

Chapter V

Impact of Changing Health Care Policies in the Villages Under Study

5.1 Introduction

Improving the health of the socially and economically disadvantaged groups is a key objective of the State. Since Independence Government of India embraced the objective of promoting the health of the poor and the disadvantaged in its policy statements and actions.

“It is important to emphasize that PHC is not just a descriptive term denoting the first level of health care. It is a comprehensive view of health that emerges from the most critical conceptual advances of twentieth- century public health. Unlike the technocentric approaches that derive from the bio-medical sciences- such as the linear campaigns against small pox and malaria- the PHC approach confronts complex socio-economic, political and technological relationships”¹.

To improve the health status of the rural people National Rural Health Mission (NRHM) has been formulated. Nevertheless, access to basic health care in the rural areas, remains unavailable to a large majority.

An attempt has been made in this chapter to examine the extent of health care facilities provided to the rural areas. Two villages (Sisabari and Polash) are selected to study the nature and utilization of health services. These villages are quite far away from the respective health center.

5.2 Existing Health Service Delivery

The sub-centre, manned by two health workers, (as mentioned earlier) is the nearest place to get medical assistance for the villagers in the two villages. Inadequacy of medicine and ill-behaviour of the health workers prevent the villagers from visiting it. According to the villagers, most of the time the sub-centre remains closed, leaving the people uncertain about its infrequent and unpredictable time of opening. They visit the sub-centre under

sheer compulsion. The health workers visit the villages very often, to enquire about diseases, to write names of the children for immunization, and to provide bleaching powder to purify the drinking water. During the study it was found that, in six months out of the total households in both the villages only 54.5 percent households have been visited by the health workers. During this period only once the health workers along with other health personnel from PHC visited the villages for AIDS awareness programme. According to the villagers, they distributed the pamphlets without making them aware about what AIDS actually is. So, the pamphlets were ultimately of no use. According to one young girl suffering from gynaecological problem understood AIDS as a blood-related disease. She filled up the proforma, in the pamphlet and went to the health workers in the sub-centre. They referred her to PHC, but she did not go there. This shows the campaign for awareness generation lead to nothing but confusion. During the survey it was found that only 31.8 percent of individuals had knowledge about AIDS in both the village. AIDS is one of the major vertical programmes and it is mentioned in NHP 2002 that zero level growth of HIV/AIDS should be achieved by 2015. But the ground reality does not conform to the strategy of NHP 2002.

The PHC is located at a distance of 22kms from the villages. In the last three years only seven women have visited PHC for sterilization and to see doctor during pregnancy. In only two cases, the health personnel came from PHC for follow-up check- up after sterilization. To go to PHC, the villagers have to catch two buses. Accessibility to the primary health center is not only difficult but is supplemented by inadequate facilities. People of the area having experience of visiting the PHC do not want to experience it further. Visits to the PHC is therefore, often frustrating; they are not much cheaper than going to the Civil Hospital (at a distance of 15kms) and private doctor, who, moreover, is probably easier to find, because private healthcare facilities are available at a distance of 10kms. These private health care facilities are largely unregulated. The main source of health care in the villages is quacks. It shows that establishment of a well-worked out referral system as proposed in NHP 1983 to ensure patient load at the higher levels of hierarchy should not be burdened by those who can be treated at the decentralized level has not yet been fulfilled.

Poor people are likely to be specially vulnerable to illness because of the generally unhygienic vulnerable conditions in which they live, and their low levels of awareness of preventive care. Lack of awareness about preventive care and health facilities are particularly acute for the villagers. Low-income households are also sensitive to economic problems associated with serious disease, given their low levels of savings, the expenses involved in treatment becomes a real risk of indebtedness in times of ill health. There is no preventive mechanism to stop the spread of these communicable diseases. Spraying of anti-mosquito chemicals and programmes of health awareness are completely absent. Physical distance prevents the villagers from seeking treatment from qualified practitioners. The absence of health services has made the people more unprotected and vulnerable to diseases. Ramamani Sundar and Abhilasha Sharma carried out similar study among the urban poor in Delhi and Chennai. In both the cities it was found that the morbidity rates are much lower for the population living in the resettlement colonies (where the economic condition is quite good) compared with the rates for the slum dwellers.².

5.3 Morbidity Rate

Table 5.1 estimates the percentage distribution of acute and chronic illness based on the reporting of illnesses in the last three years by the households during the survey. It is important to mention that a person has suffered from one or more illness at one time or different times.

Table 5.1
Percentage Distribution of Illness in the Sample Households in the Villages under Study

Villages	Acute Illness	Chronic Illness	All Illness (Acute and Chronic)	Total Population
Sisabari	121 (37.1%)	40 (12.2%)	161 (49.3%)	326
Polash	90 (30%)	20 (6.6%)	110 (36.6%)	300
Total	211 (33.7%)	60 (9.5%)	271 (17.5%)	626

During the monsoon, people are not only more prone to communicable diseases such as diarrhoea, jaundice, malaria, pneumonia but some of the chronic ailments like asthma, fever, headache, chest pain, etc. also get aggravated. The percentage of morbidity (acute

plus chronic) has worked out to be 49.3 percent in Sisabari and 36.6 percent in Polash in the last three years.

Table 5.2
Percentage Distribution of Illness by Monthly Household Income in the Sample Households in the Villages under Study

Monthly Household Income	Sisabari		Polash	
	All Illness (Acute and Chronic)	Total Population	All Illness (Acute and Chronic)	Total Population
1000-2000	26 (7.9%)	56	24 (8%)	76
2001-3000	32 (9.8%)	86	25 (8.3%)	70
3001-4000	47 (14.4%)	60	9 (3%)	61
4001-5000	24 (7.3%)	60	11 (3.6%)	57
5001 and above	18 (5.5%)	64	8 (2.6%)	36
Total	147 (45%)	326	77 (25.6%)	300

Table 5.3
Percentage Distribution of Illness by Educational Level (0-5 years excluded) in the Sample Households in the Villages under Study

Educational Level	Sisabari		Polash	
	All Illness (Acute and Chronic)	Total Population	All Illness (Acute and Chronic)	Total Population
Illiterate	66 (23.2%)	114	29 (10.8%)	101
Primary School Level	35 (12.3%)	86	24 (8.9%)	99
Middle School Level	17 (5.9%)	44	8 (2.9%)	49
High School Level	15 (5.2%)	36	1 (0.3%)	16
Higher Secondary Level	0	1	0	2
Graduate	0	3	0	0
Total	133 (46.8%)	284	62 (23.2%)	267

Table 5.4
Percentage Distribution of Illness by Ethnic Group in the Sample Households in the Villages under Study

Ethnic Group	Sisabari		Polash	
	All Illness (Acute and Chronic)	Total Population	All Illness (Acute and Chronic)	Total Population
ST	102 (31.2%)	243	30 (10%)	110
SC	45 (13.8%)	83	47 (15.6%)	190
Total	147 (45%)	326	77 (25.6%)	300

1) Income

We can see from Table 5.2 that in Sisabari, the percentage of morbidity is high in the household income category of 3001-4000 (14.4 percent) whereas in the lowest household income category it is 7.9 percent. The reason is that the reported illness in this category (3000-4001) is high because of large family size. In Polash, percentage of morbidity is 8.3 percent in the household income category of 2001-3000 whereas it is 8 percent in the household income category of 1001-2000. A similar phenomenon is also observed in lower two income categories. An inverse relation from percentage of illness and income has been observed. But the low level percentage of morbidity (5.5 percent in Sisabari and 2.6 percent in Polash) in the highest income category shows that with the improvement in economic status, the health consciousness of the people increases and nutritional status may improve resulting in lower morbidity, especially communicable diseases.

2) Educational Level

A similar trend is observed in the estimates of percentage of morbidity by the level of education (Table 5.3). In Sisabari, the percentage of morbidity sharply decreases with the increase in educational level.

3) Ethnic Group

Regarding the variations in ethnic group (Table 5.4), in Sisabari among the STs the percentage of illness is 31.2 percent as compared to SCs (13.8 percent). But the trend is reversed in Polash. The percentage of illness among SCs, which is more, is (15.6 percent) whereas in STs it is 10 percent. The reason is, Sisabari is predominantly inhabited by SCs and Polash is inhabited by STs.

5.4 Disease Pattern

Table 5.5
Percentage distribution of Diseases by Age and Sex in th Sample Households in
Sisabari

Diseases	0-14 (Children)		15-59 (Adults)		60 and above (old)		Total Males	Total Females	Total
	M	F	M	F	M	F			
Malaria	3 (1.8%)	3 (1.8%)	14 (8.6%)	12 (7.4%)	3 (1.8%)	1 (0.6%)	20 (12.4%)	16 (9.9%)	36 (22.3%)
Jaundice	7 (4.3%)	3 (1.8%)	19 (11.8%)	12 (7.4%)	1 (0.6%)	1 (0.6%)	27 (16.7%)	16 (9.9%)	43 (26.7%)
Pneumonia	1 (0.6%)	3 (1.8%)	0	4 (2.5%)	0	0	1 (0.6%)	7 (4.3%)	8 (4.9%)
Tuberculosis	0	0	2 (1.2%)	0	1 (0.6%)	0	3 (1.8%)	0	3 (1.8%)
Diarrhoea	5 (3.1%)	9 (5.5%)	7 (4.3%)	1 (0.6%)	0	2 (1.2%)	12 (7.4%)	12 (7.4%)	24 (14.9%)
Hysteria	1 (0.6%)	0	1 (0.6%)	0	0	0	2 (1.2%)	0	2 (1.2%)
Hand Fracture	1 (0.6%)	0	0	0	0	0	1 (0.6%)	0	1 (0.6%)
Leg Fracture	1 (0.6%)	0	0	0	0	0	1 (0.6%)	0	1 (0.6%)
Gynaecological Disorder	0	0	0	1 (0.6%)	0	0	0	1 (0.6%)	1 (0.6%)
Pyorrhoea	0	0	0	2	1 (0.6%)	0	1 (0.6%)	2 (1.2%)	3 (1.8%)
Typhoid	0	1 (0.6%)	0	0	0	0	0	1 (0.6%)	1 (0.6%)
Headache	0	0	3 (1.8%)	3 (1.8%)	0	0	3 (1.8%)	3 (1.8%)	6 (3.7%)
Chest Pain	0	0	2 (1.2%)	1 (0.6%)	0	0	2 (1.2%)	1 (0.6%)	3 (1.8%)
Fever	1 (0.6%)	1 (0.6%)	1 (0.6%)	1 (0.6%)	0	0	2 (1.2%)	2 (1.2%)	4 (2.5%)
Paralyses	0	0	0	0	1 (0.6%)	0	1 (0.6%)	0	1 (0.6%)
Eye Problem	1 (0.6%)	0	1 (0.6%)	2 (1.2%)	1 (0.6%)	2 (0.6%)	3 (1.8%)	4 (2.4%)	7 (4.3%)
Ear Problem	0	0	0	0	2 (1.2%)	0	2 (1.2%)	0	2 (1.2%)
Liver Problem	0	0	1 (0.6%)	0	0	0	1 (0.6%)	0	1 (0.6%)
Breast Tumour	0	0	0	1 (0.6%)	0	0	0	1 (0.6%)	1 (0.6%)
Uterus Operation	0	0	0	1 (0.6%)	0	0	0	1 (0.6%)	1 (0.6%)
Asthma	1 (0.6%)	0	0	0	1 (0.6%)	0	0	2 (1.2%)	2 (1.2%)
Gastroenterities	0	0	4 (2.4%)	1 (0.6%)	1 (0.6%)	0	5 (3.1%)	1 (0.6%)	6 (3.7%)
Mental Disorder	0	0	1 (0.6%)	1 (0.6%)	0	0	1 (0.6%)	1 (0.6%)	2 (1.2%)
Total	22 (13.6%)	20 (12.4%)	56 (34.7%)	43 (26.7%)	14 (8.6%)	6 (3.7%)	92 (57.1%)	69 (42.8%)	161 (100%)

