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# HEALTH AND FAMILY WELFARE SERVICES: SITUATIONAL ANALYSIS OF CHHATARPUR REGION, MADHYA PRADESH

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***ABSTRACT***

***The health sector has an important role to play even though some important determinants of health inequalities may reside in the broader health situation, social setting and health infrastructure is particular important in understanding health disparities. The schedule caste population of the chhatarpur region is 23.3 percent, which is highest in the state. The total fertility rate of the district is 4.1 and birth rate in 31.2. The maternal mortality rate of the district is 880 per lakh while infant mortality rate is 108 per thousand and total mortality rate 12 per thousand. Chhatarpur is one of the educationally backward districts with a total literacy rate of 53.3 per cent, of this female literacy is 39.3 per cent and child enrolments in schools only 42.6 per cent. The per capita income is 2268 and the level of rural poverty 29.8 percent. Agriculture is till main stay of the population putting cultivator and agriculture labour together, 75.3 percent of the total workers are engaged in agriculture sector.***

## INTRODUCTION:

The Madhya Pradesh Human Development Index (which is a combination of certain related indicator of the education, health and income status) of Chhatarpur district at 0.216 is the fifth lowest in the state. The sex ratio of Chhatarpur is 917. Here Health and Family Welfare Services for improvement of Health Status among the population of Chhatarpur region has been discussed within important parameters.

## MATERIAL AND METHODS:

The study area of the proposed investigation comprises total geographic area of Chhatarpur district of Madhya Pradesh. The considerable concentration of population has been selected within the systematic criteria through random sampling. The random household sampling procedure has been employed for the selection of the

respondent and for collection of the data. In all about 350 households have been investigated within a particular time frame.

The present investigation has been conducted through "Interview schedule", "group discussion" and Informal interview". The investigation has been done through information keeping in view of the following aspects:

1. A door-to-door survey of randomly selected households has been under taken among the population of Chhatarpur district, Madhya Pradesh using structured schedule.
2. The study is based on differential in health care with special reference to social, demographic and environmental variable among the population of Chhatarpur district (M.P).
3. The exploratory study to find out the causes of death, disease, illness data and the records will be collected by case study, case history methods and through public health centre information.
4. The main thrust of the present study will be on understanding the characteristic of Health and Family Welfare Services Situational Analysis of Chhatarpur Region, Madhya Pradesh.

## SITUATIONAL ANALYSIS OF THE DISTRICT:

### HEALTH CARE DELIVERY INFRASTRUCTURE:

The district health and family welfare department has a network of 1 District hospital, 1 tuberculosis hospital in Nowgong, 4 Community Health Centre, 4 Civil hospitals, 8 Block Primary Health Centre, 36 Sector Primary Health Centre and 186 sub-health centres. The availability of buildings for rural health institution is very poor.

**(a) Sub health centres:** In all 186 sub-health centres, only 59 have a governments building and 45 are running in other buildings of the *panchayats*. In Gaurihar block out of 8 sub-centres with building only two are functional. In *Dumra* village visited in *Rajnagar* block the female health worker was residing in the village, however the sub centre building being on the outskirts of the village was not utilized at all. The female health worker inform that it is not safe for him and her family to stay there and since it did not have any water or electricity connection. The antenatal care/immunisation clinics were also conducted in her house.

**(b) Primary health centres:** Building are available in about 20 Primary Health Centre including civil hospitals out of these 7 have recently required sanction for expansion to 30-beded hospitals. In Lauri block Primary Health Centre visited this work is in progress whereas in Gaurihar block the site of construction is yet to be

finalised. All the other 24 Primary Health Centre are being run in sub centre building or panchayat buildings or in rented accommodation as per the records. The infrastructure is lacking in maintenance and requires major renovations and repairs. This however, is one of the many reasons for non-utilisation of the infra structure available. The building does not display clinic timings or the services offered. The clinic timings informed are varied at different centres. At one Block Primary Health Centre the timing was from 9 AM to 4 PM. The staff however did not have clarity regarding the lunch hour, if any. Sometimes the name of the centre is also not displayed. There is no boundary or gate resulting in stray animals/dogs in the health centre. There is a problem of water supply at most health centre. Generator was not available at Primary Health Centre Maharajpur where a Laparoscopic sterilization camp was visited. An organised system of waste disposal using incinerator is also lacking.

**(c) District Hospital:** As compared to the rural health infra structure the district hospital has an impressive infrastructure with separate clinic rooms and wards for different specialties of pediatrics, orthopedics, obstetrics, gynecology, ophthalmology and so on. The hospital has private wards and private labour room run by the Red Cross society with contractual appointment of support staff. The infrastructure development of the hospital has been done through the Red Cross society. Its income generate by shops run by the society which includes operation theatre, ward etc. Chhatarpur district hospital offers an example of public private mix in curative health care. There is also a large Tuberculosis Hospital in Nowgong block functioning under the Regional Director.

