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Review of Working of PHCs in India

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In recent years there has been an acceptance of the important role of Primary Health care. It helps in achieving the objectives equity, efficiency, effectiveness and responsiveness of the health system. There by improvement in health and nutrition.

Primary health care is essential health care based on practical scientifically sound and socially acceptable methods and technology mode universally accessible to individuals in the community through then full participation. The primary health services are provided at the cost of that the community and country can afford at every stage of their development in the spirit of self-relevance and self- determination. India's primary health care system is based on primary health centres (PHC). It aims to take care of patients in early stage of the disease. Primary care physicians reduce costs and increases patient satisfaction with no average effects on quality of care or patient outcomes.

The concept of Primary Health Centre (PHC) is not new to India. The Bhore Committee in 1946 gave the concept of a PHC as a basic health unit to provide as close to the people as possible, an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The health planners in India have visualized the PHC and its Sub-Centres (SCs) as the proper infrastructure to provide health services to the rural population. The Central Council of Health at its first meeting held in January 1953 had recommended the establishment of PHCs in community development blocks to provide comprehensive health care to the rural population. These centres were functioning as peripheral health service institutions with little or no community involvement. Increasingly,

these centres came under criticism, as they were not able to provide adequate health coverage, partly, because they were poorly staffed and equipped and lacked basic amenities.

The 6th Five year Plan (1983-88) proposed reorganization of PHCs on the basis of on PHC for every 30,000 rural populations in the plains and one PHC for every 20,000 population in hilly, tribal and desert areas for more effective coverage. However, as the population density in the country is not uniform, the number of PHCs would depend upon the case load. PHCs should become functional for round the clock with provision of 24 × 7nursing facilities. Select PHCs, especially in large blocks where the CHC is over one hour of journey time away, may be upgraded to provide 24 hour emergency hospital care for a number of conditions by increasing the number of Medical Officers; preferably such PHCs should have the same IPHS norms as for a CHC. There are 23673 PHCs functioning in the country as on March 2010 as per Rural Health Statistics Bulletin, 2010. The number of PHCs functioning on 24x7 basis are 9107and number of PHCs where three staff Nurses have been posted are 7629 (as on 31-3-2011). PHCs are the cornerstone of rural health services- a first port of call to a qualified doctor of the public sector in rural areas for the sick and those who directly report or referred from Sub-Centres for curative, preventive and promotive health care. It acts as a referral unit for 6 Sub-Centres and refer out cases to Community Health Centres (CHCs-30 bedded hospital) and higher order public hospitals at sub-district and district hospitals. It has 4-6 indoor beds for patients. In India primary health centres are the corner stone of rural health care. It is a first and early approachable call for the sick. It is also an effective referral system. It forms the first level of contact and the link brings health care delivery as close as possible to where people live and work. Each PHC is targeted to cover approximately 25000 populations for providing promotion preventive, curative and

rehabilitative care. This implies offering a wide range of services such as health education, promotion of nutrition basic sanitation the provisions of matter and child family welfare serious, communicable disease control and appropriate treatment for illness and injury. With the development of health facilities it aims at increasing the production of rural areas. Thus primary health care centres also focuses on social and economic development of the community by increasing the health status. The current PHC structure is flexible in approach so as to provide cheap medical facilities. It tries to work for the rural masses for their health and nutritional level problems according to local realties and needs. The PHC are hubs for five to six sub-centres that cover 3-4 villages and are operated by an Auxiliary Nurse Midwife (ANM). These facilities are a part of the three to health care system. The man work of PHC is to provide first aid and act as referral centres for the community health centres (CHCs), 30 bed hospitals at the block and district level. PHCs also implement various government programmes for rural community. Health care is assured by community participation keeping in view the targets fixed whole public health system of PHCs is managed and overseen by district health officers.

The objectives of IPHS for PHCs are:

i. To provide comprehensive primary health care to the community through the Primary Health Centres.
ii. To achieve and maintain an acceptable standard of quality of care.
iii. To make the services more responsive and sensitive to the needs of the community.

