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ORIGINAL ARTICLE

Assessment of Indian Public Health Standards in the Primary Health Centers in a District of Uttar Pradesh, India

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ABSTRACT

Introduction: Primary health center (PHC) is a first port of call to a qualified doctor of the public sector in rural areas. Standards are the main driver for continuous improvement in quality. The performance of PHCs can be assessed against the Indian Public Health Standards (IPHS) recommended for PHCs in early 2007. The overall objective of IPHS for PHCs is to provide health care, i.e., quality oriented and sensitive to the needs of the community. These standards would also help monitor and improve the functioning of the PHCs.

Aims and objectives: This study was carried out to assess (1) the infrastructure, equipments, instruments, staffing, and other facilities; (2) the services being provided at PHCs; (3) to find out the reasons for nonutilization of health services and suggest remedial measures for the same.

Material and methods: This was a cross-sectional study at two PHCs, namely Thatiya and Umerda of Tirwa block of Kannauj District selected randomly for assessment. Health care providers, mainly medical officers, were interviewed using pretested, precoded pro forma. Descriptive analysis was used as per study requirements.

Results: It has been found that only outpatient department services were being provided with many missing components, such as one of the most important ones like maternal and child health and family planning. Physical infrastructure and facilities were inadequate at both the PHCs. Both of them were grossly underequipped and understaffed. Medical officers face their own problems; even basic amenities of life like water, electricity, canteen, etc., are lacking there.

Conclusion: Both the PHCs were not performing up to the expectations and standards of the Indian Public Health.

Keywords: Indian public health standards, Kannauj district, Primary health centers.

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INTRODUCTION

A primary health center (PHC) is a first port of call to a qualified doctor of the public sector in rural areas and caters to the sick and those who directly report or are referred from subcenters for curative, preventive, and promotive health care.[1] A typical PHC is required to serve a population of 20,000 in hilly and tribal areas and 30,000 in plains with 6 indoor/observation beds. A PHC acts as a referral unit for 6 subcenters.[2] The PHCs should become a 24-hour facility with nursing facilities.[1]

Standards are the main driver for continuous improvement in quality. The performance of PHCs can be assessed against set standards[1] called the Indian Public Health Standards (IPHS) recommended for PHCs in early 2007. The IPHS documents of 2007 have been revised in 2012, keeping in view resources available with respect to functional requirements of PHCs with minimum standards, such as building, manpower, instruments and equipment, drugs, other facilities, etc. The revised IPHS has incorporated the changed protocols of the existing health programs and initiatives, especially with respect to noncommunicable diseases.[1] A wide range of services are prescribed by the IPHS to fulfill the minimum requirements at PHCs, such as medical care through outpatient department (OPD) and 24-hour emergency services, maternal and child health (MCH) services, basic laboratory services, minor surgical procedures, implementation of various National Health Programs, etc.[1]

The overall objective of IPHS for PHCs is to provide health care, i.e., quality oriented and sensitive to the needs of the community. These standards would also help monitor and improve the functioning of the PHCs. This study was carried out under the supervision of the Department of Community Medicine of Government Medical College (GMC), which is a newly established college in the rural areas of Kannauj district of western Uttar Pradesh, a backward district with poor health indicators.

AIMS AND OBJECTIVES

- To assess the infrastructure, equipments, instruments, staffing, and other facilities

- To assess the services being provided at PHCs
- To find out the reasons for nonutilization of health services and suggest remedial measures for the same

MATERIALS AND METHODS

This was a cross-sectional study. Two PHCs, namely Thatiya and Umerda of Tirwa block of Kannauj District, were randomly selected for assessment. These PHCs are about 12 km away from the medical college. Health care providers, mainly medical officers, were interviewed using pretested, precoded pro forma for 2 months (June and July 2015). The IPHS guidelines for PHCs revised in 2012 were used to compare and assess the quality of PHCs. Ethical approval for the study was taken from the Ethics Committee of the college (Table 1).

