CHAPTER IX
DISCUSSION AND CONCLUSIONS

Drawing from the main findings of our study, we focus our discussion on (i) the most important distortions of the Health Service System, (ii) the key linkages underlying these distortions and the anomalies within them, and (iii) on the basis of these, we suggest some steps for systemic intervention which in our view will help improve the efficiency of the Public Health Services, not only in Purulia but in other districts as well.

9.1 MAJOR DISTORTIONS IN THE DISTRICT HEALTH SERVICES SYSTEM (DHSS)

We briefly present the major contortions of the DHSS as they emerge from our data.

Emphasis on Curative Services

Historically, the priority for curative services which started in Purulia in the 1920s, continued overtime without an equal emphasis for the public health services. Today, that emphasis for hospital care continues as was noted from the distribution of personnels viz., medical officers and paramedical staff.

While the urban hospitals at the district and at Raghunathpur municipality had on an average 111 percent of the sanctioned strength of medical officers, the block PHCs had only 83 percent of posts of medical officers filled. Similarly, paramedical personnel in the two urban hospitals were 86.3 percent of the sanctioned numbers as compared to only 44.2 percent posts of multipurpose personnels at the block PHCs filled.

Poor Referral Services

Our data on Leprosy, Tuberculosis and Malaria eradication and control programmes show little participation of the district hospital in the Communicable Disease Control (CDC) programmes. This and the dominance of hospitals conform to Qadeer’s analysis of the existence of two types of sub-systems simultaneously - one, of "the ill-equipped PHC network for the rural
areas which is starved of resources" and the other is "the better equipped hospital network in urban areas which continue to get the lion's share of the total resources". The hospitals got priority as well as escaped responsibility for the programmes. This resulted in one of the major reasons of the non-existence of a referral system for the Health and Family Welfare Programmes.

**Verticalisation of Programmes**

The selective approach to programmes starts right at the top, from the budgetary outlays of (i) the Central Government, and (ii) the hospitals and dispensaries, mostly in urban areas constitute the single largest category of health care spending by the State with the Family Planning Programme next and the national disease control programmes the third large category of State expenditure. Such spending patterns not only maintained the curative-preventive divide but also supported the relative verticalisation of the programmes.

The Dy.CMOH-III was separately incharge of the Family Welfare Programmes, comprising of the Family Planning and Child Survival and Safe Motherhood programmes, even though these programmes were a part of the integrated cluster of Multipurpose Health programmes. The Zonal Leprosy Officer headed the Vertical Leprosy Eradication Programme in Purulia. Thus, Tershen's contention of the practice of biomedical organisation around single diseases or interventions was evident.

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Even the Family Welfare Programmes' integration left much to be desired and got separated below the Dy.CMOH-III as the Distt. Immunisation Officer was incharge of the Immunisation programme and the Distt. Public Health Nursing Officer looked after the Maternal and Child Health services.

Such a discriminative approach was augmented further in Purulia, when the substantial inputs of the World Bank funded India Population Project-IV, in terms of institutional and manpower development, and facilitation of resources for transport (vehicles), training (programmes) and reporting (MIES) were pumped in for the improvement of only the Family Planning and Mother and Child Health Programmes in the district.

This selective focus on only two programmes enhanced the verticality of the programmes as it influenced the distinctive prioritisations among the programmes even further. Other instances of international donor agencies propagating verticality of programmes as witnessed in Purulia were, the UNICEF for the CSSM programme and the SIDA for the Leprosy programme.

These differential financial supports by the international donor agencies have been blamed for imposing the decision on the recipient countries of categorizing vertical services into programmes.

**Inadequate Integration**

The Public Health Programmes of Malaria, Diarrhoea and Tuberculosis were under the Dy.CMOH-II. The Tuberculosis programme was further separated from the other two disease programmes under the Dy.CMOH-II, as it was under another programme officer of the rank of the Asstt.CMOH who had been designated as the District Tuberculosis Officer.

The Diarrhoea programme was yet another example of inadequate integration. Decentralised to the blocks it was left by the district, to the block Medical Officers till there was

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an epidemic. Another crucial link which was missing among the programmes, was that between the CSSM programme and the general health problems of women, particularly due to the communicable diseases.  

**Low Levels of Efficiency**

**The F.P. Programme** - Achievements of this programme were: sterilisation - 75 percent of the target on an average (70 percent had 3 or more children already and 30 percent were less than 35 years of age), IUD, CC and OP had achievement rates of 80 percent, 60 percent and 55 percent respectively. Purulia had a contraceptive prevalence rate (CPR) of 42 percent in 1994-95.

**The Immunisation Programme** - Total vaccination coverage of children was not emphasised, only targets for individual vaccines were achieved. Potency tests of the vaccines to check on the cold chain system, were not being done systematically. Only 50.7 percent of children in the district were fully immunised and 17.3 percent not immunised at all, in the year 1993-94.

Among the deliveries conducted, which were merely 60 percent of the already less number of ANCs registered, 60 percent were conducted by trained Dais, 30 percent were conducted in health centres, and the rest 10 percent were conducted by untrained dais, every year.