Table 5.6
Percentage distribution of Diseases by Age and Sex in the sample Households in
Polash

Diseases	0-14 (Children)		15-59 (Adults)		60 and above (old)		Total Males	Total Females	Total
	M	F	M	F	M	F			
Malaria	4 (3.6%)	2 (1.8%)	11 (10%)	7 (6.3%)	2 (1.8%)	0	17 (15.4%)	9 (8.1%)	26 (23.6%)
Jaundice	4 (3.6%)	4 (3.6%)	9 (8.15)	2 (1.8%)	1 (0.9%)	0	14 (12.7%)	6 (5.4%)	20 (18.1%)
Tuberculosis	0	0	2 (1.8%)	0	1 (0.9%)	0	3 (2.7%)	0	3 (2.7%)
Diarrhoea	3 (2.7%)	3 (2.7%)	6 (5.4%)	6 (5.4%)	2 (1.8%)	1 (0.9%)	11 (10%)	10 (9%)	21 (19%)
Leg Fracture	0	0	1 (0.9%)	0	1 (0.9%)	0	2 (1.8%)	0	2 (1.8%)
Gynaecological Disorder	0	0	0	2 (1.8%)	0	0	0	2 (1.8%)	2 (1.8%)
Hernia Operation	1 (0.9%)	0	0	0	0	0	1 (0.9%)	0	1 (0.9%)
Heart Operation	0	0	0	1 (0.9%)	0	0	0	1 (0.9%)	1 (0.9%)
Gall Bladder Operation	0	0	0	2 (1.8%)	0	0	0	2 (1.8%)	2 (1.8%)
Typhoid	0	1 (0.9%)	0	0	0	0	0	1 (0.9%)	1 (0.9%)
Fever	1 (0.9%)	1 (0.9%)	3 (2.7%)	2 (1.8%)	2 (1.8%)	1 (0.9%)	6 (5.4%)	4 (3.6%)	10 (9%)
Paralyses	0	0	1 (0.9%)	0	0	0	1 (0.9%)	0	1 (0.9%)
Mental Disorder	0	0	1 (0.9%)	0	1 (0.9%)	0	2 (1.8%)	0	2 (1.8%)
Eye Problem	0	0	0	0	0	1 (0.9%)	0	1 (0.9%)	1 (0.9%)
Tumour in Leg	1 (0.9%)	0	1 (0.9%)	0	0	0	2 (1.8%)	0	2 (1.8%)
Blood dysentery	2 (1.8%)	1 (0.9%)	3 (2.7%)	1 (0.9%)	0	0	5 (4.5%)	2 (1.8%)	7 (6.3%)
Ulcer	0	0	0	1 (0.9%)	0	0	0	1 (0.9%)	1 (0.9%)
Night Blindness	0	2 (1.8%)	0	1 (0.9%)	0	0	0	3 (2.7%)	3 (2.7%)
Asthma	0	0	1 (0.9%)	0	0	0	1 (0.9%)	0	1 (0.9%)
Chicken Pox	2 (1.8%)	0	0	0	0	0	2 (1.8%)	0	2 (1.8%)
Measles	0	1 (0.9%)	0	0	0	0	0	1 (0.9%)	1 (0.9%)
Total	18 (16.3%)	15 (13.6%)	39 (35.4%)	25 (22.7%)	10 (9%)	3 (2.7%)	67 (60.9%)	43 (39%)	110 (100%)

In both the villages people seem to suffer more from the communicable disease; these account for malaria (22.3 percent and 23.6 percent); jaundice (26.7 percent and 18.2 percent); tuberculosis (1.8 percent and 2.7 percent); diarrhoea (14.9 percent and 19 percent); blood dysentery (6.3 percent in Polash) of the total number of reported illness episodes in Sisabari and Polash respectively. This is amply clear from Table 5.5 and 5.6. In case of adults, 74.5 percent of the reported illness episodes in Sisabari and 59.7 percent of the illness episodes in Polash belong to the communicable disease category and with age the proportion of communicable diseases seems to decrease. Sex differentials show that in both the villages males suffer a higher morbidity than females. The percentage of morbidity is 57.1 percent and 60 percent for males whereas 42.8 percent and 40 percent for females.

This is not surprising from the above figures percentage of morbidity in the two villages, given poor environmental sanitation and the low economic status of the sample population. They have improper sanitation system and disposal of solid wastes. In both the villages there are only 12.7 percent sanitary toilets, other household's use open field for defecation.

The perceived need for medical care depends both on the availability of health care facilities and the capacity to pay for health services. The diseases villagers mentioned are not necessarily diagnosed correctly since in most of the cases they have to believe what the local quacks say. The ill-health depends on whether they obtain appropriate preventive care. Non-availability of preventive care also nurtures adverse health outcomes and financial consequences. The high incidence of jaundice and diarrhoea may be due to drinking habits of the people. In fact *hariya* – a local beer is a regular consumption of every sample households.

Table 5.7
Percentage Distribution Mortality in Sisabari and Polash (2001-2003)

Causes	Sisabari			Polash			Total
	2001	2002	2003	2001	2002	2003	
Pneumonia	0	2 (9%)	0	0	0	0	2 (9%)
*Suicide	1 (4.5%)	0	0	0	0	0	1 (4.5%)
Jaundice	0	0	2 (9%)	0	1 (4.5%)	1 (4.5%)	4 (18.5%)
Hysteria	1 (4.5%)	0	0	0	0	0	1 (4.5%)
Malaria	1 (4.5%)	2 (9%)	1 (4.5%)	1 (4.5%)	1 (4.5%)	2 (9%)	8 (36.3%)
Heart Problem	0	0	0	0	0	1 (4.5%)	1 (4.5%)
*Accident	0	0	0	0	2 (9%)	0	2 (9%)
Paralyses	0	0	0	1 (4.5%)	0	0	1 (4.5%)
Tuberculosis	0	1 (4.5%)	0	0	0	1 (4.5%)	2 (9%)
Total	3 (13.6%)	5 (22.7%)	3 (13.6%)	2 (9%)	4 (18.5%)	5 (22.7%)	22 (100%)

* *Not communicable diseases.*

It is quite obvious that the main diseases causing death to the people are pneumonia, jaundice and malaria. The percentage of mortality in the two villages, in the last three years is 3.5 percent (Table 5.7). India has adopted macro-economic policy and NHP 2002 enhanced these strategies widely. It seems rural requirements were not adequately considered while making these policies. In the health sector strategy 2004 – 2013, Department of Health and Family Welfare, Government of West Bengal, “identified the burden of communicable disease in the most poorest and vulnerable groups and made strategies priority to finish these diseases in the short term”³. But it is not mentioned clearly how the goal is to be achieved.

5.5 Treatment

1) Role of Traditional Healer

One of the significant features is that the first preference of treatment of the villagers is the traditional healer. The traditional healers are considered as the first doctors. But the fact is that traditional healers are not supposed to cure the patients, they rather get rid of the evil-spirits. So, the traditional healers are consulted first. The traditional healer decides, whether the patient should go for modern treatment or not. The villagers still believe that if the disease has been caused by an evil-spirit or any super-natural agency, no medical treatment will be effective unless the traditional healer removes the influence of the evil-spirit. The traditional healer accepts both kind and cash for his performance.

Though his treatment is less expensive than modern treatment, sometimes this also becomes unaffordable for some villagers.

In 0.8 percent of cases, it is found that even the qualified practitioners ask the villagers to go to traditional healer before seeking modern treatment, which may be to assure uninterrupted treatment. Simultaneously, they feel that as the traditional healer is available in the village, they can easily avail the opportunity. If the traditional healer can cure them by driving the evil-spirit, then they do not have to go for modern treatment, which is expensive. Moreover, there is no convenient means of transporting patients to the nearest hospital, because the existing strength of medical facility is inadequate. Inadequacy in other medical facilities also exists like non-availability of doctors, infrastructure, etc. That is why, the villagers are sometimes forced to depend more or less on traditional healer. It suggests that SAP, which talks of cost-effective measures and emphasis on modern technology, are making these people more marginalized. It is important to note that the traditional healer advises the patients to go for modern treatment for almost all kinds of illness because he cannot prescribe any medicines due to non-availability of herbs, as a result of rapid deforestation. Dependency on modern medical practices has also contributed to the decline in traditional medicines.

5.6 Perception of Morbidity and Pattern of Utilization of Health Services

All respondents reported that they would consider the nature and seriousness of the symptoms and if the symptoms were not serious, they would wait for a day or two. If the problem further persists or gravitates, the patient would be taken to the nearest health care facility. Many factors are taken into account while taking a patient to a doctor. In both the villages about 53 percent of the respondents reported that the seriousness of illness was one of the deciding factors for seeking care and 9 percent of the respondents reported that availability of money at home was more important than any other factor. 28 percent of the respondents reported if free health care were available and accessible, they would immediately go for treatment. However, 10 percent of the households reported that in the event of any health problem in the family, they would immediately take the patient to the quack. This is quite evident in a study carried out in an unorganized labour in

Delhi, where it was reported that for 83 percent of the households, seriousness of illness was one of the deciding factors for seeking care⁴.

The study reveals that for 6.8 percent of illness episodes (jaundice, hysteria, mental problem, asthma and eye problem) in Sisabari and 4.5 percent of illness episodes (jaundice) in Polash no modern treatment was sought, only self-care was taken. Self-care in this context refers to any self-care measures taken by the family on its own after consulting traditional healer and no modern treatment was sought considering it was not necessary. The most important reason for not seeking treatment turns out to be illness not considered serious. The respondents mentioned that generally they do not bother about minor ailments. Financial constraints appear to be an important reason for not seeking treatment; this is mainly common among adults. Inability to earn income on regular basis forces the poor to opt for alternatives like, doing without health care, delayed or incomplete treatment, self-medication and informal and ineffective sources of care.

Patients in many instances refused certain investigations recommended by physicians in an effort to reduce the hospital bill; drug consumption in many occasions went down. In due course they have to go for more expensive medical care, which led to further impoverishment of the poor households.

The study showed that quacks were utilized for nearly half of the illness episodes (45 percent in Sisabari and 40 percent in Polash); for 33.7 percent and 31.2 percent of the illness episodes private facilities were utilized (Table 5.8 and 5.9). To be more elaborate, in both the villages out of total number of illness episodes, 17.1 percent of the patients suffering from communicable diseases and 7.2 percent of the patients suffering from non-communicable diseases were treated in government hospitals which includes government malaria hospital and government TB center. On the other hand, 21.3 percent of patients suffering from communicable diseases and 11.6 percent of patients suffering from non-communicable diseases were treated by private sources which include private practitioners and private clinics; 30.9 percent of the patients suffering from communicable diseases and 11.6 percent of the patients suffering from non-communicable diseases were treated by quacks. A detailed study of the socio-economic

background to show the difference in the pattern of utilization is mentioned in the next section.

