CHAPTER IV

EXTERNAL LINKAGES AND

THE INTERFACE OR BOUNDARY OF THE SYSTEM

From the overall description of the district's health services infrastructure we move onto the more subtle and intricate variables influencing the system of the public health services in Purulia. As mentioned by us in the chapter on the study methodology, these variables are called linkages. It was identified that these linkages were of the external and internal types.

The elements of structure, technology, personnel and prescribed functions, all interacted among each other to determine what we call the organizational process. The directions, dynamics and determinants of this process were in turn influenced by the linkages, limitations, and characteristics of the interacting elements.

In this chapter we will concentrate on the external linkages and also discuss the interface of work culture, between the external and internal linkages. The internal linkages of, linear and non-linear types, between the selected programmes will be dealt with in the following chapters. The intra-programme linkages will be taken up in the chapter following that.

However, unlike the given structures and functions of the services most of the linkages do not enjoy much official recognition. In other words, the already established and explicit infrastructural linkages of the services do not necessarily take into consideration the implicit linkages of the system. Our effort will be to explore all possible linkages so that a good understanding of the complexity of the system emerges.

The data presented here have been collected from open-ended interviews of state level and district level health administrators and officers, block level medical officers and supervisory
and technical staff. The researcher also had discussions with them in groups and individually, and observed their discussions, meetings and working hours. Where necessary and available, data from official documents have also been used.

First, we take up the direct linkages followed by the indirect linkages of the environment with the system. The influences of the direct external linkages also affect the prevalent work culture or the climate existing within the health services organisation. This is the "interface" or boundary of the Public Health Services System in the district. The second half of this chapter, therefore, deals with this aspect of the "interface" to maintain the continuity from the external to the internal linkages which will be discussed in the following chapters.

Among the external linkages we start with the backgrounds and perceptions of the health personnels on the District Public Health Service System, the types of its systemic elements and the linkages of the elements and the system. The backgrounds lead to the perceptions of these personnels by influencing their mind sets. From the perceptions of these personnels on the system's linkages, we try to assess the influences of each of the linkages on the efficiency of the system from two aspects: (a) as perceived by the personnels, and (b) as observed by the researcher.

Thereafter, based on their perception again we attempt to understand the organizational climate of the Public Health Services System in Purulia. The climate of work culture within the organization is interpreted by the perceived and observed aspects of the goals, functions and activities of the System and its subsystem of the District Health Administration respectively.

4.1 BACKGROUNDS OF THE KEY DISTRICT HEALTH PERSONNEL AND THEIR PERCEPTIONS

Here we discuss the socio-economic backgrounds of the key health personnels in the district and their resultant perceptions on the health services as a system.
(i) **Backgrounds of the Personnel:** Among the eight district level health administrators six hailed from other districts of West Bengal and five of them came from urban backgrounds. All of them had middle class family backgrounds and had graduated from the State government run medical colleges. Seven out of the eight had initially thought of becoming clinical doctors. Only the Dy.CMOH-I did not intend to practice clinical medicine and preferred non-clinical work. He was also the only bachelor in the group.

**Table 4.1.1: Backgrounds of the Health Personnels in Purulia (Percentages)**

<table>
<thead>
<tr>
<th>Category of Personnel</th>
<th>Native place</th>
<th>Dwelling background</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Same distt.</td>
<td>Other distt. Rural</td>
</tr>
<tr>
<td></td>
<td>Semi-urban/</td>
<td></td>
</tr>
<tr>
<td>District Administrators</td>
<td>25</td>
<td>75</td>
</tr>
<tr>
<td>District Supervisors</td>
<td>62.5</td>
<td>37.5</td>
</tr>
<tr>
<td>Block medical officers*</td>
<td>0</td>
<td>100.0</td>
</tr>
<tr>
<td>Block Supervisors*</td>
<td>92.0</td>
<td>8.0</td>
</tr>
</tbody>
</table>

*From the selected sample of 2 Block PHCs.
Source: Interviews.

62.5 percent of Supervisory officers at the district level and 92 percent of Supervisors at block level were from Purulia district. Through them the socio-cultural ethos of Purulia also pervaded within the system. The non-native administrators, doctors and a few supervisors were however neutralising the effect of the local personnels (Table 4.1.1). Also, the mere fact that most of the doctors belonged to urban places, from outside the district did contribute to a socio-cultural gap between the doctors and the staff as well as between the doctors and the patients, specially the rural populations of the district.

(ii) **Perceptions of the Health Services Personnel:** The socio-economic and educational backgrounds of the personnels determined their perceptions about the services, to a large extent. The data collection on the views of the personnels on the District Health Service System was a...
tricky situation. First, we had to make sure that the interviewees clearly understood the concept of systems and linkages. To do this the researcher had to assess as to what the personnels already knew in terms of a system and about its linkages, as applicable to the health services.

Since none of the district administrators or the lower officers and other personnels could conceptualise the health services as ‘a system’ the researcher then had to explain it to them citing examples. After which, the questions on the types of linkages were put.

The more obvious factors of inter-sectoral coordination, community participation, influence of the state level health administration, and the local administrative and political influences were known to the health administrators and other personnels but not as external linkages of the services. Concepts of management, operations research, resource inputs, achievement outputs, and the integration of services and programmes were also known to most of the top officers.

Private practice by the health services administrators and doctors was quite common and was an affect of the larger socio-economic milieu’s influences on the mind-sets of the personnels. All the medical officers came from middle class backgrounds with their conventional attitudes where a doctor was meant for clinical services and private practice.

The key administrative personnels namely the CMOH, Medical Superintendent (District Hospital), and the District TB officer (ACMOH-PH&FW) all indulged in private practice in spite of holding non-practising posts. On an estimate, 80 to 90 percent of the medical officers of the services at the district’s government hospitals and in the health centres in blocks practiced clinical medicine privately. Thus, duplication of services and neglect of the public services was common. It is but ironical that there was a strong ‘intersectoral coordination’ or overlap between the public and the private health sectors which was quite detrimental for the efficiency and effectivity of the public health services in the district.
The concept of the services as a system was known to one of the state level administrators, two district administrators, the statistical officer among the district supervisors and one block medical officer (Table 4.1.2). However systemic terms such as inputs, throughputs and outputs were known to more than double the number. The term operations research was used by two district administrators.

Table 4.1.2: Perceptions of Health Personnels on Systems' Concepts and Linkages

<table>
<thead>
<tr>
<th>Systems Concepts</th>
<th>Respondents (In percentage)</th>
<th>S.H.A. (n=2)</th>
<th>D.H.A. (n=8)</th>
<th>D.S. (n=8)</th>
<th>B.D. (n=10)</th>
<th>B.S. (n=23)</th>
<th>Average age (n=51)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Health Services as a system</td>
<td></td>
<td>50</td>
<td>25</td>
<td>13</td>
<td>10</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>2. Inputs, throughputs, outputs</td>
<td></td>
<td>100</td>
<td>25</td>
<td>63</td>
<td>20</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>3. External Linkages</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Intersectoral coordination</td>
<td></td>
<td>100</td>
<td>100</td>
<td>88</td>
<td>70</td>
<td>74</td>
<td>80</td>
</tr>
<tr>
<td>b) Community Participation</td>
<td></td>
<td>100</td>
<td>100</td>
<td>88</td>
<td>90</td>
<td>78</td>
<td>86</td>
</tr>
<tr>
<td>c) Influences of State Organisation</td>
<td></td>
<td>0</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>87</td>
<td>90</td>
</tr>
<tr>
<td>d) Local political and administrative linkages</td>
<td></td>
<td>50</td>
<td>63</td>
<td>75</td>
<td>90</td>
<td>91</td>
<td>82</td>
</tr>
<tr>
<td>e) Boundaries of the system</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>4. Internal Linkages</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Interacting subsystems</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>b) Integration of services</td>
<td></td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>96</td>
<td>98</td>
</tr>
</tbody>
</table>

Key: S.H.A. = State Health Administrators  
D.H.A. = District Health Administrators  
D.S. = District Supervisors  
B.D. = Block Doctors  
B.S. = Block Supervisors

Source: Interviews.