**The Malaria Eradication Programme** - On the whole, the coverage of the insecticide spray operation had been around 60 percent of the given targets. The blood smear slide collections averaged at 50 percent of the minimum yearly target of 10 percent of the total population.

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6 Model Registration Data of 1992 showed that among all women deaths in India, only 2 percent were due to pregnancy, 15 percent were due to reproductive health problems and more than 30 percent were due to communicable diseases affecting girls and women.

The number of detected cases given Radical Treatment were 72 percent in 1990, 36.5 in 1991, 75.7 in 1992, 86.5 in 1993 and 45 percent in 1994. Therefore, overall efficiency of the malaria programme had further reduced from the 50 percent mark (of blood smear collections and examinations) to around 30 percent due to the short-falls in treatment.

The Diarrhoeal Diseases Control Programme - Diarrhoeal epidemic outbreaks occurred every year in the district and lasted in different parts for periods of seven to eight months. The death rates for every 100 population, due to diarrhoeal diseases were 2.18, 2.10, 6.25, 1.76 and 2.47 for the years 1990, 1991, 1992, 1993 and 1994 respectively.

The District Tuberculosis Programme - Sputum examination rates were around 28 percent of the annual target, treatment induction of the few detected cases was around 60 percent and treatment completion rates were 30 percent of the latter. Overall the efficiency of this programme in Purulia came to as low as 5 to 10 percent only. All these shortcomings resulted in almost negligible low outputs of the TB programme's services in the district.

The Vertical National Leprosy Eradication Programme: At the basic performance achievements level, the rate of case detection every year was less than 50 percent of the estimated case load, the treatment completion rates of the above detected cases were just more than 80 percent. Overall, therefore, the efficiency of this programme's services, despite its verticality in infrastructure and activities, was not more than 40 to 45 percent of the expected achievements.

9.2 ANOMALOUS LINKAGES

We discuss here the anomalies of the external and internal linkages which led to the distortions within the District Public Health Services System.

(i) The External Linkages:

(a) The Influences of the State - The control of the State over the district's public health services was not only very strong but also debilitating. All strategic and operational planning
was done at the State level and directions were sent to the district to follow, without due consideration for the district's needs.

Even most of the day to day decisions on programmatic services and delivery tactics were communicated by the respective Deputy or Additional Directors at the State Directorate to the programme officers at the district, directly and also through the CMOH. As mentioned in Chapter IV, such dual communications led to role confusion and conflict among the district officers.

Decisions on strategies for the Health and Family Welfare programmes were in fact mostly taken at the Centre. The Centre also funded most of the national programmes in the form of grants to the State. Thus, as far as strategies and to a large extent supplies for the national programmes were concerned, the Centre played a vital role. Both, through the State and also directly vis-a-vis the district. This situation persisted though Health is a State subject and the primary responsibility of providing health care is with the State Government.

The relative priorities among programmes were also set by the State on the basis of the Centre's directives. The topmost prioritisation in favour of the Family Planning and Immunisation programme's target achievements pervaded the district's entire set up. In Purulia, along with these two programmes, the vertical Leprosy programme was also closely monitored by the State's consultant to the district.

The other disease-programmes of Malaria and Tuberculosis and to a lesser extent Diarrhoeal Diseases suffered from low priority and neglect from the State in terms of inputs, monitoring and supervision. The low importance given to these programmes was starkly evident in Purulia, for example, the crucial post of Dy.CMOH-II incharge of the above Public Health Programmes was lying vacant since 1993 till the end of 1995.
There have been suggestions from the State's Committee on the desirable changes in the form of Central assistance given in a lump for all the different National programmes\(^8\) and on the formulation of a State Health Policy as a more appropriate measure over the National Health Policy, applied to the health problems of this State.\(^9\) These issues of health, form only a part of the overall conflicts in Centre-State relations and urgent steps to resolve these are becoming more significant and imminent with time.\(^{10}\)

(b) **Effects of the District Magistrate, Zilla Parishad and Panchayats, and the Local Population**

The District Magistrate - this administrative post is the most central figure in the district in terms of authority and influence over almost all district-level activities.\(^{11}\) Consequently, the District Magistrate's influence over the public health services is also substantial.

As mentioned in Chapter IV, two successive District Magistrates in Purulia were observed to give overriding priority to target achievements of the Family Planning and Immunisation programmes. This common prioritisations not only facilitated the health services' own priority for the two programmes but also augmented their neglect of the other communicable disease programmes. By virtue of being the president of the District Leprosy Society the District Magistrates influenced the CMOH to give more attention to it, than the other disease programmes.

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9 Ibid.


The selective, target-achievement oriented approach of the magistrates was one aspect of the district administrative bureaucracy's lack of broad functional orientations. It has been analysed in the past that the bureaucracy in districts was neither goal directed nor action oriented as far as social development of people (which includes their health status also) were concerned.  

The Zilla Parishad and the Panchayats - the major component of organised Community Participation, in the district, these bodies affected the functioning of the Public Health Services through the Janasasthya Shityee Samiti at the district level.

