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GOVERNMENT OF MEGHALAYA

EVALUATION STUDY ON THE WORKING OF PRIMARY HEALTH CENTRES IN MEGHALAYA

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WORKING OF PRIMARY HEALTH CENTRES IN MEGHALAYA

In Meghalaya provision has been made for establishment of one Primary Health Centre in each of the 24 Community Development Blocks in the State. By the middle of 1979, primary health centres were found functioning in 19 blocks. In the remaining 5 blocks the primary health centres were under construction. The primary health centres were to provide treatment for outdoor patients and to accommodate a limited number of indoor patients as well. These centres also carried on maternal and child health care services, family welfare programmes, control of communicable diseases, school health services and environmental sanitation, health education and maintenance of vital statistics.

Two primary health centres have since been raised to the status of rural hospitals. One of them is at Nongstoin, the headquarter of West Khasi Hills district and the other at Williamnagar, the headquarter of East Garo Hills district.

The study of primary health centres was taken up in consultation with the State Health Department. The purpose of the study was to examine the functioning of the primary health centres in the State and also to assess the beneficiary impact on the public as well as to highlight the limitations in their functioning. Out of the 19 primary health centres in position, 9 primary health centres were selected purposively to represent the districts of the State. These were :-

i) East Khasi Hills	-	Pomlum, Cherrapunjee and Pynursla phcs.
ii) West Khasi Hills	-	Nongstoin phc.
iii) Jaintia Hills	-	Khliehriat phc.
iv) West Garo Hills	-	Assanagiri, Baghmara and Dalu phcs.
v) East Garo Hills	-	Resubelpara phc.

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Chapter II(B)

General Background

As stated earlier, the Government had been able to set up 19 primary health centres in the State. 5 more primary health centres were still under construction. The progress in establishment of primary health centre's district-wise is shown in Table 1 appended. The jurisdiction of a primary health centre is coterminus with that of the block in which it is located. Thus a primary health centre selected for this study was expected to serve the population of its block which was to be as below.

Name of the primary health centre.	Name of the block	Population covered (Census 1971)
1. Pomlum P.H.C.	Mylliem	41326
2. Pynursla P.H.C	Pynursla	37546
3. Nongstoin P.H.C	Nongstoin	47483
4. Cherrapunjee P.H.C	Shella-Bholaganj	32172
5. Khliehriat P.H.C	Khliehriat	28988
6. Resubelpara P.H.C	Resubelpara	44395
7. Assanangiri P.H.C	Rongram	28846
8. Dalu P.H.C.	Dalu	32962
9. Baghmara P.H.C.	Dambuk-Aga	28173

The functions of the P.H.C. as stated earlier were to :-

1. render medical assistance to the people.
2. act as reference centres.
3. render maternal and child care services.
4. control communicable diseases.
5. carry on school health services.

A general background of each selected P.H.C. is given below.

1) The Pomlum P.H.C. started functioning from 7th November 1977 and covers all the villages in Mylliem Block. It covers 120 villages with an estimated population of 41326 according to 1971 Census. This p.h.c. is 13 km. away from Shillong which is within an easy reach of the people of most of the villages in the Mylliem Block. Pomlum village is also covered by an Integrated Child Development Scheme.

2) The Cherrapunjee P.H.C. is about 55 km. away from Shillong and is under the Shella Bholaganj Block which has 220 villages with

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an estimated population of 32172. This p.h.c. started as a Family Welfare Centre and continued so for a long time. It was inaugurated as a full-fledged p.h.c. in November, 1977. It started functioning from January, 1978.

3) The Pynursla P.H.C. is 50 kms away from Shillong and covers 103 villages in Pynursla Development Block with an estimated population of 37546. This p.h.c. also started functioning in November, 1977

4) The Nongstoin P.H.C. is located within the township which is the headquarter of the new district. At the time of writing this report this p.h.c. has been upgraded to a rural hospital with 30 be It covers 424 villages of Nongstoin Development Block with an estimated population of 47483.

5) The Khliehriat P.H.C. is 33 km. away from Jowai, the headquarter of the Jaintia Hills District. It covers 72 villages in the Khliehriat Development Block and a population of 28988. It has a long history as it started functioning from 1957. However, the data given here are from 1972-73 onwards.

6) The Baghmara P.H.C. in West Garo Hills was started in 1962 and covers 181 villages of the Dambuk-Aga Development Block and a population of 28173. It is 106 km. away from Tura.

7) Assanangiri P.H.C. in West Garo Hills is 18 km. away from Tura and covers 301 villages and a population of 28846. This p.h.c. is situated in the Rongram Development Block.

8) The Dalu P.H.C. in the West Garo Hills is 52 kms. away from Tura. It covers 243 villages and a population of 32962 of the Dalu Development Block. This p.h.c. was started in 1956.

9) The Resubelpara P.H.C. in East Garo Hills covers 308 villag in the Resubelpara Development Block. No record was found as to wh this p.h.c. was started. The data collected relate to the year 1977-78.