The various external linkages viz., intersectoral coordination, community participation, local administrative and political links and influences of the state level organisation were mentioned by the maximum number of respondents, although these variables were not
categorised by them as external to the system as none of the interviewees could respond to the concept of the boundary of the system (Table 4.1.2). According to 82 percent of the respondents the local socio-political and administrative influences were significantly strong on the health services, but overlapped with community's participation links.

From the calculated averages based on the number of responses among the external factors, the influences of the state health administration was the strongest (90 percent responses) then the community's participation (86 percent), local administrative and political influences (82 percent) and, intersectoral coordinations (80 percent) were significant according to the personnel.

The internal linkages also could not be specified by the personnel but the need for an integrated services and programmes had the maximum number (98 percent) of the interviewees responding positively (Table 4.1.2). Most of them, however, stressed the fact that a total integration of all programmes at the district was not practically feasible. Integration as a concept of administrative, organizational, and technological integration was not forthcoming from the administrators.

Only the Dy. CMOH-III was aware of the integration of programmes according to area division of all service responsibilities in different zones between the Dy.CMOHs in a district, as practised in other states viz., Haryana. The integration of services was emphasised by all but, the interactions of the various subsystems was not clear to any of the interviewees. Only the BMOH of Kolloli BPHC had some idea of subsystems and their interactions. We will now discuss the researcher's view of the tabulated external linkages, one by one.

4.2 EXTERNAL LINKAGES

The external linkages of the system are the influences of the State level health service organisation, the local political and administrative linkages, the participation of the community, and intersectoral coordinations. Among these four linkages, the first two influence the system
Fig. 4.2.1: Key Administrative Control Lines from State to District (Schematic)

DHS

Addl. DHS (Admn.)

Addl. DHS (FW)

Jt. DHS (Admn.)

Jt. DHS (SMEIO)

DDHS (Lep)

DDHS (MCH)

ADHS (TB)

ADHS (MCH)

DADHS (Lep)

DADHS (MCH)

Zonal Malaria Officer

Divisional Commissioner (FW)

CMOH

Dy.CMOH I

Dy.CMOH II

Dy.CMOH III

ACMOH (PH&FW)

ACMOH (Med. & Admn.)

INDEX

Addl.DHS : Additional Director of Health Services
ADHS : Assistant Director of Health Services
DADHS : Deputy Assistant Director of Health Services
DDHS : Deputy Director of Health Services
DHS : Director of Health Services, Govt. of West Bengal
Jt. DHS : Joint Director of Health Services
SHEO : State Health Education Officer
SMEIO : State Media, Education and Information Officer

Addm. : Administration
EPI : Expanded Programme of Immunisation
FW : Family Welfare
Lep. : Leprosy
MCH : Maternal and Child Health
PH&CD : Public Health and Communicable Diseases
TB : Tuberculosis

Source: Adapted from SBHI, 1992, Health on the March, West Bengal, 1992. State Bureau of Health Intelligence, Directorate of Health Services, Govt. of W. Bengal, Table VI.3, p.38.
directly and the last two indirectly. We will discuss the direct linkages first and then the indirect linkages.

a) Influences of the State Organisation

These influences are discussed by first, the official perceptions and second, the observations of the researcher.

(i) Official Perception: Interestingly, as a complete contrast to the perceptions of the district personnels, none of the two state administrators perceived that there was any significant binding of the state directorate over the district services (Table 4.1.2). In their opinion, the district had enough power to freely run the services. Whereas all district level and most block level respondents viewed the state influences to be the strongest.

(ii) Researcher’s Observations: In reality, the state directorate wielded substantial authority over the activities of the district.

State Control: All service plans and programmes were decided at the Centre or State government levels and passed down to the districts via the State directorate. The means of state control were mainly through the provision of the inputs and the policies and service strategies. Officially, all activities of the district health services had to be accounted as the finances for all expenditures were borne by the State. There was no mechanism of the district to become financially independent or take strategic decisions on its own.

There were a number of deputy directors each responsible for one programme or service component and under them a number of joint directors and assistant directors with responsibilities of the technical and administrative aspects of the service components or programmes respectively (Fig.4.2.1). The state administrators communicated separately with the CMOH and with the respective programme officers of the district. However, there was no direct communication from the state to the block levels.
All official directives, guidelines, and orders and even sanctions were given to and via the district administration to the block and sector level centres. At the district level, the dual lines of command from the State directly and also via the CMOH not only undermined the latter’s authority but also caused duplications and conflicts in orders. It is therefore not wrong to say that "Much of the functional confusion and role conflict flows down from the state administration".  

State Supervision: While the state administrators seldom made visits to the district or peripheral facilities on their own, they usually accompanied high level expert delegations or the state health minister to the district. During the entire period of the field work stretching two years, there was only one visit by the state health minister to the district. On this visit, in November 1993, he inaugurated the General Nursing and Midwifery (GNM) Training Centre at Purulia, constructed under the IPP-IV. During his one day visit to the district, the CMOH accompanied him all through. But, the minister was always surrounded by his party workers and the CMOH remained sidelined. After inaugurating the training centre, the minister visited the District Hospital where he had discussions with the Medical Superintendent and other hospital officials. This was the end of his visit and his interests and concerns for the health services in Purulia. This event reflects the state ministers strong priorities for the curative services and his indifference to the other components of the district’s health organization, particularly the preventive programmes.

A number of state and divisional (comprising of a few districts) level meetings on the different programmes, mostly Family Planning and Immunisation were held often. But, there was no regular schedule for these meetings. Now and then, probably on the intimidation of the Central government, these meetings were conducted. For instance, in December, 1993, a

meeting was called by the Commissioner, Family Welfare Programme, to be held at Calcutta, with CMOHs and Dy.CMOHs-III for eradication of Polio in districts. On the same day, another meeting was organised by the Secretary, Health and F.W., Government of West Bengal, at Calcutta, with the CMOHs and Dy.CMOHs-II for Public Health Programmes. The effects of the discussions and decisions taken in these meetings did not remain for long. As aptly remarked by the Dy.CMOH-I "the reprimands faced by the district officers in these meetings have become a routine affair without any effect, and these are forgotten by the officers on their night long journey back to the district from Calcutta." No records of these meetings were maintained at the district.

Another way of communication from the State to the district was through telephonic talks. As and when necessary, the different programmatic and administrative officers of the State Directorate rang up the CMOH with their queries and commands for informations from the district, and to improve poor performances in target achievements. On two occasions when such trunk-calls were received by the CMOH in the presence of the researcher, once it was the Dy.Director (Nursing) and the other was the Commissioner, Family Welfare.