Primary health centres also work in close co-ordination with rural local bodies. Local bodies like Panchayat Samiti and Village Health Committees and the sub-centres of PHCs help them in community participation and undertake a

wide range of function, health related functions of Panchayat Samiti and Village Health Committees are listed below:

Administrative Structure

Community health is the responsibility so the gram panchayats, village health committee, village health workers, voluntary workers are involved in it. The entire administrative structure of rural health is a three tier structure with sub-centres, primary health care centres (PHCs) and the community health centres (CHCs), District health authority supervisors the functioning of this three tier structure. So over all administrative structure of rural health can be divided into following segments:

1) Community level
2) Sub-centres
3) Primary health Centres
4) Community Health Centres
5) District Health care centres

In the rural health sectors administrative structure involve government machinery, locally elected bodies and participation of community health voluntary and non- voluntary workers.

Community level- At community level primary health care is the responsibility of the Gram Panchayats, Village Health committees and village health workers.

Gram Panchayats are locally elected bodies. They carry out certain health related faction such as environmental hygiene maintenance of birth, marriage and death registration. To efficiently operate these functions government has made available financial support. They can also impose task on village society.

Village Health Committee- The village panchayat calls meeting of gram sabha. In this meeting village health committee is formed. The village health committee works on honorary basis and consist of gram panchyat representatives and the community with 59 percent members of women and SC 15.7. It works in a democratic manner with aim of social responsibility, voluntary work and social participation. The VHCs assists gram out social audit.

Village Health Workers (VHW) - The village health committee select a person to be trained for carrying out a set of health functions. He helps the village community by approaching drug depot to provide treatment for minor ailments and assist households to access basic serious. He is a voluntary worker.

Sub-centres: Though sub-centres are weak and unsatisfactory health provides but they are the first referral centres. These sub-centres take care of maternal and child health services. These sub-centres are run by one female health workers (ANM) and one male health worker. One voluntary worker also looks upon the sub-centres. Here drug are also distributed and vaccination is also done. These health workers are entitled for travel allowance and other expenses in form of contingency. These sub-centres have one building with a few equipments.

Primary Health Centres - PHC is the first contact point between 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 Programme (BMS). At present, a PHC is manned by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 Sub Centres. It has 4 - 6 beds for

patients. The activities of PHC involve curative, preventive, primitive and Family Welfare Services. There are 23887 PHCs functioning as on March 2011 in the country.

Community Health centres- CHCs are being established and maintained by the State Government under MNP/BMS programme. It is 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. As on March, 2011, there are 4809 CHCs functioning in the country.

District Health centres- Strengthening of sub-divisional /sub-district and district hospitals is an approved activity under NRHM the funds are released to States/UTs Governments as per their requirement reflected in their annual PIP. The same is examined in this Ministry and funds are released n the recommendations of NPCC. As per RHS in India 2011, there are 985 Sub Divisional Hospital (SDH) and 613 District Hospitals are functional in India.

RURAL HEALTH INFRASTRUCTURE - NORMS AND LEVEL OF ACHIEVEMENTS (ALL INDIA)

S.No.	Indicator	National Norms		Achievements
1	**Rural Population (2001) covered by a:**	**General**	**Tribal/Hilly/Desert**	
	Sub Centre	5000	3000	5085
	Primary Health Centre (PHC)	30000	20000	31954
	Community Health Centre (CHC)	120000	80000	2.21 lakhs
2	Number of Sub Centres per PHC	6		6
3	Number of PHCs per CHC	4		7
4	**Rural Population (2001) covered by a:**			
	MPW (F)	5000	3000	5574
	MPW (M)	5000	3000	11994
5	Ratio of HA (M) to MPW (M)	1:6.0		1:3
6	Ratio of HA (F) to MPW (F)	1:6.0		1:8
7	**Average Rural Area (Sq. Km) covered by a:**			
	Sub Centre	--		21.35
	PHC	--		134.20

	CHC	--	931.95
8	**Average Radial Distance (Kms) covered by a:**		
	Sub Centre	--	2.61
	PHC	--	6.53
	CHC	--	17.22
9	**Average Number of Villages covered by a:**		
	Sub Centre	--	4
	PHC	--	27
	CHC	--	191

Health delivery system

Globally, governments are searching for ways to improve equity, efficiency, effectiveness and responsiveness of their health systems. At present, there is no agreement on optimum structures, content, and ways to deliver cost-effective services to achieve health gains for the population. However, in recent years there has been an acceptance of the important role of primary healthcare in helping to achieve these aims; providing cost-effective healthcare to the general population. Primary healthcare is essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals in the community through their full participation and at a cost the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.[1]