Chapter III

Staff position

In order that a primary health centre can undertake and carry on the minimum of work expected of it, the staff provided was broadly on the pattern indicated below :

1. Doctor	-	1	13. Basic Health Worker	-	3
2. Pharmacist	-	1	14. Dresser	-	1
3. Nurse	-	2	15. Dhai	-	1
4. ANM	-	2	16. Male Attendant	-	1
5. LHV	-	1	17. Stretcher bearer	-	1
6. Sanitary Inspector	-	1	18. Cook	-	1
7. Basic Health Inspector	-	1	19. Water bearer	-	1
8. Rural Health Inspector	-	1	20. Sweeper	-	1
9. Surveilance Inspector	-	1	21. Chowkidar	-	1
10. Health Extension-Educator	-	1	22. Office Assistant	-	1
11. Microscopist	-	1	23. Typist	-	1
12. Vaccinator	-	1	24. Driver	-	1

The actual staff requirement of each primary health centre, however, depends upon its work load. Judged against the minimum staff pattern, each primary health centre had at least the essential staff in position but judged against the actual requirement almost all the primary health centres suffered from staff shortage in one or other category. In the category of doctors, only Cherrapunjee has got the staff in position according to sanctioned strength. In the remaining ~~public~~ primary health centres, the number of doctors in position was only half the sanctioned strength. Likewise was the case of pharmacists. There was acute shortage of staff nurses. In 5 out of 9 selected primary health centres there was no staff nurse at all. To a certain extent the work seemed to have been carried on by the A.N.MS.

Judge from the requirement of the posts to be filled up, it looked as if importance was laid only on the curative aspect while preventive and public health activities largely ignored. For

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example, the post of Lady Health Visitor was filled up only in 3 out of 9 primary health centres and in three primary health centres the need to fill the sanctioned post was not felt at all. The same was the case with the post of Sanitary Inspector, Basic Health Inspector, Leprosy Inspector, Surveillance Inspector and Basic Health Workers. These posts were filled up only in one or two out of the 9 primary health centres as indicated in Table IX Likewise the need for filling up the post of Health Extension Educator was filled in only 2 Primary Health Centres of Garo Hills.

In regard to the post of male and female attendant, the case was more or less the same. These posts were sanctioned to enable the indoor section of the primary health centre to function. In on 3 primary health centres these staff were in position. Only the Dalu primary health centre has stated that it required these posts

In the absence of the attendants, it was understood that th work was performed by the A.N.Ms in addition to their own work. But it is not understood why the primary health centres did not press for filling up of the post.

There was no uniformity in the provision for supporting ministerial staff. An Upper Division Assistant was sanctioned onl for Cherrapunjee, Khliehriat and Dalu primary health centres. In the remaining primary health centres there is no provision even f L.D.-Cum-Typist. Three primary health centres namely, Nongstoin, Assanangiri and Baghmara have in fact requested for ministerial and statistical posts but the remaining primary health centres appeared to be content with the statusquo. The study revealed no uniformity of the staff in position in the sanctioned strength a for that matter no clear criteria at all in this regard. Elsewhe over and above the minimum, the strength of staff is usually related to the bed strength of the institution.

The shortage of doctors, nurses and other paramedical staff in the primary health centres was due to a variety of reasons. For the doctors, those in position had grumbled that

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the facilities to enhance their professional skills are negligible. In many cases, doctors become fed up due to non-availability of the required medicines for the patients under their care. Another reason was the remoteness of the majority of the primary health centres involving virtual isolation from near and dear ones and absence of recreational facilities in the rural areas. In some cases, lack of proper housing facilities was also a cause for reluctance to take posting in the primary health centre. However, in almost all cases the incentives were not adequate enough to induce ready acceptance of rural postings except in the very few with a high sense of dedication of service to the suffering people. To a certain extent, the shortage of doctors in the primary health centres may perhaps be met by provision binding the doctors (qualified on Government assistance) to serve for a period in the rural area.

Chapter IV

Functions of the Primary Health Centre

The functions of primary health centres included both curative as well as preventive. Besides the above roles, the p.h.cs were also expected to educate the rural people in the elements of health and sanitation as well as provide maternal and child care services. Except for a few of the p.h.cs all the centres carried out the functions expected of them.

The number of patients attending the p.h.c., the facilities available to the patients attending the p.h.c. and the services rendered to them are some of the criteria that can be judged whether the p.h.cs were functioning as desired.

No.of patients:

The credit for treating the maximum number of outdoor patients goes to Nongstoin where during the year 1977 - 78 a total number of 19754 patients attended the p.h.c. for treatment. Resubelpara, on the otherhand, takes credit for treatment of the maximum number of indoor patients numbering 634 in 1977-78. The number of patients both indoor and outdoor attending the p.h.c. is indicated in Table III. From the Table number of patients attending Cherrapunjee, Pomlum and Pynursla was rather low. This was due to the fact that figures given were only for three months as these p.h.cs.had only started functioning a few months earlier before the date of visit.

In regards to indoor patients,maternity cases out-numbered other cases. This suggests that there is demand for more beds for maternity cases instead of the two beds usually reserved for these cases at present.

The study also revealed that the most common diseases treated at a Centre were intestinal, notably diarrhoea and dysentry. It would be useful for the p.h.cs as part of their preventive functions to probe into the causes of wide prevalence of these diseases in the area to enable precautionary measures.

