojana (PM-JAY) which provides health insurance cover of Rs. 5 lakhs per year to over 10 crore poor and vulnerable families for seeking secondary and tertiary care. Ayushman

Bharat was launched in April 2018. This chapter focusses on the Primary Health Care pillar which is the subject of the dissertation.

4.6.2 The public health systems at the primary care level are underutilized or ineffective, leading to an increased burden on the Community and District hospitals. Even in rural areas there is a burgeoning private health sector which offers an alternative, albeit expensive. This is leading to major out of pocket expenditure even at primary care level, especially during acute illnesses. It is hoped that Comprehensive Primary Health Care will provide the necessary care, reduce mortality and morbidity at much lower costs and significantly reduce the need for secondary and tertiary care.

4.6.3 The National Health Mission (NHM), the country's flagship health systems strengthening programme, particularly for primary and secondary health care envisages "attainment of universal access to equitable, affordable and quality health care which is accountable and responsive to the needs of people" Studies show that 11.5% households in rural areas and about only 4% in urban areas, reported seeking any form of OPD care - at or below the CHC level (except for childbirth) primary care facilities, indicating low utilization of the public health systems for other common ailments. National Sample Survey estimates for the period-2004 to 2014 show a 10% increase in households facing catastrophic healthcare expenditures. This could be attributed to the fact that the private sector remains the major provider of health services in the country and caters to over 75% and 62% of outpatient and in-patient care respectively. India is also witnessing an epidemiological and demographic transition, where non-communicable diseases such as cardiovascular

diseases, diabetes, cancer, respiratory, and other chronic diseases, account for over 60% of total mortality.

4.6.4 The Elements of CPHC

Figure 1: Elements of CPHC

From https://ab-hwc.nhp.gov.in/,MoHFW Government of India HWC Portal

4.6.5 Timelines of the launch of Ayushman Bharat

Figure 2: Timeline of the launch of Ayushman Bharat

From https://ab-hwc.nhp.gov.in/,MoHFW Government of India HWC Portal

The first HWC was launched in Bijapur, Chhattisgarh on April 18th, 2018. In the first year, over 17,000 HWCs were operationalized, more than the target of 15,000 set for FY 2018-19. Given the magnitude of inputs required to strengthen the primary

health care facilities, the operationalization of HWC has been planned in a phased manner till the year 2022.

4.6.6 Plans of the Roll Out of Ayushman Bharat

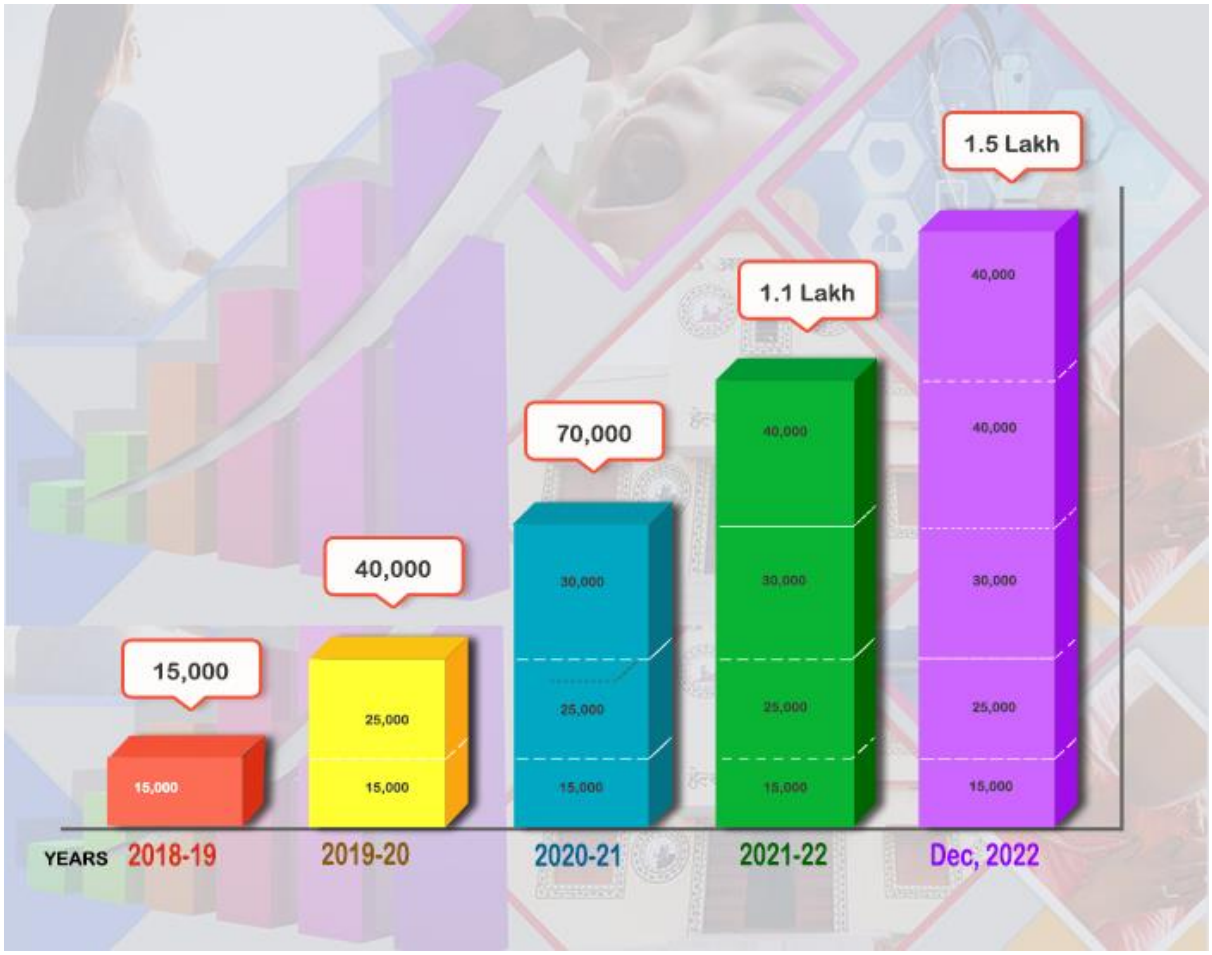


Figure 3: Plans of the Roll Out of Ayushman Bharat

From https://ab-hwc.nhp.gov.in/,MoHFW Government of India HWC Portal

4.6.7 Key Principles of CPHC in Ayushman Bharat

i) Transform existing Sub Health Centres and Primary Health Centres to Health and Wellness Centers to ensure universal access to an expanded range of Comprehensive Primary Health Care services.

ii) Ensure a people centered, holistic, equity sensitive response to people's health needs.

iii) Enable delivery of high quality care that spans health risks and disease conditions through a commensurate expansion in availability of medicines & diagnostics, use of standard treatment and referral protocols and advanced technologies including IT systems.

iv) Instil the culture of a team-based approach to delivery of quality health care encompassing: preventive, promotive, curative, rehabilitative and palliative care.

v) Ensure continuity of care with a two way referral system and follow up support.

vi) Emphasize health promotion (including through school education and individual centric awareness) and promote public health action through active engagement and capacity building of community platforms and individual volunteers.

vii) Implement appropriate mechanisms for flexible financing, including performance-based incentives and responsive resource allocations.

viii) Enable the integration of Yoga and AYUSH as appropriate to people's needs.

ix) Facilitate the use of appropriate technology for improving access to health care advice and treatment initiation, enable reporting and recording, eventually progressing to electronic records for individuals and families.

x) Institutionalize participation of civil society for social accountability.

xi) Partner with not for profit agencies and private sector for gap filling in a range of primary health care functions.

xii) Facilitate systematic learning and sharing to enable feedback, and improvements and identify innovations for scale up.

xiii) Develop strong measurement systems to build accountability for improved performance on measures that matter to people.

4.6.8 In order to ensure delivery of Comprehensive Primary Health Care (CPHC) services, existing Sub Health Centres covering a population of 3000-5000 would be converted to Health and Wellness Centres (HWC), with the principle being "time to care" to be no more than 30 minutes. Primary Health Centres in rural and urban areas would also be converted to HWCs.

4.6.9 The HWC at the sub health centre level would be equipped and staffed by an appropriately trained Primary Health Care team, comprising Multi-Purpose Workers (male and female) & ASHAs and led by a Mid-Level Health Provider (MLHP).

4.6.10 A Primary Health Centre (PHC) that is linked to a cluster of HWCs would serve as the first point of referral for the HWCs in its jurisdiction. In addition, it would also be strengthened as an HWC to deliver an expanded range of primary care services.

4.6.11 The Medical Officer at the PHC would be responsible for ensuring that CPHC services are delivered through all HWCs in her/his area and through the PHC itself. The number and qualifications of staff at the PHC would continue as defined in the Indian Public Health Standards (IPHS).

4.6.12 For PHCs to be strengthened to HWCs, support for training of PHC staff (Medical Officers, Staff Nurses, Pharmacist, and Lab Technicians), and provision of equipment for "Wellness Room", the necessary IT infrastructure and the resources required for upgrading laboratory and diagnostic support to complement the expanded ranges of services would be provided.

4.6.13 The HWC would deliver an expanded range of services. These services would be delivered at both SHCs and in the PHCs, which are transformed as HWCs. The level of complexity of care of services delivered at the PHC would be higher than at the sub health centre level

4.6.14 Expanded Range of Services

i) Care in pregnancy and child-birth.

ii) Neonatal and infant health care services.

iii) Childhood and adolescent health care services.

iv) Family planning, Contraceptive services and other Reproductive Health Care services.

v) Management of Communicable diseases including National Health Programmes.

vi) Management of Common Communicable Diseases and Outpatient care for acute simple illnesses and minor ailments.

vii) Screening, Prevention, Control and Management of Non-Communicable diseases.

viii) Care for Common Ophthalmic and ENT problems.

ix) Basic Oral health care.

x) Elderly and Palliative health care services.

xi) Emergency Medical Services.

xii) Screening and Basic management of Mental health ailments.

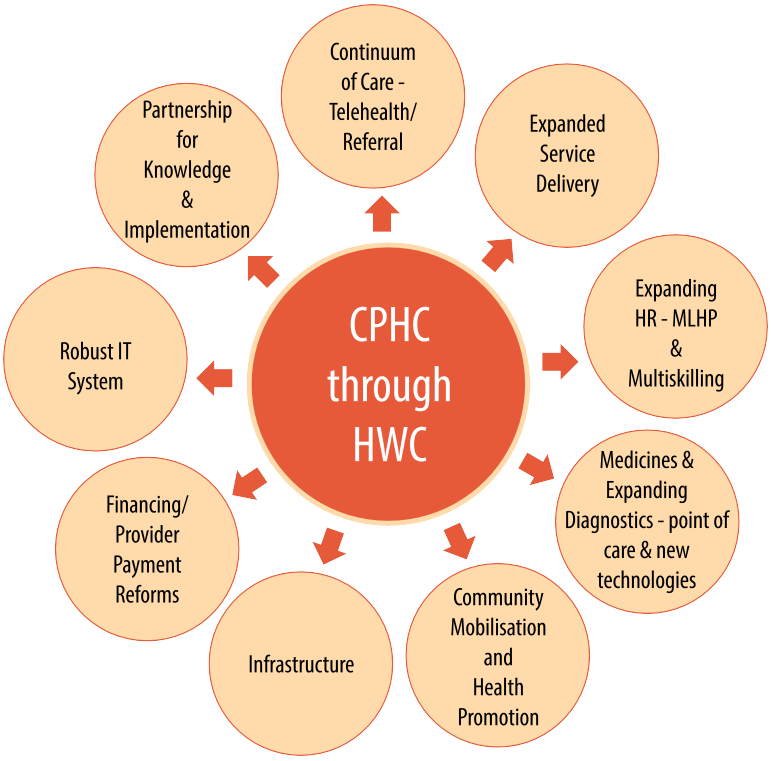


Figure 4: CPHC Through HWC

4.6.15 The services envisaged at the HWC level will include early identification, basic management, counselling, ensuring treatment adherence, follow up care, ensuing continuity of care by appropriate referrals, optimal home and community follow up, and health promotion and prevention for the expanded range of services.

4.6.16 Care provision at every level would be provided as per clinical pathways and standard treatment guidelines. This would facilitate the decongestion of the secondary and tertiary care facilities as the primary care services would be made available at the HWC level closer to the community with adequate referral linkages. Early

identification and management will prevent disease progression that would require secondary/ tertiary care interventions.

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4.6.17 Continuity of Care and Patient Centric Care

From the ASHA worker for home visits, through the ANMs, MLHPs at Sub Centres and then the Medical Officers at PHC and thereafter the Secondary and Tertiary Care hospitals through referral linkages.

4.6.18 Details of Emergency Medical Services at various levels

Health Care Services	Care at Community Level	Care at the Health and Wellness Centre- Sub Health Centers	Care at the Referral Site**
Emergency Medical Services, including for Trauma and Burns	⌘ First aid for trauma including management of minor injuries, fractures, animal bites and poisoning ⌘ Emergency care in case of disaster	⌘ Stabilization care and first aid before referral in cases of - poisoning, trauma, minor injury, burns, respiratory arrest and cardiac arrest, fractures, shock, choking, fits, drowning, animal bites and haemorrhage, infections (abscess and cellulitis),	⌘ Triage and management of trauma cases ⌘ Management of poisoning, ⌘ Management of simple fractures and poly trauma ⌘ Basic surgery and surgical emergencies (Hernia, Hydrocele, Appendicitis, Haemorrhoids, Fistula, and stitching

		acute gastro intestinal conditions and acute genito urinary condition	of injuries) etc. ⌘ Handling of all emergencies like animal bite, Congestive Heart Failure, Left Ventricular Failure, acute respiratory conditions, burns, shock, acute dehydration etc.

4.6.19 Mid Level Health Provider

A key addition to the primary health team is the Mid-level Health Provider (MLHP) who would be a Community Health Officer (CHO) - a BSc. in Community Health or a Nurse (GNM or B.SC) or an Ayurveda practitioner, trained and certified through IGNOU/other State Public Health/Medical Universities for a set of competencies in delivering public health and primary health care services.

The Mid- Level Health Provider would broadly be expected to carry out public health functions, ambulatory care, management and provide leadership at the HWCs. They would be responsible for the following:

i) Ensure that all households in the service areas are listed, empanelled and a database is maintained.

ii) Provide clinical care as specified in the care pathways and standard treatment guidelines for the range of services expected of the HWC.

iii) Clinical care provision would include coordinating care/ case management for chronic illnesses based on the diagnosis and treatment plan made by the Medical Officer/specialists who will initiate treatment for chronic diseases, dispense drugs as per standing orders by the medical officer.

iv) Focus attention in screening for chronic conditions on screening, enabling suspected cases confirmed and initiating treatment based on appropriate STGs or on basis of plans made by medical officers/specialists.

v) Coordinate and lead local response to diseases outbreaks, emergencies and disaster situations and support the medical team or joint investigation teams for disease outbreaks.

vi) Support the team of MPWs and ASHAs on their tasks, including on the job mentoring, support and supervision and undertaking the monitoring, management, reporting and administrative functions of the HWC such as inventory management, upkeep and maintenance, and management of untied funds.

vii) Support and supervise the collection of population based data by frontline workers, collate and analyse data for planning and report the data to the next level in an accurate and timely fashion.

viii) Coordinate with community platforms such as the VHSNC/MAS/SHGs and work closely with PRI/ ULB, to address social determinants of health and promote behaviour change for improved health outcomes.

ix) Address issues of social and environmental determinants of health with extension workers of other related departments.

x) Guide and be actively engaged in community health promotion including behaviour change communication.

4.6.20 Multi-Skilling of other Frontline Health Workers

Frontline workers, and Service Providers posted at all levels would also be multi-skilled to address the mismatch in the services to be provided and present levels of training of primary care team members. MPW (M & F) would need skills to function as paramedics for undertaking laboratory, pharmacy and counselling functions. Similarly, at the HWC-PHC level, staff would be appropriately skilled to function as ophthalmic technicians, dental hygienists, physiotherapists, etc. Staff that opt to provide such services would be trained and equipped with specific skills, and be provided with additional compensation. The use of technology would be harnessed to undertake the training/multi-skilling given the sheer magnitude of the task. Platforms such as ECHO, Massive Open Online Courses, SatCom, etc. would be used. States will need to enter into partnerships with a range of

academic and training organizations to help deliver such multi-skilling on an ongoing basis

4.6.21 Human Resource Requirements, Skill Requirements and Training

Facility	Human Resource Required	Skill Requirements	Training Requirements
Community level	ASHA/1000 population or ASHA/500 population for tribal and hilly areas/ ASHA for 2500 population in urban areas	**Core skills:** ⌘ Community Mobilization, Communication, Negotiation, Leadership ⌘ Skills for community level management of Reproductive, Maternal, New Born and Adolescent Health care ⌘ Skills for identification, referral follow up care and ensuring treatment compliance related to communicable diseases-TB, Leprosy, Vector Borne Diseases etc. ⌘ Skills to address issues of marginalization and violence against women **additional Skills:** ⌘ Population Enumeration and active facilitation for empanelment of families at HWCs ⌘ Community Based Health risk assessment for Chronic Illnesses ⌘ Health promotion, life style and health risk modification for management of common Non-Communicable Diseases ⌘ Skills for community level care provision for mental health, elderly care, ENT, ophthalmic care, palliative care etc.	⌘ Eight Days of Induction Training ⌘ 20 Days of Skill based training in Modules 6 and 7 ⌘ Five Days of Training in Module for ASHAs on Non- Communicable Diseases ⌘ Supplementary trainings - refresher training and training on newer topics for about 15 days every year
health and Wellness Centre	Multipurpose worker (F/M) SHC- 2 MPW (F) and 1 MPW (M), UPHC- one MPW (F) per 10000 population	**Core Skills** ⌘ Skilled Birth Attendant* ⌘ Essential New Born Care and stabilization of sick new born* ⌘ Assessment and Management of STIs and RTIs, Insertion and Removal of IUCDs; Management of Abortion and Adolescent Counselling* ⌘ Pregnancy Test, Haemoglobin, Urine Test and Blood Sugar*	⌘ 21 days of SBA Training ⌘ 4-5 Days of Training for IUCD insertion, NSSK, HBNC Supervision, Management of Childhood Illnesses ⌘ Training on National Health Programmes as per programme guidelines ⌘ 3 days of Training on

			Universal screening, prevention and management of Non- Communicable Diseases ⌘ One-day joint training with ASHAs on universal screening of NCDs

Facility	Human Resource Required	Skill Requirements	Training Requirements
		additional Skills ⌘ Screening for common NCDs-Hypertension, Diabetes, three common cancer-Cervix, Breast and Oral Cancer and timely referral and provision of follow up care, enabling periodic monitoring of BP, Blood sugar for patients on treatment ⌘ Support provision of first level of care for mental health, elderly care, palliative care, ENT, Ophthalmic care, etc. ⌘ Support to formation and handholding of Patient Support Groups ⌘ Skills to conduct some diagnostic test and dispensing of medicines as appropriate at the HWC level. ⌘ Skills to use digital applications wherever applicable for reporting, inventory management, record maintenance and use population based analytics ⌘ Maintaining Family Health Folders and Individual Health Records	⌘ 3 days training on reporting and recording information using digital applications ⌘ 3-5 days training can be planned every year based on the expansion of range of services

	Mid Level Health Provider (MLHP)	⌘ Public Health Skills ⌘ General Skills of Bio Medical Waste management, medicine dispensation, medicine refills and injections, suturing of superficial wounds ⌘ Laboratory Skills ⌘ Skills for Management of common conditions Fever, aches and pains ⌘ First aid Stabilization care for common emergencies ⌘ Maternal Health Skills ⌘ Reproductive and Adolescent Health Skills ⌘ Newborn and Child Health Skills ⌘ Skills to use digital applications wherever applicable for reporting, inventory management, record maintenance and use population based ⌘ Maintaining Family Health Folders and Individual Health Records ⌘ Supportive supervision of field level functionaries	⌘ 6 months Certificate Programme in Community Health ⌘ 5-7 days Supplementary Training on new health programmes, new skills and refreshers every year. ⌘ 3 Days Training on use of IT application and telehealth ⌘ Regular monitoring/ training through ECHO platform
PHC	Two Medical Officer, Staff Nurses, Lab technician, Pharmacist, Lady Health Visitors	⌘ Skills for provision of preventive, promotive, curative, rehabilitative and palliative care for expanded range of services ⌘ Skills for training and supportive and supervision of field functionaries of the concerned service area ⌘ Public health management involving: ➊ Implementation, monitoring and supervision of National Health Programmes ➊ Prevention and control of disease outbreaks/ epidemics, handling disaster situation ➊ Disease surveillance ➊ Administrative work, recording and reporting, conducting review meetings	⌘ 10 days BEmONC training Basic Emergency Obstetric Care; 11+2 days F.IMNCI + NSSK; Safe abortion/MTP training, NSV skills, Conventional/ mini-lap training ⌘ Training on National Health Programmes as per programme guidelines for respective cadre

Facility	Human Resource Required	Skill Requirements	Training Requirements
		❶ Using population based analytics for capacity building and dialogues with primary care teams to improve health outcomes ❶ *Skills that can be planned phase wise in the long term* ❶ Skills in family medicine for Medical Officers to enable comprehensive and integrated care ❶ Multi-skilling of paramedic staff to function as an ophthalmic technician, physiotherapist, etc.	⌘ 5 days training for PHC Staff to play a leadership role in the delivery of CPHC ⌘ Online Certificate Course on Standard Treatment Guidelines/ Continuity of Care Protocols ⌘ 5 days training in Population based screening, prevention and management of NCDs ⌘ Other Distance mode certificate programmes in areas such as- Family Medicine/ NCD management/ MCH Care/Elderly Care/Mental Health etc. to be planned in long term ⌘ Short term certificate courses for paramedic staff for multiskilling

** These functions will be undertaken by MPW (F).*

4.6.22 Use of IT

The use of standardized digital health records and establishing a seamless flow of information across all levels of health care facilities is an aspirational goal. Use of Information Technology would be essential to enable efficient delivery of services at the HWCs. IT tool would support the HWC team in Registration, Service delivery record keeping and follow up and reporting, telemedicine, research and analytics, logistics including supply chain management.

Infrastructure for Health and Wellness Centres

4.6.23 Ensuring adequate infrastructure for the delivery of Comprehensive Primary Health Care and Health and Wellness Centres would need to cater to a population size as per IPHS norms for Sub Health Centers- one per 5000 population in all areas and one per 3000 in tribal, hilly and desert areas.

4.6.24 Patient reception and registration centers, citizen charters, electronic display boards for services, provision of sitting arrangement of patients, other amenities in the waiting area, TV screens for health communication, facilities for people with disabilities, provision of privacy for patient examination area/ examination table, good quality lab, pharmacy, a wellness room for conducting physiotherapy/ Yoga sessions, rehabilitative services, separate toilets for males and females etc.

4.6.25 To ensure effective delivery of primary health care services, it is essential that protocols for quality assurance are institutionalized at HWC. Mere availability of services is not enough and the services need to be accessible, safe, patient-centred, acceptable, equitable and provided with dignity and confidentiality.

In order to assure that quality standards are followed. the following critical measures should be

taken:

i) Provision of Patient Centred and respectful care.

ii) Enable Patient Amenities at HWC.

iii) Adhere to standard treatment guidelines and clinical protocols for care provision.

iv) Achieve Indian Public Health Standards with regards to HR, infrastructure, equipment, service delivery and supplies.

v) Implement the National Quality Assurance Standards for public health facilities, by focusing on eight critical areas - a) Service provision, b) Patient rights, c) Inputs d) Support services, e) Clinical services, f) Infection control, g) Quality management and h) Health outcomes.

CHAPTER 5

EMERGENCY MEDICINE AND ITS IMPORTANCE

CHAPTER 5

Emergency Medicine and its Importance

5.1 Importance of Emergency & Acute Care at Primary Health Care Level

5.1.1 A medical emergency is, "the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."

5.1.2 In other words a **medical emergency** is an acute injury or illness that poses an immediate risk to a person's life or long-term health, sometimes referred to as a situation risking "life or limb". An emergency could be **medical** (e.g. Myocardial infarction, Stroke, Poisonings, Animal bites, Acute asthma, Seizures etc), **surgical** (e.g. Acute appendicitis, Strangulated hernia, Acute retention of urine, Acute Intestinal Obstruction, Gut perforation, Burns, Epistaxis, Injuries following trauma including head injuries, chest or abdominal injuries, fractures, polytrauma with haemorrhage etc), **Paediatric** (acute dehydration, choking due to a foreign body etc), **Obstetric**(Complicated labour, Antepartum haemorrhage, Eclampsia, Postpartum haemorrhage etc) or **Mental** (acute psychosis, mania, delirium etc). These are events of sufficient severity to cause a disruption in the normal physiology of the body and which can pose a definite threat to life or limb if not detected, assessed and managed immediately or in a time sensitive manner.

5.1.3 For the patient and the family, any health emergency is a moment of stress, anxiety and worry. The worry is not only about one's own life, but also about the spectre of impending

expenses. One major health emergency leads to huge out of pocket expenses which can push anyone and especially the poor into poverty. There is thus a definite need for our healthcare system to cater to these emergent needs of the community.

5.1.4 Unfortunately the aspect of Emergency medical services and care especially at the Primary health care Facility has been a neglected one. The following paragraphs stress upon the need for and the social and economic advantages of creating and maintaining a functional emergency care system at the Primary Healthcare level and upwards.

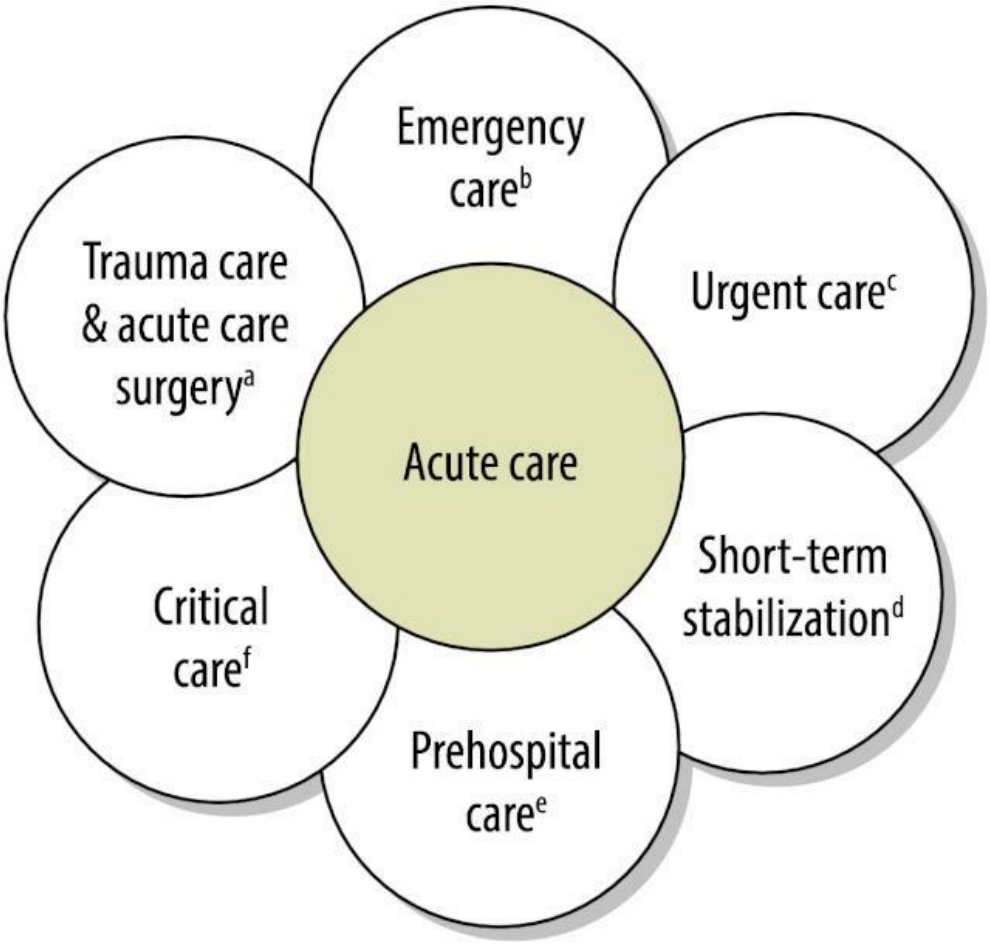
5.1.5 As populations continue to grow and age, there will be increasing demand for acute curative services responsive to life-threatening emergencies, trauma and acute exacerbation of chronic illnesses. Emergency interventions and services should be integrated with primary care and public health measures to complete and strengthen health systems.

5.1.6 Acute services include all promotive, preventive, curative, rehabilitative or palliative actions, whether oriented towards individuals or populations, whose primary purpose is to improve health and whose effectiveness largely depends on time-sensitive and, frequently, rapid intervention.

5.1.7 A reasonable working definition of acute care would include the most time-sensitive, individually-oriented diagnostic and curative actions whose primary purpose is to improve health. A proposed definition of acute care includes the health system components, or care delivery platforms, used to treat sudden, often unexpected, urgent or emergent episodes of injury and illness that can lead to death or disability without rapid intervention. The term *acute care* encompasses a range of clinical health-care functions, including emergency medicine,

trauma care, pre-hospital emergency care, acute care surgery, critical care, urgent care and short-term inpatient stabilization

Figure 5: Domains in Acute Care



Domains in acute care

[a] Treatment of individuals with acute surgical needs, such as life-threatening injuries, acute appendicitis or strangulated hernias.

[b] Treatment of individuals with acute life- or limb-threatening medical and potentially surgical needs, such as acute myocardial infarctions or acute cerebrovascular accidents, or evaluation of patients with abdominal pain.

[c] Ambulatory care in a facility delivering medical care outside a hospital emergency department, usually on an unscheduled, walk-in basis. Examples include evaluation of an injured ankle or fever in a child.

[d] Treatment of individuals with acute needs before delivery of definitive treatment. Examples include administering intravenous fluids to a critically injured patient before transfer to an operating room.

[e] Care provided in the community until the patient arrives at a formal health-care facility capable of giving definitive care. Examples include delivery of care by ambulance personnel or evaluation of acute health problems by local health-care providers.

[f] The specialized care of patients whose conditions are life-threatening and who require comprehensive care and constant monitoring, usually in intensive care units. Examples are patients with severe respiratory problems requiring endotracheal intubation and patients with seizures caused by cerebral malaria.

5.1.8 It is important to get the patient to the right place at the right time for the right intervention. Failure to consider the time component of curative services produces fragmentation through poor coordination of care and application of clinical interventions, can lead to death or disability.

