



Grassroots Research and Advocacy Movement

**Study of the performance of
24 X 7 PHCs in the 'C' Category
districts of Karnataka**

Final Report

Presented to

**The Executive Director
Karnataka State Health Systems Resource Centre
Dept of Health and Family Welfare
Government of Karnataka**

Grassroots Research and Advocacy Movement (GRAAM), Mysore, Karnataka, India
Visit us at: www.graam.org.in



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Grassroots Research And Advocacy Movement

CA-2, KIADB Industrial Housing Area, Ring Road, Hebbal, Mysore, INDIA ± 570016

+91-96866-66306 | graam@graam.org.in | www.graam.org.in

Evaluation Team

Principal Advisor

Dr. R Balasubramaniam
Executive Director, GRAAM

Principal Investigator

Sham N Kashyap
Head of Research, GRAAM

Research Associate

Chandrika Shetty
Sr. Research Associate

Field Research Team

Mahesh, Kumar
Ravi C S, Ashwath Gowda
Banu, Mamta

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Abbreviations

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda Yoga Unani Siddha Homeopathy
BemOC	Basic Emergency Medical Obstetric Care
BRGF	Backward Regions Grant Fund
CBR	Crude Birth Rate
CHC	Community Health Centre
ENT	Ear Nose Throat
FGD	Focus Group Discussion
H	High performing Primary Health Centre
HB	Hemoglobin
HIV	Human Immunodeficiency Virus
HMIS	Hospital Management Information System
HR	Human Resources
ICTC	Integrated Counseling and Testing Centre
IFA	Iron and Folic Acid
IMNCI	Integrated Management of Neonatal and Child Illness
IMR	Infant Mortality Rate
IPD	In Patient Data
IPHS	Indian Public Health Standards
JSSK	Janani Shishu Suraksha Karyakrama
JSY	Janani Suraksha Yojana
L	Low performing Primary Health Centre
M	Median performing Primary Health Centre
MBBS	Bachelor of Medicine, Bachelor of surgery
MHV	Male Health Visitor
MMR	Maternal Mortality Rate

NRHM	National Rural Health Mission
OBC	Other Backward Class
OPD	Out Patient Data
OT	Operation Theatre
PHC	Primary Health Centre
PNC	Postnatal Care
PPH	Postpartum Hemorrhage
PPTCT	prevention of parent-to-child transmission
RMPS	Registered Medical Practitioner
SAGY	Sansad Adarsh Gaon Yojana
SC	Schedule Caste
ST	Schedule Tribe
STD	Sexual Transmitted Diseases
TB	Tuberculosis
TT	Tetanus Toxoid Injection
UPA	United Progressive Alliance
UPS	Uninterruptible Power Supply
VDRL	Veneral diseases
WHO	World Health Organization

Executive Summary

Many Primary Health Centres in Karnataka were upgraded to function round the clock, with additional financial and human resources, to enhance the reach of public health services in rural areas and to give thrust to the efforts to reduce MMR and IMR in the state. This process began in 2008-09 and has resulted in more than 1000 24x7 PHCs in the state.

Though there is a general agreement that establishing 24 X 7 PHCs has resulted in better provisioning of health-care services, there are also complaints of these facilities being ill-equipped, under-staffed and also under-utilized. There is an urgent need to re-look at their performance, see if they are serving the intended purpose and take appropriate policy decisions to improve their efficiency and effectiveness.

Grassroots Research and Advocacy Movement (GRAAM) conducted an in-depth assessment of the factors affecting the performance (both positively and negatively) of 24 X 7 PHCs in the C category districts of Karnataka, and suggest measures (both at policy and operational levels) to better their performance, at the behest of the Karnataka State Health System Resource Centre (KSHSRC). The objectives of this study were:

1. To get the snapshot of functionality of 24X7 Primary Health Centres

2. To find out the aiding and hindering factors affecting the performance of 24X7 PHCs
3. To suggest the required operational and policy change and also highlight on the possible impact due to those changes

The evaluation is conducted on a sample of 37 24x7 PHCs across the 7 C districts of North Karnataka, namely: Bidar, Gulbarga, Yadgir, Koppal, Raichur, Bagalkot and Bijapur, forming about 10% of the existing 24x7 PHCs in these districts. For the purposes of this study, 5 PHCs were chosen in each district, except for Bijapur and Gulbarga districts, where one additional PHC was chosen in each district, since these districts had higher number of PHCs in comparison to other districts.

The study used *Five deliveries reported in PHCs per thousand population per year* as the primary indicator to assess the performance of 24x7 PHCs. This variable was used to assess and categorize the performance of 24x7 PHCs into 3 categories: High (H), Median (M) and Low (L).

The major findings of the study are listed below:

- Most PHCs (21 out of 37) selected for the evaluation covered populations

ranging between 20,000 to 40,000 (columns 4 and 5). There were 8 PHCs covering more than 40,000 people. There were no patterns that associate the population covered by the PHC or the distance to taluk hospitals with the performance of PHCs.

