Engaging Communiti c Health Care Services

Inadequacies in infrastructure coupled with paucity of personnel, absenteeism and poor supply of medicine are resulting in poor service delivery across the nation

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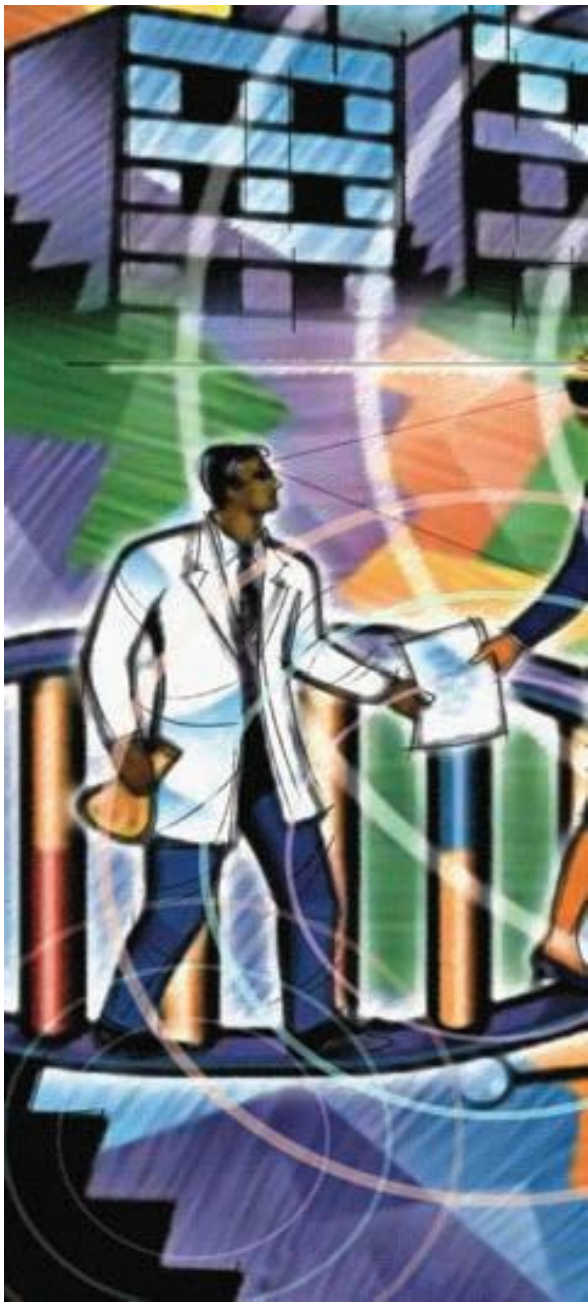

It has been now two days, since seven years old Ravi is down with fever. His mother, Sita, a poor landless labourer's wife, must wind up her day's chores before she can attend to him. The fever is high and he badly needs medical assistance. But the nearest Primary Health Centre (*PHC*) at Barbaas is 23 kilometers from Sitarampura in Todaraisingh block in Tonk district of Rajasthan. She will have to spend three hundred rupees just to get there, but she doesn't have a choice. Sita and Ravi are unfortunate symbols of grossly deficient medical services in the world's largest democracy.

Indian Economic Survey 2009-10, supports the above mentioned ground reality, which says only 13% of rural residents have access to a PHC, 33% to a sub-centre, 9.6% to a hospital and 28.3% to a dispensary or clinic. About two-thirds of country's registered hospitals are private. The survey also highlights a shortage of 20,486 sub-centers, 4,477 PHCs and 2,337 community health centers (*CHCs*) based on 2001 population norm. Village level health and sanitation committees were

