

' HEALTH FOR ALL' - A VIEW FROM BELOW  
(A study of a Primary Health Centre as an  
instrument of the National Health Policy).

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This is to certify that I, P. Rama Devi have carried out the research embodied in the present thesis for the full period prescribed under Ph .D. ordinances of the University.

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## CONTENTS

|              |                                                                                            | <b><u>Page</u></b> |
|--------------|--------------------------------------------------------------------------------------------|--------------------|
|              | LIST OF FIGURES AND MAPS                                                                   | (i)                |
|              | LIST OF TABLES IN TEXT                                                                     | (ii-v)             |
|              | LIST OF TABLES IN APPENDIX                                                                 | <b>(vi-xii)</b>    |
| CHAPTER I    | INTRODUCTION                                                                               | 1-45               |
| CHAPTER II   | ORGANIZATION OF MEDICAL AND HEALTH CARE SERVICES IN ANDHRA PRADESH                         | <b>46-102</b>      |
| CHAPTER III  | <del>PROFILE</del> OF PERSONNEL                                                            | <b>103-130</b>     |
| CHAPTER IV   | WORKLOAD AND PROGRAMMEWISE PERFORMANCE                                                     | 131-184            |
| CHAPTER V    | SUPERVISION AND SUPERVISORY STYLES AND LINKAGES WITH THE COMMUNITY                         | 185-211            |
| CHAPTER VI   | <del>SOCIODEMOGRAPHIC</del> PROFILE OF THE BENEFICIARIES                                   | 212-237            |
| CHAPTER VII  | UTILIZATION AND OUTREACH OF PRIMARY HEALTH CARE SERVICES AS PERCIEVED BY THE BENEFICIARIES | 238-281            |
| CHAPTER VIII | CONCLUSION                                                                                 | 282-313            |
|              | BIBLIOGRAPHY                                                                               | 1-17               |
|              | <u>APPENDICES</u> :                                                                        |                    |
|              | APPENDIX I                                                                                 | 18-32              |
|              | APPENDIX II                                                                                | 33-47              |
|              | APPENDIX III                                                                               | <b>48-62</b>       |
|              | APPENDIX IV                                                                                | 63-73              |
|              | APPENDIX V                                                                                 | 74-110             |
|              | APPENDIX VI                                                                                | 111-127            |
|              | APPENDIX VII                                                                               | 128-178            |



LIST OF FIGURES AND MAPS

| NUMBER | TITLE                                                                          | PAGE |
|--------|--------------------------------------------------------------------------------|------|
| 2.1    | Organization of Medical & Health Services at the District Level.               | 67   |
| 2.2    | Organization of the Directorate of Health                                      | 85   |
| 2.3    | Organization of Medical & Health Services at the Regional Level.               | 86   |
| 2.4    | Organization of the Directorate of Family Welfare.                             | 94   |
| 2.1    | Ranga Reddy district map showing the revenue mandals.                          | 71   |
| 2.2    | Map showing the network of medical & health care institutions in the district. | 72   |

LIST OF FIGURES AND MAPS

| NUMBER | TITLE                                                                          | PAGE |
|--------|--------------------------------------------------------------------------------|------|
| 2.1    | Organization of Medical & Health Services at the District Level.               | 67   |
| 2.2    | Organization of the Directorate of Health                                      | 85   |
| 2.3    | Organization of Medical & Health Services at the Regional Level.               | 86   |
| 2.4    | Organization of the Directorate of Family Welfare.                             | 94   |
| 2.1    | Ranga Reddy district map showing the revenue mandals.                          | 71   |
| 2.2    | Map showing the network of medical & health care institutions in the district. | 72   |

**LIST OF TABLES IN TEXT**

| NUMBER | TITLE                                                                                                                                                  | PAGE  |
|--------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------|
| 1.1    | Birth Rate, Death Rate and Natural Growth Rate in India (1976-1983)                                                                                    | 5     |
| 1.2    | Infant Mortality Rates in India (1976-1983)                                                                                                            | 6     |
| 1.3    | Notified cases of cholera and positive cases of Malaria in India (1976-1983)                                                                           | 6     |
| 1.4    | Distribution of Villages according to population range & amenities available in Ranga Reddy District.                                                  | 38    |
| 1.5    | Number of primary health centre personnel in position, & number interviewed.                                                                           | 41    |
| 2.1    | Position of staff at PHCs proper                                                                                                                       | 75    |
| 2.2    | Position of staff at sector & sub-centre level.                                                                                                        | 76    |
| 2.3    | Number of Hospitals, Dispensaries, PHC's and MM units in A. P. as on 31.03.90.                                                                         | 89    |
| 2.4    | Distribution of Population, Health Services, and Health Personnel - districtwise as on 31.03.91.                                                       | 90    |
| 2.5    | Beds in government, local body institutions & doctors & nurses in government service in the districts as on 01.04.1987, and population served by each. | 91    |
| 2.6    | Position of staff at the directorate, district & sub-district level.                                                                                   | 95-96 |
| 3.1    | Distribution of functionaries by age & sex                                                                                                             | 104   |
| 3.2    | Distribution of functionaries by educational qualifications.                                                                                           | 108   |
| 3.3    | Recruitment of PHC staff                                                                                                                               | 112   |
| 3.4    | Emoluments of the PHC staff                                                                                                                            | 124   |
| 4.1    | Distribution of Health Workers by number of job duties performed.                                                                                      | 138   |

|      |                                                                                                                      |     |
|------|----------------------------------------------------------------------------------------------------------------------|-----|
| 4.2  | Distribution of Health Workers by number of eligible couples registered.                                             | 140 |
| 4.3  | Distribution of Health Workers by number of eligible couples protected by various family planning methods.           | 141 |
| 4.4  | Distribution of Health Workers by number of eligible couples yet to be protected by various family planning methods. | 142 |
| 4.5  | Performance of women workers with regard to sterilizations, IUDS, and Oral Pills, for the year 1988-89.              | 145 |
| 4.6  | Distribution of Health Workers according to their assessment of the Family Planning Programme.                       | 146 |
| 4.7  | Performance of Women Workers with regard to Maternal & Child Health Care for the Year 1988-89.                       | 148 |
| 4.8  | Distribution of Health Workers by number of children registered (below 1 year & 1 to 5 years).                       | 153 |
| 4.9  | Performance of Women Workers with regard to number of children (below one year) immunized during 1988-89.            | 155 |
| 4.10 | Distribution of Health Workers by number of job duties performed.                                                    | 162 |
| 4.11 | Performance of men Workers with regard to sterilizations, and condoms during 1988-89.                                | 164 |
| 4.12 | Number of children immunized (below 1 year) by the Health Workers during 1988-89.                                    | 167 |
| 4.13 | Distribution of Village Health Guides by number of patients treated per day for minor ailments.                      | 171 |
| 4.14 | Distribution of Village Health Guides by number of diarrhoea cases identified during 1988-89.                        | 173 |
| 4.15 | Performance of Village Health Guides with regard to sterilizations for the year 1988-89.                             | 174 |
| 4.16 | Distribution of Dais (trained) by number of antenatal cases registered during 1988-89.                               | 177 |

|      |                                                                                                                                             |            |
|------|---------------------------------------------------------------------------------------------------------------------------------------------|------------|
| 4.17 | Distribution of Dais by number of sterilization casca motivated during 1988-89.                                                             | <b>179</b> |
| 5.1  | Distribution of Women Workers by frequency of visits by supervisors.                                                                        | 188        |
| 5.2  | Distribution of Village Health Guides by frequency of meetings with the Women Workers.                                                      | 197        |
| 6.1  | Villages according to population range, & amenities available in Hayatnagar Mandal.                                                         | 213        |
| 6.2  | Study village according to their population size, location, vis-a-vis the sub-center, PHC & amenities available.                            | 216        |
| 6.3  | Distribution of household members in terms of their age & sex.                                                                              | 222        |
| 6.4  | Distribution of household members by marital status.                                                                                        | 223        |
| 6.5  | Distribution of household members by level of education.                                                                                    | 224        |
| 6.6  | Age & sex wise distribution of household members by level of education.                                                                     | 225        |
| 6.7  | Distribution of households according to their predominant occupation.                                                                       | 227        |
| 6.8  | Distribution of respondents by income                                                                                                       | 230        |
| 6.9  | Distribution of respondents according to type of housing, & number of rooms                                                                 | 233        |
| 6.10 | Distribution of respondents according to income, type of housing & number of rooms.                                                         | 234        |
| 6.11 | Distribution of respondents by type of housing and civic amenities.                                                                         | 236        |
| 7.1  | Distribution of respondents by frequency of visits by health personnel.                                                                     | 244        |
| 7.2  | Distribution of respondents by distance between sub-center and other <b>villages</b> and frequency of visits by Health Supervisors (Women). | 246        |
| 7.3  | Distribution of respondents by distance between sub-center and other villages and frequency of visits by Health Supervisors (Men).          | 247        |

