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Health and Morbidity in North Bengal: A Field Report from Mahipal Village in Phansidewa Block

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Abstract: *The Alma Ata declaration of which India was a signatory promised Health for all by 2000 AD, in the year 2016 we find the government still grappling with problems of infant and maternal mortality. Tuberculosis is on the rise and new health issues like those related to environment, increasing use of pesticides and occupational hazards all contribute to the vulnerable health status of our people, leading to increasing levels of morbidity. At the same time rural people lack access to quality health care and those belonging to the poorer sections are prone to different types of morbidity due to their poor health. The present study tries to understand health and morbidity by taking up a village in the Phansidewa block of Siliguri subdivision in North Bengal.*

Keywords: Morbidity, Health Care, Maternal Health, Disease Prevalence.

Introduction

The study of health especially of the common people which belongs to the domain of public health has received considerable attention since the late seventies when the Alma Ata declaration was signed in 1978. The declaration declares public health to be a mission and the governments which were signatories agreed upon making public health asocial movement the success of which would be ultimately judged by the attainment of 'health for all by the year 2000.' We have now approached the year 2016 and till now morbidity remains widespread. Diseases like tuberculosis is spreading, leprosy continues to afflict people, there is a continuous spread of AIDS and respiratory diseases and malaria and every year encephalitis, dengue kala-zar break out which undermines the health status of the people in addition to causing considerable number of deaths.

One of the important factors that is affecting public health care in the recent years in addition to poor socioeconomic status of a large section of our people is the dismal expenditure which the government makes on health.

As early as the mid-nineties the annual plan of 1994– 95 stated that the government's priority is no longer in enlarging health infrastructure but selectively strengthening facilities, accordingly the targets for setting up of Primary Health Centres and Sub-Centres had been drastically reduced. This inevitably shifts the focus to private health infrastructure and the government has for many years now been preparing various means for privatizing health. The government of India spent near about 1 pc of its GDP for health in 2010-2011 which is "abysmally" low compared to the other countries. The BJP government had reduced the health budget by 14 percent after coming to power.

In a study by Chaudhury and Nath (2012) we get a detailed idea about public expenditure on health in India. Their estimates show that in 2009-10 and 2010-11, public expenditure on health in India was around 1.1 percent of GDP. This estimate includes health expenditure by the Ministry of Health and Family Welfare, medical reimbursement by central and state governments, other central ministries (including the Ministry of Railways and the Ministry of Defence) and state's expenditure on Health and Family Welfare. Expenditure by other central ministries like that of Railways and Defence are confined to certain sections of the population and if these expenditures are excluded the estimate of health expenditure in the country is about 0.93 percent of GDP. If we add expenditure on water supply and sanitation to the estimate of 1.1 percent of GDP, the figure rises to 1.5 percent of GDP in 2010-11. Further, if expenditure on nutrition is added then, the expenditure will be about 1.7 percent of GDP. It has increased by 0.2 percent of GDP between 2004-05 and 2010-11.

Sociology actually understands health to be a function of social reality, health status varies from society to society depending upon the ability of the same to provide its members adequate income, employment, education, health awareness and nutrition in addition to institutional care. When the society provides the above to its people the latter have a higher health status compared to the society where the above are lacking. The present study tries to understand health and morbidity by taking up a village in the Phansidewa block of Siliguri subdivision in North Bengal.

Objective of the study

The present study on Health and Morbidity aims at understanding the health status of a village in North Bengal. Keeping in mind the low expenditure the government incurs on health and the poor socio-economic condition of

the villages of North Bengal, the study aims at understanding different dimensions of health in the rural setting. North Bengal has not been able to reap much benefit from the growth oriented development paradigm currently being followed by the government of India. It is being increasingly realised that poor people have shorter, more illness ridden lives than their more affluent counterparts.

At the same time the public health care system is on the decline with the persistent effort of the government to reduce its responsibilities of providing health care, the health of the poorer sections is bound to suffer. As such, the present study aims at understanding morbidity by trying to identify the nature of ailments which people predominantly suffer from, the utilisation they make of health care facilities, their modes of tackling communicable diseases like tuberculosis. The study would also attempt to identify the prevalence of diseases like AIDS which is taking serious proportion due to the increasing migration of male folk to distant places in search of employment who contact the disease and pass it on to their wives and children. An attempt will be made to take up all the above issues related to health and morbidity.

Public health in West Bengal

The following is an account from an assignment on Public Health in West Bengal taken up by the Administrative Training Institute, Govt. of West Bengal.

The population of West Bengal as per 2011 census was 9.13 crore, which is around 7.6 percent of the total population of our country. The growth rate of population during the decade 2001-2011 has been 14 pc in the state compared to national growth rate of 17.5 percent. The growth rate of population in the state in the previous decade was 17.8 percent indicating further reduction of fertility. As per SRS (Sample Registration System) data 2008conducted by the Registrar General of India TFR of West Bengal was1.9 compared to TRF of 2.6 for the Country.

The birth rate and the death rate of the state as per SRS 2009 was 17.2 in rural areas and in urban areas 6.4 respectively. In respect of the former West Bengal was behind three bigger states namely Kerala, Tamil Nadu and Punjab. In respect of the latter the state was behind two bigger states namely Delhi and Jammu and Kashmir. As per the National Family Health survey (NFHS) 2005-2006, the state had 54 percent of women of the age

group 20-24 married before the age of 18 years. The same was as high as 63.2 percent for rural areas. Also, 25.3 percent (30 percent for rural areas) of all women aged 15-19 years were already mothers or pregnant at the time of survey. Early conception is fraught with risk of the mother and the child. At the same time 8 pc of the mothers had unmet need for family planning indicating poor access to services. Again, the child sex ratio had declined during the period 2001-2011; it was650 during 2001 and has dropped to 640 during 2011. This declining child sex ratio is a serious threat to the gender balance which is so very necessary for the survival of society. The decline also points out to the status of women in society and the threats they face right from the period of conception when female feticide and infanticide deprives them of getting a chance to live and contribute to societal development. As per SRS 2009 the IMR of the state was 33 (rural 34and urban 27) which was the fourth lowest in the Country. Thus when IMR is declining the fact that child sex ratio is also declining reveals the practice of sex selective feticide and infanticide.