For data collection, transmission, and management, data were entered in standardized formats by the investigator. Each patient was given a unique identifier, and the personal name of the patient was not used in data analysis. The data captured through the questionnaire were entered into a computer-generated excel sheet. For statistical analysis, Statistical Package for the Social Sciences was used. The information was randomly checked for completeness by the faculty of community medicine in GMC Kannauj before entry onto a computer. Descriptive analysis was used as per study requirements.

Table 1: Subcenters and population covered under PHCs

Thatiya PHC, N = 77,939		*Umerda PHC, N = 72,792*	
PHC subcenter	*Population*	*PHC subcenter*	*Population*
Khama	9,567	Umerda	13,937
Basta	9,873	Kudrina	8,706
Paithana	10,324	Khanpur	9,822
Thatiya	8,182	Bahosi	11,361
Behata	10,078	Majhila	8,923
Badohosi	13,431	Diyora	9,617
Jainpur	16,484	Balanpur	10,426

Implications of the Study

Despite the small sample size due to time and logistics constraints, the study will provide sufficient insights into the planning and management of health services. Improved quality care at the primary level will reduce avoidable burdens at the tertiary level. It will enhance the treatment sought and will reduce the burden of disease in the community.

RESULTS

It was found that both of the PHCs were catering to more than 70,000 people and had seven subcenters serving the health needs of about 8,000 to 16,000 people. The location of both PHCs was accessible to almost all people as reported by them. Thatiya PHC has 12 rooms, while Umerda PHC is being run only with 3 rooms.

Although waiting places were available at both the PHCs, their conditions were pathetic. The building was in need of maintenance and repair. At Umerda, injections were being given in waiting areas. Electrical supply was around 10 to 12 hours. Regarding water supply, it was found that although hand pumps were installed at both the PHCs, at Thatiya, they were not functional. As there was no water supply at Thaitya PHC, water outlet, wash basin, and toilets were nonfunctional. The most distressing fact was that there were no sweepers at both the PHCs. The medical officers-in-charge (MO-IC) were paying from their own pocket for cleanliness. Boundary and fencing was present at Thatiya PHC again in dilapidated conditions, while there was no fencing or boundary at the Umerda PHC. There was no computer, telephone,

Table 2: Physical infrastructure of PHC

Thatiya PHC			*Umerda PHC*		
Type of room	*Function*	*No.*	*Type*	*Function*	*No.*
OPD	Allopath – F AYUSH – NF	2	OPD	Allopath – F AYUSH – NF	01
Indoor	NF	2	Indoor	–	–
Laboratory	Only sputum	1	Laboratory	–	0
Store	F	1	Store	–	0
Injection room	F	1	Injection room	–	0
Emergency	NF	1	Emergency	–	–
Drug store	F	1	Drug store	F	1
OT	NF	1	OT	–	0
NHP	RNTCP, Leprosy	1	NHP	–	0
Cloak room	Functional	1	Clark room	F	1

*F: Functional; NF: Nonfunctional; NHP: National Health Program; OT: Operation theater; RNTCP: Revised National Tuberculosis Control Program; AYUSH: Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy

Table 3: Some other characteristics of physical infrastructure

	Thatiya PHC		*Umerda PHC*	
Waiting place available	Yes		Yes	
Is waiting place protected from sun/rain water?	Yes	But plastering and painting are not well done	Yes	Plastering and painting are not well done
Room flooring/plastering done	Yes	Not in good condition	Yes	Not in good condition
Electrical supply	Yes	For 10 hrs	Yes	For 12 hrs
Type of water supply	No	Stalled – NF	Yes	Hand pump – functional
Room for clinic	Yes	Attached examination room	Yes	Single
Water outlet in clinic room	Yes	But not used	Yes	Working
Wash basin provided and functioning	Yes	NF due to no water supply	Yes	Functioning using hand pump water
Toilet available	Yes	NF – no water supply	Yes	Functional
Is location of PHC accessible to all?	Yes	Almost	Yes	Almost
Maintenance of cleanliness		By an external sweeper paid by MO from his salary (Rs 300/month)		External sweeper paid by MO from his salary (Rs 250)
Boundary wall/fencing	Yes	But no proper plastering.	No	–
Telephone, computer	No	–	No	–
Waste disposal	done	Not properly disposed; collected at the corner and burned by sweeper weekly	Done	Collected outside of the PHC and burned by sweeper
Transport/ambulance	No	–	No	–
Residential facility	Yes	But not used by anyone	No	–
No. and type of residential quarters	Yes	Type I – III, Type-II room and Type III – I room suite	No	–
Is MO-IC staying at PHC?	No	Reason – no basic facilities	No	No residential facility