5.1.9 As a clinical service, acute care responds to immediate life- or limb-threatening health conditions, regardless of their ultimate cause. Thus, acute care necessarily supports progress towards strong health systems (horizontal approach) rather than from patchwork efforts that may improve outcomes for specific conditions but not the overall functioning of the health system (vertical programmes). Notably, many of the material, consumable and human resources required to implement acute care platforms are the same as those needed in traditional "disease-centred" programmes. Additionally, it is important to dispel common misperceptions about acute care, such as believing it to be the same as ambulance transport or fundamentally reliant on high technology. On the contrary, excellent acute care is driven by a temporal element – i.e. responding to immediate threats to life or limb – and involves a redistribution of resources to minimize impending death and disability. The integration of acute care with preventive and primary care completes a health-care system paradigm that fully encompasses all essential aspects of health care delivery.

5.1.10 Acute care plays a vital role in the prevention of death and disability. Primary care is not positioned, and is frequently unable, to assume this role. Within health systems, acute care also serves as an entry point to health care for individuals with emergent and urgent conditions.

5.1.11 There is a need to call to action leaders, policy-makers and academics to acknowledge the key contribution of acute care systems towards the care of patients with communicable and non-communicable conditions and injuries. However, the creation of such acute care systems should not be used as a pretext for diverting resources to the construction of poorly-resourced and ill-managed health facilities. The development of the best mix of acute and preventive services needed to address the growing disease burden is an urgent priority for health systems and society. (Hirshon et al ,2013)

5.2 Emergency Care in LMIC

5.2.1 The concept of emergency care has largely been overlooked or disregarded as beyond the reach of health systems in resource limited countries, like the LMIC. Those within the field of emergency medicine have made significant contributions in their own ways but somehow emergency care has attracted little attention outside of this circle. In most health systems there has been a predominant focus on disease centric approach and various programmes against specific diseases. There has been disproportionate allotment of funds and resources for HIV etc as compared to Emergency Care including for injuries caused due to road accidents, social violence etc

5.2.2 Traditionally Emergency care has been assumed to be a high cost service as compared to Primary Healthcare which is cheap and low cost. However, it is time that it is realized that emergency and acute care are also provided at primary care level. Thus, it should be considered as an "Essential Service" and not as a luxury of advanced countries.

5.2.3 Acute and emergent needs arise in both communicable and non-communicable diseases. The latter is becoming more prevalent in the last decades. Many individuals do not seek advice or care until the disease reaches an emergent stage, in part because of lack of access and affordable care.

5.2.4 Emergency care can be conceptualized as the ability of a healthcare system to provide access to acute healthcare, such as injury stabilisation and initial treatment of acute illnesses. It also becomes an access point for preventive and more definitive healthcare. Emergency care provides three important roles:

i) Improves health of a population

ii) Responds to their expectations and needs

iii) Protects against financial costs of worsening ill health

5.2.5 Both Emergency Care and Primary health care are critical for any health system and it is very important to integrate the two into the overall primary healthcare system. Emergency care can be provided at a wide range of healthcare settings including Primary Health Care. The range and scope of management of patients at various levels of healthcare will vary based on available manpower equipment and technology. However, the basic elements of emergency care viz. Airway, Breathing, Circulation (ABC); standard wound management, fracture stabilization etc remain the same even at the Primary Care echelon.

5.2.6 There is a critical need for documenting the role and impact of emergency care on morbidity and mortality. Presently there is a paucity of data on emergency care in the health systems.

5.2.7 Emergency care MUST be on the list of priorities. It is an important healthcare need and is also cost effective. To understand the cost effectiveness of Emergency care, take an example of Traumatic Brain Injury or Head Injury following an accident. Simple immediate management of the ABC i.e. Airway, Breathing and Circulation (to maintain oxygenation, ventilation and blood pressure) can prevent tremendous subsequent costs to the individual and society: Costs of neurosurgery, lifelong or long-term disability, opportunity costs to the individual and the family and costs to the social service systems. Studies have shown that lifetime costs of managing a Traumatic Brain Injury patient could range from 600,000$ to 1,875,000 $. So, investing in Emergency Care is cost effective.

5.2.8 There is no need to create a new setting or infrastructure. Requirements of emergency care can be incorporated into existing Primary Health Care setups. This should be combined with training of all levels of the Healthcare personnel in basics of emergency management, triage and emergency procedures and augmentation of staff.

5.2.9 Emergency care should be accorded priority in Government policy and resource allocation. There is a need for policy makers in administration and Government to be convinced about the potential health and economic gains of investing in Emergency care. (Razzak & Hirshon,2010)

5.3 Importance of Emergency Care and Training of Healthcare Professionals (HCP) in Emergency Medicine

5.3.1 Training of HCPs in the management of emergencies is of vital necessity in order to save life and limb. There are various courses available. Two very accepted and universally accepted worldwide programmes the Advanced Cardiovascular Life Support,ACLS programme of the American Heart Association and the Advanced Trauma Life Support, ATLS of the American College of Surgeons are discussed briefly below. They deal with the prioritized management of medical cardiovascular and respiratory emergencies and acute trauma management respectively.

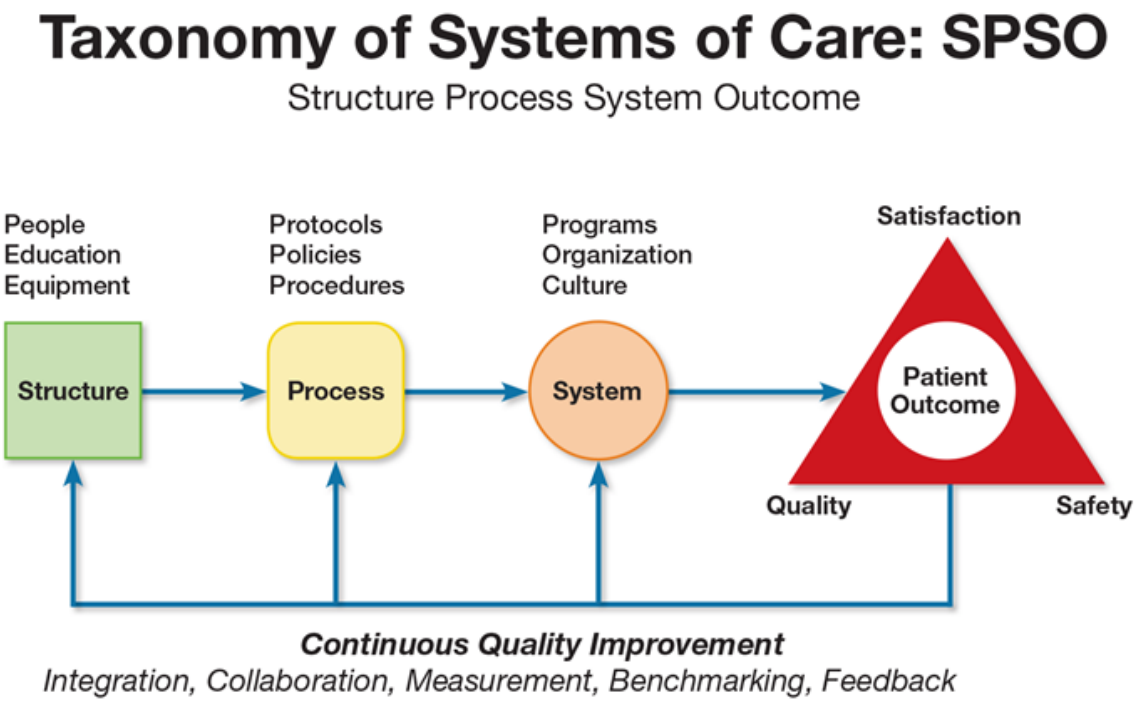
Both programmes focus not only on individual actions but also the Systems and Team approach to management of emergencies.

Systems of Care

5.3.2 A system is a group of regularly interacting and interdependent components. The system provides the links for the chain and determines the strength of each link and the chain as a whole.

The System determines the ultimate outcome and provides collective support and organization. Any Healthcare delivery requires Structure (People, Equipment, Education and Training), Processes (Policies, Protocols, Procedures) which when integrated produce a System (programmes, cultures) leading to Outcomes (patient safety, quality and satisfaction).

Figure 6: Taxonomy of Systems of Care



5.3.3 Some of the common acute cardiorespiratory emergencies which need prompt, prioritized and coordinated actions at healthcare facilities for successful outcomes include Acute Coronary Syndromes like a Heart attack (Acute myocardial infarction), Acute Strokes, Acute respiratory arrest after poisonings, asthmatic attacks, acute arrhythmias of the heart, cardiac arrest etc.

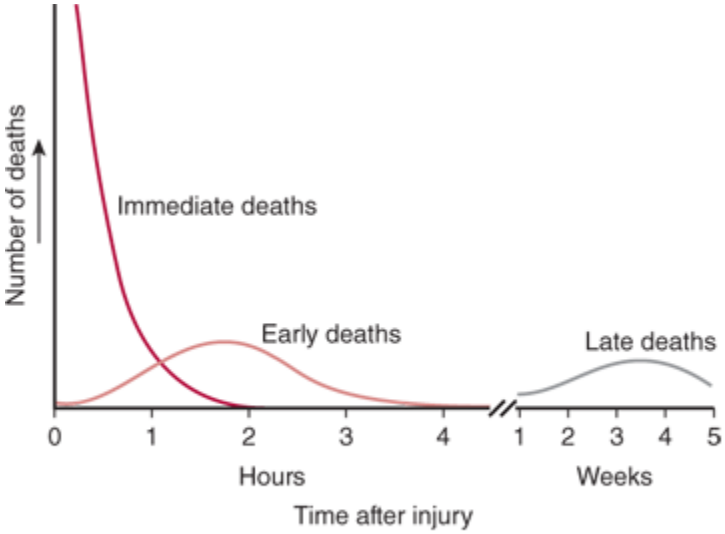
5.3.4 Just as in trauma care, medical emergencies also have their Golden Hour concept stressing the need for urgent interventions and actions as specified for different situations. (Advanced Cardiovascular Life Support Manual, AHA 2016)

5.3.5 Training courses like the Advanced Trauma Life Support (ATLS) provide content and skills that are designed to assist doctors in providing emergency care for trauma patients. The concept of the "golden hour" emphasizes the urgency necessary for successful treatment of injured patients and is not intended to represent a fixed time period of 60 minutes. Rather, it is the window of opportunity during which doctors can have a positive impact on the morbidity and mortality associated with injury. Such training courses provide the essential information and skills for doctors to identify and treat life-threatening and potentially life-threatening injuries under the extreme pressures associated with the care of these patients in the anxiety of an emergency or trauma room.

5.3.6 According to the World Health Organization (WHO) and the Centre for Disease Control (CDC), more than nine people die every minute from injuries or violence, and 5.8 million people of all ages and economic groups die every year from unintentional injuries and violence. accounting for 18% of the world's total diseases. Motor vehicle crashes alone cause more than 1 million deaths annually and an estimated 20 million to 50 million significant injuries; they are the leading cause of death due to injury worldwide. Significantly, more than 90% of motor vehicle crashes occur in the developing world. Injury-related deaths are expected to rise dramatically, and deaths due to motor vehicle crashes are projected to increase by 80% from current rates in low- and middle-income countries.

5.3.7 Trimodal Pattern of Deaths in Trauma & the Golden Hour

Figure 7: Trimodal Pattern of Deaths in Trauma & the Golden Hour



First described in 1982, the trimodal distribution of deaths implies that death due to injury occurs in one of three periods, or peaks. The first peak occurs within seconds to minutes of injury. During this early period, deaths generally result from apnea due to severe brain or high spinal cord injury or rupture of the heart, aorta, or other large blood vessels. Very few of these patients can be saved because of the severity of their injuries. Only prevention can significantly reduce this peak of trauma-related deaths. The second peak occurs within minutes to several hours following injury. Deaths that occur during this period are usually due to subdural and epidural hematomas, hemopneumothorax, ruptured spleen, lacerations of the liver, pelvic fractures, and/or multiple other injuries associated with significant blood loss. The third peak occurs days to weeks later and is usually due to septicaemia following infections. It is the second peak which needs to be especially targeted in order to save lives once the victim reaches a healthcare facility, hence it's called the Golden Hour. The golden hour of care after injury is characterized by the

need for rapid assessment and resuscitation, and appropriate interventions, which are the fundamental principles of trauma care.

5.3.8 Trauma courses like the ATLS emphasize that injury kills in certain reproducible time frames. For example, the loss of an airway kills more quickly than does loss of the ability to breathe. The latter kills more quickly than loss of circulating blood volume. The presence of an expanding intracranial mass lesion is the next most lethal problem. Thus, the mnemonic ABCDE defines the specific, ordered evaluations and interventions that should be followed in all injured patients: **A**irway with restriction of cervical spine motion **B**reathing **C**irculation, stop the bleeding **D**isability or neurologic status **E**xposure (undress) and **E**nvironment (temperature control). Teaching and practice of the simple ABCDE model to all our Primary healthcare medical personnel will make a significant impact on mortality and morbidity of trauma.

Trauma Care at Primary Health Care Facilities

5.3.9 There is a need to have trauma care expertise and facilities at all levels of healthcare starting from prehospital care to primary healthcare and thereafter through to secondary and tertiary level hospitals and exclusive advanced trauma centres. This is an Inclusive model of Trauma Care, which as the name suggests, proposes that all healthcare facilities in a region be involved with the care of injured patients, at a level commensurate with their commitment, capabilities, and resources. Thereafter through the EMS, the system should efficiently match an individual patient's needs with the most appropriate facility, based on resources and proximity. At the same time, there should be sufficient local resources and expertise to manage the less severely injured, thus avoiding the unnecessary risks and resource utilization incurred for transportation to a high-level facility.

5.3.10 An inclusive system ensures that all hospitals participate in the system and are prepared to care for injured patients at a level commensurate with their resources, capabilities, and capacity; The model of the inclusive trauma system has been well developed. There is substantial evidence to show the efficacy of these systems in improving outcomes after injury.

5.3.11 The system has a scale and function that places it in the realm of essential public services, yet it operates within the largely private sector market-driven world of healthcare delivery. In most areas, the public health dimensions of the trauma system are not well recognized and not well funded by states or regions. Lacking a federal mandate or federal funding, the responsibility to develop trauma systems has fallen to state and local governments, and progress highly depends on the interest and engagement of public leadership at that level. As a result, some states have well-organized and well-funded systems whereas others have made little success.

5.3.12 Unfortunately, most low- and middle-income countries have severely limited infrastructure for patient transportation and definitive care. These nations face severe challenges in providing adequate care for the injured, and in providing health care across the board. These challenges are clearly demonstrated by the disproportionately high rates of death related to injury seen in such countries. In these settings, training like the ATLS has are likely to have the greatest impact on systems development, bringing knowledge and basic pathways of trauma care directly to the providers, independent of the healthcare infrastructure. These courses help to bring in a systematized approach to care, including the concept of transferring patients to more capable facilities as dictated by injury severity, the importance of communication between providers at various levels of care. In many low- and middle-income countries, ATLS provides both the impetus to improve trauma care and the basic tools to begin to construct a system. (Advanced Trauma Life Support Manual,2018)

CHAPTER 6

RESEARCH METHODOLOGY

AND

LIMITATIONS OF THE STUDY

CHAPTER 6

Research methodology & Limitations of the Study

6.1 Research Design

6.1.1 This study was a Descriptive Cross-Sectional Research Study with a mixed methods research approach i.e. both Quantitative and Qualitative research approach for data collection and analysis. The topic and research proposal were duly approved by the Institutional Screening Committee.

6.2 Methodology

6.2.1 The study was conducted in the National Capital Region (NCR) of India. The NCR includes four sub regions which cover 11 districts of NCT-Delhi, 13 districts of Haryana, 08 districts of Uttar Pradesh and 02 districts of Rajasthan spreading over an area of about 55,083 sq. kms. One district each of Uttar Pradesh and Haryana sub regions of NCR was studied. The district of Uttar Pradesh chosen was Gautam Buddh Nagar, and the district in Haryana selected was Palwal. The sampling of districts was of convenience, keeping in view the distance from Delhi and the short period of time available for the study during the course.

6.2.2 After meeting with the Chief Medical Officer/Civil Surgeon of the district and obtaining his permission and support, 03 Primary Health Centres in the district were visited. An attempt was made to visit PHCs which were in remote rural locations. As per the initial research

proposal, it was also planned to study 03 nearby private healthcare facilities. However, the same could not be done due to reasons as mentioned in the section on Limitations of the study.

6.2.3 Indian Public Health Standards (IPHS) Guidelines 2012 were used as a tool to gather data for Research Objectives 1,2 and 4 (Availability, capacity and training of the MOs and paramedical staff in Emergency Medicine and the Infrastructure available). The IPHS guidelines have been issued by the Directorate General of Health Services, Ministry of Health & Family Welfare,Government of India first in 2007 and subsequently revised in 2012. The Standards have been issued for all levels of Rural Public Health Care including for the Sub Centres, Primary Health Centres,Community Health Centres,Sub District and District Hospitals. The guidelines and subsequent revisions have been formulated by a Task Force of eminent personalities associated with healthcare. The IPHS standards for Primary Health Centres (PHCs) have been revised keeping in mind the resources available for functional requirements of PHC with minimum standards of building,manpower,instruments,equipment,drugs and other facilities as also the changing disease profile and protocols especially with regard to non communicable diseases. They have been devised by the Government with the hope that they would be drivers for continuous quality improvement of Primary Health Care. The IPHS guidelines for PHCs (2012) are quite exhaustive and only the portions of it as relevant to this study have been utilised as a tool for assessment of the PHCs including the Proforma for Facility Survey for PHC.

(IPHS Guidelines for Primary Health Centres, Revised 2012).

6.2.4 To assess the challenges and problems faced by the staff (Research Objective No 3) semi-structured In-depth Interviews (IDIs) were held with Medical Officers, and Focussed Group Discussions (FGDs) with the paramedical staff. Informed consent was obtained from the

interviewees and confidentiality assured. All gathered data was analysed including content analysis of IDIs and FGDs.

6.4 Definitions of Terms Used in The Study

6.4.1 Emergency:

An adverse health situation due to a medical,surgical,obstetric,pediatric,neonatal or mental illness or injury causing serious disruption to the physiology of the body and which poses an imminent danger to life or limb if not detected,assessed and managed immediately or in a time sensitive manner.

6.4.2 Emergency Medical Services

Emergency Medical Services by definition and common usage includes the entire organizational system for detection,immediate response,treatment,transportation and management of emergency patients of any cause,beginning from Out of hospital(or Pre Hospital) management,Ambulance Services, In Hospital Management ranging from Primary Care and resuscitation to Advanced Intensive Care Unit treatment and rehabilitation. However, for the purposes of this study the Term has been limited to the emergency services within the Primary Health Centre, including transportation facilities for onward referral. This term " Emergency Medical Services" is also included in the list of Expanded range of Services being provided under Ayushman Bharat at the PHC level, and hence has been used in this study too.

6.4.3 Emergency Medicine

“Emergency Medicine is a specialty based on the knowledge and skills required for the prevention, diagnosis and management of urgent and emergency aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. It is a specialty in which time is critical.The practice of Emergency Medicine encompasses the pre-hospital and in-hospital triage, resuscitation,initial assessment and management of undifferentiated, urgent and emergency cases until discharge or transfer to the care of another physician or health care professional. It also includes involvement in the development of pre-hospital and in-hospital emergency medical systems” (WHO Europe,2008)

6.4.4 Family Medicine

Family medicine is a clinical medical specialty which is devoted to comprehensive health care for people of all ages and provides personalized, continuing and comprehensive health care for the individual and family across all ages, genders, disease, and parts of the body. (Raman Kumar,2016)

6.4.5 Availability and Adequacy of Emergency Medical Services

The Terms ‘Availability’ and ‘Adequacy’ of Emergency Medical Services in this study pertain to the existence within the PHC of facilities to manage emergencies. These facilities should be present 24/7, accessible both financially and geographically, of a minimum standard and quality (as per IPHS norms and beyond), and which is appropriate, and includes the provision of continuity of care through safe and timely referral. The term “Facilities for Emergency Medical Services” is comprehensive and includes manpower and staff which are trained,infrastructure in terms of building,equipment, medicines, supplies and communication etc.

6.5 Limitations of the Study

6.5.1 The study was focussed on and restricted to the Government Primary Health Care Centres and did not cover the activities at the Sub Centre, Community Health Centre and District Hospital levels. The study does not include Pre Hospital Emergency Care and Services and is restricted to the Primary Health Centre only.

6.5.2 The study also did not include inputs from patients or Government Health Department officials.

6.5.3 The role of the Panchayati Raj Institutions was not included in the study.

6.5.4 Owing to paucity of time due to the short duration of the course, districts of the NCR within reasonably accessible distance were chosen.

6.5.5 During the course of the study, it was realized that near the remotely located PHCs there were no private healthcare facilities except for individual small-time informal practitioners, and in the vicinity of the PHCs closer to the city/town there were numerous large corporate multi-speciality hospitals with well-established Emergency Services. Therefore, the study of the private healthcare facilities for emergency services was abandoned and not performed.

6.5.6 Specific tools of assessment of emergency services for Obstetrics or Trauma were not used. The IPHS (2012 Revision) format for facility inspection of PHCs was used as a single all inclusive tool instead.

6.5.7 It was not possible to obtain data from the PHCs visited about the number and type of emergencies managed at their Centres, since such records were not being maintained or unavailable.

CHAPTER 7

RESEARCH FINDINGS AND ANALYSIS

CHAPTER 7

Research Findings and Analysis

7.1 Introduction

7.1.1 This study on the "Availability and Adequacy of Emergency Medical Services in Rural Primary Health Care Units in the National Capital Region (NCR)" was conducted with the objectives of studying the availability, capacity and training of the MOs and the paramedical staff at PHCs and private healthcare facilities of rural India as well as the challenges and problems faced by them as also the infrastructure available in the PHCs to handle emergencies.

7.1.2 The two districts of NCR chosen for this study were Gautam Buddh Nagar in Uttar Pradesh and Palwal in Haryana. Gautam Buddh Nagar district has four blocks; Bisrakh, Dadri, Jewar and Dhankaur. The PHCs in Bisrakh and Jewar blocks were studied. Bisrakh block has 02 CHCs at Bhangel and Badalpur and 06 PHCs at Bisrakh (Additional PHC), Dujana, Makoda, Thapkedha, Barola and Mamoora. After due permission and meeting with the Chief Medical Officer and with his support, 4 PHCs were visited and studied; PHC Barola and PHC Mamoora in Bisrakh block and PHC Jewar and PHC Jaunchana in Jewar block. In Palwal district, there are three Tehsils Hathin, Hodal and Palwal. After obtaining due permission from the Civil Surgeon Palwal District, 03 PHCs in Palwal Tehsil were visited and studied; PHC Dudhola, PHC Allika and PHC Amarpur .

7.2 Data Collection

7.2.1 During the visit to each PHC, the following points were observed and recorded. The Indian Public Health Standards, 2012 guidelines were used as a template for assessment.

i) Location, Surroundings, Accessibility

ii) General area cleanliness of the premises; outside and inside

iii) Signages

iv) Availability of Power, Water supply

v) Layout of the PHC

vi) Services being provided

vii) Manpower and staffing

viii) Training received by staff

ix)Building infrastructure

x)Labour Room

xi)Operation Theatre, OT

xii)Emergency Room

xiii)Waiting areas

xiv)Laboratory

xv)Pharmacy/Dispensary

xvi)Ambulance and other transport availability

xvii)Workload documentation and protocols

7.2.2 In each PHC, semi structured In Depth Interviews were held with the available Medical Officers, and Focussed Group discussions, FGDs were held with the paramedical staff.

7.3 Private Healthcare Facilities

7.3.1 It was originally planned in this study that along with the 03 Government Primary Health Centres in each district, 03 private healthcare facilities in the vicinity of the PHCs would also be visited and assessed for their Emergency Care facilities. In Gautam Buddh Nagar, the Government PHCs studied were Barola, Mamoora in Bisrakh block and Jewar and Jaunchana in Jewar Block. There are many large to medium sized corporate hospitals in NOIDA close to Barola and Mamoora e.g. Fortis, Kailash, Prayag, Jaypee and many more superspecialty hospitals which would obviously have adequate Emergency Care services; hence they were not studied. On the other hand, the PHCs at Jewar and Jaunchana are so remote and peripheral that there are no nearby private healthcare facilities except for few individual practitioners. Hence the same could not be studied.

7.3.2 Similarly, in Palwal District there are big nursing homes and hospitals close to PHC Dudhola, which would have definitely had good emergency care and hence were not visited. Likewise, the PHCs at Allika and Amarpur are located remotely with no private healthcare facilities close by except for few individual practitioners. Hence they were also not studied.

7.3.3 This is a limitation of the study and a deviation from the original research proposal. This study, thus exclusively focuses on the Government Primary Health Centres.

7.4 Findings

7.4.1 A Table comparing important characteristics of each PHC is as below:

Characteristic	UTTAR PRADESH (Dist GB Nagar)				HARYANA (Dist Palwal)		
	Barola	**Mamoora**	**Jewar**	**Jaunchana**	**Dudhola**	**Allika**	**Amarpur**
Population	52,000	3,50,000	2.00,000	24,000	62,000	49,700	26,707
Daily OPD	160	180	190	80	120	160	114
No. of beds	4	4	6	4	6	6	6
% Occupancy	35	9	90	34	55	35	32
Labour Room	Yes	No	Yes	No	Yes	Yes	Yes
OT	Yes	No	No	No	No	No	No
Emergency Room	No	No	No	No	No	No	No
Ambulance	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MOs	1	1	2	1	2	2	1
MO AYUSH	1	1	1	1	1	1	1
Dental Surg.	Nil	Nil	Nil	Nil	Nil	Nil	1
Nurses	2	1	3	1	3	3	5
Pharmacist	1	1	1	Nil	1	1	Nil
Lab Tech	Nil	1	2	Nil	1	1	1
Clerk	1	Nil	1	Nil	1	1	Nil
Other Staff	3	1	2	1	3	4	7
Total Staff	**8/19**	**6/19**	**12/19**	**4/19**	**12/19**	**13/19**	**16/19**
Cleanliness	Fair	Fair	Fair	Good	Fair	Excellent	Very Good

The detailed findings of the visit to the 7 PHCs (4 in UP, 3 in Haryana) have been tabulated separately as per the IPHS 2012 guidelines format. They have been placed in the Master Chart after the Annexures.

7.4.2 Comparative Table : Facilities for Emergency Care

Facility/ Equipment	UTTAR PRADESH (Dist GB Nagar)				HARYANA (Dist Palwal)		
	Barola	**Mamoora**	**Jewar**	**Jaunchana**	**Dudhola**	**Allika**	**Amarpur**
Emergency Room	No	No	No	No	No	No	No
Trauma Crash Cart *	No	No	No	No	No	No	No
Oxygen Cylinders	Yes	Yes	Yes	Yes	Yes	Yes	Yes
BP Instrument Manual	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pulse Oximeter*	No	No	No	No	No	No	No
Multi-parameter Monitor*	No	No	Yes(01)	No	No	No	No
Instruments for Labour Room as per IPHS Guidelines	Yes	No LR	Yes	No LR	Yes	Yes	Yes
Newborn baby corner Equipment as per IPHS Guidelines	Yes	No LR	Yes	No LR	Yes	Yes	Yes
Training of MOs	No	No	No	No	No	No	No

in Structured BLS, ACLS, ATLS courses*							
Training of Paramedical Staff in Structured BLS, PHTLS courses*	No	No	No	No	No	No	No
ECG Machine**	No	No	No	No	No	No	No
Defibrillator Manual*	No	No	No	No	No	No	No
AED*	No	No	No	No	No	No	No
Anaesthesia machine*	No	No	No	No	No	No	No
Ventilator Basic*	No	No	No	No	No	No	No
Central oxygen supply*	No	No	No	No	No	No	No
X-Ray Machine Portable*	No	No	No	No	No	No	No
Ultrasound Machine*	No	No	No	No	No	No	No
Nebulizer	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Facility for Blood Transfusion*	No	No	No	No	No	No	No

Note: * : Not in IPHS Standards

**: Mentioned as Desirable in IPHS Standards

7.5 Summary of Findings

7.5.1 Services Provided

i) The visit to the PHCs revealed that the Centres were active foci of healthcare, and in the remotely located areas, the only immediately available healthcare facilities. The daily OPDs ranged from 120-250 per day.

ii) Common illnesses noticed were Upper Respiratory infections, Allergies, Joint pains, Minor trauma, Gastroenteritis, Paediatric illnesses etc.

iii) The Antenatal care and Immunization programmes in all PHCs were actively pursued and achieving near 100 % coverage in the dependent population.

iv) The recent emphasis on Non-Communicable Diseases monitoring like Diabetes, Hypertension, etc has also been taken on by the PHCs and their dependent sub centres actively.

v) Doctors were found to be available and attending to the OPDs regularly. Necessary blood tests were ordered for and Pulse, BP were being recorded in all suspected cases and new cases.

vi) Waiting areas were available but could be improved upon.

vii) Most PHCs did not have an active and well-equipped Emergency Room to efficiently manage acute emergencies.

viii) Few patients who were interviewed, were satisfied with the services provided. However, few patients felt that the doctors did not spend enough time with them and medicines were given only for a few days. The delivery facilities in the PHCs were appreciated by the users spoken to.

7.5.2 Manpower and Staffing

i) All the PHCs were understaffed and did not have their full quota of authorized staff.

ii) Most common deficiencies were of Pharmacist, Nurses/Midwives, Data entry operators, Clerks/Accountant, Multipurpose workers and Health assistant

iii) Medical Officers were usually available. Half of the PHCs also had AYUSH doctors who would prescribe common allopathic medicines too in addition to AYUSH preparations

iv) Any available suitable staff would double up or be used as a Pharmacist, if not posted at the PHC

v) None of the PHCs had a dedicated Cold Chain and Vaccine Logistic Agent posted

vi) The PHCs in Palwal, Haryana were better staffed.

