Chapter IV

Organisation of Health Care

4.1 Organisation of Health Care Delivery System at the National Level

"In 1997, the Government of India launched a Rural Health Scheme, based on the principle of "placing people's health in people's hands". It is a three tier system of healthcare delivery in rural areas based on the recommendation of the Shrivastav Committee in 1975.....As a signatory to the Alma-Ata declaration, the Government of India is committed to achieving the goal of Health for All through primary health care at a cost which seeks to provide universal comprehensive health care at a cost which is affordable.

.....The National Health Policy has laid down a plan of action for reorienting and shaping the existing rural health infrastructure with specific goals to be achieved by 1985, 1990 and 1995 within the framework of the Sixth (1980-85) and Seventh (1985-90) Five year plans and the new 20 point programme"[1]. On the contrary, the NHP 2002 has no provision to improve the existing rural health infrastructure rather it has undermined it. Following were the steps taken to achieve the goal of Health for All by the year 2000.

1) "District Level

Under the Multipurpose Workers Scheme, it has been suggested to the states to have an integrated set-up at the district level by having a Chief Medical Officer of the district with 3 Deputy CMO's (drawn from the cadre of existing civil surgeons, District Health Officers and District Family Welfare Officers) with each of the Deputy CMO being in charge of one-third of the district for all the health, Family Welfare and MCH programmes. It has been suggested that the district pattern should be based on the number of PHCs"[2].

2) Block Level

Community Health Centres are built at block level "covering a population of 80,000 to 1.20 lakh (one in each community development block) with 30 beds and specialists in surgery, medicine, obstetrics and gynaecology, and paediatrics with X-ray and laboratory

facilities. For strengthening preventive and promotive aspects of health care, a new non-medical post called community health officer has been created at each community health center. The community health officer is from amongst the supervisory category of staff at the PHC and district level with minimum of 7 years experience in rural health programmes.

The specialist at the community health center may refer a patient directly to the state level hospital or the nearest/appropriate Medical College Hospital, as may be necessary, without the patient having to go first to the sub-divisional or district hospital.

a) Staff of Community Health Centre

Medical Officer	4
Nurse mid-wives	7
Dresser	1
Pharmacist/Compounder	1
Lab. Technician	1
Rdiographer	1
Ward boys	2
Dhobi	1
Sweepers	3
Mali	1
Choukidar	1
Aya	1
Peon	1
	25

3) "Village Level

a) Primary Health Center (PHC) level

The functions of the primary health center in India cover all the 8 "essential" elements of primary health care as outlined in the Alma-Ata Declaration. They are: 1)Medical Care 2) MCH including family planning 3) Safe water supply and reporting of vital sanitation.

4) Prevention and control of locally endemic diseases. 5) Collection and reporting of vital statistics. 6) Education about health 7) National Health Programmes- as relevant 8) Referral services 9) training of health guides, health workers, local dais and health assistants 10) Basic laboratory services.

When fully staffed (by 3 medical officers including one lady doctor and supporting personnel) the PHC is expected to provide fairly comprehensive "essential health care" including family planning care. The medical officers are usually trained to provide MTP and sterilization services. The programme of insertion of Copper-T IUDs has been intensified. It is intended that laparoscopic services which have become very popular will be made widely available at the PHC.

It is proposed to equip the primary health centers with facilities for selected surgical procedures (e.g., vasectomy, tubectomy, MTP and minor surgical procedures) and for paediatric care. In order to reorient medical education (ROME) Programme towards the needs of the country and community care, three primary health centers have been attached to each of the 148 medical colleges. The NHP 1983 proposed reorganization of primary health care on the basis of one PHC for every 30000 rural population in the plains"[3].

i) **Staffing Pattern**

Medical Officer	1
Pharmacist	1
Nurse mid-wife	1
Health Workers (female) ANM	1
Block Extension Educator	1
Health Assistant (Male)	1
Health Assistant (female) LHV	1
UDC	1
LDC	1
Lab technician	1
Driver (subject to availability of vehicle)	1
Class IV	4
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b) Sub-centre (SC) level

Each sub-centre is manned by one male and one female multipurpose health worker. At present the function of a sub-centre are limited to mother and child health care, family planning and immunization. It is proposed to extend the facilities at all sub-centres for IUD insertion, and simple laboratory investigations like routine examination of urine for albumin and sugar. The sub-centre is the peripheral outpost of the existing health delivery system in rural areas. They are being established on the basis of one sub-centre for every 5000 population. The work at sub-centre is supervised by male and female health assistant. According to the revised norm, one female HA will supervise the work of 6 female HWs. The job description of these workers have been published as Manuals by the Rural Health Division of the Ministry of Health and Family Welfare.

ii) Staffing pattern

Health Worker (female) ANM	1
Health Worker (male)	1
Voluntary worker (paid Rs50 per as honorarium)	1
	3

One of the basic tenets of primary health care is universal coverage and equitable distribution of health resources. That is, health care must penetrate into the furthest reaches of rural areas, and that everyone should have access to it. To implement this policy at the village level, the following schemes were introduced:

a) Village Health Guides Scheme
b) Training of the local dais
c) ICDS Schemes

iii) Village Health Guides

A band of Village Health Guides (mostly women) was created, one for each village or a population of 1000. They were made responsible for spreading knowledge and information to the eligible couples and provide them with supplies of family planning methods. A village health guide should be a woman and a person with an aptitude for social service and not a fulltime government functionary. The health guides come from the villages in which they work and are chosen by the community of the same village. They serve as link between the community and the governmental infrastructure. They provide the first contact between the individual and the health system. The Health Guides are free to attend to their normal vocation. They are expected to do community health work in their spare time of about 2 to 3 hours daily for which they are paid an honorarium of Rs50 per month and drugs worth Rs600 per annum. As the training involves expenditure, the govt. will not train another Health Guide from the same village before three years. Broadly, the duties assigned to health guides include treatment of simple ailments and activities in first aid, mother and child health including family planning, health education and sanitation. In practical terms, they know exactly what should be

done when confronted with a situation, when they can begin treatment by themselves and when they should refer the patient immediately to the nearest health center[4].

