RESEARCH ARTICLE

QUALITY ASSESSMENT OF FACILITIES AVAILABLE AT PRIMARY HEALTH CARE CENTRES IN RAJKOT DISTRICT: A CROSS SECTIONAL STUDY

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ABSTRACT
Background: Primary health care through the setup of sub centre and PHCs build up the base of the health of community. Primary health care includes not only the curative care for the diseases, but also the preventive, promotive and rehabilitative care to the specified population of the defined area.
Aims & Objectives: To assess the quality of facilities available at primary health care centres as per IPHS guidelines.
Materials and Methods: This is a cross-sectional study conducted in 14 PHCs randomly selected, 2 from 7 blocks of Rajkot district. Pretested close ended questionnaire was used.
Results: The facility was assessed according to IPHS guidelines. 50% PHCs was located within the village area and 28% was within 1 KM from village. Doctor, Nurse, lab-technician and Pharmacist is available in 92%, 57%, 100% and 100% PHCs respectively. Residential facility is available in 21% of PHCs. More than 85% of Doctors, staff nurses and health worker are trained for IMNCI and ANC services. All PHCs were providing all RCH services but none of the PHC was providing MTP services.
Conclusion: Incentives should be given to work at remote places and all the post of staff should be filled up as early as possible.
Key Words: Indian Public Health Standards (IPHS); Primary Health Care (PHC); Gujarat; Facilities; Services

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Introduction

After the recommendations by Bhore committee in 1946, the concept of the primary health care centre came in existence. After the recommendation of Bhore committee, many different committees have suggested many changes, but the concept of primary health care remains the same. India was committed to "Health for all by 2000 AD" through the strategy of the PHCs. Primary health care through the setup of sub centre and PHCs build up the base of the health of community. Primary health care does not include only the curative care for the diseases but also the preventive, promotive and rehabilitative care to the specified population of the defined area. The National Rural Health Mission (NRHM) was launched by the Hon'ble Prime Minister of India in the year of 2005 with the goal of improving the availability and accessibility of the quality health care to the people, especially for those residing in rural areas, the poor, and women.[1] Right now, the three tier system exists in all over country in India in rural area.[2] Coverage of large population by a PHC in large majority of the cases is indicative of the facts that adequate numbers of PHCs have not been established against their requirement – leading to deterioration of the quality and delivery of health care services, and it has also accentuated the problem of overcrowding in CHCs and district hospitals.[3] The sub centres are the first (lower most) tier of this system. The second one is primary health centre and the upper most is the community health centre. The establishment of the PHCs was started in India in 1952 after the recommendations of Bhore committee. After that, many changes had been made to fulfil the requirement and demand. NRHM is aiming towards the improvement of the quality of the services like preventive, promotive, curative and rehabilitative care through the strengthening of the PHC. One PHC is catering the population of 30,000 in rural plain areas and 20,000 in the hard to reach and tribal-hilly areas. To improve the quality of the care at PHCs, the NRHM has developed the standards called Indian Public Health Standard (IPHS) - following the launching of the National Rural Health Mission (NRHM) on 12th April2005.[6] Primary objective of the IPHS is to provide healthcare, which is quality oriented and sensitive to the need of community.[4]

PHCs were established with proper infrastructure and aimed to provide comprehensive quality health care to the defined rural population. After the establishment of the PHCs, many studies were carried out on the existence of infrastructure, manpower and essential drugs, suggesting lack of some or many of them. Taking these into consideration, the Ministry of the Health and Family

Welfare (MOHFW) had developed the IPHS standards under the NRHM, to monitor and evaluate the PHCs. The IPHS mainly focuses on manpower of PHC, infrastructure of PHC, essential drugs available at PHC and services provided by PHC. Adequate and essential supply of drugs, provision of 24×7 services in at least 50% of PHCs and immediately addressing the shortage of doctors are of paramount importance, if the PHCs have to be efficient, and to cater to the essential services for the people of rural areas and the vulnerable population.[2] Facility surveys are being conducted in different states to find the required numbers, and in turn, fill the gaps.[5] For continuous improvement in quality of care, standards are the main drive. Aim of this study was to assess the quality of facilities available at primary health care centres as per IPHS guidelines and to find out gap in delivering quality health care to community by PHCs.

Materials and Methods

This was the cross sectional study carried out in primary health care centres of Rajkot district in the August 2010 to May 2011. Multi stage sampling method was used. Rajkot District was consisting of 7 blocks and total 43 PHCs at the time of study. List of all the PHCs were obtained from the Jilla Panchayat, Rajkot. Then, from each block, total 2 PHCs were selected randomly by lottery method. Thus total 14 (2×7) PHCs were selected from Rajkot district.

Study Tool: For the quality assessment of the facilities at PHCs, the observational and interview methods were used. Check list was prepared as per the standard of the IPHS. The facilities available in the PHC were compared with IPHS standards.

Data Analysis: Data were collected and entered and analysed in the Microsoft Office Excel 2007.

Results

The most important factor affecting the provision of health services is the accessibility of health centre. 50% PHCs were located within the village area and 28% were within 1 KM from village. 92.8% PHCs were in designated government building. Signboard was available in 85% PHCs, but Only 42% PHCs had signboard available within premises showing important parts of PHC. 92% PHCs had RO system for drinking water. Separate toilet facility for ladies and gents was available in 42% PHCs. Locked suggestion and complain box was available in only 21% PHCs. Transport vehicle in working condition was available in 35% PHCs. All PHCs were providing OPD services, but emergency and inpatient services were available in 92% PHCs. Bed occupancy rate for last 12 months was less than 40% in 85% PHCs. All PHCs were providing all RCH services, but none of the PHC was providing MTP services. OPD, drug, immunization, temperature, ANC and family planning register were available, but all were poorly maintained. Scoring was given from very poor to very good for record maintenance. Only OPD and ANC register record was maintained as ‘good’. Operation theatre was not available in any PHC. Residential facility is available in 21% of PHCs. Different colour coded buckets for bio-medical waste management was available in 71% of PHCs. In 42.8% PHCs, instructions for waste disposal were displayed on wall above the buckets. According to drug register, all essential drugs were available in all PHCs.