The tables show the number of visits by the kind of facility utilized. It reveals that those utilizing private facilities and quacks had to pay more number of visits per episode as compared to those using the government facilities as government facilities are less accessible. One of the respondents was suffering from malaria. He sought treatment from private practitioner whose fees is Rs100 per visit. He again visited as he could not recover from his illness and purchased medicine worth Rs190. His wife was also suffering from fever. She sought treatment from quack. The quack first prescribed some medicines, which did not work. Then he gave her 13 injections and three vitamins for which she spend Rs1800. For this her husband had to dispose a pair of pigs and one goat to bear the expenses of the entire treatment.

Table 5.8**Source of Treatment of Different Diseases in the Sample Households in Sisabari**

Diseases	Government Hospital	Government Malaria Hospital	Government TB Centre	Private Practitioner	Quacks	Total
Malaria	4 (2.6%)	6 (3.9%)	0	10 (6.6%)	16 (10.5%)	36 (23.8%)
Jaundice	3 (1.9%)	0	0	11 (7.2%)	18 (11.9%)	32 (21.1%)
Pneumonia	3 (1.3%)	0	0	3 (1.9%)	4 (2.6%)	10 (1.9%)
Tuberculosis	0	0	1 (0.6%)	1 (0.6%)	1 (0.6%)	3 (1.9%)
Diarrhoea	7 (4.6%)	0	0	8 (5.2%)	11 (7.2%)	26 (17.2%)
Hand Fracture	0	0	0	1 (0.6%)	0	1 (0.6%)
Leg Fracture	0	0	0	1 (0.6%)	0	1 (0.6%)
Gynaecological Disorder	0	0	0	1 (0.6%)	0	1 (0.6%)
Pyorrhoea	1 (0.6%)	0	0	1 (0.6%)	2 (1.3%)	4 (2.6%)
Typhoid	0	0	0	1 (0.6%)	0	1 (0.6%)
Headache	0	0	0	2 (1.3%)	4 (2.6%)	6 (3.9%)
Chest Pain	0	0	0	1 (0.6%)	2 (1.3%)	3 (1.9%)
Fever	1 (0.6%)	0	0	3 (1.9%)	1 (0.6%)	5 (3.3%)
Paralyses	0	0	0	0	1 (0.6%)	1 (0.6%)
Gastroenterities	2 (1.3%)	0	0	2 (1.3%)	3 (1.9%)	7 (4.6%)
Mental Disorder	0	0	0	1 (0.6%)		1 (0.6%)
Eye Problem	0	0	0	3 (1.9%)	3 (1.9%)	6 (3.9%)
Ear Problem	0	0	0	1 (0.6%)	1 (0.6%)	2 (1.3%)
Liver Problem	1 (0.6%)	0	0	0	0	1 (0.6%)
Breast Tumour	1 (0.6%)	0	0	0	0	1 (0.6%)
Uterus Operation	1 (0.6%)	0	0	0	0	1 (0.6%)
Asthma	1 (0.6%)	0	0	0	1 (0.6%)	2 (1.3%)
Total	25 (16.5%)	6 (3.9%)	1 (0.6%)	51 (33.7%)	68 (45%)	151 (100%)

Table 5.9
Source of Treatment of Different Diseases in Sample Households in Polash

Diseases	Government Hospital	Government Malaria Hospital	Government TB Centre	Private Practitioner	Quacks	Total
Malaria	6 (4.2%)	6 (4.2%)	0	11 (7.8%)	14 (10%)	37 (26.4%)
Jaundice	6 (4.2%)	0	0	10 (7.1%)	12 (8.5%)	28 (20%)
Tuberculosis	0	0	1 (0.7%)	2 (1.4%)	1 (0.7%)	4 (2.8%)
Diarrhoea	4 (2.8%)	0	0	6 (4.2%)	13 (9.2%)	23 (16.4%)
Leg Fracture	0	0	0	1 (0.7%)	1 (0.7%)	2 (1.4%)
Gynaecological Disorder	0	0	0	2 (1.4%)	0	2 (1.4%)
Hernia Operation	0	0	0	1 (0.7%)	0	1 (0.7%)
Heart Operation	0	0	0	1 (0.7%)	0	1 (0.7%)
Gall Bladder Operation	1 (0.7%)	0	0	2 (1.4%)	1 (0.7%)	4 (2.8%)
Typhoid	1 (0.7%)	0	0	0	6 (4.2%)	1 (0.7%)
Fever	4 (2.8%)	0	0	0	0	1 (0.7%)
Paralyses	0	0	0	0	1 (0.7%)	1 (0.7%)
Mental Disorder	0	0	0	1 (0.7%)	0	1 (0.7%)
Eye Problem	0	0	0	0	1 (0.7%)	1 (0.7%)
Tumour in Leg	2 (1.4%)	0	0	2 (1.4%)	1 (0.7%)	5 (3.5%)
Blood dysentery	3 (2.1%)	0	0	0	4 (2.8%)	7 (5%)
Measles	0	0	0	1 (0.7%)	0	1 (0.7%)
Ulcer	0	0	0	1 (0.7%)	0	1 (0.7%)
Night Blindness	3 (2.1%)	0	0	3 (2.1%)	0	6 (4.2%)
Asthma	0	0	0	1 (0.7%)	0	1 (0.7%)
Chicken Pox	2 (1.4%)	0	0	0	0	2 (1.4%)
Total	32 (22.8%)	6 (4.2%)	1 (0.7%)	45 (32.1%)	56 (40%)	140 (100%)

Secondly, the reason for going to government hospital is due to inability to meet the expenses of private sources and hope of getting medicines free of cost from government hospital. Ironically, these government facilities are also not free of cost. One of the respondents said that he went to Government TB Centre for his treatment. The doctor on duty immediately advised him to undergo certain tests from private laboratory, as these facilities are not available in the center. So, he had to spend Rs80 for Ultrasonography, Rs100 for blood test, Rs200 for X-ray. This suggests how cost-effective is the treatment in upper level of health care. Moreover, the NHP 2002 is encouraging user charges in secondary and tertiary level care.

The percentage of illness episodes for which treatment is sought from private practitioners or private hospitals work out to be marginally higher in Sisabari, for 33.7 percent of the illness episode treatment is sought from private sources, while in Polash 32.1 percent of illness episode treatment is sought from private sources. These difference could be due to the fact that pneumonia and diarrhoea patient are also preferring private treatment even whose monthly income group ranges from 1000 - 2000 and 2001 - 3000 in Sisabari. It shows household having meagre income are confined to go for private treatment for diseases like diarrhoea and pneumonia which need a lot of money in order to get adequate treatment. One of the respondents and his wife were suffering from malaria. They sought treatment from private practitioner. As they could not recover by first visit, they had to make several visits to recover from illness by spending Rs2500 on medicine and Rs500 for X-ray. Another respondent's story is quite similar to the previous one. She was suffering from malaria, she went to see a private doctor. He took Rs100 as fees and gave medicine worth Rs150. But even after one week, she could not recover.

We can see from the two tables that in a high proportion of illness episodes involving from malaria and jaundice, treatment is sought from quacks i.e. in Sisabari it is 23.8 percent and 21.1 percent and in Polash it is 26.4 percent and 20 percent. While government doctors treated 28.5 percent of TB patients, another 28.5 percent were treated by quacks and qualified private practitioner treated 42.8 percent. It is found that one patient had died after being treated by a quack. In case of jaundice, 50 percent of patients were treated by quacks in both the villages; for malaria 41 percent were treated by quack and for pneumonia 2.6 percent were treated by quack. It is found that 25 percent of the patients died after being treated by quacks for pneumonia, malaria and jaundice. Still the villagers go to quacks for treatment, mainly because of financial implications. NHP 1983 started as a movement to provide comprehensive health care to all through primary health care. But NHP 2002 mainly emphasized on privatization undermining the primary health care totally.

5.7 Role of Quacks

Villagers do not give a second thought when they go to the local quacks, because they stock some medicines and give them to the patient on credit. This facility is not available

with the government hospitals or qualified private practitioners. The patients are taken to the qualified doctors only when the local quack declares his failure. Quacks mainly deal with communicable diseases because these diseases provide a lot of money. For the local quack the treatment is universal for all the illness. He first prescribes medicines and if the condition of the patient deteriorates, he gives saline, which is followed by more medicines. One of the respondents was not feeling well. His father took him to see the quack. The quack gave him medicine worth Rs200. But his condition did not improve. The second day his father again went to the quack and brought medicine worth Rs300. His condition became critical and in the fourth day, he died. The quack said that he was suffering from jaundice. These non-trained practitioners are recognized as doctors of the village. According to the villagers, as doctors are not available, they prefer to go to quacks with whom medicine is always available.

These healers bridge the gap between people's needs for health care and "limping" government institutions. The study revealed that the villagers unhesitantly choose the "village doctor" or self-trained healer in the informal network. When any person falls ill, the quacks are called for check-up. The quack takes Rs50 to Rs80 for the visit and prescribes medicines, ranging from Rs100 to Rs150, essentially to be purchased from his shop. If the patients become more serious, than the quack brings another quack- "*boro daktar*" (big doctor) who is more experienced than him to treat the patient. He even arranges, in which private clinic the patient is to be admitted for treatment and also looks after the financial dealings, required for treatment.

This shows that the quacks act as the "middleman" between the villagers and the qualified private practitioners. Set in this background, people are deprived of health services both ways, poor delivery system denies them any service and their low economic status makes them to seek treatment from qualified practitioners limited. But in other way we can say, quacks are helping in providing basic treatment.

Accessibility to government hospital is not only difficult but also supplemented by inadequate facilities. If any person somehow manages to go to government hospital, he is denied medicines and proper check-up by government doctors. One of the respondents

was suffering from malaria. He went to North Bengal Medical College (NBMC) to see a doctor. The doctor prescribed him some medicines and advised him to undergo a blood test. He was denied medicines and blood tests in NBMC. So, he had to purchase medicine from medicine shops by paying Rs200 and got the test in a private laboratory by paying Rs50.

In some cases apart from paying charges to undergo different tests in the government institutions, they have to bribe the authorities to get the reports early. Moreover, to get the reports they have to go several days which results in income loss and physical strain (those who are too weak, are unable to stand long in the queue). Another respondent was suffering from TB. He went to the Civil Hospital to see the doctor. The doctor advised him to carry out an X-ray. His X-ray was done in the Civil Hospital. But to get the test report early he had to pay a bribe of Rs20. He also did not get medicine from Civil Hospital and purchased medicine worth Rs100. One of the female respondents was suffering from malaria. She went to malaria hospital for treatment and undergone a blood test. She went three days to get the report. The villagers mentioned that physicians only prescribe medicines which they have to purchase from chemist shop. They seldom get medicines from government hospitals free of cost, but these medicines are spurious. Sometimes, the medicines they purchase from chemist shop are also spurious.