Indoor patients: 6 out of the 9 selected centres had their indoor section operating and the number of beds varied from one p.h.c. to another. No uniformity was observed. The required criterion laid down was 6 beds per p.h.c. and 30 beds for rural hospital. However, the study revealed that Cherrapunjee, Resubelpara and Nongstoin had 20 beds even before being upgraded to rural hospital while 4 beds in Cherrapunjee and 6 beds in Resubelpara were reserved for

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maternity cases, the rest were for patients of other diseases. All the p.h.cs except Cherrapunjee supplied free food to the patients. The condition of the Cherrapunjee indoor section during the time of investigation was rather disheartening. During the rainy season, there were leakages in the building leading to flooding of the rooms. In many cases, patients were rather hesitant to get themselves admitted as indoor patients of the Cherrapunjee centre.

The buildings of the Khliehriat p.h.c. was in a dilapidated condition. No repair was carried out, there was no light nor water connection and so with the absence of these essential services, the indoor section of the p.h.c. could not be opened though it is one of the oldest p.h.c. in Meghalaya.

Medicines - Medicines are perhaps the most important pre-requisite for the functioning of p.h.c. However, the study revealed that the most common complaint of the doctors in-charge and of the patients as well was that medicines were given whenever available. For common diseases like cold, cough, diarrhoea and dysentri medicine was available but for more complicated diseases patient had to bear the expenditure of costly medicines. Thus it was not much relief to the rural patients by going to the p.h.c.

The non-availability of medicines seemed to be due to the fact that the Medical Officer in-charge did not have the discretionary powers to buy medicines whenever needed. A procedu to be followed was laid down in that the indents were to be made only through the Civil Surgeon who is also responsible for payme Emergency indents were also placed from the District Medical Stores, but this did not help. Perhaps, if some powers was given to the Medical Officer-incharge, the irk due to non-available of medicines would be somewhat eased.

In the rural area where pharmacy and medicine shop were non-existent, it is only essential that more medicines are kept in the p.h.c. even, on payment basis.

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Chapter V

SITE SELECTION OF BUILDINGS AND EQUIPMENT

In order to serve the rural masses in effective manner, it is most essential that a primary health centre be located in a convenient and well spaced area easily accessible to the surrounding villages. Except for the primary health centre at Pynursla, the other contres were suitably located, and within easy reach of the public. Punursla Primary health centre, on the other hand, was originally located at the gate prior to its being shifted to the present site near the Block Office. The beneficiaries complained that the present site is out of the way.

The usual practice followed in all primary health centres was that land was donated by the village and the construction of the building was done by the Government. In all the selected centres this procedure was followed. In some cases, p.h.c. and the private dispensaries/practitioners were found functioning side by side as if competing for the simple rural patients. One example is the Pomlum primary health centre, whereas the villagers of Umtyngar preferred the private dispensary at Laitlyngkot to Pomlum which is 11 kms away. Again as communication facilities have greatly improved, the people of Pomlum preferred coming to Civil Hospital, Shillong than attending the primary health centre. In such cases, the attendance in the p.h.c. was rather thin.

Building: All the selected primary health centres were housed in their own buildings most of which were newly constructed. Though the staff quarters were also attached to a Centre, the general complaint was that these were not properly maintained. In some cases, water, light and sanitary facilities were not available, in others, the building suffered from leakage and requiring repair. One of the incentives to the staff posted to the p.h.c. being proper accommodation, so unless and until the buildings are reasonably equipped and maintained it is difficult for the staff to feel at home in the primary health centres thereby affecting the quality of service to the masses.

Another essential requirement with regards to the building is the presence of compound walls. Except for two or three of the selected centres, all the centres did not have compound walls. Compound walls are essential to keep

the centre clean and prevent stray animals from entering the buildings. This also helps to keep the primary health centre free from contamination through stray animals.

Equipment: With the setting up of primary health centre it is essential that certain equipments like microscope and even X-Ray be installed at the Centre so as to ensure effective service to the people. In course of the investigation it has been found that four out of the nine selected centres had some facilities in this regard. These included Khliehriat, Nongstoin, Baghmara and Cherrapunjee where facilities for testing of blood, urine and stool were present.

Only Nongstoin had an X'Ray machine but was yet to function at the time of study. It has been observed that patients have shown great satisfaction due to the presence of the above facilities. If these facilities can be installed in all the centres, the service of the centre will have greater meaning by saving the patients the trouble of travelling elsewhere for the simple tests.

Table IV gives the number of beneficiaries undergoing different pathological test at the p.h.c's.

Transport facilities: In order to reach out to the rural masses it is essential that provision of either a car or a jeep be provided for each centre. Only six out of nine selected centres were provided with either an Ambassador car or a UNICEF Jeep. Only Nongstoin and Cherrapunjee have been provided with Ambulance. The presence of transport facilities has increased the efficacy of the p.h.c. and proved helpful to the masses at large.

Khliehriat, Pomlum and Pynursla are the centres with no vehicles. Khliehriat seems to suffer other setbacks as well. Khliehriat was provided with an Ambassador but this remained out of order for a long time and till the time of visit nothing was done to get it repaired or replaced by a new vehicle. Centres situated in remote areas should be provided with better facilities so that the work of primary health centres can be carried out smoothly.

Chapter VI

Family Welfare Programme.

The study revealed that the public have not taken advantage of the maternal and child-care services in the p.h.cs but have gone in more for the family planning programmes offered by the Centres. Table V gives an idea of the popular method adopted by the public. There was a wrong notion among the rural people that family welfare programme means only family planning. The p.h.cs were yet to educate the public as to the full coverage of the family welfare programme. Though the facilities were available in the p.h.cs, these were not availed of fully due to the misconception of the programme.