As discussed earlier in Chapters III and IV, their prime concern was with the constructions of health infrastructure under the Minimum Needs Programme or the special projects like the IPP-IV, West Bengal. Among the services, these locally elected bodies remained interested in the availability and accessibility of the curative services mainly.

At the block level, the panchayats decided on the sites for construction of new tubewells and also for reboring of defunct tubewells. Their control over the selection of members of spray teams of the respective blocks and in decisions on the specific villages to be sprayed with insecticides for the Malaria Programme without any consideration for the technical aspects such as API was noteworthy. Understandably, these purely political interferences in technical matters undermined the efficacy of the preventive and promotive activities of the already inefficient programmes even further.

The above mentioned priorities of the Zilla Parishad and Panchayats, and their interferences in the programme activities need to be kept in mind when recommending, the involvement of the Panchayats and the Zilla Parishads for proper monitoring of the activities of

both the curative and preventive components of the health services,\textsuperscript{13} under the decentralisation process.

The general population demanded mainly institution based curative services. Their lack of concern for the public health programme activities could be due to the lack of any collective experience of a properly functioning effective programme which in turn generates demand. Studies in the past\textsuperscript{14,15} have revealed a substantial KAP-gap in the utilisation of the health services and programmes, in West Bengal's villages.

It has been accepted that while on one hand community participation of any degree lowers the costs of implementation of the programmes and services,\textsuperscript{16} on the other, lack of people's participation causes serious problems in the maintenance of different public services, particularly the physical infrastructures.\textsuperscript{17} The latter was also evident in Purulia, in the destruction of quite a few newly constructed subcentre buildings.

Thus, the essential nature of participation of the people in taking decisions on the provision of health care services under the Primary Health Care approach was selective, minimal and distorted in the district of Purulia. It is worth mentioning here that, we should not be naively optimistic and enthusiastic about community participation.


As noted by Kamat\textsuperscript{18} "rural India is socially stratified, ethnically divided and politically factionalized". Also, past experiences with community development programmes in this country do not leave much scope to be very hopeful about community participation.\textsuperscript{19} In Purulia, under the Multipurpose Health Programme,\textsuperscript{20} participation and co-operations was sought by the Health Department from the Local Panchayats. However, the co-ordination meetings to be held at various levels were grossly neglected by both sides.

Additionally, criticism of the capabilities of Panchayati Raj Institutions as an alternative delivery system to the State Government has been quite vocal.\textsuperscript{21} The new theory of empowerment is seen to subvert the old theories of organizational effectiveness, qualities of leadership and decision making.\textsuperscript{22}

On the other hand, it does not subvert but adds to it. The important thing is the context that makes both possible. They can be perceived as subvertive only when the emphasis shifts from the interest of the patients or community to the authority of the doctors or providers. Before such levels of participation could be conceived of, we need to build effective delivery systems and adequate levels of information base or knowledge of the community.

On the contrary, dominant models persist, which need to take a stand and accept variations and therefore, the importance of better public sector management should be realised.

A significant outcome of the decentralisation in Purulia, was the empowerment of the Zilla

\textsuperscript{19} Ibid.
\textsuperscript{20} Govt. of West Bengal, 1985, Multipurpose Health Programme, Deptt. of Health and Family Welfare, Govt. of W.B., Calcutta, p.11.
\textsuperscript{22} Gamage, Cyril, 1995, "Holistic and Fragmented Approaches in Culture and Their Implications for Management", Marga, vol.13, no.4, p.73.
Parishad in 1995, to appoint medical officers on yearly contract basis in the vacant posts of PHCs.

(c) **District Level Committees, Planning and Intersectoral Coordination**

There were three district level committees for the Health Services in Purulia viz., the Highpower Committee, the Monitoring Committee and the Hospital Committee which were constituted mostly by a common set of officials. The purposes of the first two were to be linked, to plan, monitor, coordinate and implement the Health and Family Welfare programmes in the district. The third committee had to supervise the running of the hospitals in an efficient and effective manner.

However, except for the Hospital Committee and the earlier mentioned Jansasthya Sthayee Samiti which were active, the other two committees were mostly defunct. There was no link, though desired, between the activities of either between the committees or with the Samiti.

Similarly, the three different District Purchase Committees as discussed in Chapter VI, Section-4, were constituted of the same group of officials. So many committees with similar or overlapping functions caused duplication, wastage, confusion and loss of interest in the repetitive tasks of each of them.

One of the most essential and basic purposes of the Committees was planning for the health services and health of the population of Purulia. Planning for health according to primary health care incorporates planning for total development of the people of the district and requires intersectoral development and coordination.\(^{23}\)

**Developmental planning** was decentralised to the districts in West Bengal in 1985. A **District Planning Committee** with subordinate subdivisional and block planning committees

\(^{23}\) Qadeer, I. and Baru, R., 1994, op.cit., p.79.
were constituted to implement a process of bottom-up planning. However, like individual sectoral planning as seen in the case of the Health Department in Purulia, the overall planning process also got reduced to a routine formality.