|      |                                                                                                                                       |     |
|------|---------------------------------------------------------------------------------------------------------------------------------------|-----|
| 7.4  | Distribution of respondents by distance between sub-center and other villages and frequency of visits by Health Workers (Women).      | 249 |
| 7.5  | Distribution of respondents by distance between sub-center and other <b>villages</b> and frequency of visits by Health Workers (Men), | 250 |
| 7.6  | Distribution of respondents by sub-center .<br>PHC users, users of other services, & non users.                                       | 257 |
| 7.7  | Percentage distribution of respondents by sub-center and <b>utilisation</b> of sub-centre / PHC services.                             | 269 |
| 7.8  | Percentage distribution of respondents by frequency of visits by Health Workers (Women) & utilisation of sub-center / PHC services.   | 271 |
| 7.9  | Percentage distribution of respondents by distance between sub-centres and other villages & utilisation of sub-center / PHC services. | 273 |
| 7.10 | Percentage distribution of respondents by availability of transport facility & utilisation of sub-center / PHC services.              | 274 |
| 7.11 | Percentage distribution of respondents by caste & utilisation of sub-center / PHC <b>services</b> .                                   | 276 |
| 7.12 | <b>Percentage</b> distribution of respondents by income & utilisation of sub-center / PHC <b>services</b> .                           | 277 |
| 7.13 | Percentage distribution of education of respondents head of households & utilisation of sub-center / PHC services.                    | 278 |



## LIST OF TABLES IN APPENDIX

| NUMBER | TITLE                                                                                                                                                                | PAGE |
|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
| 5.1    | Minimum Needs Programme - Progress & Achievement during the Fifth Plan.                                                                                              | 81   |
| 5.2    | Goals for Health & Family Welfare Programmes                                                                                                                         | 94   |
| 5.3    | Establishment of Primary Health Centres & Sub-centres in India since First Five Year Plan                                                                            | 98   |
| 5.4    | Pattern of investment on Health, Family Welfare & Water Supply, etc (Plant Outlays) in different Plan Periods in Public Sector - Centre, States & Union Territories. | 100  |
| 7.1    | Sub-center wise distribution of respondents by utilisation of sub-center / PHC for treatment of minor ailments.                                                      | 128  |
| 7.2    | Sub-center wise distribution of respondents by utilisation of sub-center / PHC for treatment of antenatal care.                                                      | 128  |
| 7.3    | Sub-center wise distribution of respondents by place of delivery.                                                                                                    | 129  |
| 7.1    | Sub-center wise distribution of respondents by persons responsible for conducting deliveries at home and the PHC.                                                    | 129  |
| 7.5    | Sub-center wise distribution of respondents by immunization of children for BCG. and place of immunization.                                                          | 130  |
| 7.6    | Sub-center wise distribution of respondents by immunization of children for DPT and Polio (I dose) and place of immunization.                                        | 130  |
| 7.7    | Sub-center wise distribution of respondents by immunization of children for DPT and Polio (II dose) and place of immunization.                                       | 131  |
| 7.8    | Sub-center wise distribution of respondents by immunization of children for DPT and Polio (III dose) and place of immunization.                                      | 131  |
| 7.9    | Sub-center wise distribution of respondents by immunization of children for measles and place of immunization.                                                       | 132  |

|      |                                                                                                                                                                  |            |
|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| 7.10 | <b>Sub-center</b> wise distribution of respondents by sterilization.                                                                                             | <b>132</b> |
| 7.11 | Sub-center wise distribution of respondents by place of <b>sterilization</b> .                                                                                   | 133        |
| 7.12 | <b>Distribution</b> of respondents by frequency of visits by Health Workers (Female) and utilisation of sub-center / PHC for treatment of minor ailments.        | 134        |
| 7.13 | Distribution of respondents by frequency of visits by Health Workers (Female) and utilisation of sub-center / PHC for antenatal care.                            | 135        |
| 7.14 | Distribution of respondents by frequency of visits by Health Workers (Female) and place of delivery.                                                             | 136        |
| 7.15 | Distribution of respondents by frequency of visits by Health Workers (Female) and persons responsible for conducting deliveries at home & the MIC.               | 137        |
| 7.16 | Distribution of respondents by frequency of visits by Health Workers (Female) and immunisation of children for BCG and place of immunization.                    | 138        |
| 7.17 | Distribution of respondents by frequency of visits by Health Workers (Female) and immunisation of children Cur DPT and Polio (I Dose) & place of immunization.   | 139        |
| 7.18 | Distribution of respondents by frequency of visits by Health Workers (Female) and immunisation of children for DPT and Polio (II Dose) & place of immunization.  | 140        |
| 7.19 | Distribution of respondents by frequency of visits by Health Workers (Female) and immunisation of children for DPT and Polio (III Dose) & place of immunization. | 141        |
| 7.20 | Distribution of respondents by frequency of visits by Health Workers (female) <del>and</del> immunisation of children for measles and place of immunization.     | 142        |
| 7.21 | Distribution of respondents by frequency of visits by Health Workers (Female) and sterilisation.                                                                 | 143        |



|      |                                                                                                                                                                 |     |
|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| 7.22 | Distribution of respondents by frequency of visits by Health Workers (Female) and place of sterilisation.                                                       | 144 |
| 7.23 | Distribution of respondents by distance between sub-center and other villages. and utilization of sub-center / PHC for treatment of minor ailments.             | 145 |
| 7.24 | Distribution of respondents by distance between sub-center and other villages. and utilization of sub-center / PHC for antenatal care.                          | 145 |
| 7.25 | Distribution of respondents by distance between sub-center and other villages. and place of delivery.                                                           | 146 |
| 7.26 | Distribution of respondents by distance between sub-center and other villages. and persons responsible for conducting deliveries at home and the PHC.           | 146 |
| 7.27 | Distribution of respondents by distance between sub-center and other villages. and immunization of children for BCG & place of immunization.                    | 147 |
| 7.28 | Distribution of respondents by distance between sub-center and other villages. and immunization of children for DPT & Polio (I dose) & place of immunization.   | 147 |
| 7.29 | Distribution of respondents by distance between sub-center and other villages. and immunization of children for DPT & Polio (II dose) & place of immunization.  | 148 |
| 7.30 | Distribution of respondents by distance between sub-center and other villages. and immunization of children for DPT & Polio (III dose) & place of immunization. | 148 |
| 7.31 | Distribution of respondents by distance between sub-center and other villages. and immunization of children for measles and place of immunization.              | 149 |
| 7.32 | Distribution of respondents by distance between sub-center and other villages. and sterilization.                                                               | 149 |

|      |                                                                                                                                                       |            |
|------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| 7.33 | Distribution of respondents by distance between sub-center and other <b>villages</b> . and place of sterilization.                                    | 150        |
| 7.34 | <b>Distribution of respondents by availability of transport facility. utilization of sub-center / PHC for treatment of minor ailments.</b>            | <b>150</b> |
| 7.35 | Distribution of respondents by availability of transport facility. utilization of sub-center / PHC for antenatal care.                                | 151        |
| 7.36 | Distribution of respondents by availability of transport facility, and place of delivery.                                                             | 151        |
| 7.37 | Distribution of respondents by availability of transport facility, and persons responsible for conducting deliveries at home and the PHC.             | 152        |
| 7.38 | Distribution of respondents by availability of transport facility. and immunization of children for BCG and place of immunization.                    | 152        |
| 7.39 | Distribution of respondents by availability of transport facility. and immunization of children for DPT & Polio (1 Dose) and place of immunization.   | 153        |
| 7.40 | Distribution of respondents by availability of transport facility. and immunization of children for DPT & Polio (II Dose) and place of immunization.  | 153        |
| 7.41 | Distribution of respondents by availability of transport facility. and immunization of children for DPT & Polio (III Dose) and place of immunization. | 154        |
| 7.42 | Distribution of respondents by availability of transport facility. and immunization of children for measles & place of immunization.                  | 154        |
| 7.13 | Distribution of respondents by <b>availability of transport facility. and sterilization.</b>                                                          | <b>155</b> |
| 7.44 | Distribution of respondents by availability of transport facility. and place of sterilization.                                                        | 155        |