The guidelines for their selection are:

a) They should be permanent residents of the local community, preferably women.
b) They should be able to read and write, having minimum formal education at least up to the sixth standard.
c) They should be acceptable to all sections of the community and
d) They should be able to spare at least 2 to 3 hours every day for community health work"[5].

iv) Local Dais

The national target is to provide one trained dai per 1000 population to conduct safe deliveries in rural areas. They are also supposed to act as family planning counsellors and motivators, supplementing the delivery system. Each dai is paid a stipend of Rs300 during her training period. Training is given at the PHC, sub centre or MCH center for 2 days in a week, and on the remaining four days of the week they accompany the Health Worker (female) to the villages preferably in the dais own area. During her training each dai is required to conduct at least 2 deliveries under the guidance and supervision of the HW (F), ANM or HA (F).

v) Anganwadi Worker

Under the ICDS (Integrated Child Development Services) Scheme, there is anganwadi worker for a population of 1000. The anganwadi worker is selected from the community she is expected to serve. She is a part-time worker and is paid an honorarium of Rs200-250 per month for the services rendered, which include health check-up, immunization, supplementary nutrition, health education, non-formal pre-school education and referral services. The beneficiaries are especially nursing mothers, other women (15-45 years) and children below the age of 6 years. Along with Village Health Guides, the anganwadi workers are the community's primary link with the health services and other services for young children. She undergoes training in various aspects of health, nutrition, and child development for 4 months.

4) "Incentives and disincentives

The use of incentives and disincentives to encourage couples to practice family planning was first introduced in 1966; over the years, it has been gradually increased. The acceptors of a terminal method (vasectomy or tubectomy) used to receive a one – time payment of Rs200 for conventional tubectomy, Rs145 for laproscopic tubectomy and Rs 180 for vasectomy. Motivators also used to receive a small amount (Rs10 for tubectomy and Rs40 for vasectomy)"[6].

5) Delivery System of family planning services:

"The current policy is to promote family planning on the basis of voluntary and informal acceptance with full community participation. The emphasis is on a 2-child family. Recently there have been two major changes in the approach to delivery of family planning services: first, a greater emphasis on spacing methods side by side with terminal methods, and secondly, to take services to every doorstep and motivate families to adopt the small family norm"[7].

The NHP 2002 has not highlighted any changes to strengthen primary health care rather it has emphasized on entry of private sector and the process of decentralization. In the next section organizational structure of the health care delivery in the studied area is discussed.

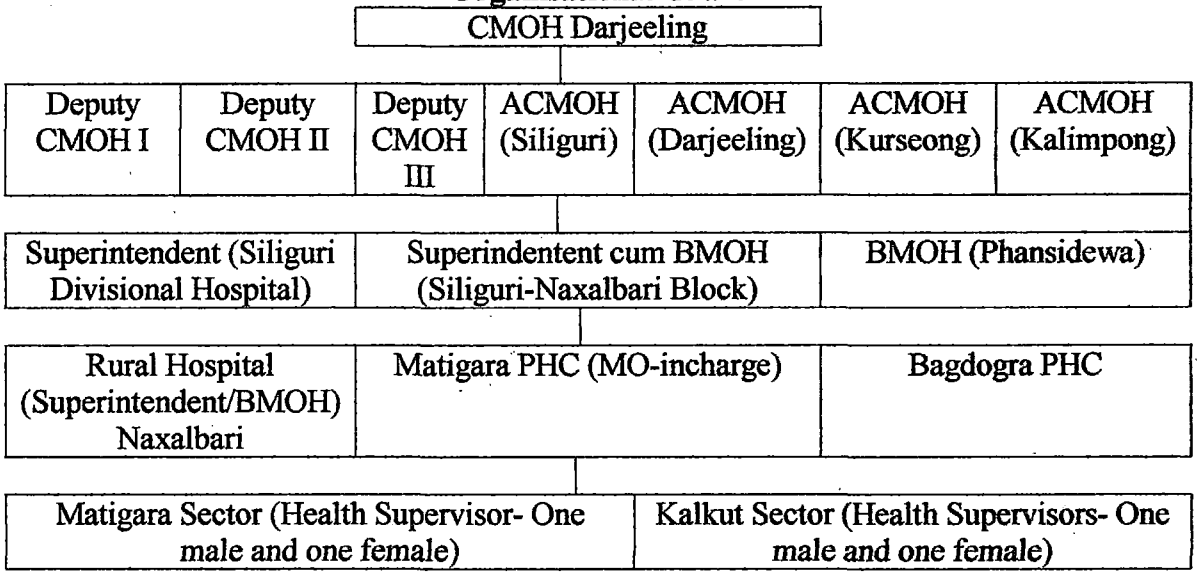
4.2 Organisational Structural and Health Care Delivery in Matigara Block

1) Organisational Set-up

The health care system existing in Matigara block is part of the system working at the district level. The CMOH, Darjeeling is in control of health care delivery operating right up to the level of the villages. Administratively the area under study falls under the Naxalbari rural hospital cum BPHC. However, the distance between the two makes any effective link nearly impossible. It is not possible for the villagers to access any medical facility from Naxalbari. Thus, Matigara PHC, provides the next option to the villagers to get health care facilities at a level higher than the subsidiary center. Matigara PHC provides both preventive and curative services. To deliver services in the village level it

is divided into two sectors. viz. Matigara sector and Kalkut sector. Matigara sector provides both preventive and curative services whereas Kalkut sector provides only preventive services. Each sector has six sub-centres. Figures 4.1, 4.2 and 4.3 show the organizational chart of Darjeeling district.