5.8 User Charges

NHP 2002 expresses the need to levy user charges for secondary and tertiary health care services. The utilization of the government hospital also declined due to introduction of user charges. This is well reflected in studies carried in some developing countries. User charges introduced in Zimbabwe, Ghana and Kenya did not contribute to the quality of services as utilization level of health care declined in public sector. “ In Zimbabwe user charges were introduced in 1992. The government expenditure on health fell by 14 percent between 1990-91 and 1991-92, and by a further 29 percent in the following year.....In Ghana introduction of fees led to a 50 percent drop in outpatient attendances.....In Kenya too the number of outpatient visits declined by about 40 percent despite the fact that user charges were small”⁵. Table 5.10 gives an opinion of the user charges given by the respondent of each household.

Table 5.10
Opinion of User Charges Given by the Respondents of Sample Households in the
villages under Study

Opinion about User Charges	Responses							
	Sisabari				Polash			
	Yes	No	*Not Aware	Total	Yes	No	*Not Aware	Total
Whether getting adequate treatment from government hospitals after paying user charges	6 (10.9%)	20 (36.3%)	29 (52.7%)	55 (100%)	3 (5.4%)	12 (21.8%)	40 (72.7%)	55 (100%)
Whether they have to purchase medicines from medicine shops after paying user charges	22 (40%)	4 (7.2%)	29 (52.7%)	55 (100%)	13 (23.6%)	2 (3.6%)	40 (72.7%)	55 (100%)
Whether any problem was faced for paying User charges	40 (72.7%)	5 (9%)	10 (18.1%)	55 (100%)	39 (70.9%)	4 (7.2%)	12 (21.8%)	55 (100%)
Whether any problem was faced for high charges required for getting admitted to government hospitals	38 (69%)	5 (9%)	12 (21.8%)	55 (100%)	37 (67.2%)	5 (9%)	13 (23.6%)	55 (100%)

**Not aware here refers to the households whose members never got admitted in any government hospital for treatment in the last three years.*

From the first opinion it is amply clear that villagers are less interested in getting treatment from government hospitals as from both the villages (52.7percent in Sisabari and 72.7 percent in Polash) are not aware about the fact that user charges are introduced in government hospital. Among those who got admitted, 36.3 percent (Sisabari) and 21.8 percent (Polash) complained of inadequate treatment after paying user charges.

In the second opinion also we can see 40 percent in Sisabari and 23.6 percent in Polash reported that they have to purchase medicines from shops after paying user charges. In the third opinion 72.7 percent from Sisabari and 70.9 percent from Polash complained of problem faced due to user charges. The villagers also faces problem due to high charges required in getting admitted to government hospitals. In Sisabari it is 69 percent and in Polash it is 67.2 percent.

It is apparent from the table that in both the villages, respondents are not satisfied with the treatment after paying user charges. The strategies of macro-economic policies to introduce user charges, which NHP 2002 also encouraged without thinking about the poor, is certainly making the people more marginalized.

It shows that user fee is marginalizing the poor who are already marginalized. Because the infrastructure fails to identify the poor in order to collect fee from the rich. This is quite reflected in a study in south Delhi that ability to pay for health care is affected by both ability to pay and non ability to pay factors by the household.⁶

In such cases, the poor patients have no option but to go to the private practitioner resulting in further impoverishment. What we can see is that, the percentage of illness episode, including both communicable and non-communicable diseases, treatment is confined to private sources. For non-communicable diseases, which require surgical intervention, the villagers prefer to go to the private sources, because they do not rely upon the government hospitals for surgery. So, in both the villages, out of the total illness episode seen by private practitioners, 53.3 percent were seen by private practitioners, which involved surgical intervention.

5.9 Differentials in Outpatient Care

Table 5.11
Percentage Distribution of Outpatient (non-hospitalised) Care in the Sample Households in Sisabari

Source of Treatment	0-14 (Children)			15 + (Adults)			Total Male	Total Female	Total
	M	F	T	M	F	T			
Government Hospital	0	5 (13.5%)	5 (13.5%)	9 (9.3%)	0	9 (9.3%)	9 (12.8%)	5 (7.9%)	14 (10.5%)
Government TB Centre	0	0	0	1 (1%)	0	1 (1%)	1 (1.4%)	0	1 (0.7%)
Government Malaria Hospital	2 (5.4%)	0	2 (5.4%)	3 (3.1%)	1 (1%)	4 (4.1%)	5 (7.1%)	1 (1.5%)	6 (4.5%)
Private Practitioner	7 (18.9%)	7 (18.9%)	14 (37.8%)	13 (13.5%)	17 (17.7%)	30 (31.2%)	20 (28.5%)	24 (38%)	44 (33%)
Quack	8 (21.6%)	8 (21.6%)	16 (43.2%)	27 (28.1%)	25 (26%)	52 (54.1%)	35 (50%)	33 (52.3%)	68 (51.1%)
Total	17 (45.9%)	20 (54%)	37 (100%)	53 (55.2%)	43 (44.7%)	96 (100%)	70 (100%)	63 (100%)	133 (100%)

Table 5.12
Percentage Distribution of Outpatient (non-hospitalised) Care in the Sample Households in Polash

Source of Treatment	0-14 (Children)			15 + (Adults)			Total Male	Total Female	Total
	M	F	T	M	F	T			
Government Hospital	5 (10.6%)	6 (12.7%)	11 (23.4%)	14 (17.9%)	0	0	15 (22.3%)	10 (17.2%)	25 (20%)
Government TB Centre	0	0	0	0	0	0	1 (1.4%)	0	1 (4%)
Government Malaria Hospital	3 (6.3%)	0	3 (6.3%)	0	3 (3.8%)	3 (3.8%)	3 (4.4%)	3 (5.1%)	6 (4.8%)
Private Practitioner	7 (14.8%)	6 (12.7%)	13 (27.6%)	12 (15.3%)	12 (15.3%)	24 (30.7%)	19 (28.3%)	18 (31%)	37 (29.6%)
Quack	12 (25.5%)	8 (17%)	20 (42.5%)	17 (21.7%)	19 (24.3%)	36 (46.1%)	29 (43.2%)	27 (46.5%)	56 (44.8%)
Total	27 (57.4%)	20 (42.5%)	47 (100%)	43 (55.1%)	34 (43.5%)	78 (100%)	67 (100%)	58 (100%)	125 (100%)

As can be seen from tables 5.11 and 5.12, the data do not reveal any glaring sex differentials in the pattern of utilization of health facilities. However, there are interesting differences between children and adults. Firstly, compared with children home remedies are tried more in case of adults, and secondly, directly buying medicines from quacks is resorted to be more in case of children.

Table 5.13

Distribution of Non-Hospitalised (outpatient) Illness Episodes by Source of Treatment and Monthly Household Income in the Sample Households in Sisabari

Monthly Income Household	Government Hospital	Government TB Hospital	Government Malaria Hospital	Private Practitioner	Quacks	Total
1000-2000	3 (14.2%)	1 (4.7%)	1 (4.7%)	5 (23.8%)	11 (52.3%)	21 (100%)
2001-3000	2 (6.8%)	0	1 (3.4%)	5 (17.2%)	21 (72.4%)	29 (100%)
3001-4000	2 (5.1%)	0	2 (5.1%)	17 (43.5%)	18 (46.1%)	39 (100%)
4001-5000	7 (30.4%)	0	0	4 (17.3%)	12 (52.1%)	23 (100%)
5001 and above	0	0	2 (9.5%)	13 (61.9%)	6 (28.5%)	21 (100%)
Total	14 (10.5%)	1 (0.7%)	6 (4.5%)	44 (33%)	68 (51.1%)	133 (100%)

Table 5.14

Distribution of Non-Hospitalised (outpatient) Illness Episodes by Source of Treatment and Educational Level in the Sample Households in Sisabari

Educational Level	Government Hospital	Government TB Hospital	Government Malaria Hospital	Private Practitioner	Quacks	Total
Illiterate	5 (8.6%)	1 (1.7%)	5 (8.6%)	17 (29.3%)	30 (51.7%)	58 (100%)
Primary School Level	7 (17.9%)	0	1 (2.5%)	13 (33.3%)	18 (46.1%)	39 (100%)
Middle School Level	0	0	0	9 (40.9%)	13 (59%)	22 (100%)
High School Level	2 (14.2%)	0	0	5 (35.7%)	7 (50%)	14 (100%)
Secondary School Level	0	0	0	0	0	0
Graduate	0	0	0	0	0	0
Total	14 (10.5%)	1 (0.7%)	6 (4.5%)	44 (33%)	68 (51.1%)	133 (100%)

Table 5.15
Distribution of Non-Hospitalised (outpatient) Illness Episodes by Source of Treatment and Ethnic Group in the Sample Households in Sisabari

Ethnic Group	Government Hospital	Government TB Hospital	Government Malaria Hospital	Private Practitioner	Quacks	Total
ST	6 (8.5%)	1 (1.4)	3 (4.2%)	30 (42.8%)	30 (42.8%)	70 (100%)
SC	8 (12.6%)	0	3 (4.7%)	14 (22.2%)	38 (60.3%)	63 (100%)
Total	14 (10.5%)	1 (0.7%)	6 (4.5%)	44 (33%)	68 (51.1%)	133 (100%)

Table 5.16
Distribution of Non-Hospitalised (outpatient) Illness Episodes by Source of Treatment and Household Monthly Income in the Sample Households in Polash

Household Monthly Income	Government Hospital	Government TB Hospital	Government Malaria Hospital	Private Practitioner	Quacks	Total
1000-2000	8 (18.6%)	0	1 (2.3%)	8 (18.6%)	26 (60.4%)	43 (100%)
2001-3000	11 (30.5%)	0	2 (5.5%)	13 (36.1%)	10 (27.7%)	36 (100%)
3001-4000	2 (10%)	1 (5%)	2 (10%)	5 (25%)	10 (50%)	20 (100%)
4001-5000	4 (26.6%)	0	1 (6.6%)	5 (25%)	5 (33.3%)	15 (100%)
5001 and above	0	0	0	6 (54.5%)	5 (45.4%)	11 (100%)
Total	25 (20%)	1 (4%)	6 (4.8%)	37 (29.6%)	56 (44.8%)	125 (100%)

Table 5.17
Distribution of Non-Hospitalised (outpatient) Illness Episodes by Source of Treatment and Educational Level in the Sample Households in Polash

Educational Level	Government Hospital	Government TB Hospital	Government Malaria Hospital	Private Practitioner	Quacks	Total
Illiterate	10 (20%)	0	2 (4%)	13 (26%)	25 (50%)	50 (100%)
Primary School Level	8 (19.5%)	1 (2.4%)	2 (4.8%)	10 (24.3%)	20 (48.7%)	41 (100%)
Middle School Level	7 (25%)	0	2 (7.1%)	8 (28.5%)	11 (39.2%)	28 (100%)
High School Level	0	0	0	6 (100%)	0	6 (100%)
Secondary School Level	0	0	0	0	0	0
Graduate	0	0	0	0	0	0
Total	25 (20%)	1 (4%)	6 (4.8%)	37 (29.6%)	56 (44.8%)	125 (100%)

Table 5.18
Distribution of Non-Hospitalised Illness (outpatient) Episodes by Source of Treatment and Ethnic Group in the Sample Households in Polash

Ethnic Group	Government Hospital	Government TB Hospital	Government Malaria Hospital	Private Practitioner	Quacks	Total
ST	5 (10.2%)	1 (2%)	3 (6.1%)	15 (30.6%)	25 (51%)	49 (100%)
SC	20 (26.3%)	0	3 (3.9%)	22 (28.5%)	31 (40.7%)	76 (100%)
Total	25 (20%)	1 (4%)	6 (4.8%)	37 (29.6%)	56 (44.8%)	125 (100%)

In tables (5.13, 5.14, 5.15, 5.16, 5.17, 5.18) percentage distribution of non-hospitalised illness episodes by source of treatment is presented by household characteristics like monthly income and level of education and ethnic group.