**(d) Ayurvedic Dispensaries:** There are 23 government Ayurvedic dispensaries in the district each Ayurvedic dispensary is staffed by a medical officer and a compounder or attendant. They offer only outdoor services. Co-ordination with these is lacking and their involvement in the government programs could be strengthened.

**AMBULANCE, TRANSPORT FACILITIES:**

There are 26 vehicles with the health system and all have been reported to be in working condition. The posts of drivers sanctioned in the district is 21, of which 1 is vacant. The distribution of these vehicles needs reworking since in the most remote block of Gaurihar there was no vehicle available with the Primary Health Centre medical officer. Public transport and taxis are also not readily available in a proportion of blocks in the district. When vehicles were available with the block medical officers, transport was seldom given for emergency obstetric care and patients have to make their own arrangements, which are expensive. Interviews with clients in villages of

*Ghur* revealed that due to this, despite being referred for obstetric complications (retained Placenta etc), Women do not get timely help resulting in maternal mortality. There are no regular mobile services to access the remote areas as well as those cut off during the rainy season. However, in inaccessible areas "catch up" round for immunisation is sometimes done.

**HEALTH PERSONNEL:**

**(a) District programme officers:** There is a Chief Medical and Health Officer under which there are 5 programme officers for immunisation, family welfare, training, media, extension activities and malaria. In Chhatarpur one post of medical officer is vacant. Beside this there is a post of district health officer (which perhaps has potential for more utilization) and also a district public health nurse. The program postings and activities have however been the activity of choice with health managers and these continue to be implemented in a mechanical manner with little innovations and experimentation.

**(b) Medical officers:** There are 101 positions of medical officers (including specialists) in the district out of which 24 are lying vacant. Of these 22 vacancies are at the Primary Health Centre only. There is non-residence at the place of posting and is informed, majority of staff was staying at the head quarters. Client interview show that some Primary Health Centre receives services by a doctor only few days in a month for some hours only. In a block visited one medical officer is in charge of 5 Primary Health Centers. Through the government allows private practice to rural posting doctors, they practice mostly at the headquarters town where they are residing. Private practice is also prevalent among the doctors posted in urban areas, as thus this is not considered a sufficient incentive to serve in rural areas. Some of the other reasons are for the dearth of doctors in rural areas include doctors on long unauthorised leave, lack of residential accommodation, more administrative than clinical work, transport/vehicle problems, inadequate equipment. There is a lack of recognition for good work and punishment for not working is also absent.

**(c) Health workers:** For female health worker there are only 5 vacancies (total sanctioned 245) and for male there are 30 vacancies (total 220). However a large proportion of these workers are not staying at the place of posting. One female health worker interview informed the considerable portion of her time is spent in completing the 10-odd reporting formats (some weekly and those on Target free approach (TFA), shiver report, Maternal and child health (MCH) and Family planning (FP), *Mahila swasth sangh* (MSS) monthly. Though the antenatal care register indicate blood pressure records and hemoglobin estimation of pregnant

women's the instrument for blood pressure measurement was packed as new and necessary equipment and expendables for urine and blood examination were not available.

The attendance of the health workers visits to the village is sent by the panchayat. This has resulted in some problems for few workers. However by and large, panchayat was verifying that female health workers are visiting the village and salary was being released, though the client's views were to the contradictory in the village visited. Auxiliary Nurse Midwives (ANM) however functions under difficult circumstances. They are required to travel extensively in a cluster of villages and have little security or comfort. The role and status of the Auxiliary Nurse Midwives (ANM) need to be substantially strengthened. Her responsibilities should be commensurate with training and capacity.

**(d) Male workers:** There are 220 male multipurpose workers (MPWs) (30 vacancies) in the district. The role of the male worker needs revamping. They are mostly malaria workers who chlorinate wells and informed that they are involved in calling the clients for immunisation on the clinic day, making malaria slides and helping with the report writing. The Target free approach (TFA) manual assigns the responsibility of health care and family planning primarily to the Auxiliary Nurse Midwives (ANM). Given the existing workload training received, capabilities, support structure and supervisory system, there is concern over the ability of Auxiliary Nurse Midwives (ANM) to do all that is expected of them. Multipurpose workers (MPWs) seem to have been involved of primary responsibility.

**(e) Supervisors:** There are 57 posts of paramedical supervisors in the district with only one vacant. These include health visitors, malaria inspectors and health assistants. There is lack of any type of facilitative supervision being conducted. Supervisory visits are few and far between and probably the main activity of the functionaries is compiling the reports and forwarding them to the district.