Another significant feature of the 'political will' of the Left Front Government in power for more than twenty-five years in West Bengal, was that despite strong recommendations of the government's own Subject Committee to declare a State Health Policy, none has been formulated so far, and work was being done in an adhoc fashion.2

In 1995, that the ADHS (Ophthalm.) was appointed the District Monitoring Officer from the State, for Purulia. He had to monitor the performances of the FP, MCH, Diarrhoea and Malaria programmes mainly. In the only district level meeting he presided in, during the period of field work, his inaugural discussion was on the Blindness Control Programme, its personnel,

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equipments, and services. The other programmes were left to be discussed by the district officers. Such whimsical prioritisation and responsibilities for monitoring of district’s health and F.W. programmes was due to clinical personnel being put in Public Health responsibilities by the State.

Feedback to State: All feedbacks from the district to the State were on the behest of the State. The prioritisation among programmes was done at the State level itself. The districts were ranked and the list for the whole state is prepared every year on the basis of performance achievements against targets given for Family Planning and Immunisation programmes. This list was circulated among the districts and prizes were given in cash to the first three districts every year. Purulia had won the second and third prizes in 1991 and 1992 and ranked fourth in 1993.

Instances of sudden radiograms arrival to the district health offices via the D.M. or the Suptdt. of Police from the State secretariat were many. These radiograms result from issues and questions on Purulia’s health services raised by opposition parties in the State Assembly to the Minister in charge. Immediate replies were asked and sent by the district. Such feedbacks were again sporadic and did not contribute to any significant and sustained improvement of the system.

The top-down centralised approach of the health services has affected the functioning at the district level. Funds, personnel, technology and directions that were ‘given’ by the State to the district, the job responsibilities, feedback, coverage etc. all were seen by the district as something that was being done for the State and not for the population of the district. Thus, statistical reports were prepared only to be sent to the State level and not for use at the district. This was apparent from all interviews at the district level.

The handing down of the scarce resources also gave a picture of the district always looking up towards the State for more resources and supplies. Similarly the blocks were mostly
running to the district for technology supply, funds or other administrative matters. So, in a way we can say that with the top-down approach to the services the different levels of the services were mostly facing towards the higher level authorities for directions or resources than towards the lower level to the population of the district involve themselves in the delivery of services. This is a contradiction in the process of the organisation of the Public Health Services System.

The routine repetitions of programmatic activities year after year without any checks and balances from the State level or the district level had led to the state of the services where only numbers shown on paper mattered and there was no cross-checking of these numbers for any programme’s performances either by the State for the district’s performances or by the district of the blocks.

b. Local Administrative and Political Linkages

The local political and administrative influences on the services occurred mainly through the various district level and peripheral level committees where the district’s general administration (the District Magistrate and the Block Development Officers) and the people’s representatives (the Zilla Parishad and the Panchayats) played significant roles.

**The District Magistrates (D.M.)** - The District Magistrate was the highest central government representative in the district. An IAS and from a general administrative background these officers with two to three years of postings in the district remained least aware of the local public health problems and programmes. During a span of three years from 1993 to 1995 for which the researcher kept track of the D.M.’s, office in Purulia there were three different district magistrates with different priorities and working patterns.

But, to all of them either the programme for population control or immunisation remained the most important and also the only ones of major concern. Since, these two programmes incorporate only preventive technologies and services, and were assessed by targets, these
general administrators could discuss about the 'target achievements' without getting into medical technicalities. The rest of the programmes being on diseases and cure-oriented, were better left to the medical officers. This district ranked second and third in 1990-91 and 1991-92 respectively, in the State for F.P. performance for which the D.M. of Purulia was sent by the Central Government on a foreign trip. No health service officer was similarly rewarded however.

The District Magistrate was also an important member of almost all district level health committees and in the meetings of these Committees, his priorities significantly influenced the decisions in favour of the programmes of Family Planning and Immunization. The District Magistrate is the district incharge of the ICDS programme also.

The Magistrate was invited to every district level review meeting held monthly. In these meetings all block level medical officers and supervisors were called by the district to review the programmes' performances for the previous month. These meetings were meant to be intradepartmental deliberations, yet the District Magistrate and the Zilla Parishad representatives, and sometimes even the Divisional Commissioner of the Family Welfare programme were specifically asked to attend. Their attendance "adds much needed credence" to these meetings the Dy.CMOH-III.

During the field work, this researcher observed in eight of the district level monthly review meetings. Two consecutive district magistrates could be watched attending these. The superior official status enjoyed by these general administrators was obvious in the meetings. Among the two magistrates observed, the first one gave prime importance to the Family Planning programme. He even formed a District Task Force Committee comprising of the health administrators and supervisory officers to supervise the achievements of this programme.

The second magistrate's emphasis was on the Immunization programme's achievements. In one meeting, he wanted to know the block level birth, death and infant mortality rates. None
of the blocks could provide any of these informations. The salience of the concern of the 'Collectors' for the programmes was that they only asked the quantitative achievements of the targets of these two programmes.

The target oriented and programme priorities of the DMs was well illustrated by an official letter found by the researcher. This letter dated 16.1.1991 from the D.M. to all block level officers and people's representatives viz., Sabhapatris, BDOs, BMOHs and CDPOs (ICDS) is quoted here:

In spite of our all out efforts the performance of sterilisation operations under Family Welfare Programmes are far from satisfactory. The target of sterilisation operations fixed for Purulia District is 19,000 (Nineteen thousand) for the year 1990-91. With hardly 2 months left for the close of this financial year, we have so far completed around 6000 operations. The situation has reached such a stage that the target cannot be achieved without your active involvement in this programme.

In the last meeting of Task Force on 15.1.1991 it has been decided that the Block Development Officers shall arrange at least 2 sterilisation camps with not less than 200 operations in the forthcoming "Sastha Mela" with the assistance of Gram Sevikas. Gram Sevikas in turn are being motivated and suitably instructed to arrange such camps by A.P.O. (Women Development).

Hence you are requested to arrange for two such camps in consultation with Sabhapati, Gram Panchayat Pradhans and Block Medical Officers of Health.

Each Panchayat Samity that achieves the target fixed for that Panchayat Samity is entitled for a colour TV set under IPP-IV Project.

I hope you could win the colour TV set for your Panchayat Samiti.

Sd/-
D.M. & Collector, Purulia

Along with the administrative bureaucracy, the local political body at the district also influenced the health services. The Zilla Parishad represented all the Panchayats in the district and was the highest political body in Purulia.

The Zilla Parishad (ZP) - In none of the monthly meetings mentioned above, the members of the ZP were present though they were invited. The People's representative body at the district level, headed by the Sabhadhipati and the Karmadhakshya (Health and Environment) of the ZP were the Chairman and the member secretary respectively of numerous
health committees in the district. On interviewing the Sabhadhipati, who was a member of the CPI(M), he said that it was the responsibility of the Karmadhakshya (Health) to supervise and represent the Zilla Parishad to the health services. For him, inadequate curative infrastructures and less than sanctioned number of personnels in position, were the major problems for the health services in the district.