[1]**Neesha Patel**, Evaluating the role of Primary Health Centers in India

i. Distribution of medicine- Drugs and medicines from a substantial portion of the out of pocket spending on health by households. The component of drug and medicines accounts for only 10 percent of the overall health budget of both Central and State Government. Timely supply of drugs of food quality that involves procurement as well as logistic management is of critical importance in the health system.[2] Service delivery is dependent on a regular supply of a comprehensive range of quality controlled medicines, falling under various generic categories included in the 'essential drug list' drawn up for different levels of Public health facilities. The idea is to provide medical aid of a basic level (SC) and intermediate level (PHC, CHC) at decentralised centres in order to cater to commonplace health needs of physically dispersed rural communities. The latter two act as gatekeepers for serious or complicated cases, which may then be referred to the sub-divisional or district hospital. Apart from administrative fee of Rs. 2 charge for the prescription, PHFs are supposed to dispense medicines free of cost to BPL families and other deprived patients. The pattern of distribution of medicines at PHCs level is given below-

a. All the drugs available in the Sub-Centre should also be available in the PHC. All the drugs as per state/UT essential drug list shall be available.

b. In addition, all the drugs required for the National Health Programmes and emergency management should be available in adequate quantities so as to ensure completion of treatment by all patients.

c. Adequate quantities of all drugs should be maintained through periodic stock-checking, appropriate record maintenance and inventory methods. Facilities for local purchase of drugs in times of epidemics/outbreaks/emergencies should be made available.

d. Drugs of that discipline of AYUSH to be made available for which the doctor is present. (IPHS guideline for Primary health centres.)

[2]Satyabrant Mishra, Delivery, Accessibility and Financing of Health care in India, IEJ 2011, pp. 691-704.

ii. Vaccination- Roughly 3 million children die each year of vaccine preventable diseases (VPDs) with a disproportionate number of these children residing in developing countries.[3]

India's rural health care system has a strong dependence on community health infrastructure and outreach, particularly in remote villages. The health care delivery system in rural India relies on a combination of primary health care infrastructure and community outreach. The key role in immunization delivery is that of the ANM; she is responsible for not only administering vaccines, but also for monitoring immunization coverage.[4]Universal Immunization Programme is one of the key interventions for protection of children from life threatening conditions, which are preventable. Immunization Programme in India was introduced in 1978 as Expanded Programme of Immunization. Immunization is one of the key areas under National Rural Health Mission (NRHM) launched in 2005. Under the Universal Immunization Programme, Government of India is providing vaccination to prevent seven vaccine preventable diseases i.e. Diphtheria, Pertussis, Tetanus, Polio, Measles, severe form of Childhood Tuberculosis and Hepatitis B.[5]

[3]Kane M, Lasher H. The case for childhood immunization. Occasional Paper No. 5. Children's vaccine program at PATH. Seattle, WA; 2002.

[4]Ashlesha Datar, Arnab Mukherji* & Neeraj Sood, Health infrastructure & immunization coverage in rural India, Indian J Med Res 125, January 2007, pp 31-42.

[5](NRHM, annual repot 2012-13)

Immunization programme provide vaccination against seven vaccine preventable diseases