In 2 centres there was no interest among the beneficiaries in the family planning programmes. These are Pomlum and Pynursla. The Pomlum p.h.c., however, was intensifying the drive to educate the people as regards the various family welfare programmes including family planning. On the other hand, the beneficiaries of Pynursla expressed reluctance to accept the family planning programme. This underlines the need for more vigorous drive to create a sense of awareness of the benefit of the programme among the simple folks of the area. In Garo Hills, the public were aware of the benefits of family planning and so larger numbers have come forward to avail of the facilities in the p.h.cs. Vasectomy scored to be more popularly accepted followed by contraceptives.

Chapter VII

Opinion of the beneficiaries

The assessment was based on the views of a sample of beneficiaries in the jurisdiction of the p.h.c. Three villages were selected in each p.h.c. One village was situated in and around the p.h.c., another 5 kms away and the third 10 kms away from the p.h.c. respectively. 10 households were selected for interview in each village.

For Pomlum P.H.C. the villages selected were Umtyngar, Myllien Kyndong and Pomlum itself. Umtyngar was about 11 kms away from Pomlum. None of the households at Umtyngar availed of the facilities of the p.h.c. as they found the private dispensary at Laitlyngkot was more convenient to them and in more serious cases they preferred coming to Shillong. On Pynursla market day they would avail the services of private doctors passing through their place. Since this village did not avail the facilities offered by the p.h.c., another village was selected in its place and this was 12th Mile village which was 10 kms. from Pomlum. The people of this substitute village generally availed the facilities of the Pomlum p.h.c. and were quite satisfied with the services they got there.

But Myllien Kyndong only 5 kms away from the p.h.c. preferred the Ram Krishna Dispensary nearby for minor ailments while in more serious cases they preferred coming to Shillong. Even the beneficiaries at Pomlum preferred coming to Shillong in more serious cases.

Out of the 30 respondents selected to represent Pomlum p.h.c. from the 3 villages, only 18 were found to have availed the services of the p.h.c. Out of these, 4 only visited the centre regularly, that is, once a week. The others once a year or whenever they felt necessary. The beneficiaries of Pomlum generally found the personnel when visiting the p.h.c. A major complaint was that medicines were not always available. These beneficiaries felt that medicine is a must in the p.h.c. even on payment. Any subsidy in this regard will be most welcome to them. Another complaint was that no help was given by the p.h.c. for admission to the Civil Hospital in serious cases.

Cherrapunjee P.H.C. - The villages selected to represent this p.h.c. were Saitsohpen, Mawblang 7 kms. and Laitryngew kms away from the p.h.c. respectively. Out of 30 households selected, 29 could be located and these have availed the services of the p.h.c.

The beneficiaries of the p.h.c. expressed great satisfaction in the services available. Out of respondents in 29 households interviewed, in 10 households the members visited the p.h.c. once a month, in 12 once a year and the rest either once a week or twice a month. There was generally no complaint regarding treatment received. The complaint was in regard to the building housing the p.h.c. which was leaking thereby causing great discomfort to indoor patients. The other was in regard to medicines which were not frequently available thereby frustrating patients expecting relief of their ailments. Only a few availed of the p.h.c. facilities for maternal and child care but these were satisfied with the treatment received. A majority of the beneficiary households were not in favour of family planning.

Pynurlsa P.H.C. - The villages selected to represent this p.h.c. were Siatbakon 10 kms away. Rangthylliang 5 kms and Pynrusla village itself. Previously when there was only a dispensary at the Pynurlsa Gate being centrally located in close proximity of the market and embarking and landing place. This was quite convenient to patients coming from interior villages especially on market days when they have other chores to perform besides attending the p.h.c. When the dispensary was upgraded to a p.h.c. the location was shifted to the Block Complex about 2 kms away from the market and bus stop. This brought difficulty for patients to reach the p.h.c. especially those in weak condition. It would be most helpful if transport arrangement between the p.h.c. and the bazar can be provided during the market days when the maximum number of patients is expected.

Out of 30 households interviewed, members from 4 households visited the p.h.c. once a week, another 4 twice a month from 10 once a month and from 12 once a year.

The main complaint in regard to Pynursla was that the personnel and medicines were not regularly available at the p.h.c. Sometimes only nurse and Pharmacist were present while the doctor could not be found even during the consulting hours fixed.

At the time of the investigation, the indoor section of the p.h.c. has not functioned. The would be indoor patients had, therefore, to be brought to Shillong at great expense by the patients

patients themselves. Another problem was the absence of a vehicle which handicapped movement of the personnel and thereby restricting their visits for seeing the health and sanitation conditions of the villages. In many cases programme for such work had to be abandoned.

The maternal and child health services were availed of by 17 of the 30 households interviewed. None of the households, however, was in favour of the family planning, none thought advisable for their neighbours to adopt it.

Nongstoin P.H.C. - The villages selected for this p.h.c. were Nongpyndeng village 5 kms. away, Nongstoin itself and Nongspung 10 kms. away. Of the 30 beneficiary households selected, 8 visited the centre once a week, 12 once or twice a month and 10 visited once a year. The general complaint of these beneficiaries was the non-availability of medicines and the absence of the personnel at the p.h.c. This tended to undermine the confidence of the people in the p.h.c. 28 respondents had availed of the maternal and child-care facilities but none was in favour of family planning.