|      |                                                                                                                         |     |
|------|-------------------------------------------------------------------------------------------------------------------------|-----|
| 7.45 | Distribution of respondents by caste and utilization of sub-center / PHC for treatment of minor ailments.               | 156 |
| 7.46 | Distribution of respondents by caste and utilization of sub-center / PHC for antenatal care.                            | 156 |
| 7.47 | Distribution of respondents by caste and place of delivery.                                                             | 157 |
| 7.48 | Distribution of respondents by caste and persons responsible for the conduct of delivery.                               | 157 |
| 7.49 | Distribution of respondents by caste and immunization of children for BCG & place of immunization.                      | 158 |
| 7.50 | Distribution of respondents by caste and immunization of children for DPT & Polio (I dose) and place of immunization.   | 158 |
| 7.51 | Distribution of respondents by caste and immunization of children for DPT & Polio (II dose) and place of immunization.  | 159 |
| 7.52 | Distribution of respondents by caste and immunization of children for DPT & Polio (III dose) and place of immunization. | 159 |
| 7.53 | Distribution of respondents by caste and immunization of children for measles and place of immunization.                | 160 |
| 7.54 | Distribution of respondents by caste and sterilization.                                                                 | 160 |
| 7.55 | Distribution of respondents by caste and place of sterilization.                                                        | 161 |
| 7.56 | Distribution of respondents by income and utilization of sub-center / PHC for treatment of minor ailments.              | 161 |
| 7.57 | Distribution of respondents by income and utilization of sub-center / PHC for antenatal care.                           | 162 |
| 7.58 | Distribution of respondents by income and place of delivery.                                                            | 162 |

|      |                                                                                                                                     |     |
|------|-------------------------------------------------------------------------------------------------------------------------------------|-----|
| 7.59 | Distribution of respondents by income and persons responsible for conducting deliveries at home and the MIC.                        | 163 |
| 7.60 | Distribution of respondents by income and immunization of children for BCG and place of immunization.                               | 163 |
| 7.61 | Distribution of respondents by income and immunization of children for DPT and Polio (I dose) and place of immunization.            | 164 |
| 7.62 | Distribution of respondents by income and immunization of children for DPT and Polio (II dose) and place of immunization.           | 165 |
| 7.63 | Distribution of respondents by income and immunization of children for DPT and Polio (III dose) and place of immunization.          | 166 |
| 7.64 | Distribution of respondents by income and immunization of children for measles and place of immunization.                           | 167 |
| 7.65 | Distribution of respondents by income and sterilization.                                                                            | 167 |
| 7.66 | Distribution of respondents by income and place of sterilization.                                                                   | 168 |
| 7.67 | Distribution of respondents by education of head of households and utilization of sub-center / PHC for treatment of minor ailments. | 168 |
| 7.68 | Distribution of respondents by education of head of households and utilization of sub-center / PHC for antenatal care.              | 169 |
| 7.69 | Distribution of respondents by education of head of households and place of delivery.                                               | 170 |
| 7.70 | Distribution of respondents by education of head of households and persons responsible for conducting deliveries at home.           | 171 |
| 7.71 | Distribution of respondents by education of head of households and immunization of children for BCG and place of immunization.      | 172 |

|      |                                                                                                                                                   |     |
|------|---------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| 7.72 | Distribution of respondents by education of head of households and immunization of children for DPT & Polio (I Dose) and place of immunization.   | 173 |
| 7.73 | Distribution of respondents by education of head of households and immunization of children for DPT & Polio (II Dose) and place of immunization.  | 174 |
| 7.74 | Distribution of respondents by education of head of households and immunization of children for DPT & Polio (III Dose) and place of immunization. | 175 |
| 7.75 | Distribution of respondents by education of head of households and immunization of children for measles and place of immunization.                | 176 |
| 7.76 | Distribution of respondents by education of head of households and sterilization.                                                                 | 177 |
| 7.77 | Distribution of respondents by education of head of households and place of sterilization.                                                        | 178 |

## CHAPTER I

### INTRODUCTION

An attempt has been made in this chapter to discuss the (i) concept and strategy for achieving 'Health for All by 2000'; (ii) evolution of the health policy in brief; (iii) review of formulation and implementation of health policy; (iv) statement of the problem and objective of the study ; (v) conceptual perspective ; (vi) methodology and (vii) limitations of the study.

#### 1.1 THE CONCEPT AND STRATEGY FOR ACHIEVING 'HEALTH FOR ALL BY 2000':

~~Health~~ in the expression "Health for All" means the availability and provision to all, services normally associated with individual and community health which is viewed as the necessary precondition for the creation and maintenance of socially and economically productive life.

Primary health care approach is considered to be the basis for achieving 'Health for All' especially in the developing countries. The Alma Ata Conference described primary health care as : "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in



the spirit of self-reliance and self-determination. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of continuing health care process" (WHO-UNICEF, 1978: 3-4).

It is, therefore, natural that primary health care should deal with the main health problems of the people and provide comprehensive, promotive, preventive, curative and rehabilitative services to all those who need such services. The nature and extent of these services will depend on the kind and magnitude of the problems, values, scientific and technological development, and above all, what the people desire to have. The essential components included are proper nutrition, adequate and safe water, basic sanitation including personal and food hygiene; maternal and child health including family planning; immunization against communicable diseases; prevention and control of local endemic diseases; education concerning health and health related matters; and appropriate and timely treatment and care for common diseases and injuries (WHO-UNICEF, 1978: 4),.

The Alma Ata Declaration was accepted by the Government of India in their own health policy document (National Health Policy, 1983) which calls for the achievement of 'Health for All by 2000 A.D'. The primary instruments of this policy are the Primary Health Centres (PHC's), for a manageable block of

population.

Having stated the strategy for achieving 'Health for All' through primary health care approach, it needs to be examined as to how far our country is following this, and with what results. In this context it would be appropriate to look at the policy developments in the field of health.

The major objective of the study is to gain insights into the role and potential of the PHCs as instruments of the NHP. This is being attempted by indepth case study of one PHC in Andhra Pradesh. I am acutely conscious of the fact that one case cannot bring forth a conclusive evidence on the actual potential of the PHCs as the policy instrument. However, it should, nevertheless provide one an understanding of the working of PHCs.

Before we take up the specific case study we would like to briefly present the background to the evolution of the policy and the public health system in India.

## 1.2 EVOLUTION OF THE HEALTH POLICY AND THE PUBLIC HEALTH SYSTEM

The idea of developing Primary Health Centres (PHCs) as the focal point for providing comprehensive, curative and preventive health services in the rural areas in India was

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\* For a detailed presentation of the evolution of the health policy, see appendix V : 74-110 .



presented by the 'Health Survey and Development Committee' (1946) also known as the Bhore Committee. It was conceived as an organization that was relatively simple to provide health services for the rural population of the country.

Since then the PHC organization has been subject to many changes based on the recommendations of the various committees setup by the government from time to time to review its progress and suggest future course of action. Quantitatively, there has been a significant increase in the establishment of PHCs and sub-centres, and the number of medical and paramedical personnel. Qualitatively, there have been four major changes (GOI, 1987). Firstly, many special mass campaigns related to communicable disease prevention have been integrated with PHCs, in terms of their staff as well as functions. Thus there have been national programmes for specific health problems related to tuberculosis, malaria, leprosy and blindness prevention. Secondly, there has been a functional integration of work of the personnel at PHCs. This has led to the creation of male and female Multipurpose Workers. Thirdly, a twenty-five bed hospital has been developed for every four PHCs in the country and: finally, and perhaps most importantly, a decision was taken by the Government of India in 1977 to entrust people's health in people's hands by offering opportunities to village communities to choose from among themselves a person who would work as a Community Health Volunteer (CHV. now called Health Guide). The government authorities also arranged for

the training of CHVs, paying them an honorarium and supplying some drugs and equipment.