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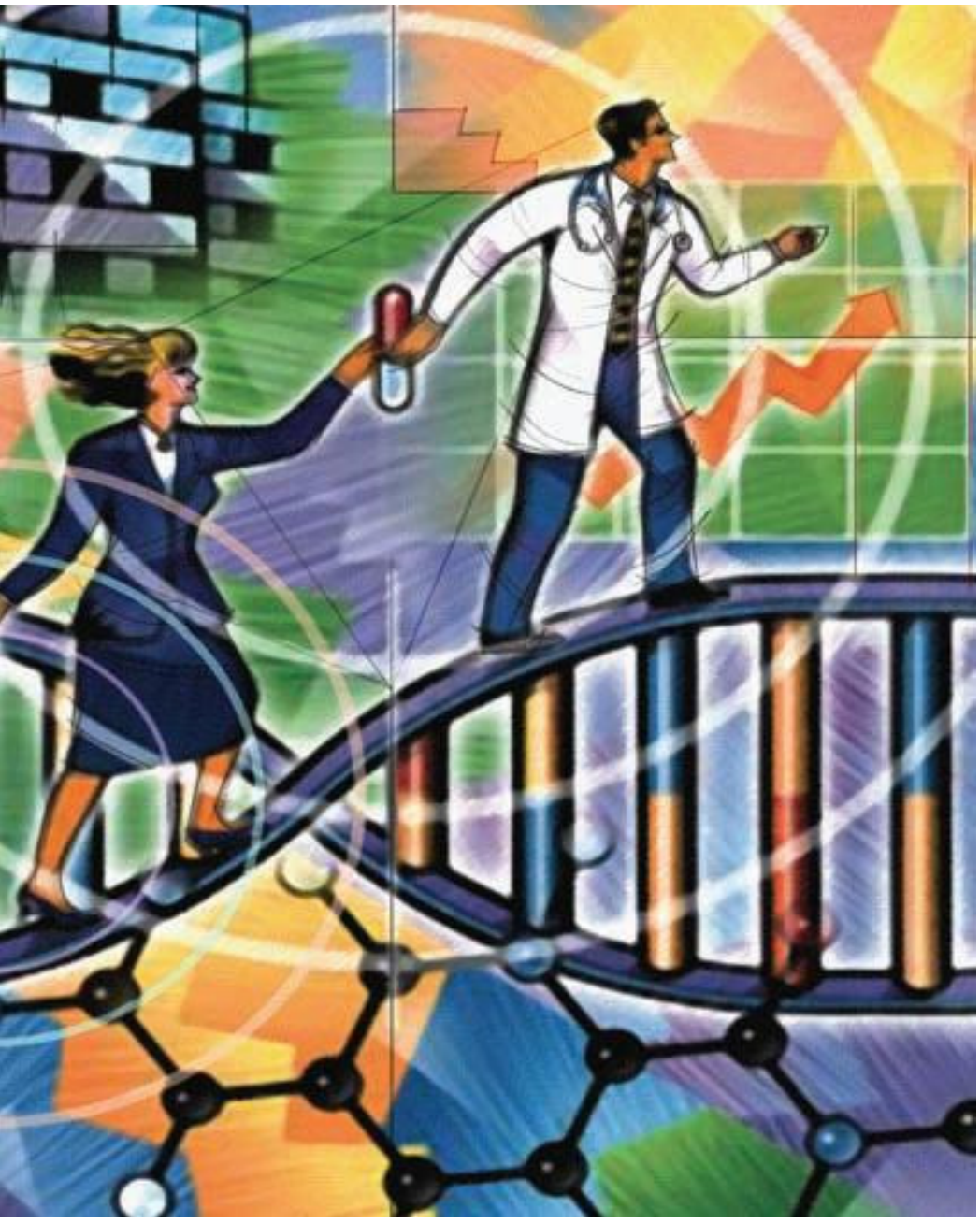


still to be constituted in nine states.

India's primary healthcare system is based on a well structured three tier public health infrastructure comprising of Community Health Centre (*CHCs*), Primary Health Centres (*PHCs*) and its attached sub-centres, each of them covering 5-6 or more villages, spread across rural and semi-urban areas. However inadequacies in infrastructure including shortage of personnel, absenteeism, poor supply of medicine etc., are resulting in poor quality of service delivery and waste of public funds.

Governments in developing countries spend substantial amount on public services including public health care. In 2010-11, 37% of the total plan outlay in India goes to social sector. Despite this, dissatisfaction is frequently expressed over the performance and quality of services.

In order to address inadequacies and to provide accessible health services to the poorest households in the remotest regions of the country, the National Rural Health Mission (*NRHM*) was launched in 2005. It is a national effort at ensuring effective healthcare in rural areas, especially to the poor and vulnerable sections of the society. It also aimed at undertaking architectural correction of the health system to enable it to effectively handle increased allocations and strengthen public health management and delivery.

Simultaneously, India's financial allocation for the health sector also increased from 10,040 crore in FY 2005-06 to Rs. 22,641 in FY 2009-10, a rise of 125 percent. NRHM allocations more than doubled from Rs. 6,788 cr in 2005-06 to Rs. 14,178 cr in 2009-10 and Rs.15,154 cr in 2010-11. NRHM allocations constitute 63% of the total allocations for health and family welfare.

Absenteeism is widespread across the country among the physicians and health care personnel of public health care facilities, as in many other developing countries, and have wide financial implications. Surprisingly, however, these issues are not as widely discussed in the policy framework in the health systems, despite their potentially adverse effects on health service delivery.

Recently, a study was done by CUTS International, an Indian origin International advocacy group, in one of the districts (*Tonk*) of Rajasthan to measure the rate of absenteeism among health service providers and the status of service delivery. As part of Transparency and Accountability Programme (*TAP*), implemented in 18 countries, the study was in collaboration with Results for Development (*R4D*) Institute, Washington DC and the Human Development Network of the World Bank.