NF: Nonfunctional

transport, and ambulance facility at both the PHCs. Waste disposal of the PHCs was not proper. It was being collected at the corner and burned by sweeper weekly. There was no residential facility at Umerda PHC, so there was no question of a staying MO-IC at the PHC. At Thatiya PHC, three types of residences were present, but they were not in good condition and due to lack of basic amenities, the MO-IC was not staying there.

Doctors were running the centers mainly with stethoscope, blood pressure (BP) instruments, and thermometers. Even the weighing machine, only for adults, was available at only one PHC, Thatiya. Similarly, among the list of desirable equipments, mainly tuning fork and otoscopes were available at both the PHCs. As far as essential reagents and instruments required in laboratory were concerned, at Umerda PHC, no laboratory was present; so no reagents were available. At Thatiya PHC, only sputum testing was being done; hence, related reagents like Gram's iodine, KOH solution, etc., were available. Similarly, light microscope was available only at Thatiya PHC. In the name of furniture, both the PHCs have only one examination table, two writing tables, few rickety chairs, bench, three almirahs, dustbins, bucket and mugs, etc. Puncture proof bags were available only at one PHC (Thatiya).

Table 4 reveals lists and number of furniture as per the IPHS guidelines, and furniture and their number available at PHCs. One can see that only basic furniture was available and was not in the required numbers. In the name of furniture, they have only one examination table, two writing tables, few rickety chairs, bench, three almirahs, dustbins, bucket and mugs, etc. They have no wheelchairs, stretchers, curtains, gas stoves, utensils, and generators. Puncture-proof bags were available only at one PHC (Thatiya).

Again, only stethoscope, BP instruments, thermometer, not in required numbers, were present. They have no hub cutter or needle destroyer.

Both the PHCs were grossly understaffed. Thatiya was being run by 8 and Umerda by only 3 health personnel.

Services Provided at PHCs

Only allopathy OPDs at both PHCs were running for 4 to 5 hours. No 24-hour emergency services, inpatient services, operational labor room, and OT were there. Laboratory services (only sputum testing) were available at Thatiya PHC only.