All the sample beneficiaries have expressed the need for a hospital and presence of specialized staff and good stock of medicines. (Shortly after the investigation the Nongstoin p.h.c. was upgraded to a rural hospital).

Khliehriat P.H.C. - was one of the oldest p.h.cs which caters to the needs of 72 villages. Started way back in 1957, this p.h.c. should have been one of the well established and advanced centres. The study, however, revealed it to be one of the most neglected. The three villages selected were Rymbai 10 kms. away from the p.h.c., Byndihati 5 k.ms and Khliehriat village itself.

There was no indoor section in this p.h.c. and there was unanimous resentment among the beneficiaries in this regard. In more serious cases the patients had to come all the way to Jowai for admission to the Civil Hospital. However, as regards minor ailments such as cough, flu, diarrhoea and dysentry, the beneficiaries were satisfied with the treatment received in the p.h.c. though they preferred to attend the dispensary of the Border Road Task Force situated nearby as the facilities were considered better.

In regard to the Khliehriat p.h.c. the suggestions of the beneficiaries for opening of the indoor section, provision of adequate medicines and anti-rabic injections, repairing and improvement of building and provision for an ambulance were only to be expected.

As regards maternal and child-care, only one sample household had not availed of the services. The majority were satisfied with the services. In regard to family planning programme, only 4 welcomed the idea while the rest were stubbornly against it.

It was rather a welcome surprise that even with all the short-comings in the face of a dilapidated building, absence of vehicles and irregularity of medicine supply, the beneficiaries were very satisfied with the personnel of the p.h.c. in rendering whatever possible help to the people at large.

Dalu P.H.C. - The p.h.c. is situated in Dalu Block of West Garo Hills and covers 243 villages many near the border of Bangladesh. The villages selected were Barengapara, Chondbhui and Sesingpara. Out of the 30 sample households, 29 had visited the centre and 14 had visited at least once a week. All these households expressed satisfaction with the treatment received. As in other p.h.c., the main complaint was in regard to medicines. The households in Barengapara in addition have complained of the lack of proper water supply, sanitary facilities and also that though there was indoor section, there was no separate labour room. The villagers of Sesingpara on the other hand, have to face great transport difficulties to reach the p.h.c. at Dalu. To give relief to them, they suggested that a nurse, a pharmacist and a good supply of medicine should be provided at the existing sub-centre nearby their village at least in cases of minor ailments.

In this p.h.c. none of the households had availed of the maternal and child health services offered by the centre and none was in favour of the family planning programme conducted by the centre in recent years.

Assanangiri P.H.C. - The p.h.c. is situated at Rongram Development Block of West Garo Hills and covers an estimated number of 301 villages. The villages selected were Sibasalgiri, Assanangiri and Ganolgiri. During the course of the interview it was found that

that 8 households had attended the p.h.c. once a week 8 once or twice a month and 6 once a year.

The complaint of the households in regard to this p.h.c was that the personnel were not always available at the p.h.c. During the investigation the personnel including the Doctor incharge stayed at Tura instead of at the quarters in the p.h.c. This was understood, however, to be due to absence of proper accommodation at the p.h.c.

Another complaint of the households was non availability of medicines.

The maternal and child care services of the p.h.c. have not been availed of by any of the sample households and nonewas in favour of the family planning.

Resubelpara P.H.C. - The centre is situated at Resubelpara Block and cover 308 villages. The villages selected were Nirang Chol, Mendipathar and Dilma Songsak. Only 6 sample household had visited the centre at different intervals as shown on Table 1. The attendance at the centre seemed to be on the decline. This was due to the transport difficulties from remoter villages and to the opening of a sub-centre at Mendipathar which is more easily accessible to the villages and had greater facilities in other respects.

The maternal and child care facilities in this p.h.c. remained largely un-utilised by the people.

Baghmara P.H.C.- The p.h.c. is located at Dambuk-Aga Block of West Garo Hills and covers 181 villages. Malikona, Balsalgiri and Jogsongram were selected for the investigation. Only one sample household had not visited the p.h.c. The others who have visited the centre had stated that they were facing great transport difficulties in attending the centre.

The main complaint of the benefficiaries was that the p.h.c. was ill-equiped in many respects. (This was understood to be due to its being recently established). The indoor unit was not functioning, water and sanitary facilities were not available and besides medicine was given only when available. The households were also not aware of the maternal and child care services facilities in the p.h.c. Though the households had many complaints, they admitted that the p.h.c. had proved useful to them. The establishment of this p.h.c. had at least saved them from going all the way to the nearest civil hospital at Tura more than 100 kms away. This was considered a blessing especially in maternity cases.

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Summary of the findings and suggestions.

1. The basic requirement of a primary health centre was that it should have provision for both indoor and outdoor sections with at least 6 beds as prescribed in the case of a primary health centre and 30 beds in a rural hospital. The study revealed that, there was no uniformity in practice in this regard. In fact 2 primary health centres or 22 per cent did not have indoor section at all. In regard to beds, however, all primary health centres with indoor sections had at least 6 beds and some 10 beds and some as many as 20 beds. It should be insisted upon that a primary health centre should invariably have an indoor section. Chapter II

2. There was no uniformity in the staffing pattern of the primary health centres. There was a shortfall of staff in all the centres except Khliehriat and Cherrapunjee. Posts remaining vacant should be minimized so that a primary health centre can play the role expected of it and maintain standard of service. Chapter III

3. (a) The functions of the primary health centres include both curative and preventive as well as maternal and child care. The study revealed that the maximum number of patients went to the primary health centre for cure of ailments such as intestinal disorders notably, diarrhoea and dysentry. The preventive side of the function appeared to have been neglected. This aspect is to be stressed if common diseases in the villages are to be prevented if not eradicated.