The Karmadhakshya’s post, held by a lady member of the Forward Bloc was the representative of the ZP to look after the health problems of the population and the provision of health services to them. According to her, leprosy was the biggest public health problem of Purulia. On the role of the Panchayats in influencing the health services, her opinion was that these people’s representatives could and should be able to extract proper services from the field workers once they are under the Panchayat’s control.

She also mentioned that the technical aspects of the programmes and the curative services should be better left to the doctors. During her term, in the last two years, she had visited almost all the BPHCs in the district along with either the Dy. CMOH-III or the ACMOH (Med. and Admn.). Her opinion on the health administrators was favourable. Her lack of knowledge on the preventive programmes for the communicable diseases restricted her actions to get better services.

The panchayats and the Zilla Parishad, in the situation that existed in Purulia, could not influence or improve the services in a major way because their priorities and knowledge were only of curative services and the resources inputs. They could influence the community to demand for better preventive services only if there awareness for provision of integrated systematic prevention based health programme is raised. The required knowledge and activism for better health services with the Primary Health Care Approach were lacking in Purulia.
The influences of the local administrative and political authorities on the district’s public health services acted mainly through the various district health committees. These committees in Purulia were:

(i) **The Highpower Committee** - formed on the basis of the order of March 1992, from the Health Secretary of the Government of West Bengal, this Committee had to oversee the activities of the hospitals, BPHCs, PHCs, subcentres and other health institutions. The Committee required to meet at least once in a month. It was constituted after instances occurred where immediate intervention was required to ensure (i) smooth delivery of services and (ii) security of the health services staff. The Committee consisted of: Sabhadhipati of Zilla Parishad - chairman, District Magistrate - member, Suptdt. of Police - member, CMOH - member-convenor, Karmadhakshya - member, and one nominee of Minister incharge of Deptt. of Health and FW - member. On demand no records of meetings of this committee could be made available to the researcher. It was said that this committee sat together only on emergency situations and not regularly.

(ii) **District Level Monitoring Committee for Family Welfare and Public Health** - this committee existed hierarchically, at the subcentre, sector, block, subdivisional, and district levels. These committees at the different levels were formed for effective and successful implementation of the Health and Family Welfare Programmes. The aim was to start from the grassroots level, to mobilise all concerned on a common platform, for a concerted effort for the success of the programmes of Family Welfare, Immunisation, and Mother and Child Health.

The district level committee was to have a perspective plan for implementation of all the Health and Family Welfare programmes with special emphasis on the latter. These plans required to detail out goals to be achieved, the strategies to be adopted, and the activities and responsibilities of various departments and officials. The plans were also required to decide on
The specific time frames within which the activities have to be phased out and the mechanisms for continuous monitoring and feedback.

The permanent members of the Committee were: the Sabhadhipati, Zilla Parishad - chairman; Distt.Magistrate - member; Karmadhakshya, Janaswastha Sthayee Samiti - member-secretary; representative of the District Red Cross Society and Secretary of St.John’s Ambulance - members; two representatives of voluntary organisations (including one lady) predominant in the district (to be nominated by the Sabhadhipati in consultation with the Distt. Magistrate - members; three members to be nominated by the State Health and F.W Deptt. - members; and the CMOH - member secretary. Surprisingly and quite ominously there was no record of any meeting held by this committee. As gathered from the CMOH’s office, Purulia, this committee was not functioning in the district. During the discussions with the CMOH, the reasons given by him for not holding this Committee meetings were:

i) “difficulty in getting the District Magistrate, the Sabhadhipati, and other members together as they remain very busy”; and

ii) “so many committees and meetings are not necessary for the health services.”

To the researcher the reason for nonfunctioning of this most vital committee for an integrated health service system was that the prevailing power structure in the district did not enable the CMOH, who was the Secretary of the Committee to call the Distt. Magistrate or the Sabhadhipati for these meetings unless the latter took interest on their own.

Another factor could be that the centralised decision making authority controlled by the State did not allow the district health administrators to exercise their knowledge, authority and control over the processes of delivery of the health services in Purulia. It was apparent that the CMOH and Dy.CMOHs had least enthusiasm and initiatives to improve the functioning of the system.
(iii) **The Janasasthya Sthayee Samiti (JSS)** - This Samiti under the Zilla Parishad, had been constituted to give feedbacks from the community to the health service officials and also to make the health administrators and officers more accountable to the coverage population and their problems.

The members of the JSS were: Sabhadhipati, Zilla Parishad - chairman; District Magistrate - member; CMOH - member; Dy. CMOHs-I,-II &-III - members; local MLA - member; Executive Engineers of the PHE Deptt. - member; Sabhapatis of Panchayats - members; Secretary, Zilla Parishad - member secretary; and Karmadhakshya, Zilla Parishad - member convenor. The meetings of this Samiti were to be held monthly, but actually were held quarterly.

The minutes of the past JSS meetings were not allowed to be scrutinised, by the Sabhadhipati. However, this researcher was allowed to attend one meeting, as the CMOH's assistant, and scrutinising the records of the discussions of a previous meeting available with the CMOH some idea could be had as to the JSS's actual functions and priorities.

It came to the fore that this Samiti was mainly concerned with the curative services in Purulia. The main interests were on the presence of doctors and nurses in the PHCs and hospitals, the Panchayat members stressed on the absence of ANMs in the subcentres. The construction of subcentres and the construction of tubewells in rural areas were also discussed in the meetings.

The other topics discussed were the coordination between the panchayats and the health centres, availability of ambulances and other vehicles for transport of patients, diet of patients, and purchase of drugs under the decentralised scheme. In other words, the main interest of the JSS was the availability of institutional medical care services.

The atmosphere in the observed JSS meeting was more of a question-answer session where the CMOH and his associates gave explanations to queries raised. For the health officials
the ZP and its members were more of a threat, as the Dy. CMOH-III commented "the Zilla Parishad do not want health care for Purulia's people, they want us to start and participate in class struggles and peoples' movements". The concern of the JSS for the curative services at the District Hospital also, was in spite of the committee specifically for that purpose.

Table 4.2.1: Number of Meetings of Different District Level Committees of Health and Planning

<table>
<thead>
<tr>
<th>Committee</th>
<th>Number of meetings</th>
<th>Prescribed no. per year</th>
<th>Held in 1993</th>
<th>Held in 1994</th>
<th>Held in 1995</th>
<th>Average per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Highpower Committee</td>
<td>12</td>
<td>nil</td>
<td>nil</td>
<td>nil</td>
<td>nil</td>
<td>nil</td>
</tr>
<tr>
<td>2. The Monitoring Committee</td>
<td>12</td>
<td>nil</td>
<td>nil</td>
<td>nil</td>
<td>nil</td>
<td>nil</td>
</tr>
<tr>
<td>3. The Janasasthya Sthayee Samity</td>
<td>12</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>4.00</td>
<td></td>
</tr>
<tr>
<td>4. The District Hospital Committee</td>
<td>12</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4.33</td>
<td></td>
</tr>
<tr>
<td>5. The District Planning Committee</td>
<td></td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1.00</td>
</tr>
</tbody>
</table>

Source: CMOH's Office, District Planning Office, and Zilla Parishad, Purulia.