vaccine	When to give	Dose	Route	Site
For Pregnant Women				
TT- 1&2	Early in pregnancy and 4 weeks after TT-1* [one dose (booster)* if previously vaccinated within last 3 years]	0.5 ml	Intra-muscular	Upper Arm
TT- Booster	If pregnancy occur within three years of last TT vaccination*	0.5 ml	Intra-muscular	Upper Arm
For Infants				
BCG	At birth (for institutional deliveries) or along with DPT-1 (up to one year if not given earlier)	0.1 ml (0.05 ml for infant up to 1 month)	Intra-dermal	Left Upper Arm
Hepatitis B-0	At birth for institutional delivery, preferably within 24 hrs of delivery	0.5 ml	Intra-muscular	Outer Mid-thigh (Anterolateral side of mid thigh)
OPV - 0	At birth for institutional deliveries within 15 days	2 drops	Oral	Oral
OPV 1, 2 & 3	At 6 weeks, 10 weeks & 14 weeks	2 drops	Oral	Oral
DPT 1, 2 & 3	At 6 weeks, 10 weeks & 14 weeks	0.5 ml	Intra-muscular	Outer Mid-thigh (Anterolateral side of mid thigh)
Hepatitis B-1, 2 & 3	At 6 weeks, 10 weeks & 14 weeks	0.5 ml	Intra-muscular	Outer Mid-thigh (Anterolateral side of mid thigh)
Measles 1 & 2	At 9-12 months and 16-24 months	0.5 ml	Sub-cutaneous	Right upper Arm
Vitamin-A (1st dose)	At 9 months with measles	1 ml (1 lakh IU)	Oral	Oral
For Children				
DPT booster	16-24 months 2nd booster at 5 years of age	0.5 ml	Intra-muscular	Outer Mid-thigh (Anterolateral side of mid-thigh)
OPV Booster	16-24 months	2 drops	Oral	Oral
JE^	16-24 months	0.5 ml	Sub-cutaneous	Upper Arm
Vitamin A (2nd to 9th dose)	2nd dose at 16 months with DPT/ OPV booster. 3rd to 9th doses are given at an interval of 6 months interval till 5 years age	2 ml (2 lakh IU)	Oral	Oral
DT Booster	5 years	0.5 ml	Intra-muscular	Upper Arm
TT	10 years & 16 years	0.5 ml	Intra-muscular	Upper Arm

* TT-2 or Booster dose to be given before 36 weeks of pregnancy.
^ JE in Selected Districts with high JE disease burden (currently 112 districts)
A fully immunized infant is one who has received BCG, three doses of DPT, three doses of OPV, three doses of Hepatitis B and Measles beforeone year of age.
Note: The Universal Immunization Programme is dynamic and hence the immunization schedule needs to be updated from time to time.
(IPHS Guideline for Primary Health Care,2012)

iii. Health check-up-

a) Clinical Health Services

Clinical Health Services may include, but not be restricted to, the following services provided by medical practitioners and/or appropriately qualified allied health professionals, trained Aboriginal Health Workers or qualified nursing staff using standard treatment procedures:

- Diagnostic and clinical care
- Treatment of illness/disease
- Management of chronic illness
- Referral to secondary health care (inpatient hospital and other health residential facility) and tertiary health care (specialist services and care) when not available at the PHCs
- Dialysis services and endocrinology referral
- Collections for pathology testing and/or referral
- Radiology services or referral
- Sterilisation of equipment meeting Indian standards
- Respiratory disease testing, services and referral
- Cardiovascular testing, services and referral
- Outreach clinical health services to satellite clinics or communities without services
- Domiciliary health care

b) Pharmaceutical Services

- Prescription of medication and drugs
- Pharmaceutical supplies,(subject to State and Federal legislation and mindful of the W.H.O. Alma Ata Declaration advocating provision of essential drugs

- Pharmaceutical supply arrangements with hospital pharmacies or local pharmacists when not available at the PHCs

c) Preventative Care

- Population health promotional program
- Early intervention
- Otitis Media examination and testing
- Immunisation
- Health education and promotion
- Socially communicable disease control, manuals and education programs
- Health protection supplies and distribution
- Antenatal instruction and classes
- Maternal and child care (0 – 5 years)
- Diabetic screening, testing and counselling
- Screening, individual and mass screening programs
- Infection control
- Injury/accident prevention education
- Outreach health promotional programs
- Dietary and nutrition education

iv. Other facilities-

➢ Dietary Facilities for indoor Patients

Nutritious and well- balanced diet shall be provided to all IPD patients keeping in mind their cultural prefernces. A suitable arrangement with a local agency like a local women's group/NGO/Self-Help Group for provision of nutritious and hygienic food at reasonable rates may be made wherever feasible and possible.

➢ The Transport Facilities

(i) Referral Transport Facility

It is desirable that the PHC has ambulance facilities for transport of patients for timely and assured referral to functional FRUs in case of complications during pregnancy and child birth. This may be outsourced either through Govt./PPP model or linkages with Emergency Transport system should be in place.

(ii)Transport for Supervisory and Other Outreach Activities

It is desirable that the vehicle is made available through outsourcing.

➢ Equipment and Furniture

- The necessary equipment to deliver the assured services of the PHC should be available in adequate quantity and also be functional.
- Equipment maintenance should be given special attention.
- Periodic stock taking of equipment and preventive round the year maintenance will ensure proper functioning equipment. Back up should be made available wherever possible.

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