1) Income

In both Sisabari and Polash, with increase in income the dependency on both government health facilities and private sources increase, because in government hospitals also money is required to seek treatment. As far as the lowest income category is concerned, in both the villages 52.3 percent and 60.4 percent of illness episodes, treatment is sought from quacks. Perhaps buying medicines after consulting with quack works out to be the cheapest. Apart from the cost, the households would be also saving time. For these reason the poor people must be resorting to treatment from quacks without realizing its harmful effects. In both the villages, the common thing is that in all the income category in the highest number of cases treatment is sought from private practitioners and quacks.

2) Educational level

In both the villages, with an increase in the education of the main earner, a sharp increase in the utilization of private sources (from 29.3 percent to 40.9 percent in Sisabari and from 26 percent to 100 percent in Polash) has been observed. However, no clear trend is visible in government hospital. Interestingly, in Polash treatment from quack decreases with the rise in the educational level of the households. This may be due to the fact that, since educated people have greater awareness and they realize the risk of treatment from quack.

3) Ethnic Group

In respect to ethnic group, in Sisabari, 12.6 percent of SC people are going for government hospital whereas in tribes it is 8.5 percent. But in both the groups we can see, preferring private hospitals is more evident than preference for government sources. In Polash SC represents are utilizing government facilities i.e. 26.3 percent to a greater extent than STs. Though this does not make any difference because between both the groups preference for private hospitals and quacks are more than that for government hospitals.

5.10 Differentials in Inpatient Care

Table 5.19
Distribution of Hospitalised (Inpatient) Cases by Sex, Age Group and Source of Treatment in the Sample Households in Sisabari

Source of Treatment	0-14 (Children)			15+ (Adults)			Total Male	Total Female	Total
	M	F	T	M	F	T			
Government Hospital	3 (50%)	2 (33.3%)	5 (83.3%)	1 (8.3%)	5 (41.6%)	6 (50%)	4 (36.3%)	7 (100%)	11 (61.1%)
Private Clinics	1 (16.6%)	0	1 (16.6%)	6 (50%)	0	6 (50%)	7 (63.6%)	0	7 (38.8%)
Total	4 (66.6%)	2 (33.3%)	6 (100%)	7 (58.3%)	5 (41.6%)	12 (100%)	11 (100%)	7 (100%)	18 (100%)

Table 5.20
Distribution of Hospitalised (inpatient) Cases by Sex, Age Group and Source of Treatment in the Sample Households in Polash

Source of Treatment	0-14 (Children)			15+ (Adults)			Total Male	Total Female	Total
	M	F	T	M	F	T			
Government Hospital	1 (20%)	2 (40%)	3 (60%)	2 (20%)	2 (20%)	4 (40%)	3 (42.8%)	4 (50%)	7 (46.6%)
Private Clinics	2 (40%)	0	2 (40%)	2 (20%)	4 (40%)	6 (60%)	4 (57.1%)	4 (50%)	8 (53.3%)
Total	3 (60%)	2 (40%)	5 (100%)	4 (40%)	6 (60%)	10 (100%)	7 (100%)	8 (100%)	15 (100%)

In both the villages, in contrast to the non-hospitalised illness episodes, for inpatient treatment, the sample households seem to rely both on government hospitals and private clinics. In Sisabari, for 61.1 percent of the cases, treatment has been sought in government hospital, though this percentage is much lower in case of Polash i.e. 46.6 percent (Table 5.19 and 5.20). The reason for availing both the facilities is that there is not much difference between cost of treatment in government and private facility. It is also evident from the tables that in Sisabari, for 100 percent of illness episodes of female patients, treatment is sought from government hospital whereas for males 36.3 percent of illness episodes, treatment is sought from government hospital and for 63.6 percent of illness episodes treatment is sought from private sources which shows female prefer to go to government hospital in order to get the treatment at minimum expenditure. The same trend is visible in Polash also. In case of children, government hospitals are more preferred more than private sources.

Table 5.21

Distribution of Hospitalised (inpatient) Illness Episodes by Source of Treatment and Household Monthly Income in the Sample Households in Sisabari

Household Monthly Income	Government Hospital	Private Clinics	Total
1000-2000	1 (50%)	1 (50%)	2 (100%)
2001-3000	1 (33.3%)	2 (66.6%)	3 (100%)
3001-4000	6 (85.7%)	1 (14.2%)	7 (100%)
4001-5000	2 (40%)	3 (60%)	5 (100%)
5001 and above	1 (100%)	0	1 (100%)
Total	11 (61.1%)	7 (38.8%)	18 (100%)

Table 5.22

Distribution of Hospitalised (inpatient) Illness Episodes by Source of Treatment and Educational Level in the Sample Households in Sisabari

Educational Level	Government Hospital	Private Clinics	Total
Illiterate	6 (66.6%)	3 (33.3%)	9 (100%)
Primary School Level	0	1 (100%)	1 (100%)
Middle School Level	2 (50%)	2 (50%)	4 (100%)
High School Level	3 (75%)	1 (25%)	4 (100%)
Secondary school Level	0	0	0
Graduate	0	0	0
Total	11 (61.1%)	7 (38.8%)	18 (100%)

Table 5.23**Distribution of Hospitalised (inpatient) Illness Episodes by Source of Treatment and Ethnic Group in the Sample Households in Sisabari**

Ethnic Group	Government Hospital	Private Clinics	Total
ST	4 (44.4%)	5 (55.5%)	9 (100%)
SC	7 (77.7%)	2 (22.2%)	9 (100%)
Total	11 (61.1%)	7 (38.8%)	18 (100%)

Table 5.24**Distribution of Hospitalised (inpatient) Illness Episodes by Source of Treatment and Household Monthly Income in the Sample Households in Polash**

Household Monthly Income	Government Hospital	Private Clinics	Total
1000-2000	4 (66.6%)	2 (33.3%)	6 (100%)
2001-3000	1 (100%)	0	1 (100%)
3001-4000	1 (33.3%)	2 (66.6%)	3 (100%)
4001-5000	1 (25%)	4 (75%)	5 (100%)
5001 and above	0	0	0
Total	7 (46.6%)	8 (53.3%)	15 (100%)

Table 5.25**Distribution of Hospitalised (inpatient) Illness Episodes by Source of Treatment and Educational Level in the Sample Households in Polash**

Educational Level	Government Hospital	Private Clinics	Total
Illiterate	4 (40%)	6 (60%)	10 (100%)
Primary School Level	2 (66.6%)	1 (33.3%)	3 (100%)
Middle School Level	1 (50%)	1 (50%)	2 (100%)
High School Level	1 (100%)	0	1 (100%)
Secondary school Level	0	0	0
Graduate	0	0	0
Total	7 (46.6%)	8 (53.3%)	15 (100%)

Table 5.26**Distribution of Hospitalised Illness Episodes by Source of Treatment and Ethnic Level in the Sample Households in the Sample Households in Polash**

Ethnic Group	Government Hospital	Private Clinics	Total
ST	1 (20%)	4 (80%)	5 (100%)
SC	6 (60%)	4 (40%)	10 (100%)
Total	7 (46.6%)	8 (53.3%)	15 (100%)

1) Income

We can see from table 5.21, in Sisabari, in the lowest household income category 50 percent of the patients sought treatment from government hospitals while another 50 percent sought treatment from private clinics. In the household income category of 2001-

3000, for 33.3 percent of illness episodes, treatment is sought from government hospitals and for 66.6 percent of illness episode treatment is sought from private sources. On the other hand, in the household income category of 3001-4000, for 85.7 percent of illness episodes, treatment is sought from government hospitals whereas for 14.2 percent of illness episodes treatment is sought from private sources. This shows that income is not the factor behind getting admitted to private sources, what matters is the adequate treatment though it may lead to indebtedness and other financial problems. In both the villages, of the illness episodes in the highest household income category, three percent get admitted to different medical institutions for treatment while of the illness episodes in the lowest household income category, 24.2 percent get admitted to different medical institutions. This is probably the reason that the households of the highest income category seek treatment from private sources which could be quacks or qualified practitioners in the initial stage of illness. As the households of lower income category cannot make it at the initial stage of illness, in contrast, it is the life saving emergencies, which drives the poor households income category to go for treatment.

In Polash (Table 5.24), the trend is inverse. As we move towards highest income category we can see, the utilization of government hospital decreases with the increase in the income level of the households and that of the private hospital increases. The reason may be that Polash is predominantly inhabited by people belonging to the SC.

2) Educational Level

In case of education it seems that, in Sisabari, the dependency on government hospital increases with the increase in educational level and that of private clinic decreases. However, no clear trend is visible in Polash, because family members of the ex-armymen inhabited in the village underwent a few surgical cases in army hospitals.

3) Ethnic Group

In case of ethnic groups, in both the villages, people belonging to the SC are utilizing the government hospitals more (77.7 percent and 60 percent) whereas in tribes it is 44.4 percent and 20 percent, because economic condition of caste is poor than tribes.

5.11 Expenditure on Health

Table 5.27
Distribution of Hospitalization (inpatient) Cases by Household Income and Expenditure in the Sample Households in Sisabari

Monthly Household Income	Civil Hospital		North Bengal Medical College		Private Clinic	
	Days	Expenditure	Days	Expenditure	Days	Expenditure
1000-2000	0	0	2	Rs3000 (Malaria)	8	Rs1000 (Diarrhoea)
2001-3000	2	Rs300 (Fever, leg ache)	0	0	2½ months	Rs3000 (jaundice)
	0	0	0	0	3	Rs500 (jaundice)
3001-4000	3	Rs500 (Malaria)	7	Rs600 (Typhoid)	8	Rs1500 (Hand Fracture)
	3	Rs300 (malaria)	0	0	0	0
	1	Rs300 (malaria)	0	0	0	0
	2	Rs150 (Diarrhoea)	0	0	0	0
	1	Rs300 (Pneumonia)	0	0	0	0
4001-5000	22	Rs2000 (Breast Tumour)	0	0	3	Rs1500 (Eye Operation)
	10	Rs4000 (Uterus Operation)	0	0	1	Rs3000 (Gastroenterities)
	0	0	0	0	3	Rs20000 (Leg fracture)

Table 5.28
Distribution of Hospitalization (inpatient) Cases by Household Income and Expenditure in the Sample Households in Polash

Monthly Household Income	Civil Hospital		North Bengal Medical College		Private Clinic	
	Days	Expenditure	Days	Expenditure	Days	Expenditure
1000-2000	7	Rs800 (Mental Disorder)	7	Rs550 (Stomachache)	5	Rs3000 (Jaundice)
	3	Rs500 (Fever)	0	0	12	Rs25000 (Gall Bladder stone-operation)
2001-3000	5	Rs1000 (Blood Dysentery)	6	Rs3000 (Leg fracture)	0	0
3001-4000	3	Rs7000 (Tumour)	3	Rs200 (Jaundice)	3	Rs3000 (Hernia operation)
	0	0	0	0	5	Rs5000 (malaria, jaundice)
	0	0	0	0	7	Rs22000 (heart problem)
	0	0	0	0	5	Rs20000 (ulcer, Gall Bladder stone-operation)

In Table 5.27 and 5.28 we can see, in both the villages, the average expenditure for treatment in secondary level medical care ranges between Rs5000 and Rs10125; the average expenditure for treatment in tertiary level medical care ranges between Rs4000 and Rs1250; the average expenditure for treatment in private clinic ranges between Rs1006 and Rs2325.