- The overall monthly OPD rates show a positive relationship with delivery rates. However, the comparison within the districts does not provide a uniform picture of this relationship. Similarly, OPD rates and distance to private clinic/hospitals, presence of medical officers and similar factors did not provide any discernible relationships. In-patient rates too display a wide diversity between districts and between the 3 levels of 24x7 PHCs in some districts.
- *H level 24x7 PHCs recorded higher numbers of night deliveries and complicated deliveries.* This proportion was less in M and L level 24x7 PHCs. The average infant deaths in the PHC areas in 2013-14 in H level PHCs was 9, in M level PHCs, 7.11 and in L level PHCs, it was 12.38. However, these averages aren't statistically significant to draw conclusions.
- *H level PHCs were able to provide beneficiaries of JSY and Madilu kits*

in a more timely fashion in comparison to other levels. Infrastructure and medicine availability (both generic as well as specific to delivery related) did not differ substantially between the three levels of 24x7 PHCs.

- *H level PHCs were significantly better staffed than M and L level PHCs.* The proportion of H level PHCs a) having lady doctors, b) having more than 2 doctors and c) having 3 or more staff nurses was higher in comparison to other levels. In 50% of the cases, doctors in H level PHCs were reported to be staying in head-quarters (This ratio was about 22% and 15% respectively).
- The study found that *PHCs with lady doctors had considerably higher average deliveries* per thousand per year and hence, this affect was visible in H level PHCs, since the proportion of H level PHCs with lady doctors was high.
- Patterns of *fund released are associated with districts rather than with performance levels* of the PHCs. Thus, in terms of funds available for contingency expenditures or those related to hospital management there is no difference between H, M and L level PHCs.

- By and large, funds are released in two tranches, a) between July-September and b) November-December. This, together with the observation that about 62% of the PHCs received close to the earmarked funds during the financial year shows that most PHCs had received their funds, well in time, during the financial year. However, fund release during the first quarter of the financial year may further help the PHCs to plan their expenditures better.
- *Staff nurses of H level PHCs were technically more competent* in recalling issues to be observed during ANC checkups and were slightly better trained than those in other PHC levels.
- The satisfaction levels of clients (pregnant women and mothers undergoing ANC and PNC in the evaluation PHCs) was higher among H level PHCs.

The analysis of other contextual factors that affect the performance of 24x7 PHCs revealed the following insights:

- *Anemia and TB* were the most discussed ailments by service providers in group discussions. Other issues of concern were: Complications due to *multiple pregnancies, skin related allergies,*

sexually transmitted diseases (including HIV) and health problems due to substance abuse (alcohol and tobacco).

- *Child marriages, preference for male child, large family sizes, lack of nutrition and safe sanitation practices* were the most important socio-cultural problems recognized by doctors, ANMs and communities.
- The *issue of RMPs issuing steroids* and their other questionable practices and the impact on overall health of the communities were noted as causes of concern.

Based on these findings, the following observations were made in the study:

- Given that staff nurses had considerable responsibilities in performing deliveries, it was a matter of concern that very few staff nurses had received essential training like BEmOC and IMNCI.
- Basic infrastructure like patient toilets, water filters, running water supply and presence of UPS/Generators are still lacking in some 24x7 PHCs
- The high level of ANM vacancies were bottlenecks in effective field level detection of complications of pregnancy.

- The group discussions from service providers and community members show that lack of awareness and information are clearly not the reasons for social evils like child marriage, preference for male child, multiple pregnancy, neglect of women and unsafe sanitation practices to be prevalent.

Based on the results and observations, the following recommendations were made.

- Improving the technical competence of staff nurses with *compulsory training in BEmOC and IMNCI* and motivating the Staff Nurses for providing the best services, specifically in deliveries and over night care.
- Streamlining job responsibilities of AYUSH doctors, keeping in mind their larger role in the provision of health care.
- Exploring options for *phased regularization of staff nurses and AYUSH doctors*
- Exploring options for enforcement of head-quarters stay for medical doctors and encouraging rural services for lady doctors.
- *Including number of deliveries as performance criteria* with the highest weights, for performance based

funding of Untied Grants (as suggested by recent changes in NRHM).

- For 24x7 PHCs which have high patient loads, exploring the option of providing special grants (or upgrading these PHCs to CHCs) for provision of extra beds, staff, transportation facilities, medicine and other infrastructure.
- Providing at least *3 staff nurses and at least one lady doctor per PHC*, and more importantly, *stability in staff patterns and provision of services*.
- Strict enforcement of anti-quackery act.
- Developing simple SOPs for tracking complicated deliveries and referral decisions.
- Exploring possibilities of *integrated interventions* (poverty alleviation, sanitation, nutrition and women empowerment) on pilot basis, using opportunities like Sansad Adarsh Gaon Yojana, BRGF etc.