Emergency Services

No 24-hour emergency services were being provided at both the PHCs

Table 4: Availability of equipments and furniture at the PHCs

	Thatiya PHC		*Umerda PHC*	
Name of furniture and no. as per IPHS guidelines (No.)	*Yes/No number*	*F/NF*	*Yes/No number*	*F/NF*
Examination table (4)	1	F	1	F
Writing table with two sheets (6)	2	F	2	F
Plastic chairs for patient's attendant (6)	4	F	4	F
Armless chairs (16)	3	F	2	F
Full size steel almirah (7)	3	F	3	F
Table for immunization (1)	No	–	1	F
Bench for waiting area (2)	2	F	2	F
Wheelchair (2)	No	–	No	–
Stretcher on trolley (2)	No	–	No	–
Wooden screen (1)	No	–	No	–
Foot step (5)	No	–	No	–
Coat rack (2)	No	–	No	–
Bedside table (6)	6	NF	3	NF
Bed stead iron for inpatient (6)	No	–	3	NF
Baby cot (2)	No	–	No	–
Stool (10)	3	F	1	F
Medicine chest (1)	1	F	No	–
Lamp (3)	No	–	No	–
Side wooden racks (4)	2	F	No	–
Fans (6)	3	F	2	F
Basin (2)	2	NF	2	F
Basin stand(2)	2	NF	2	F
Buckets and mugs (4 each)	2	F	2	F
LPG stove (1)	No	–	No	–
LPG cylinder (2)	No	–	No	–
Saucepan with lid (2)	No	–	No	–
Tube lights (8)	5	F	2	F
Water receptacle (3)	No	–	No	–
Rubber plastic shutting (2 m)	2 mt	F	2 mt	F
Drum with tap for storing water (2)	No	–	No	–
Mattress for beds (12)	6	NF	3	NF
Foam mattress for operation theater (3)	No	–	No	–
Bed sheets (30)	6	NF	6	NF
Pillow with cover (30)	6	NF	6	NF
Blankets (18)	6	F	6	F
Baby blankets (4)	No	–	No	–
Towels (18)	No	–	No	–
Foam mattress for labor operation theater (2)	No	–	No	–
Curtains with rods (20 m)	No	–	No	–
Dustbins (2)	2	F	2	F
Puncture proof bags – as per need	5	F	No	–
Generator (1)	No	–	No	–

F: Functional; NF: Nonfunctional; LPG: Liquefied petroleum gas

Table 5: List of medicine/surgical equipments

Name of equipment and no. as per IPHS guidelines (No.)	*Thatiya PHC*		*Umerda PHC*	
	Yes/No number	*F/NF*	*Yes/No number*	*F/NF*
BP apparatus (3)	1	F	1	F
Stethoscope (3)	1	F	1	F
Tongue depressor (10)	No	–	No	–
Torch (2)	1	F	1	F
Thermometer (4)	1	F	1	F
Hub cutter (2)	No	–	No	–
Needle destroyer (2)	No	–	No	–
Labor OT	1	NF	No	–
OT table (1)	No	–	No	–
Arm board for adult and child (4)	No	–	No	–
Instrumental trolley (2)	1	NF	No	–
Intravenous stand (10)	6	NF	3	NF
Shadowless lamp (2)	No	–	No	–
Mackintosh for labor OT – as per need	No	–	No	–
Red bags – as per need	5	F	No	–
Black bags – as per need	No	–	No	–
Blackboard (1)	No	–	No	–
Public address system (1)	No	–	No	–

F: Functional; NF: Nonfunctional; OT: Operation theater

Table 6: Manpower at PHCs

	Essential	*Thatiya PHC*		*Umerda PHC*	
Staff		*Available*	*Remarks*	*Available*	*Remarks*
Medical Officer – Bachelor of Medicine & Bachelor of Surgery	1	1	–	1	–
MO – AYUSH/Lady medical officer	1	0	Vacant	0	Vacant
Accountant/clerk	1	0	Vacant	0	Vacant
Pharmacist	1	1	–	0	Vacant from March 18, 2015
Nurse-midwife/staff-nurse	3	1	2 needed	0	Vacant
Health workers (F)	1	0	Vacant	0	Vacant
Health Assistant (Male)	1	1	–	1	
Health Assistant/Lady Health Visitor (F)	1	0	Vacant	0	Vacant
Health educator	1	0	Vacant	1	Vacant
Computer operator	1	0	Vacant	0	Vacant
Laboratory technician	1	1	–	1	–
Cold chain and vaccine logistic assistant	1	1	–	0	Vacant
Multiskilled Gp D worker	2	2	–	1	Optometrist, 1 – vacant
Sanitary worker cum watchman	1	0	Vacant	0	Vacant
Pharmacist AYUSH	1	0	Vacant	0	Vacant

*Vacant, vacant from the beginning as told by MO-IC – never filled; AYUSH: Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy

Table 7: OPD services

Thatiya PHC				*Umerda PHC*			
	Hours spent by MO-IC in field		*Average daily*		*Hours spent by MO-IC in field*		*Average daily*
OPD Timing	Per day	Days/week	*patient load*	OPD Timing	Per day	Days/week	*patient load*
10 am–2 pm	3 hrs	2	30–35	9 am–2 pm	3 hrs	2	15–20