Figure 4.1
The PHC System of Darjeeling District
Organisational Chart



CMOH- Chief Medical Officer of Health

ACMOH- Assistant Chief Medical Officer of Health

BMOH- Block Medical Officer of Health

MO- Medical Officer

Figure 4.2
SCs under Matigara Sector

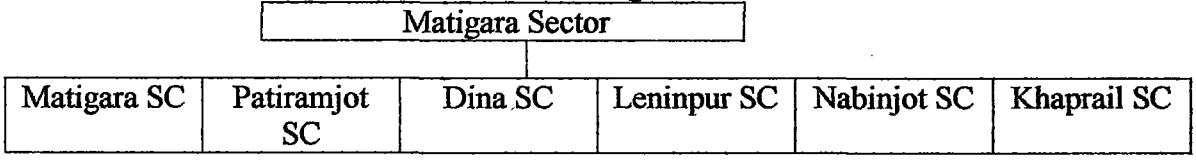
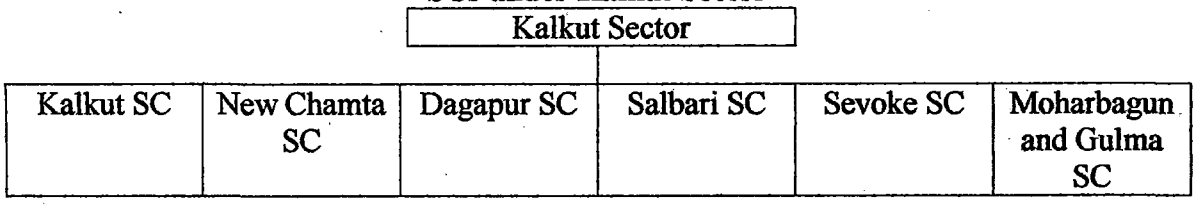


Figure 4.3
SCs under Kalkut Sector



2) Organisation of Health Care Delivery at the Block Level

a) Primary Health Centre (PHC), Matigara

i) Infrastructure

The PHC was constructed in 1970. During the study it was found that the windows and doors had not been repaired for a long period. At present it is neither whitewashed nor painted. The PHC has no running/drinking water or sanitation, no proper ventilation and electricity supply is also unreliable. The road to the PHC is quite approachable, hence, patients flow to the PHC is quite high. Due to the limited space there is no sitting arrangement for the outdoor patients, which creates a lot of inconvenience.

ii) Population covered by PHC

The PHC is catering to a population of 1,26,320 (the figure is according to census 2001). Apparently, it does not meet the norm of having PHC for 30,000 population as envisaged in the National Health Policy of 1983. Each doctor attends to at least 200 outpatients on an average per day. In PHC most people come from nearby areas (at a radius of 6kms) who are mostly wage labourers. One of the Medical Officers informed that on an average 3500 patients are admitted per year. However, information collected from the Rural Hospital, Naxalbari shows figure to be much less (table 4.2). The PHC has 10 beds for indoor patients. This is amply clear from table 4.1.

Table 4.1
Existing Facilities of Matigara PHC from January 2000 to December 2003

Information	Jan 2000 To Dec 2000	Jan 2001 To Dec 2001	Jan 2002 To Dec 2002	Jan 2003 To Dec 2003
Dispensary	NA	1	1	1
Number of doctors	2	2	2	3
Total bed	10	10	10	10

Source: Rural Hospital, Naxalbari

Table 4.2
Total Number of Patients Treated in Matigara PHC from January 2000 to December 2003

Patients	Jan 2000 To Dec 2000	Jan 2001 To Dec 2001	Jan 2002 To Dec 2002	Jan 2003 To Dec 2003
Indoor patient	787	869	1053	1321
Outdoor+emergency	64063+4642= 69492	65007+4492= 70368	61578+5011= 67642	68134+6631= 76086
Total	70279	71237	68695	77407

Source: Rural Hospital, Naxalbari

iii) Staffing Pattern

Medical Officer	3
Pharmacist	1
Nurses	3
Supervisors	6
Male Health Assistants	6
Female Health Assistants	5
UDC	1
LDC	1
Lab technician	1
Class IV	1
	28

NHP 2002 recognises the need for contract employment in order to provide trained medical manpower in under-served areas. It is found that among the total staff, two are working on contract basis (one pharmacist and one laboratory technician). All the contract services are recruited from office of the Superintendent cum BMOH, Naxalbari. The two staff complained of, not getting salary regularly. Moreover laboratory technicians job is only to test sputum (DOTS) of TB patients, because the PHC does not possess any other laboratory to carry out other tests.

The Medical Officer-in-charge of the PHC is working here for 8 years. He worked here on contract basis for seven years. He became a permanent staff only a year back. At the same time it should be noted that the Medical Officer-in-charge ascribed with lot of

administrative responsibilities and functions viz. management of man-power and material support, physical verification of stores, conduct meeting at different levels, maintain records and registers, sending reports monthly to Rural Hospital, Naxalbari and training of health personnel. The remaining two doctors joined after the medical officer-in-charge became permanent. The staffing pattern in the PHC shows that it does not fulfil the norm of NHP 1983.

iv) Working Hours

The working hour of PHC is from 9a.m to 2p.m. After 2p.m one doctor and a nurse is assigned for emergency duty.

v) Programmes and activities of PHC

In accordance with NHP 1983, the PHC is running seven National Health Programmes viz. Pulse Polio Immunisation (PPI), Reproduction and Child Health (RCH), National Leprosy Eradication Programme (NLEP), National Malaria Control Programme (NMCP), Revised National Tuberculosis Control Programme (RNTCP), etc. The preventive measures taken by the health center regarding epidemic are- 1) for acute gastroenteritis, chlorination of drinking water is done by bleaching powder and ORS are distributed 2) for malaria blood slides are collected for every fever cases and initial treatment is done 3) immunization for TB, Diptheria, Whooping cough, Tetanus, Measles 4) for polio- routine immunization and PPI. Other activities conducted by the PHC are training course of health guides, health workers, local dais and health assistants (done routinely).