As is well known, emphasis on operational planning at the expense of strategic planning is dangerous, particularly, when strategic planning is carried out from the top downwards, the participation of the deliverers of the services is lost and as a result implementation is hampered. Of relevance are Ackoff's principles of iterative planning consisting of participation, continuity and comprehensiveness, which are applicable to both general strategic planning and planning within the health services.

The criticality of planning of local health programmes was highlighted by WHO as early as 1954. Recently, Tarimo also has emphasised, the importance of national (or state) policies, strategies and plans of action for health for all and simultaneously the requirement of providing support and guidance to districts for local planning. According to his illustration, district planning for health and health services is a cyclical process with nine consecutive and essential steps.


28 Added by us.


30 Ibid, Fig.1, p.2.
One of the most important concepts behind district planning for health and also for total development is decentralization. Not only for participation and strategic planning at local levels, but also for the facts that (i) decentralized planning and management structures are likely to be more efficient than centralized structures,\(^{31}\) and (ii) the new public health has stressed more on the understanding of as opposed to describing the needs of a community,\(^{32}\) because "in a dynamic context decentralized structures offer greater potential for generating new information, learning, and adaptation regarding the organisation and delivery of health care services."\(^{33}\) Therefore, decentralization and district health planning are inseparable, only, the pattern and degree of decentralization\(^{34}\) needs to be worked out.

However, in the Indian context decentralization is not a new issue. It has been put once again on the agenda, though, it continues to suffer from some basic defects. Primary among these are that no devolution of powers from the Centre is envisaged, and usually the rural-urban dichotomy is perpetuated.\(^{35}\)

One basic aspect of planning and implementation of developmental activities in a district is intersectoral coordination. Coordination of the Department of Health in Purulia, was visible with four departments only, viz., the ICDS, PHE department, and the Education and Forestry departments. The coordinations were minimum in effect and mostly concerned with the achievements of targets for the Family Planning and Immunisation Programmes.

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The Health Services did not have any significant role in the activities of the Public Health Engg. department, ICDS or the department of Education. All these departments influenced the working of the Health Services but instead of strengthening actually weakened each other.

Intersectoral coordinations are not only necessary but also essential, for the development of an effective health system in the district to raise the health status of its population\(^{36,37}\) as well as, for cost-effectiveness of the different sectors of welfare and development.\(^{38}\)

Lack of coordination on the other hand, can be detrimental for the health of the population. For example, the Agricultural Policy and its links with Health, including the use of pesticides and their toxic effect, and the effect of irrigation projects on the problem of malaria,\(^{39}\) could be very important for Purulia where the main occupation of the population was agriculture. Therefore, integrated intersectoral planning and implementation at the district is mandatory.

Notwithstanding the above facts, it was noticed from the minutes of the District Planning Committee’s meetings in Purulia, that Health received a much lower priority than the sectors of irrigation, rural development, education, development of backward communities etc., and similarly, at the State level also, in the planning of prioritisation of schemes.\(^{40}\)


Hence, it is most crucial for district planning of today to set forth a long-term perspective,\textsuperscript{41} with the optimal sectoral-mix for integrated and overall development of the district and its population.\textsuperscript{42} This is only possible by ensuring that all the sectors have their goals coordinated in the same direction,\textsuperscript{43} preferably as units of one integrated district system.

Such a planning, implementing and monitoring system, with an alternative programme of action could be, the "Nature, Health and Education Committees" starting hierarchically from the village level to the Panchayat, Taluk, District, State and National levels, as has been suggested already.\textsuperscript{44}

(d) The Non-Governmental Organizations (NGOs) in Purulia

As far as the programmatic services were concerned, the NGOs in Purulia were actively involved with only the Family Welfare programmes and the Leprosy Programme. As discussed in Chapter VII and VIII, various small and big NGOs contributed appreciably in the achievement of targets for the Family Planning and Immunisation programmes.

The activities of the Leprosy Programme were carried out by four NGOs even more meaningfully in Purulia. As we have described in Chapter VIII, 36.5 percent of the district's population was covered by these NGOs for the programme of eradication of Leprosy. However, no NGO contributed to any other health programme in the district.

The actions of the NGOs in Purulia were commendable, yet, from the point of view of health and the health services as one aspect of social change and development: (i) NGOs or


\textsuperscript{42} Ibid, pp.171-180.

\textsuperscript{43} Chaturvedi, Anil, 1988, op.cit., p.163.

voluntary organisations needed to take up the agenda of improving governance, and (ii) they also needed to link micro action with the macro movement of political reforms.45

(ii) The Interface of Work Culture

As discussed by us in Chapter IV, all district health officials came from middle class backgrounds with conservative mind sets. The medical officers with their clinical oriented education and without any significant pre-service or in-service managerial and administrative training or public health orientation led to their emphases on medical care and selective approaches to programmes. The prevailing work culture of individual-directed health care of the Public Health Services in Purulia was also an effect of this.

Likewise, the middle-level supervisory officials with similar backgrounds and orientations had similar perceptions on the goals, functions and major activities of the District Health Services System. Quite significantly, while all officials were unanimously for the integration of the programmes and services, none could think beyond the integration of the functions of the paramedical personnels.