The findings in the tables reveal that apart from surgical cases, the treatment in private clinics, secondary and tertiary level medical care, the expenditure is more or less same, because in secondary and tertiary level medical institutions, after paying user charges for staying in the ward, the households have to incur a huge out-of-expenditure right from providing food to the patient, transportation cost, different pathological tests, medicines, and giving bribes to 'ayas' (attendant) for staying in the wards. After prescribing medicines and different tests by the government doctors, the patient has to purchase medicines from medicine shops and tests are to be done in private laboratories. On the contrary, even after paying user charges they do not get adequate treatment.

Secondly, duration of stay in hospitals does not determine the expenditure required for the particular treatment. In government hospitals, apart from paying user charges (for staying in the wards) they have to spend on different types of medicines (which are purchased from the chemist shop) and number of tests required for the particular illness. In private clinics, the expenditure depends upon the type of treatment required for the particular illness. Thus they loose both way; they have to spend money on government hospitals and do not get adequate treatment. In this adverse situation, NHP 2002 emphasizes the contribution of the private sector in providing health services. Here we can see those who cannot afford, are also paying. NHP 2002 has undermined the requirements poor people at totally. First it has not categorized who are the poor people. Secondly, these poor people are spending more than the required charges. It is also quite evident in other rural areas. In rural Rajasthan villagers spend lot on health care, still they have poor health⁷.

Table 5.29
Source of Money for Health Care in the Sample Households in Sisabari

Diseases	Borrowing	Borrowing +sells wood	Sells forest wood+ mortgaging land	Borrowing+ selling animals	Sells forest wood	Borrowing+ selling animals+ mortgaging land	Savings	Total
Malaria	9 (9.6%)	7 (7.5%)	3 (3.2%)	5 (5.3%)	3 (3.2%)	3 (3.2%)	0	30 (32.2%)
Jaundice	5 (5.3%)	3 (3.2%)	2 (2.1%)	6 (6.4%)	6 (6.4%)	5 (5.3%)	0	27 (29%)
Pneumonia	2 (2.1%)	2 (2.1%)	0	1 (1%)	1 (1%)	1 (1%)	0	7 (7.5%)
TB	0	1 (1%)	1 (1%)	0	0	1 (1%)	0	3 (3.2%)
Diarrhoea	0	2 (2.1%)	0	2 (2.1%)	5 (5.3%)	5 (5.3%)	1 (1%)	15 (16.1%)
Hysteria	1 (1%)	1 (1%)	0	0	0	0	0	2 (2.1%)
Hand Fracture	1 (1%)	0	0	0	0	0	0	1 (1%)
Leg Fracture	0	0	0	1 (1%)	0	0	0	1 (1%)
Typhoid	1 (1%)	0	0	0	0	0	0	1 (1%)
Eye Operation	0	0	0	0	0	0	1 (1%)	1 (1%)
Gastroenterities	0	0	0	0	0	0	2 (2.1%)	2 (2.1%)
Breast Tumour	0	0	0	0	0	0	1 (1%)	1 (1%)
Uterus operation	0	0	0	0	0	0	1 (1%)	1 (1%)
Gynaecological disorder	0	1 (1%)	0	0	0	0	0	1 (1%)
Total	19 (20.4%)	17 (18.2%)	6 (6.4%)	15 (16.1%)	15 (16.1%)	15 (16.1%)	6 (6.4%)	93 (100%)

Table 5.30
Source of Money for Health Care in the Sample Households in Polash

Diseases	Borrowing	Borrowing +sells wood	Sells forest wood+ mortgaging land	Borrowing+ selling animals	Sells forest wood	Borrowing+ selling animals+ mortgaging land	Savings	Total
Malaria	3 (6%)	2 (4%)	3 (6%)	3 (6%)	2 (4%)	0	2 (4%)	15 (30%)
Jaundice	4 (8%)	1 (2%)	1 (2%)	0	3 (6%)	1 (2%)	0	10 (20%)
TB	1 (2%)	0	0	1 (2%)	0	0	0	2 (4%)
Diarrhoea	2 (4%)	0	2 (4%)	1 (2%)	2 (2%)	0	1 (2%)	8 (16%)
Gynaecological Disorder	0	0	0	1 (2%)	0	0	0	1 (2%)
Hernia Operation	0	1 (2%)	0	0	0	0	0	1 (2%)
Heart Problem	0	0	0	1 (2%)	0	0	0	1 (2%)
Gall Bladder stone-operation	0	0	0	1 (2%)	0	0	1 (2%)	2 (4%)
Tumour	0	0	0	0	1 (2%)	0	0	1 (2%)
Leg fracture	1 (2%)	0	0	0	0	0	0	1 (2%)
Mentally sick	0	0	0	0	1 (2%)	0	0	1 (2%)
Blood dysentery	1 (2%)	1 (2%)	0	0	0	0	0	2 (4%)
Paralyses	0	0	0	0	1 (2%)	0	0	1 (2%)
Chicken Pox	0	0	0	0	0	0	1 (2%)	1 (2%)
Typhoid	0	0	0	0	0	1 (2%)	0	1 (2%)
Measles	0	0	0	0	0	0	1 (2%)	1 (2%)
Night Blindness	1 (2%)	0	0	0	0	0	0	1 (2%)
Total	13 (26%)	5 (10%)	6 (12%)	8 (16%)	10 (20%)	2 (4%)	6 (12%)	50 (100%)

The expenditure pattern on health care reveals that for seeking treatment, outpatient and inpatient care as well in both government and private sources costs the patients dearly. The study reveals that to meet the hospitalization expenses the households have to borrow money and even liquidate their assets. Any hospitalization in the households involves huge expenditure, both medical and non-medical expenses and this very badly affect the household budget. Table 5.29 and 5.30 represents the different source of money for health care. The major source of money to spend on health care is borrowing. In Sisabari, it is 20.4 percent and in Polash it is 26 percent. The next source of earning is selling of forest wood, i.e. 16.1 percent in Sisabari and 20 percent in Polash (which is leading to severe deforestation). The villagers have to spend not only in hospitalization cases but also for paying to quacks and private practitioners. Sometimes, a family gets completely ruined by paying quacks and private practitioners, in the process of becoming a pauper. The economic condition of the households does not allow them to save much, nevertheless, ailments make pauperization rapid and much more acute. Due to high prevalence of malaria and jaundice, borrowings become the main source of money (for malaria in Sisabari it is 32.2 percent and 29 percent in Sisabari; 30 percent and 20 percent in Polash). Moreover, disposing of movable (animals) and immovable (land) properties also prevent them from boosting the family income. Thus, costs of seeking treatment typically include financial expenses and income losses. While illness weakens the people physically, the burden of treatment makes them more helpless. This is aptly shown from what a villager had to say- "*Daru pike so jate hein*" (gets boozed off), said a villager who could not recover from his illness, have no money, no place left to borrow, no assets to sell and physically weak to gather forest wood. This phenomena is also evident in a study carried out in Jharkhand. Due to lack of available facilities, the tribes of Dumka district in Jharkhand suffering from malaria have to dispose of their movable and immovable properties⁸. This shows how macro-economic policies are badly affecting the marginal people. The policies never dealt with rural requirements.

5.12 Utilization of Maternal Health Services

1) Antenatal Care Services

Table 5.31

Percentage of Women Utilizing Antenatal Care by Household Monthly Income (in the last three years) in Sample Households in the Villages under Study

Household Monthly Income	Went for Antenatal Check up					
	Sisabari			Polash		
	Yes	No	Total	Yes	No	Total
1000-2000	2 (9.5%)	2 (9.5%)	4 (19%)	3 (14.2%)	3 (14.2%)	6 (28.5%)
2001-3000	1 (4.7%)	2 (9.5%)	3 (14.2%)	4 (19%)	1 (4.7%)	5 (23.8%)
3001-4000	4 (19%)	1 (4.7%)	5 (23.8%)	2 (9.5%)	2 (9.5%)	4 (19%)
4001-5000	3 (14.2%)	2 (9.5%)	5 (23.8%)	1 (4.7%)	0	1 (4.7%)
5001 and above	4 (19%)	0	4 (19%)	4 (19%)	1 (4.7%)	5 (23.8%)
Total	14 (66.6%)	7 (33.3%)	21 (100%)	14 (66.6%)	7 (33.3%)	21 (100%)

Table 5.32

Percentage of Women Utilizing Antenatal Care by Educational Level (in the last three years) in the Sample Households in the Villages under Study

*Educational Level	Went for Antenatal Check up					
	Sisabari			Polash		
	Yes	No	Total	Yes	No	Total
Illiterate	6 (28.5%)	3 (14.2%)	9 (42.8%)	3 (14.2%)	4 (19%)	7 (33.3%)
Primary School Level	4 (19%)	1 (4.7%)	5 (23.8%)	7 (33.3%)	1 (4.7%)	8 (38%)
Middle School Level	2 (9.5%)	2 (9.5%)	4 (19%)	1 (4.7%)	1 (4.7%)	2 (9.5%)
High School Level	2 (9.5%)	1 (4.7%)	3 (14.2%)	2 (9.5%)	1 (4.7%)	3 (14.2%)
Secondary School Level	0	0	0	1 (4.7%)	0	1 (4.7%)
Total	14 (66.5%)	7 (33.3%)	21 (100%)	14 (66.4%)	7 (33.3%)	21 (100%)

**Husband's educational level.*

Table 5.33

Percentage of Women Utilizing Antenatal Care by *Ethnic Group*
(in the last three years) in the Sample Households in the villages under study

Ethnic Group	Went for Antenatal Check up					
	Sisabari			Polash		
	Yes	No	Total	Yes	No	Total
ST	10 (47.6%)	3 (14.2%)	13 (61.9%)	2 (14.2%)	4 (19%)	6 (28.5%)
SC	4 (19%)	4 (19%)	8 (38%)	12 (85.7%)	3 (14.2%)	15 (71.4%)
Total	14 (66.5%)	7 (33.3%)	21 (100%)	14 (66.4%)	7 (33.3%)	21 (100%)

The information collected about antenatal care in the household schedule is presented in above tables. The above tables represent an encouraging figure of expecting mothers going for antenatal check-up (in both the villages only 66.6 percent of the sample women have had antenatal check-up). However, it is found that even though who have had antenatal check-up, they could not avail the TT injection and folic tablets from government sources, rather they had to manage it from private sources. It again highlights the lack of awareness due to poor and non-functional delivery of health services. The utilization of ANC services in a given population depends upon availability and accessibility of services, socio-economic status of the household and distance of the health facility. Most of the women said that unless and until they have any complication, they do not go for antenatal check-up. However, it was found that women have visited doctors, paramedics and traditional healer for antenatal check-up. Paramedics appear to be the main care giver for antenatal care outside the home in both the villages. Economic reasons for not availing antenatal check-ups were cited in the study. The place of residence is also an important indicator of accessibility as health institutions (facilities are located at urban areas). Cultural taboos coupled with lack of knowledge among pregnant mothers also prevent them from going for antenatal care. Similarly, in states like Uttaranchal, Jharkhand and Chattisgarh it was observed that utilization of ANC services varies with the socio-economic characteristics of its population⁹. "Traditionally, little attention has been paid to women in the antenatal period, even traditional dais coming into the picture only at delivery. The maternal and child health programme seeks to address this period of neglect. Under this programme, all pregnant women are to be routinely followed up either in the health center or at home, and provided immunization,

supplementation and regular check-ups to monitor the pregnancy”¹⁰. Though family planning programme gets highest priority in the vertical health programmes, it is still inadequate to deal with the situation. On the other hand NHP 2002 emphasised on integration of all vertical programmes in spite of inadequate health service delivery.

a) Income

Table 4.73 shows that higher income level leads to higher antenatal check up because households belong to higher income category can afford treatment from private sources.

b) Educational Level

In case of education level, considering both the village together we can see 66.4 percent has gone for antenatal check-up. Though this is the findings, they are not able to indicate, whether there is any positive association between the going for antenatal check-up educational attainment. A line worth adding here; education does play an important role in increasing the gap between two pregnancies and thereby reducing fertility. So, it is evident from the table that fertility is low in higher educational level.

c) Ethnic Group

In case of ethnic group, in Sisabari, tribes are going more for antenatal check-up (71.4 percent) whereas in Polash castes are going more for antenatal check-up (85.7 percent). This does make any difference because tribes are inhabited in Sisabari and castes are inhabited in Polash.