"To optimize the utilization of the public health infrastructure at the primary level NHP 2002 envisages the gradual convergence of all health programme under a single field administration. Vertical programmes for control of major diseases like TB, Malaria, HIV/AIDS, as also the RCH and Universal Immunization Programmes, would need to be continued till moderate levels of prevalence are reached" (NHP 2002). But we can see that services do not touch one of the major programmes, AIDS. So, it is not clear, what is to be integrated.

vi) Diseases Treated in PHC

The diseases, which are treated in PHC, are Acute Respiratory Infection (ARI), diarrhoea, injuries, malaria, typhoid, TB, leprosy and other communicable diseases and PHC also conducts deliveries. The PHC is inadequately stocked with antibiotics, lacks supply of preventive medicines and supportive drugs for emergencies, though the PHC possess deep freezer to preserve vaccines for polio and measles and ice lined refrigerator to preserve DPT, TT and BCG. It does not provide medicines for mental health patients. On the other hand, the labour room is poorly equipped and operation theatre is not available. The survey found that only stocks available at the PHC were those of contraceptives, nutritive supplements (ORS) and emergency equipments like I.V. Fluids, oxygen, instruments for arresting bleeding and Ambu bag for respiratory arrest. But the equipments, which are of utmost importance like ECG machine, X-ray machine and nebuliser, are not available. However, NHP 2002 envisages in providing some essential drugs under Central Government funding through the decentralized health system, which has not come into practice as yet.

vii) Supply of Drugs

The drugs and equipments are supplied from Central Reserve Store to District Reserve Store and then to Block Reserve Store (controlled by BMOH) and finally to PHC. Central government provides funds for vaccines, RCH training, sterilization and remuneration (if required) while State government provides funds for equipments, medicines and salary for staff.

b) Sub-Center (SC), Kalkut

The sub-centres under the PHC are situated at a distance of 5 to 25kms. This Kalkut SC is situated at a distance of 22 kms.

i) Infrastructure

The SC was established around 1975. Like the PHC it is also an old building and has not been whitewashed or painted for a long period. The SC has two rooms and one bathroom and kitchen is attached to the second room. The second room is meant for female health assistant (FHA), but she does not reside there, because the SC is in an isolated place with

no electricity and no running water. According to villagers, residing nearby to the SC, the first FHA appointed in the SC used to stay in the SC. But as the present FHA does not reside in the SC, the room is converted into an office room dealing with preventive care. The SC has neither boundary wall to prevent the entry of stray animals nor any system of garbage disposal.

ii) Staffing Pattern

The SC is manned by one male and one female health assistant, one trained birth attendant (TBA) and two Community Health Guides (CHGs), which fulfills the criteria of NHP 1983. The FHA has training of ANM (Auxiliary Nurse Midwife), whereas, the male health assistant (MHA) has no professional training. The health assistants are permanent government Group C employee, but the TBA and CHGs are part time workers. While the TBA gets Rs 10 for every delivery, the CHGs get Rs 50 per month.

iii) Nature of Duties of Health Personnel

a) Male Health Assistant (MHA)

The MHA has no professional training regarding the job he is assigned for. He commutes from the nearby town (Siliguri) and has joined the SC a year back (one year before the fieldwork was conducted). His duties include home visits (for motivation for infant and child immunization, provides medicine if available for minor ailments like cold and cough, fever, distribution of bleaching powder), whereas duties during clinic days involve treatment of TB, leprosy, diarrhoeal cases and minor ailments, collection of blood slides and treatment of malaria; maintenance of registers, preparing monthly reports and sending to BPHC, Naxalbari; preparing of job manuals for next month and communication with members of panchayat and filling up the vaccination card of children and mothers (in this way new born babies are registered).

b) Female Health Assistant (FHA)

The FHA is trained as ANM (Auxiliary Nurse Midwife) and is working here since 1985. She commutes from Matigara. The duties of FHA include all the above activities performed by MHA except maintenance of register, preparing monthly reports and job manuals. Apart from this, she has some additional responsibilities such as motivation for

immunization of mothers to be and accepting of family planning methods; eligible couple and child registration (ECCR); registration of antenatal and prenatal cases.

c) Trained Birth Attendant (TBA)

The TBA is totally attached with the SC and she commutes from a different village. On an average she performs three deliveries per month. She gets Rs 10 per delivery. For her job she also gets other favours from the villagers like clothes and other kinds. The TBA said she never needed to purchase clothes. Apart from this, she also works as an assistant to the FHA, for which FHA pays her Rs250 per month from her personal account. Her job involves, helping the women to visit SC; taking medicine from SC to be given to the women in the villages; cleaning the SC; bringing water to SC; assisting during immunization; preparing injection; accompanies the FHA for home visits; looking after mother and child birth. The FHA said that, if the TBA does not come, the important problem she faces is the cleaning of SC and bringing water to SC from a distant area. This shows how a FHA works in a distress condition.

d) Community Health Guide (CHG)

Two CHGs are attached to the SC, though it is not mentioned in SC reports. Like other staff they also reside in different village. Since the last three years, they have never visited the SC. Before that, they used to bring the women for sterilization from the villages. The FHA said that if she complains against them to the higher authorities, they have to loose their job. But as they get only Rs50, she does not take any step.

The above description shows neither the staff of SC belong to the community nor they reside in the villages to whom they render their services. Secondly, the job of CHGs are done by TBA, that also with the additional payment of FHA. The initiative taken by the 1983 policy is not meeting the requirement of the rural health scheme.

iv) Working of the SC

a) Population covered by SC

According to the records, the SC is catering to a population of 8,500, but the health assistants said that unofficially, the population is estimated to be 15,000 because the

migrant wage labours also avail the service from the SC. However, according to NHP 1983 SC is supposed to cater 5000 population. The SC is covering 12 villages consisting of 1050 households, according to the records. In a week they have only two days for field duty. The health assistants have been instructed to visit all the villagers at least once in a month. Seemingly, on an average there may be 88 households in a village.

b) IEC (Information, Education and Communication)

The health assistants are not provided with teaching materials, literature or booklets. In the last three years only once, the Social Welfare Officer of Rural Hospital Cum BPHC, Naxalbari along with panchayat members and health assistants camped for MCH and communicable diseases in the SC.

c) Running of National Programmes

The SC is dealing with following national programmes-

1) Family Welfare and RCH (Reproductive and Child Health)
2) Eradication of diseases like malaria, leprosy and TB.
3) Awareness programmes for AIDS
4) Treatment of Gastroenterities/Diarrhoeal diseases and other minor ailments.
5) Environmental Sanitation.

The highest priority is given to Family Welfare and RCH whereas others are considered secondary activities. It shows that PHC does not provide comprehensive primary health care (which was a primary concern of NHP 1983) but only family planning services and selected immunization services. As mentioned earlier NHP 2002 envisaged on integration of programmes where TB, Malaria, AIDS are mainly envisaged. But this SC is giving priority to only Family Welfare and RCH.

d) Clinic and Field Duties

The clinic days in SC are Monday- for treatment of TB patients; Wednesday- for immunization of children; Friday- for maternal care. During the clinic days, the schedule

time of opening up of SC is 9a.m and should be closed at 5p.m. According to the health assistants, per day they attend 80 to 90 patients.