(ii) The District Hospital Committee - constituted by the Deptt. of Health and Family Welfare to look after the maintenance and functioning of the district hospital, this Committee had the following members: Chairman, Purulia Municipality - member chairman; CMOH - member; Subdivisional Officer (Sadar) - member; Asstt. Engineer (PWD) - member; Asstt. Engineer (PHE) - member; Karmadhakshya (Health and Environment), Zilla Parishad - member; two representatives of the Minister in charge (Health and Family Welfare) - members; and the Medical Superintendent, District Hospital - member convenor.

This Committee held the maximum number of meetings among all the district health committees (Table 4.2.1). The minutes of these meetings were also available and when
scrutinised, showed repetitions of the agenda every year, on the same problems as no progress
could be made even after many years, viz., X-ray machine repair, cleanliness of hospital,
medicine supply etc. In the light of this committee's frequency of meetings, its powerful
members, and its concern for improvement of functioning of the district hospital the following
extract from the audit report on the hospital is worth mentioning.

In the report of the Audit officer for the period 1.11.1990 to 31.7.1992, old unsettled
irregularities of the Distt. Hospital in Purulia were also highlighted. The major ones among
those mentioned since 1.7.85 included irregularities such as (i) excess expenditures of
Rs.20,000 beyond the approved rate of diet, (ii) board for disposal of condemned and
unserviceable stores not formed, (iii) staff retained after closure of nurses training school at the
district hospital - avoidable expenditure of Rs.1,51,700, (iv) medicines not utilised in time,
damaged - write off order not obtained and damaged medicines lying in stock, (v) non-
conducting of physical verification of stores, (vi) repairable articles yet to be repaired and put
to use, (vii) expenditure of Rs.2,77,379 incurred towards vehicles unaccounted for, (viii) two
X-ray machines procured before 1956 lying unutilised since, and irregularities regarding
maintenance of records on X-ray films, and (ix) non-maintenance of records regarding the
amount realised by issue of injury certificates, post-mortem reports, medical fitness certificates,
physically handicapped certificates etc. and the accounts credited to the government account.

Also, as was observed by the researcher, there was no maintenance of records of the inpatients
admitted or outpatients treated by the Medical Supdt.'s office.

(v) District Planning Committee (DPC) - Other than the specific health committees at the
district, the DPC was also important for the health services. This Committee constituted to
prepare an integrated plan of the district every year, needed to incorporate a bottom up
approach. Like the various hierarchical levels of the Monitoring committee for Health and
Family Welfare, there is the Block Planning Committees (BPC) where all the welfare sectors
have to submit the respective plans and estimates of funds required for the coming year. These had to be compiled and submitted to the district committee which compiles the block plans and prepares the annual plan for the whole district. The DPC then compiles the plan reports of all departments and finalises the final District Annual Plan and sends it to the State Planning Board. However, this process did not take place in reality and planning was a routine affair confined to the district level. Yearly plans were decided at the district level without much contributions from the blocks or the different departments for the district’s development and welfare.

No account of actual flow of fund to the district or expenditures finally incurred was incorporated in the plan documents. This made it difficult to examine the capability of the districts in the implementation of the plans. This routine formality continued year after year, thus reducing the role of the DPC to a vestigial body.

The Members of the DPC were: Sabhadhipati, Zilla Parishad - member chairman; District Magistrate - member convenor; District Planning Officer - member; representative of State Planning Board - member; CMOH - member; other departmental heads of the district - members; Chairmen of Block Planning Committees - members.

This committee met once every year to alter and finalise the Block Plan reports. A review of minutes of the meetings of the DPC showed that among sector allocations, minor irrigation, SC/ST welfare programmes, education, cottage and small scale industries etc. were given higher priorities than Health and Family Welfare. This trend continued year after year irrespective of the changes in the constitution of the committee’s individual members or even with changing magnitude of health problems.

The number of meetings held, of the various district level health committees were much less than the prescribed number as shown in Table 4.2.3. Two of the most vital committees for an integrated and efficient health services, the Highpower and the Monitoring Committees were non-functional. The various political and administrative members, as well as the departmental
representatives did not find time nor did they consider it important to hold the committee meetings regularly and meaningfully.

There were too many committees also, according to the district authorities. Since, many functions and responsibilities were repeated for different committees and the members were also the same, less number of committees or may be even a single committee for Health and Family Welfare at the district would be more prudent.

This apathetic situation of the existing district level committees percolated down to the block, sector, and village level health committees also. In the two selected Block PHCs, none of the coordinating committee meetings were held regularly. The interests of the Block Development Office and the Panchayats, in the health services and programmes, were feeble. Concern for curative services was shown by these institutions but the preventive services and programmes received least importance.

To sum up, the influences of this category of external linkages therefore, was that the priorities of the state the district general administration, and the Zilla Parishad and the Panchayats, remained conflicting by being essentially and selectively focussed on either the curative services or the Family Planning and Immunisation programmes.

It was obvious that the State Health Organisation and the Zilla Parishad had curative care as their top priority, whereas, the Central Government's representatives, the Distt. Magistrates, were all for the Family Planning and Immunisation programmes.

Wholistic perceptions, concepts, and planning for health were missing and instead piece-meal, short term strategies and objectives were being chased, that too not in unison. Different ideological and technical backgrounds of the committee members coupled with their different priorities, motives, and interests all contributed to the situation of confusion and complacency, in Purulia.
It is a different matter however that most of the crucial committees which could play a major constructive role simply did not function as envisaged. After the direct linkages we shall now briefly discuss the indirect linkages of the external type.

(c) Community Participation

Community participation is the final external linkage discussed by us. Participation of the people is an essential component of the Primary Health Care approach\(^3\) that has been adopted for health service delivery in the National Health Policy of 1983.\(^4\) There are alternative interpretations about the role of community participation but for our analysis, we see this participation as an instrument for increasing the efficiency of the service delivery system.\(^5\) Such participation did occur in the existing "Provider - Consumer model" of the health services in Purulia, through: (i) the demand for curative services made mainly by the diseased people, and (ii) by the peoples' representatives viz., the ZP and the Panchayats, as discussed earlier. The demand for and involvement in the preventive service programmes, however, was rudimentary and required significant promotions. The instances of any involvement of the community leadership in the programmes were:

(i) The local panchayat on repeated requests by the BMOH of Kolloli BPHC cooperated with the health personnel to educate and mobilise the population for prevention and treatment of attacks of acute diarrhoea during the seasonal outbreaks.

(ii) The panchayats selected and employed the insecticide spray gangs locally, every year, and also decided on the number of spray rounds and the villages to be sprayed. This

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severely undermined the spraying component of the Malaria Programme as villages with higher API also remained unsprayed. Though, the number of villages to be sprayed was fixed by the district but, the names of the villages to undergo spraying were decided locally at the block levels, and mostly by the local leaders on their preferences.

(iii) The Sabhapati of Balarampur Panchyat sent messages to the BMOH of Bansgarh BPHC in cases of any of his family members falling sick. During the researchers stay at this BPHC, the Sabhapati's wife was pregnant and for the slightest problems with her health the BMOH was called to attend her at their residence. The BMOH had to comply at times neglecting his official duties for the fear of troubles that could be caused by the politician.