Others

Services	*Thatiya PHC*	*Umerda PHC*
Referral services – Yes	Medical college and district hospitals	Medical college and district hospitals
Inpatient services – No	–	–
No. of beds	6	3
Bed occupancy rate	0	0
MCH including family planning – No		
Antenatal services	Not at PHC	Not at PHC
Deliveries at PHC	No	No
Postnatal care	–	–
Family planning	Not at PHC	Not at PHC
Care of child		
Routine and emergency care of sick children including integrated management of neonatal and childhood illnesses strategy, in patient care and prompt referral	No	No
Counseling on feeding, immunization	No	Yes, 1st Wednesday of month
Vaccines and Vitamin A prophylaxis given	No	Yes, 1st Wednesday of month
Condition of cold chain	No	No vaccine storage at PHC
Cases of severe malnutrition	No	No
Management of RTIs/STIs		
No. of cases/month	–	About 2
Kit available	No	No

RTI: Reproductive tract infection; STI: Sexually transmitted infection

No MCH and family planning services were being provided at both the PHCs; only immunization services were being given at the Umerda PHC. The auxillary nurse midwifes (ANMs) provided these services at subcenters and directly reported to community health centers (CHCs). No records regarding these services were available at both the PHCs. We interviewed ANMs and accredited social health activist (ASHAs). They reported that they were motivating and counseling women on early initiation of breast feeding and immunization. The ANMs were providing

immunization to pregnant women and children, but when asked about weighing of newborn children, they replied that they have a weighing machine (Salter's type), but did not know how to use it; hence, weighing of infants was not taking place.

Nutrition Services [Coordinated with Integrated Child Development Services (ICDS)]

Thatiya PHC	*Umerda PHC*
Yes	Yes
Health worker (HW) visiting aangan wadi centers (AWC): 4 times/month	HW visiting AWC: 4 times/month

School Health

Service	*Thatiya*	*Umerda*
ANMs/AWWs (a team of 2) visiting school once/week for screening, treatment of minor ailments, and referral	Yes	Yes
Doctor visiting based on screening report	Yes	Yes

Promotion of Safe Drinking Water and Sanitation

Service	*Thatiya*	*Umerda*
Disinfection of water sources and coordination with public health department for safe drinking water	No	No

Prevention and Control of Locally Endemic Diseases Like Malaria, Kala-azar, Japanese Encephalitis, Filaria, etc.

They were not being done at both the PHCs. No antimalarial drugs and other drugs for various endemic diseases were found at PHCs. One MO-IC reported confidentially that even if they diagnosed malaria, they provided negative reports. This was so as positive reports needed verification.

Other National Programs being Implemented through PHC

National program	*Thatiya PHC*	*Umerda PHC*
RNTCP	Yes	No
National leprosy eradication programme (NLEP)	Yes	No
Pulse polio immunization	Yes	Yes
Integrated child development services	Yes	Yes
Others (e.g., *Janani Suraksha Yojana*, Janani Shishu Suraksha Karyakaram, etc.)	No	No

RNTCP: Revised national tuberculosis control program

Among national health programs, only RNTCP and NLEP were being implemented through Thatiya PHC only, not at Umerda PHC. School health program and ICDS were being coordinated through both the PHCs

Collection and Reporting of Vital Events

No records were present at both the PHCs; grassroot level workers directly reported to the CHC.