Tuesdays and Thursdays, the health assistants go for home visits. The home visits can be classified into broad categories such as counselling and motivation for immunization of infant and children and mothers-to-be, for family planning, contacting of eligible couples and registration of antenatal cases. Chlorination of drinking water sources, treatment of minor ailments and referrals were some of the activities carried out by health assistants.

Saturday is selected for sector meeting. All the health assistants from other SC and the supervisors assemble at the Kalkut SC and discuss about their weekly performance, their problems and flood victims, epidemic (if any). There is no fixed job manual, it is prepared ahead of one month depending upon the situation.

v) Equipments

The SC possesses very limited equipments, namely, slides to test malaria, equipments to test urine and sugar during pregnancy, vaccine carrier and a sterilizer. It has also one bed to check the patients.

c) Decentralisation

To encourage the process of decentralization as envisaged in NHP 2002 integrated and co-ordinated approach has been made in West Bengal to carry out the activities of all National Public Health Programmes in block level, "Block Health and Family Welfare Samiti" is formulated[8]. In Matigara Block following step has been taken.

i) Health Sthayi Samiti

In this block 'Health Sthayi Samiti' has been formulated to oversee the functioning of the health system in block level. It is the monitoring authority consisting of BMOH (Block Medical Officer of Health), Block Sabhadipati, Assistant Sabhadipati, BDO (Block Development Officer) and CDPO (Child Development Programme Officer).

d) Naxalbari-Matigara-Kalkut link up

Officially, Naxalbari and Matigara are separate blocks, but regarding health, Naxalbari Rural Hospital cum BPHC is controlling both Naxalbari and Matigara Block health care services. Hence, PHC Matigara and Kalkut SC are functioning under BPHC, Naxalbari. The SC only receives vaccines from PHC Matigara. Apart from this all the activities are done according to BPHC, Naxalbari's instruction. According to policies all the blocks should have their own BPHC to render services. Despite the initiative taken in NHP 1983, to provide better health services by establishing more public health institutions at a decentralized level, a large gap in facilities still persists. The ground reality of PHC and SC do not reflect the policy initiatives of NHP 1983 and 2002 as well.

4.3 Functioning of the Health Centres

1) Primary Health Centre

The functioning of primary health centre depends on the following agencies. The adequate requirement of these agencies makes the health centre to provide better health service. The strategy of NHP 2002 is required to build an objective assessment of the quality and efficiency of the existing public health machinery in the field. In spite of the inadequate public health facilities, it has been found that these public facilities are over-loaded, as most of the patients do not have the means to make out-of-pocket payments for private health services. Since 2000, Department of Health and Family Welfare, Government of West Bengal has also embarked on a process of improving the health systems and services within the State. It has also formulated samities in state, district and block level.

a) Infrastructure

The infrastructure is poor (despite repeated grants for construction under various foreign aided projects, namely, WHO, World Bank, GTZ and KfW). The PHC building is in a deplorable condition and pose serious problems for MOs and other staff. The idea of construction of a building has been completely neglected.

The laboratory facilities in the PHC are in poor condition. It has only one laboratory for DOTS (Directly Observed Treatment, Short Course Study) to test tuberculosis. It is

accommodated in a very small room and there is a scope of direct entry to the room by outsiders. As direct entry is possible, people come inside smoking cigarettes and *bidis* which pollute the atmosphere inside the room. The laboratory technicians have placed instructions outside the door but because the villagers are illiterate they cannot read them. Also, the equipments used in the laboratories need replacement for conducting proper test. There are four residential quarters in the PHC- MO, nurse, pharmacist and GrD staff quarters. As MO and other staff have to perform emergency duties, some facilities should be provided to enable the staff to carry on their respective duties. Lack of basic amenities often creates disinterest in the work the staff is supposed to carry out. Some work is going on under a German sponsored Project, which is providing finances to construct the PHC building, to purchase equipments, medicine, and for renovation. It is first constructing one indoor ward of 12 beds, one room for generators, one staff quarters for MO and two nursing staff quarters. For poor infrastructural facilities, the MOs have informed higher authorities several times but there was no response before the financing of the German sponsored project. So, to undergo different tests for inpatient care, they advice the patients to go to private laboratories.

b) Problem in Patients and Staffing Pattern

Though there are three MOs in the PHC, considering the number of beds available, there should be two MOs, thus, there is a scope of increasing the number of beds. The PHC has 28 health personnel, still it lacks appropriate health personnel. The health centre does not have a lady Medical Officer in position, and it is likely that a rural woman would feel shy to get examined by a male Medical Officer. As mentioned earlier some sub-centres under the PHC is situated at long distances, so, even if the patients are referred to PHC, they do not come. Despite this, the PHC in Matigara is over-loaded by inpatient and outpatient services. This practice, therefore, provides few seconds per patient and a lot of inconvenience to the patients, because of long waiting hours.

It is also found that the trainings received by health assistants emphasize cure at the expense of prevention. In PHC, shortage of supervisory staff was noticed. According to the present health programmes two supervisors are put in charge of six sub-centers but in Kalkut sector one post of supervisor is lying vacant, hence, one supervisor is attending

6 sub-centres. In PHC, there are four posts of supervisors, but only three had been appointed. The supervisors thus face difficulty in covering all the areas because the sub-centres are not on the same road and buses are not frequently available.

c) Problems of Residence and Transport

It should be mentioned here that both Medical Officers and other staff of the PHC do not stay in Matigara and commute from nearby town, Siliguri, because only four quarters are available in PHC and most of them are permanent residents of Siliguri. This creates a lot of problem for emergency patients. It is noticed that due to lack of facilities, doctors as well as other staff are not willing to work in the PHC. Moreover, if the doctors and staff go to field by their own vehicle no TA is admissible within 8 kms radius. They neither have ambulance nor any other vehicle, so that the doctors and supervisory staff can visit the field and sub-centre conveniently. The supervisors visit the sub-centre by bus. Transport is the major problem for field supervisors. The basic duty of supervisors is to supervise the field staff. They visit public places, sub-centres and multipurpose health workers who are working in the field. The male supervisors sometime use cycles but they can hardly cover one or two sub-centres. Therefore, it is important that PHC should be provided a separate vehicle by the government. They also suggested that if government provides a separate vehicle for supervisory staff, the field workers could be supervised more frequently.

d) Problems in the Functioning of the Health Care System

The PHC emphasizes more on family planning programme. But the ground reality is something else. It is more than three years that no sterilization has been done in the PHC. In PHC conducting sterilization was not a regular activity. Particular day was selected for camp to conduct tubectomy for which a team came from District Hospital, Darjeeling and Rural Hospital, Naxalbari. One Group D staff said that vasectomy was conducted 8 to 10 years back, and the patient used to get Rs150/- for the operation. After that the money was stopped and also due to low awareness, vasectomy has totally stopped. He also said that nurses conducted vasectomy and he used to assist them.