However, the progress achieved, upto the early 80's in the area of primary health care and in general the health status of the people, had not been encouraging. The demographic and health profile of the country still constituted a cause for serious and urgent concern. The high rate of population growth (see table 1.1 & 1.2), high mortality rates for women and children continued to have an adverse effect on the health of the people and the quality of their lives. Efforts at raising the nutritional levels did not bear fruit and malnutrition continued to be exceptionally high.

Table 1.1 :

Birth Rate, Death Rate and Natural Growth Rate in India (1976-1983) :

| Year | Crude Birth Rate |      |      | Crude Death Rate |     |      | Natural Growth Rate |      |      |
|------|------------------|------|------|------------------|-----|------|---------------------|------|------|
|      | R                | U    | C    | R                | U   | C    | R                   | U    | C    |
| 1976 | 35.8             | 28.4 | 34.4 | 16.3             | 9.5 | 15.0 | 19.5                | 18.9 | 19.4 |
| 1981 | 35.6             | 27.0 | 33.9 | 13.7             | 7.8 | 12.5 | 21.9                | 19.2 | 21.4 |
| 1982 | 35.5             | 27.6 | 33.8 | 13.1             | 7.4 | 11.9 | 22.4                | 20.2 | 21.9 |
| 1983 | 35.3             | 28.3 | 33.7 | 13.1             | 7.9 | 11.9 | 22.2                | 20.4 | 21.8 |

R=Rural, U=Urban, C=Combined.

Source : Health Information India - 1988 : 30-31  
CBHI, DGHS, Ministry of Health and Family Welfare,  
GOI, New Delhi

Table 1.2 :

Infant Mortality Rates in India (1976-1983) :

| Period | Infant Mortality Rate<br>(per thousand live births) |    |     |
|--------|-----------------------------------------------------|----|-----|
|        | R                                                   | U  | C   |
| 1976   | 139                                                 | 80 | 129 |
| 1981   | 119                                                 | 62 | 110 |
| 1982   | 114                                                 | 65 | 105 |
| 1983   | 114                                                 | 66 | 105 |

R=Rural, U=Urban, C=Combined.

Source : Health Information India - 1988 : 37  
CBHI, DGHS, Ministry of Health and Family Welfare,  
GOI, New Delhi

Table 1.3 :

Notified cases of cholera and positive cases of Malaria in  
India (1976 - 1983) :

| Year | Cholera |        | Malaria   |        |
|------|---------|--------|-----------|--------|
|      | Cases   | Deaths | Cases     | Deaths |
| 1976 | 17,492  | 861    | 64,67,215 | 59     |
| 1981 | 6,073   | 200    | 27,01,141 | 170    |
| 1982 | 4,693   | 217    | 21,82,302 | 187    |
| 1983 | 9,202   | 432    | 20,18,605 | 239    |

Source : Health Information India - 1988 : 151-154  
CBHI, DGHS, Ministry of Health and Family Welfare,  
GOI, New Delhi

Malaria which was almost eradicated had staged a comeback (see table 1.3). It was estimated that there were eight million active cases **of tuberculosis** in the country of which two million were believed to be infective sputum positive cases. The population at risk of filariasis had increased from 25 million in 1953 to 136 million in 1975. India had one-third of the leprosy affected persons in the world and half of its population was at risk of the disease. Although cholera had been significantly reduced other water borne diseases still account for a large proportion of morbidity and mortality, especially among children. Acute diarrhoeal diseases alone were believed to take away 1.5 million lives each year. Communicable and non-communicable diseases therefore still had to be brought under control (ICSSR-ICMR, 1981 : 6-7).

The situation as prevalent during the early 80's, according to health administrators and experts, was due to the wholesale adoption of the western models of health care (hospital based and cure oriented) which are inappropriate and irrelevant to the needs of the people. The existing approach according to them had resulted in the development of a cultural gap between the people and the personnel providing care, and had enhanced dependency instead of self-reliance. In this context it was felt that an integrated, comprehensive approach towards future development of medical education, **research**, and health services required to be established to serve the health needs and priorities of

the country. (ICSSR-ICMR, 1981 : 81-84)

To put an end to the then existing all-round unsatisfactory situation, the NHP statement (1983) underlined an urgent need for restructuring the health services around the following broad approaches :

1. Provision of a well dispersed network of comprehensive primary health care services with the organized support of volunteers, auxiliaries, paramedics, and adequately trained multipurpose workers.

2. Large scale transfer of knowledge, simple skills and technologies to Health Volunteers, selected by the communities and enjoying their confidence.

3. Positive efforts to build up individual self-reliance and effective community participation by enlisting the support of local leaders, village elders, registered medical practitioners, local organizations like *mahila mandals* and youth clubs.

4. Establishment of a well worked out referral system to provide adequate expertise at the various levels of the organization setup nearest to the community depending upon the actual needs and problems of the area. This it was expected, would ensure the optimal utilization of expertise at the higher levels of the hierarchical structure.

5. High priority was to be accorded to high risk groups, under-privileged segments of the population living in remote and underserved areas.

6. For proper utilization of primary health care services, the PHCs and sub-centres had to be geographically accessible to the people.

7. Inter-sectoral coordination of health was to be ensured between health and health related sectors like agriculture, pharmaceuticals, housing, environmental sanitation, nutrition, social welfare, education, medical education and rural development. The policy also called for a decentralized primary health care system for harmonizing the activities of the various sectors that jointly promoted development.

8. Full utilization of untapped resources through organized logistic, financial and technical support to voluntary agencies active in the health field.

9. Greater emphasis was to be placed on communicable diseases (malaria, leprosy and tuberculosis), and establishment of a nationwide network of sanitary-cum-epidemiological stations to tackle the entire range of poor health conditions.

10. Special efforts were to be made for the disabled to offer them mental health and medical care and physical and social rehabilitation.

11. In addition to the above approaches the policy also emphasised the need for integration of indigenous systems of



medicine at appropriate levels in the delivery of primary health care services.

12. As a part of the concern, appropriate training of the health personnel oriented to the peoples needs was suggested. This was to form an integral component of the National Medical and Health Education Policy.

13. Establishment of practice by private medical practitioners.

14. Strengthening of ophthalmic care facilities at the peripheral and intermediate levels for control of blindness.

15. Strengthening of the health information system for assessing medical and health manpower requirements, monitoring and evaluating the various ongoing programmes.

16. Emphasis was to be placed on applied, operational research for improving the delivery of health services (NHP, 1983 : 33-50).

There has not been any further review of the health policy since 1983.

The burden of implementing the welfare programmes rests with the state governments, while resources and policy directives are provided by the central government. The Government of Andhra Pradesh has been broadly following the policies laid down by the centre with respect to medical and public health, with greater emphasis on the curative aspects

of health care. For further details, see appendix V : 74-107.

Although the National Health Policy aimed at achieving 'Health for All by 2000' studies have shown that the performance of the Primary Health Centres is still far from satisfactory and they have failed to achieve the purpose for which they were established.

From the rapid review of policy it is obvious that the institution of PHC's was the fulcrum around which the 'Health for All' was designed. How effective were these as the instruments of the policy. The studies reviewed in the following sections throw light on this problem in the context of policy formulation and implementation.

### 1.3 REVIEW OF FORMULATION AND IMPLEMENTATION OF HEALTH POLICY :

For the purpose of this study the following literature has been reviewed which can be broadly classified under four major heads.

(1) those dealing with the evaluation of health policy ICSSR-ICMR (1981); Bose, A and Desai (1983); Banerji, D (1984,1988); Jeffery Rogers (1986); GOI (1990); Oommen T.K. (1985).

(2) those concerned with health administration - Praphulla Dutta (1955); Dutt, P.R.(1962); Raghu Ram N.V.(1971); Raghavender Rao (1975); Naik J.P. (1977); Park and Park ,



(1979); Goe1 S.L. (1981).

(3) studies pertaining to the managerial aspects regarding the working of primary health centres and its programmes, and government evaluation reports on the working of primary health centres, and sub-centres - GOAP (1971); Gandatra M.M. et.al (1987); Reddy P.M. and Narayana (1978); Reddy P.M. et.al (1983); Bose, A (1983); Rao T.V. (1984); IIMA, Public Systems Group (1985); David, L.H. and Narayana, G (1983, 1985); IIPS (1982, 1985); ICMR (1980); ICMR (1989); USAID report (1985); GOAP (1985); Misra B.D. and Simmons (1982).