The child Mortality Rate (CMR) in West Bengal was 40 as per SRS 2009. West Bengal is placed at a lower position ii teems of CMR as compared to IMR and hence deserves greater attention so that it can be reduced. Though the MMR of the state is better than most of the states it is the only state where the MMR increased has during 2004-2006. It is estimated that there are around 2100 cases of maternal deaths in the state every year. There are many reasons behind the inability of the state to reduce MMR as compared with states like Tamil Nadu and Maharashtra. Some of the reasons are that the state is lagging behind in institutional delivery. It was 71 percent at the end of the year 2010-2011 in the state compared to 100 percent in states like Maharashtra and Tamil Nadu. So even after five years of the implementation of NRHM programmes institutional delivery could not reach out to all the corners of the state. The assignment of the Administrative Training Institute, Govt. of West Bengal (2012) observes that there is, lack of training of all nurses posted in labour rooms and there is a need for providing them skill for safe delivery, inadequate facilities and not following recommended protocols in the labour rooms including maintaining high level of sterility for preventing infection, inadequate beds and specialist doctors in Govt. Hospital for properly attending all health centre are serious issues. Providing facilities for delivery and having arrangement for blood transfusion and caesarean operation on a 24x7 basis as well as inability of identification and management of pregnancies having risk of delivery through better antenatal checking and appropriate interventions in mitigating the risks are of immediate concern. Poor status of nutrition, high incidence of anaemia

and early age at first birth of the child also contribute to higher MMR in this state.

Proper antenatal and postnatal check-ups (ANC and PNC) are very important for reducing morbidity and avoiding mortality of the mother and the new born. There should be three ANC during the first three trimesters and preferably a fourth check-up around 36thto 37the week. The expecting mother should register for first ANC within the first trimester of pregnancy. For the state as a whole 46pc of pregnant women got themselves registered for ANC within first trimester in 2009-2010. Out of all those registered for ANC only 69pc completed three ANCs.

Universal immunization is another very important public health measure for preventing vaccine preventable illness. Proper functioning of the Sub Centres, awareness of the mothers and coordination with Sub-Centres as well as reaching out through Village Health and Nutrition Day (VHND) are crucial for successful immunization of 100 percent children. The percentage of immunized children varies from district to district; it was 54.1 percent in Uttar Dinajpur and 98 percent in Hugli in 2010-2011. On an average approximately 70 percent of the children could be said to be immunized. Thus the average achievements mask the poor performances in many pockets. This is the reason for delay in eradication of polio from the state. The last known case of polio in the country was detected in Howrah in early 2011 while 72.2 percent of children were immunized in the district.

As far as nutrition is concerned, West Bengal is facing a huge challenge. Recently Dr. Binayak Sen has identified the improperly managed sick teagardens in the Terai and Dooars as having famine like situation where more than40 pc people have lower Body Mass Index (BMI) than the standard. Taking up the communicable diseases, people of the state, particularly the poorer section, face a very high burden of communicable diseases such as diarrhoea, tuberculosis, malaria, dengue encephalitis, HIV and AIDs etc.

Like the rest of the country the state of West Bengal is also facing growing incidence of several non-communicable diseases such as diabetes, hypertension, cancer and mental illness.

As far as health infrastructure is concerned the state has 10356 Sub Centres (SC) catering to around 622 lakh rural population as per 2011 census. Thus, average population covered by one SC comes to around 6000against the

normal of 5000 and 3000 in tribal, hilly and backward areas. Thus there is a shortage of more than 2000 SCs.

Health and morbidity in Mahipal village

The study of morbidity and health was taken up in Mahipal village of Phansidewa Block in Siliguri subdivision of Darjeeling District. North Bengal is a backward region of the country as well as of the state hence, the social and economic conditions of the people do not show a bright picture, a substantial number of the village people have little life chance to improve their condition. The present study has taken up about ten percent of the villagers to understand the status of health and morbidity the sample is purposive and focuses upon the poorest segment of the villages.

Prevalence and incidences of diseases and the nature of treatment

Good health is a primary requirement for society's to survive. Adequate food shelter and clothing are all necessary for good health. These basic preconditions are not to be found at the desired level in the village under study due to poverty, inadequate sources of livelihood and unequal access to the resources, there is a clear picture of increasing morbidity. The problem gets all the more acute as increasing privatization of healthcare has put health facilities out of reach of the poor people. In the words of Imrana Qadeer (2011) there has been a shift from comprehensive PHC to packaged PHC which is rooted in a different notion of public health. According to her the above has the following characteristics.

1. There is a shift in emphasis from programmes rooted in the needs and priorities of different sections to age and sex based clusters, arising out of the prerogatives of the donor – provider nexus.
2. The alternative to the state medical care – service is the market driven model where quality, costs and efficiency will be ensured by the competition between provider and by informed consumers.
3. It recognizes neither the importance of planning for regional priorities nor the necessity of a central coordinating agency. It advocates decentralization which is nothing but the diversification of health financing and services.

4. The brunt of this fragmentation falls on the national programmes for disease control, whose curative components are now offered in the market as lucrative goods for sale.

5. Clearly, it takes public health back to the bio – medical model where technology dominates and there is no feel for the social political, cultural and economic realities of a people. Thus financial considerations are the prime concern, societal dimensions become irrelevant, and the government withdraws itself leaving the marginal section vulnerable to the whims of the market.