The perceptions of the lowest categories of personnels were somewhat different. They expressed the need for and appeared more sensitive to the needs of the community and its health priorities. Their proximity to the communities and their constant interactions with the latter played an important role in generating this awareness of theirs. Though different, the perceptions of the lower level workers got subsumed by the more dominant work culture of their officers.

The importance of organizational climate and work culture in administrative and managerial reforms have been notable. 46, 47 The role of organizational culture in the success of a system has been admitted in the new public administration concept also. 48 Changing organizational culture for more accountability, is now considered the most important managerial task in optimisation of organizational efficiency with the existing financial constraints. 49

We had aptly identified the work culture of the organization of the Public Health Services in Purulia district, as the boundary of this system. It could be discerned as one of the most crucial variables affecting the inefficiency of the system.

The throughputs of the Public Health Services System in Purulia were influenced most by the work culture of the system. The throughputs were also very much dependent on the inputs and they were as much influenced by the external linkage factors. This was because organisation of the district health services was related to broader patterns of government administration. Thus, the structure and function of the health services were greatly constrained by the Centre and State level organizational contexts. 50

At the same time, if administrative or managerial requirements are counterposed to professional expertise as, in the case of the health services, then, the former skills and

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techniques get seriously underestimated and undermined.\textsuperscript{31} This last phenomenon was very much evident with the medical officers as district health administrators in Purulia.

Some of the administrators, including the CMOH, indulged in private practice. Most block level medical officers also indulged in private clinical practice at the neglect of the public health services. Such work culture on the part of the top officials in the most responsible posts affected the lower level personnels and resulted in the prevailing neglect of duties and apathy for systematic delivery of effective services for the programmes.

On an estimate only 9 percent of the total State Health Expenditure went for health administration, the major expenditure being for the production of doctors and nurses, and for every three doctors trained by the State for its health services, seven were trained for the private sector at public cost.\textsuperscript{52} Consequently, we can also say that, one of the main reasons behind the low efficiency of the public health services system is, the private practice of government doctors.\textsuperscript{53}

\textbf{iii) The Internal Linkages -}

The distortions in the external linkages affected the internal linkages adversely as brought out by the following:

(a) \textbf{The District Health Administration}

According to Lott,\textsuperscript{54} "most systems failures appear to be caused by the lack of involvement of the top management, which must be concerned with the systemic requirements of the organization in addition to providing the necessary resources". Such concern on the part

\begin{itemize}
\item \textsuperscript{51} Maile, Stella, 1995, op.cit.
\item \textsuperscript{54} Lott, Richard W., 1971, \textit{Basic Systems Analysis}, Harper & Row, New York, p.11.
\end{itemize}
of the district health administrators in Purulia was the least, if not totally absent, as mentioned in Chapter IV. Their dominant work culture and its significance for the organization's inefficiency, discussed in the earlier subsection, was perpetuated and propagated by the administrative officers of the district public health services the most.

Among the various health administrators in Purulia the post of the CMOH was obviously the most crucial. There was no provision for any promotee-administrative-training for this post. His authority and discretionary powers were also limited. On the recommendation of the Subject Committee, the State Health and Family Welfare Department in 1993, vested the CMOHs with the power to transfer employees other than medical officers within the district.\(^55\)

However, in reality, as observed in Purulia, it was the medical officers who were transferred (on deputation) the most, within the district and not the other personnel. The strong control of the State in administrative matters, reduced the posts of CMOHs, Dy.CMOHs and ACMOHs to pawns. These officers were only capable of carrying out orders from above and not able to take decisions on their own.

The local political associations of the health services doctors and para-medical personnel were also strong enough to get decisions of the CMOH, on postings, transfers and disciplinary actions, influenced in their favour. In any case, the transfer, posting and promotion policy of the health personnel in the State, is supposed to be guided by rules and procedures formulated by the Finance Department,\(^56\) but, could not be ascertained in Purulia.

Therefore, the main problems of the district health administration, as was in Purulia, can be summarised as bureaucratic inefficiency, organizational structures that work against


integration and decentralization, and lack of managerial expertise. Moreover, the management of public service delivery systems are also hampered by: (a) low motivation, (b) regulatory mind-set, and (c) inadequate skills.

(b) **Transport** - The Mobile Maintenance Unit (Transport) at Purulia district had been attached to the Dy.CMOH-III instead of the Dy.CMOH-I as prescribed. As analysed by us in Chapter V, this shift was facilitated by the much higher number of vehicles allotted to the different Family Welfare Programmes.

This crucial internal link in its distorted form favoured the Family Planning Programme at the cost of the other less favoured programmes. Many a times the vehicles for the Malaria programme and the Audio-Visual unit were being used for the Family Planning Programme. The only vehicle with the District Tuberculosis Programme was more often than not used for the activities of the District Hospital.

Also distorted was the distribution of vehicles to the blocks, which had only seven vehicles among the twenty blocks. This was on top of the fact that there were a large number of additional vehicles at the District Family Welfare Bureau to be distributed to the Block PHCs. The situation in Purulia was therefore, quite far from the mobility of personnels envisaged in the National Health Policy.