7.5.3 Cleanliness of premises and surroundings

i) It was found that the surrounding areas and access to the PHC were not clean, with open garbage, open drains and narrow access. This was seen especially in the cases of the PHCs in Uttar Pradesh district of Gautam Buddh Nagar. The neatness, cleanliness and general ambience of the PHCs of Palwal, Haryana was visibly better

ii) Within the PHC building, the cleanliness was only fair. There is a scope of much improvement. Again, the PHCs of Palwal were much cleaner than the ones in GB Nagar

iii) Lack of posted sweeper/sanitation staff affects general cleanliness of the PHC premises

7.5.4 Emergency Care Services

i) None of the PHCs had a dedicated Emergency Department or Room with laid out beds, and resuscitative equipment. Most of the PHCs would use either the Dressing Room or the Ward for emergency patient care.

ii) Oxygen cylinders were available in all PHCs. Oxygen delivery masks and tubings were also available. However, apart from an Ambu bag, there was no ventilator (not scaled) available to provide artificial mechanical ventilation if needed.

iii) Suction apparatus was usually available only in the Labour Room.

iv) Monitoring equipment for emergency patients included only a BP apparatus and Thermometer. Essential monitoring and resuscitative equipment during emergencies like an ECG machine, Pulse oximeter, Defibrillator and Ventilator(basic) was not available in any of the PHCs. AEDs (Automated External Defibrillators) for use in cardiac arrest by paramedics were also not available. These equipment are not on the IPHS list too however. One of the PHCs, Jewar PHC had procured a multiparameter monitor out of some funds allocated to him and had placed it in the Postnatal ward.

v) Resuscitative equipment like oral and nasopharyngeal airways, laryngoscopes and endotracheal tubes were, if available kept in cupboards. Nursing staff did not appear to be confident and knowledgeable about their use.

vi) A Crash Cart with all necessary equipment, drugs, IV cannulas of various sizes and IV fluids was not seen in any of the PHCs

vii) Posters, ready reckoners and guidelines for management of common medical, surgical and obstetric emergencies were not observed. These would have been useful for the duty medical staff.

viii) Similarly, a few educational posters for the benefit of the patients visiting the PHC on the early symptoms and signs of common emergencies like a heart attack, stroke etc which would have been useful were not there.

ix) The overall attitude towards emergency care did not appear to be proactive. There appeared to be a tendency to offer some immediate first aid measures and transfer to the higher facility at the earliest.

x) Except in one of the PHCs, (PHC Jewar) doctors were not available on the premises 24/7. After OPD hours the doctors were on call from their homes which were at times one to one and a half hours away. During non OPD hours, the only staff available would be one or two nurses.

xi) Except for PHC Jewar, indoor patient facilities were being underutilized by the PHCs to admit and treat emergencies. If at all, the beds were used for delivery cases; immediate prenatal and up to 24 hours post natal care.

xii) Some of the MOs had undergone Basic Life Support courses many years ago, but no other courses in emergency medicine like ACLS or Trauma Life Support. Similarly, the nurses and paramedics had not undergone any course/update/workshop in emergency medicine except for training in emergency obstetric and neonatal care.

xiii) Ambulance services were available in all the PHCs. They were usually the 108 or 102 ambulance services which were outsourced by the NHM. The ambulances were the basic transport ambulances with only facility for oxygen enroute. The EMTs with the ambulances, had undergone some training but did not appear to be knowledgeable at all. The ambulances were also being used to pick up and drop patients from and to their homes most often for obstetric cases. During the turnaround time, in case another ambulance was needed it would have to be called for.

xiv) The common emergencies which the PHCs were receiving included trauma due to road accidents, animal bites, burns, dehydration due to gastroenteritis, acute asthma etc

7.5.5 Salient points from the In-depth Interviews with Medical Officers

Semi structured interviews were held with the Medical Officers of the PHCs to try and understand the challenges and problems they were facing. Some of the salient points which emanated from these interviews are as below:

i) By and large the doctors appeared to be enthusiastic, motivated and sincere about their job and seemingly content. Each of the doctors was attending to about 60-100 patients a day in addition to contributing to administrative work like reports, returns and making field visits.

ii) Many of them had joined the Government healthcare service out of choice and had been appointed after undergoing a fairly rigorous selection system. They thus had a feeling of self confidence and self esteem.

iii) One of the Lady MOs was very happy with the working hours. Despite having to commute every day for an hour one way from Faridabad to Palwal and back, she was happy to be working in Govt service, instead of being at home or toiling in private sector corporate hospitals.

iv) Regarding the pay and emoluments, the permanent employees were reasonably satisfied. The doctors posted in the remote PHCs and who had to commute long distances everyday in their own vehicles however were upset that no additional transport or fuel allowance was given to them.

v) Career progression was somewhat slow. They move up the ladder from Level IV MOs to Level I (CMO and Additional CMO) with salary increments periodically.

vi) The doctors were also satisfied with the job content and working hours. On specifically asking about working in rural areas and away from their homes and cities, they said that they are taking it in their stride. They were willing to wait their turn for a change of posting.

vii) The MOs universally said that they felt a sense of duty and national service while working in the rural areas and were glad to serve the medical needs of our villagers.

viii) Challenges they faced in the performance of their duties were manpower shortage, lack of proper infrastructure in terms of emergency rooms, wards, medical equipment. Some of them said that PHCs should have an ECG machine, X ray machine and an Ultrasound for immediate aids in diagnosis and further management. Routine medicines were available, but in a limited inventory. Some of the doctors were enthusiastic and willing to treat more patients at their own level at the PHC provided that they had more equipment, monitoring and staff to assist them

ix) Non availability of blood in emergencies was also cited by one MO

x) At many PHCs there are no Lady MOs. The female patients from the villages were hesitant to show themselves to male doctors for their gynaecologic or obstetric problems.

xi) Some of the younger MOs looked forward to some training, courses and specialisation which the State Health Service might make provision for. They were also on the lookout for more exciting and better career prospects outside. One of the MOs had done a 6 month Life Saving Anaesthesia Skills, LSAS course conducted by NHM/NHRM but was now posted in a rural PHC without utilising his training.

xii) Some of the MOs were keen on performing minor surgeries in the PHCs but were hesitant due to lack of equipment and trained staff.

xiii) Regarding the postings within the State or even within the district, some of the MOs felt that the system could be more transparent and fairer. They hinted that those with the right 'connections' would get more attractive postings while those without, would be shunted to peripheral and remote PHCs. They also felt that everything was in the hands of the CMO of the district and that he could move any MO anywhere based on his discretion.

xiv) Most of the MOs had made arrangements to stay in the cities or closest towns for the sake of their families and children's education. They would therefore commute long distances every day, but preferred this system so that their children could go to good schools in the city. MOs posted in some of the PHCs of Gautam Buddh Nagar were luckier because of good schools in NOIDA close to their place of work.

xv) Some of the older MOs lamented that, with each passing year they were getting more and more out of touch with modern medicine and learning and would thereby gradually lose confidence in managing complicated or serious emergencies.

xvi) The MOs universally felt that there were too many reports and returns to be prepared. There were too many vertical National programmes for prevention and control of various diseases and health conditions, each having their own reports to be submitted. There was a lot of overlap too. Periodic field visits to the sub centre level also had to be made. While they didn't grudge the additional work, it definitely imposed a lot on their hands in addition to the daily OPD at the PHC.

xvii) The AYUSH MOs who were interviewed were also quite content about their job at the PHCs. They were able to continue with their AYUSH practice for patients who wanted it, as also to prescribe common allopathic medications. However, the salaries of the AYUSH doctors were lesser than the MBBS doctors.

xviii) With regard to Emergency Care, the MOs were quite open to the idea of undergoing training courses, workshops like BLS, ACLS, ATLS etc especially if the State Health Service could sponsor or make arrangements for it.

xix) The MO in Charge of the PHC can play a major role in improving services of the PHC. This was especially noted in the case of the PHC at Jewar, where the Moi/c was very proactive, energetic and had a keen desire to improve the facilities. He had paid special attention to the Labour Room, Wards, Monitoring, and Safety of patients. In order to provide 24/7 cover he has insisted on and ensured availability of a duty doctor within the premises. Through management of funds he has created a somewhat comfortable rest room accommodation for the duty doctor within the premises, by using existing accommodation and furniture. He has also paid special attention to biomedical waste management which is an often ignored aspect.

xx) The MOs were by and large satisfied with the working environment. They said that they had a fair degree of independence in their professional work. However various national and state level health initiatives announced by the Govts (for their own political visibility) increase the workload of the doctors and the staff; for e.g. In UP the CM recently announced holding of Aarogya

xxi) Melas on Sundays for the villagers, whence they would come to the PHCs to get their medical check ups done for Non Communicable Diseases, NCDs. The one day

in the week where the doctors get to spend time with their families has also been taken away.

7.5.6 Focussed Group Discussions with paramedical staff

Focussed group discussions were held with the paramedical staff in the PHCs to assess their challenges and problems while working in the PHCs. The paramedical staff include the Staff Nurses, ANMs, Pharmacists, Lab Technicians, Ward boys, Sanitation workers etc. The salient points which emanated from these discussions are as follows:

i) The paramedical staff appeared to be well motivated and content with their job and working environment despite the significant workload.

ii) Salaries for the permanent staff were somewhat reasonable; Rs 25-28000 p.m for a ward boy, Rs 55,000 p.m approx. for an ANM, Rs 60-65000 p.m for a Staff Nurse, Rs 42,000 p.m for a Lab Tech etc. The salaries for the contractual staff was almost half of this, which became too less.

iii) Some of the young contractual nurses were not happy with being posted in peripheral rural areas far away from their families. They were looking for job opportunities elsewhere

iv) The Laboratory Technicians were one of the most overworked staff, dealing with a large number of tests to be done every day and single handed with minimal equipment. However, despite the heavy workload and low salaries, they were found to be working very hard and sincerely, with zeal and a sense of service to humanity.

v) The nurses appeared competent, cheerful and willing to take on the workload

vi) Teamwork between the MOs and the paramedical staff appeared to be of a good order

vii) While the ANMs and Nurses didn't mind the field work, they did feel that documentation, reports and returns could be reduced.

viii) The ANMs were given digital tablets in some PHCs in Palwal, and they were quite excited to use them for their documentation and reporting.

ix) As like for the MOs, the Aarogya Melas to be conducted on Sundays as directed by the State Govt is not popular with the paramedical staff, since it was taking away the one rest day in the week.

x) The paramedical staff were quite willing to undergo training and courses in Emergency Care, provided it was arranged for and sponsored by the Govt.

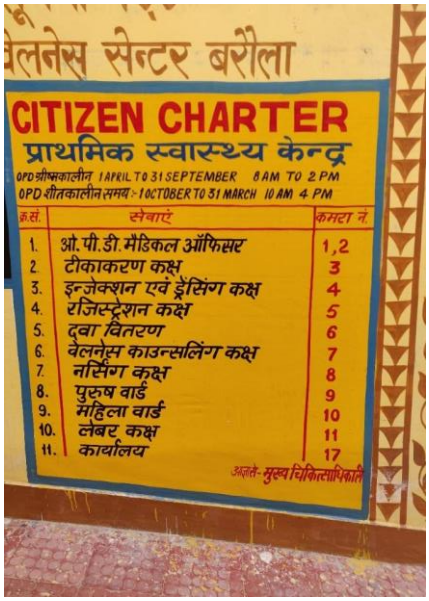
IMAGES OF PHC BAROLA

Block Bisrakh

Dist Gautam Buddh Nagar

State U.P

Entrance of PHC Barola



Citizen Charter

Operation Theatre (Not in Use)

Patients waiting to see the MO (PHC Barola)

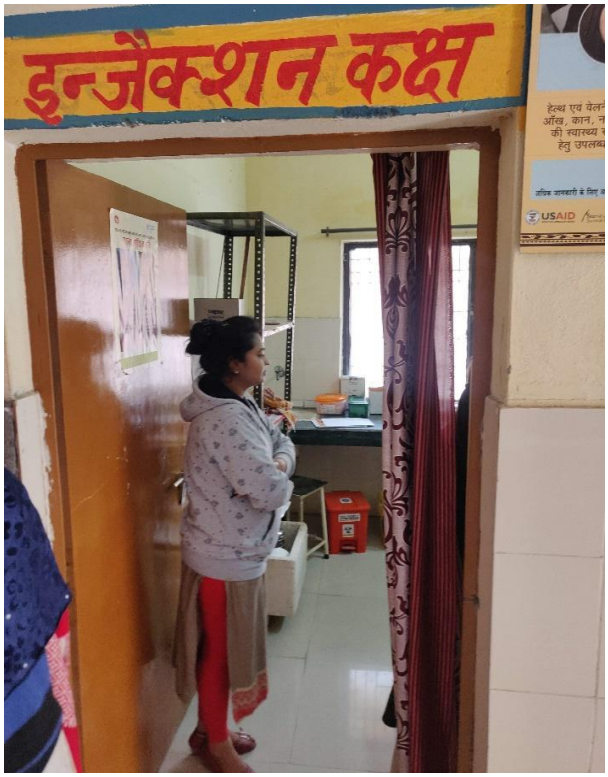
Autoclave machine for sterilization

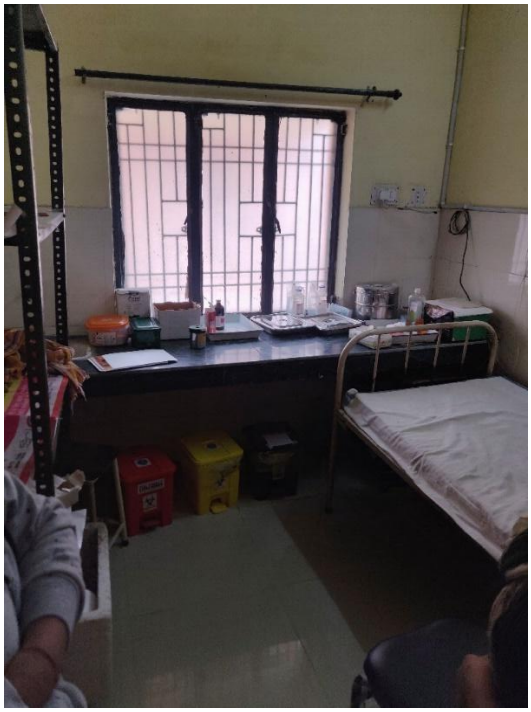
Mothers lined up for Immunization of children

Duty Room for Staff

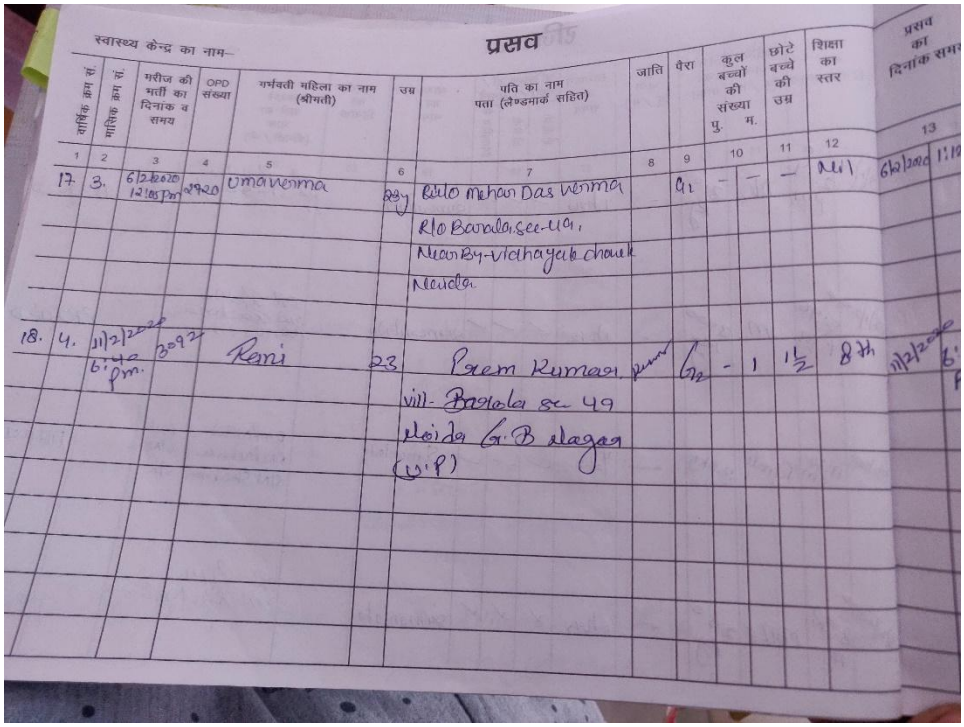
ANM checking Immunization Card

Injection Room used as Emergency Room(Barola)





Delivery Register and Entries PHC Barola



IMAGES OF PHC MAMOORA

Block Bisrakh

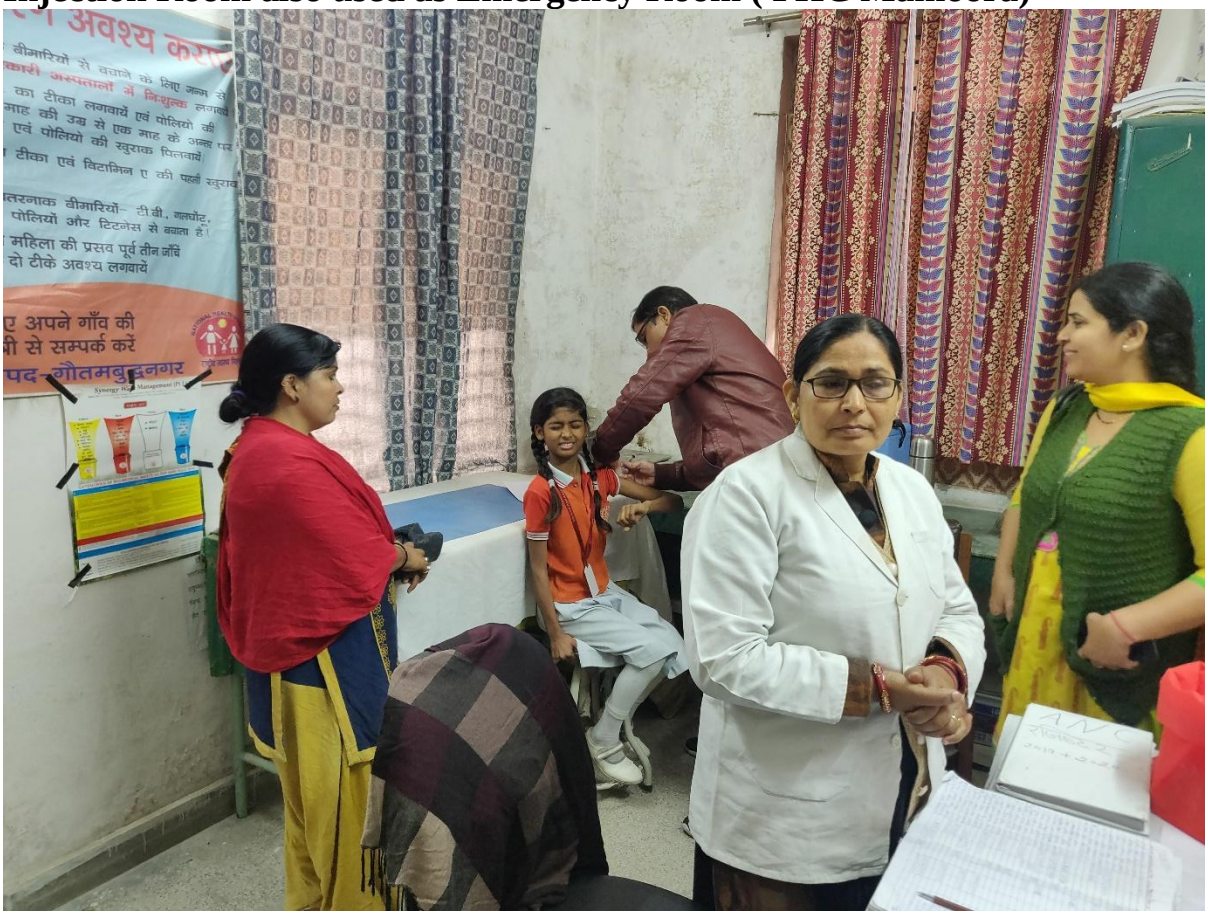
District Gautam Buddh Nagar

State Uttar Pradesh

Entrance and Registration PHC Mamoora

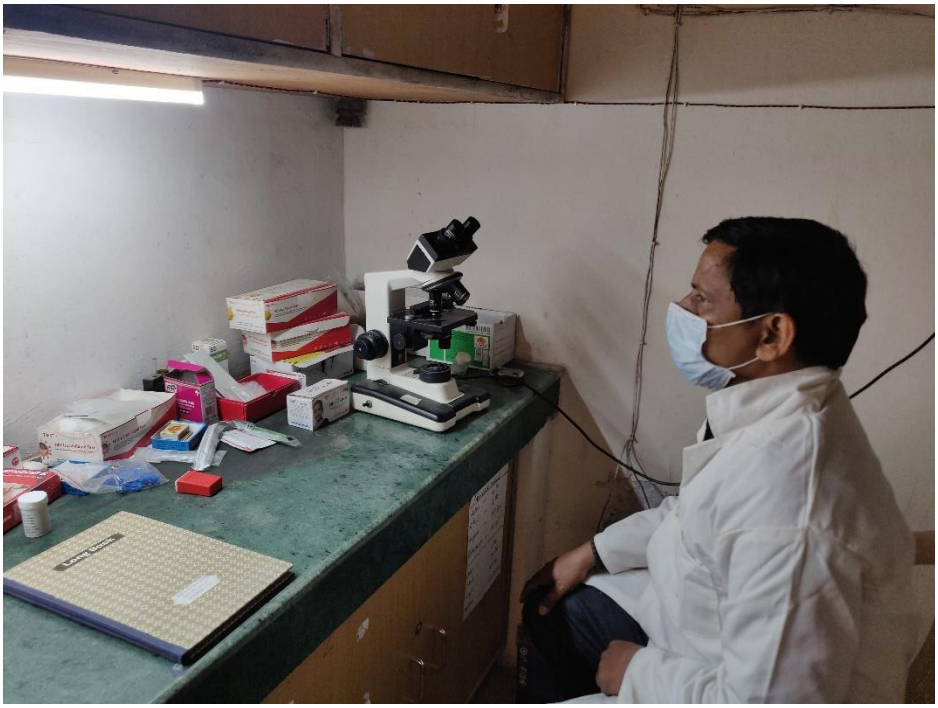
Patients waiting to see the MO (PHC Mamoora)

Injection Room also used as Emergency Room (PHC Mamoora)



Medicine distribution (PHC Mamoora)

Laboratory at PHC Mamoora



Laboratory. Overworked. Unclean fans and windows

ANM looks after the Cold Chain Vaccine Logistics in addition (PHC Mamoora)

Open drains outside the PHC premises

IMAGES OF PHC JEWAR

Block Jewar

District Gautam Buddh Nagar

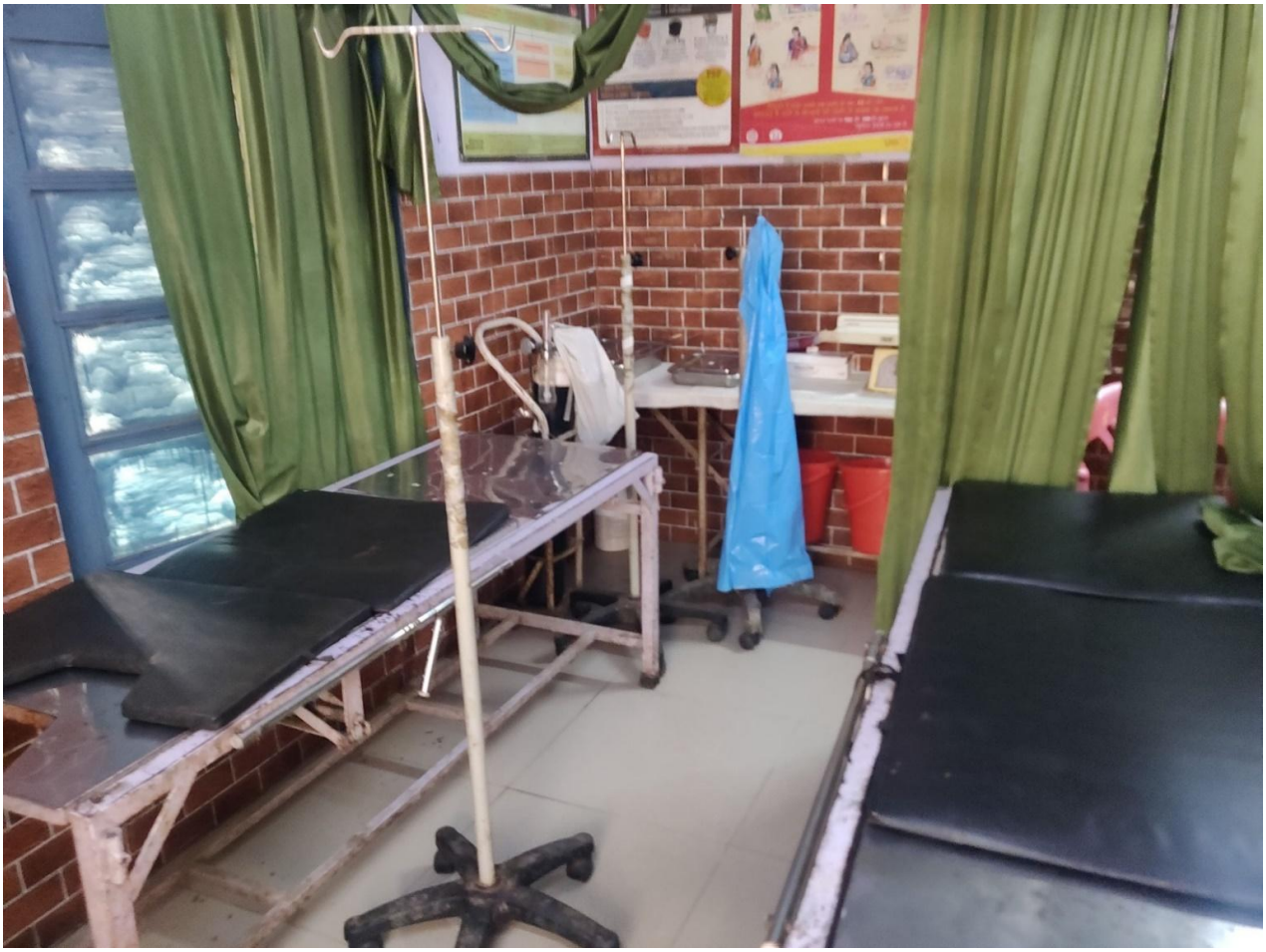
State Uttar Pradesh

Entrance to PHC Jewar

Patients waiting outside the OPD (PHC Jewar)

Dispensary

Labour Room PHC Jewar



Emergency Room PHC Jewar

PHC MO examining newborn baby in postnatal ward

Post natal ward

Staff Nurse with postnatal patients

Researcher along with PHC team Jewar

Educational posters and CCTV camera in the ward

MO’s Duty Rest Room (Needs improvement)