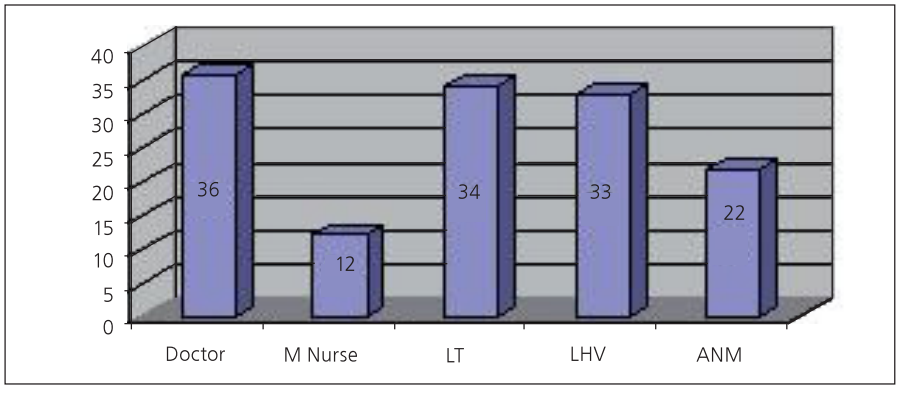
Citizens' Report Card (*CRC*) tool was used to know about their perception on the status of health service delivery. In addition, through the Participatory Absenteeism Tracking Process (*PATP*), 900 unannounced on the spot observations were made for 35 consecutive days, except on Sundays, by 150 monitors selected from the catchments of the PHCs.

On an average one third of the health services personnel was observed missing during duty hours in PHCs. Absenteeism was as high as 36 percent among doctors while in five categories of health service providers it was found to be 27 percent on an average.

The financial loss on account of absenteeism was 84 lakh per year for the target district, with out taking in to consideration the opportunity cost.

The PHCs lacked facilities like clean drinking water and toilets. The study found that 30 percent of the PHCs had either

Figure 1: Absenteeism (%) among Health Officials in Tonk District



poor or no proper drinking water facility. A 10 percent of the PHCs lacked toilets and 13 percent, electricity. An interesting co-relation also was found between the absenteeism and physical infrastructure. Wherever the physical infrastructure was poor, absenteeism was high.

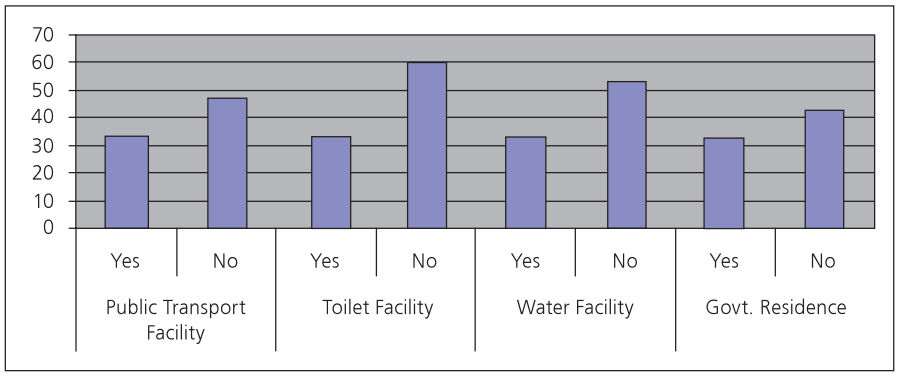
Along with rampant absenteeism, the study observed that on average 12 percent posts of health personnel in PHCs are vacant. The vacant posts ranged from five percent in the case of male nurses to 25 percent in Lady Health Visitors.

44 percent of the service recipients were not found satisfied with health service delivery. 69 percent of respondents were complaining of either not getting any medicines or getting only a few. As many as 47 percent said they did not know about the existence of Village Health and Sanitation Committee (*VHSC*), while a whooping 82 percent reported that they had no knowledge of any existing grievance redress mechanism.

Janani Suraksha Yojna (*JSY*) is aimed at encouraging intuitional delivery. However, 'Pregnant women refuse to come to PHCs, because of non-availability of female staff at the PHCs. They don't want to consult a male doctor', says Gayatri Verma, who is an ASHA (*Accredited Social Health Activist under NRHM*) Sahyogini in village Pachewar. 32 percent of beneficiaries said they did not receive any cash assistance under JSY.

Many doctors themselves complained about meager supply (*once or twice in a year*) of medicines and poor diagnostic facilities at the primary health centers (*PHCs*). It was observed that absence of governance and accountability structure was the major impediment in the process of service delivery, though NRHM suggests an accountability framework with three pronged process.

Figure 2: Doctor's Absenteeism vs. Presences of Facilities



On an average one third of the health services personnel was observed missing during duty hours

People expressed lack of faith in the PHC and its services, and they prefer to go to quacks with medicines rather than a PHC without doctors, diagnostic facilities and medicines. This is a serious matter of concern and waste of public money.

Two core strategies, community monitoring and third party engagement, of NRHM was found not gained a momentum yet, even after five years of implementation of the mission.

The success of any scheme lies in the civic engagement in the implementation of schemes as the accountability improves with civic participation. But unfortunately, this aspect is generally ignored. Community ownership and participation can only be the solution to these issues. IER

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The views expressed in the write-up are personal and do not reflect the official policy or position of the organization.)