(4) studies pertaining to utilization of the primary health centres, and sub-centre services - Ram, Eric R. and Dutta B.K. (1976); Chuttani C.S. et.al (1976); Jorapur, P.B. (1979); Sholapurkar, et.al. (1983); Devi, Manjula (1986); Lakshamma T. (1989); Maurya, K. (1989); Shah M.H. (1989); Indira Kapoor (1989).

Although the Bhore Committee had recommended establishment of a strong primary health care system, and had suggested an intersectoral approach to health services development, the experience of the last fortyfour years had not been very encouraging.

✓ In 1978, the Planning Commission undertook a review of the performance in the health sector, and identified several draw backs. According to the commission, our health care

delivery system did not take into consideration the social, economic, ecological factors, conditions of work etc., secondly, it was concentrated mostly in the urban areas; thirdly, it was based on medical education system which orients the doctors not for the health of the people but instead for medical practice; and lastly, it undermines the traditional health care systems, and encourages the use of drugs (Bose A, 1983 : 35).

Many studies on the health policy (Qadeer, I, 1985; Banerji, D. 1985; Pannikar, P.G.K. 1976) have pointed out that health services were essentially curative oriented. capital intensive, hospital based, and urban oriented. Given this kind of an imbalance in the development of health services, "two types of subsystems existed simultaneously. One consisted of illequipped primary health centre network for the rural areas which is starved of resources, and the other was the better equipped hospital network in urban areas which gets the lions share of the total resources" (Qadeer, I, 1985: 205).

Studies (Ram and Dutta, 1976: 136-137; Reddy, 1989: 123-124; Mouli and Guruswamy, 1982: 28-37; Ashish Bose, 1987: 11-15) show that health policies have not taken note of problems of physical accessibility and logistic support which are essential to attain 'Health for All' by the year 2000. According to them, as far as planning for health was concerned the planners have adopted a uniform pattern for the establishment of primary health centres, and sub-centres

throughout the country based on population size.

In addition to these studies, the Indian Government sponsored a study group set up by the **ICSSR-ICMR** in 1980, to look into the social aspects of medicine with a view to suggest reforms which would lead to improvement in the health status of the people.

The Committee recognized that the implementation of health policy has been defective and that there is a wide gap between theory and practice in this regard. According to the committee, the health services functioned as two, different systems, one the modern, expensive, curative and highly professionalized health system, and the other, a conglomeration of semi-professionals, and paramedical personnel, based in primary health centres in rural areas which was expected to provide preventive services but is actually delivering poor quality curative services (ICSSR-ICMR, 1981:89).

The Committee also observed that the 'camp' and 'target' approach advocated by the present professional workers was highly disruptive, and should be replaced by continuous, and sustained activity which is effective (ICSSR-ICMR: 1981:114).

According to the committee report, medical **education**, and the health care delivery system have gone their separate ways, and there was little congruence between the role of the

physician, and the needs of the society. The report also states that "the growth of the health services in the country had been haphazard, and unrelated to the needs of the poor. Overcentralization of authority and **compartmentalization** still continued .to plague the services despite several efforts to bring about integrated comprehensive health care, and that the health personnel structure was still distorted (ICSSR-ICMR; 1981: 156-157).

Accessibility to health care institutions was determined not only by spatial distribution of services but also was determined by the social position that the person seeking treatment occupies in the community (Banerji, 1984).

Banerji (1984) also observes that the primary health care network as other welfare services were inaccessible to the poor. The overall image of the Auxiliary Nurse Midwife is that of a person who is quite distant from them, and was meant only for special people or for those who can pay for her services.

Studies conducted by the Public System Group, IIM, Ahmedabad, 1985 in the States of Bihar, Madhya Pradesh, Uttar Pradesh and Rajasthan, identified programme as well as non-programme factors which play an important role in the implementation of Family Welfare Programmes. The programme factors identified included (a) short term of Health Secretaries, and Directors coupled with political pressures at the state level; (b) inadequate powers to the District

Medical and Health Officers, and primary health centre Medical Officers; (c) Medical Officers strongly oriented towards clinical practice with very little training in public health, (d) poor infrastructure facilities (e) poor management information system (f) involvement of Medical Officers in private practice, and (g) lack of motivation and morale on the part of the primary health centre staff.

The non-programme factors identified included political disturbances in states; drought and scarcity; migration; support received from kingroups; level of education of the people; other welfare programmes operating in the area; income, religion, and caste. The group also pointed out that services provided at the primary health centres were highly unsatisfactory, and lack of concern for quality rather than lack of facility was responsible for poor performance.

According to the study, the training of the village Dais, and the Health Guides was not adequate as it was imparted through lower level functionaries, and the doctors (at the primary health centres) take very little interest. As a result, these functionaries were not performing the functions envisaged in the programme.

✓ From the observations of the study sponsored by the division of human resource development research, and the ICMR, in 1989, it was clear that the quality of family welfare services rendered through the primary health centre network was **poor**, and that the maternal and child health

component was substantially weak in most instances. Even in those primary health centres where the availability of manpower, and infrastructural resources was adequate, it was observed that the quality of maternal and child health, and family planning services was still not satisfactory. The study recognizes that while enough attention was to be given for improving the manpower, and other infrastructural facilities, greater emphasis was required to enhance the managerial, supervisory, and technical skills of medical, and other health functionaries for improving both the quality, and coverage of maternal and child health, and family planning services. Further the study calls for continuous monitoring, and evaluation which are two very important tools for improving the performance - both qualitatively, and quantitatively.

According to some of the studies (Jorapur, P.B 1979 : Sholapurkar, et.al 1983) the primary health centre being the lowest administrative unit, and the sub-centre being the most peripheral service delivery point for various primary health care programmes, can deliver efficient and effective comprehensive health services provided some of the bottle necks discussed above are removed.

#### 1. 4 STATEMENT OF THE PROBLEM AND OBJECTIVE OF THE STUDY:

The overall impression of the research scholars, research teams, government evaluation reports on the performance of Primary Health **Centres**, and in particular the



family welfare services is that they have failed to achieve the purpose for which they were launched. The studies (Public System Group, IIMA, 1985) have identified a number of factors responsible for the poor performance of these centres. However, a wholistic approach based on in-depth studies of the PHC's as an institution within the system of social relations is absent.

Most of the studies quoted above have evaluated the performance of these centres in terms of the Family Welfare Programme which includes family planning and maternal and child health services. Other important health programme components such as control of communicable diseases, school health, health education and environmental sanitation which are an integral part of primary health care services have not been given sufficient attention. In order to understand the functioning of a centre in its totality, appraisal of all primary health care components is essential. This kind of an exercise will show whether or not a particular Primary Health Centre is providing integrated comprehensive primary health care services at the doorsteps of the people through the organized effort of the health personnel and the community. If not, why?

Let us, at this stage, briefly discuss the structure of our thesis in the context of the holistic evaluation of the PHC as an instrument of National Health Policy.

First step in this would be to study the organization structure of the PHC to see how its functions are differentiated and coordinated to achieve its objective. Studying the organization structure alone is not enough, we also need to study the various important processes implied within the organization as a functioning whole such as - a) selection procedures (which ensure selection of right persons for the jobs); b) socialization and training procedures (which help the personnel to understand what the organization expects from them and enhances their ability to fulfill these expectations); c) evaluation of the performance of the personnel with regard to various activities; d) target setting practices which monitor the degree to which the objectives of the organization are being met and provide the means for remedial action; and e) supervision and supervisory practices to check whether the personnel are actually performing their job or not.

Apart from the organizational processes mentioned above, formation of groups based on differences in social background of the personnel, availability of resources to the PHC, working conditions of the personnel and their linkages with the beneficiary community could influence linkages at the grassroot level which in turn could be a positive factor in achieving the objectives of the organization. However, these are some of the areas which the studies (ICMR, 1989) have not adequately addressed. Therefore examining these would provide us with insights into the functioning of the



centres, and could give leads into the exploration of alternatives both at the level of implementation and at the level of policy.

Again the studies (Public System Group, **IIMA**, 1985) have not taken into account the perceptions of the beneficiary households at the village level regarding the outreach of services while evaluating the performance of the centres. Some studies (David, L.H and Narayana, G, 1983, 1985) have tried to logically show that there is a **tendency** to inflate performance figures; however these are not tested by interviewing beneficiaries. Our study takes into account the perceptions of the beneficiary households at the village level. This should prove useful for two reasons, firstly, it would show whether the centre is performing its role as designed and secondly, it would also show whether or not the services are functionally accessible to the people for whom they are meant, that is the poor and the underprivileged segments of the community.