(c) **Supervision** - it is one of the most important functions of the district health administration and was also perceived to be so by the health personnels themselves. This link between mainly

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the different hierarchical levels in the district's public health services, was however, a neglected activity in Purulia. Most Supervisory visits of the district health administrators to the block PHCs were unipurpose, for the appraisal of Family Planning and Immunisation targets' achievements.

There were virtually no supervision by the district for, the programmes of Tuberculosis and Malaria. For the Diarrhoea programme, district supervision was only during epidemic outbreaks. But, the Zonal Leprosy Officer on the instigation of the CMOH did undertake supervisory visits to the leprosy units.

The need for integrated supervision carried out regularly and systematically as discussed in Chapter VIII, Section 2, cannot be overemphasised. Studies in India\(^1\) and other countries\(^2\) with similar problems have revealed the requirement of and benefits from systematic supervision using objective indicators and integrated checklists\(^3\) for the improvement in the quantity and quality of services provided by peripheral health facilities.

The activities of disease surveillance and personnel administration were not observed to be pursued in Purulia. There was almost no surveillance of diseases, and personnel administration, a vital component of the district health administration, was mostly State controlled.

(d) **Training** - An entirely innovative perspective to health manpower development with the **Health Team approach** was prophecied by the National Health Policy.\(^4\) But, even after the

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64 Lok Sabha Secretariat, 1985, *op.cit.*
IPP-IV in Purulia, with its massive inputs for training of all categories of personnels, the health personnels remained selectively trained or untrained in their respective job requirements (discussed in Chapter VI, Section 1). The situation has remained almost the same as found by the State Committee on Health and Family Welfare in 1988.\textsuperscript{64}

All training programmes of short or long durations were decided by the State. Most district training programmes were on the Family Welfare Programmes and that too confined to the medical officers only. Training for the Malaria and Diarrhoea programmes were negligible in the reference period of five years. Trainings for the Tuberculosis programme personnels were imparted by the National Tuberculosis Institute, Bangalore and there were none in the reference period.

However, trainings for the personnels of the Leprosy programme were more regular as they were decided locally by the District Leprosy Society and organised by the voluntary organisation, the Leprosy Mission in Purulia. The Public Health Services training activities were therefore, confined to the Family Planning and CSSM Programmes.

The paramedical personnels were seldom given any training except for once in 1994-95 when quite a few of the female Health Supervisors and ANMs were trained on the Family Welfare programmes. Training of dais was also suffering from a large number of shortfalls than the required number of trained dais in the district. The absence of any regular on-the-job

\textsuperscript{65} Block Medical Officers have little training in preventive work, the supervisory staff were inadequately trained and incompetent to guide the multipurpose workers, the multipurpose workers were seldom taught the real causes of health and disease and all categories of personnels were least motivated also, in, WBLA, 1988, Report of the Committee on Health and Family Welfare 1987-88, First Report, West Bengal Legislative Assembly, Assembly House, Calcutta, p.6.
supervisory training practice also made training a discrete and isolated activity instead of the continuous and dynamic process of learning as it should be.\(^{66}\)

Training of the different categories of health personnel has been the point of extensive discussion lately. First, it has been recognised that types of personnel required in a district depends on the local situation so that the level of manpower and skills is matched with the tasks.\(^{67,68}\) Second, planners should examine the significant aspects of workforce quality and utilization by follow-up assessments and support for trainees particularly for the short-term training programmes.\(^{69,70}\)

Moreover, training of the personnel for public health services in India have been broadly categorised into two groups with overlapping curricula: (a) the medical officers and (b) the paramedical workers. For both categories of personnel integrated training programmes covering everything instead of vertical training courses are considered essential.\(^{71,72,73}\)

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For medical officers as well as other health service managers the understandings of applied epidemiology and health promotion and their practice is also vital. Significantly, epidemiologists and other health professionals are expected to be creative, flexible, nondogmatic, and critical in their thinking to be effective. Most importantly, a dialectical process of learning and critical reassessment in training programmes needs to be built. Therefore, the requirement is becoming more pressing for Managerial Physicians and more so of leaders than simply managers.

The necessary reorientation of health manpower can be achieved through proper training, as outlined in details by Gupta et al. However, it should be mentioned the fact that the district level supervisory officers of the supportive activity units need specific trainings for their respective jobs also. In Purulia, none of these officers, be it the Statistical Officer, Media and Education Officers, Asstt. Malaria Officer or the Storekeeper incharge of the District Reserve Store, had any proper in-service or promotee-trainings.

78 Banerji, D., 1985, Health and Family Planning Services in India, Lok Paksh, New Delhi, pp.400-401.
81 Gupta, J.P., Sharma, Monica and Murali, Indira, 1989, Reorganisation and Reorientation of the Health Services Delivery System in India, NIHFW, New Delhi, pp.9-17.
Nonetheless, from the experience of China, it has been well established that a nation does not need sophisticated educated health personnel to deliver basic health care.\(^{82,83}\) Therefore, there is a most urgent need to adequately train the hither-to neglected paramedical personnels particularly the grassroot-workers.