TV and Cupboard in MO’s Rest room

Ambulance Service PHC Jewar

Ambulance driver and EMT

Inside of the ambulance

Researcher in Moi/c PHC Jewar Office along with other MOs

IMAGES OF PHC JAUNCHANA

Block Jewar

District Gautam Buddh Nagar

State Uttar Pradesh

Ayush MO in Emergency Room/Ward PHC Jaunchana

Ward boy/Guard/Sanitation worker in Store Room

Invertor at PHC Jaunchana

Poster for CM Arogya Mela on Sundays

Researcher with MOs in front of PHC Jaunchana

With full Team of PHC Jaunchana

IMAGES OF PHC DUDHOLA

Block Palwal

District Palwal

State Haryana

Entrance to PHC Dudhola

Patients waiting outside the OPD PHC Dudhola

Outside and Inside Labour Room

Labour Room
PHC Dudhola

Labour room with suction, heater, Needle destroyer and Newborn Radiant heater

Lab Asst and Laboratory Dudhola

Ward with admitted/detained patients PHC Dudhola

Dispensary

Pharmacist with his store PHC Dudhola

Nurse checking Pulse BP of Antenatal case PHC Dudhola

Patients near Registration

IMAGES OF PHC ALLIKA

Block Palwal

District Palwal

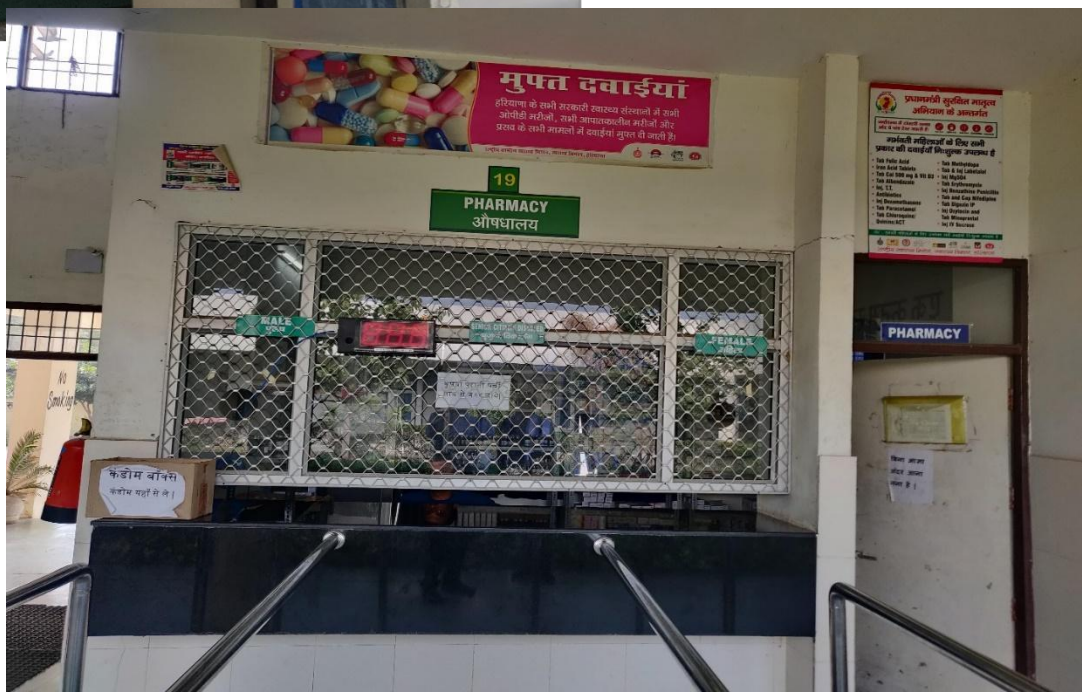
State Haryana

Entrance to PHC Allika

Registration Counter

OPD

PHC Allika



Pharmacy

Pharmacy

Dispensary

Lab Tech PHC Allika

Laboratory PHC Allika

Ward PHC Allika

Post natal case with Staff Nurses,ANM

Labour Room with NewBorn Resuscitation Corner

Newborn Radiant Heater and Monitors PHC Allika

Oxygen and Suction apparatus in Labour Room

Health Education Posters

Ayurvedic medicines

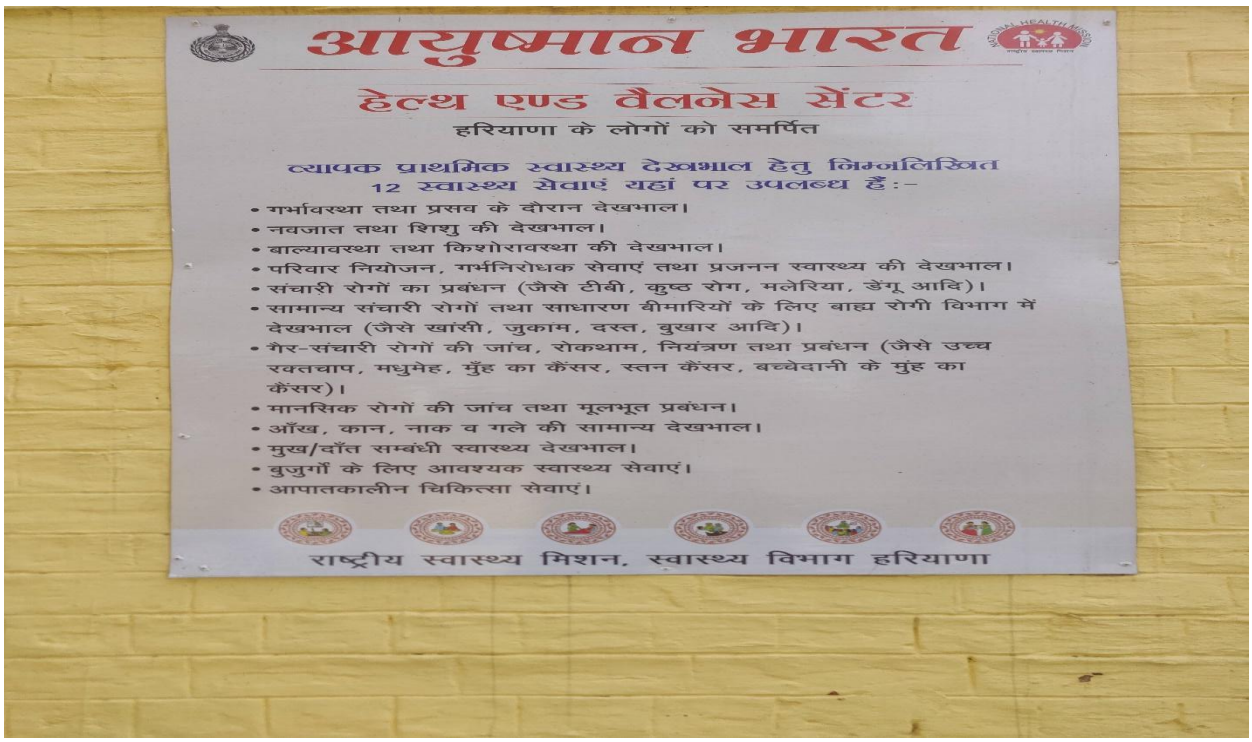
IMAGES OF PHC AMARPUR

Block Palwal

District Palwal

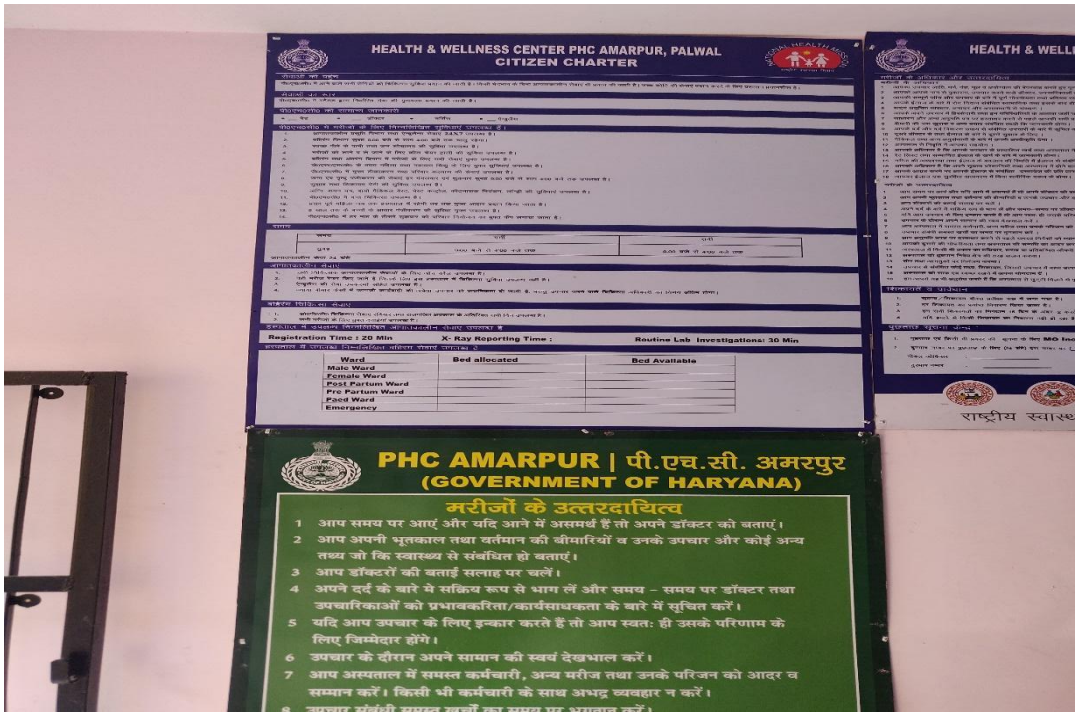
State Haryana

Entrance to PHC Amarpur



Ayushman Bharat Poster indicating Services available in the HWC

Birth and Deaths Registration



Citizen’s Charter

Dental Surgeon’s office

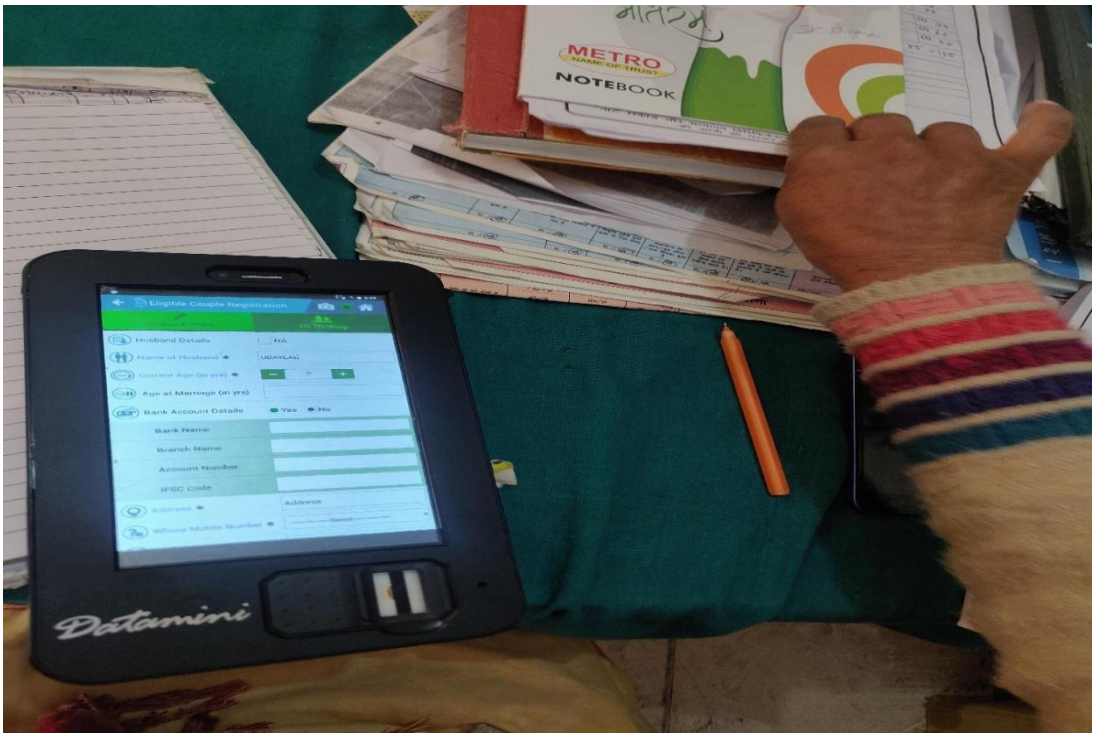
Pharmacy

BP of elderly being checked

Wards PHC Amarpur

Staff Nurses/ANMs in their office

Tablets being used by Nurses



Ambulance Service PHC Amarpur

CHAPTER 8
CONCLUSIONS

CHAPTER 8

Conclusions

8.1 Conclusions of the Study

8.1.1 The study was conceived and conducted to assess the 'Availability and Adequacy of Emergency Medical Services in Rural Primary Health Care Units'. The same was conducted in 07 Primary Health Centres in two districts of NCR,one each in Uttar Pradesh(Gautam Buddh Nagar) and Haryana (Palwal). The findings of the study lead to the following conclusions and answers to the Research questions as detailed in subsequent paras.

8.1.2 The Research Questions and their answers after the conduct of the study are as under:

RQ 1: Are the Government Primary Health and Wellness Centres in rural India capable of providing adequate Emergency Medical Care?

No, they are not. This is due to a combination of multiple factors including lack of manpower and staff, inadequate equipment and infrastructure for emergency management, lack of focus and importance given to this issue, lack of 24/7 availability of doctors, low standards in the IPHS itself and tendency to transfer emergencies and complex cases at the earliest

RQ 2 What is the capacity of the Private Health Care Facilities in rural India to provide emergency medical care?

Not assessed.

RQ 3 Is there a need for further training of Medical Officers and Nursing Staff in Emergency medical care?

Yes definitely. It was found that none of the Medical Officers and Nursing staff had undergone Emergency management training in structured courses like the

BLS, ACLS,PHTLS or ATLS. Most of them had undergone training only in Emergency Obstetric and neonatal Care.Thus,training will provide them with the latest knowledge, skills and confidence to handle emergencies at their own level instead of referring straight away to higher centres. This training will also keep the doctors and staff motivated to continue working in rural areas'

vi) RQ 4 Is there a case for mandatory and Government sponsored training of MOs in essential Emergency medicine courses/workshops like BLS (Basic Life Support), ALS (Advanced Life Support), ATLS (Advanced Trauma Life Support), PALS (Paediatric Life Support) and NALS (Neonatal advanced Life Support)?

Yes, definitely. As of now,none of the PHCs studied had such a system of sponsored and mandatory training. Thus,there is a need for such initiatives. These courses are structured, time tested and universally recognized and accepted the world over. Individuals, on their own are very unlikely to attend such courses due to apathy, lack of motivation, non availability of time and transport, pressure of routine work and cost of fees. The Government should therefore sponsor such courses and make it mandatory for all staff to complete these courses successfully and also subsequent refresher courses. This would improve the quality of emergency care being provided at the PHCs by leaps and bounds.

vii) RQ 5 Will Public Private Partnership be a feasible and win-win option to improve Emergency Medical Care in rural India?

Yes. None of the PHCs visited during this study had a component of private sector involvement except for the 108 Ambulance Services. Therefore the possibility and opportunity for a Public Private Partnership of some sort definitely

exists and which may prove mutually beneficial.The Government has constraints in providing quality Primary Health Care to all its citizens, especially in remote rural areas and achieving the goal of HFA and Universal health coverage UHC by 2030. These are mainly budgetary, lack of manpower and equipment and problems of bureaucratic sloth, red tapism, inefficiency and corruption. The private sector brings with it advantages of more abundant finances, better managerial expertise and efficiency and less corruption. Suitable models of PPP can be carefully designed as per local requirements so as to improve Primary Health Care in rural areas. These are described more in detail in the next chapter on Recommendations and way forward.

8.2 Summary of Conclusions

8.2.1 The Emergency Medical Services being provided at our Primary Health Centres in rural areas are rudimentary and need to be improved on multiple fronts. These include improved infrastructure with an Emergency Department which is well equipped with all necessary resuscitative drugs,equipment and supplies, adequate staff of doctors and paramedics who are well trained and available 24/7. This research does not claim to be an in depth and comprehensive study. It is hoped however, that it provides a glimpse into the current status, challenges and possibilities for the future as regards this important but ignored aspect of Emergency Medical Care.

CHAPTER 9

RECOMMENDATIONS AND WAY FORWARD

CHAPTER 9

RECOMMENDATIONS AND WAY FORWARD

9.1 Introduction

9.1.1 After centuries of foreign rule, subjugation and exploitation during which the nation was plunged into depths of hunger, poverty, famine and abject neglect of the health of its lakhs of population India has come a long way since Independence in her quest for achieving goals of good health for citizens. The vast majority of India's population still lives in rural areas (70%) where lack of accessible and quality public healthcare facilities is pushing its population into ill health and poverty due to increased out of pocket expenses while going to expensive private healthcare setups. Successive governments have rolled out various health schemes and policies based on recommendations from expert committees set up for the same. The country has achieved significant success in improving our maternal and child healthcare with reductions in maternal and infant mortality rates. India has fought well against numerous infectious diseases like cholera, smallpox, polio, tetanus, diphtheria and the battle against Tuberculosis, Malaria, Leprosy, AIDS, Dengue and Japanese Encephalitis is still on. There are numerous specific vertical programmes for specific diseases, which are being executed nationwide with immense effort and positive outcomes. India is a signatory to the Alma Ata Declaration and the WHO goal of Health for All, which stress that the path to HFA is through Primary Health Care. Through its National health Policies over the decades India has established a wide network of Primary Health Care. As on date there are more than 28500 PHCs,1,50,000 sub centres and 5,300 Community Health Centres in the country. Many of them however lack the necessary infrastructure and manpower for effective functioning. Thus, the country has a basic framework already laid out;

what is needed is to build, modify and improve on it. The need of the hour is a grand vision, clear goals, political will and a governance mechanism which should work on Mission Mode. Small, temporary, and half measures while providing some element of healthcare to the rural population are in many ways incomplete and probably actually a waste of resources.

9.1.2 The review of literature, research and findings of this study have convinced this researcher that the Way Forward to Good Health and Universal Health Coverage including Emergency Care as a priority is via Primary Health Care. Views, suggestions and recommendations on the steps and path ahead are listed below.

9.2 Recommendations

9.2.1 The first step in improving Primary Health Care in India is for the nation and its polity to realize and accept with full conviction and spirit that Primary Health Care is the route which India should follow. And that, this should be driven by the Government. Primary Health Care should not be a mere slogan for Governments which is paid lip service to, and established and run in a piecemeal and incomplete fashion.

9.2.2 The definition of Health is important to understand. “Not just merely an absence of disease, but a state of complete physical, mental and social well being”. “A state of harmonious functioning of the body and mind in relation to the physical and social environment, so as to enable the person to enjoy life to the fullest extent possible and reach the maximum level of his or her capacity and potential”. The Community and the Government needs to take heed of this in their attempts to achieve the goals of Health For All.

9.2.3 Each word or phrase in the attributes of Primary Health Care is important and full of meaning. ‘Universally accessible ', ‘Equitable’, ‘Affordable’, ‘Close to the community’,

‘Acceptable’, ‘Scientifically sound’, ‘Quality care with continuity’, ‘With participation of the community’. These are all in fact essential principles not just of Health Care but indeed of any democracy. It should be the bounden duty of any government to provide Primary Health Care, and not abdicate this responsibility to other players.

9.2.4 Investments made by nations in promoting and ensuring health are worth every rupee. A healthy population, and a nation which is prepared to deal with health situations which may be of individual, community or epidemic proportions, will benefit immensely economically. No nation can progress without ensuring the health of every citizen of their country.

9.2.5 Political will of a very high order, which should translate into actions at every level of governance. The actions and steps undertaken should be sustainable and outlive changes in governments.

Good governance in Health Administration

9.2.6 The Panchayati Raj Institutions, PRI should become much more actively involved in planning, policy making, execution, day to day monitoring, assessment of current and future Primary healthcare needs of their respective communities. To enable the PRI to do this, they need to be empowered and provided the necessary budget and delegation of financial powers. Then and only then, can they also be made accountable for the Primary Healthcare system.

9.2.7 Involvement of the community is vital and the PRI and Health administration should periodically interact with the dependent community they are serving, in order to get their feedback and gain their trust. Predominant involvement and encouragement of the women in the community should be undertaken, since they are most often the caregivers at their homes and are

also more vulnerable to malnutrition, abuse and neglect. Their participation can make a very significant impact on improving healthcare.

9.2.8 Best practices of different states in India, which have a more robust and flourishing Primary Healthcare System for example, Kerala and Tamilnadu can be studied and suitably adopted by the other States. International examples of best practices in PHC (for example, Cuba which is supposed to have one of the best PHC systems) should also be studied and adopted with modifications as suited to our conditions.

9.2.9 The PHC system should provide comprehensive care which should include preventive, promotive, curative, rehabilitative and palliative care. Implementation of these requires consistent, proactive efforts of a huge scale with active participation of all stakeholders

9.2.10 Enhanced Budgeting for Primary Health Care is a MUST. The Government (Union and States) must increase its spending on health from the current 1.13% of GDP to at least 2.5%. This will help improve the public healthcare facilities, and reduce the out of pocket expenditure on healthcare by the population and households from the existing whopping 62% to a much more manageable and affordable level. Since health is a State subject, all States must realize the importance of health and allocate abundant budgetary support for the same. Needless to say, there should also be a pragmatic and regular monitoring and outcome-based audit of expenditure, so as to ensure that resources are utilised appropriately.

9.2.11 Improvements in Primary Health Care will need to be done, by a Systems approach looking at every element of the Structure-Process-System-Outcome Chain. A successful Health administration which can achieve the goals of Primary Healthcare of universal access, equity, affordability, quality, continuity and Comprehensive Health for All, will need to ramp up on the

pillars of Health Governance, Health Information, Health Finance, Service Delivery, Workforce Management and Supply Chain Management. Each of these pillars is a major task needing inputs and expert management. The question to be answered honestly is whether the existing rural health administrative set up has the knowledge, aptitude and competence to execute this challenging task on ground?

9.2.12 Health is a State subject and it is time now for it to be shifted to the Concurrent list so that the Union and State Governments can work in a spirit of cooperative federalism and accountability and responsibility.

9.2.13 There is a need to avoid repeated tinkering of the health structure with multiple health schemes announced by Central and State Governments every now and then. This leads to multiplicity, duplication or overlap, wastage of resources and lack of clarity in the minds of the healthcare workers on ground in the periphery.

9.2.14 Good health in a society cannot be achieved without the contribution from multiple sectors. These include Agriculture, Food processing, Water, Sanitation, Environmental engineering, Infrastructure, Transportation and Communications, Police and law and order, etc etc. Therefore, Health administration in rural India must evolve a mechanism for intersectoral coordination and participation. The various sectors should converge at the DM level in the PRI so that appropriate prioritization, coordination and planning can be done towards Primary Health Care.

9.2.15 Good Governance is of prime importance in ensuring desired outcomes. Planning, Leadership, Coordination, Communication, Financial prudence, Feedback and review; Continuous quality improvement, CQI; these are some of the buzz words which should be kept

in mind all the time. Transparency in all activities will reduce corruption. There is a requirement of the political class not to interfere in health administration with unreasonable, popular demands and pressures for their own political gain; rather they should provide the guidance, support and backing to the health administration at all levels.

9.2.16 Think big and not be satisfied with token measures of primary health care and emergency care at PHCs. Demand for quality services closer to them should emanate from the Community itself. The Media and the Civil Society have a major role to play in bringing to light these concerns and requirements and to keep up the pressure on the Government.

9.2.17 Health governance at all levels; Centre, State, and the PRI is the key to achieving goals of quality Primary Health Care. The role of the PRI is vital and they should take keen and direct interest in the roll out of primary health care services including emergency care. There should be frequent meetings of all concerned stakeholders including community representatives to discuss the needs, aspirations, realities and way forward

9.2.18 Health governance should look into the administration and service delivery in a systematized manner going into details of every element of the Structure- Process -Outcome algorithm. More importantly, for each element, it is also important to see what are the obstacles and bottlenecks and what are the possible solutions to overcome them. Continuing assessment and evaluation of the PHCs is a must in order to review and make necessary course corrections.

9.2.19 The PRI at all levels, the Health Administration-CMO in District downwards, all concerned stakeholders, representatives of related sectors should meet/coordinate on a regular basis.

9.2.20 Health being a State subject, States have over the years rolled out various health schemes. There are often overlapping schemes of the Centre and the States. This duplication should be looked into and smoothened.

9.2.21 The Health administrators and policy planners also need to be trained. After all, what are their qualifications to run the Primary Health Programme of the entire district? They too need Advisors with experience and expertise in public healthcare and should be provided the same. What is needed from them is vision, a sense of purpose, clarity of goals and empowerment down the line. The officials will not only need to be trained, they must also be provided a fixed tenure and with no political interference and pressure. The unfortunate series of deaths of CMOs in suspicious circumstances in Uttar Pradesh in the alleged mega scam of the NRHM are stark pointers of where matters can go wrong.

9.2.22 Success stories of the country like the Delhi Metro which was conceived, planned, executed and still being run with clinical efficiency despite huge volumes and numbers of passengers can be taken as examples to build and sustain our Primary Health Care systems. Other similar success stories of the country include the Aadhaar Roll out, Polio eradication campaign and National Immunization programme to name a few which can be studied as templates.

9.2.23 Treat the person and not just the disease. The community from where the patient has come from, its traditions, cultures, language, socioeconomic conditions play a big role in determining the causation of disease and also the long-term management of the disease, and its further prevention or control in the community. Primary Health Care has to be rooted in the community it serves to be truly effective.

Infrastructure build up at PHCs

9.2.24 The Infrastructure and facilities available at PHCs should be improved drastically. The various aspects and departments which need to be improved are the location and access, the entrance, Registration counter, waiting rooms, doctors' chambers, laboratory, OT, labour room, Pharmacy, Toilets etc. Cleanliness, ambience, ventilation, lighting, facilities for drinking water etc should be provided. Patients deserve the best possible amenities and should not be taken for granted.

9.2.25 Ambulance facility with essential resuscitation equipment aboard along with an Emergency medicine Technician, EMT should be available 24/7 for urgent or semi

urgent evacuation of patients to a higher centre. This, along with well laid out referral channels and communication will ensure seamless transfers and continuity of care.

9.2.26 The IPHS Standards have been made keeping in mind the available resources of the country. However, there is a need to upscale the standards for the Primary Health Centre in terms of manpower, equipment and infrastructure if we have to truly bring quality care closer to the community as is envisaged in our National Health Policies. This should include a Portable X- ray machine with all necessary infrastructure like a dark room and developing films by a posted Xray technician, An ECG monitor cum defibrillator and a Multiparameter monitor, Nebulizer.

9.2.27 Digitisation and use of Information Technology to smoothen and facilitate functioning including registration, documentation, maintenance of health records, procurement and inventory management of supplies and stores, telemedicine consultations, monitoring, reporting, research and analysis should be put into place at all PHCs.

9.2.28 The use of Telemedicine, Teleconsultations by the MOs in the PHC should be promoted, for immediate guidance and tips on management of difficult cases or emergencies. This would save lives, reduce unnecessary referrals and reduce the overburdening of the secondary and tertiary hospitals.

9.2.29 Procurement system of medicines, lab reagents and other consumables must be made efficient. A centralized procurement system and in bulk with adequate reserve stock will ensure the constant availability of medicines to all the patients and will also be cost effective.

Increasing availability of HCP in rural areas

9.2.30 How to increase the workforce of medical professionals including doctors, nurses, paramedics and technicians in rural PHCs? This has been the bane of our healthcare, where there has been a skewed rural-urban distribution with more population in the rural areas but fewer available doctors and HCPs. To increase the number of doctors there is a need to make the prospect more attractive. This can be made through better remuneration, better facilities provided (accommodation, schooling for children, parks, playgrounds, shopping areas, offering scope for career progression through further specialization (PG), training in various courses, better HR management in terms of rotation of postings from difficult areas to more congenial and desirable centres. A RURBAN model wherein the doctors are provided with a fair degree of urban facilities and environment in the rural areas itself.

9.2.31 The incorporation of the AYUSH doctors into Primary Health Care is a welcome step and can be further propagated.

9.2.32 Another option which is strongly recommended is to make a mandatory 02 year Rural posting for the newly passed out doctors after completing their MBBS and internship. The rural

tenure should be a prerequisite for appearing for Post Graduation NEET entrance examination. During this tenure the doctors can be rotated through two or three PHCs and also a stint at the CHC. This simple step would not only provide the necessary addition to the number of doctors available in rural areas, but also give the young doctors first-hand experience into the realities of rural India, which would hold them in good stead when they continue their career later in urban areas. This mandatory 02 year rural tenure should be implemented strictly without fear or favour. The exceptions to this could be the doctors in the Armed Forces who in any case are doing their peripheral postings in border and remote areas of the country.

9.2.33 Medical education also needs to bring in more focus and attention to primary health care in rural India. Similarly Nursing education also needs to have a rural orientation to it and a compulsory two year rotation in a Primary Health Centre should be implemented strictly.

9.2.34 Scaling up the number of doctors in the country is already underway and the Government, and MCI/NMC should actively look at increasing the number of medical colleges and turnout of qualified medical graduates

9.2.35 There is a need to scale up the turnout of paramedics of various trades e.g. Nursing, X-ray, Laboratory and OT technicians, etc by increasing the number of training centres and faculty.

9.2.36 The concept of a Mid Level Health Provider (MLHP), who will be a graduate; (a B.Sc. in Community Health or a GNM/ B.Sc. Nursing) and perform duties of a Community Health Officer is an excellent one. The legalization and regularization of this category of health care professional will help to fill up the current vacuum due to lack of MBBS doctors in rural areas. The MCI/NMC and the medical fraternity should cooperate and encourage this idea and help

train and strengthen this cadre. Properly nurtured this group of healthcare workers could become a major force multiplier and an asset to rural primary health care.

9.2.37 There is a need to prop up and regularize the Post graduation in 'Family Medicine' in our medical education both through an MD as well as through DNB. Doctors qualified in Family Medicine would be a great asset to rural practice at PHCs. Family Medicine as a speciality also needs to be glamoured and incentivised by the Government and the Medical fraternity. Excessive focus on specialisation, super specialisation and super-super specialisation has made our healthcare system bereft of good general practitioners with a sound knowledge of essential medicine and emergency medicine. Also, the higher specialized doctors and centres are all at urban locations, further widening the rural-urban healthcare divide.

9.2.38 Attracting and retaining healthcare professionals especially doctors to rural areas is a major challenge. This has to be addressed with full importance and concern. Enhanced salaries for rural postings, better working and living facilities, govt accommodation of decent and appropriate standard in a clean environment, transparency in postings and transfers, assured career progression, govt sponsored training for short courses and workshops, options and opportunity for postgraduate specialization, perks and allowances like uniform allowance, book allowance, vehicle/transport allowance, laid down working hours for normal and emergency duties, congenial, hygienic work environment, comfortable duty rooms when on night duties are some of the measures which should be undertaken. The doctors should be given due respect and dignity by the health administration so as to maintain their morale.

Need to enlarge PHC capacity

9.2.39 The Bhore Committee, way back in 1943-46 had recommended the strengthening of the Primary Healthcare System with one PHC for every 10- 20000 population and each with a 75 bedded hospital with adequate staff of doctors, nurses and paramedics and a 650 bedded Community Hospital at the Block level. Our current standards are 6 beds in a PHC, 30 bedded CHC, 31-100 bedded Sub District Hospital and a 101-500 bedded District Hospital. The Sub district and the District Hospitals are overcrowded, understaffed and unable to provide the quality of care and comfort which the citizen deserves.

9.2.40 It is time to reconsider Bhore Committee's recommendations. They might at first sight appear too idealistic, but even their recommendations fall short of the actual requirements. It is imperative therefore that we strengthen the PHC with enhanced bed capacity and staff. It is proposed that each PHC should have at least a 50 bedded hospital with Staff as under:

6 MOs (including at least 2 women MOs)

12 Nurses

01 Pharmacist

01 Laboratory technician

01 X Ray technician

01 OT technician

Cold Chain and Vaccine Logistic Asst: 01

02 Multipurpose workers (01 F,01 M)

Ward boys: 04

Ayahs: 04

Cook:01

Housekeepers:04

Clerks: 02

Admin Asst: 01

Data Entry Operator: 01

Total :42

This is about 4 times the standards of manpower recommended by the IPHS (2012). If the country has to make a success of its Primary Healthcare programme, there is a need to invest heavily in it. These investments will result in improved health outcomes of the community. They will also provide employment opportunities.. To start with one PHC in each block may be upscaled to this level. As each PHC becomes upgraded, the CHCs will no longer be needed and the next chain of referral could be the Sub district or the District hospital.

9.2.41 Ayushman Bharat scheme of Health and Wellness Centres propounds the concept of multi-skilling of frontline workers at the HWC-PHC who will multi-task as Pharmacist, Lab assistant, Physiotherapist, Ophthalmic technician etc with minimal training. This is wishful thinking, incorrect and unfair on the population. These trades are all highly technical and need specific training and expertise. The idea of multitasking, while appearing at first sight to be an easy solution, is not advisable. It will bring down the quality of care and may jeopardize the health of the community.

9.2.42 Paramedics in the PHC are already overworked due to the shortage of manpower. Multitasking and expecting them to take on additional roles will be asking for too much and not advisable. Dissatisfaction with working conditions may also lead to incidents of corruption.

9.2.43 Doctors in the Primary Health Centres of India have to spend significant time and energy on compiling and dispatching reports of a Daily, Weekly, Monthly, Annual etc nature. The

reports are quite exhaustive and at times difficult to fill. While the importance of data collection, compilation and analysis cannot be denied at all, reducing unnecessary documentation and paperwork, and maximal use of digital technology and online reporting should be encouraged. Sub departments within PHCs should be given digital tablets for data entry, storage and transmission.

Role of private sector and PPP in PHC

9.2.44 To achieve the goal of Universal Health Coverage by 2030,which is part of the SDG 3, there is a requirement of the private sector to also participate because the Public Sector has its limitations and may not be able to take on this monumental task on its own in such a vast and populous country as ours. The possible advantages of the private sector would include better efficiency, more available funds, less corruption, faster responsiveness, better managerial expertise and better technology. The country should try out (as has been done in a few States, e.g. Odisha, Rajasthan, Arunachal Pradesh) various models of PPP (Public private partnership).

9.2.45 One option is to hand over the entire running of the PHC to a private enterprise with pre-established terms of engagement and remuneration. This can be tried initially for 01 PHC per block. This might serve as a healthy competition between the PPP model PHC and the Govt owned and run model PHC. The other option is to handover certain services of the PHC across a taluk to the private sector for e.g Laboratory Services, Waste including Biowaste management, Ambulance Services, IT and Telemedicine network services, Support services like Security, Housekeeping etc.

9.2.46 PPP models, although appearing at first sight an easy solution, need to be monitored closely for their functioning especially with regard to equity and access. The Terms of Reference should include periodic audit and inspections as per laid down criteria (for example the IPHS standards) and private agents not maintaining the standards should be penalized monetarily or their contracts rescinded accordingly.