(iv) On one occasion during the field work, when there was no doctor available for two days at the Kotshila BPHC due to administrative lapses, the people of that block took to road blockade and agitation so that immediate action was taken by the district authorities to provide the BPHC with at least one doctor. As a result the CMOH along with the ACMOH (Admin.) had to rush to Kotshila to treat the outpatients and attend to the inpatients. The medical officer at the nearby new PHC was deputed at the BPHC as an emergency measure till one of the doctors posted at the BPHC returned from the unauthorised leave.

(v) Since early 1995, some of the leading Bengali and English news-dailies posted their reporters in Purulia. This was an effect of the major diarrhoea epidemic that struck Purulia in 1994. So, news on the health problems and services in Purulia had started appearing frequently in these newspapers. People in Purulia got these informations via the print media and their awareness affected the health officials and institutions. Such mass media campaign had made the district health administrators more accountable and responsible.

It is notable that the above instances of involvement of the community at large in the demand for better health services were mostly for curative medical services. Apparently, the felt need for preventive services was not asserted. As observed at the BPHCs and on the
visits to the subcentres, among the programme services, demand was on the rise for vaccinations.

Table-4.2.2: Awareness, Dissatisfaction, and problems faced by users of the Public Health Services in the Four IPP-IV Districts Including Purulia (Figures in percentages)

<table>
<thead>
<tr>
<th>I. Awareness of Services Available</th>
<th>1988</th>
<th>1993</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Immunisation</td>
<td>62</td>
<td>79</td>
</tr>
<tr>
<td>b) ANC</td>
<td>45</td>
<td>80</td>
</tr>
<tr>
<td>c) Family Planning</td>
<td>45</td>
<td>76</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. Dissatisfaction with Services</th>
<th>1988</th>
<th>1993</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Treatment for the sick</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>b) ANC</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>c) Immunisation</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III. Problems Faced by Users</th>
<th>1988</th>
<th>1993</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) No problem</td>
<td>82</td>
<td>71</td>
</tr>
<tr>
<td>b) Problems</td>
<td>18</td>
<td>29</td>
</tr>
<tr>
<td>i) Infrastructure related</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>ii) Service related</td>
<td>8</td>
<td>22</td>
</tr>
</tbody>
</table>


The Endline Survey report of the IPP-IV, showed that 96 percent of the population of the four project districts including Purulia had correct knowledge about the location of the nearest health centre (Table 4.2.2). However, the awareness of services available at the health centres was not equally high. Over the years the level of dissatisfaction and the problems faced by those who used the health services have been on the increase, probably due to the fact that with the passing of time, as more people were using the service facilities but, the services have not grown at the same pace, particularly in their efficiency (Table 4.2.2). It is noteworthy that problems faced were related more to the service components than related to the infrastructure of the public health services

d) Intersectoral Coordination

In this subsection we take up four such sectors or departments which apparently co-ordinated with the department of Health and Family Welfare in Purulia. These four departments
were the ICDS, the Public Health Engineering (PHE), and the departments of Forestry and Education.

(i) **The ICDS Project** - A Central government’s scheme under the Ministry of Social Welfare, the District Magistrate is the overall incharge of the ICDS in the district. Thus, the activities of this scheme were strongly influenced by the magistrates. In the district level and block level review meetings, there was a significant amount of coordination of the Deptt. of Health and Family Welfare with the ICDS. But, the bulk of this coordination remained confined to the achievement of targets of Family Planning and Immunization.

The District Project Officer (DPO) was a block officer (CDPO) acting as the DPO. He and the Community Development Project Officers (CDPO), the ICDS supervisors and the Anganwadi workers, were involved at their respective levels in cooperating with the health personnels to achieve the targets for the two programmes. In doing so there was always some conflict as to who should get the motivators incentive money for sterilization targets.

A joint orientation training programme of the Anganwadi workers and ICDS supervisors and the ANMs and female Health Supervisors was introduced in 1989 by the Central Ministry of Health and Family Welfare. It was desired that the organisation of these training programmes will be planned, monitored, and followed up in a systematic manner in coordination with the officers of ICDS, Rural Development Department and the Department of Health and Family Welfare of the different levels from the State to the PHCs. Such a system of coordinated training on a regular basis was not in existence at the district. Such trainings took place irregularly. Some orientation trainings were conducted in the years 1990-91, 1991-92, and 1992-93 with only medical officers as the trainees, as we will show in Chapter VI, in the section on Training. None of the multipurpose personnels were given such joint orientation trainings.

The health officials were to be assigned the responsibilities of advisors of the project. The district level health administrators as the district advisors, BMOHs as block advisors, and
MOs of PHCs as sector advisors. But, such designations and job responsibilities had not been assigned by the CMOH till the middle of 1995. It was decided in the district review meeting of June 1995 that coordination between the two departments has to be improved.

But, the conflict as to who will do health check ups and who will do the reporting among Health and ICDS staff could not be resolved. The coordination therefore, was limited and unidirectional in nature and hampered ICDS activities such as health checkups, nutrition assessment and health education where the health personnels should be equally involved.

(ii) The Public Health Engineering (PHE) department - There was not much of coordination between the departments of the PHE and the Health and Family Welfare, in Purulia. The existing scenario was such that the PHE worked independently, and the health department did not consider the supply of potable water to be its responsibility. The two department’s representatives met in the Janaswasthya Shayee Samity’s meetings. Mostly the Asstt. Engineer (Rural Water Supply) represented the Executive Engineer in these meetings.

But, in the meeting observed by the researcher, both the Executive Engineers (Civil and Mechanical) had attended. They, however, did not interact with the CMOH in the meeting. The decisions on sites for construction of new tubewells and for repair of defunct tubewells were taken by the BDOs in consultation with the Panchayats and the sub Assistant Engineers of the PHE posted at the blocks.

In this meeting the engineers demanded that the PHE should be allowed to take its own decisions on boring sites and not to be forced by the Panchayats to make repeated attempts at the failed (dry) sites. It was also decided in the meeting that the health workers (MPWs) will provide the PHE with their respective village-wise count of tubewells roughly, 61,000 tubewells were in the district. Yet, there was no decisive role of the health department in ensuring the supply of safe drinking water to the population, even to those affected by seasonal diarrhoeal epidemics repeatedly, year after year.
(iii) **The Department of Forests** - According to a government order of 31.12.1992 inter-departmental collaboration between the Forest department and the Health and Family Welfare department was launched as a pilot project in Purulia. For this project, state level, district level, and block level committees were constituted to set collaborative programmes in motion.

The District Level Committee consisted of: the District Magistrate, Karmadhakshya, Ban-o-Bhumi Sanskar Sthayee Samiti, Karmadhakshya, JSS: the CMOH, Dy. CMOH-III, Dy. DIEMO (one), one NGO selected by the Health and Family Welfare Department, and the Divisional Forest Officer concerned - convenor. The terms of reference for this committee were:

i) Exchange of information regarding calendar of Health Programmes and list of villages with receptive Forest Protection Committees.

ii) Deciding about holding of special camps for sanitation, nutrition, MCH, Family Planning, etc. in selected locations.

iii) Quarterly review and monitoring of implementation of the agreed programmes.

iv) Selection of competent NGO(s) for different blocks.

Meetings of the Committee were to be convened once in 3 months. During the field work one such meeting was held and in this the various forest department officers and staff were initiated into the procedures and techniques of the Family Planning, Immunisation, Diarrhoea control and Malaria Control Programmes. Interest was shown by the Forestry personnels only for the methods of contraception. Here again there was hardly any effective intersectoral coordination, that improved the working of the health services.