As a result two systems thrive on the one side we have big multispecialty hospitals with all facilities to cater to those who can provide for health insurance or are solvent otherwise and on the other hand we have the multitude of common people including those from the middle and lower middle classes who have the govt. hospitals with most of them having dismal services as the only place to go.

The World Health Organization, New Public Health approach also shifts the onus of providing public health by the government to the people by emphasizing upon healthy life styles which can hardly be expected from a poverty and malnutrition ridden society like that of ours. The poor who constitute about 50 percent of our population can hardly be expected to follow healthy life system, having unhealthy life style can be nobody's choice other than the rich, it is imposed upon the poor accompanied with illiteracy, lack of awareness, and malnutrition and an indifferent state.

In the village under study there is substantial degree of morbidity including communicable diseases. The villagers have a number of problems like problem of vision, weakness, respiratory diseases or diseases of the digestive system. However only acute afflictions are categorized as sickness, living a low standard of life common ailments have become a part of their daily lives and they do not consider them to be worthy of being addressed by medical experts.

Fever, stomach troubles, rheumatism, weakness, skin problems afflict about 75 pc of the respondents. Communicable diseases like tuberculosis and AIDs also are found in the village. With increasing use of pesticides eye and dermatological problems are on the rise.

Problems of a more serious nature have also been found to prevail in the village, kidney problem, gall bladder stone, heart problems, diabetes, and hepatitis. Most of the respondents were of the opinion that every month

one member of the family or another falls sick. At the same time they are not bothered about their illnesses as long as they can carry on their daily chores. The need for money which is basic for survival is so great that they think earning for livelihood is most important. Even a day spent for going for treatment makes them to forego their daily wage which they can ill afford. In addition there is transport cost as well as expenditure for medicines. Hence it is only when the malady becomes unbearable that they visit the medical college even if they suffer from serious diseases.

This becomes clearer when we see the nature of treatment which they seek. This can be seen from all the forty households. About 25 percent of the households reported that it is either the quack or the traditional healer to whom they go for treatment. The quack is found in close proximity to the village and he can even provide emergency care like giving intravenous fluids. So a type of a parallel health care practice is flourishing in the villages and there is no means to regulate the activities of the quacks. Very often the villagers cannot afford to make payments to the quacks and he reduces the dosage of medicine, so it is really a havoc being played at the hands of ill trained quacks.

The other 75 percent of households do visit the primary health centre or medical college but they too fall back upon traditional healers and quacks. If we see the following instances the picture will become clearer to us and we will get a view of the situation.

1. One woman who suffered from typhoid during the birth of a child continues to suffer from symptoms of the invalidating disease without any hope of recovery and neither she nor any of her family members can afford to be concerned of her health.

2. A man suffered from a leg bone fracture in a road accident, the initial treatment was done in North Bengal Medical College but financial constraints led him to stop the treatment half way and at present the traditional healers have taken up.

3. Due to chemical reaction from pesticides one person is suffering from skin problems, His hands have become infected, yet the person is not taking any preventive measure during the use of pesticides. The initial treatment was done at the Medical College, but this involved a lot of expenditure hence the respondent stopped treatment and is now dependent on quacks. However the infection has not been cured.

4. The fourth afflicted respondent has been suffering from kidney problem; she has stones in her kidney. However due to financial constraints she has not been able to continue her treatment. She gets cheeked up at the Medical College Hospital but she cannot afford to take all the medicines, she buys whatever she can afford and then goes to the traditional healer.

5. There are many households where aged people live, for them quacks and traditional healers are the only option, in one particular household the aged father was suffering from respiratory problems, he was physically unable to move out, his sons too could not afford to get a medical practitioner at home and hence the aged seem to be totally left out of the health care system.

6. In this household a woman was found to be suffering from heart problem but no one seemed to be bothered about it, initially she got treatment from the Medical College and it was stopped after some time. Even when the family members understand the gravity of the affliction they remain helpless as any incident which disturb their daily routine is a threat to their sustenance.

7. In this instance a young a girl was seen to be showing symptoms of ill health which included breathing problem as well as pain in the joints with swelling. Despite the seriousness of the situation the family could not afford to provide her any treatment, she was not taken for any check-ups and a traditional healer who is referred to as *ojha* in the village caters to her health requirements.

8. An aged woman was seen to be suffering from chest pain and another woman of the same family was suffering from chest pain as well as gall bladder stone. The patient visited the Medical College Hospital for the stone but a date for operation could be fixed only after two months as such they are still waiting for the date. The family members meanwhile are worried about the expenses to be incurred and from where they would be able to provide the required amount necessary to pay for tests and medicines as they live a hand to month existence.

9. In another household a female member was suffering from multiple ailments like diabetes, high blood pressure and also a bone fracture in one of her legs In this case too the initial treatment was taken from the Medical College Hospital but it was half done. She did not continue her treatment and has also stopped taking medicines.

10. A female member here was suffering from a problem of the uterus she too goes to the *ojha* for treatment.

Similarly there are others suffering from fever, headache, chest pain who do not go to the Medical College and prefer local healers. However about 25 percent of the respondents reported that whenever their family members fell ill they were taken either to the BPHC or the Medical College Hospital to be provided treatment. Other diseases include hepatitis, tuberculosis, HIV, AIDS etc.

The aged are also vulnerable, about 20 percent of the households had aged members. They suffer from ailments like cataract and rheumatism and other types of physical ailments. In most of the cases the aged are not provided any treatment, in case of any serious problem the quack is called and no special care is taken of the aged as the families can hardly afford bare sustenance. One aged lady was suffering from cancer but she was not being provided any treatment, she was lying lonely in one of the rooms. The same can be seen in the sick teagardens of North Bengal, people afflicted with diseases like cancer, tuberculosis, heart problems etc. just cannot afford to get any worthwhile treatment.