Table 5.34
Number of Deliveries in Different Medical Institutions by Income and Expenditure
in Sample Households in th Villages under Study

Monthly Household Income	Sisabari		Polash	
	Government Hospital	Private Clinics	Government Hospital	Private Clinics
1000-2000	Rs500 (caesarian section)	*Rs200	Rs1050	0
	Rs300	*Rs500	Rs700	0
	0	0	Rs700	0
	0	0	Rs1250	0
	0	0	Rs1000	0
2001-3000	0	0	Rs200	Rs12000 (caesarian section)
	0	0	Rs3000	Rs8000
	0	0	Rs200	0
	0	0	Rs1100	0
3001-4000	0	0	Rs1000	0
4001-5000	Rs1000	Rs20000 (caesarian section)	Rs2000	0
5001 and above	Rs3000 (caesarian section)	0	0	Rs8000

* Charitable Hospital

Table (table 5.34) represents the expenditure on hospital birth on government hospital and private sources. It shows that in government hospitals villagers had to spend a huge amount. In the private sources we can see only the higher income category sought treatment.

Table 5.35
Number of Deliveries in Different Medical Institutions by Educational Level in
Sample Households in Sisabari (in the last three years).

*Educational Level	At Home	Government Hospital	Private Clinics	Total
Illiterate	6 (21.4%)	3 (10.7%)	1 (3.5%)	10 (35.7%)
Primary School Level	9 (32.1%)	0	0	9 (32.1%)
Middle School Level	4 (14.2%)	0	1 (3.5%)	5 (17.8%)
High School Level	2 (7.1%)	1 (3.5%)	1 (3.5%)	4 (14.2%)
Total	21 (75%)	4 (14.2%)	3 (10.7%)	28 (100%)

*Husband's educational level.

Table 5.36
Number of Deliveries in Different Medical Institutions by Ethnic Group in the
Sample Households Sisabari (in the last three years).

Ethnic Group	At Home	Government Hospital	Private Clinics	Total
ST	15 (53.5%)	2 (7.1%)	3 (10.7%)	20 (71.4%)
SC	6 (21.4%)	2 (7.1%)	0	8 (28.5%)
Total	21 (75%)	4 (14.2%)	3 (10.7%)	28 (100%)

Table 5.37
Number of Deliveries in Different Medical Institutions by Educational Level in the
Sample Households in Polash (in the last Three Years)

*Educational Level	At Home	Government Hospital	Private Clinics	Total
Illiterate	3 (12.5%)	5 (20.8%)	1 (4.1%)	9 (37.5%)
Primary School Level	4 (16.6%)	5 (20.8%)	0	9 (37.5%)
Middle School Level	0	1 (4.1%)	0	1 (4.1%)
High School Level	3 (12.5%)	0	1 (4.1%)	4 (4.1%)
Secondary School Level	0	0	1 (4.1%)	0
Total	10 (41.6%)	11 (45.8%)	3 (12.5%)	24 (100%)

**Husband's educational level*

Table 5.38
Number of Deliveries in Different Medical Institutions by Ethnic Group in the
Sample Households in Polash (in the last Three Years)

Ethnic Groups	At Home	Government Hospital	Private Clinics	Total
ST	5 (20.8%)	1 (4.1%)	1 (4.1%)	7 (29.1%)
SC	5 (20.8%)	10 (41.6%)	2 (8.3%)	17 (70.8%)
Total	10 (41.6%)	11 (45.8%)	3 (12.5%)	24 (100%)

Tables (5.35, 5.36, 5.37, 5.38) depict the number of deliveries in different medical institutions which reveals a clear picture of preference of deliveries at home, that is, 75 percent (in both the villages). Traditional birth attendants seemed to be the main care givers for delivery in Sisabari. In both the villages it is found that in government hospital (in case of normal deliveries), nurses and 'ayas' are the care givers during delivery (because in government hospital doctors are not present during deliveries). Utilization of hospitals is greater among women in Polash (45.8 percent in government hospitals and 12.5 percent in private clinic). The possible reason may be in Polash people belonging to

SCs are more than STs who prefer hospital birth. In Sisabari, preference of birth is at home, whereas, in Polash among SCs, preference of birth is at government hospital (41.6 percent).

It is found that, generally women are reluctant to go to hospital for a number of reasons. Firstly, hospitalization involves transportation cost and disturbance of household routine. Moreover, traditional birth attendant is present in the village. Secondly, until there is any complication, they do not move to hospital. Thirdly, if they register for hospital birth, they have to undergo certain tests which require money along with paying fees for staying in the maternity ward and giving bribes to 'ayas' and nurses. Fourth, in case of normal delivery, doctors do not assist, only nurses and 'ayas' are present during the delivery in both government and private sources. This is quite evident in rural areas of other states. In the rural areas of Andhra Pradesh women opt for home deliveries due to unfriendly behaviour of governmental health staff and high fee charged by private practitioners¹¹.

2) Utilization of Family Planning Methods

Table 5.39

Utilization of contraceptive Methods among Women in the Age Group 15-45 by Household Monthly Income in the Sample Households in the villages under Study in the last three years.

Sisabari n=58

Polash n=59

Monthly Household Income	Sisabari				Polash			
	Sterilized	Oral pill	Condom	Total	Sterilized	Oral pill	Condom	Total
1000-2000	10 (17.2%)	2 (3.4%)	0	12 (20.6%)	5 (8.4%)	2 (3.3%)	0	7 (11.8%)
2001-3000	2 (3.4%)	3 (5.1%)	0	5 (8.6%)	3 (5%)	3 (5%)	0	6 (10.1%)
3001-4000	4 (6.8%)	2 (3.4%)	0	6 (10.3%)	3 (5%)	2 (3.3%)	0	5 (8.4%)
4001-5000	3 (5.1%)	0	0	3 (5.1%)	2 (3.3%)	0	1 (1.6%)	3 (5%)
5001 and above	4 (6.8%)	0	1 (1.7%)	5 (8.6%)	2 (3.3%)	0	0	2 (3.3%)
Total	23 (39.4%)	7 (12%)	1 (1.7%)	31 (53.4%)	15 (25.4%)	7 (11.8%)	1 (1.6%)	23 (38.9%)

Table 5.40
Utilization of contraceptive Methods among Women in the Age Group 15-45 by Educational Level in the Sample Households in the villages under study in the last three years.
Sisabari n=58
Polash n=59

*Educational Level	Sisabari				Polash			
	Sterilized	Oral pill	Condom	Total	Sterilized	Oral pill	Condom	Total
Illiterate	12 (20.6%)	0	0	12 (20.6%)	10 (16.9%)	2 (3.3%)	0	12 (20.3%)
Primary School Level	5 (8.6%)	2 (3.4%)	0	7 (12%)	3 (5%)	3 (5%)	0	6 (10.1%)
Middle School Level	4 (6.8%)	1 (1.7%)	0	5 (8.6%)	1 (1.6%)	0	1 (1.6%)	2 (3.3%)
High School Level	2 (3.4%)	4 (6.8%)	0	6 (10.3%)	1 (1.6%)	2 (3.3%)	0	3 (5%)
Secondary School Level	0	0	0	0	0	0	0	0
Graduate	0	0	1 (1.7%)	1 (1.7%)	0	0	0	0
Total	23 (39.4%)	7 (12%)	1 (1.7%)	31 (53.4%)	15 (25.4%)	7 (11.8%)	1 (1.6%)	23 (38.9%)

*Husbands educational level

Table 5.41
Utilization of contraceptive Methods among Women in the Age Group 15-45 by Ethnic Group in the Sample Households in the villages under Study in the last three years.
Sisabari n=58
Polash n=59

Ethnic Group	Sisabari				Polash			
	Sterilized	Oral pill	Condom	Total	Sterilized	Oral pill	Condom	Total
ST	17 (29.3%)	4 (6.8%)	1 (1.7%)	22 (37.9%)	6 (10.1%)	4 (6.7%)	1 (1.6%)	11 (18.6%)
SC	6 (20%)	3 (5.1%)	0	9 (15.5%)	9 (15.2%)	3 (5%)	0	12 (20.3%)
Total	23 (39.4%)	7 (12%)	1 (1.7%)	31 (53.4%)	15 (25.4%)	7 (11.8%)	1 (1.6%)	23 (38.9%)

Utilization of contraception methods among women in the age group 15-45 is presented in tables (5.39, 5.40 and 5.41). We can see from the table that the use of contraception is not encouraging though it is higher in Sisabari (53.2 percent) whereas in Polash it is 38.7 percent which may be due to less contact with health workers in Polash. In Sisabari, 39.4 percent has undergone sterilization, whereas in Polash it is 25.1 percent. In both the villages both among castes and tribes preference for sterilization is more than utilization of contraceptives. However, in Polash the women reported that they have to take rest

after sterilization, which results in income loss. Some women said they do not rely on sterilization, because of failure of this method. A few women who have undergone sterilization in PHC five to six years back have again become pregnant. Therefore, we can say, not only provision but also efficiency is simultaneously essential for proper utilization of health facilities. But the study gives a contrasting picture regarding the utilization of other contraceptive methods in both the villages. The women reported that they do not use oral pills because of side effects like dizziness, headache, menstrual problem, inconvenience etc. If we consider the two villages, the total percentage of acceptance of family planning method is 45.2 percent, which is significantly low. It gives support to the fact that less contact with health staff causes less awareness. The remaining women who are not using any contraceptive methods- a few women have taken herbs, some are newly married, some women attained menopause, some do not like the contraceptives due to side effect, some are pregnant, some are intending for sterilization, and some are waiting for son. These findings are also not able to indicate whether there is a positive association between family planning and educational attainment because it is evident from the table that rate of sterilization is highest among the illiterates. This is due to the fact that in the illiterate section most household belong to the low income category, so they cannot afford other methods which are to be purchased from private sources, but in case of higher educational level, use of other methods are more, because they want to increase the gap between two births. Another interesting finding is that, in respect to permanent family planning measure, it is the women only who had undergone sterilization for birth control. In the last three years except one case of sterilization (undergone in private clinic) others have undergone it in PHC. Only in 28.5 percent case, the health personnel came for follow-up check-up the next day. Another aspect is that, for other methods, the villagers have to purchase the contraceptives from medicine shop. It seems that from the last three years the villagers have availed the health services of PHC only for sterilization. The NHP 2002 has not taken any step to improve family planning services which is still a primary vertical programmes running in PHC. In a study in Orrisa it was found that by strengthening Maternal Child Health services, the possibility of increase in the practice of family planning increases¹².