Emergency medical care in PHCs

9.2.47 Emergency Care to be given prime importance at all PHCs. The value and benefit of timely and appropriate emergency care has not been realized by all levels. If anything, it has been equated with first aid and subsequent transfer to the higher-level hospital. Facilities for emergency care, resuscitation and stabilization are scant. This has led to overburdening of the secondary and tertiary care hospitals with cases that could have been managed at the PHC level had they possessed 24/7 care with an adequate number of trained doctors, nurses and support staff. For the patients also, having a PHC close to or within their community, which can provide them and their families with lifesaving immediate care, admission and stabilisation is a great boon and a relief. Otherwise they would have had to in many cases rush to a private sector provider leading to huge OOPE and financial distress or have had to be sent to a distant sub district or district hospital causing disruption in their lives and families.

9.2.48 The list of Expanded Range of Services being provided at the HWC under Ayushman Bharat also has Emergency Medical Services placed at the 11th position out of 12! The others

being Maternal, Neonatal and Infant healthcare, Childhood and adolescent care, Communicable and Non communicable disease management, Eye and ENT care, Oral health, Elderly care and Mental health. This seems almost like an afterthought!! It has to be realized that Emergency Medical Care is **the only** service which is common to all the other eleven. Any person of any age, gender can have an emergency. Obstetric emergencies, Emergencies in communicable diseases like Malaria, Dengue, Diarrhoea , acute complications of Non-Communicable diseases like diabetes, heart disease, or respiratory disease,poisonings,trauma may occur at any time and the PHC should be in a position to handle them safely and effectively. Access to emergency care should be universally available without any bias.

9.2.49 There has been a tendency for PHC to become very disease or programme specific with numerous vertical programmes to tackle those health issues e.g. RCH, Malaria, AIDS, Blindness etc. Emergency medical care is the only Horizontal programme which connects all these verticals. Emergency care is an important safety net for the community and this should be impressed upon the health administration.

9.2.50 Effective Emergency Care leads to economic gains and is Cost Effective. Additionally, the myth that it is very expensive, and can only be given in big urban centres needs to be busted. With minimal equipment and supplies but adequate training, emergency care can be provided by the doctors and nurses in an effective manner which would save lives and reduce the burden of disease in the community.

9.2.51 Training of PHC doctors in standardized, universally accepted and respected emergency medicine courses like the Basic Life Support (BLS) and Advanced Cardiovascular Life Support (ACLS), Neonatal and Paediatric Advanced Life Support, NALS and PALS, Advanced Trauma Life Support, ATLS should be made mandatory. Periodic refresher courses should also be made

compulsory. The course fees for all these courses must be borne by the Government as an incentive and motivation, as also to ensure that the Medical Officers are trained in handling emergencies.

9.2.52 Similarly, nurses should undergo the BLS, ACLS and Advanced Trauma Course for Nurses, ATCN and paramedics should undergo BLS and Prehospital Trauma Life Support, PHTLS and subsequent refresher courses. All these courses should also be made compulsory and expenses for the course should be borne by the Government. Necessary arrangements to attend these courses should be made by the administration. These courses will enable, motivate and build confidence amongst the PHC team to tackle any emergency. Their knowledge and outlook towards handling emergencies will change and the Community will be greatly benefitted.

9.2.53 Ambulance services exist in most PHCs, usually outsourced to 108 or 102 services.. However, this has to be ensured and the ambulances should be equipped with essential resuscitation equipment and drugs. As and when needed there should be provision for calling a critical care ambulance with more advanced resuscitation equipment including ventilator, defibrillator in addition along with a trained Emergency Medicine Technician, EMT.

9.2.54 Transport and referral of seriously ill patients should be done in a safe, coordinated manner with the receiving hospital having been informed in advance and facilities for receiving and managing the case confirmed. Communication is very important in such cases, with relevant information being conveyed to the referral hospital. Telemedicine and IT can be of immense value in these situations, by passing on images of ECGs, and X-rays for example. In case of long transit time in the ambulance, the facility for the EMT to be in communication with the receiving hospital or EMS control room for guidance can be lifesaving.

9.2.55 In the enhanced PHC staffing and 50 bedded hospital it is suggested that the Emergency Department (ED) be integrated with the routine PHC. Of the six MOs, one MO should exclusively man the ED with a nurse and other support staff, while 02 MOs will run the routine OPD, 02 MOs can be on field work/National health Programme related duties. Patients once stabilized at the ED can thereafter be followed up in the PHC on subsequent follow up visits. Experts in the field of Emergency medicine can be called in periodically to the PHCs for training and guidance.

9.2.56 Emergency services should be available 24/7 in all PHCs. This would necessarily mandate the availability of MOs on site. Currently in most PHCs, MOs are not available after OPD hours. They remain on call at their homes. Often, they stay in urban areas at quite a distance from the rural PHC with travel times of up to or more than an hour. There is therefore, also a need for providing a comfortable duty room with bed, toilet, bath and basic recreation facilities like TV within the premises or in close proximity to the PHC.

9.2.57 Primary Health Care Centres play a very important role in large public health emergencies like natural disasters, mass casualties, and epidemics/pandemics like the ongoing Coronavirus COVID 19. In most emergencies, a large percentage (60- 80%) of casualties would be of a mild severity and only 20-40% would need specialized care. If the Emergency Care services have been streamlined and put into place, the PHC can absorb, resist and accommodate major public health emergency shocks in a timely and efficient manner. This would drastically reduce the load of the secondary and tertiary level hospitals which would otherwise get flooded and overwhelmed with even mild cases, which could well have been managed at the Primary level. India as a nation should beef up its Primary Health Care facilities to be better prepared to respond to public health emergencies.

9.2.58 Trauma following Road accidents, domestic and social violence or burns is a very common emergency and more so in rural areas. The first hours after trauma are exceedingly important and vital. It is in this Golden Hour that the casualty should receive immediate and prioritized ABC management to secure his Airway, Breathing and Circulation. Availability of equipped and manned Emergency service at the PHC would save lives since the casualty would not have to be transported to a distant bigger hospital. Once stabilized, the trauma victim should be safely transferred to the appropriate referral hospital. Thus, the PHC should become part of an Inclusive Trauma Care System of the district, instead of being kept out.

9.2.59 It is important to realize that ultimately all programmes converge onto emergency care. Emergency care can serve as an access point for future preventive strategies and definitive care. Emergency care, thus also provides and caters for the social needs of the community.

9.2.60 Separating Emergency services from non-urgent routine healthcare needs will streamline the running of the PHC and ensure that a person coming to the PHC with a medical, obstetric or surgical emergency is attended to immediately and does not have to wait for his or her turn along with the other OPD patients.

9.2.61 Government should promote research into various aspects of Primary Health Care and Emergency Care at PHC level.

9.2.62 Training activities at the PHC should be frequent and should also focus on Teamwork dynamics. In Emergency Care especially, for best results and patient outcomes, good Team Work is essential. Teamwork drills should focus on the various elements of Team Dynamics; Clear roles and responsibilities, Knowledge sharing, Closed loop Communication, Mutual respect, Summarizing, debriefing, feedback and leadership.

9.2.63 Tertiary care is very expensive, labour intensive and consumes a large amount of resources. This could prove very costly for the society and the individual pushing them especially the individual into a financial catastrophe. The preventive, promotive and immediate curative role of the Primary Health Care including Emergency care assumes tremendous importance in this context too.

9.2.64 To conclude, in order to achieve our stated goals of Universal Health Coverage, there is no doubt that healthcare in rural India needs major improvements. Our citizens deserve the best possible care. Primary Health Care is the way forward to ensure that every Indian citizen, especially in our large rural population, gets access to quality healthcare including Emergency Medical Care which is timely, affordable, and assured.

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ANNEXURES

PROFORMA FOR FACILITY SURVEY FOR PHC ON IPHS

Services

Population covered (in numbers)

Type of PHC:

a. TypeA
b. TypeB

Number of beds available

a. Bed Occupancy Rate in the last 12 months (1- less than 40%; 2 - 40-60%; 3 - More than 60%)

Average daily OPD Attendance

a. Males
b. Females

Assured Services available (yes/No)

a. OPDServices
b. Emergency services (24Hours)
c. ReferralServices
d. In-patientServices

Treatment of specific cases (yes/No)

a. Is the primary management of wounds done at the PHC?
b. Is the primary management of fracture done at the PHC?
c. Are minor surgeries like draining of abscess etc. done at thePHC?
d. Is The Primary Management Of Cases Of Poisoning/ snake, insect or scorpion bite done at thePHC?
e. Is the primary management of burns done at PHC?

MCH Care including Family Welfare

Service availability (yes/No)

a. Ante-natalcare
b. Intranatal care (24 - hour delivery services both normal and assisted)
c. Post-natalcare
d. Newborn Care
e. Child care including immunization
f. FamilyPlanning
g. MTP
h. Management ofRTI/STI
i. Facilities under Janani Suraksha Yojana

Availability of specific services (yes/No)

a. Are antenatal clinics organized by the PHC regularly?
b. Is the facility for normal delivery available in the PHC for 24hours?
c. Is the facility for tubectomy and vasectomy available at thePHC?
d. Is the facility for internal examination for gynaecological conditions available at thePHC?
e. Is the treatment for gynecological disorders like leucorrhoea, menstrual disorders available at the PHC?
f. If women do not usually go to the PHC, then what is the reason behind it?
g. Is the facility for MTP (abortion) available at the PHC?
h. Is there any precondition for doing MTP such as enforced use of contraceptives after MTP or asking for husband's consent forMTP?
i. Do women have to pay forMTP?
j. Is treatment for anemia given to both pregnant as well as non-pregnant women?
k. Are the low birth weight babies managed at the PHC?
l. Is there a fixed immunization day?
m. Is BCG and Measles vaccine given regularly in the PHC?
n. How is the vaccine received at PHC and distributed toSub-Centres?
o. Is the treatment of children with pneumonia available at thePHC?
p. Is the management of children suffering from diarrhea with severe dehydration done at the PHC?

Other functions and services performed (yes/No)

a. Nutrition Services.
b. School Health Programmes.
c. Promotion of safe water supply and basic sanitation.
d. Prevention and control of locally endemic diseases.
e. Disease surveillance and control of epidemics.
f. Collection and reporting of vital statistics.
g. Education about health/behaviour changes communication.
h. National Health Programmes including HIV/AIDS control programmes.
i. AYUSHservices as per local preference.
j. Rehabilitation services (please specify).

Monitoring and Supervision activities (Yes/No)

a. Monitoring and supervision of activities of Sub- Centres through regular meetings/periodic visits, etc.
b. Monitoring of National HealthProgrammes
c. Monitoring activities ofASHAs
d. Visits of Medical Officer to all Sub-Centres at least once in a month.
e. Visits of Health Assistants (Male) and LHV to Sub- Centres once a week.
f. Timely payment of JSY beneficiaries.
g. Timely payment of TA/DA toASHAs.

Manpower

Sl. No.	Staff	Recommended	Current Availability at PHC (Indicate Numbers)	Remarks/ Suggestions/ Identified Gaps
1	Medical Officer- MBBS			
2	MO –AYUSH			
3	Accountant/Clerk			
4	Pharmacist			
5	Pharmacist AYUSH			
6	Nurse-midwife (Staff-Nurse)			
7	Health workers (F)			
8	Health Asstt. (Male)			
9	Health Asstt. (Female)/LHV			
10	Health Educator			
11	Data entry cum computer operator			
12	Laboratory Technician			
13	Cold Chain & Vaccine Logistic Assistant			
14	Multi-skilled Group D worker			
15	Sanitary worker cum watchman			

	Total			

Training of personnel during previous (full) year

Sl. No.	Available training for	Number trained
1	Traditional birth attendants	
2	Health Worker (Female)	
3	Health Worker (Male)	
4	Medical Officer	
5	Initial and periodic training of paramedics in treatment of minor ailments	
6	Training of ASHAs	
7	Periodic training of Doctors through Continuing Medical Education, conferences, skill development training etc. on emergency obstetric care, Training in FP services.-IUCD, Minilap and NSV, LSAS	
8	Training of Health Workers in antenatal care and skilled birth attendance	

Essential Laboratory Services

Sl. No.	Current Availability at PHC	Remarks/Suggestions/Identified Gaps
1	Routine urine, stool and blood tests	
2	Blood grouping	
3	Bleeding time, clotting time	
4	Diagnosis of RTI/STDs with wet mounting, grams stain etc.	
5	Sputum testing for TB	
6	Blood smear examination for malaria parasite	
7	Rapid tests for pregnancy	
8	RPR test for Syphilis/yAWS surveillance (in high endemic area only)	
9	Rapid tests for HIV	
10	Others (specify)	

Any other Services if available e.g., ECG Physical Infrastructure (As per specifications)

Sl No.	Current Availability at PHC	If available, area in Sq. mts.	Remarks/ Suggestions/ Identified Gaps
1	Where is this PHC located? a. Within Village Locality b. Far from village locality c. If far from locality specify in km		
2	Building a. Is a designated government building available for the PHC? (yes/No) b. If there is no designated government building, then where does the PHC located? Rented premises/Other government building/Any other specify c. Area of the building (Total area in Sq. mts.) d. What is the present stage of construction of the building Construction? Complete/Construction Incomplete e. Compound Wall/Fencing (1-All around; 2-Partial; 3-None) f. Condition of plaster on walls (1- Well plastered with plaster intact everywhere; 2- Plaster coming off in some places; 3- Plaster coming off in many places or no plaster) g. Condition of floor (1- Floor in good condition; 2- Floor Coming off in some places; 3- Floor coming off in many places or no proper flooring) h. Whether the cleanliness is Good/Fair/Poor?(Observe) OPD Wards Toilets Premises (compound) i. Are any of the following close to the PHC?(Observe) (yes/No) i. Garbage dump ii. Cattle shed iii. Stagnant pool iv. Pollution from industry		

l. No.	Current Availability at PHC	If available, area in Sq. mts.	Remarks/ Suggestions/ Identified Gaps
	j. Is boundary wall with gate existing? (yes/No)		
3	Location a. Whether located at an easily accessible area?(yes/No) b. Distance of PHC (in Kms.) from the farthest village in coverage area c. Travel time (in minutes) to reach the PHC from farthest village in coverage area d. Distance of PHC (in Kms.) from the CHC e. Distance of PHC (in Kms.) from District Hospital		
4	Prominent display boards regarding service availability in local language (yes/No)		
5	Registration counters (yes/No) a. Pharmacy for drug dispensing and drug storage (yes/No) b. Counter near entrance ofPHC to obtain contraceptives, ORS packets, Vitamin A and Vaccination (yes/No)		
6	Separate public utilities for males and females (yes/No)		
7	Suggestion/complaint box (yes/No)		
8	OPD rooms/cubicles (yes/No) (Give numbers)		
9	OPD rooms/cubicles (yes/No) (Give numbers) each room (yes/No)		
10	Family Welfare Clinic (yes/No)		
11	Waiting room for patients (yes/No)		

12	Emergency Room/Casualty (yes/No)		
13	Separate wards for males and females (yes/No)		
14	No. of beds: Male		
15	No. of beds: Female		
16	Operation Theatre (if exists) a. Operation Theatre available (yes/No) b. If operation theatre ispresent, are surgeries carried out in the operation theatre? yes/No/Sometimes c. If operation theatre is present, but surgeries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/staff Lack of equipment/poor physical state of the operation theatre No power supply in the operation theatre/Any other reason (specify) d. Operation Theatre used for obstetric/gynaecological purpose (yes/No) e. Has OT enough space(yes/No)		
17	Labour room a. Labour room available?(yes/No) b. If a labour room ispresent, are deliveries carried out in the labour room? yes/No/Sometimes		

Sl. No.	Current Availability at PHC	If available, area in Sq. mts.	Remarks/Suggestions/ Identified Gaps
	c. If labour room is present but deliveries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/staff Poor condition of the labour room/No power supply in the labour room/Any other reason (specify) d. Is separate areas for septic and aseptic deliveries available? (yes/No) e. Is Newborn care corner available (yes/No)		
18	Laboratory a. Laboratory (yes/No) b. Are adequate equipment and chemicals available?(yes/No) c. Is laboratory maintained in orderly manner?(yes/No)		
19	Ancillary Rooms - Nurses rest room (yes/No		
20	Water supply a. Source of water (1- Piped; 2- Bore well/hand pump/tube well; 3- Well; 4- Other (specify) b. Whether overhead tank and pump exist (yes/No) c. If overhead tank exists whether its capacity sufficient? (yes/No) d. If pump exists whether it is in working condition?(yes/No)		
21	Sewerage Type of sewerage system (1- Soak pit; 2- Connected to Municipal Sewerage)		
22	Waste disposal How the waste material is being disposed (please specify)?		

23	Electricity a. Is there electric line in all parts of the PHC? (1- In all parts; 2- In some parts; 3- None) b. Regular Power Supply (1- Continuous Power Supply; 2-Occasional power failure; 3- Power cuts in summer only; 4- Regular power cuts; 5- No power supply c. Stand by facility(generator) available in working condition (yes/No)		
24	Laundry facilities a. Laundry facility available(yes/No) b. If no, is it outsourced?		
25	Communication facilities a. Telephone (yes/No) b. Personal Computer(yes/No) c. NIC Terminal (yes/No) d. E.Mail (yes/No) e. Is PHC accessible by i. Rail (yes/No) ii. All whether road(yes/No) iii. Others (Specify)		
26	Vehicles Vehicle (jeep/other vehicle) available? (yes/No)		
27	Office room (yes/No)		

Sl. No.	Current Availability at PHC	If available, area in Sq. mts.	Remarks/ Suggestions/ Identified Gaps
28	Store room (yes/No)		
29	Kitchen (yes/No)		

30	Diet: a. Diet provided by hospital (yes/No) b. If no, how diet is provided to the indoor patients?		
31	Residential facility for the staff with all amenities Medical Officer Pharmacist Nurses Other staff		
32	Behavioral Aspects (yes/No) a. How is the behaviour of the PHC staff with the patient? Courteous/Casual/indifferent/Insulting/derogatory b. Any fee for service is being charged from the users? (yes/ No). If yes, specify. c. Is there corruption in terms of charging extra money for any of the services provided? (yes/No) d. Is a receipt always given for the money charged at thePHC? (yes/No) e. Is there any incidence of any sexual advances, verbal or physical abuse, sexual harassment by the doctors or any other paramedical? (yes/No) f. Are woman patients interviewed in an environment that ensures privacy and dignity? (yes/No) g. Are examinations on woman patients conducted in presence of a woman attendant, and procedures conducted under conditions that ensure privacy?(yes/No) h. Do patients with chronic illnesses receive adequate care and drugs for the entire duration? (yes/No) i. If the health centre is unequipped to provide the services; how and where the patient is referred and how patients transported? j. Is there a publicly displayed mechanism; whereby a complaint/grievance can be registered? (yes/No) k. Is there an outbreak of any of the following diseases in the PHC area in the last three years? Malaria Measles Gastroenteritis Jaundice l. If yes, did the PHC staff responded immediately to stop the further spread of the epidemic m. Does the doctor do private practice during or after the duty hours? (yes/No) n. Are there instances where patients from particular social backgrounds? SC, ST, dalits, minorities, villagers have faced derogatory or discriminatory behavior or service of poorer quality? (yes/No) o. Have patients with specific health problems (HIV/AIDS, leprosy) suffered discrimination in any form? (yes/No)		

Equipment (As per list)

Equipment	Available	Functional	Remarks /Suggestions/ Identified Gaps

Drugs (As per essential drug list)

Drug	Available	Remarks/ Suggestions/ Identified Gaps

Furniture

Sl. No.	Item	Current Availability at PHC	If available, area in Sq. mts.	Remarks/ Suggestions/ Identified Gaps
1	Examination Table			
2	Delivery Table			

3	Footstep			
4	Bed Side Screen			
5	Stool for patients			
6	Arm board for adult & child			
7	I V stand			
8	Wheel chair			
9	Stretcher or trolley			
10	Oxygen trolley			
11	Height measuring stand			
12	Iron bed			
13	Bed side locker			
14	Dressing trolley			
15	Mayo trolley			
16	Instrument cabinet			
17	Instrument trolley			
18	Bucket			
19	Attendant stool			
20	Instrument tray			

21	Chair			

Sl. No.	Item	Current Availability at PHC	If available, area in Sq. mts.	Remarks/ Suggestions/ Identified Gaps
22	Wooden table			
23	Almirah			
24	Swab rack			
25	Mattress			
26	Pillow			
27	Waiting bench for patients/attendants			
28	Medicine cabinet			
29	Side rail			
30	Rack			
31	Bed side attendant chair			
32	Others			

Quality Control

Sl. No.	Particular	Whether functional/ available as per norms	Remarks
1	Citizen's charter (yes/No)		
2	Constitution of Rogi Kalyan Samiti (yes/No) (give a copy of office order notifying the members)		
3	Internal monitoring (Social audit through Panchayati Raj Institution/Rogi Kalyan Samitis, medical audit, technical audit, economic audit,disaster preparedness audit etc. (Specify)		
4	External monitoring/Gradation by PRI (Zila Parishad/ Rogi Kalyan Samitis)		
5	Availability of Standard Operating Procedures (SOP)/ Standard Treatment Protocols (STP)/Guidelines etc. (Please provide a list)		

MASTER CHARTS

FACILITY SURVEY FOR PHC AS PER FORMAT OF IPHS

PHC BAROLA, GAUTAM BUDDH NAGAR

Name of the State: **Uttar Pradesh**

District: **Gautam Buddh Nagar**

Tehsil/Taluk/Block: **Bisrakh**

Location & Name of PHC: **PHC Barola**

Is the PHC providing 24 hours and 7 days delivery facilities: **Yes**

Date: **19/02/2020**

Identification

Services

Population covered (in numbers)

52,000

Type of PHC:

a. Type A- **Yes**
b. Type B

Number of beds available **4**

a. Bed Occupancy Rate in the last 12 months
(1-less than 40%; 2 - 40-60%; 3 - More than 60%)- **<40%(35.48%)**

Average daily OPD Attendance

Total: **160**

Assured Services available (Yes/No)

a. OPD Services- **Yes**
b. Emergency services (24 Hours)- **Yes**
c. Referral Services- **Yes**
d. In-patient Services- **Yes**

Treatment of specific cases (Yes/No)

a. Is the primary management of wounds done at the PHC? **Yes**
b. Is the primary management of fracture done at the PHC? **Yes**
c. Are minor surgeries like draining of abscess etc. done at the PHC? **Yes**
d. Is the primary management of cases of poisoning/ snake, insect or scorpion bite done at the PHC? **Yes**
e. Is the primary management of burns done at PHC? **Yes**

MCH Care including Family Welfare

Service availability (Yes/No)

a. Ante-natal care- **Yes**
b. Intranatal care (24 - hour delivery services both normal and assisted)- **Yes**
c. Post-natal care- **Yes**
d. New born Care- **Yes**
e. Child care including immunization- **NA**
f. Family Planning- **NA**
g. MTP- **NA**
h. Management of RTI/STI- **NA**
i. Facilities under Janani Suraksha yojana- **NA**

Availability of specific services (Yes/No)

a. Are antenatal clinics organized by the PHC regularly? **Yes**
b. Is the facility for normal delivery available in the PHC for 24 hours? **Yes**
c. Is the facility for tubectomy and vasectomy available at the PHC? **NA**
d. Is the facility for internal examination for gynaecological conditions available at the PHC? **NA**
e. Is the treatment for gynecological disorders like leucorrhoea, menstrual disorders available at the PHC? **NA**
f. If women do not usually go to the PHC, then what is the reason behind it? **NA**
g. Is the facility for MTP (abortion) available at the PHC? **NA**
h. Is there any precondition for doing MTP such as enforced use of contraceptives after MTP or asking for husband's consent for MTP? **NA**
i. Do women have to pay for MTP? **NA**
j. Is treatment for anemia given to both pregnant as well as non-pregnant women? **NA**
k. Are the low birth weight babies managed at the PHC? **NA**
l. Is there a fixed immunization day? **NA**
m. Is BCG and Measles vaccine given regularly in the PHC? **NA**
n. How is the vaccine received at PHC and distributed to Sub-Centres? **NA**
o. Is the treatment of children with pneumonia available at the PHC? **NA**
p. Is the management of children suffering from diarrhea with severe dehydration done at the PHC? **NA**

Other functions and services performed (Yes/No)- **NA**

a. Nutrition services

b. School Health programmes
c. Promotion of safe water supply and basic sanitation.
d. Prevention and control of locally endemic diseases.
e. Disease surveillance and control of epidemics.
f. Collection and reporting of vital statistics.
g. Education about health/behaviour change communication.
h. National Health Programmes including HIV/AIDS control programmes.
i. AYUSH services as per local preference.
j. Rehabilitation services (please specify)

Monitoring and Supervision activities (Yes/No)

a. Monitoring and supervision of activities of Sub- Centres through regular meetings/periodic visits, etc. **Yes**
b. Monitoring of National Health Programmes **Yes**
c. Monitoring activities of ASHAs **Yes**
d. Visits of Medical Officer to all Sub-Centres at least once in a month. **Yes**
e. Visits of Health Assistants (Male) and LHV to Sub- Centres once a week. **Yes**
f. Timely payment of JSY beneficiaries. **NA**
g. Timely payment of TA/DA to ASHAs **NA**

Manpower

Sl. No.	Staff	Recommended	Current Availability at PHC (Indicate Numbers)	Remarks/Suggestions/ Identified Gaps
1	Medical Officer- MBBS	**1**	1	Another 01 MO from Fortis Hospital
2	MO –AYUSH	**1**	1	On Contractual basis
3	Accountant/Clerk	**1**	Nil	
4	Pharmacist	**1**	1	Permanent
5	Pharmacist AYUSH	**1**	Nil	AYUSH MO dispenses himself
6	Nurse-midwife (Staff-Nurse)	**4**	2	Contractual,01NHM,01 HWC
7	Health workers (F)	**1**	1	
8	Health Asstt. (Male)	**1**	Nil	
9	Health Asstt. (Female)/LHV	**1**	Nil	
10	Health Educator	**1**	Nil	
11	Data entry cum computer operator	**1**	Nil	
12	Laboratory Technician	**1**	Nil	
13	Cold Chain & Vaccine Logistic Assistant	**1**		

14	Multi-skilled Group D worker	**2**	1	
15	Sanitary worker cum watchman	**1**	1	Permanent
	Total	**19**	8	

Training of personnel during previous (full) year

Sl. No.	**Available training for**	**Number trained**
1	Tradition birth attendants	Initial training for all categories received. Continuing on-the-job training. Training imparted at District Hospital periodically in the form of workshops.
2	Health Worker (Female)	
3	Health Worker (Male)	
4	Medical Officer	
5	Initial and periodic training of paramedics in treatment of minor ailments	
6	Training of ASHAs	
7	Periodic training of Doctors through Continuing Medical Education, conferences, skill development training etc. on emergency obstetric care, Training in FP services.-IUCD, Minilap and NSV, LSAS	
8	Training of Health Workers in antenatal care and skilled birth attendance	

Essential Laboratory Services

Sl. No.	Current Availability at PHC	Remarks/Suggestions/Identified Gaps
1	Routine urine, stool and blood tests	No Laboratory Technician available.
2	Blood grouping	
3	Bleeding time, clotting time	
4	Diagnosis of RTI/STDs with wet mounting, grams stain etc.	
5	Sputum testing for TB	
6	Blood smear examination for malaria parasite	
7	Rapid tests for pregnancy	
8	RPR test for Syphilis/yAWS surveillance (in high endemic area only)	
9	Rapid tests for HIV	
10	Others (specify)	

Any other Services if available e.g., ECG Physical Infrastructure (As per specifications) **NA**

Sl. No.	Current Availability at PHC	Remarks/Suggestions/ Identified Gaps
1	Where is this PHC located? a. Within Village Locality **Yes** b. Far from village locality c. If far from locality specify in km	
2	Building a. Is a designated government building available for the PHC? (Yes/No) **Yes** b. If there is no designated government building, then where does the PHC located? Rented premises/Other government building/Any other specify **NA** c. Area of the building (Total area in Sq. mts.) **NA** d. What is the present stage of construction of the building Construction? Complete/Construction incomplete **Complete** e. Compound Wall/Fencing (1-All around; 2-Partial; 3-None) f. Condition of plaster on walls (1- Well plastered with plaster intact everywhere; 2- Plaster coming off in some places; 3- Plaster coming off in many places or no plaster) **1- Well plastered** g. Condition of floor (1- Floor in good condition; 2- Floor coming off in some places; 3- Floor coming off in many places or no proper flooring) **2- Floor coming off in some places** h. Whether the cleanliness is Good/Fair/Poor? (Observe) OPD- **Fair** | Wards- **Fair** | Toilets- **Fair** | Premises (Compound)- **Fair** i. Are any of the following close to the PHC? (Observe) (Yes/No) i. Garbage dump- **Yes, and open drainage** ii. Cattle shed- **No** iii. Stagnant pool- **No** iv. Pollution from industry- **No**	

Sl. No.	Current Availability at PHC	Remarks/Suggestions/ Identified Gaps
	j. Is boundary wall with gate existing? (Yes/No)- **Yes**	
3	Location a. Whether located at an easily accessible area? (Yes/No) **Yes** b. Distance of PHC (in Kms.) from the farthest village in coverage area **18 kms (Chaproli Mangroli)** c. Travel time (in minutes) to reach the PHC from farthest village in coverage area **60 mins** d. Distance of PHC (in Kms.) from the CHC **NA** e. Distance of PHC (in Kms.) from District Hospital **5.2 kms**	
4	Prominent display boards regarding service availability in local language (Yes/No) **Yes**	
5	Registration counters (Yes/No) **Yes** a. Pharmacy for drug dispensing and drug storage (Yes/No) **Yes** b. Counter near entrance of PHC to obtain contraceptives, ORS packets, Vitamin A and Vaccination (Yes/No) **No**	
6	Separate public utilities for males and females (Yes/No) **Yes**	
7	Suggestion/complaint box (Yes/No) **No**	
8	OPD rooms/cubicles (Yes/No) (Give numbers) **Yes, 2**	
9	OPD rooms/cubicles (Yes/No) (Give numbers) each room (Yes/No) **Yes, 2**	
10	Family Welfare Clinic (Yes/No) **No**	
11	Waiting room for patients (Yes/No) **Yes**	
12	Emergency Room/Casualty (yes/No) **No**	Injection Room being used as Emergency Room