We find from the above that poor people due to their poverty cannot access proper health care and also that sickness can be both a cause and consequence of poverty. Though income is essential to buy healthcare, sickness impoverishes poor people further and gives rise to extreme deprivations (Borkar 2014).

Households in poor areas often spend enormously, borrow and fall in debts to pay up for health care, in the village under study 70 percent of the households had incurred some type of debt in order to get treatment both from institutional as well as non-institutional sources. In the above instances cited, there is a larger number of women who are afflicted, as Borkar (2014) suggests that morbidity varies on the basis of age, gender literacy and socio – economic status. However for women more morbidity is reported from all age groups. As observed by the above scholar, (Borkar 2014: 118) 'Also women in the reproductive age groups were found to have higher prevalence of illness, perhaps due to complications arising from pregnancy and child birth. The morbidity rates of sickness and morbidity of treated sickness showed high morbidity among females as compared to men. …Women here experience higher levels of morbidity as they continuously work in a very degraded environment and seems to face a dual burden from paid work outside the home and household work pressure like raising

children'. Added to this are also the other domestic chores and as Unnithan (1999) observes that morbidity both self-perceived and clinically observed is highly affected by gender and is rooted in material, ideological and political dynamics of rural households. At the same time women have longer life expectancy and hence they live a life affected by morbidity till an advanced age and bear the pain and associated afflictions.

Coming to the question of health and hygiene we found in the village that health and hygiene is closely related to literacy, socio-economic conditions as well as willingness to accept the widely prevalent practices associated with them. At the same time there should be spread of awareness among the villagers as to the basic requirements of maintaining cleanliness and hygienic practices.

There is no proper means of waste disposal in the village; practice of washing hands before eating is also not found. The agricultural workers involved in spraying of pesticides do not follow the prescribed measures of wearing masks and gloves, even the practice of putting pesticides away from the reach of children is not observed. When a person is afflicted with cold and fever care is rarely taken regarding not sneeze or coughing openly.

Drinking water is available for 80 percent of the respondents, they get water from tube wells and 20 percent of the respondents use the public sources of water provided by the government or get water from their neighbours. 70 percent of the people do not have any toilet at their home premises and they defecate in open spaces. Many of them live on vested land and fear if their land is taken away then constructing a toilet would be a more wastage of money. This shows that the fact that a toilet is as necessary as a shelter to live in has not become a mental construct for the people. Had this been the case having a toilet would be as important as having a kitchen but as yet this has not become a part of the cognition of the villages. As a result of open defecation problems like pollution of underground water and spread of diseases like diarrhoea, dysentery etc. is widely prevalent. There are a number of villagers who also do not have the required money to construct toilets.

The fact that healthy practices are not followed is also seen at the time of child birth, even when bathing the baby, tonsuring it or putting oil is forbidden these are all done following traditional practices. Secluding the mother and baby and keeping them in isolation even during winter often leads them to suffer from respiratory problems, as an extra room with proper suitable conditions to keep a mother and her baby is hard to come by.

In the village under study taking all the forty households into consideration only 10pc of the households had ability to provide initial treatment but they also are not in a position to continue the treatment. All of them took loans from different sources banks and micro finance organizations. At times loans are taken from multiple sources like private loans as well as institutional loans and money is also borrowed from relatives. As many of the respondents were daily labourers they have to borrow to provide food for their families if they cannot work even for a day due to sickness. Thus treatment is beyond the ability of nearly 90 percent of the households. Even very low cost treatment is beyond their means. These households therefore go to the BPHC or North Bengal Medical College when health problem gets acute otherwise they get treated through quacks and traditional healers. There are even cases of land being sold or mortgaged to meet initial costs of acute illness episodes. Only 2.5 percent of the respondents reported their ability to provide treatment without any loan for some period of time at govt. health institutes.

In this section we cite four cases of patients afflicted with serious ailments. The names of the patients have been changed.

Case -1

Mr. Dinesh Roy, aged 41, is a driver. He is HIV positive and wife and child have also tested HIV positive. His wife is 26 years old and son only six years old, Mr. Roy went to Calcutta in 1995 and started working there as taxi driver. He came in contact with sex workers and contacted HIV. He came to know about his ailment only after returning in 2003. He started falling ill frequently and when he went to the BPHC for treatment he was diagnosed as HIV positive, after he did not respond to any type of treatment earlier, and his ailments started assuming serious proportions. At that time he know nothing about the disease and after receiving counselling from a counsellor he came to know about its seriousness. He got married in 2004 when he was already infected, the bride's family was not informed about his health problems and after marriage his wife got infected and their son also got infected from his parents.

The whole family including his parents is dependent on Mr. Roy and what is more surprising is that his wife conceived the baby even after knowing that they were both infected, it may have been the case that they were not aware of the full implication of their behaviour, but surprisingly even now

they want to have another child. Mr. Roy seems to be quite worried about his own and family's future.

Case-2

Mrs. Bakultala Roy is a housewife and her husband is a daily wage earner. They have two children, a daughter Ripa and son Suman. At the time of her daughter's birth in North Bengal Medical College and Hospital the attendant doctor took recourse to forceps delivery. The child's head started growing abnormally and she started having many health problems. At Shivmandir a private practitioner attended her and suggested a brain operation. Her parents took her to Vellore and a tumour was diagnosed on her head as a result of the pressure of forceps on her head. The tumour was operated upon and Ripa's father borrowed money from different sources for the treatment. However the girl has not been totally cured and now her father has sold off his land to fend for the treatment. Even now the treatment is going on and every single day Ripa must be given medicine, the family is finding it increasingly difficult to meet the expenses of treatment.