Health Education and Behavior Change Communication

Service	*Thatiya*	*Umerda*
Information, education and communication material	No	On human immunodeficiency virus, malaria, filarial, tuberculosis, and polio
Counseling room	No	Counselor does counseling on reproductive and sexual health to 10- 18-yr-olds and immunization

Basic Laboratories and Investigation Facilities Available

Investigations	*Thatiya*	*Umerda*
Routine urine, stool, and blood test	No	No
Blood grouping	No	No
Bleeding time, clotting time	No	No
Diagnosis of RTI/STI with wet mounting Gram stain	No	No
Sputum testing for TB	Yes	No
Blood smear examination for malaria parasite	No	No
Rapid test for pregnancy	No	No
Rapid plasma reagin test for syphilis/ Yaws surveillance	No	No
Rapid test for human immunodeficiency virus	No	No
Other (specify)	No	No

RTI: Reproductive tract infection; STI: Sexually transmitted infection; TB: Tuberculosis

Training given to Health Workers

Training of health worker	*Thatiya PHC*	*Umerda PHC*
Cadre of health worker (ANMs, ASHAs)	At block level	No training at the PHC, provided at CHC and district hospital
Training of MO in last 5 yrs	No	No

Mainstreaming of AYUSH

No Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) staff

Charter of Patients' Right and Signposts in Local Languages

Not present at both the PHCs

Monitoring and Supervision

	Thatiya PHC	*Umerda PHC*
Internal mechanism	*Records maintained, checked, and supervised by MO	*Records maintained, checked, and supervised by MO
Medical audit (State level)	Yes	Yes
Death audit	No	No
Survey of patients' satisfaction and referral services	No	No
External mechanism (Panchayati Raj Institution, Village health Sanitation, Rogi Kalyan Samiti, etc.)	No	No

*Records, such as patient's register and logistics.

Various difficulties faced by MOs were scarcity of staff and medicines and the doctor not being consulted about need of medicines, and lack of basic amenities like water, electricity, and canteen. There were no fourth class employee and sanitation worker, no generator, and transport facility. At Umerda PHC, there were no residences for any category of employee. So, it was difficult for them to serve people in those areas.

DISCUSSION

The PHCs play a vital role in delivering health care to rural India. A PHC is established with a population norm of 20,000 people for hill and tribal areas and 30,000 for plain areas.[2] In our areas, we found that both the PHCs were serving more than twice the prescribed norms of population (Thatiya; 77,939 and Umerda; 72,792). The PHC is also required to serve 6 subcenters within its jurisdiction.[1] Here, both the PHCs had 7 subcenters. The national norms of population for subcenters are 3,000 for hills and tribal areas and 5,000 for plains. In our study areas, these subcenters were catering to the health needs of about 8,000 to 16,000 people, which are much more than the prescribed norms.

Regarding infrastructure, it was found that infrastructure at both the PHCs was not up to the standards set by IPHS. Thatiya PHC has 12 rooms, while conditions of Umerda PHC were more deplorable, as it was being run only in 3 rooms. Although waiting place was available at both the PHCs, they were in need of repair and were not very comfortable. As per IPHS guidelines,[1] waiting areas should have adequate space and seating arrangements. Walls should carry posters imparting health education along with booklets/leaflets in local languages for the same purpose. Safe drinking water and toilets with adequate water supply, separately for males and females, should be available. Waiting areas should have fans and coolers.[1] At Thatiya PHC, there was no water facility and the only toilet was nonfunctional. At Umerda PHC, a hand pump was there, and toilet could be used by using water from hand pump. The OPD room should have an attached room for examination.[1] Thatiya PHC has an attached room, but at Umerda PHC, OPD was being run in a single room. There was boundary/fencing at Thatiya PHC, which was in need of repair, while no fencing at all was present at Umerda PHC. Cleanliness was not satisfactory, as there was no sweeper/IV class employee posted at both the PHCs. The MO told that they were paying from their own pocket (around Rs. 300) to a sweeper for cleanliness and disposing waste on weekly or bi-weekly basis. There were no transport and communication facilities at both the PHCs. Residences was constructed at Thatiya PHC only, but MO-IC did not stay there because of lack of basic amenities of life. Almost similar were the findings of a study report prepared by STEM 6II-7II on the health needs assessment in Uttar Pradesh.[3]

When the availability of equipments at both the PHCs was assessed against the list prescribed by IPHS guidelines, it was found that few essential equipments, mainly stethoscope, BP equipment and thermometer, were available at both the PHCs but not in required numbers. Adult weighing machine and binocular microscope were available at Thatiya PHC only. In desirable lists of equipments as per IPHS guidelines, only otoscope and tuning fork were available at both the PHCs. Few other studies in Uttar Pradesh[3] and Rajasthan[4] reported shortages of equipments at PHCs.