Let us briefly present a resume of the argument thus far. The prime objective of the proposed study is to gain insights into the role and potential of the Primary Health Centre (PHC) as an instrument of the National Health Policy.

This objective can be achieved by examining some of the important components of the health care delivery system which include:

1. the analysis of the existing organization structure,
2. the recruitment, selection, training and social background of the personnel,
3. work load, programmewise performance of the personnel and target setting practices,
4. supervision and supervisory practices, and linkages with the community,
5. socio-demographic profile of the beneficiaries,
6. perceptions of beneficiaries regarding outreach and utilization of primary health care services at the village level.

In the sections below we shall examine each of the above components of the PHC in the context of the theory of formal organization.

#### 1.5 CONCEPTUAL PERSPECTIVE:

In sociological terms one can conceptualize the Primary Health Centre (PHC) as an organization to understand and explain its role and functioning. The PHC like other formal organizations (as defined by various social and behavioural scientists - Blau and Scott, 1963; Etzioni, 1964; Parsons, 1960 et. al) is composed of individuals and groups who have come together to achieve certain objectives employing

deliberate means to coordinate and direct the activities of the organization over a period of time.

The PHC according to the typology of Blau & Scott (1963) can be classified as a "service organization" where the clients or "public-in-contact" is the prime beneficiary. Its main objective is to provide integrated health care, both curative and preventive, and to serve as a focal point from which health services radiate into the area covered by the development block. It is supposed to educate the individual, the family and through them the community. This objective is expected to be achieved by providing the following services : (i) medical relief; (ii) control of communicable diseases; (iii) environmental sanitation; (iv) maternal and child health services; (v) family planning; (vi) school health; (vii) health education, and (viii) collection of vital statistics (GOAP, 1985: 1-2).

#### 1.5.1 Organization Structure :

In order to fulfill the above objectives, the PHC has to depend upon a well articulated organization structure each component of which should be suitably designed to achieve the objective of the organization. Since the sub-centres are the most peripheral units which deliver services in the villages we shall start the analysis of the existing organization structure at this level and proceed upwards to the district and state levels. This is being done because these centres do not function in isolation but function as a part and parcel

of the broader healthcare organization. It is the district level authorities who are responsible for **planning**, executing, and evaluating all the **programmes** in the district as per the policy guidelines of the State Directorate. We will therefore analyze the structure at the district as well at the state level.

The organization analysis will be done from two points of view : (i) the structural perspective, and (ii) the behavioural perspective.

While it is possible that there are many ways in which the work in organizations can be performed, two major types of differentiated functions can be identified: those differing along the "horizontal" dimension of the organization, and those differing along the "vertical" dimension (Strother, 1963: 23).

The structural analysis, therefore, will be done taking into account the horizontal and vertical differentiation and integration with emphasis on coordination at different levels. Two aspects of coordination, **intradepartmental** and **interdepartmental** will be covered. This exercise will be essentially of a qualitative nature.

"Horizontal" differentiation refers to the division of activities among individuals and groups all of whom occupy the same authority, and responsibility level. In other words, this kind of differentiation can be labelled as "division of labour" (the various ways in which the personnel

may be grouped together in an organization. "Vertical" differentiation deals with differences along dimensions such as the amount of authority or power an individual has to influence organizational actions, the degree of responsibility he has for these actions, and the number of personnel he or she supervises. Vertical differentiation within organizations provides for specialized types of coordinative activities. The division of labour on the horizontal plane creates the need for this type of function (Strother, 1963: 23-25).

Most organizations are confronted with the task of reducing instability, and unpredictability of individual actions. This is achieved by a system of authority, status and role differentiation. According to Katz and Kahn, compliance with authority becomes a generalized role expectation in organizations (Katz and Kahn, 1966: 203-204). "Roles" are sets of expectations that are attached to organizational positions. They provide a coordinative device both for the members who occupy the positions, to which the roles are attached, and for the other members of the organization who come into contact with them. For the occupants, the role helps to define the limits of the activities to be performed by providing a basis for deciding what should or should not be done. Others who come into contact with the occupant of a role, can adjust their own efforts in the context of the mutuality of their role - relationship. In most formal organizations the roles played

by the people are a "function of the social setting than of their own personality characteristics" state Katz and Kahn (1966: 174).

Given the horizontal and vertical differentiation of functions, the behavioural aspects within the structural framework assume importance.

Differentiated functions associated with specific 'roles' and 'statuses' are a necessary part of any organization. However, certain consequences that occur may or may not be beneficial to the organization. Firstly, the way in which functions are divided among the different personnel, especially with regard to the horizontal division of labour, strongly determines who will interact with whom. Sometimes the structure forces people to interact more with some persons rather than with others and also aids in the formation of informal groups within the organization. Though division of labour does not completely determine these interactions it could place certain restrictions on the activity of the personnel leading to disharmony within the organization. The longer the period of time over which particular patterns of interactions occur, the more stabilized they may become; often leading to the emergence of an informal structure within the formal structure of the organization. In this sense, the structure, and differentiated functions with their resulting interaction patterns cannot be considered as two separate entities.



secondly, differentiated functions affect the attitudes of individuals in different positions within the organization. When a person must concentrate more on a specific aspect of the total work, he/she may develop certain dogmatic viewpoints about the importance of the specialized activities which are so much a part of his/her immediate experiences (Herman and Hulin, 1972; Schneider, 1972; Porter and Stone, 1973). The attitudes or viewpoints thus developed will, in turn, affect the individual's relations with other people; his/her motivation to perform effectively; and the degree of commitment to the organization as a whole. Thus differentiation of functions is one of the crucial factors influencing an individual's attitudes towards his/her job, colleagues, and the organization.

Differentiation of functions (horizontal and vertical), coordination of activities at different levels, and the infrastructural facilities available have been discussed in chapter II of the thesis.

#### 1.5.2 Social background, selection and training of personnel:

To ensure the achievement of objectives, organizations need certain formal processes and one such process is related to personnel which includes social background of the personnel; recruitment and selection; socialization and training -(pre-service & in-service); experience in the present job; transfers; and emoluments. Besides these processes, the value orientations of the personnel towards

their job also affects their performance on the job.

Differences in social background characteristics of the personnel could impose certain constraints on inter personnel relationships, formation of groups and team work within the organization. As we have already seen hierarchical organization serves an important function for achieving coordination which it does by restricting the free flow of communication. These hierarchical obstacles to communication may foster consultation among peers and may give rise to an informal differentiation of status which may create obstacles in communicating with each other just as the formal status differences do. Therefore an attempt has been made to study the social background of the personnel. Social background broadly measured in terms of religion, caste, nativity, and educational qualifications gives an indication of the homogeneity and heterogeneity of personnel working in the organization. The social background characteristics have been discussed in chapter III of the thesis.

Recruitment involves finding **manpower**, and encouraging potential employees to seek jobs in the organization. Recruitment is done either by advertising or through employment exchanges or through professional associations. Here job specification serves as a major guide to select the right persons for the right job. This is important as it is bound to influence the working of an organization.

Once the selection process is complete, the personnel



and the organization have to mutually learn to adjust towards each other (socialization). **This** helps the personnel to understand their role in the organization, and their capacity to fulfill its objectives. Effective socialization can influence their commitment to the organization. One important and explicit means of promoting socialization of the new as well as the existing employees is 'training' - (both in-service and on-the-job). The employees need training to develop the necessary technical skills that are needed to carry out their job effectively. Thus a training programme should provide for the learners active participation, knowledge of results about his or her attempts to improve, a meaningful integration of the learning experience so that the trainee can transfer what is learnt to the job situation, and for practice and repetition in a situation that is similar to the job situation (Porter et.al, 1975:211). Given these positive aspects, the effectiveness of training depends on the curriculum developed, nature of training, design of the programme, and facilities available.