Case-3

This relates to Gouri Roy who is a housewife her husband is a daily wage-earner, they have two sons who are around eighteen and twelve years old. Gouri started having health problems after the birth of her second child, she was having pain in her stomach and when she visited the Medical College the Doctor diagnosed her with suffering from kidney stone. Her financial situation is such that she cannot undergo any surgical treatment or any other costly treatment, so during acute pain she visits the Medical College Hospital to get medicines and otherwise depends on traditional healers. At present she is bed ridden and can hardly do any work. She does not have anyone to help her financially, her husband's income is not enough to provide for household expenditures including the education of her sons, as such she has stopped taking treatment and is ready to accept whatever is waiting for her.

Case-4

The women who is the subject of the case study is Rumpa Roy, she is thirty five years old and is working in one of the outlets of shopping Mall in

Siliguri. After the birth of her son her husband left for Mumbai in search of work and started working as a driver, he came in contact with sex workers and got HIV infected. Having fallen ill he returned to Phansidewa and got himself treated at Medical College Hospital but died after a few months soon after Rumpa also started feeling unwell and was identified as HIV positive as she had got infected from her husband. Now she is undergoing treatment and, she looks after her children as well as her in-laws, however, she keeps on suffering from different kinds of ailments like fever, body ache, stomach problems, and respiratory infections etc. She is easily prone to getting infected from any source of infection; she also misses out on her work quite often.

These case studies give us on idea of only the tip of an iceberg. If this is the health situation is such in a small study of forty households in a village which is quite accessible and near the BPHC how widespread the maladies related to morbidity would be in the more remote and inaccessible villages can be surmised.

Maternal and child health

The importance of maternal health lies in the following factors.

1. Woman in the reproductive age group (between 15-49 years of age) constitute a substantial part of the population.
2. Mothers, infants and children under five years account for three fifths of the total deaths in our country while 50pc of all the deaths in the developed countries are among people above seventy years of age the same proportion of deaths are observed amongst children less than five years of age in developing countries.
3. Morbidity among mothers is rather high.
4. Women in India are overburdened. They often share the jobs of their husbands besides hard physical work and household chores. They bear the added burden of pregnancy over which they hardly have any control. They are undernourished and anaemic and need special care.

The major goal of maternal and child health services in primary healthcare is to reduce the incidence of illness, disabilities and deaths amongst mothers by providing treatment for illness during pregnancy and lactation. The National Rural Health Mission (NRHM) has been launched in the country in 2005 with a view to improve health status of people living in the rural

areas. 'The mission seeks to provide universal access to equitable, affordable and quality healthcare which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance'(ATI 2012: 19). The specific objectives of the mission are:

a. Reduction in IMR and MMR to 30 and 100 by 2012.

b. Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunization.

c. Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.

d. Access to integrated comprehensive primary health care.

e. Population stabilization, gender and demographic balance.

f. Revitalization of local health traditions and mainstreaming AYUSH.

g. Promotion of healthy life styles.

From the above it can be seen that NRHM lays considerable stress on Maternal and Child health. We will try to see how far the mission has impacted upon the health of mothers and children in the village understudy. We have already seen the poor health status of the sample respondents in the earlier section which does not reflect the implementation of the programmes of the NRHM in right earnest. Villages continue to face acute health problems along with rising costs of health care. The last point regarding promotion of healthy life styles also is meaningless in the context of poverty, malnourishment illiteracy and increasing costs of living.

The idea of institutional delivery is slowly catching on and at present attempts are being made to ensure delivery at the BPHC or Medical College Hospital. Despite the NRHM functioning since 2005 it is only very recently that there is some seriousness regarding institutional delivery.

It was found in the study that in about 60 percent of the households delivery was done at home, very often when there was more than one baby in the house one could have been born at an institution but the others were born at home. Two households, that is five percent, reported delivery in private nursing homes, only 35 percent of the households reported delivery of all babies in institutions.

Antenatal care was not available for most of the mothers; about 70 percent of the women did not have any source of prenatal care. The ICDS provides pregnant mothers egg and food before and after delivery, iron, calcium tablets and tetanus toxide was given by the primary health centre. However most of the mothers being daily wage earners did not get the time for regular check-ups. It also happened that check-up was done once and the taking of iron tablets was also not regular. Only about 50pc of the households reported the intake of the above nutrient supplements.

However very recently the ASHA workers are seen to be moving around the village trying to convince the women about utility of antenatal, and post-natal care though much more could be done.

The NRHM has introduced the following programmes for ensuring maternal and child health (ATI 2012).

1. Promoting Institutional Delivery and safe motherhood. One major drive under NRHM is to improve access to institutional delivery for the safety of the mother and the new born.
2. Janani Suraksha Yojana (JSY) The JSY has been launched with the vision of reducing MMR and IMR and increasing institutional delivery of pregnant mothers from BPL families. The strategy adopted has been promoting early registration, identification of risk pregnancies ensuring three ANC and post-delivery visit.
3. Janani-Shishu Suraksha Karyakaram (JSSK) The JSSK was launched in 2011 by Govt. of India as an initiative under the NRHM for providing free and cashless services to all pregnant mothers including normal deliveries and caesarean operations and also treatment of sick new born in all govt. health institutions across the country.
4. Referral Transport system for getting quick access to the health facilities for the expecting mother and the sick infants an arrangement has been made by placing ambulance /vehicle which may carry mother to health facility providing round the clock delivery services.
5. Improving neonatal care. In order to prevent neonatal deaths there is provision for both improving more home based neonatal care through training of ASHA and improving the level of consciousness of the mothers.
6. Integrated Management of Neonatal and Childhood Illness (IMNCI). This refers to a training programme developed for better management

of neonatal and childhood illness and all the ANMS and Asha as well as ICDS workers are being imparted the training.