13	Separate wards for males and females (Yes/No) **No**	
14	No. of beds: Male No. of beds: Female	
15	**Total: 4**	
16	Operation Theatre (if exists) a. Operation Theatre available (Yes/No) **Yes** b. If operation theatre is present, are surgeries carried out in the operation theatre? Yes/No/Sometimes **No** c. If operation theatre is present, but surgeries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/staff Lack of equipment/poor physical state of the operation theatre/No power supply in the operation theatre/Any other reason (specify) **Non-availability of doctors/staff** d. Operation Theatre used for obstetric/gynaecological purpose (Yes/No) **No** e. Has OT enough space (Yes/No) **Yes**	
17	Labour room a. Labour room available? (Yes/No) **Yes** b. If labour room is present, are deliveries carried out in the labour room? Yes/No/Sometimes **Yes**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**

	c. If labour room is present but deliveries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/staff Poor condition of the labour room/No power supply in the labour room/Any other reason (specify) **NA** d. Is separate areas for septic and aseptic deliveries available? (Yes/No) **No** e. Is Newborn care corner available (Yes/No) **Yes**	
18	Laboratory a. Laboratory (Yes/No) **No** b. Are adequate equipment and chemicals available? (Yes/No) c. Is laboratory maintained in orderly manner? (Yes/No)	
19	Ancillary Rooms - Nurses rest room (Yes/No) **Yes**	
20	Water supply a. Source of water (1- Piped; 2- Bore well/hand pump/tube well; 3- Well; 4- Other (specify) **1- Piped** b. Whether overhead tank and pump exist (Yes/No) **Yes** c. If overhead tank exists whether its capacity sufficient? (Yes/No) **Yes** d. If pump exists whether it is in working condition? (Yes/No) **Yes**	
21	Sewerage Type of sewerage system (1- Soak pit; 2- Connected to Municipal Sewerage) **2- Municipality Sewerage**	
22	Waste disposal How the waste material is being disposed (please specify)? **Outsourced- Waste collection by Synergy Waste management, Meerut thrice a week. BMW Room at PHC available.**	
23	Electricity a. Is there electric line in all parts of the PHC? (1- In all parts; 2- In some parts; 3- None) **1- all parts** b. Regular Power Supply (1- Continuous Power Supply; 2-Occasional power failure; 3- Power cuts in summer only; 4-Regular power cuts; 5- No power supply) **1- Continuous** c. Stand by facility (generator) available in working condition? (Yes/No) **Yes, 24hr inverter backup, no generator**	

24	Laundry facilities a. Laundry facility available(Yes/No) **No** b. If no, is it outsourced? **Outsourced locally**	
25	Communication facilities a. Telephone (Yes/No) **No** b. Personal Computer (Yes/No) **No** c. NIC Terminal (Yes/No) **No** d. Email (Yes/No) **No** e. Is PHC accessible by i. Rail (Yes/No) **No** ii. All weather road (Yes/No) **Yes** iii. Others (Specify)	
26	Vehicles Vehicle (jeep/other vehicle) available? (Yes/No) **Yes, jeep**	
27	Office room (Yes/No) **Yes**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
28	Store room (Yes/No) **Yes**	
29	Kitchen (Yes/No) **No**	
30	Diet: a. Diet provided by hospital (Yes/No) **No** b. If no, how diet is provided to the indoor patients? **Outsourced**	
31	Residential facility for the staff with all amenities Medical Officer **Yes, 1 (Staff Quarter Type 1)** Pharmacist **No** Nurses **Yes, 2 (Staff Quarter Type 2)** Other Staff **Ward Boy and Sweeper, 2 (Staff Quarter Type 3)**	

32	Behavioral Aspects (Yes/No) **NA** a. How is the behaviour of the PHC staff with the patient? Courteous/Casual/indifferent/Insulting/derogatory b. Any fee for service is being charged from the users? (yes/ No). If yes, specify. c. Is there corruption in terms of charging extra money for any of the service provided? (yes/No) d. Is a receipt always given for the money charged at the PHC? (yes/No) e. Is there any incidence of any sexual advances, verbal or physical abuse, sexual harassment by the doctors or any other paramedical? (yes/No) f. Are woman patients interviewed in an environment that ensures privacy and dignity? (yes/No) g. Are examinations on woman patients conducted in presence of a woman attendant, and procedures conducted under conditions that ensure privacy? (yes/No) h. Do patients with chronic illnesses receive adequate care and drugs for the entire duration? (yes/No) i. If the health centre is unequipped to provide the services; how and where the patient is referred and how patients transported? j. Is there a publicly displayed mechanism; whereby a complaint/grievance can be registered? (yes/No) k. Is there an outbreak of any of the following diseases in the PHC area in the last three years? Malaria Measles Gastroenteritis Jaundice l. If yes, did the PHC staff responded immediately to stop the further spread of the epidemic m. Does the doctor do private practice during or after the duty hours? (yes/No) n. Are there instances where patients from particular social background? SC, ST, Dalits, minorities, villagers have faced derogatory or discriminatory behavior or service of poorer quality? (yes/No) o. Have patients with specific health problems (HIV/AIDS, leprosy) suffered discrimination in any form? (yes/No)	**Not assessed**

Furniture

Sl. No.	Item	Current Availability at PHC	Remarks
1	Examination Table	Available	
2	Delivery Table		
3	Footstep		
4	Bed Side Screen		
5	Stool for patients		
6	Arm board for adult & child		
7	I V stand		
8	Wheel chair		
9	Stretcher or trolley		
10	Oxygen trolley		
11	Height measuring stand		
12	Iron bed		
13	Bed side locker		
14	Dressing trolley		
15	Mayo trolley		
16	Instrument cabinet		

17	Instrument trolley		
18	Bucket		
19	Attendant stool		
20	Instrument tray		
21	Chair		

22	Wooden table	**Available**	
23	Almirah		
24	Swab rack		
25	Mattress		
26	Pillows		
27	Waiting bench for patients/attendants		
28	Medicine cabinet		
29	Side rail		
30	Rack		
31	Bed side attendant chair		

32	Others		

FACILITY SURVEY FOR PHC MAMOORA AS PER FORMAT OF IPHS

PHC Mamoora

Name of the State: **Uttar Pradesh**

District: **Gautambudhnagar**

Tehsil/Taluk/Block: **Bisrakh**

Location & Name of PHC: **PHC Mamoora**

Is the PHC providing 24 hours and 7 days delivery facilities: **Yes**

Date: **19/02/2020**

Identification

Services

Population covered (in numbers)

3.5 lakhs

Type of PHC:

a. Type A- **Yes**
b. Type B

Number of beds available

4

a. Bed Occupancy Rate in the last 12 months
(1-less than 40%; 2 - 40-60%; 3 - More than 60%)- **<40%(8.87%)**

Average daily OPD Attendance

Total: **180**

Assured Services available (Yes/No)

a. OPD Services- **Yes**
b. Emergency services (24 Hours)- **Yes**
c. Referral Services- **Yes**
d. In-patient Services- **Yes**

Treatment of specific cases (Yes/No)

a. Is the primary management of wounds done at the PHC? **Yes**
b. Is the primary management of fracture done at the PHC? **Yes**
c. Are minor surgeries like draining of abscess etc. done at the PHC? **Yes**
d. Is the primary management of cases of poisoning/ snake, insect or scorpion bite done at the PHC? **Yes**
e. Is the primary management of burns done at PHC? **Yes**

MCH Care including Family Welfare

Service availability (Yes/No)

a. Ante-natal care- **Yes**
b. Intranatal care (24 - hour delivery services both normal and assisted)- **Yes**
c. Post-natal care- **Yes**
d. New born Care- **Yes**
e. Child care including immunization- **NA**
f. Family Planning- **NA**
g. MTP- **NA**
h. Management of RTI/STI- **NA**
i. Facilities under Janani Suraksha yojana- **NA**

Availability of specific services (Yes/No)

a. Are antenatal clinics organized by the PHC regularly? **Yes**
b. Is the facility for normal delivery available in the PHC for 24 hours? **Yes**
c. Is the facility for tubectomy and vasectomy available at the PHC? **NA**
d. Is the facility for internal examination for gynaecological conditions available at the PHC?

NA

e. Is the treatment for gynecological disorders like leucorrhoea, menstrual disorders available at the PHC? **NA**
f. If women do not usually go to the PHC, then what is the reason behind it? **NA**
g. Is the facility for MTP (abortion) available at the PHC? **NA**
h. Is there any precondition for doing MTP such as enforced use of contraceptives after MTP or asking for husband's consent for MTP? **NA**
i. Do women have to pay for MTP? **NA**
j. Is treatment for anemia given to both pregnant as well as non-pregnant women? **NA**

k. Are the low birth weight babies managed at the PHC? **NA**
l. Is there a fixed immunization day? **NA**
m. Is BCG and Measles vaccine given regularly in the PHC? **NA**
n. How is the vaccine received at PHC and distributed to Sub-Centres? **NA**
o. Is the treatment of children with pneumonia available at the PHC? **NA**
p. Is the management of children suffering from diarrhea with severe dehydration done at the PHC? **NA**

Other functions and services performed (Yes/No)- **NA**

a. Nutrition services

b. School Health programmes
c. Promotion of safe water supply and basic sanitation.
d. Prevention and control of locally endemic diseases.
e. Disease surveillance and control of epidemics.
f. Collection and reporting of vital statistics.
g. Education about health/behaviour change communication.
h. National Health Programmes including HIV/AIDS control programmes.
i. AYUSH services as per local preference.
j. Rehabilitation services (please specify)

Monitoring and Supervision activities (Yes/No)

a. Monitoring and supervision of activities of Sub- Centres through regular meetings/periodic visits, etc. **Yes**
b. Monitoring of National Health Programmes **Yes**
c. Monitoring activities of ASHAs **Yes**
d. Visits of Medical Officer to all Sub-Centres at least once in a month. **Yes**
e. Visits of Health Assistants (Male) and LHV to Sub- Centres once a week. **Yes**
f. Timely payment of JSY beneficiaries. **NA**
g. Timely payment of TA/DA to ASHAs **NA**

Manpower

Sl. No.	Staff	Recommended	Current Availability at PHC (Indicate Numbers)	Remarks/Suggestions/ Identified Gaps
1	Medical Officer- MBBS	**1**	1	Permanent
2	MO –AYUSH	**1**	1	Permanent
3	Accountant/Clerk	**1**	Nil	
4	Pharmacist	**1**	1	Permanent

5	Pharmacist AYUSH	**1**	Nil	AYUSH MO dispenses himself
6	Nurse-midwife (Staff-Nurse)	**4**	1	Permanent. 01ANM
7	Health workers (F)	**1**	Nil	
8	Health Asstt. (Male)	**1**	Nil	
9	Health Asstt. (Female)/LHV	**1**	Nil	
10	Health Educator	**1**	Nil	
11	Data entry cum computer operator	**1**	Nil	
12	Laboratory Technician	**1**	1	Contractual
13	Cold Chain & Vaccine Logistic Assistant	**1**	Nil	
14	Multi-skilled Group D worker	**2**	Nil	
15	Sanitary worker cum watchman	**1**	1	Permanent
	Total	**19**	6	

Training of personnel during previous (full) year

Sl. No.	**Available training for**	**Number trained**

1	Tradition birth attendants	Initial training for all categories received. Continuing on-the-job training. Training imparted at District Hospital periodically in the form of workshops.
2	Health Worker (Female)	
3	Health Worker (Male)	
4	Medical Officer	
5	Initial and periodic training of paramedics in treatment of minor ailments	
6	Training of ASHAs	
7	Periodic training of Doctors through Continuing Medical Education, conferences, skill development training etc. on emergency obstetric care, Training in FP services.-IUCD, Minilap and NSV, LSAS	
8	Training of Health Workers in antenatal care and skilled birth attendance	

Essential Laboratory Services

Sl. No.	Current Availability at PHC	Remarks/Suggestions/Identified Gaps
1	Routine urine, stool and blood tests	
2	Blood grouping	
3	Bleeding time, clotting time	

4	Diagnosis of RTI/STDs with wet mounting, grams stain etc.	Available
5	Sputum testing for TB	
6	Blood smear examination for malaria parasite	
7	Rapid tests for pregnancy	
8	RPR test for Syphilis/yAWS surveillance (in high endemic area only)	
9	Rapid tests for HIV	
10	Others (specify)	

Any other Services if available e.g., ECG Physical Infrastructure (As per specifications)

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
1	Where is this PHC located? a. Within Village Locality **Yes** b. Far from village locality c. If far from locality specify in km	

2	Building a. Is a designated government building available for the PHC? (Yes/No) **Yes** b. If there is no designated government building, then where does the PHC located? Rented premises/Other government building/Any other specify **NA** c. Area of the building (Total area in Sq. mts.) **NA** d. What is the present stage of construction of the building Construction? Complete/Construction incomplete **Complete** e. Compound Wall/Fencing (1-All around; 2-Partial; 3-None) f. Condition of plaster on walls (1- Well plastered with plaster intact everywhere; 2- Plaster coming off in some places; 3- Plaster coming off in many places or no plaster) **1- Well plastered** g. Condition of floor (1- Floor in good condition; 2- Floor coming off in some places; 3- Floor coming off in many places or no proper flooring) **2- Floor coming off in some places** h. Whether the cleanliness is Good/Fair/Poor? (Observe) OPD- **Fair** **|** Wards- **Fair** **|** Toilets- **Fair** **|** Premises (Compound)- **Fair** i. Are any of the following close to the PHC? (Observe) (Yes/No) i. Garbage dump- **Yes** ii. Cattle shed- **Yes** iii. Stagnant pool- **Yes** iv. Pollution from industry- **No**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**

	j. Is boundary wall with gate existing? (Yes/No)- **Yes**	
3	Location a. Whether located at an easily accessible area? (Yes/No) **Yes** b. Distance of PHC (in Kms.) from the farthest village in coverage area **15 kms** c. Travel time (in minutes) to reach the PHC from farthest village in coverage area **45 mins** d. Distance of PHC (in Kms.) from the CHC **NA** e. Distance of PHC (in Kms.) from District Hospital **16 kms**	
4	Prominent display boards regarding service availability in local language (Yes/No) **Yes**	
5	Registration counters (Yes/No) **Yes** a. Pharmacy for drug dispensing and drug storage (Yes/No) **Yes** b. Counter near entrance of PHC to obtain contraceptives, ORS packets, Vitamin A and Vaccination (Yes/No) **No**	
6	Separate public utilities for males and females (Yes/No) **Yes**	
7	Suggestion/complaint box (Yes/No) **No**	
8	OPD rooms/cubicles (Yes/No) (Give numbers) **Yes, 2**	
9	OPD rooms/cubicles (Yes/No) (Give numbers) each room (Yes/No) **Yes, 2**	
10	Family Welfare Clinic (Yes/No) **No**	
11	Waiting room for patients (Yes/No) **Yes**	
12	Emergency Room/Casualty (yes/No) **No**	
13	Separate wards for males and females (Yes/No) **No**	
14	No. of beds: Male No. of beds: Female	

15	**Total: 4**	
16	Operation Theatre (if exists) a. Operation Theatre available (Yes/No) **No** b. If operation theatre is present, are surgeries carried out in the operation theatre? Yes/No/Sometimes c. If operation theatre is present, but surgeries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/staff Lack of equipment/poor physical state of the operation theatre/No power supply in the operation theatre/Any other reason (specify) d. Operation Theatre used for obstetric/gynaecological purpose (Yes/No) e. Has OT enough space (Yes/No)	
17	Labour room a. Labour room available? (Yes/No) **No** b. If labour room is present, are deliveries carried out in the labour room? Yes/No/Sometimes	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
	c. If labour room is present but deliveries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/staff Poor condition of the labour room/No power supply in the labour room/Any other reason (specify) d. Is separate areas for septic and aseptic deliveries available? (Yes/No) e. Is Newborn care corner available (Yes/No)	
18	Laboratory a. Laboratory (Yes/No) **Yes** b. Are adequate equipment and chemicals available? (Yes/No) **Yes** c. Is laboratory maintained in orderly manner? (Yes/No) **Yes**	Fair maintainance

19	Ancillary Rooms - Nurses rest room (Yes/No) **No**	
20	Water supply a. Source of water (1- Piped; 2- Bore well/hand pump/tube well; 3- Well; 4- Other (specify) **1- Piped** b. Whether overhead tank and pump exist (Yes/No) **Yes** c. If overhead tank exists whether its capacity sufficient? (Yes/No) **Yes** d. If pump exists whether it is in working condition? (Yes/No) **Yes**	
21	Sewerage Type of sewerage system (1- Soak pit; 2- Connected to Municipal Sewerage) **2- Municipal Sewerage**	
22	Waste disposal How the waste material is being disposed (please specify)? **Outsourced- Waste collected by Synergy Waste Management, Meerut thrice a week. BMW available at PHC.**	
23	Electricity a. Is there electric line in all parts of the PHC? (1- In all parts; 2- In some parts; 3- None) **1- all parts** b. Regular Power Supply (1- Continuous Power Supply; 2-Occasional power failure; 3- Power cuts in summer only; 4-Regular power cuts; 5- No power supply) **1-Continuous** c. Stand by facility (generator) available in working condition? (Yes/No) **Yes, inverter backup, no generator**	
24	Laundry facilities a. Laundry facility available (Yes/No) **Yes** b. If no, is it outsourced?	
25	Communication facilities a. Telephone (Yes/No) **No** b. Personal Computer (Yes/No) **No** c. NIC Terminal (Yes/No) **No** d. Email (Yes/No) **No** e. Is PHC accessible by i. Rail (Yes/No) **No** ii. All weather road (Yes/No) **Yes** iii. Others (Specify)	

26	Vehicles Vehicle (jeep/other vehicle) available? (Yes/No) **Yes, jeep**	
27	Office room (Yes/No) **Yes**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
28	Store room (Yes/No) **Yes**	
29	Kitchen (Yes/No) **No**	
30	Diet: a. Diet provided by hospital (Yes/No) **No** b. If no, how diet is provided to the indoor patients? **Outsourced**	
31	Residential facility for the staff with all amenities Medical Officer **No** Pharmacist **No** Nurses **No** Other Staff **No**	

32	Behavioral Aspects (Yes/No) **NA** a. How is the behaviour of the PHC staff with the patient? Courteous/Casual/indifferent/Insulting/derogatory b. Any fee for service is being charged from the users? (yes/ No). If yes, specify. c. Is there corruption in terms of charging extra money for any of the service provided? (yes/No) d. Is a receipt always given for the money charged at the PHC? (yes/No) e. Is there any incidence of any sexual advances, verbal or physical abuse, sexual harassment by the doctors or any other paramedical? (yes/No) f. Are woman patients interviewed in an environment that ensures privacy and dignity? (yes/No) g. Are examinations on woman patients conducted in presence of a woman attendant, and procedures conducted under conditions that ensure privacy? (yes/No) h. Do patients with chronic illnesses receive adequate care and drugs for the entire duration? (yes/No) i. If the health centre is unequipped to provide the services; how and where the patient is referred and how patients transported? j. Is there a publicly displayed mechanism; whereby a complaint/grievance can be registered? (yes/No) k. Is there an outbreak of any of the following diseases in the PHC area in the last three years? Malaria Measles Gastroenteritis Jaundice l. If yes, did the PHC staff responded immediately to stop the further spread of the epidemic m. Does the doctor do private practice during or after the duty hours? (yes/No) n. Are there instances where patients from particular social background? SC, ST, Dalits, minorities, villagers have faced derogatory or discriminatory behavior or service of poorer quality? (yes/No) o. Have patients with specific health problems (HIV/AIDS, leprosy) suffered discrimination in any form? (yes/No)	

Furniture

Sl. No.	Item	Current Availability at PHC	Remarks
1	Examination Table		

2	Delivery Table		
3	Footstep		
4	Bed Side Screen		
5	Stool for patients		
6	Arm board for adult & child		
7	I V stand		
8	Wheel chair		
9	Stretcher or trolley		
10	Oxygen trolley		
11	Height measuring stand	Available	
12	Iron bed		
13	Bed side locker		
14	Dressing trolley		
15	Mayo trolley		
16	Instrument cabinet		
17	Instrument trolley		
18	Bucket		
19	Attendant stool		

20	Instrument tray		
21	Chair		

22	Wooden table	Available	
23	Almirah		
24	Swab rack		
25	Mattress		
26	Pillows		
27	Waiting bench for patients/attendants		
28	Medicine cabinet		
29	Side rail		
30	Rack		
31	Bed side attendant chair		
32	Others		

FACILITY SURVEY FOR PHC AS PER FORMAT OF IPHS

PHC JEWAR

Name of the State: **Uttar Pradesh**

District: **Gautambudhnagar**

Tehsil/Taluk/Block: **Jewar**

Location & Name of PHC: **PHC Jewar**

Is the PHC providing 24 hours and 7 days delivery facilities: **Yes**

Date: **24/02/2020**

Identification

Services

Population covered (in numbers)

2 lakhs

Type of PHC:

a. Type A- **Yes**
b. Type B

Number of beds available

6

a. Bed Occupancy Rate in the last 12 months
(1-less than 40%; 2 - 40-60%; 3 - More than 60%)- **>60%**

Average daily OPD Attendance

Total: **190**

Assured Services available (Yes/No)

a. OPD Services- **Yes**
b. Emergency services (24 Hours)- **Yes**
c. Referral Services- **Yes**
d. In-patient Services- **Yes**

Treatment of specific cases (Yes/No)

a. Is the primary management of wounds done at the PHC? **Yes**
b. Is the primary management of fracture done at the PHC? **Yes**
c. Are minor surgeries like draining of abscess etc. done at the PHC? **Yes**
d. Is the primary management of cases of poisoning/ snake, insect or scorpion bite done at the PHC? **Yes**
e. Is the primary management of burns done at PHC? **Yes**

MCH Care including Family Welfare

Service availability (Yes/No)

a. Ante-natal care- **Yes**

b. Intranatal care (24 - hour delivery services both normal and assisted)- **Yes**
c. Post-natal care- **Yes**
d. New born Care- **Yes**
e. Child care including immunization- **NA**
f. Family Planning- **NA**
g. MTP- **NA**
h. Management of RTI/STI- **NA**
i. Facilities under Janani Suraksha yojana- **NA**

Availability of specific services (Yes/No)

a. Are antenatal clinics organized by the PHC regularly? **Yes**
b. Is the facility for normal delivery available in the PHC for 24 hours? **Yes**
c. Is the facility for tubectomy and vasectomy available at the PHC? **NA**
d. Is the facility for internal examination for gynaecological conditions available at the PHC?

NA

e. Is the treatment for gynecological disorders like leucorrhoea, menstrual disorders available at the PHC? **NA**
f. If women do not usually go to the PHC, then what is the reason behind it? **NA**
g. Is the facility for MTP (abortion) available at the PHC? **NA**
h. Is there any precondition for doing MTP such as enforced use of contraceptives after MTP or asking for husband's consent for MTP? **NA**
i. Do women have to pay for MTP? **NA**
j. Is treatment for anemia given to both pregnant as well as non-pregnant women? **NA**

k. Are the low birth weight babies managed at the PHC? **NA**
l. Is there a fixed immunization day? **NA**
m. Is BCG and Measles vaccine given regularly in the PHC? **NA**
n. How is the vaccine received at PHC and distributed to Sub-Centres? **NA**
o. Is the treatment of children with pneumonia available at the PHC? **NA**
p. Is the management of children suffering from diarrhea with severe dehydration done at the PHC? **NA**

Other functions and services performed (Yes/No)- **NA**

a. Nutrition services
b. School Health programmes

c. Promotion of safe water supply and basic sanitation.
d. Prevention and control of locally endemic diseases.
e. Disease surveillance and control of epidemics.
f. Collection and reporting of vital statistics.
g. Education about health/behaviour change communication.
h. National Health Programmes including HIV/AIDS control programmes.
i. AYUSH services as per local preference.
j. Rehabilitation services (please specify)

Monitoring and Supervision activities (Yes/No)

a. Monitoring and supervision of activities of Sub- Centres through regular meetings/periodic visits, etc. **Yes**
b. Monitoring of National Health Programmes **Yes**
c. Monitoring activities of ASHAs **Yes**
d. Visits of Medical Officer to all Sub-Centres at least once in a month. **Yes**
e. Visits of Health Assistants (Male) and LHV to Sub- Centres once a week. **Yes**
f. Timely payment of JSY beneficiaries. **NA**
g. Timely payment of TA/DA to ASHAs **NA**

Manpower

Sl. No.	**Staff**	**Recommended**	**Current Availability at PHC (Indicate Numbers)**	**Remarks/Suggestions/ Identified Gaps**
1	Medical Officer- MBBS	**1**	2	Permanent
2	MO –AYUSH	**1**	1	Permanent
3	Accountant/Clerk	**1**	1	Permanent
4	Pharmacist	**1**	1	Permanent

5	Pharmacist AYUSH	**1**	Nil	AYUSH MO dispenses himself
6	Nurse-midwife (Staff-Nurse)	**4**	3	Contractual,01NHM,01 HWC
7	Health workers (F)	**1**	Nil	
8	Health Asstt. (Male)	**1**	Nil	
9	Health Asstt. (Female)/LHV	**1**	Nil	
10	Health Educator	**1**	Nil	
11	Data entry cum computer operator	**1**	Nil	
12	Laboratory Technician	**1**	2	1 Permanent, 1 Contractual
13	Cold Chain & Vaccine Logistic Assistant	**1**	Nil	
14	Multi-skilled Group D worker	**2**	1	Permanent
15	Sanitary worker cum watchman	**1**	1	Permanent
	Total	**19**	12	

Training of personnel during previous (full) year

Sl. No.	Available training for	Number trained
1	Tradition birth attendants	Initial training for all categories received. Continuing on-the-job training. Training imparted at District Hospital periodically in the form of workshops.
2	Health Worker (Female)	
3	Health Worker (Male)	
4	Medical Officer	
5	Initial and periodic training of paramedics in treatment of minor ailments	
6	Training of ASHAs	
7	Periodic training of Doctors through Continuing Medical Education, conferences, skill development training etc. on emergency obstetric care, Training in FP services.-IUCD, Minilap and NSV, LSAS	
8	Training of Health Workers in antenatal care and skilled birth attendance	

Essential Laboratory Services

Sl. No.	Current Availability at PHC	Remarks/Suggestions/Identified Gaps
1	Routine urine, stool and blood tests	
2	Blood grouping	
3	Bleeding time, clotting time	

4	Diagnosis of RTI/STDs with wet mounting, grams stain etc.	Available
5	Sputum testing for TB	
6	Blood smear examination for malaria parasite	
7	Rapid tests for pregnancy	
8	RPR test for Syphilis/yAWS surveillance (in high endemic area only)	
9	Rapid tests for HIV	
10	Others (specify)	

Any other Services if available e.g., ECG Physical Infrastructure (As per specifications)

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
1	Where is this PHC located? a. Within Village Locality **Yes** b. Far from village locality c. If far from locality specify in km	

2	Building a. Is a designated government building available for the PHC? (Yes/No) **Yes** b. If there is no designated government building, then where does the PHC located? Rented premises/Other government building/Any other specify **NA** c. Area of the building (Total area in Sq. mts.) **NA** d. What is the present stage of construction of the building Construction? Complete/Construction incomplete **Complete** e. Compound Wall/Fencing (1-All around; 2-Partial; 3-None) f. Condition of plaster on walls (1- Well plastered with plaster intact everywhere; 2- Plaster coming off in some places; 3- Plaster coming off in many places or no plaster) **1- Well plastered** g. Condition of floor (1- Floor in good condition; 2- Floor coming off in some places; 3- Floor coming off in many places or no proper flooring) **2- Floor coming off in some places** h. Whether the cleanliness is Good/Fair/Poor? (Observe) OPD- **Fair** | Wards- **Fair** | Toilets- **Fair** | Premises (Compound)- **Fair** i. Are any of the following close to the PHC? (Observe) (Yes/No) i. Garbage dump- **Yes** ii. Cattle shed- **Yes** iii. Stagnant pool- **No** iv. Pollution from industry- **No**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
	j. Is boundary wall with gate existing? (Yes/No)- **Yes**	
3	Location a. Whether located at an easily accessible area? (Yes/No) **Yes** b. Distance of PHC (in Kms.) from the farthest village in coverage area **15 kms** c. Travel time (in minutes) to reach the PHC from farthest village in coverage area **45 mins** d. Distance of PHC (in Kms.) from the CHC **NA** e. Distance of PHC (in Kms.) from District Hospital **55**	

	kms	
4	Prominent display boards regarding service availability in local language (Yes/No) **Yes**	
5	Registration counters (Yes/No) **Yes** a. Pharmacy for drug dispensing and drug storage (Yes/No) **Yes** b. Counter near entrance of PHC to obtain contraceptives, ORS packets, Vitamin A and Vaccination (Yes/No) **No**	
6	Separate public utilities for males and females (Yes/No) **Yes**	
7	Suggestion/complaint box (Yes/No) **No**	
8	OPD rooms/cubicles (Yes/No) (Give numbers) **Yes, 3**	
9	OPD rooms/cubicles (Yes/No) (Give numbers) each room (Yes/No) **Yes, 3**	
10	Family Welfare Clinic (Yes/No) **No**	
11	Waiting room for patients (Yes/No) **Yes**	
12	Emergency Room/Casualty (Yes/No) **No**	
13	Separate wards for males and females (Yes/No) **No**	
14	No. of beds: Male No. of beds: Female	
15	**Total: 6**	

16	Operation Theatre (if exists) a. Operation Theatre available (Yes/No) **No** b. If operation theatre is present, are surgeries carried out in the operation theatre? Yes/No/Sometimes c. If operation theatre is present, but surgeries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/staff Lack of equipment/poor physical state of the operation theatre/No power supply in the operation theatre/Any other reason (specify) d. Operation Theatre used for obstetric/gynaecological purpose (Yes/No) e. Has OT enough space (Yes/No)	
17	Labour room a. Labour room available? (Yes/No) **Yes** b. If labour room is present, are deliveries carried out in the labour room? Yes/No/Sometimes **Yes**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
	c. If labour room is present but deliveries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/staff Poor condition of the labour room/No power supply in the labour room/Any other reason (specify) **NA** d. Is separate areas for septic and aseptic deliveries available? (Yes/No) **No** e. Is Newborn care corner available (Yes/No) **Yes**	
18	Laboratory a. Laboratory (Yes/No) **Yes** b. Are adequate equipment and chemicals available? (Yes/No) **Yes** c. Is laboratory maintained in orderly manner? (Yes/No)	Maintained in fair manner

	Yes	
19	Ancillary Rooms - Nurses rest room (Yes/No) **Yes**	
20	Water supply a. Source of water (1- Piped; 2- Bore well/hand pump/tube well; 3- Well; 4- Other (specify) **1- Piped** b. Whether overhead tank and pump exist (Yes/No) **Yes** c. If overhead tank exists whether its capacity sufficient? (Yes/No) **Yes** d. If pump exists whether it is in working condition? (Yes/No) **Yes**	
21	Sewerage Type of sewerage system (1- Soak pit; 2- Connected to Municipal Sewerage) **2- Municipal Sewerage**	
22	Waste disposal How the waste material is being disposed (please specify)? **Outsourced, BMW room available**	
23	Electricity a. Is there electric line in all parts of the PHC? (1- In all parts; 2- In some parts; 3- None) **1- all parts** b. Regular Power Supply (1- Continuous Power Supply; 2-Occasional power failure; 3- Power cuts in summer only; 4-Regular power cuts; 5- No power supply) **1- Continuous** c. Stand by facility (generator) available in working condition? (Yes/No) **Yes, inverter available, no generator**	
24	Laundry facilities a. Laundry facility available(Yes/No) **Yes** b. If no, is it outsourced?	