3. (b) As regards the indoor facilities, it was found that maternity facilities were the most sought after. In almost all the p.h.cs the maternity cases often out-numbered other indoor patients. Even if the number of maternity beds is increased from the present 2 to 8 or even 10, there would be no under utilization of the capacity. This of course also entail addition of midwives in the p.h.cs.

3. (c) In all the p.h.cs, medicine was found to be utterly inadequate. The stock was far too short to render meaningful treatment to the public even in the case of minor diseases. The stock of medicine in the p.h.cs should, therefore, be improved both in quantity and in range. Chapter IV.

4. The study revealed that though the p.h.cs have the standard buildings, there was no compound wall to keep the premises clean and keep out stray animals. Some p.h.cs manifested lack of maintenance and repair and some were without proper water and light and sanitation. Chapter V.

5. The absence of transport facilities was a handicap to the smooth functioning of the p.h.c. An ambulance or at least a car or jeep should be provided.

6. The Family Welfare Programme of the p.h.c. remained practically unknown to the public. There was rather a popular misconception that family planning and family welfare was one and the same thing. The p.h.c. has to be more active to educate the public as to which is which. From the records with the p.h.cs, a large number in Garo Hills had availed of the family planning facilities. On enquiry from the beneficiary villages, however, none of the households had informed anything to corraborate these records claimed by the p.h.cs. Government may like to prove into this discrepancy to find out the real facts. Chapter VI.

7. The main complaint of the beneficiaries was in regard to medicine not being always available. In Garo Hills, transport difficulties in getting to the p.h.c. was also one of the main complaints. It was a general feeling of the beneficiaries that with improved transport facilities, adequate provision of medicines, regular attendance of doctors and personnels of the p.h.cs, provision of anti-rabi injections, suitable location, the p.h.cs can render invaluable services in the rural area itself. Chapter VII.

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TABLE 1

Distribution of P.H.Cs among different districts in Meghalaya as on 1.3.78

Sl. No.	Name of the District.	Total no.of Blocks	Total no.of p.h.cs.	No.of Blocks having no p.h.c.	Percentage of Blocks covered by p.h.cs.	remarks.
1	2	3	4	5	6	7
1.	East Khasi Hills	7	6	1	86%	
2.	West Khasi Hills	3	2	1	67%	
3.	Jaintia Hills	3	2	1	67%	
4.	East Garo Hills	3	2	1	67%	
5.	West Garo Hills	8	7	1	88%	
	T o t a l	24	19	5	79%	

T A B L E - II

Staff position of phcs in Meghalaya for the year 1977-78 Project Level

Designation	Name of selected phcs. Pomlum phc		Pynursla phc		Cherra-punjee phc		Nongstoin phc		Khlieh-riat phc		Baghmara phc		Dalu phc		Aosanan-giri phc		Resubel-para phc		re-marks
	a	b	a	b	a	b	a	b	a	b	a	b	a	b	a	b	a	b	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
A. Medical & Para medical staff:																			
1. Medical Officer	N.A	1	2	1	4	4	N.A	2	1	1	N.A	1	4	2	2	1	2	1	
2. Pharmacist	N.A	1	1	1	2	2	N.A	1	3	1	N.A	1	1	1	1	1	N.A	1	
3. Aux. Nurse & Midwife	N.A	-	4	4	8	8	N.A	10	5	5	N.A	2	3	2	2	2	N.A	5	
4. Lady Health Visitor	N.A	-	-	-	6	6	N.A	-	1	1	-	-	-	-	-	-	N.A	1	
5. Staff Nurse	N.A	2	1	1	2	2	N.A	2	-	-	N.A	-	-	-	-	-	N.A	2	
6. Sanitary Inspector	N.A	-	-	-	1	1	N.A	1	1	1	N.A	1	1	1	1	1	N.A	1	
7. Basic Health Inspector	N.A.	1	2	2	10	10	-	-	-	-	N.A	-	-	-	-	-	N.A	-	
8. Extn. Health Educator	N.A.	-	-	-	1	1	-	-	-	-	-	-	1	1	-	-	-	-	
9. Rural Health Inspector	N.A.	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-	N.A	1	
10. Leprosy Inspector	N.A.	-	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-	
11. Surveilance Inspector	N.A.	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	-	-	
12. Radiographer	N.A.	-	-	-	1	1	-	-	-	-	-	-	-	-	-	-	-	-	
13. Microscopist	N.A.	-	-	-	1	1	-	-	-	-	-	-	1	1	1	1	N.A.	1	
14. Asstt. Microscopist	N.A.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	
15. Basic Health Worker	N.A.	3	6	6	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
16. Vaccinators	N.A.	1	3	3	3	3	N.A.	5	-	-	N.A.	2	4	4	6	6	N.A.	1	
17. Dresser	N.A.	-	-	-	-	-	N.A.	1	-	-	-	-	-	-	-	-	-	-	
18. Dhai	N.A.	-	-	-	-	-	-	-	-	-	N.A.	1	-	-	-	-	-	-	
19. Male Attendant	N.A.	-	-	-	-	-	-	-	-	-	N.A.	1	-	-	1	1	N.A.	2	
20. BEE	N.A.	-	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-	
Total: Medical & Para Medical Staff	N.A.	9	19	18	39	39	N.A.	22	12	10	N.A.	9	17	14	16	15	2	17	

B. .....

Table - II ...contd.