7. Birth and Death Audit for Maternal and Infant Death. Death audit is conducted for knowing the cause of death. Such audit is done through collecting information verbally from the members of the family when the death takes place at residence. In case of death at the hospital audit is to be done by the hospital authority.

8. Village Health and Nutrition Day (VHND). The purpose of the VHND is to extend services related to nutrition and health particularly of the mother and child, to the village level by bringing all services given by the S C and the ICDS centre on fixed days.

In the village under study villagers were not aware of these programmes. Taking into account the number of babies born during the last five years in case of around 50pc of the pregnancies taking of iron tablets and iron folic acid was reported. At the same time the women reported diverse types of problems faced during pregnancy. Around50pc of the pregnancies was associated with problems related to anaemia. Due to general weakness the mothers were not able to give required effort at childbirth which increased their suffering and pain. A number of them had to undergo caesarean section with its related complications. Transport problem was a very serious issue involved, often the women were forced to give birth at home as transport facilities were not available at the time of need or they could not just afford the transport cost. About 10 pc of the respondents had miscarriages and another 10 percent reported death of their babies just after birth. At present through the activities of the NRHM some efforts can be seen regarding prenatal and post-natal care but the office bearers seem to be more interested in reaching targets rather than providing quality care. Numbers attended are more important for them than actual quality care being provided.

Family planning has been the focus of maternal and child health for a long period of time. Reducing fertility, increasing spacing of childbirths, allowing the women to decide upon the time of her pregnancy and use of birth control measures are all important to improve maternal and child health as well as for stabilising population.

Though man and women are both involved in reproduction it is usually the husband and his family that mostly decides about when and how many times a woman is to become pregnant it is women who are targeted for implementation of birth control programmes.

Reproductive behaviour is only associated with women though men and the patriarchal family are primarily responsible for reproduction. It is either irresponsible sexual behaviour or the desire for a son that makes a woman to face repeated pregnancies at the risk of her own health and that of her children. We have seen how in Madhya Pradesh recently a large number of women died undergoing tubectomy. The operation was undertaken in unhygienic condition and medicines provided were also spurious. The women are herded together and after the operation they are just made to lie down on the floor crowded with women who had undergone the same operation. The men are hardly found to have undergone vasectomy, even though it is more simple than tubectomy, a general feeling is nurtured which suggests that such an operation would reduce the strength of the males and women as they are already used to taking all burden upon themselves are also reluctant to allow their husbands to undergo vasectomy. The use of condoms too has not become as widespread as it could have been especially among the lower socio-economic categories. The use of condoms in addition to controlling births also prevents the spread of sexually transmitted diseases. In the village under study two persons were found to be HIV positive and they have infected their wives and children, such irresponsible behaviour can be controlled by using condoms to which most men do not agree. Thus the whole responsibility of birth control vests upon women and they have to accept the different methods of birth control as well as their negative consequences.

In the village under study about 80 percent of the respondents felt that both husband and wife have the responsibility of having a small family. However in actual situations the women felt they the above did not prevail as they felt that giving birth to a child was very often out of their control. About 50 percent said they were not responsible for the size of the family, accepting measures for contraception by males was also not approved by the dominant social values and norms prevailing in the village. Thus it remains that the prime responsibility of having a small family and taking precautions against the birth of a child vests upon the women who in the final run do not have the final say regarding the number of children they would give birth to.

As far as vasectomy and tubectomy are concerned the opinion of the respondents conforms to the general pattern of male involvement in contraceptive use all over the world (Karim 1996). The husband being the bread earner it was felt by more than 60pc of the women that vasectomy could affect the working ability which in turn would affect the family this also indicates the low self-worth among women who feel that their lives

are of lesser worth them their husbands. The respondents were asked if their husbands would agree to vasectomy, 90pc of the women said that they would not agree. Thus utilization of health care as far as sterilization is concerned shows a very high gender bias against women. This govt. programme is directed mainly at women and conducted primarily for them. However a woman as the one who bears main responsibility regarding child bearing is the main target of the operation and face all the risks attendant upon the same. Proximity to the BPHC could not change the attitude of the males which could have been done with the spread of awareness.

In Mahipal only 37.5 pc of all the respondents asked about acceptance of family planning methods replied in the affirmative. Tubectomy after the birth of the second child if one of the earlier births was a male child seemed to be the option preferred. About two or three males were found to be using condoms, there are instances of forced pregnancy also, a woman was forced to get pregnant after giving birth to five daughters the sixth one was a son, about 40 percent of the respondents reported forced pregnancy for the birth of a son.

More than 63 percent of the respondents were not using any methods, as Mohan Rao (1993) wrote and it is still applicable to the area under study that despite repeated efforts the Family Planning programme has failed to take off, even the piecemeal way in which the programme was undertaken did not prove to be a success.

Family planning measures and the way they have been implemented shows that they have not become a part of health care system of women in the total implementation in the sphere of family welfare and planning. This becomes all the more important because the question of women's health in India is inextricably linked with their reproductive function.

Coming to maternal care, at present the NRHM is more or less in control of maternal and child care, despite the rule of going for three antenatal check-ups it is not done by the villagers however in recent months there is some seriousness in the NRHM, even when the check-ups are done it is not possible for the expecting mothers to follow the doctor's advice. Very often the doctors suggest nutritious food, vitamin supplements and rest from work. The women under the present study belonging to the very poor section are hardly able to afford any of the above. They have to carry out all the domestic chores, at the same time they cannot afford nutritious food. We have seen that govt. expenditure on health is about one percent

of the GDP, hence whatever nutrition is derived from the ICDS in case the village Health and Nutrition day is observed is a drop in the ocean. As the respondents mostly belong to the very poor sections it was found that hardly 10 percent of them had access to some type of nutritious food every day. The others could only provide for the basic minimum, this has led to the prevalence of anaemia among women who are precariously placed during child birth and remain highly vulnerable. As the women remain malnourished the babies born are often of low birth weight and suffer from different types of problems. Even after birth the neonatal and post neonatal care given to them is not adequate, and in the absence of proper hygienic condition they remain susceptible to infections of the digestive as well as respiratory system. As regards immunization of the new born it was found that the babies at present are immunized against different types of diseases, only about 10 percent of the households reported that the new born were not vaccinated.