The impact of separation of health from family planning can be felt right up to the PHC level. The schedule for immunization, maternal health and family planning services do not match with services for tuberculosis, leprosy, malaria, etc. Over the years the mode of delivery by campaigning for immunization and seasonal sterilization camps have effectively under valued routine and sustained service delivery throughout the year. Though the PHC has privacy for women patients (it has separate OPD, separate indoor with attached labour room for females patients) still the women have little access to non-MCH (Maternal and Child Health) and FP (Family Planning) services. While interviewing a few paramedical workers, it was found that medicines for gastroenteritis patients are also inadequate. The MO also stated that 50 percent of the referred cases do not go to Civil Hospital due to distance. The referred cases go to Civil Hospital and North Bengal Medical College (NBMC) only when the patient is in serious condition and cannot afford private treatment. At the lower level also problems are faced. As per order of the Chief Medical Officer (CMO), daily chlorination of water was necessary during the summer and rainy season while no extra supply of labour was available for daily chlorination of water. The necessary chemicals are issued but not extra labour with the result that daily chlorination suffered.

In rural areas illiteracy is major problem in implementing the health programmes. The villagers are not fully aware of advantages of immunization as most of them are wage labourers and do not want to waste time. Moreover, lack of education is also not encouraging the family planning measures.

e) Other problems

The other problems in the health center are inadequate qualitative services like proper diagnosis of diseases, attitude of the health staff toward patients and effective treatment of the health problems. Adequate coverage is even not visible with simple promotional services like antenatal, immunization and care during labour which are the main objectives of PHC. As a result, the demand for curative care is met either by Civil Hospital, NBMC or by private practitioners. The above description shows that the health center is characterized by preventive programmes like national disease control programme and family planning programmes which is also inadequate . Curative care in

the health center is therefore, the weakest component in spite of a very high demand for such services as evident from the number of inpatient and outpatients coming for treatment. People need basic curative and preventive services but the existing system is obsessed with a fragmented health care delivery.

2) Sub-Center (SC), Kalkut

a) Problems in SC

i) It is ill equipped and is in a poor condition because of poor maintenance.

ii) As the salaries of CHGs are quite low they are reluctant to do their job. They are demanding permanent posts and increase in their salary. From the last three years they have isolated themselves from SC. Once in a year they go to BPHC, Naxalbari to collect their salary.

iii) IEC activity is in a poor condition provided DHFW, GoWB suggested "to ensure proper disease surveillance, and plan and coordinate all the Information, Education and communication activities in the State"[9].

iv) The CHG is supposed to cover all the households under the SC every month. As 1050 households fall under this category it is not possible to cover 88 households in a single day. If they work for six hours, they get only 4 minutes for each household, which is too little to even complete writing the names of the children. According to the health assistants, they are instructed to visit at least 40 households which is not possible. The health assistants also complained that two days field visit is not enough to complete the targets, in spite of that, they work for six hours. They get TA if the field is beyond 8kms.

b) Nature of Duties of Female Health Assistant (FHA)

The female health assistant who shoulders the additional responsibility of extension work is also over-worked. These jobs often throw insights into dynamics of rural health care delivery and the role of health assistants to link the road between villagers and health department.

It was found that female health assistant prioritises her visit and services to women who are pregnant (for antenatal and prenatal care registration, TT immunization, distribution of Iron and Folic tablets) and who have delivered child in the recent weeks (for post-natal care advice); those having young babies (for immunization); non-acceptors of family planning having two or more children (mostly for motivating them to accept sterilization) and acceptor of oral pills and condoms. This seems that FHA is not keen to visit recently married couples or couples without a child, couples who have accepted sterilization long ago and households without an eligible couple because they do not constitute her target group for provision of services.

The other women are not newly married and not having at least one birth have not been advised about spacing methods, according to the villagers. In rural areas, as the couples generally do not accept family planning between marriage and first birth the FHA also does not take initiative to motivate couple for family planning adoption. It is quite evident from the village study (next chapter) that spacing methods have not been accepted by the rural people in spite of high rate of eligible women.

c) Target Oriented Approach

As the national programmes are target oriented it increasingly hinges into the activity of the female health assistant at village level. The FHA spends most of the time on identifying and motivating eligible cases for family planning and ignores other basic duties. Interestingly, there is no pressure from higher authorities to complete the target. So, even if these targets are not completed by March, no action is taken against her, because the SC is catering to more than the respective number of population. Due to this reason, the female health assistant whose basic duty is to educate the people about the health programme is not able to do her duty sincerely because she spends most of her time in searching for sterilization cases and other forms of birth control. She completely neglects the health aspect of rural population. The heavy emphasis on family planning programme has adversely affected the health programmes in particular the MCH (Maternal and Child Health).

d) Inadequacy in service delivery by Female Health Assistant

The questions that arise are whether the female health assistant will be able to visit all the eligible couples during her routine visit to the village and carry out her assigned work. The service delivery is affected because the female health assistant does not reside in the SC village. This being the situation, the FHA would not be able to reach the village in time during her field duties. By the time she reaches the village, some of the eligible women would have gone out for work or elsewhere for other purposes, and some houses would have been locked. Also the female health assistant would not be able to spend sufficient time in the field and it is possible that she would hurry through the household visit. Moreover, the number of households she covers is more than the respective number she is supposed to cover. The amount of time the health assistant spends in a household varies in relation to health care needs of the households, particularly, for women and children, and the type of services she provides.