**(f) Community health Volunteer/*Jan swasth Rakshak*:** The youth from villages have undergone training for six months under Tribal rural youth self employment scheme (TRYSEM) in giving curative services for minor ailments and for the delivery of public health services in villages. Usually less than 50 percent of the youth who come for the training finally clear the course. Only a proportion of these do render services to the villages. Some community health visitors (CHVs) who possibly only joined the course for the stipend offered and belong to the higher well off class of the village are not providing any services. Community health visitors (CHVs) informed that they receives 50 rupees per month stipend from the government and involve themselves in chlorinating and

other activities like pulse polio, which are given by the medical officer (MO). There is no co-ordination with the female health workers (FHWs) and multipurpose workers (MPWs) nor-attempt made to involve the Community health visitors (CHVs) as depot holders for condoms or oral contraceptive pills (OCPs).

## RESULT AND DISCUSSION:

The Madhya Pradesh Human Development Index (which is a combination of certain related indicator of the education, health and income status) of Chhatarpur district at 0.216 is the fifth lowest in the state. The sex ratio of Chhatarpur is 917. The population growth rate for the district in 2001 was 2.68 [Urban 4.8, rural 2.23] and the population density of the district is 170. The schedule caste population of the district is 23.3 percent, which is highest in the state. The total fertility rate of the district is 4.1 and birth rate in 31.2. The maternal mortality rate of the district is 880 per lakh while infant mortality rate is 108 per thousand and total mortality rate 12 per thousand. Chhatarpur is one of the educationally backward districts with a total literacy rate of 53.3 per cent, of this female literacy is 39.3 per cent and child enrolments in schools only 42.6 per cent. The per capita income is 2268 and the level of rural poverty 29.8 percent. Agriculture is till main stay of the population putting cultivator and agriculture labour together, 75.3 percent of the total workers are engaged in agriculture sector.

India is a multi-ethnic, multi-linguistic and multi-religious state. It is difficult to summarize the condition and contents of the lives of people in a country of such size and with wide differences in geographic, social, economic and cultural form. Statistical averages rarely communicate the true picture of a diverse reality. Thus, whenever we present statistics, we have tried to portray the range of diversity, taking a holistic view rather than a sectorial path of analysis. The health status of India population is directly related to the ecology, human settlements and amenities available. The natural life support systems of land, water and air have been weakening over time as a result of the pressure of population and certain demands made by economic growth. In consequence, the symbiotic relationship between society and nature is disturbed.

The observation on Government Health and Family Welfare Services for improvement of Health Status among the population in Chhatarpur district is as follows:

1. The health and family welfare resources figure shows that the condition is very poor in terms of infrastructure as well as service providers.
2. The health personal is also lacking and most of the positions are vacant in the studied field area.

3. The health coverage is inadequate in the district as well as very poor in these tribal areas.
4. There is no blood bank in the district as well as field area so that center could not provide emergency obstetric care.
5. The coverage level of immunization as per record is good while vaccine preventable disease have not reduced proportionately.
6. The quality of health care facilities is very worse, besides there were several issue regarding non-residential staff in tribal areas as well as road facilities is lacking and it is difficult for clients in reaching the health center.
7. The cost factor in terms of private doctor is very high as well as non-availability of medicines is also being there in the tribal areas.
8. There are several schemes running in the district i.e. integrated child development schemes, maternity benefit schemes, Vatsalya yojana, Ayushmati yojana, Gramya yojana but the concern people are unaware of these schemes and they do not know the detail regarding these schemes.
9. The programme management for health care facilities shows that auxiliary nurse midwives have to collect large amount of information and fill out innumerable registers and form but these do not relate to their task nor they don't know why she is collecting these information.
10. The health care delivery service in the studied villages is inadequate due to limitation of money and manpower as well as health care facilities is not up to the expected mark.

The health care infrastructure is very poor, while most of the primary health centre are running in the panchayat building or rented accommodation. The health centre does not display clinic timings or the service offered. There is a problem of water supply in most of the centre. There are 24 medical officers post are vacant in the dictrict. There is a non-residential staff at the place of posting, majority of staff are staying at the headquarters. The auxiliary nurse midwives have to work in difficult circumstances, they are required to travel extensively in a cluster of villages and have little security and comfort. The deliveries rarely occur at the sub centre and few only at the primary health centre. The coverage levels of immunization reported in the district are very good. However, the morbidity and mortality due to vaccine preventable diseases are not reduced proportionately. The quality of family planning camps in terms of infection prevention practices, timing convenient to clients, pre-operative checkup including per vaginal examination, privacy, counseling, post operator case and follow up need strengthening.

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