(ii) **The Education Department**

In the spate of the Total Literacy Campaign, the education department along with other political and administrative bodies in Purulia had become very active during 1993 to 1995. The collaboration of the Health and Family Welfare department was also sought. The difference in
this case was that the personnels of the health department were being involved to propagate the literacy campaign.

In the years 1993-1995 when this campaign was in full swing, there were meetings every month where the District Magistrate, the Sabhadhipati, the CMOH, the District Education Officer and other departmental representatives sat together to review, monitor, and plan future actions to make the population of the district fully literate. The health officials were of the opinion that this mission will help their cause indirectly in the sense that a "literate population" should be "more health and hygiene conscious". Such a population was also expected to be more aware of the health services and the possibilities of their participation in it.

These observations were indicative of three things. One, that there was hardly any effective intersectoral coordination, but for the targets of Family Planning and Immunisation. Two, that wherever some efforts were made to strengthen intersectoral activity, within the health services, the initiative always came with the view to strengthen the Family Planning Programme. Three, that areas such as water supply, housing, public distribution system, and education were not used to strengthen basic health care.

These external linkages influence the system as discussed and, also separately influence the internal linkages between the subsystems through the interface.

4.3 INTERFACE OR BOUNDARY OF THE SYSTEM (BETWEEN THE EXTERNAL AND THE INTERNAL LINKAGES)

The effects of the direct and indirect external linkages on the system are reflected in the work ethos of the individual actors of the system and also the overall work culture of the organisation. As discussed in Chapter II, this work culture of the health services in the district forms its organizational boundary also. We have categorised it as the interface between the

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external and internal linkages. This aspect of the linkages was assessed by the perceptions of the key personnels on the goals and objectives of the District Health Service System (DHSS), its major functions and the level of efficiency of the system that is acceptable to its administrators. We begin with the discussion on the goals of the system.

Since the goals of a system are of various denominations, as the reviewed literature pointed out in Chapter I, we decided to question the personnels on their perceptions about the goals of the health services system of the district. The goals were broadly divided into seven headings as enlisted in Table 4.3.1. The different headings had some overlap over one another as the system was a complex and dynamic whole, with continuously interacting parts. The responses, gave an understanding on the perceptions of the personnels regarding their attitude towards the services.

Table 4.3.1: Perceptions of Personnels on the Goals of the district health services system (Number of respondents in percentages)

<table>
<thead>
<tr>
<th>Major Goals</th>
<th>Respondents (In percentage)</th>
<th>S.H.A. (n=2)</th>
<th>D.H.A. (n=8)</th>
<th>D.S. (n=8)</th>
<th>B.D. (n=10)</th>
<th>B.S. (n=23)</th>
<th>Average (n=51)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medical Care</td>
<td>100</td>
<td>100</td>
<td>88</td>
<td>90</td>
<td>48</td>
<td>70.5</td>
<td></td>
</tr>
<tr>
<td>2. Prevention</td>
<td>100</td>
<td>100</td>
<td>75</td>
<td>100</td>
<td>61.75</td>
<td>82.0</td>
<td></td>
</tr>
<tr>
<td>3. Community Welfare</td>
<td>100</td>
<td>37.5</td>
<td>50</td>
<td>30</td>
<td>22</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>4. Health Education</td>
<td>50</td>
<td>25</td>
<td>37.5</td>
<td>30</td>
<td>52</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>5. Vital Statistics</td>
<td>50</td>
<td>12.5</td>
<td>37.5</td>
<td>40</td>
<td>35</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>6. Infrastructure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development</td>
<td></td>
<td>12.5</td>
<td>25</td>
<td>20</td>
<td>39</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>7. Professional Growth</td>
<td></td>
<td>25</td>
<td>62.5</td>
<td>60</td>
<td>61</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>of Personnel</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Interviews.

Most of the respondents perceived medical care as the most important goal, though more respondents (82 percent) opined that prevention was a major goal of the services but not the most important (Table 4.3.1). The non-medical goals of community welfare (33 percent), health
education (41 percent), vital statistics (33 percent) and infrastructure development (27 percent) all received much less priorities.

The goal of professional growth of personnels was highlighted by more than half of the district level supervisors, block medical officers and block level supervisors. Other goals, not shown in Table 4.3.1, were of environmental sanitation and social change, were mentioned by four block supervisors. Overall, however, medical care was given more importance at the district level while prevention (particularly the programme of family planning and immunization) was more important for the block level respondents. It is to be noted, that both the state administrators did not consider infrastructure development and growth of the careers of the personnels as important goals of the district health services and only two of the district administrators (25 percent) thought the latter to be a goal of the services (Table 4.3.1).

Nevertheless, these goals were not only overlapping, but also, the priority ranks of the activities was not clear from the above information. So, we questioned the health personnels on their prioritisations of the different activities of the district health services. The responses when tabulated and analysed showed the following viewpoints (Table 4.3.2).

**Table 4.3.2: Priorities in ranks of Different Activities of the District health services, as per Responses of Personnels**

<table>
<thead>
<tr>
<th>Service Activity</th>
<th>S.H.A</th>
<th>D.H.A</th>
<th>D.S.</th>
<th>B.D.</th>
<th>B.S.</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Curative work</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td>2. Immunisation &amp; MCH</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>3. Family Planning</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>4. Malaria</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>5. Tuberculosis</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3.6</td>
</tr>
<tr>
<td>6. Leprosy</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>2.6</td>
</tr>
<tr>
<td>7. Seasonal Diarrhoea</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>8. Environmental sanitation</td>
<td>5</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>6</td>
<td>6.2</td>
</tr>
<tr>
<td>9. Health Education</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>4.6</td>
</tr>
<tr>
<td>10. Vital Statistics</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Source: Interviews.
The difficulty faced during analysis was that none of the respondents could definitely prioritise the activities of the total district public health services, one by one. Thus, the first priority of most interviewees was three or four activities at the same time. Moreover, different members of each category of personnels did not always have similar priorities. We analysed the data by finding the frequency of each of the different priorities, according to the category of personnels and the most common priority in a group determined the response for that whole category of personnels. All the rankings for a single activity by each group members were averaged and the final average has been used to determine the overall prioritisation of the activity for the district, by the personnel of the services (Table 4.3.2).

We had also put the different selected programmes as separate activities. From our analysis using the Rank-order method (Table 4.3.2), curative work got the top ranking (1.0), family planning next (1.2), MCH services third (1.4), and seasonal diarrhoea fourth (1.6). A point to be noted here is that during the diarrhoea season, when there were outbreaks of acute diarrhoea in different pockets of the district, all public health personnel of the district were involved with diarrhoea control work. But, none of the personnels of the District Family Welfare Bureau were involved in this activity.

Among the programmes for malaria, leprosy and tuberculosis, leprosy got the first priority (2.6) and overall fifth among the ten activities. This was probably due to the fact that leprosy has been highly endemic in Purulia. Next came the malaria and tuberculosis programmes. The important activities of vital statistics and health education got eighth and ninth ranks. Environmental sanitation had the least priority (Table 4.3.2).