The NRHM has not been able to make its presence felt in the village understudy as far as maternal and child care is concerned. The way maternal and child care is being carried out raises questions about the real intention of the government and its sense of responsibility towards the poor and illiterate women of our country. A large number of programmes are announced and advertised widely whereas allocation of funds continues to be meager.

Involvement of non-governmental organizations in the field of health care

The Voluntary Health Association (VHA) is working with HIV affected people. An attempt was made to understand the problems faced by the HIV affected people who are saved by the VHA. A meeting was convened with a number of HIV affected patients in the office of the VHA at Bagdogra, all the patients were from Phansidewa Block and included both men and women. The VHA helps HIV affected people to overcome the initial shock they suffer with the knowledge that they are HIV affected. The organization also is involved in counselling the patients as to how they should regulate their lives and receive funds from the government along with other sources. This NGO works with AIDS affected people who comprise sex workers, migrant labour and other people migrating to distant places for work. It was learnt from the NGO that there are 6000 HIV positive people in Darjeeling of them 3000 are migrants, 1220 reside in the

hill areas and 1780 reside in the plains areas. All of them can take help from VHA, the main purpose of the association is to provide a platform where HIV positive patients can interact with one another, learn from one another's experiences and get encouragement to live their lives as normally as possible. This also helps them to get out of the state of depression into which many of them get once diagnosed with HIV and once they come to face all the associated miseries. The NGO organizes sports for HIV affected children, and provides all types of guidance as to how they should organize and lead their lives.

Talking with the HIV positive men and women we could get an idea of the social world they live in, how they struggle on with their lives and how they strive to have a normal life even after knowing the vulnerability involved in being HIV positive. The HIV positive patients if married are advised not to conceive and even if they decide to have a baby they are advised about all the precautions they should take. It the new born baby is not HIV positive then the mother is barred from breast feeding the baby and thereby preventing the baby from getting infected.

Often when the HIV positive parents die their children do not get any place to stay, their relatives are also not ready to keep them and hence the HIV positive parents are very worried about what would happen to their children if they died.

In the villages the HIV positive patients do not reveal their sickness to other villagers as they fear being ostracized, even educated people behave in a very insensitive manner with them, whenever they go to a diagnostic centre their tests are done after the technician has finished with all the others even if they have arrived much earlier. This causes physical strain as they are already sick and are suffering from many health-related problems. One patient reported that after being tested positive he went to a doctor but the latter shut the door on his face, he then came to know of the VHA and the latter helped him to contact the centre providing treatment for AIDs.

The NGO in its limited capacity is playing an important role in providing hope and succour to HIV positive patients. They realize that they are not the only ones to be afflicted and everything is not lost if one gets infected with HIV.

At the same time some new social processes become clear, more and more men are migrating to distant places in search of work and in the process they have to stay away from home for a long period. They interact

with sex workers, get infected, ultimately passing on the infection to their wives and children, thus here too wives become the victims of their husbands undisciplined lives and they continue with the relationship and have children just because there is no alternative for them.

Summary and conclusion

The present study started out with the proposition that real health cannot be obtained for the poorer sections unless there is an improvement in their living standards. Education, income, nutritious food and proper conditions of living all come together and in the absence of all these and a paltry amount of expenditure being made by the government in the health sector morbidity is never going to be checked. At the same time increasing privatization of health care is taking place, the poor are totally left out of the purview of the same as they just cannot afford the expenditure involved and are forced to fall back upon the meagre health care services provided by the government. The government at the same time announces many programmes but allocates meagre financial outlays for the same and hence even when statistical figures regarding health care delivery like institutional delivery shows a rising trend the health condition of the mother and the new born continue to be poor.

The fact that social and economic conditions are the most important determining factors for health status is commonly agreed with. Williams (1995), in this context, observes: 'evidence continues to grow concerning the link between class and health and the fact that poorer people have shorter, more illness ridden lives than their more affluent counter parts, sociological studies have shown how peoples general beliefs about health and the degree to which they feel they have control over their daily lives are shaped by their position within the broader social structure, low norms regarding health are adopted by those living in poor socio-economic circumstances due to the relatively greater experience of illness suffered by this group.' The norms of behavior regarding health which the poor adopt are also related to the *habitus* which reveals the way they cognitively interpret the world in terms of their own life experiences.

The study shows how poor people do not give importance to their illness unless they assume serious dimensions and even in such situations they may begin the treatment but are not able to continue the same to achieve final recovery. Any illness episode disturbs the normal functioning of the family, as daily wage earners they have to forego a day's wage of both the

sick person and the one assisting the patient to the health care institute whether it is to the BPHC or the North Bengal Medical College and Hospital.

Borkar (2014) observed: 'morbidity has a distinct social class gradient with infant and adult mortality falling and days of work lost owing to ill health decreasing as one moves from lower social groups to higher ones' in this study people reported serious ailments like gall bladder stone, cancer, AIDS, malaria, tuberculosis and diseases of the respiratory and digestive system. Like any other part of the country the villagers make use of government health care, traditional healers and quacks. The last two are sought regularly and only when they fail is a visit to institutions made. The elderly however in most of the households have to be satisfied with traditional healers or quacks. It is in the case of children that institutional care is most sought of compared to the other age groups.