Designation	Name of selected phcs.																		remarks
	Pomlum phc		Pynursla phc		Cherra-punjee phc		Nongstoin phc		Khliehriat phc		Baghmara phc		Dalu phc		Assangiri phc		Rebubelpara phc		
	a	b	a	b	a	b	a	b	a	b	a	b	a	b	a	b	a	b	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Administrative Staff:																			
1. U.D.A.	N.A.	-	-	-	1	1	-	-	-	-	1	-	1	1	-	-	-	-	
2. L.D.A.	N.A.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
3. Computer	N.A.	-	-	-	-	-	-	-	-	-	-	-	+	-	+	1	-	-	
4. Driver	N.A.	-	-	-	1	1	N.A	1	2	2	1	1	1	1	1	1	N.A	1	
5. Peon	N.A.	1	1	1	2	2	-	-	2	2	-	-	-	-	-	-	-	-	
6. Chowkidar	N.A.	1	-	-	3	3	N.A	3	3	3	1	1	1	1	N.A.	1	N.A	2	
7. Sweeper	N.A.	1	1	1	2	2	N.A	1	1	1	1	1	1	1	1	1	N.A	1	
8. Cook	N.A.	1	1	1	1	1	-	-	-	-	1	1	1	1	1	1	N.A	2	
9. Pani-wala	N.A.	-	-	-	-	-	N.A.	1	1	1	-	-	1	1	-	-	N.A	1	
10. Mali	N.A.	-	-	-	1	1	-	-	-	-	-	-	-	-	-	N.A	N.A	1	
11. Stretcher bearer	N.A.	-	-	-	1	1	-	-	-	-	-	-	-	-	-	-	-	-	
12. Ward Girl/Boy	N.A.	2	-	-	2	2	-	-	-	-	-	-	-	-	-	-	-	-	
13. Masal-Chi	N.A.	-	-	-	1	1	-	-	-	-	-	-	-	-	-	-	-	-	
14. Vol. Health Worker	N.A	-	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-	
Total: Administrative Staff	N.A.	6	3	3	15	15	N.A.	6	9	9	5	4	8	7	4	5	N.A.	8	
Grand Total	N.A.	15	22	21	54	54	N.A.	28	21	19	5	13	25	21	20	20	2	25	

Staff of Khliehriat phc include those of Sub-centre

(a) No.of posts sanctioned
(b) No.of posts in position.

r.7.8

TABLE III

No.of patients treated at the P.H.Cs/R.Hs. for the year 1977-78.

Name of p.h.c.	No.of patients treated				grand total
	male	female	child	total	
1	2	3	4	5	6
1. Pomlum p.h.c:					
O.P.	737	1138	1217	3092	3092
I.P.	-	-	-	-	-
2. Cherrapunjee p.h.c:					
O.P.	718	632	476	1826	1826
I.P.	-	-	-	-	
3. Pynursla p.h.c:					
O.P.	54	71	112	237	237
I.P.	-	-	-	-	
4.Nongstoin p.h.c:					
O.P.	N.A.	N.A.	N.A.	19754	19798
I.P.	11	31	2	44	
5.Khliehriat p.h.c:					
O.P.	2857	2054	3075	7986	7986
I.P.	-	-	-	-	
6.Resubelpara p.h.c:					
O.P.	4721	3705	3499	11925	12559
I.P.	295	251	88	634	
7.Baghmara p.h.c:					
O.P.	2479	1403	1905	5787	6005
I.P.	125	82	11	218	
8.Asanagiri p.h.c:					
O.P.	1770	884	2001	4655	4693
I.P.	21	2	15	38	
9.Dalu p.h.c:					
O.P.	3338	3211	6554	13103	13174
I.P.	N.A.	N.A.	N.A.	71	
Total: O.P.				68365	69370
I.P.				1005	

TABLE IV

No.of beneficiaries for Pathological Test, 'X' Ray Test, etc. for the year 1972-73 to 1977-78

Name of p.h.c.	Pathological Test etc.	No.of Beneficiaries 1972-1973	1973-1974	1974-1975	1975-1976	1976-1977	1977-1978	Total
1	2	3	4	5	6	7	8	9
1. Pomlum phc	Blood test Urine test	Nil						
2.Cherrapunjee phc.	Blood test	341	370	330	497	398	382	2318
	Urine test	341	370	330	497	398	382	2318
3.Pynursla phc.		Nil						
4.Nongstoin phc.		Nil						
5.Khliehriat phc.	Blood test							
	(a) HB	-	-	-	-	-	6)	12
	(b) ESR	-	-	-	-	-	6)	
	Urine Test	-	-	-	-	-	1	1
	Stool Test	-	-	-	-	-	3	3
6.Resubelpara phc.		Nil						
7.Baghmara phc	Blood test	-	-	-	-	-	7111	7111
	Urine test	-	-	-	-	111	118	229
	Stool test	-	-	-	-	225	265	490
8.Assanagiri phc.		Nil						
9.Dalu phc		Nil						
T o t a l:	Blood test	341	370	330	497	398	7505	9441
	Urine test	341	370	330	497	509	501	2548
	Stool test	-	-	-	-	225	268	493