One obvious point to be noted here is the fact that there was not much variation in the ranks given to the activities across the different levels of the personnels. There were however, two interesting contrasts. Though the SHA and DHA ranked malaria as third and fourth and
seasonal diarrhoea as second and third priorities respectively, the field level workers saw them as higher priorities.

It was observed by the researcher that the personnels involved with a particular programme tended to give it a higher priority. For example, for the Assistant Malaria Officer the anti-malaria programme had top most priority among all the activities, barring curative work. Another reason for the difference could be the direct contact of field level workers with the people as compared to the district officials. In general, after curative work, family planning and MCH programmes respectively, were given the highest priorities by the majority of the personnels.

Since the nerve centre of the health service system in Purulia was the district health administration, we looked into this subsystem’s activities in more detail. Thus, discussions and interviews were held on this component also, during the field work.

Table 4.3.3: Profile of Opinions of Personnels on Functions of the District Health Administration (Percentage of Respondents)

<table>
<thead>
<tr>
<th>Critical Functions</th>
<th>S.H.A. (n=2)</th>
<th>D.H.A. (n=8)</th>
<th>D.S. (n=8)</th>
<th>B.D. (n=10)</th>
<th>B.S. (n=23)</th>
<th>Average (n=51)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning</td>
<td>100</td>
<td>75</td>
<td>50</td>
<td>80</td>
<td>69.5</td>
<td>70.5</td>
</tr>
<tr>
<td>2. Procurement and distribution of Technology</td>
<td>100</td>
<td>87.5</td>
<td>75</td>
<td>90</td>
<td>91</td>
<td>88</td>
</tr>
<tr>
<td>Personnel Administration</td>
<td>50</td>
<td>75</td>
<td>50</td>
<td>70</td>
<td>48</td>
<td>56.8</td>
</tr>
<tr>
<td>Training</td>
<td>100</td>
<td>62.5</td>
<td>75</td>
<td>50</td>
<td>69.5</td>
<td>66.7</td>
</tr>
<tr>
<td>Supervision</td>
<td>100</td>
<td>87.5</td>
<td>75</td>
<td>100</td>
<td>87</td>
<td>92</td>
</tr>
<tr>
<td>6 Intersectoral coordination</td>
<td>50</td>
<td>50</td>
<td>37.5</td>
<td>70</td>
<td>39</td>
<td>49</td>
</tr>
<tr>
<td>Integration of services</td>
<td>100</td>
<td>62.5</td>
<td>50</td>
<td>60</td>
<td>26</td>
<td>47</td>
</tr>
<tr>
<td>Disease Surveillance</td>
<td>100</td>
<td>100</td>
<td>87.5</td>
<td>90</td>
<td>61</td>
<td>78.4</td>
</tr>
<tr>
<td>9 Feedback to State</td>
<td>100</td>
<td>37.5</td>
<td>62.5</td>
<td>50</td>
<td>30</td>
<td>43</td>
</tr>
</tbody>
</table>

Source: Interviews.

The opinions of the personnels on the important functions of the district health administration, have been grouped categorywise and tabulated as in Table 4.3.3. Then, we
found out the average of all the opinions of all categories of personnel, on each function and, calculated the overall ranking of that function (column 7 of Table 4.3.3).

Other than personnel administration and intersectoral coordination, all the other functions were thought to be important for the district, by both the state administrators. One of them the ADHS (Admn.) agreed that the role of the district in personnel transfer and posting and disciplining was minimal as, mostly it was controlled by the state. He also said that the function of intersectoral coordination, presently, lacked the significance it deserved from the district administrators. However, he emphasised that both should be major functions of the district (column 2, Table 4.3.3).

Disease surveillance was singled out by all district administrators as an important but neglected function. Technology management and Supervision, each with 87.5 percent responses were also ranked highly. The functions of Planning and Personnel Administration received 75 percent support, rank ahead of Training and Integration of services (with 62.5 percent each). The role of the district health administration in Inter-sectoral Coordination received a low response of 50 percent and the least prioritised function was that of Feedback to the State from the district (37.5 percent). Only three administrators out of eight found it to be a function (column 3 of Table 4.3.3).

For the district level supervisory officers, again Disease Surveillance was considered an important function by most (seven out of eight respondents) and management of technology, Supervision of peripheral workers, and Training of personnel were mentioned by 75 percent (i.e., six out of eight respondents). As seen from column 4 of Table 4.3.3, while Feedback to state got more points, the functions of Planning, Personnel Administration and Integration of services received 50 percent support of the respondents. The least number of responses was for the function of Intersectoral Coordination (37.5 percent).
In the case of the block Medical Officers, Supervision from the district was felt by all to be the most important (100 percent), next important were Disease, Surveillance and Technology management, both with 90 percent of (column 5, Table 4.3.3). Planning got more support from this group than the previous, with a score of 80 percent followed by Personnel Administration, Intersectoral Coordination, and Integration of services with 70 percent, 70 percent, and 60 percent responses respectively. Training and Feedback to State were the lowest ranking functions of the district health administration, according to this group.

The lowest level of personnels interviewed, that of the block level supervisors felt Technology management and Supervision as the two most significant functions of the district administration. Next were Planning and Training (column 6, Table 4.3.3) and then came Disease Surveillance with 61 percent of their support. The functions of Personnel Administration, Intersectoral Coordination, Feedback to State, and Integration of services all were mentioned by less than fifty percent of these supervisors and among these the last two functions had the lowest scores of 30 percent and 26 percent respectively.

From the different groupwise priorities, the overall average was calculated. Supervision received maximum rating of 98 percent, then Technology Management (88 percent) followed by Disease Surveillance (78.4 percent) and Planning with 70.5 percent of the responses.

Table 4.3.4: Ranking of the Identified Critical Functions of the District Health Administration, by the Health Personnels

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Function</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Supervision</td>
<td>1</td>
</tr>
<tr>
<td>2.</td>
<td>Procurement and distribution of Technology</td>
<td>2</td>
</tr>
<tr>
<td>3.</td>
<td>Disease Surveillance</td>
<td>3</td>
</tr>
<tr>
<td>4.</td>
<td>Planning</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td>Training</td>
<td>5</td>
</tr>
<tr>
<td>5.</td>
<td>Personnel Administration</td>
<td>6</td>
</tr>
<tr>
<td>6.</td>
<td>Intersectoral coordination</td>
<td>7</td>
</tr>
<tr>
<td>7.</td>
<td>Integration of services</td>
<td>8</td>
</tr>
<tr>
<td>9.</td>
<td>Feedback to State</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: Interviews.
The rest of the functions could be ranked in this order. Training followed by Personnel Administration, then Intersectoral Coordination and Integration of Services and last Feedback to State (column 7, Table 4.3.3). Thus, the overall ranking of the functions of the district administration were as shown in Table 4.3.4.

'Planning' and 'Disease Surveillance' should get topmost priorities both individually, and as complementary to each other but did not get the desired attention. There was no 'Planning' whatsoever, at the district level of the health services and it was largely a State activity.

The discussions on the external linkages in reality and influences of these on the perceptions of the personnel of the health services signify the distortions in the existing system. The distorted prioritisations and linkages are at the same time, both cause and effect of one another. As a result, as discussed earlier, the system proceeds on the premises of strong emphases upon curative, centralised, technical, doctor centred services with neglect of a planned, integrated services with constructive intersectoral coordinations. We will move onto the internal linkages in the next chapter.