Table-1: Training of Staff of PHCs (n=14)

Training status of Person	Antenatal Care	Skilled birth attendance	IMNCI	Newborn Care
Medical Officer	85.7%	57.1%	85.7%	57.1%
Health Worker	92.85%	57.1%	92.85%	50%
Staff Nurse	100%	71.42%	100%	50%
ANM	85.79%	57.1%	92.85%	42,85%

Table-2: Manpower availability at PHCs

Staff	Sanctioned	Filled (%)
Medical Officer	2	92.85
Pharmacist	1	100
Nurse-Midwife	3	57.14
Health Worker	1	100
Health Educator	1	85.71
Health Assistant (1 male and 1 Female)	2	92.85
Clerks	2	71.42
Laboratory Technician	1	100
Driver	1	35.71
Class IV	4	50

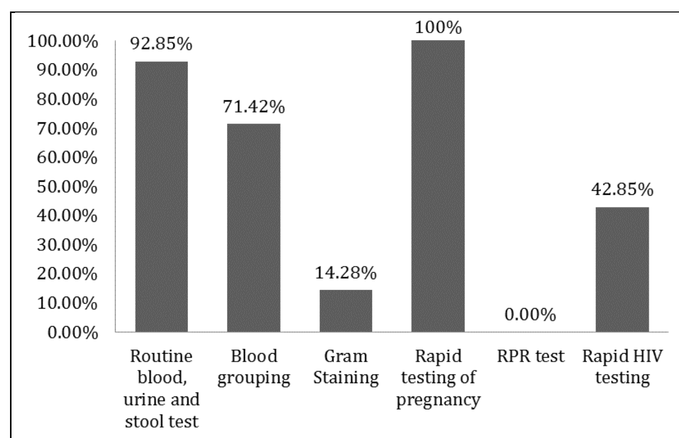

Figure-1: Availability of basic laboratory services at PHCs (N=14)

Discussion

In a study by Zaman et al, All the PHCs in both the studied districts (Two districts, Dhubri from Assam and

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Gulbarga from Karnataka) were rendering the assured services of OPD, 24 hours general emergency services and referral services; while 24 hour delivery services were being provided by 80% of the PHCs of the selected districts of both the states. Functional labour rooms were available only in 80% and 90% of the studied PHCs in Assam and Karnataka respectively. Basic laboratory facilities, for routine blood, urine and stool examination were available in 80% of the studied PHCs in the non-EAG state of Karnataka, while it was only in 20% of the studied PHCs of the EAG state of Assam.[7]

In Evaluation study on functioning of primary health centres (PHCs), assisted under Social Safety Net Programme (SSNP), adequacy of doctors against their sanctioned posts seems to be encouraging, while 75 per cent of doctors were in the position in assisted PHCs, 96 per cent of them were found in position in non-assisted PHCs. Observation room, labor room running water facility and ambulance were present in less than 10% of PHCs.[3]

In Shah et al, It was observed that post of medical officer was filled in 80% PHCs, while in 20% PHCs the post was vacant. Post of compounder and nurse were filled in 70% PHCs, while post of ANM/FHW were filled in 88.7% PHCs. Hemoglobin estimation and blood group facilities were available in 80% PHCs, urine examination and peripheral smear examination for malarial parasites (MP) was carried out in all PHCs. While sputum for AFB was done in only 20% PHCs. ESR facility was available in 2 PHC out of 10, but they were not doing the test. As regards to the vehicle availability, 8 (80 %) of the PHCs had their own vehicle. Of these, the vehicle was in working order in 7 (87.5%); fuel supply was adequate in 4 (50%); absence of a permanent driver in 100% and absence of a daily wages driver in 2 (25%) of these PHCs. These vehicles were employed in 37.5% cases for transferring patients to higher centers in emergency situations.[8]

In the study carried out by Narayan et al it was found that among six PHCs in Pondicherry, post of medical officer was filled in 80% PHCs and 88.7 % posts of ANM/FHW were filled.[9] In the study of Biswas et al, the data reveals that except in the case of MOs, all other posts are not filled in compliance with IPHS. It was found that 3 block PHCs had more doctors than the prescribed norm. All the APHC had only AYUSH doctors. The AYUSH doctors practicing at these centres were feeling demoralized as they are forced to prescribe allopathic medicines instead of prescribing their own medicines. Two PHCs did not have a pharmacist.

Laboratory technician was posted in only 1 PHC. The PHC buildings were not maintained. There was general lack of hygiene in all the centres. Water and electricity were available regularly in all the PHCs. Only 1 PHC had an irregular supply of electricity. All the PHCs had a functional labour room. In 2PHCs, surgeries were not being carried out since last 6 months. Only 7 have their own building, and rest of the APHCs were functioning from rented houses. In the APHCs, there was a general lack of hygiene in all centres with irregular electricity supply. It was observed that furniture and equipment were available even though the maintenance was poor[10].

Recommendations

The continuous availability of good quality curative services satisfies people and motivates the community for preventive and promotive services. Incentives should be given to work at remote places and all the post of medical and paramedical workers should be filled up as early as possible.

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Conclusion

Incentives should be given to work at remote places and all the post of staff should be filled up as early as possible.

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