25	Communication facilities a. Telephone (Yes/No) **No** b. Personal Computer (Yes/No) **Yes** c. NIC Terminal (Yes/No) **No** d. Email (Yes/No) **Yes** e. Is PHC accessible by i. Rail (Yes/No) **No** ii. All weather road (Yes/No) **Yes** iii. Others (Specify)	
26	Vehicles Vehicle (jeep/other vehicle) available? (Yes/No) **Yes, jeep**	
27	Office room (Yes/No) **Yes**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
28	Store room (Yes/No) **Yes**	
29	Kitchen (Yes/No) **No**	
30	Diet: a. Diet provided by hospital (Yes/No) **No** b. If no, how diet is provided to the indoor patients? **Outsourced**	
31	Residential facility for the staff with all amenities Medical Officer **Yes, 1 (Staff Quarter Type 1)** Pharmacist **No** Nurses **Yes, 2 (Staff Quarter Type 2)** Other Staff **Yes, 2 (Staff Quarter Type 3)**	

32	Behavioral Aspects (Yes/No) **NA** a. How is the behaviour of the PHC staff with the patient? Courteous/Casual/indifferent/Insulting/derogatory b. Any fee for service is being charged from the users? (yes/ No). If yes, specify. c. Is there corruption in terms of charging extra money for any of the service provided? (yes/No) d. Is a receipt always given for the money charged at the PHC? (yes/No) e. Is there any incidence of any sexual advances, verbal or physical abuse, sexual harassment by the doctors or any other paramedical? (yes/No) f. Are woman patients interviewed in an environment that ensures privacy and dignity? (yes/No) g. Are examinations on woman patients conducted in presence of a woman attendant, and procedures conducted under conditions that ensure privacy? (yes/No) h. Do patients with chronic illnesses receive adequate care and drugs for the entire duration? (yes/No) i. If the health centre is unequipped to provide the services; how and where the patient is referred and how patients transported? j. Is there a publicly displayed mechanism; whereby a complaint/grievance can be registered? (yes/No) k. Is there an outbreak of any of the following diseases in the PHC area in the last three years? Malaria Measles Gastroenteritis Jaundice l. If yes, did the PHC staff responded immediately to stop the further spread of the epidemic m. Does the doctor do private practice during or after the duty hours? (yes/No) n. Are there instances where patients from particular social background? SC, ST, Dalits, minorities, villagers have faced derogatory or discriminatory behavior or service of poorer quality? (yes/No) o. Have patients with specific health problems (HIV/AIDS, leprosy) suffered discrimination in any form? (yes/No)	

Furniture

Sl. No.	**Item**	**Current Availability at PHC**	**Remarks**
1	Examination Table		

2	Delivery Table		
3	Footstep		
4	Bed Side Screen		
5	Stool for patients		
6	Arm board for adult & child		
7	I V stand		
8	Wheel chair		
9	Stretcher or trolley		
10	Oxygen trolley		
11	Height measuring stand	Available	
12	Iron bed		
13	Bed side locker		
14	Dressing trolley		
15	Mayo trolley		
16	Instrument cabinet		
17	Instrument trolley		
18	Bucket		
19	Attendant stool		

20	Instrument tray		
21	Chair		

22	Wooden table	Available	
23	Almirah		
24	Swab rack		
25	Mattress		
26	Pillows		
27	Waiting bench for patients/attendants		
28	Medicine cabinet		
29	Side rail		
30	Rack		
31	Bed side attendant chair		
32	Others		

FACILITY SURVEY FOR PHC JAUNCHANA AS PER FORMAT OF IPHS

PHC Jaunchana

Name of the State: **Uttar Pradesh**

District: **Gautambudhnagar**

Tehsil/Taluk/Block: **Jewar**

Location & Name of PHC: **PHC Jaunchana**

Is the PHC providing 24 hours and 7 days delivery facilities: **Yes**

Date: **24/02/2020**

Identification

Services

Population covered (in numbers)

24,000

Type of PHC:

a. Type A- **Yes**
b. Type B

Number of beds available

4

a. Bed Occupancy Rate in the last 12 months
(1-less than 40%; 2 - 40-60%; 3 - More than 60%)- **<40% (34.67%)**

Average daily OPD Attendance

Total: **80**

Assured Services available (Yes/No)

a. OPD Services- **Yes**
b. Emergency services (24 Hours)- **Yes**
c. Referral Services- **Yes**
d. In-patient Services- **Yes**

Treatment of specific cases (Yes/No)

a. Is the primary management of wounds done at the PHC? **Yes**
b. Is the primary management of fracture done at the PHC? **Yes**
c. Are minor surgeries like draining of abscess etc. done at the PHC? **Yes**
d. Is the primary management of cases of poisoning/ snake, insect or scorpion bite done at the PHC? **Yes**
e. Is the primary management of burns done at PHC? **Yes**

MCH Care including Family Welfare

Service availability (Yes/No)

a. Ante-natal care- **Yes**
b. Intranatal care (24 - hour delivery services both normal and assisted)- **Yes**
c. Post-natal care- **Yes**
d. New born Care- **Yes**
e. Child care including immunization- **NA**
f. Family Planning- **NA**
g. MTP- **NA**
h. Management of RTI/STI- **NA**
i. Facilities under Janani Suraksha yojana- **NA**

Availability of specific services (Yes/No)

a. Are antenatal clinics organized by the PHC regularly? **Yes**
b. Is the facility for normal delivery available in the PHC for 24 hours? **Yes**
c. Is the facility for tubectomy and vasectomy available at the PHC? **NA**
d. Is the facility for internal examination for gynaecological conditions available at the PHC?

NA

e. Is the treatment for gynecological disorders like leucorrhoea, menstrual disorders available at the PHC? **NA**
f. If women do not usually go to the PHC, then what is the reason behind it? **NA**
g. Is the facility for MTP (abortion) available at the PHC? **NA**
h. Is there any precondition for doing MTP such as enforced use of contraceptives after MTP or asking for husband's consent for MTP? **NA**
i. Do women have to pay for MTP? **NA**
j. Is treatment for anemia given to both pregnant as well as non-pregnant women? **NA**

k. Are the low birth weight babies managed at the PHC? **NA**
l. Is there a fixed immunization day? **NA**
m. Is BCG and Measles vaccine given regularly in the PHC? **NA**
n. How is the vaccine received at PHC and distributed to Sub-Centres? **NA**
o. Is the treatment of children with pneumonia available at the PHC? **NA**
p. Is the management of children suffering from diarrhea with severe dehydration done at the PHC? **NA**

Other functions and services performed (Yes/No)- **NA**

a. Nutrition services

b. School Health programmes
c. Promotion of safe water supply and basic sanitation.
d. Prevention and control of locally endemic diseases.
e. Disease surveillance and control of epidemics.
f. Collection and reporting of vital statistics.
g. Education about health/behaviour change communication.
h. National Health Programmes including HIV/AIDS control programmes.
i. AYUSH services as per local preference.
j. Rehabilitation services (please specify)

Monitoring and Supervision activities (Yes/No)

a. Monitoring and supervision of activities of Sub- Centres through regular meetings/periodic visits, etc. **Yes**
b. Monitoring of National Health Programmes **Yes**
c. Monitoring activities of ASHAs **Yes**
d. Visits of Medical Officer to all Sub-Centres at least once in a month. **Yes**
e. Visits of Health Assistants (Male) and LHV to Sub- Centres once a week. **Yes**
f. Timely payment of JSY beneficiaries. **NA**
g. Timely payment of TA/DA to ASHAs **NA**

Manpower

Sl. No.	**Staff**	**Recommended**	**Current Availability at PHC (Indicate Numbers)**	**Remarks/Suggestions/ Identified Gaps**
1	Medical Officer- MBBS	**1**	1	Permanent
2	MO –AYUSH	**1**	1	Permanent
3	Accountant/Clerk	**1**	Nil	
4	Pharmacist	**1**	Nil	

5	Pharmacist AYUSH	**1**	Nil	
6	Nurse-midwife (Staff-Nurse)	**4**	1 Staff-Nurse	Contractual
7	Health workers (F)	**1**	Nil	
8	Health Asstt. (Male)	**1**	Nil	
9	Health Asstt. (Female)/LHV	**1**	Nil	
10	Health Educator	**1**	Nil	
11	Data entry cum computer operator	**1**	Nil	
12	Laboratory Technician	**1**	Nil	
13	Cold Chain & Vaccine Logistic Assistant	**1**	Nil	
14	Multi-skilled Group D worker	**2**	Nil	
15	Sanitary worker cum watchman	**1**	1	Permanent
	Total	**19**	4	

Training of personnel during previous (full) year

Sl. No.	**Available training for**	**Number trained**

1	Tradition birth attendants	Initial training for all categories received. Continuing on-the-job training. Training imparted at District Hospital periodically in the form of workshops.
2	Health Worker (Female)	
3	Health Worker (Male)	
4	Medical Officer	
5	Initial and periodic training of paramedics in treatment of minor ailments	
6	Training of ASHAs	
7	Periodic training of Doctors through Continuing Medical Education, conferences, skill development training etc. on emergency obstetric care, Training in FP services.-IUCD, Minilap and NSV, LSAS	
8	Training of Health Workers in antenatal care and skilled birth attendance	

Essential Laboratory Services

Sl. No.	Current Availability at PHC	Remarks/Suggestions/Identified Gaps
1	Routine urine, stool and blood tests	
2	Blood grouping	
3	Bleeding time, clotting time	
4	Diagnosis of RTI/STDs with wet mounting, grams stain etc.	

5	Sputum testing for TB	No Laboratory Technician available.
6	Blood smear examination for malaria parasite	
7	Rapid tests for pregnancy	
8	RPR test for Syphilis/yAWS surveillance (in high endemic area only)	
9	Rapid tests for HIV	
10	Others (specify)	

Any other Services if available e.g., ECG Physical Infrastructure (As per specifications)

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
1	Where is this PHC located? a. Within Village Locality **Yes** b. Far from village locality c. If far from locality specify in km	

2	Building a. Is a designated government building available for the PHC? (Yes/No) **Yes** b. If there is no designated government building, then where does the PHC located? Rented premises/Other government building/Any other specify **NA** c. Area of the building (Total area in Sq. mts.) **NA** d. What is the present stage of construction of the building Construction? Complete/Construction incomplete **Complete** e. Compound Wall/Fencing (1-All around; 2-Partial; 3-None) f. Condition of plaster on walls (1- Well plastered with plaster intact everywhere; 2- Plaster coming off in some places; 3- Plaster coming off in many places or no plaster) **1- Well plastered** g. Condition of floor (1- Floor in good condition; 2- Floor coming off in some places; 3- Floor coming off in many places or no proper flooring) **2- Floor coming off in some places** h. Whether the cleanliness is Good/Fair/Poor? (Observe) OPD- **Fair** | Wards- **Fair** | Toilets- **Fair** | Premises (Compound)- **Fair** i. Are any of the following close to the PHC? (Observe) (Yes/No) i. Garbage dump- **No** ii. Cattle shed- **No** iii. Stagnant pool- **No** iv. Pollution from industry- **No**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
	j. Is boundary wall with gate existing? (Yes/No)- **Yes**	
3	Location a. Whether located at an easily accessible area? (Yes/No) **Yes** b. Distance of PHC (in Kms.) from the farthest village in coverage area **8 kms** c. Travel time (in minutes) to reach the PHC from farthest village in coverage area **30 mins** d. Distance of PHC (in Kms.) from the CHC **NA** e. Distance of PHC (in Kms.) from District Hospital **70**	

	kms	
4	Prominent display boards regarding service availability in local language (Yes/No) **Yes**	
5	Registration counters (Yes/No) **No** a. Pharmacy for drug dispensing and drug storage (Yes/No) **No** b. Counter near entrance of PHC to obtain contraceptives, ORS packets, Vitamin A and Vaccination (Yes/No) **No**	
6	Separate public utilities for males and females (Yes/No) **Yes**	
7	Suggestion/complaint box (Yes/No) **No**	
8	OPD rooms/cubicles (Yes/No) (Give numbers) **Yes, 1**	
9	OPD rooms/cubicles (Yes/No) (Give numbers) each room (Yes/No) **Yes, 1**	
10	Family Welfare Clinic (Yes/No) **No**	
11	Waiting room for patients (Yes/No) **No**	
12	Emergency Room/Casualty (yes/No) **No**	
13	Separate wards for males and females (Yes/No) **No**	
14	No. of beds: Male No. of beds: Female	
15	**Total: 4**	

16	Operation Theatre (if exists) a. Operation Theatre available (Yes/No) **No** b. If operation theatre is present, are surgeries carried out in the operation theatre? Yes/No/Sometimes c. If operation theatre is present, but surgeries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/staff Lack of equipment/poor physical state of the operation theatre/No power supply in the operation theatre/Any other reason (specify) d. Operation Theatre used for obstetric/gynaecological purpose (Yes/No) e. Has OT enough space (Yes/No)	
17	Labour room a. Labour room available? (Yes/No) **No** b. If labour room is present, are deliveries carried out in the labour room? Yes/No/Sometimes	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
	c. If labour room is present but deliveries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/staff Poor condition of the labour room/No power supply in the labour room/Any other reason (specify) d. Is separate areas for septic and aseptic deliveries available? (Yes/No) e. Is Newborn care corner available (Yes/No)	

18	Laboratory a. Laboratory (Yes/No) **No** b. Are adequate equipment and chemicals available? (Yes/No) c. Is laboratory maintained in orderly manner? (Yes/No)	
19	Ancillary Rooms - Nurses rest room (Yes/No) **No**	
20	Water supply a. Source of water (1- Piped; 2- Bore well/hand pump/tube well; 3- Well; 4- Other (specify) **1- Piped** b. Whether overhead tank and pump exist (Yes/No) **Yes** c. If overhead tank exists whether its capacity sufficient? (Yes/No) **Yes** d. If pump exists whether it is in working condition? (Yes/No) **Yes**	
21	Sewerage Type of sewerage system (1- Soak pit; 2- Connected to Municipal Sewerage) **2- Municipality Sewerage**	
22	Waste disposal How the waste material is being disposed (please specify)? **Outsourced**	
23	Electricity a. Is there electric line in all parts of the PHC? (1- In all parts; 2- In some parts; 3- None) **1- all parts** b. Regular Power Supply (1- Continuous Power Supply; 2-Occasional power failure; 3- Power cuts in summer only; 4-Regular power cuts; 5- No power supply) **1- Continuous** c. Stand by facility (generator) available in working condition? (Yes/No) **Yes, inverter backup, no generator**	
24	Laundry facilities a. Laundry facility available(Yes/No) **Yes** b. If no, is it outsourced?	

25	Communication facilities a. Telephone (Yes/No) **No** b. Personal Computer (Yes/No) **No** c. NIC Terminal (Yes/No) **No** d. Email (Yes/No) **No** e. Is PHC accessible by i. Rail (Yes/No) **No** ii. All weather road (Yes/No) **Yes** iii. Others (Specify)	
26	Vehicles Vehicle (jeep/other vehicle) available? (Yes/No) **No**	
27	Office room (Yes/No) **Yes**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
28	Store room (Yes/No) **Yes**	
29	Kitchen (Yes/No) **No**	
30	Diet: a. Diet provided by hospital (Yes/No) **No** b. If no, how diet is provided to the indoor patients? **Outsourced**	
31	Residential facility for the staff with all amenities Medical Officer **No** Pharmacist **No** Nurses **No** Other Staff **No**	

32	Behavioral Aspects (Yes/No) **NA** a. How is the behaviour of the PHC staff with the patient? Courteous/Casual/indifferent/Insulting/derogatory b. Any fee for service is being charged from the users? (yes/ No). If yes, specify. c. Is there corruption in terms of charging extra money for any of the service provided? (yes/No) d. Is a receipt always given for the money charged at the PHC? (yes/No) e. Is there any incidence of any sexual advances, verbal or physical abuse, sexual harassment by the doctors or any other paramedical? (yes/No) f. Are woman patients interviewed in an environment that ensures privacy and dignity? (yes/No) g. Are examinations on woman patients conducted in presence of a woman attendant, and procedures conducted under conditions that ensure privacy? (yes/No) h. Do patients with chronic illnesses receive adequate care and drugs for the entire duration? (yes/No) i. If the health centre is unequipped to provide the services; how and where the patient is referred and how patients transported? j. Is there a publicly displayed mechanism; whereby a complaint/grievance can be registered? (yes/No) k. Is there an outbreak of any of the following diseases in the PHC area in the last three years? Malaria Measles Gastroenteritis Jaundice l. If yes, did the PHC staff responded immediately to stop the further spread of the epidemic m. Does the doctor do private practice during or after the duty hours? (yes/No) n. Are there instances where patients from particular social background? SC, ST, Dalits, minorities, villagers have faced derogatory or discriminatory behavior or service of poorer quality? (yes/No) o. Have patients with specific health problems (HIV/AIDS, leprosy) suffered discrimination in any form? (yes/No)	

Furniture

Sl. No.	**Item**	**Current Availability at PHC**	**Remarks**
1	Examination Table		

2	Delivery Table		
3	Footstep		
4	Bed Side Screen		
5	Stool for patients		
6	Arm board for adult & child		
7	I V stand		
8	Wheel chair		
9	Stretcher or trolley		
10	Oxygen trolley		
11	Height measuring stand	Available	
12	Iron bed		
13	Bed side locker		
14	Dressing trolley		
15	Mayo trolley		
16	Instrument cabinet		
17	Instrument trolley		
18	Bucket		
19	Attendant stool		

20	Instrument tray		
21	Chair		

22	Wooden table	Available	
23	Almirah		
24	Swab rack		
25	Mattress		
26	Pillows		
27	Waiting bench for patients/attendants		
28	Medicine cabinet		
29	Side rail		
30	Rack		
31	Bed side attendant chair		
32	Others		

FACILITY SURVEY FOR PHC DUDHOLA AS PER FORMAT OF IPHS

PHC Dudhola

Name of the State: **Haryana**

District: **Palwal**

Tehsil/Taluk/Block: **Palwal**

Location & Name of PHC: **PHC Dudhola**

Is the PHC providing 24 hours and 7 days delivery facilities: **Yes**

Date: **28/02/2020**

Identification

Services

Population covered (in numbers)

62,000

Type of PHC:

a. Type A- **Yes**
b. Type B

Number of beds available

6

a. Bed Occupancy Rate in the last 12 months
(1-less than 40%; 2 - 40-60%; 3 - More than 60%)- **40-60%**

Average daily OPD Attendance

Total: **120**

Assured Services available (Yes/No)

a. OPD Services- **Yes**
b. Emergency services (24 Hours)- **Yes**
c. Referral Services- **Yes**
d. In-patient Services- **Yes**

Treatment of specific cases (Yes/No)

a. Is the primary management of wounds done at the PHC? **Yes**
b. Is the primary management of fracture done at the PHC? **Yes**
c. Are minor surgeries like draining of abscess etc. done at the PHC? **Yes**
d. Is the primary management of cases of poisoning/ snake, insect or scorpion bite done at the PHC? **Yes**
e. Is the primary management of burns done at PHC? **Yes**

MCH Care including Family Welfare

Service availability (Yes/No)

a. Ante-natal care- **Yes**
b. Intranatal care (24 - hour delivery services both normal and assisted)- **Yes**
c. Post-natal care- **Yes**
d. New born Care- **Yes**
e. Child care including immunization- **NA**
f. Family Planning- **NA**
g. MTP- **NA**
h. Management of RTI/STI- **NA**
i. Facilities under Janani Suraksha yojana- **NA**

Availability of specific services (Yes/No)

a. Are antenatal clinics organized by the PHC regularly? **Yes**
b. Is the facility for normal delivery available in the PHC for 24 hours? **Yes**
c. Is the facility for tubectomy and vasectomy available at the PHC? **NA**
d. Is the facility for internal examination for gynaecological conditions available at the PHC?

NA

e. Is the treatment for gynecological disorders like leucorrhoea, menstrual disorders available at the PHC? **NA**
f. If women do not usually go to the PHC, then what is the reason behind it? **NA**
g. Is the facility for MTP (abortion) available at the PHC? **NA**
h. Is there any precondition for doing MTP such as enforced use of contraceptives after MTP or asking for husband's consent for MTP? **NA**
i. Do women have to pay for MTP? **NA**
j. Is treatment for anemia given to both pregnant as well as non-pregnant women? **NA**
k. Are the low birth weight babies managed at the PHC? **NA**
l. Is there a fixed immunization day? **NA**
m. Is BCG and Measles vaccine given regularly in the PHC? **NA**
n. How is the vaccine received at PHC and distributed to Sub-Centres? **NA**
o. Is the treatment of children with pneumonia available at the PHC? **NA**
p. Is the management of children suffering from diarrhea with severe dehydration done at the PHC? **NA**

Other functions and services performed (Yes/No)- **NA**

a. Nutrition services

b. School Health programmes
c. Promotion of safe water supply and basic sanitation.
d. Prevention and control of locally endemic diseases.
e. Disease surveillance and control of epidemics.
f. Collection and reporting of vital statistics.
g. Education about health/behaviour change communication.
h. National Health Programmes including HIV/AIDS control programmes.
i. AYUSH services as per local preference.
j. Rehabilitation services (please specify)

Monitoring and Supervision activities (Yes/No)

a. Monitoring and supervision of activities of Sub- Centres through regular meetings/periodic visits, etc. **Yes**
b. Monitoring of National Health Programmes **Yes**
c. Monitoring activities of ASHAs **Yes**
d. Visits of Medical Officer to all Sub-Centres at least once in a month. **Yes**
e. Visits of Health Assistants (Male) and LHV to Sub- Centres once a week. **Yes**
f. Timely payment of JSY beneficiaries. **NA**
g. Timely payment of TA/DA to ASHAs **NA**

Manpower

Sl. No.	**Staff**	**Recommended**	**Current Availability at PHC (Indicate Numbers)**	**Remarks/Suggestions/ Identified Gaps**
1	Medical Officer- MBBS	**1**	2	Permanent
2	MO –AYUSH	**1**	1	Permanent
3	Accountant/Clerk	**1**	1	Permanent
4	Pharmacist	**1**	1	Permanent

5	Pharmacist AYUSH	**1**	Nil	AYUSH MO dispenses himself
6	Nurse-midwife (Staff-Nurse)	**4**	3	Contractual
7	Health workers (F)	**1**	Nil	
8	Health Asstt. (Male)	**1**	Nil	
9	Health Asstt. (Female)/LHV	**1**	Nil	
10	Health Educator	**1**	Nil	
11	Data entry cum computer operator	**1**	1	Permanent
12	Laboratory Technician	**1**	1	Permanent
13	Cold Chain & Vaccine Logistic Assistant	**1**	Nil	
14	Multi-skilled Group D worker	**2**	1	Permanent
15	Sanitary worker cum watchman	**1**	1	Permanent
	Total	**19**	8	

Training of personnel during previous (full) year

Sl. No.	**Available training for**	**Number trained**

1	Tradition birth attendants	Initial training for all categories received. Continuing on-the-job training. Training imparted at District Hospital periodically in the form of workshops.
2	Health Worker (Female)	
3	Health Worker (Male)	
4	Medical Officer	
5	Initial and periodic training of paramedics in treatment of minor ailments	
6	Training of ASHAs	
7	Periodic training of Doctors through Continuing Medical Education, conferences, skill development training etc. on emergency obstetric care, Training in FP services.-IUCD, Minilap and NSV, LSAS	
8	Training of Health Workers in antenatal care and skilled birth attendance	

Essential Laboratory Services

Sl. No.	Current Availability at PHC	Remarks/Suggestions/Identified Gaps
1	Routine urine, stool and blood tests	
2	Blood grouping	
3	Bleeding time, clotting time	

4	Diagnosis of RTI/STDs with wet mounting, grams stain etc.	Available.
5	Sputum testing for TB	
6	Blood smear examination for malaria parasite	
7	Rapid tests for pregnancy	
8	RPR test for Syphilis/yAWS surveillance (in high endemic area only)	
9	Rapid tests for HIV	
10	Others (specify)	

Any other Services if available e.g., ECG Physical Infrastructure (As per specifications)

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
1	Where is this PHC located? a. Within Village Locality **Yes** b. Far from village locality c. If far from locality specify in km	

2	Building a. Is a designated government building available for the PHC? (Yes/No) **Yes** b. If there is no designated government building, then where does the PHC located? Rented premises/Other government building/Any other specify **NA** c. Area of the building (Total area in Sq. mts.) **NA** d. What is the present stage of construction of the building Construction? Complete/Construction incomplete **Complete** e. Compound Wall/Fencing (1-All around; 2-Partial; 3-None) f. Condition of plaster on walls (1- Well plastered with plaster intact everywhere; 2- Plaster coming off in some places; 3- Plaster coming off in many places or no plaster) **1- Well plastered** g. Condition of floor (1- Floor in good condition; 2- Floor coming off in some places; 3- Floor coming off in many places or no proper flooring) **2- Floor coming off in some places** h. Whether the cleanliness is Good/Fair/Poor? (Observe) OPD- **Fair** | Wards- **Fair** | Toilets- **Fair** | Premises (Compound)- **Fair** i. Are any of the following close to the PHC? (Observe) (Yes/No) i. Garbage dump- **Yes** ii. Cattle shed- **No** iii. Stagnant pool- **No** iv. Pollution from industry- **No**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
	j. Is boundary wall with gate existing? (Yes/No)- **Yes**	
3	Location a. Whether located at an easily accessible area? (Yes/No) **Yes** b. Distance of PHC (in Kms.) from the farthest village in coverage area **16 kms** c. Travel time (in minutes) to reach the PHC from farthest village in coverage area **60 mins** d. Distance of PHC (in Kms.) from the CHC **NA** e. Distance of PHC (in Kms.) from District Hospital **10**	

	kms	
4	Prominent display boards regarding service availability in local language (Yes/No) **Yes**	
5	Registration counters (Yes/No) **Yes** a. Pharmacy for drug dispensing and drug storage (Yes/No) **Yes** b. Counter near entrance of PHC to obtain contraceptives, ORS packets, Vitamin A and Vaccination (Yes/No) **No**	
6	Separate public utilities for males and females (Yes/No) **Yes**	
7	Suggestion/complaint box (Yes/No) **No**	
8	OPD rooms/cubicles (Yes/No) (Give numbers) **Yes, 3**	
9	OPD rooms/cubicles (Yes/No) (Give numbers) each room (Yes/No) **Yes, 3**	
10	Family Welfare Clinic (Yes/No) **No**	
11	Waiting room for patients (Yes/No) **No**	
12	Emergency Room/Casualty (yes/No) **No**	
13	Separate wards for males and females (Yes/No) **Yes**	
14	No. of beds: Male **2** No. of beds: Female **4**	
15	**Total: 6**	

16	Operation Theatre (if exists) a. Operation Theatre available (Yes/No) **Yes** b. If operation theatre is present, are surgeries carried out in the operation theatre? Yes/No/Sometimes **No** c. If operation theatre is present, but surgeries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/staff Lack of equipment/poor physical state of the operation theatre/No power supply in the operation theatre/Any other reason (specify) **Non-availability of doctors/staff** d. Operation Theatre used for obstetric/gynaecological purpose (Yes/No) **No** e. Has OT enough space (Yes/No) **Yes**	
17	Labour room a. Labour room available? (Yes/No) **Yes** b. If labour room is present, are deliveries carried out in the labour room? Yes/No/Sometimes **Yes**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
	c. If labour room is present but deliveries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/staff Poor condition of the labour room/No power supply in the labour room/Any other reason (specify) **NA** d. Is separate areas for septic and aseptic deliveries available? (Yes/No) **No** e. Is Newborn care corner available (Yes/No) **Yes**	
18	Laboratory a. Laboratory (Yes/No) **Yes** b. Are adequate equipment and chemicals available? (Yes/No) **Yes** c. Is laboratory maintained in orderly manner? (Yes/No)	Fair maintainance

	Yes	
19	Ancillary Rooms - Nurses rest room (Yes/No) **Yes**	
20	Water supply a. Source of water (1- Piped; 2- Bore well/hand pump/tube well; 3- Well; 4- Other (specify) **1- Piped** b. Whether overhead tank and pump exist (Yes/No) **Yes** c. If overhead tank exists whether its capacity sufficient? (Yes/No) **Yes** d. If pump exists whether it is in working condition? (Yes/No) **Yes**	
21	Sewerage Type of sewerage system (1- Soak pit; 2- Connected to Municipal Sewerage) **2- Municipal Sewerage**	
22	Waste disposal How the waste material is being disposed (please specify)? **Outsourced**	
23	Electricity a. Is there electric line in all parts of the PHC? (1- In all parts; 2- In some parts; 3- None) **1- all parts** b. Regular Power Supply (1- Continuous Power Supply; 2-Occasional power failure; 3- Power cuts in summer only; 4-Regular power cuts; 5- No power supply) **1- Continuous** c. Stand by facility (generator) available in working condition? (Yes/No) **Yes, inverter backup, no generator**	
24	Laundry facilities a. Laundry facility available(Yes/No) **Yes** b. If no, is it outsourced?	

