



Services for rural health buildings

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A SAFE AND functioning building is a prerequisite for quality health care service. Rural health buildings include Sub Centre (SC), Additional Primary Health Centre or PHC (New), Primary Health Centre (PHC) and Community Health Centre (CHC). Location, siting and functional requirements of these buildings demand special attention to planning and designing the building and site services within cost constraints and sustainable maintenance.

Due consideration for services is called for at the formulation and appraisal stages to overcome project-end difficulties such as non-occupancy, non-functioning health building, deficient built-environment, capacity and facility under-utilisation and cost over-run. This paper outlines the factors for planning, appraisal and coordination for services with special reference to O.D.A. funded rural and primary health care project in Orissa Area Development Programme (ADP) Phase-I (1980-87) and ADP Phase-II (1990-1996) and the recommendations for the proposed ADP Phase-III (1996-2003).

Overall objective of ADP

Orissa, with a population of 35 million has alarming and adverse health indicators as shown in Table 1. With geographically and demographically scattered areas such as coastal, hilly/tribal, etc, the incidence of poverty and shortage of organised health care facilities is acute in the State. Against this background, the Area Development Programme was launched in the 80's to improve health and family welfare services, promote national population policy and strengthen child health services.

The activities are concentrated in the 5 old districts of Puri, Ganjam, Cuttack (coastal), Phulbani and Kalahandi (Tribal). ADP Phase-II was launched in 1990 to provide an

integrated and comprehensive approach to the development of primary health and family welfare services and improve HFW status, particularly of the rural population. Phase-II covered the 5 old tribal/interior district of Sambalpur, Sundergarh, Mayurbhanj, Dhenkanal and Keonjhar.

ADP-III is in the planning stage and will be launched shortly to cover the remaining 3 old districts. It will have the broader objective of strengthening the State health service for providing quality primary health care to meet people's priority needs within available resources.

Project inputs

The main thrust in ADP-I was on physical infrastructure. Other components were training, manpower development, IEC activities and evaluation and monitoring. ADP-II tried to consolidate ADP-I assets and provide physical infrastructure in Phase-II districts along with training, IEC activities, MIS, Operations Research, Evaluation and Monitoring. Cost components of physical infrastructure in both Phase-I and II were above 60 per cent of the project cost and thus dominant. ADP-III is now clear on one point, viz., that it is a health project, not a physical infrastructure project. Hence, investment should be reflected in maximised health gains.

Lessons from ADP-I

The main lessons from ADP-I were:

- State level multi-disciplinary team was not composed.
- Site selection criteria were not followed.
- Most of the subcentre sites were in isolated locations, with low plinth and without complete building services.
- Sewer line was not connected to septic tank in subcentres and the latter were subsequently defunct.
- Rising main was not connected to overhead tank in CHCs leading to breakdown in OT services and subsequently non-maintenance/theft of pump etc.
- Detailed site survey was not conducted.
- Orientation and layout were not properly done.
- Lack of details led to badly functioning buildings.
- RCC flat roof leaked in nearly 50 per cent of the SCs.

Lessons from ADP-II

The lessons from ADP-II were:

- Composition of State level design team led to inter-disciplinary interaction.

Table 1. Major Health Indicators of Orissa

	National goal for 2000 A.D.	Existing situation	
		Orissa (1994)	India (1994)
1. I.M.R.	60	103	73
2. C.D.R.	9	11.1	9.2
3. Under 5 mortality	50	131	109
4. M.M.R.		6	2
5. Life expectancy			
• Male	64	60.13	60.6
• Female	64	58.40	61.7
6. Growth rate	1.2	1.69	1.94

- Users views were given priority in Building Cell workshop at Keonjhar in May 1991.
- Site selection and land acquisition is a lengthy process and in some sites takes practically two years to get the site conforming selection criteria.
- Site survey was useful for site specific planning, technology and optimising cost on services.
- External electrical service connection to some subcentres has taken two years due to lack of inter-departmental co-ordination.
- Due to scattered location of SCs, uniform quality could not be maintained due to lack of supervision, communication gap between central office and the site.
- The State Design Team/Construction Agency Design wing was understaffed and not directed to visit and facilitate work at sites.
- Maintenance difficulties have not been solved. Case study - 800 tube wells have been installed (500 by IDCO and 300 by RWPH). At some SCs, the functioning is affected due to missing nuts, washers or damaged connecting rod. In some cases dry bores have been reported. Water investigation (resistivity test) was not conducted.
- Adequate time for inter-departmental co-ordination and agreement for saving cost on time and delay, to make health centres functional.
- Effecting policy changes in maintenance and authorising users to undertake petty maintenance (for preventing breakdowns) while streamlining and operationalising cyclic maintenance management under one wing (Civil + PH + EI + Services). Introduction of MIS for maintenance. Involving local NGO in maintenance.
- Site survey should be more broadbased and take place during pre-selection and selection of sites.
- Site specific details to be prepared in a package form incorporating specified parameters.
- Planning concept may vary from district to district, block to block.
- Execution of pilot projects in year-1 and evaluation.
- Training and orientation of construction supervisors in rural health buildings.

Recommendations for ADP-III

The recommendations for ADP-III are:

- Planning concept to shift from State to district level with back-up support from the core experts' group.
- Adequate time for local need-based planning for maximising health gains.
- Parameters for services should be adequately covered in survey and appraisal. (Table of parameters is available with the author).

Conclusion

Adequate coverage of services in project formulation and cost appraisal according to site condition, needs and functional requirements is an essential component of planning for a rural and primary health project. Low level of supervision, lack of inter-departmental coordination, scattered and difficult location of project sites demand greater care at the design stage and specific directives from the policy making authority. Site survey and site-specific detailing plays a crucial role in optimising cost. NGO and community involvement is imperative for increased interaction and upkeep of the facilities in the long run as a part of sustainable maintenance.