During the course of field study, it was found that villagers generally give adverse opinion on the female health assistant about her work. Quality of services rendered by female health assistant depends on several factors like accessibility to clients whenever in need, timing of household visit and travel from long distance.

e) Apathy of Health Assistants

Over the years training for collection of data and maintenance of records has been given more importance than clinical training and work performance. A few incidents witnessed during field survey are cited below in support of the above understanding.

i) When interview of the health assistants was going on, two women came with their children for immunization. One child was suffering from malaria also. But the FHA refused to give them medicines and vaccines, and asked them to come on clinic days, as that particular day was their field duty day.

ii) According to the neighbouring people (residing near the SC), the health assistants hardly go for home visits. Moreover, most of the time the SC remains closed. They said that, poor people who cannot afford medicines from private sources return empty handed

everyday. One woman, who is residing near the SC for 30 years, explained that, the first FHA appointed in this SC was a very responsible person. She used to go for door-to-door visit most of the time and to motivate the people in a very cordial way to accept the family planning method. She even used to carry plenty of medicines during her home visits. But the present female health assistant is reluctant to do her job.

iii) When information was being collected in the SC, a man came with high fever and asked the health assistants to test his blood. The health assistants however insisted upon him to go to malaria hospital. But the patient said that, he was too weak to go there and wanted his blood test to be done in the SC. The health assistants said that, the blood slide would be sent to BPHC, Naxalbari and the report would come after 10 days. The patient also said that his blood had been tested one and half months back, but he had not got the report yet. The health assistants managed to convince him by saying that there were no positive findings in the earlier report. After a lot of insistence, the person managed to give his blood for test again that day.

f) Problems Faced by Health Assistants During Service Delivery

i) According to the health assistants, the villagers are reluctant to come to SC. The villagers feel that, the health assistants should render their services during the home visit. Even after repeated advice by health assistants, the villagers do not take medicines properly. The MHA during home visit, found that one leprosy patient did not touch the medicine and kept it in a damp place, which he had given him a month back. The health assistants also found that not even one TB patient was taking medicines properly. After they referred the patient to get sputum test in the nearest Government institution, they asked for medicines in BPHC, Naxalbari. The whole medicine packet came under the patient's name. The whole course is divided into two phases-Intensive Phase (IP) and Continuation Phase (CP). The patient completed taking medicines for IP but stopped taking medicines for CP. The MHA visited the patient's house twelve times and urged upon him to get the medicines from SC, but he (patient) did not turn up to SC for medicines. Then he requested the family members and neighbouring people to convince the patient. At last, left with no option, the MHA approached the panchayat member.

The panchayat member finally succeeded in convincing the patient to take medicines again.

ii) The SC lacks adequate supply of vaccines, contraceptives and medicines which is a major problem for health assistants. These workers complained that when they visit houses, people ask for medicines for some common ailments such as diarrhoea, fever, cold and cough, but if they do not give medicines, the villagers avoid them during their next visit.

In the clinic, in absence of any real capacity to undertake effective treatment for ailing individuals, the only choice left to these workers is to refer them for medical treatment to a nearby government health facility. This disinterestedness is the outcome of lack of inputs by the government. No educational materials such as booklets, literature, teaching aids were distributed to the health assistants. Supply of job manuals, working kits, cotton, slides, phenyl, bleaching powder are rarely available with them. With this type of back-up, it can be understood that the health assistants are ill-equipped to play a consequential role in improving the health condition of the rural people.

iii) It is also revealed that the health assistants have to face tremendous problems during (Pulse Polio Immunization) PPI camp. These two health assistants have to manage four booths. But the fact is that, single booth requires four persons to handle the situation. The health assistants complained that the health department closed its eyes regarding these key problems. So, they have to make their own arrangements. During the PPI camp, they request some young people from the village itself to help them, but these people sometimes refuse to work, because they have to work for ten hours without having food and paid only Rs25 for the work.

iv) During epidemic such as malaria, the health assistants have to collect 500 blood slides, which is very difficult for the health assistants to manage in such acute situation. Sometimes, they have to extend treatment to more than 100 children, which create hindrances for target-oriented programmes. Illiteracy is also one of the factors hinging to improve the health status of the people. When vaccines like DPT are administered to

children, the children suffer from mild fever. Due to this reason, the parents are apprehensive about coming for vaccination for their children.

g) Success Stories

i) Quacks are making a huge profit by running their own business. Villagers never give a second thought to seek treatment from quacks, because they feel that treatment from private sources will yield good result, though it may be through informal network. The MHA during his home visits once found that a patient in the family of a panchayat member had been given saline drip at his home for which the quake took Rs350, whereas, a bottle of saline actually costs Rs55 only. Surprisingly, the quack had managed three fake reports of a single test from a renowned clinic in the nearby town. In the first report it was PV (Plasmodium Vivax); in the second report it was PF (Plasmodium Falcipuram) and in third report it was both PV and PF which is absolutely absurd. If a person suffers from malaria, there will be only one report which will mention either positive or negative or if positive it will be PV or PF. Ironically, for the three reports, the quack had taken Rs300. The MHA intervened into the matter and advised the panchayat member not to seek treatment from quacks. In this process, the panchayat member managed to recover the money, paid to the quack.

ii) One day a 20 year old man came to SC with high fever. The MHA advised that the patient should be shifted immediately to the hospital. In the meantime, the MHA took his blood sample to be tested. The MHA personally took his blood slide to the malaria hospital and found it positive. The next day when the MHA went for home visit, he found the man at his home in a serious condition. The family members did not take him to the hospital and started consulting traditional healer. The MHA somehow managed to convince the family members and gave medicine (for malaria) and the patient recovered soon. Soon after the incident, the villagers developed faith in the SC and the health assistants treated many malaria patients after that incident.

It seems that the success stories are very few. Not only the health assistants are reluctant to do their jobs but also the health system is also very poor. Though the health assistants

done a few good jobs but these does not mean that system is appropriate enough to meet the requirement of the people.

h) Awareness Program regarding AIDS

According to the health assistants, they organized a health awareness program regarding AIDS (27th June 2003 to 7th July 2003) and went door-to-door in the villages to distribute pamphlets. They also distributed proforma to fill up to identify anyone suffering from sexsually transmitted diseases (STD). If there were any such case, they would be referred to the nearest government health institutions. The MHA admitted that no serious step is taken regarding AIDS. When funds are allotted, a few simple steps are taken as stated above. After sometime everything gets diluted. Even the villagers said that, the health assistants did not make door-to-door visits to aware them for AIDS.