All the above details on training, to be implemented fruitfully, requires the development of district primary health care teams\(^{84}\) which can interrelate training and management activities at the district, block, subcentre and community levels.\(^{85}\)

The need for novel training cultures and techniques viz., participatory training of trainers and trainees as well, for the above is also well understood.\(^{86}\) In the Primary Health Care Approach, prevailing hierarchical working relationships are not recognised\(^{87}\) and to best embody this approach comprehensive trainings involving a mixture of clinical and community skills\(^{88}\) should be imparted to the health personnels.

(e) Health Education and the District Media, Education and Information Cell - As we have discussed in Chapter VI, this cell for Information, Education and Communication had been performing very limited activities of health education to the community. Placed under the Dy.CMOH-III, this cell's concerns were once again confined to the Family Welfare Programmes

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only. The tactics used for the health education of the population was of unidirectional communication, from the personnel to the people.

This technique, used for health information and education has been severely criticised, from the people's point of view, as victim blaming, and by communication specialists, as exploitative and manipulative like Kaplan's Law of Instrument which is found to be a dominant phenomenon in health care interventions, under the existing provider-consumer model.

Such faulty strategies and techniques was one of the most important implicit factors for the low outputs of this cell in Purulia. Significantly, it was noted that the people of the district received and recalled much more health information and education from the various mass media sources than from the interpersonal communications with the health workers.

The absence of any coordination of this cell with the Panchayats, various mass media, and the department of Education in Purulia was detrimental for an efficient, effective and lasting effort toward educating and informing the population on health services, programmes and their health problems.

The case of Patriotic Health Campaigns practiced in China as a method of mass education can be cited as a leading example of health information and education technique for the public health problems and their preventions and cure. Incidentally, the State Subject Committee suggested mass education for the Community by the Health Department, to give information to the people including the Panchayat members on the major Communicable Disease

Programmes. However, such activities were not visible in Purulia even five years after the recommendation.

(f) Reporting, Recording and the Management Information and Evaluation System (MIES) and the Statistical Cell - The MIES was developed as a result of the IPP-IV in Purulia. Though intended to work towards a uniform reporting system to augment managerial decision-making, it remained mainly selective to the Family Welfare Programmes, under the Dy.CMOH-III. The Statistical Cell under the Dy.CMOH-II continued the under-reporting of vital statistics and principal diseases. There were significant duplications in the posts of personnel among the MIES and the Statistical Cell also.

Though the items of all diseases' (except leprosy) programmes were enlisted in the revised PHC monthly report forms, the positioning of the MIES and the standing practice of separate reportings for Malaria and Tuberculosis and to a certain extent Diarrhoea led to the neglect of reporting on these programmes in the MIES, than for the Family Planning and Immunisation Programmes. The Eligible Couple and Children Registers (ECCRs) were mostly incomplete and not updated.

As a result, there was gross under-reporting, duplication, non-reporting and confusion as far as reliable information on the communicable disease programmes were concerned. There was not much feedback from the district to the blocks on performances either. Such a situation was not only specific to Purulia and West Bengal but also exists in other states. Therefore, there has been non-utilisation of the MIES's potential and purpose.

Management scientists have come up with innovative designs of the MIES to improve the functioning of the health services: (i) MIES designed for rural health schemes which would integrate various health programme data for monitoring, and also integrate environmental data with health programme data for long term planning.\textsuperscript{95} The purpose of such an MIES is to go beyond the usual planning and monitoring function and to force functionaries to share information to enable the organization to function as an integrated system;\textsuperscript{96} and (ii) a heuristic-based method for decision making. Developed to help decision makers involved in Primary Health Care within developing countries, this Multiple Criteria Utility Assessment model was for finding acceptable rather than, optimal solutions to complex multifaceted problems.\textsuperscript{97}

(g) The Stores Including the District Reserve Store - We have discussed the stores along with the procurement, distribution and maintenance of supplies in Chapter VI. As mentioned there, there were four stores to procure and distribute technology for the six different programme's. None of the Storekeepers were trained in storekeeping or in inventory management. There were, therefore, a lot of wastage in supplies as well as in repeated procurement and distributions due to multiple and avoidable trips. Such adhoc functioning of stores also led to non-availability of drugs at the peripheral centres on many occasions.

As is well established, improving drug availability and accessibility is a first priority for improving the quality of services.\textsuperscript{98} Though, irrational use of drugs is equally if not more

\begin{itemize}
\item \textsuperscript{96} Ibid, p.15.
\item \textsuperscript{97} Blumenfeld, Stewart N., et al, 1988, "Perspectives on Utility-based Decision Models in Primary Health Care within Developing Countries", \textit{Socio-Econ. Plann. Sci.}, vol.22, no.1, p.49.
\item \textsuperscript{98} Haddad, Salim and Fournier, Pierre, 1995, "Quality, Cost and Utilization of Health Services in Developing Countries: A Longitudinal Study in Zaire", \textit{Soc. Sci. Med.}, vol.40, no.6, p.752.
\end{itemize}
detrimental\textsuperscript{99} to the situation of inadequate supply of drugs, yet, the techniques such as ABC value analysis and sensitivity analysis are capable of substantially improving their public procurement.\textsuperscript{100} This is more applicable to the \textit{decentralised drug procurement} procedure in implementation in Purulia along with other districts.