TABLE V

No.of beneficiaries of the Family Welfare Methods from 1972-73 to 1977-78

Name of the phc.	Methods adopted.	No. of beneficiaries 1972-1973	1973-1974	1974-1975	1975-1976	1976-1977	1977-1978	Total
1	2	3	4	5	6	7	8	9
1.Pomlum phc:					Nil			
2.Cherrapunjee phc.	1.Sterelisation (a)Male	4	-	-	4	153	1	162
	2.IUCD/Loop	8	11	30	55	23	16	143
	3.Contraceptives	-	-	48	80	55	4	187
	4.Oral pills	-	-	8	20	2	5	35
3.Pynursla phc.					Nil			
4.Nongstoin phc.	1. IUCD/Loop	-	1	-	2	-	-	3
	2. Contabs	-	-	-	9	-	1	10
	3.Jelly-cum-applicator	-	-	-	-	7	-	7
	4.Oral pills	-	-	-	21	7	-	28
	5.Nirodh	-	-	-	13	27	6	46
4.Khliehriat phc.	1.Sterelisation (a) Male	-	-	-	-	-	354	354
	2.IUCD/Loop	2	2	10	17	13	1	45
	3.Oral Contraceptives	-	6	6	32	47	56	147
	4.Nirodh	11	13	16	28	15	2	85
	5.Jelly-cum-applicator	4	7	9	5	-	-	25
	6.Contabs	1	-	-	-	2	-	3
6.Resubelpara phc.	1.Sterelisation (a)Male	-	-	-	1	23	-	24
	(b)Female	-	-	-	38	75	-	113
	2.IUCD/Loop	-	-	-	3	-	-	3
7.Baghmara phc.	1.Sterelisation (a)Male	-	-	6	-	50	3	59
	(b)Female	-	-	-	-	12	-	12
	2.IUCD/Loop	10	11	12	-	4	-	37
8.Asanagiri phc.	1.IUCD/Loop	-	-	-	5	7	-	12
9.Dalu phc.	1.Sterelisation (a) Male	-	-	-	550	-	-	550
Total:	1.Sterilisation (a)Male	4	-	6	555	226	358	1149
	(b)Female	-	-	-	38	87	-	125
	2.IUCD/Loop	20	25	52	82	47	17	243
	3.Contraceptives	-	6	54	112	102	60	334
	4.Oral Pills	-	-	8	41	9	5	63
	5.Contabs	1	-	-	9	2	1	13
	6.Jelly-cum-applicator	4	7	9	5	7	-	32
	7.Nirodh	11	13	16	41	42	8	131

 Table No.6 Showing the opinion of the Beneficiaries

Name of PHC	Total No. of respondents.	Number of times visited the centre						If personnels are available		Whether Medicines are available.		Whether satisfied with treatment.	
		Once a week	Once a Month	Twice a Month.	Once a Year	Not stated	Never visited	Yes	No	Yes	No.	Yes	No.
1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.
1. Pomlum PHC	18	4	1	-	6	3	4	13	1	14	-	10	4
2. Cherrapunjee PHC.	29	5	2	1	8	6	7	22	-	22	-	21	1
3. Pynursla PHC	30	4	10	4	12	-	-	24	6	29	1	21	9
4. Nongstoin PHC	30	8	7	5	10	-	-	28	2	30	-	26	4
5. Khliehriat PHC	29	13	5	4	7	-	-	29	-	29	-	28	1
6. Resubelpara PHC.	30	1	-	1	2	2	24	6	-	6	-	6	-
7. Baghmara PHC	30	3	4	5	17	-	1	29	-	20	9	29	-
8. Assanangiri PHC.	30	8	5	3	6	1	7	1	21	13	9	21	1
9. Dalu PHC	30	14	5	3	6	-	2	28	-	21	7	28	-
TOTAL:-	256	60	39	26	74	12	45	180	30	184	26	190	20

Table No. 7 Showing opinions on Maternal and Child Health Services

Name of the PHC	Whether availed Maternal and Child Care Service.		Whether satisfied with treatment.		Whether in favour of family planning.		Whether satisfied with the method practised.		Is there any monetary assistance given for family planning.		Would you encourage your neighbours to adopt Family Planning.	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No.
1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.
1. Pomlum PHC	-	14	-	-	-	14	-	-	-	-	-	14
2. Cherrapunjee PHC.	3	19	3	-	2	20	1	1	-	1	2	20
3. Pynursla PHC	17	13	17	-	-	30	-	-	-	-	-	30
4. Nongstoin PHC	28	2	28	-	2	28	1	1	-	1	2	28
5. Khliehriat PHC	26	3	25	1	4	25	1	3	-	1	4	25
6. Resubelpara PHC	-	6	-	-	-	-	-	-	-	-	-	6
7. Baghmara PHC	-	29	-	-	-	29	-	-	-	-	-	29
8. Assanangiri PHC	-	23	-	-	-	23	-	-	-	-	-	23
9. Dalu PHC	-	28	-	-	-	28	-	-	-	-	-	28
T O T A L :-	74	137	73	1	8	203	3	5	-	3	8	203