DHFW, GoWB, during the 2003-2012 has taken the strategy "to improve equity of health service delivery, with an emphasis on Primary Health Care services, through an Essential Services Approach"[10]. 'Essential Services Approach' is not a new approach. India has already adopted this approach prescribed by World Bank in 1990's and the visible consequence is, delinked clinical and public health services. At this stage, the service is limited to family planning and immunization.

3) Decentralisation

DHFW, GoWB has determined decentralization in health planning and management as a key development in ensuring improved targeting of services to the most needy and so ensure improved equity of access. Its strategy includes "developing partnerships with Panchayati Raj Institutions so as to improve the accountability, transparency, coverage, equity and quality of health services"[11]. This is also included in short-term strategy of 2003-2005. Along with the state and district level, Block Health and Family Welfare Samiti is also supposed "to prepare action plans for each National Health Programme and to ensure systematic and decentralized planning of programme activities in accordance with technical, administrative and financial guidelines"[12]. To ensure proper disease surveillance, and plan and coordinate all the information, but the study gives a different

observation. To encourage the process of decentralization following steps have been taken.

4) Health Sthayi Samiti

In principle, this Samity constructively collaborate with the PHC (Matigara) to play a positive role in helping solve the problems of the health of the rural people, but ironically, it carries on constant bickering over petty concern and at time, matters of personal interest of the members dominate committee meetings rather than the health concern of the rural people, as stated by BDO. The BDO tends to play a limited role. Whenever any resolution is passed or ICDS workers are recruited, only work left for BDO is to complete the administrative responsibilities.

5) Role of Panchayat

a) Most villages do not use toilets and defecate in the open. This causes serious environmental contamination. It is also a matter of concern that water sources are not very well protected. According to the villagers, a simple thing like water chlorination is not done on a regular and scientific bases in the villages (though the SC reports possess evidence of chlorination of water). Disposal of solid waste and storage of clean water is also not done properly and stagnant water is a source of mosquito breeding. As a result of such negligence, epidemics (malaria, diarrhoea) are very common in the villages. Panchayat does not have the political will to improve the water and sanitation situation and this is a major constraint of the health scene of the villages.

b) Panchayat is supposed to take up the responsibility of monitoring the health workers work routine and village level provision of care. As a result of poor level of health awareness in association with inadequacy and non-availability of health services, the community accords low priority to health. The health system, moreover, does not systematically make efforts to inform the community of the services it is entitled to. Both the villagers and panchayat members are unaware of the working hour of SC, what type

of health services (including outreach services) is supposed to be available. The SC opens late and closes early. According to the villagers, health workers are irregular and not easily accessible as they do not stay in the proximity of the SC to which they are attached. Panchayat does not have the political will to improve the water and sanitation situation and this is a major constraint of the health scene of the villages.

According to the 'pradhan', the panchayat has the right to suspend, if the work of health workers is unsatisfactory. But no such incidence has taken place so far. 'Pradhan' also explained that gram panchayat meetings are held regarding water, nutrition, sanitation and hygienic awareness (which is absolutely contradictory to the ground reality). On the other hand, the health workers complained that the local leaders do not participate actively to improve the health status of the people. For health awareness programmes, the health workers very often send letters to panchayat members but they never responded to their letters. Even the deputy 'pradhan' who is a woman does not take any initiative. Local leaders, if they take the initiative, can be active in ensuring the benefit of planned services. Moreover, their understanding of local condition can help them suggest operational modifications to various developmental activities. Both the 'pradhan' and deputy 'pradhan' very often pay visit to the SC, check the records and put their signature wherever required, but overlook all the problem of SC and health workers, particularly about the infrastructure.

The health workers claimed that though the SC came under panchayat two years back, still the latter is not playing any significant role. The possible reason may be the absence of proper guideline of panchayat members (kind of duty or authority they been assigned for development of health sector in rural areas). Though the panchayat has resource, they never use it for development. Only one advantage is noticeable due to decentralization, the villagers now avail the birth and death certificate from the office of 'gram panchayat'.

The Social Welfare Officer of BPHC, Naxalbari said that even if the local leaders are given controlling power, it may create some ego problem, as health workers are more educated than local leaders. In some cases it is found that local leaders are illiterate.

6) Naxalbari-Matigara-Kalkut link up

The distance between BPHC cum rural hospital, Naxalbari is 40 kms. Due to this setback, communication has become a major problem, because during epidemic, it becomes difficult for health officials to commute from Naxalbari to Kalkut SC, as it is quite far away. Secondly, the staff strength is not sufficient enough to deal with the Naxalbari and Matigara block health services, specially the field staff. The health officials, the administration and the government have closed their eyes regarding this problem.

One of the basic objectives of NHP 1983 is to build one BPHC at the block level, but the Matigara block lacks a proper BPHC. Though the staff strength of Matigara PHC is equivalent to a BPHC, it is not recognized as BPHC because it lacks basic infrastructure facilities of a BPHC. NHP 2002 mentioned upgradation of infrastructure by increasing budget outlays, but it is yet to be implemented. On the other hand, PHC and SC are catering to more than the number of population they are supposed to cater to, which does not meet the norm of NHP 1983.

The function of the PHC is to cover all the eight 'essential' elements as outlined in the Alma Ata Declaration, but this PHC is unable to do so, due to lack of proper infrastructure and large number of population it is catering to. Over the years the function of PHC and SC has been limited to family welfare services, ironically, in spite of this, basic reproductive services have been stopped because both PHC and SC lacks proper equipments and infrastructure.

The study also reveals that the implementation of strategies of decentralization is also not meeting the requirement of the rural people. In accordance with its implementation, a Health Sthayi Samiti has been formulated to deal with the rural health problems, but the panchayat does not have the political will to improve the deterioted rural health scenario. As mentioned in NHP 2002, the immediate step is, to formulate one monitoring and surveillance network to sove these problems.

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