Transfers and orientation of the members towards their job are two other important ways which could influence the overall performance of the PHC organization. Transfers are generally meant to ensure that an individual does not develop too deep loyalties with certain sections of the beneficiaries, and use the local influences for pecuniary benefits. At the same time the positive aspect of transfers is the general knowledge of different areas and aspects of

the organization. The experience gained from one area can be transferred to another area. However, the transfers when too frequent could be a seriously disturbing element in the system as well. Number of years of experience and transfers go together. Frequent transfers can influence the working of the organization either in a positive or a negative manner. Therefore it is important to know the number of times the personnel are transferred, and their perceptions and preferences regarding transfers.

Orientation of the employees towards their job is important as it could profoundly influence the functioning of the organization. Orientation involves attitudes, a member in an organization imbibes towards its functioning. This involves a) internalising the goals and values of the organization and b) learning appropriate ways of behaviour conducive to the health of the organization and its members. Orientation has been studied in terms of the employees personal preference vis-a-vis the priorities laid down by the organization with regard to the various primary health care programmes. The members of an organization usually weigh the advantages and disadvantages of being in service in terms of their satisfaction with regard to the job, promotions, salary, colleagues, cooperation from villagers and facilities available.

The recruitment, selection, training, transfers and orientation towards their job have been discussed in chapter III of the thesis.

### 1.5.3 Programme wise performance and target setting practices:

The performance of any organization should be measurable in simple and quantitative terms. All employees are expected to perform various tasks in their individual capacity as well as members of a team to ensure that the objectives of the organization are met. Performance evaluation is essentially a process by which the actual and expected performance can be compared. It is a process designed to both, facilitate information exchange, and influence performance. Data from such an evaluation helps in pinpointing the strengths, the weaknesses of the members, as well as their individual potential to grow further within the organization. It (the evaluation) can lead to a clearer definition of the job to be performed, and also helps in improving the relationship between the Supervisors, and the Workers regarding what constitutes acceptable performance.

Thus one reason why organizations need to appraise performance is that they need the information it yields in order to plan, coordinate, and administer training and development programmes to overcome the weaknesses of the low performers, and to increase the potential of the high performers. The performance appraisal process is also used by organizations as a way of influencing intrinsic, and extrinsic work. Rewards such as promotion, and pay increases are often tied to the results of performance appraisal in the hope of creating the belief that good performance leads to

desired rewards, In case of poor performance, the feedback may become difficult to accept especially if the employee hopes to obtain extrinsic rewards resulting in conflicting situation, From the superior's point of view, evaluating a subordinate's performance and giving a feedback may not be very pleasant especially when the feedback is negative. In such cases unpleasant interpersonal situations may develop between the supervisor's and their subordinate's.

The performance of the members can be evaluated from two perspectives. It can be looked at in terms of the activities the personnel perform and it can be seen also in terms of the results of that activity. Performance evaluation can focus either on results, or activities or both. Research findings on performance evaluation suggest that focussing on results produces a different impact than focussing on activities or on a combination of the two (Tosi, Rizzo and Carroll, 1970: 70-78).

Focussing on results often motivates employees to behave in ways which are dysfunctional from the point of view of organizational effectiveness but provides good scores on the measures, that is, workers tend to perform well only in those areas in which they are evaluated, especially if the evaluation determines whether or not they receive rewards. Evaluation based on results may fail to provide the information needed to counsel, and develop individuals.

Evaluation of performance which focusses **only** on the activities the person engages in, tends only to motivate the activity rather than what is being accomplished. Thus any performance evaluation system if it is to meet the objectives of the organization as well as its personnel must measure both activities, and results.

Sometimes there may be a wide gap in the expected and actual performance of the personnel. This could be because of, a) excessive work load, or b) too high targets. Excessive work load would include the population to be covered, number of villages to be covered, distance to be travelled from place of stay to place of work, time spent on travel and mode of transportation. With regard to target setting practices it is important to know as to who sets the target, what is the basis of target setting, and whether targets are given to individuals or the teams.

The workload, programmewise performance of the personnel, and target setting practices have been discussed in chapter IV of the thesis.

#### 1.5.4 Supervision. Supervisory practices and **linkages with the community**:

Supervision and supervisory practices are often tied with control and delegation of authority. They have to be designed in order to **help** the members effectively meet organizational expectations **as well** as to check the degree to

which the personnel are actually doing so.

The supervisor is the critical link in the chain of command within the organization. To most Workers what the Supervisor says and does, represents the attitude of the organization. The Workers view the organization as favourable if their Supervisor is good, and unfavourable if their Supervisor is ineffective. A Supervisor therefore must have the necessary skill, and competence of the activities to be performed under his direction, and must set, and maintain standards of performance in terms of quantity as well as quality. He or she must be able to appraise the skill, competence, and contributions of the Workers he or she directs, and must be able to make decisions and at the same time create an assurance of fairness and equity for all the Workers of his or her team. The Supervisor must help, stimulate, motivate, control, and lead his/her team workers. In essence the Supervisor is the leader of his group and has to get the workers to do whatever work is to be done.

Supervision and supervisory practices can be examined in terms of frequency of interaction between Workers and Supervisors, amount of time spent, tasks supervised, type of instructions given, nature of controls exercised (recognition for good performance and reprimands for poor performance), and time spent at PHC monthly meetings.

Level of interaction and relationship between the personnel and village level workers has also been examined in



this chapter, This is important because the personnel are supposed to coordinate their work at the village level with the help of the village level workers. Maintaining proper communication linkages with the village level workers is not sufficient in itself and the Workers have also to maintain proper communication linkages with other prominent members of the village community, and voluntary organizations who could aid in the effective implementation of the primary health care programmes. This is because the villages in India exhibit certain unique features of unity and diversity in terms of its 'caste', 'class', and 'power' composition resulting in different types of relationships, and pattern of interaction between units.

Supervision and supervisory practices and linkages with the community have been discussed in chapter V of the thesis.

#### **1.5.5 Sociodemographic profile of the beneficiaries:**

An important component of all service organizations is its 'clients' or beneficiaries. Therefore provision of adequate health care services always depends on the interplay of the beneficiaries, the providers, and other social factors.

Whenever beneficiaries approach health personnel they have an image which reflects the societal definition of the health personnel's role and expectations. These perceptions are formed by the beneficiaries own experience or from

earing about experiences of other people (significant others), It is within this frame of reference that the beneficiaries attempt to evaluate the health personnel performance and also the performance of the organization as a whole, Therefore in order to understand the working of the HC organization in its totality it is important to study the beneficiary component,

As the primary health care services are meant to be delivered at the village level, the location of villages vis-à-vis the health centres, size of settlements and amenities available would show whether the centres are geographically accessible to the beneficiaries.

Examining the social background characteristics of the beneficiary households in terms of their caste, religion, income, occupation, type of family and size of the households would tell us who the users of these services are as they are essentially meant for the socially and economically backward sections of the community.

The sociodemographic profile of the beneficiaries, the location and amenities available to them have been discussed in chapter VI of the thesis.



#### 1.5.6 Outreach and utilization of primary health care services as perceived by the beneficiaries:

Perceptions of the beneficiaries regarding the outreach and utilization of primary health care services to a large extent would reflect the performance of the personnel and also the PHC. Perceptions of the beneficiaries would provide information on the extent to which the general public is availing the various services being provided, the problems encountered in utilising the services, and what they expect from the health centre and its personnel.

The outreach and utilization of primary health care services as perceived by the beneficiaries has been discussed in chapter VII of the thesis.

#### 1.6 METHODOLOGY:

The methodology used in this study is essentially case study method. We have chosen to study indepth one PHC in terms of its organization structure, its functioning, and its outreach and utilization by the beneficiaries. It is exploratory and uses both quantitative and qualitative indicators to describe the status of the PHC as a tool for implementing the policy which expects to achieve 'Health for All by the year 2000'.

#### 1.6.1 Area of Study:

This study has been conducted in Ranga Reddy district of Andhra Pradesh. The district is primarily a rural hinterland for Hyderabad city, but is backward in terms of overall development. The district was previously divided into eleven taluks but now in the revised administrative setup the district consists of thirty seven revenue mandals.

The total geographical area of the district is 7,498 Sq.kms. and has a population of 15,82,062 according to the 1981 census. The district has 949 inhabited villages, and the density of population is 211 per square kilometre. The literacy rate for the district as a whole is 29.41%. However among the women the literacy rate is as low as 19%. If one looks at the amenities available in the district one finds that medical services, market facilities, communications, and posts and telegraphs are inadequate in villages which have a population of less than 5000. The table below gives a picture of the amenities available in the district.