Similarly social processes which have been initiated by globalization have also affected the health of the people. Production is mainly for the market, paddy cultivation is giving place to vegetable cultivation with large scale use of chemical fertilizers and pesticides, the vegetable growers do not follow the prescribed measures in the spraying of pesticides like spraying from a distance or wearing masks, heavy clothes and gloves and also use amount of pesticides much above the prescribed limits as allowing the crops to grow faster will enable them to sell the same quickly. As a result dermatological problems and problem of the eyes are increasing while the crops themselves are a source of ill health for both the producers and consumers due to the health hazard of chemical pesticides and fertilizers. Again due to the fact that employment is not available in the villages many people migrate to distant places in the south and west of the country leaving their families behind. Once away from home they indulge in sexual practices with the sex workers and get infected with HIV. On returning they infect their wives and new born children, the problem is such that a man was diagnosed only after the blood specimen of his wife was tested and she tested positive and her husband followed and undertook a blood test. Government institutions provide medicines for HIV positive patients but this is a debilitating infection which reduces the working capacity of the infected people. These patients being poor cannot afford healthy, nutritious food and this affects their performance of daily activities and thus they cannot perform income earning activities on a regular basis. This in turn affects their standard of life, thus poverty becomes both a cause and as well as a consequence of morbidity.

The latest Human Development Report (Rao and Kurian 2013) puts India at the 134th position out of a total of 187 countries. Among the 47 countries in the 'Medium Human Development' group, India stands eighth from the bottom. These reveal the actual priority which health and education get by the policy formulators. It calls for higher government expenditure and a worthwhile public health care system. Another problem is also the availability of health care personnel in the government institutions, posts of nurses and doctors are not filled up, even where doctors are appointed often they come from urban areas and are not really interested in serving the rural areas. Most of them are involved in private practice and look upon their job in the government institution as a secondary one, and the beneficiaries of public health being the poor sections of society there is also hardly any sustained health movement observed in the region.

As far as the NRHM is concerned it covers maternal and child care as well as communicable diseases like leprosy, tuberculosis, encephalitis, dengue, AIDS and also acute respiratory infection. However in the village under study NRHM was found to be somewhat active in matters related to maternal and child care and to some extent in the treatment of AIDS and tuberculosis. However as maternal and child health as well as all these diseases are related to the basic requirements of life which is not available to the poor villages the NRHM has not really been able to provide real health to the people. Institutional delivery, antenatal check-ups and treatment to health institutions are being provided but the nutrition which the mother and baby is supposed to get is not available. The hygienic and healthy conditions of life required for the mother as well as the baby cannot be made available without improving the socio economic conditions of the people. Medicines for tuberculosis, leprosy and AIDS may be available but the widespread poverty in which the first two are found and the prevailing value systems as well as livelihood crises which feed the last cannot be addressed without providing for adequate sources of livelihood along with proper education and awareness.

Moreover, we have seen that the BJP government had reduced expenditure on health; in addition it has also reduced the ICDS budget from Rs.10,000 crores to Rs. 8,245 crores (*The Statesman* 12.3.15). Senior officials of the state government feel that implementing different programmes of the ICDS would be affected. This assume added significance as programmes under NRHM like village Health Nutrition day when some nutritious food would be given to mother is closely tied to the ICDS. The officials were further of the opinion that it would be difficult for them even to prepare the state

budget due to the reduction in allocation of funds. For normal children the rate of supplementary diet under ICDS was Rs.4 which was increased to Rs.6, the diet for lactating mother was Rs.5 increased to Rs.7 for severely malnourished children it was Rs.6 increased to Rs.9. Now that the total amount has been reduced the above amounts would also fall, one would wonder as to how real nutrition could be provided at the earlier rates and what is going to happen if even that is not available.

Ina study on National Rural Health Mission, Sharma (2014) observes that while discussing the strategies of National Rural Health Mission the Eleventh Five year plan admits that there are formidable problems. 'The central government has focused on reducing the MMR the most. Efforts are made to minimise maternal deaths in the country, which still has an unusually high Maternal Mortality Rate. Janani Suraksha Yojana is precisely about this. At the same time the plan recognises that encouraging women to go to health facilities for delivery alone would not reduce maternal mortality to zero. It accepts that the country does not have adequate institutional capacity to receive all women giving birth each year and that half of the maternal deaths occur outside delivery, that is , during pregnancy, abortions and postpartum complications. The problem is mixed up with several issues such as lack of concern for women's health, malnutrition, lack of proper transport facilities, lack of awareness of danger signs, lack of full ante-natal care, and lack of stress management.'

Thus though a minimum of public care is accepted with immense gratitude by the poor people it does not really fulfill their health requirements. The costs involved cannot be met, the basic health requirement of cleanliness, adequate nutrition, proper shelter a sense of health and hygiene all have remained unaddressed. The poor are out of focus as far as any development agenda is concerned. Thus it must be realized that preventive care is as important as curative care and the former does not only mean vaccination, it means a wholesome life where all the basic necessities of life like food, shelter, clothing, education and employment are met. In the absence of these the minimum curative care which is provided by government institutions can only provide some temporary succour. It will not be able to solve the real health issues which the people of our country face today.

The village under study is no different from the rest of the country, the available health care services are inadequate, at the same time poverty makes the poor vulnerable to different health problems which does not get adequate medical attention and remains untreated after some initial treatment. Maternal and child health also suffers due to the poor socio

economic standards of the families and the usual indifference to the cause of women's health.

Thus, health and morbidity needs to be addressed, the former by raising the capability of the villages and the latter by having institutional health care which is sufficiently equipped with both financial allocation and health personnel which will only be able to address the health issue of the villages and ensure better health and reduced morbidity.

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