Inventory models such as that proposed by Nagaty\textsuperscript{101} can be used also, to reduce stock-outs and, spoilage at the community level, if applied by peripheral and local managers, thus, substantially contributing to the more efficient use of scarce resources.

(h) The \textbf{Epidemiological Squad} - Positioned under the Dy.CMOH-II, its activities automatically got confined to the Malaria and Diarrhoea Programmes only.

The lack of any epidemiological training and orientation of the Squad's members was obvious not only from the absence of any systematic Epidemic Control method adopted, but also, in the fact that this squad was known to the personnel as the "Epidemic" as distinct from "Epidemiological", Squad.

The lack of any use whatsoever, of the epidemiological approach and principles,\textsuperscript{102} or epidemic control activities\textsuperscript{103} during diarrhoeal outbreaks every year, and epidemiological surveys\textsuperscript{104} for disease surveillance, was glaringly obvious in Purulia.

\begin{itemize}
  \item Quick, Jonathan D., 1982, "Applying Management Science in Developing Countries: ABC Analysis to Plan Public Drug Procurement", \textit{Socio-Econ. Plann. Sci.}, vol.16, no.1, p.49.
  \item Ibid, pp.67-69.
  \item Ibid, pp.71-86.
\end{itemize}
(i) **The Techno-organisational links** - Separate laboratories for the Public Health Services and the Leprosy Programme, non use of biological insecticides for spray, and separate procurement and distribution of Rifampicin capsules for the Tuberculosis and Leprosy Programmes were areas which caused a lot of wastage by duplication and inefficiencies. Such technological links provide ample scope for optimisation of resources.

The above discussions on the nine internal linkages and their anomalous existences in the Public Health Services System of the study district of Purulia gives a vivid picture of the complexity, dynamicity, dimensions and magnitude of the problems of the system and their solutions. These anomalies were crucial in affecting the distortions of the programmes and their service delivery activities resulting in their low achievements.

**9.3 POINTS OF INTERVENTION**

It is a common place view, that most developing countries will never reach a satisfactory level of health services if patterned on the hospital-based and physician-oriented model. Our data show that even an alternative system based on public health will not succeed if it is riddled with distortions and anomalous linkages. This is the major cause for the inefficiency of the Public Health Services system in Purulia with the existing constraints. We suggest some feasible interventions to improve upon the existing system.

Any intervention for change will have to take into account the readiness of the system and the political conditions within which it operates. It is therefore necessary, to think of two sets of interventions. Administrative interventions within the prevailing conditions and other certain broader interventions when the political constraints have themselves been removed.

Thus, our points of interventions will be of two categories: (a) limited to the district, and (b) with broader changes involving the State and Centre.

Interventions within the District Health Services System:

1. Public Health and managerial trainings to CMOHs and Dy.CMOHs to develop their skills must be compulsory.

2. Only one Public Health Committee at the District to lookafter all planning, monitoring and evaluation activities, instead of three. Similarly, one Drug Purchase Committee for the decentralised purchases of drugs and other supplies.

3. Better intersectoral coordinations, particularly with the PHE department, ICDS, Deptt. of Education NGOs, and the private health sector.

4. Strengthening of components such as in-service training, stores, laboratories, MIES, and health education. These supportive activity units should be independent of programmes and must be programmatically integrated. Systematic Supervision needs to be intensified.

5. Better use of the Epidemiological Squad for all Communicable Disease Control Programmes.

6. Rationalising work for the paramedical workers. Distributing workload for Malaria blood-slide collection and spraying, sputum-smear collection for Tuberculosis, case-detection for Leprosy, and disinfection of wells for the Diarrhoea programme on population and personnel basis of respective blocks.

7. More training inputs for paramedical officers, supervisors, and particularly for the multipurpose workers.

8. Feedback system from the paramedical workers to be incorporated in the MIES.

9. Prescribed norms for the distribution, use and maintenance of vehicles must be adhered to.

10. Information to the people and Panchayats for taking initiatives on their own and raising accountability of the services.
11. Curative centres should take due responsibility of programmatic activities and improve the referral system.

12. The CMOH-Distt. Magistrate link should be supportive and not of subservience.

(b) Broader changes

This set of interventions is feasible only when the relationship between the State and District itself is altered. Certain corrective steps can then be taken at the district level. Similarly, the political interference of the Panchayats and the administrative interferences of the District Magistrate in technical matters, must be stopped or at least minimised.

1. Planning process of the State should be less controlled by the Centre.

2. State must redefine its own priorities in health.

3. District Planning must be taken as a more serious and essential exercise.

4. Integrated planning, at the State level based on district plan that takes into account disease priorities, available manpower, technology and community’s perceptions and needs across classes.

5. The ICDS and PHE departments should be integrated under the Department of Health and Family Welfare.

6. The Family Planning, CSSM and Communicable Disease Control programmes must be fully integrated to develop a Primary Health Care Programme.

7. Appropriate forums should be created to encourage participation of different social classes irrespective of their social and economic power.