5.13 Utilization of Child Health Services

Table 5.42
Percentage Distribution of Immunization of Children in the Sample Households in the villages under Study

Name of the villages	Immunization					Total
	BCG	DPT	OPV	Measles	Vitamin A	
Sisabari	20 (22.4%)	15 (16.8%)	33 (37%)	10 (11.2%)	11 (12.3%)	*89 (100%)
Polash	28 (23.1%)	23 (19%)	40 (33%)	17 (14%)	13 (10.7%)	**121 (100%)

* Total number of vaccines provided to 42 children in Sisabari.

** Total number of vaccines provided to 43 children in Polash.

The data from immunization came from a sample of 42 children in Sisabari and 43 children in Polash under 5 years of age (Table 5.42). In both the villages we can see the coverage of OPV (Oral Polio Vaccine) is highest among all the vaccines that is, in Sisabari it is 37 percent and in Polash it is 33 percent. The highest coverage of OPV is due to the pulse polio programmes held in the village primary school every year.

During the study it was found that in Sisabari 47.6 percent have immunization card and in Polash 62.7 percent have immunization card. The reason is that, most of the birth took place at home and villagers are reluctant to make vaccination card, because they feel it is a complicated process (they have to go to different places and bribe the authorities). Another factor behind low percentage of vaccination is that, when a case is found where an infant get infected even after vaccination, neighbours refuse to vaccinate their children, moreover, they feel if the child has no health problem, what is the need of vaccination.

Post-neonatal (1 month to 1 year) mortality accounted for 7 percent due to pneumonia, diarrhoea and fever. Though these diseases are contributing to mortality, ORS (Oral Rehydration Salt) is not provided to them free of cost which was introduced by WHO two decades ago. Moreover, there are no ICDS centers in the villages. Even ICDS workers are also not present to do routine check-up to determine the health status of the children.

The trends in the rate and pattern of mortality in this study has brought out the direct and indirect contribution of socio-economic factors. Improvement in the living and working conditions are necessary for improvement in the health status of people. It is found that the health status of people is highly correlated with different components of socio-economic development.

The existence of basic socio-economic infrastructure in the form of transportation, communication, literacy, income etc. is a precondition for utilization of health care services. The provision of health care is also related with sanitation, approach road to the health centers and drinking water, but the availability of all these were found to be low and hence proving to be a barrier in the availability and utilization of health care.

The development of infrastructure and that of the rural economy are closely associated with health status. Other factors which adds to the improvement in the health status of the people are poverty, unemployment, illiteracy and ill-health. Major reforms are needed in the areas like agriculture and education, not merely provision of certain health services.

Krishna Soman in a study in Birbhum district of West Bengal found that health of the people in stratified villages, is an outcome of their social existence. "Forty-five percent households in the above villages constituted the poor- largely wage earning dalits and adivasis. Unlike the well-off upper caste who consulted the qualified allopaths in private clinics as did the middle economic category of the occupational castes; besides, frequently visiting the qualified homeopaths"¹³.

The SC is inadequate in providing services, leading to the fact that the existing health care delivery in the villages is poor. According to the villagers, the performance of the health workers is far from satisfactory. In NHP 2002, AIDS awareness programme has been emphasized more than other vertical programmes, but in villages it is found that awareness of AIDS programme is not going on properly. The multipurpose health worker scheme, one of the basic objectives of NHP 1983, seems to have lost its significance. Simultaneously, NHP 2002 has ignored both preventive and curative care in the primary

level of care. It has not mentioned anything about upgrading the performance of health workers.

The locational problems of the PHC has made the villagers to opt for urban health institutions to seek treatment, as these urban facilities are easier to access than the PHC. Due to this reason, the upper level care in the urban areas are overloaded and have become incapable of providing proper health care to the rural people. Lack of proper referral system is also an added problem of the villagers in accessing urban facilities. The NHP 1983 proposed well-established referral system to minimize the patient load on higher level of care, which seems to be absent in the health care system of the studied villages. Moreover, the study does not show any sign of decentralized health care system in the villages. The consequences of SAP are reflected in the nature of health care system existing in the villages. Even if the villagers are paying user charges in the upper level of care, they are not getting adequate treatment. As a result, they had to move to private sources which is mostly unregulated. People had become dependent on quacks, because they cannot afford the cost of treatment of trained medical practitioners in private sources.

We can see the resurgence of communicable diseases after studying the morbidity rate and disease pattern of the villages, provided the service delivery in PHC and SC is limited to preventive care. The NHP 2002 has set up goals to eradicate these diseases through integration of vertical programmes under single field administration without mentioning what is the actual procedure to integrate these programmes.

While seeking treatment from both public and private sources, the expenditure has led the people to indebtedness. In case of antenatal cases, it is found that the information collected for antenatal care is quite encouraging. But the fact is that most of the women sought treatment from private sources. In spite of these problems in the villages, NRHM is opting for privatization of family welfare services. Apart from this the study also reveal that 60 percent of birth took place at home. On the other hand, the Government of West Bengal, Department of health and Family Welfare has set up goal of 80 percent institutional delivery by 2010, when this is the condition in villages. The health care

system in the studied villages reveals how the people are left impoverished due to entry of privatization in the health sector in the rural areas.

5.14 Case Studies

Poor economic condition forces the poor to go for alternatives like ineffective and informal sources of care, self-medication, doing without health care, delayed or incomplete treatment.

The government hospital not only provides inadequate treatment but also do not go for treatment unless they are paid required payment and bribe. The ill-behaviour and irresponsibility of hospital authorities sometimes lead the patient to die. Even if medicines are provided from the government institutions, these are found spurious.

The inadequate facilities in government institutions lead the villagers to opt private treatment and traditional healers. But the villagers who cannot afford these have nowhere to go. To seek treatment from private sources they have to incur huge out-of-pocket expenditure, which leads to impoverishment and indebtedness.

As doctors are not available the villagers prefer to go to quacks with whom medicine is always available. The villagers unhesitantly choose these quacks in the informal network. They not only provide medicines at market rate but also act as middle man between villagers and the big nursing homes and earns a huge profit. Following are some of the case studies which are based on above understandings. (Names have been changed).

Case I

Sarbeshwari Roy is 50 years old. She lives with her husband, two daughters and a son. All the members of the family except her husband (who is too old and remains sick most of the time) work as wage labour, when they get work. Her monthly income is Rs1500. She is suffering from severe stomachache, for many years. To reduce expenses, she first sought treatment from traditional healer, for which she has to pay fees of Rs50 and a fowl. Then she went to private practitioners several times and spent Rs3000, but could not recover from her illness. As she has no money left, she sought treatment from

government doctor. She mentioned that though she got medicines free of cost from government hospital, she knows that these medicines will not work, because every time she went to government hospital, she was given the same tablets in a white packet. Now, she has stopped taking medicines.

Case II

Buno Burman is 45 year old. She has four children. She and her husband work as wage labour, as they don't have agricultural land now and earns an amount of Rs1500 per month. She was suffering from stomachache for a long period. She started taking medicines from quack, as he is available nearby. But her condition became more serious. So, she went to NBMC to see doctor. The doctor checked her and said that she has stone in her Gall Bladder and to be operated soon. At the same time he also said that if she (Eno) wants to get her operation done at NBMC she has to wait for two months. As she could not tolerate the pain, she went to a private nursing home and got operated. The expenditure required for the treatment is Rs25000 for which she had to sell two cows. Even that was not sufficient to pay the doctor in full- she had to mortgage 0.6 acre of land.

Case III

During the fieldwork it was found that Tamalu Saibo was suffering since last eight months. She has four children. Her husband is the only earner in the family. He works in a private firm as a fourth grade employee and earns Rs3000 per month. At first she had stomach ache. So, she first consulted the village quack. He gave her medicines for two months which costs Rs2000. But she could not recover. Then he brought another quack and introduced him as a "famous" doctor. The so-called "famous" doctor after checking his patient took Rs150 as his fees and prescribe medicines and saline drips of Rs1500. But when her condition became critical, the village quack took her to a private practitioner, who is known to him. The doctor after examining her immediately advised her to get admitted in his nursing home, because she has to be operated soon, as she has stone in Gall Bladder. The village quack arranges everything and looked after all the financial dealings.

But after three months of the operation she could not recover from her illness. Her condition became more serious and she has become very weak. She has pain in her stomach, which prevents her from talking, sitting and taking food. Still she was consulting the same quack and in return he was giving her vitamins and saline drip for which he was taking a huge amount. As she has no other way to go, she went to the quack, only doctor she knows. A sum of Rs25000 was spent on her treatment. Now, she has no money for further treatment. This acute situation brought the family in an uncertain destiny.

Case IV

Neha Tori's husband is a carpenter and she is a '*hariya*' seller. Their monthly income is Rs3000. They have seven children. Their one year and three months old daughter was suffering from malaria and jaundice. They took her to NBMC for treatment. After checking, the doctor advised them to admit the child. While admitting the health personnel asked them for money, which includes both admission charges and bribe. Her husband requested them to admit her child and assured them to give the money by the evening. The whole day the child remained unattended. By the evening when her husband came with money, the child was no more.

Case V

Rima's husband is a carpenter and her father-in-law is a wage labour. They are the only earner of the family and support 10 members of her family. Her 2-year-old son was suffering from fever. She went to Civil Hospital to see the doctor. He advised her to admit her child. During the stay she gave Rs100 as bribe to the '*aya*' (attendant). As soon as her child got admitted, the nurse inserted the saline drip, which started swelling her child's body after one hour. After repeated request neither doctor nor any nurse came to see her son. She then pulled-out the needle herself and came out from the hospital with her child and consulted private practitioner immediately.

Case VI

Arati has two children. Her first child was born in Civil Hospital. When she was admitted in the hospital, she was in a critical condition. The doctor said that she had to be operated

immediately. She had not gone for antenatal check-up during her pregnancy, because there was no one to take care of her. Her husband is an alcoholic unemployed man. She works as wage labour to earn a meager amount of Rs1000 per month. Before the operation, the nurses misbehaved with her and said that if she died, the hospital authority would not be responsible. She had to bribe the attendant before her discharge from the hospital.

The above case studies show the problems faced by villagers while seeking treatment from both public and private health care sources. In public institutions ill-behaviour of health personnel is not the only problem, but inadequate treatment also creates a hindrance in seeking treatment from these institutions. Due to this reason people are forced to seek treatment from private sources by spending huge amount of money which are acquired by selling their limited assets. These case studies reveal how primary health care has deteriorated over the years, provided the fact that the strategy of NHP1983 was to achieve Health For All through primary health care. Though these are the problems in villages, the second NHP (2002), the new draft policy of private-public partnership by Government of West Bengal and NRHM have talked about strengthening privatization in health sector without ensuring provision of basic health services to the less privileged.

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