25	Communication facilities a. Telephone (Yes/No) **No** b. Personal Computer (Yes/No) **Yes** c. NIC Terminal (Yes/No) **No** d. Email (Yes/No) **Yes** e. Is PHC accessible by i. Rail (Yes/No) **No** ii. All weather road (Yes/No) **Yes** iii. Others (Specify)	
26	Vehicles Vehicle (jeep/other vehicle) available? (Yes/No) **Yes, jeep**	
27	Office room (Yes/No) **Yes**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
28	Store room (Yes/No) **Yes**	
29	Kitchen (Yes/No) **No**	
30	Diet: a. Diet provided by hospital (Yes/No) **No** b. If no, how diet is provided to the indoor patients? **Outsourced**	
31	Residential facility for the staff with all amenities Medical Officer **NA** Pharmacist **NA** Nurses **NA** Other Staff **NA**	

32	Behavioral Aspects (Yes/No) **NA** a. How is the behaviour of the PHC staff with the patient? Courteous/Casual/indifferent/Insulting/derogatory b. Any fee for service is being charged from the users? (yes/ No). If yes, specify. c. Is there corruption in terms of charging extra money for any of the service provided? (yes/No) d. Is a receipt always given for the money charged at the PHC? (yes/No) e. Is there any incidence of any sexual advances, verbal or physical abuse, sexual harassment by the doctors or any other paramedical? (yes/No) f. Are woman patients interviewed in an environment that ensures privacy and dignity? (yes/No) g. Are examinations on woman patients conducted in presence of a woman attendant, and procedures conducted under conditions that ensure privacy? (yes/No) h. Do patients with chronic illnesses receive adequate care and drugs for the entire duration? (yes/No) i. If the health centre is unequipped to provide the services; how and where the patient is referred and how patients transported? j. Is there a publicly displayed mechanism; whereby a complaint/grievance can be registered? (yes/No) k. Is there an outbreak of any of the following diseases in the PHC area in the last three years? Malaria Measles Gastroenteritis Jaundice l. If yes, did the PHC staff responded immediately to stop the further spread of the epidemic m. Does the doctor do private practice during or after the duty hours? (yes/No) n. Are there instances where patients from particular social background? SC, ST, Dalits, minorities, villagers have faced derogatory or discriminatory behavior or service of poorer quality? (yes/No) o. Have patients with specific health problems (HIV/AIDS, leprosy) suffered discrimination in any form? (yes/No)	

Furniture

Sl. No.	**Item**	**Current Availability at PHC**	**Remarks**
1	Examination Table		

2	Delivery Table		
3	Footstep		
4	Bed Side Screen		
5	Stool for patients		
6	Arm board for adult & child		
7	I V stand		
8	Wheel chair		
9	Stretcher or trolley		
10	Oxygen trolley		
11	Height measuring stand	Available	
12	Iron bed		
13	Bed side locker		
14	Dressing trolley		
15	Mayo trolley		
16	Instrument cabinet		
17	Instrument trolley		
18	Bucket		
19	Attendant stool		

20	Instrument tray		
21	Chair		

22	Wooden table	Availabale	
23	Almirah		
24	Swab rack		
25	Mattress		
26	Pillows		
27	Waiting bench for patients/attendants		
28	Medicine cabinet		
29	Side rail		
30	Rack		
31	Bed side attendant chair		
32	Others		

FACILITY SURVEY FOR PHC ALLIKA AS PER FORMAT OF IPHS

PHC Allika

Name of the State: **Haryana**

District: **Palwal**

Tehsil/Taluk/Block: **Palwal**

Location & Name of PHC: **PHC Allika**

Is the PHC providing 24 hours and 7 days delivery facilities: **Yes**

Date: **28/02/2020**

Identification

Services

Population covered (in numbers)

49,700

Type of PHC:

a. Type A- **Yes**

b. Type B

Number of beds available

6`

a. Bed Occupancy Rate in the last 12 months
(1-less than 40%; 2 - 40-60%; 3 - More than 60%)- **<40%**

Average daily OPD Attendance

Total: **160**

Assured Services available (Yes/No)

a. OPD Services- **Yes**
b. Emergency services (24 Hours)- **Yes**
c. Referral Services- **Yes**
d. In-patient Services- **Yes**

Treatment of specific cases (Yes/No)

a. Is the primary management of wounds done at the PHC? **Yes**
b. Is the primary management of fracture done at the PHC? **Yes**
c. Are minor surgeries like draining of abscess etc. done at the PHC? **Yes**
d. Is the primary management of cases of poisoning/ snake, insect or scorpion bite done at the PHC? **Yes**
e. Is the primary management of burns done at PHC? **Yes**

MCH Care including Family Welfare

Service availability (Yes/No)

a. Ante-natal care- **Yes**
b. Intranatal care (24 - hour delivery services both normal and assisted)- **Yes**
c. Post-natal care- **Yes**
d. New born Care- **Yes**
e. Child care including immunization- **NA**
f. Family Planning- **NA**
g. MTP- **NA**
h. Management of RTI/STI- **NA**
i. Facilities under Janani Suraksha yojana- **NA**

Availability of specific services (Yes/No)

a. Are antenatal clinics organized by the PHC regularly? **Yes**
b. Is the facility for normal delivery available in the PHC for 24 hours? **Yes**
c. Is the facility for tubectomy and vasectomy available at the PHC? **NA**
d. Is the facility for internal examination for gynaecological conditions available at the PHC?

NA

e. Is the treatment for gynecological disorders like leucorrhoea, menstrual disorders available at the PHC? **NA**
f. If women do not usually go to the PHC, then what is the reason behind it? **NA**
g. Is the facility for MTP (abortion) available at the PHC? **NA**
h. Is there any precondition for doing MTP such as enforced use of contraceptives after MTP or asking for husband's consent for MTP? **NA**
i. Do women have to pay for MTP? **NA**
j. Is treatment for anemia given to both pregnant as well as non-pregnant women? **NA**

k. Are the low birth weight babies managed at the PHC? **NA**
l. Is there a fixed immunization day? **NA**
m. Is BCG and Measles vaccine given regularly in the PHC? **NA**
n. How is the vaccine received at PHC and distributed to Sub-Centres? **NA**
o. Is the treatment of children with pneumonia available at the PHC? **NA**
p. Is the management of children suffering from diarrhea with severe dehydration done at the PHC? **NA**

Other functions and services performed (Yes/No)- **NA**

a. Nutrition services
b. School Health programmes
c. Promotion of safe water supply and basic sanitation.
d. Prevention and control of locally endemic diseases.
e. Disease surveillance and control of epidemics.
f. Collection and reporting of vital statistics.
g. Education about health/behaviour change communication.
h. National Health Programmes including HIV/AIDS control programmes.
i. AYUSH services as per local preference.
j. Rehabilitation services (please specify)

Monitoring and Supervision activities (Yes/No)

a. Monitoring and supervision of activities of Sub- Centres through regular meetings/periodic visits, etc. **Yes**

b. Monitoring of National Health Programmes **Yes**

c. Monitoring activities of ASHAs **Yes**

d. Visits of Medical Officer to all Sub-Centres at least once in a month. **Yes**

e. Visits of Health Assistants (Male) and LHV to Sub- Centres once a week. **Yes**

f. Timely payment of JSY beneficiaries. **NA**

g. Timely payment of TA/DA to ASHAs **NA**

Manpower

Sl. No.	**Staff**	**Recommended**	**Current Availability at PHC (Indicate Numbers)**	**Remarks/Suggestions/ Identified Gaps**
1	Medical Officer- MBBS	**1**	2	Permanent
2	MO –AYUSH	**1**	1	Permanent
3	Accountant/Clerk	**1**	1	Permanent
4	Pharmacist	**1**	1	Contractual
5	Pharmacist AYUSH	**1**	Nil	AYUSH MO dispenses himself
6	Nurse-midwife (Staff-Nurse)	**4**	3	Contractual
7	Health workers (F)	**1**	1	Permanent
8	Health Asstt. (Male)	**1**	Nil	

9	Health Asstt. (Female)/LHV	**1**	Nil	
10	Health Educator	**1**	Nil	
11	Data entry cum computer operator	**1**	Nil	
12	Laboratory Technician	**1**	1	Permanent
13	Cold Chain & Vaccine Logistic Assistant	**1**	Nil	
14	Multi-skilled Group D worker	**2**	2	Permanent
15	Sanitary worker cum watchman	**1**	1	Permanent
	Total	**19**	13	

Training of personnel during previous (full) year

Sl. No.	**Available training for**	**Number trained**
1	Tradition birth attendants	Initial training for all categories received. Continuing on-the-job training.
2	Health Worker (Female)	
3	Health Worker (Male)	
4	Medical Officer	
5	Initial and periodic training of paramedics in treatment of minor ailments	
6	Training of ASHAs	

7	Periodic training of Doctors through Continuing Medical Education, conferences, skill development training etc. on emergency obstetric care, Training in FP services. - IUCD, Minilap and NSV, LSAS	Training imparted at District Hospital periodically in the form of workshops.
8	Training of Health Workers in antenatal care and skilled birth attendance	

Essential Laboratory Services

Sl. No.	Current Availability at PHC	Remarks/Suggestions/Identified Gaps
1	Routine urine, stool and blood tests	Available
2	Blood grouping	
3	Bleeding time, clotting time	
4	Diagnosis of RTI/STDs with wet mounting, grams stain etc.	
5	Sputum testing for TB	
6	Blood smear examination for malaria parasite	
7	Rapid tests for pregnancy	

8	RPR test for Syphilis/yAWS surveillance (in high endemic area only)	
9	Rapid tests for HIV	
10	Others (specify)	

Any other Services if available e.g., ECG Physical Infrastructure (As per specifications)

Sl. No.	Current Availability at PHC	Remarks/Suggestions/ Identified Gaps
1	Where is this PHC located? Within Village Locality **Yes** Far from village locality If far from locality specify in km	

2	Building Is a designated government building available for the PHC? (Yes/No) **Yes** If there is no designated government building, then where does the PHC located? Rented premises/Other government building/Any other specify **NA** Area of the building (Total area in Sq. mts.) **NA** What is the present stage of construction of the building Construction? Complete/Construction incomplete **Complete** Compound Wall/Fencing (1-All around; 2-Partial; 3-None) Condition of plaster on walls (1- Well plastered with plaster intact everywhere; 2- Plaster coming off in some places; 3- Plaster coming off in many places or no plaster) **1- Well plastered** Condition of floor (1- Floor in good condition; 2- Floor coming off in some places; 3- Floor coming off in many places or no proper flooring) **2- Floor coming off in some places** Whether the cleanliness is Good/Fair/Poor? (Observe) OPD- **Fair** | Wards- **Fair** | Toilets- **Fair** | Premises (Compound)- **Fair** a. Are any of the following close to the PHC? (Observe) (Yes/No) i. Garbage dump- **No** ii. Cattle shed- **No** iii. Stagnant pool- **No** iv. Pollution from industry- **No**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
	Is boundary wall with gate existing? (Yes/No)- **Yes**	
3	Location Whether located at an easily accessible area? (Yes/No) **Yes** Distance of PHC (in Kms.) from the farthest village in coverage area **14 kms** Travel time (in minutes) to reach the PHC from farthest village in coverage area **45 mins** Distance of PHC (in Kms.) from the CHC **NA** Distance of PHC (in Kms.) from District Hospital **12 kms**	

4	Prominent display boards regarding service availability in local language (Yes/No) **Yes**	
5	Registration counters (Yes/No) **Yes** Pharmacy for drug dispensing and drug storage (Yes/No) **Yes** Counter near entrance of PHC to obtain contraceptives, ORS packets, Vitamin A and Vaccination (Yes/No) **Yes**	
6	Separate public utilities for males and females (Yes/No) **Yes**	
7	Suggestion/complaint box (Yes/No) **Yes**	
8	OPD rooms/cubicles (Yes/No) (Give numbers) **Yes, 3**	
9	OPD rooms/cubicles (Yes/No) (Give numbers) each room (Yes/No) **Yes, 3**	
10	Family Welfare Clinic (Yes/No) **No**	
11	Waiting room for patients (Yes/No) **Yes**	
12	Emergency Room/Casualty (Yes/No) **Yes**	
13	Separate wards for males and females (Yes/No) **Yes**	
14	No. of beds: Male **2** No. of beds: Female **4**	
15	**Total: 6**	

16	Operation Theatre (if exists) Operation Theatre available (Yes/No) **No** If operation theatre is present, are surgeries carried out in the operation theatre? Yes/No/Sometimes If operation theatre is present, but surgeries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/staff Lack of equipment/poor physical state of the operation theatre/No power supply in the operation theatre/Any other reason (specify) Operation Theatre used for obstetric/gynaecological purpose (Yes/No) Has OT enough space (Yes/No)	
17	Labour room Labour room available? (Yes/No) **Yes** If labour room is present, are deliveries carried out in the labour room? Yes/No/Sometimes **Yes**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
	If labour room is present but deliveries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/staff Poor condition of the labour room/No power supply in the labour room/Any other reason (specify) **NA** Is separate areas for septic and aseptic deliveries available? (Yes/No) **No** Is Newborn care corner available (Yes/No) **Yes**	
18	Laboratory Laboratory (Yes/No) **Yes** Are adequate equipment and chemicals available? (Yes/No) **Yes** Is laboratory maintained in orderly manner? (Yes/No) **Yes**	Good maintainance

19	Ancillary Rooms - Nurses rest room (Yes/No) **Yes**	
20	Water supply Source of water (1- Piped; 2- Bore well/hand pump/tube well; 3- Well; 4- Other (specify) **1- Piped** Whether overhead tank and pump exist (Yes/No) **Yes** If overhead tank exists whether its capacity sufficient? (Yes/No) **Yes** If pump exists whether it is in working condition? (Yes/No) **Yes**	
21	Sewerage Type of sewerage system (1- Soak pit; 2- Connected to Municipal Sewerage) **2- Municipal Sewerage**	
22	Waste disposal How the waste material is being disposed (please specify)? **Outsourced**	
23	Electricity Is there electric line in all parts of the PHC? (1- In all parts; 2- In some parts; 3- None) **1- all parts** Regular Power Supply (1- Continuous Power Supply; 2- Occasional power failure; 3- Power cuts in summer only; 4- Regular power cuts; 5- No power supply) **1-Continuous** Stand by facility (generator) available in working condition? (Yes/No) **Yes, inverter backup, no generator**	
24	Laundry facilities Laundry facility available(Yes/No) **Yes** If no, is it outsourced?	
25	Communication facilities Telephone (Yes/No) **Yes** Personal Computer (Yes/No) **Yes** NIC Terminal (Yes/No) **No** Email (Yes/No) **Yes** Is PHC accessible by Rail (Yes/No) **No** All weather road (Yes/No) **Yes** Others (Specify)	
26	Vehicles Vehicle (jeep/other vehicle) available? (Yes/No) **Yes, jeep**	

27	Office room (Yes/No) **Yes**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
28	Store room (Yes/No) **Yes**	
29	Kitchen (Yes/No) **Yes**	
30	Diet: Diet provided by hospital (Yes/No) **Yes** If no, how diet is provided to the indoor patients?	
31	Residential facility for the staff with all amenities Medical Officer **NA** Pharmacist **NA** Nurses **NA** Other Staff **NA**	

32	Behavioral Aspects (Yes/No) **NA** a. How is the behaviour of the PHC staff with the patient? Courteous/Casual/indifferent/Insulting/derogatory Any fee for service is being charged from the users? (yes/ No). If yes, specify. Is there corruption in terms of charging extra money for any of the service provided? (yes/No) Is a receipt always given for the money charged at the PHC? (yes/No) Is there any incidence of any sexual advances, verbal or physical abuse, sexual harassment by the doctors or any other paramedical? (yes/No) Are woman patients interviewed in an environment that ensures privacy and dignity? (yes/No) Are examinations on woman patients conducted in presence of a woman attendant, and procedures conducted under conditions that ensure privacy? (yes/No) Do patients with chronic illnesses receive adequate care and drugs for the entire duration? (yes/No) If the health centre is unequipped to provide the services; how and where the patient is referred and how patients transported? Is there a publicly displayed mechanism; whereby a complaint/grievance can be registered? (yes/No) Is there an outbreak of any of the following diseases in the PHC area in the last three years? Malaria Measles Gastroenteritis Jaundice If yes, did the PHC staff responded immediately to stop the further spread of the epidemic Does the doctor do private practice during or after the duty hours? (yes/No) Are there instances where patients from particular social background? SC, ST, Dalits, minorities, villagers have faced derogatory or discriminatory behavior or service of poorer quality? (yes/No) Have patients with specific health problems (HIV/AIDS, leprosy) suffered discrimination in any form? (yes/No)	

Furniture

Sl. No.	**Item**	**Current Availability at PHC**	**Remarks**
1	Examination Table		

2	Delivery Table		
3	Footstep		
4	Bed Side Screen		
5	Stool for patients		
6	Arm board for adult & child		
7	I V stand		
8	Wheel chair		
9	Stretcher or trolley		
10	Oxygen trolley		
11	Height measuring stand	Available	
12	Iron bed		
13	Bed side locker		
14	Dressing trolley		
15	Mayo trolley		
16	Instrument cabinet		
17	Instrument trolley		
18	Bucket		
19	Attendant stool		

20	Instrument tray		
21	Chair		

22	Wooden table	Available	
23	Almirah		
24	Swab rack		
25	Mattress		
26	Pillows		
27	Waiting bench for patients/attendants		
28	Medicine cabinet		
29	Side rail		
30	Rack		
31	Bed side attendant chair		
32	Others		

FACILITY SURVEY FOR PHC AMARPUR AS PER FORMAT OF IPHS

PHC Amarpur

Name of the State: **Haryana**

District: **Palwal**

Tehsil/Taluk/Block: **Palwal**

Location & Name of PHC: **PHC Amarpur**

Is the PHC providing 24 hours and 7 days delivery facilities: **Yes**

Date: **28/02/2020**

Identification

Services

Population covered (in numbers)

26,707

Type of PHC:

a. Type A- **Yes**

b. Type B

Number of beds available

6

a. Bed Occupancy Rate in the last 12 months
(1-less than 40%; 2 - 40-60%; 3 - More than 60%)- **<40%**

Average daily OPD Attendance
Total: **114**

Assured Services available (Yes/No)

a. OPD Services- **Yes**
b. Emergency services (24 Hours)- **Yes**
c. Referral Services- **Yes**
d. In-patient Services- **Yes**

Treatment of specific cases (Yes/No)

a. Is the primary management of wounds done at the PHC? **Yes**
b. Is the primary management of fracture done at the PHC? **Yes**
c. Are minor surgeries like draining of abscess etc. done at the PHC? **Yes**
d. Is the primary management of cases of poisoning/ snake, insect or scorpion bite done at the PHC? **Yes**
e. Is the primary management of burns done at PHC? **Yes**

MCH Care including Family Welfare

Service availability (Yes/No)

a. Ante-natal care- **Yes**
b. Intranatal care (24 - hour delivery services both normal and assisted)- **Yes**
c. Post-natal care- **Yes**
d. New born Care- **Yes**
e. Child care including immunization- **NA**
f. Family Planning- **NA**
g. MTP- **NA**
h. Management of RTI/STI- **NA**
i. Facilities under Janani Suraksha yojana- **NA**

Availability of specific services (Yes/No)

a. Are antenatal clinics organized by the PHC regularly? **Yes**
b. Is the facility for normal delivery available in the PHC for 24 hours? **Yes**
c. Is the facility for tubectomy and vasectomy available at the PHC? **NA**
d. Is the facility for internal examination for gynaecological conditions available at the PHC?

NA

e. Is the treatment for gynecological disorders like leucorrhoea, menstrual disorders available at the PHC? **NA**
f. If women do not usually go to the PHC, then what is the reason behind it? **NA**
g. Is the facility for MTP (abortion) available at the PHC? **NA**
h. Is there any precondition for doing MTP such as enforced use of contraceptives after MTP or asking for husband's consent for MTP? **NA**
i. Do women have to pay for MTP? **NA**
j. Is treatment for anemia given to both pregnant as well as non-pregnant women? **NA**

k. Are the low birth weight babies managed at the PHC? **NA**
l. Is there a fixed immunization day? **NA**
m. Is BCG and Measles vaccine given regularly in the PHC? **NA**
n. How is the vaccine received at PHC and distributed to Sub-Centres? **NA**
o. Is the treatment of children with pneumonia available at the PHC? **NA**
p. Is the management of children suffering from diarrhea with severe dehydration done at the PHC? **NA**

Other functions and services performed (Yes/No)- **NA**

a. Nutrition services
b. School Health programmes
c. Promotion of safe water supply and basic sanitation.
d. Prevention and control of locally endemic diseases.
e. Disease surveillance and control of epidemics.
f. Collection and reporting of vital statistics.
g. Education about health/behaviour change communication.
h. National Health Programmes including HIV/AIDS control programmes.
i. AYUSH services as per local preference.
j. Rehabilitation services (please specify)

Monitoring and Supervision activities (Yes/No)

a. Monitoring and supervision of activities of Sub- Centres through regular meetings/periodic visits, etc. **Yes**
b. Monitoring of National Health Programmes **Yes**
c. Monitoring activities of ASHAs **Yes**
d. Visits of Medical Officer to all Sub-Centres at least once in a month. **Yes**
e. Visits of Health Assistants (Male) and LHV to Sub- Centres once a week. **Yes**
f. Timely payment of JSY beneficiaries. **NA**
g. Timely payment of TA/DA to ASHAs **NA**

Manpower

Sl. No.	**Staff**	**Recommended**	**Current Availability at PHC (Indicate Numbers)**	**Remarks/Suggestions / Identified Gaps**
1	Medical Officer- MBBS	**1**	1+1	Permanent Lady MO +1 Dental surgeon
2	MO –AYUSH	**1**	1	Permanent
3	Accountant/Clerk	**1**	Nil	
4	Pharmacist	**1**	Nil	

5	Pharmacist AYUSH	**1**	Nil	AYUSH MO dispenses himself
6	Nurse-midwife (Staff-Nurse)	**4**	2+3	01 Contractual, 01 Permanent ANM + 3 Staff Nurse
7	Health workers (F)	**1**	Nil	
8	Health Asstt. (Male)	**1**	1	Permanent
9	Health Asstt. (Female)/LHV	**1**	1	Permanent
10	Health Educator	**1**	Nil	
11	Data entry cum computer operator	**1**	1	Permanent
12	Laboratory Technician	**1**	1	Contractual
13	Cold Chain & Vaccine Logistic Assistant	**1**	Nil	
14	Multi-skilled Group D worker	**2**	2	Permanent
15	Sanitary worker cum watchman	**1**	1+1	Permanent
	Total	**19**	16	

Training of personnel during previous (full) year

Sl. No.	**Available training for**	**Number trained**

1	Tradition birth attendants	Initial training for all categories received. Continuing on-the-job training. Training imparted at District Hospital periodically in the form of workshops.
2	Health Worker (Female)	
3	Health Worker (Male)	
4	Medical Officer	
5	Initial and periodic training of paramedics in treatment of minor ailments	
6	Training of ASHAs	
7	Periodic training of Doctors through Continuing Medical Education, conferences, skill development training etc. on emergency obstetric care, Training in FP services.-IUCD, Minilap and NSV, LSAS	
8	Training of Health Workers in antenatal care and skilled birth attendance	

Essential Laboratory Services

Sl. No.	Current Availability at PHC	Remarks/Suggestions/Identified Gaps
1	Routine urine, stool and blood tests	Available.
2	Blood grouping	
3	Bleeding time, clotting time	
4	Diagnosis of RTI/STDs with wet mounting, grams stain etc.	
5	Sputum testing for TB	
6	Blood smear examination for malaria parasite	
7	Rapid tests for pregnancy	
8	RPR test for Syphilis/yAWS surveillance (in high endemic area only)	
9	Rapid tests for HIV	
10	Others (specify)	

Any other Services if available e.g., ECG Physical Infrastructure (As per specifications)

Sl. No.	Current Availability at PHC	Remarks/Suggestions/ Identified Gaps
1	Where is this PHC located? a. Within Village Locality **Yes** b. Far from village locality c. If far from locality specify in km	

2	Building a. Is a designated government building available for the PHC? (Yes/No) **Yes** b. If there is no designated government building, then where does the PHC located? Rented premises/Other government building/Any other specify **NA** c. Area of the building (Total area in Sq. mts.) **NA** d. What is the present stage of construction of the building Construction? Complete/Construction incomplete **Complete** e. Compound Wall/Fencing (1-All around; 2-Partial; 3-None) f. Condition of plaster on walls (1- Well plastered with plaster intact everywhere; 2- Plaster coming off in some places; 3- Plaster coming off in many places or no plaster) **1- Well plastered** g. Condition of floor (1- Floor in good condition; 2- Floor coming off in some places; 3- Floor coming off in many places or no proper flooring) **2- Floor coming off in some places** h. Whether the cleanliness is Good/Fair/Poor? (Observe) OPD- **Fair** **|** Wards- **Fair** **|** Toilets- **Fair** **|** Premises (Compound)- **Fair** i. Are any of the following close to the PHC? (Observe) (Yes/No) i. Garbage dump- **No** ii. Cattle shed- **No** iii. Stagnant pool- **No** iv. Pollution from industry- **No**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
	j. Is boundary wall with gate existing? (Yes/No)- **Yes**	
3	Location a. Whether located at an easily accessible area? (Yes/No) **Yes** b. Distance of PHC (in Kms.) from the farthest village in coverage area **10 kms** c. Travel time (in minutes) to reach the PHC from farthest village in coverage area **20 mins** d. Distance of PHC (in Kms.) from the CHC **NA** e. Distance of PHC (in Kms.) from District Hospital **12 kms**	

4	Prominent display boards regarding service availability in local language (Yes/No) **Yes**	
5	Registration counters (Yes/No) **Yes** a. Pharmacy for drug dispensing and drug storage (Yes/No) **Yes** b. Counter near entrance of PHC to obtain contraceptives, ORS packets, Vitamin A and Vaccination (Yes/No) **Yes**	
6	Separate public utilities for males and females (Yes/No) **Yes**	
7	Suggestion/complaint box (Yes/No) **Yes**	
8	OPD rooms/cubicles (Yes/No) (Give numbers) **Yes, 3**	Including Dental OPD
9	OPD rooms/cubicles (Yes/No) (Give numbers) each room (Yes/No) **Yes, 3**	
10	Family Welfare Clinic (Yes/No) **No**	
11	Waiting room for patients (Yes/No) **Yes**	
12	Emergency Room/Casualty (yes/No) **No**	
13	Separate wards for males and females (Yes/No) **Yes**	
14	No. of beds: Male **2** No. of beds: Female **4**	
15	**Total: 6**	

16	Operation Theatre (if exists) a. Operation Theatre available (Yes/No) **No** b. If operation theatre is present, are surgeries carried out in the operation theatre? Yes/No/Sometimes c. If operation theatre is present, but surgeries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/staff Lack of equipment/poor physical state of the operation theatre/No power supply in the operation theatre/Any other reason (specify) d. Operation Theatre used for obstetric/gynaecological purpose (Yes/No) e. Has OT enough space (Yes/No)	
17	Labour room a. Labour room available? (Yes/No) **Yes** b. If labour room is present, are deliveries carried out in the labour room? Yes/No/Sometimes **Yes**	

Sl. No.	**Current Availability at PHC**	**Remarks/Suggestions/ Identified Gaps**
	If labour room is present but deliveries are not being conducted there, then what are the reasons for the same? Non-availability of doctors/staff Poor condition of the labour room/No power supply in the labour room/Any other reason (specify) **NA** Is separate areas for septic and aseptic deliveries available? (Yes/No) **No** Is Newborn care corner available (Yes/No) **Yes**	
18	Laboratory Laboratory (Yes/No) **Yes** Are adequate equipment and chemicals available? (Yes/No) **Yes** Is laboratory maintained in orderly manner? (Yes/No) **Yes**	Fair maintainance
19	Ancillary Rooms - Nurses rest room (Yes/No) **Yes**	

20	Water supply Source of water (1- Piped; 2- Bore well/hand pump/tube well; 3- Well; 4- Other (specify) **1- Piped** Whether overhead tank and pump exist (Yes/No) **Yes** If overhead tank exists whether its capacity sufficient? (Yes/No) **Yes** If pump exists whether it is in working condition? (Yes/No) **Yes**	
21	Sewerage Type of sewerage system (1- Soak pit; 2- Connected to Municipal Sewerage) **2- Municipal Sewerage**	
22	Waste disposal How the waste material is being disposed (please specify)?	
23	Electricity Is there electric line in all parts of the PHC? (1- In all parts; 2- In some parts; 3- None) **1- all parts** Regular Power Supply (1- Continuous Power Supply; 2- Occasional power failure; 3- Power cuts in summer only; 4-Regular power cuts; 5- No power supply) **1-Continuous** Stand by facility (generator) available in working condition? (Yes/No) **Yes, inverter backup, no generator**	
24	Laundry facilities a. Laundry facility available(Yes/No) **Yes** b. If no, is it outsourced?	
25	Communication facilities Telephone (Yes/No) **Yes** Personal Computer (Yes/No) **Yes** NIC Terminal (Yes/No) **No** Email (Yes/No) **Yes** Is PHC accessible by Rail (Yes/No) **No** All weather road (Yes/No) **Yes** Others (Specify)	
26	Vehicles Vehicle (jeep/other vehicle) available? (Yes/No) **No**	

27	Office room (Yes/No) **Yes**	

Sl. No.	Current Availability at PHC	Remarks/Suggestions/ Identified Gaps
28	Store room (Yes/No) **Yes**	
29	Kitchen (Yes/No) **Yes**	
30	Diet: Diet provided by hospital (Yes/No) **No** If no, how diet is provided to the indoor patients? **Outsourced**	
31	Residential facility for the staff with all amenities Medical Officer **NA** Pharmacist **NA** Nurses **NA** Other Staff **NA**	

32	Behavioral Aspects (Yes/No) **NA** a. How is the behaviour of the PHC staff with the patient? Courteous/Casual/indifferent/Insulting/derogatory Any fee for service is being charged from the users? (yes/ No). If yes, specify. Is there corruption in terms of charging extra money for any of the service provided? (yes/No) Is a receipt always given for the money charged at the PHC? (yes/No) Is there any incidence of any sexual advances, verbal or physical abuse, sexual harassment by the doctors or any other paramedical? (yes/No) Are woman patients interviewed in an environment that ensures privacy and dignity? (yes/No) Are examinations on woman patients conducted in presence of a woman attendant, and procedures conducted under conditions that ensure privacy? (yes/No) Do patients with chronic illnesses receive adequate care and drugs for the entire duration? (yes/No) If the health centre is unequipped to provide the services; how and where the patient is referred and how patients transported? Is there a publicly displayed mechanism; whereby a complaint/grievance can be registered? (yes/No) Is there an outbreak of any of the following diseases in the PHC area in the last three years? Malaria Measles Gastroenteritis Jaundice If yes, did the PHC staff responded immediately to stop the further spread of the epidemic Does the doctor do private practice during or after the duty hours? (yes/No) Are there instances where patients from particular social background? SC, ST, Dalits, minorities, villagers have faced derogatory or discriminatory behavior or service of poorer quality? (yes/No) Have patients with specific health problems (HIV/AIDS, leprosy) suffered discrimination in any form? (yes/No)	

Furniture

Sl. No.	Item	Current Availability at PHC	Remarks
1	Examination Table		

2	Delivery Table		
3	Footstep		
4	Bed Side Screen		
5	Stool for patients		
6	Arm board for adult & child		
7	I V stand		
8	Wheel chair		
9	Stretcher or trolley		
10	Oxygen trolley		
11	Height measuring stand	Available	
12	Iron bed		
13	Bed side locker		
14	Dressing trolley		
15	Mayo trolley		
16	Instrument cabinet		
17	Instrument trolley		
18	Bucket		
19	Attendant stool		

20	Instrument tray		
21	Chair		

22	Wooden table	Available	
23	Almirah		
24	Swab rack		
25	Mattress		
26	Pillows		
27	Waiting bench for patients/attendants		
28	Medicine cabinet		
29	Side rail		
30	Rack		
31	Bed side attendant chair		
32	Others		