There were no fully equipped and operational labor room and equipment for Papanicolaou smear test as prescribed by the IPHS at both the PHCs. As far as essential reagents and instruments required in laboratory were concerned, there was no laboratory at Umerda PHC, so no reagents were available. At Thatiya PHC, only sputum testing was being done; so, related reagents like Gram's iodine, KOH solution etc., were available. Similarly, light microscope was available only at Thatiya PHC.

There were only few basic furniture and not in required numbers; only one examination table, two writing tables, few rickety chairs, bench, three almirahs, dustbins, bucket and mugs etc were present. They have no wheelchairs, stretchers, curtains, gas stoves, utensils, and generators. Puncture-proof bags were available only at one PHC (Thatiya). This is in consonance with findings of some other studies.[3,4]

Both the PHCs were understaffed. Thatiya PHC was being run by 8 and Umerda by only 3 health personnel; no AYUSH component was there. Understaffing is a common problem reported in many studies.[3,4,6]

When enquired about services being provided at both the PHCs, we found only OPDs were running for 4 to 5 hours. A total of 6 hours of OPD services out of which 4 hours in the morning and 2 hours in the afternoon for 6 days in a week is the prescribed norm of IPHS.[1] Patient load was low at Umerda (15–20), while at Thatiya, it was 30 to 35, which is below the expected load of 40 patients as per IPHS.[1] Raghunath et al[5] reported overcrowding at center in Puducherry. The MO-IC spent 3 hours, twice a week, in the field as desirable by IPHS guidelines.

As per IPHS guidelines, 24-hour emergency services, which include appropriate management of injuries and accident, first aid, stitching of wounds, incision and drainage of abscess, stabilization of the condition of the patient before referral, dog bite/snake bite/scorpion bite cases, and other emergency conditions should be provided primarily by the nursing staff. However, in case of need, the MO may be available to attend to emergencies on call basis. The 24-hour emergency services were not being provided at both the PHCs.

Regarding MCH and family planning services, it was found that no components, except immunization services at Umerda PHC, were being provided at the PHCs. No deliveries and MTPs were taking place there. The records were present with ANMs; they were providing their services at subcenters and directly reporting to CHC. In some studies,[4,6] MCH services were being provided at PHCs. Sadani and Sharma[4] reported that in Rajasthan, MCH was being provided at PHCs, while no equipped newborn care center was present. Ninama et al[6] also found that MCH services excepting MTP were being given to patients.

CONCLUSIONS AND RECOMMENDATIONS

It has been found that both the PHCs are not performing up to the expectations and standards due to various reasons like inadequate physical infrastructure and facilities at both the PHCs. Both of them are grossly underequipped and understaffed. The supply of medicine is irregular and insufficient. They are providing inadequate and piecemeal services. Only OPD services are being provided that have many missing components like the MCH and family planning. Medical officers have their own problems; even the basic amenities of life like water, electricity, and canteen etc., are found lacking. Hence, medical officers cannot be blamed entirely. There are no fourth class employee and sanitation worker, generator, and transport facility. At Umerda PHC, there are no residences for any category of employee, so it is difficult for MOs to serve in those areas as they do not stay there. There is an urgent need to address these issues and ensure accountability at each level of health system. To ensure accountability, the Charter of Patient's Rights in the local language should be available in each PHC. Each PHC should have a Rogi Kalyan Samiti (RKS) for improvement of the management and service provisions of the PHC as per the guidelines of Government of India. Various agencies of villages like Panchayati Raj Institution, Village Health Sanitation and Nutrition Committee and RKS should also monitor the functioning of PHCs.

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