Table 1.4 :

Distribution of villages according to population range and amenities available in **Ranga Reddy** District.

| Population range | Number of inhabited villages in each range and percentage to total | Education      | Number (with percentage) *f villages having the amenity of |                |                |               |                |                        |                 |
|------------------|--------------------------------------------------------------------|----------------|------------------------------------------------------------|----------------|----------------|---------------|----------------|------------------------|-----------------|
|                  |                                                                    |                | Medical                                                    | Drinking water | P & T          | Market        | Communication  | Approach by pucca road | Power supply    |
| - 499            | 250<br>(26.34)                                                     | 170<br>(68.00) | 6<br>(2.40)                                                | 244<br>(97.60) | 36<br>(14.40)  | 4<br>(1.60)   | 73<br>(29.20)  | 93<br>(37.20)          | 157<br>(68.00)  |
| 500 - 1,999      | 537<br>(56.59)                                                     | 529<br>(98.51) | 100<br>(18.62)                                             | 536<br>(99.81) | 293<br>(54.56) | 20<br>(3.72)  | 297<br>(55.31) | 331<br>(61.64)         | 469<br>(87.34)  |
| 2,000 - 4,999    | 147<br>(15.49)                                                     | 147<br>(100.0) | 100<br>(68.03)                                             | 147<br>(100.0) | 139<br>(94.56) | 35<br>(23.81) | 130<br>(88.44) | 135<br>(*1.4)          | 147<br>(100.00) |
| 5,000 +          | 15<br>(1.58)                                                       | 15<br>(100.0)  | 13<br>(86.67)                                              | 15<br>(100.0)  | 15<br>(100.0)  | 6<br>(40.00)  | 15<br>(100.0)  | 15<br>(100.0)          | 15<br>(100.0)   |
| Total            | 949<br>(100.0)                                                     | 861<br>(90.73) | 219<br>(23.00)                                             | 942<br>(99.23) | 483<br>(50.90) | 65<br>(6.85)  | 515<br>(54.27) | 574<br>(60.48)         | 788<br>(83.53)  |

(Figures in brackets represent percentage)

Source : District Census Hand Book, 1981.

### Medical facilities in Ranga Reddy District:

| Sl. No. | Item                              | Year | Unit |
|---------|-----------------------------------|------|------|
| 1.      | Civil Hospitals, and Dispensaries | 1987 | 25   |
| 2.      | Primary Health Centres            | 1987 | 9    |
| 3.      | Sub-centres                       | 1987 | 205  |
| 4.      | Rural Health Centre               | 1987 | 1    |
| 5.      | Mandal Primary Health Centres     | 1987 | 14   |
| 6.      | Postpartum Unit                   | 1987 | 1    |
| 7.      | Number of Government Doctors      | 1987 | 71   |
| 8.      | Total Bed strength                | 1987 | 620  |

(Source: District Medical and Health Office, R.R. District 1987)

For the district as a whole, there is only one doctor for a population of 23,000, and one bed for a population of 2,552.

#### 1.6.2 Universe of study:

One Primary health centre located in the Hayatnagar Mandal of Ranga Reddy district has been chosen for the study. The reason for choosing this centre is that, (1) it is one of the best performing primary health centre, according to the District Medical and Health Office; (ii) it is more accessible when compared to the other primary health centres in the district, and (iii) it caters to a mixed population being closer to the City.

The **study** of **Hayatnagar** Primary health centre would **therefore yield insights** into the working of other primary health centres in the district. The primary health centre caters to a population of **55,421**, according to the 1981 census, covering thirty five inhabited **villages**.

#### 1.6.3 **Sampling, data collection and analysis:**

All personnel working in the primary health centre have been included in the **study**. In the primary health centre there are three Medical officers - one in-charge Medical Officer, another in-charge of the **Family Welfare Programme** and third in-charge of the Village Health Guides Scheme. All the three Medical Officers have been interviewed.

Below the Medical Officers are the first line Supervisors, one Block Extension Educator; one Block Health **inspector**; and Seven Multipurpose Health Supervisors (men and women). Next in hierarchy are the fifteen Multipurpose Health Workers (men and women) in position of whom **fourteen** have been interviewed with the help of structured - interview schedules.

In addition to the full time **field workers** the programme also operates through the Village Health Guide\* **and** midwives or Dais (trained). Thirty Village Wealth Guide\* out of the forty in position, and **twentyfour Dais** out of the

twenty eight Dais trained, and ~~in~~ position, ~~have been inter-~~viewed depending on their availability ~~in~~ the ~~field.~~ the table below gives the number of primary health ~~centre person-~~nel in position, and the number interviewed:

Table 1.6:

Number of Primary Health Centre ~~personnel~~ ~~in~~ position, and number interviewed:

| Sl.No. | Category                              | Total number in position | Total number interviewed |
|--------|---------------------------------------|--------------------------|--------------------------|
| 1.     | Medical Officers<br>(women)           | 3                        | 3                        |
| 2.     | Multipurpose Health Supervisors (Men) | 7                        | 7                        |
|        | (Women)                               | 2                        | 2                        |
| 3.     | Multipurpose Health Workers (Men)     | 4                        | 4                        |
|        | (Women)                               | 11                       | 10                       |
| 4.     | Village Health Guides                 | 40                       | 30                       |
| b.     | Dais (trained)                        | 28                       | 24                       |

The information from the primary health centre has been collected both from primary, ~~as~~ well as secondary sources. The primary data has been collected from the personnel with the help of interview schedules. Different interviews schedules were prepared for each category of personnel as their job functions differ. Each interview schedule included questions about their socio-economic background, orientation towards the primary health care ~~approach,~~ details of job experience, perception of the problems in the ~~implementation~~ of the different programmes, relationship with ~~supervisors.~~ information on ~~infrastructural~~ facilities and community participation. Most of the questions are closed and only a



few open ended. The interview schedules were pretested and the necessary changes were **incorporated** (see appendix **I-III**). Since the number of personnel interviewed is not large, the data has been analyzed manually for each category, and their performance has been discussed programme wise.

The secondary sources include registers and reports from the sub-centres and primary health health centre. at the sub-centre level performance of workers for one year on all **activities**, number of villages, and population covered, registers and reports maintained have formed the part of data collection.

At the primary health centre level, the secondary data included facilities available, sanctioned and staff in position, materials received and distributed, expenditure of the primary health centre, target achievements under various programmes, camps held, and types of incentives given, **have** been taken into consideration. However collection of performance data posed problems as no proper records were maintained at the sub-centre level and even where **it** was available it was not in order. **So** most of the information had to be collected from the primary health centre **records**.

Apart from collecting data from the primary health centre **personnel**, data has also been collected **from** the households to study their perceptions regarding the **outreach**, and utilization of primary **health** care services.

The household study however was limited to an area covered by three sub-centres as ~~it~~ was not possible to cover households within the entire primary health centre area. The three subcentre areas were chosen based on the availability of the health workers at the head quarters, **availability** of transport facilities, availability of other health care facilities in, and around the area. All the villages (numbering twelve) falling within the jurisdiction of the three sub-centres have been taken up for the survey to get a better representation of households from the sub-centre villages as well as other villages.

The twelve villages have a total population of 15,948, and 2,713 households. However for the purpose of the study, households with children ~~between~~ the age group of eleven months to two years have been chosen, as it is only these households who form the bulk of users as far as the sub-centre, primary health centre services are concerned. A total number of 477 households were selected from the household survey lists prepared by the Family Planning Association of India (FPAI) as the household registers at the sub-centre were not upto date in some cases, and were totally absent in some others.

The interview schedule for the households included questions about their socio-economic background, their per-



**ceptions** regarding the outreach and utilization of primary health care **services** (See **appendix:IV**). Information **collect-**ed regarding utilization, and outreach of services has been limited only to a period of one year because most of the respondents were not able to recollect information beyond a period of one year.

Collection of data from households took a considerable amount of time as many of the women folk were available only during the early hours of the day, or late in the evenings. Most of them were engaged as agricultural labourers.' Because of this, repeated trips had to be made to the villages.

The data collected from the households has been analyzed with the help of VAX computer at the Administrative Staff College of India, Hyderabad. The data was initially entered into the coding forms, and the programme had been written to get simple frequency tables in the first instance after which it has been subject to cross tabulations.

Apart from collecting data through primary and secondary sources, information has been collected from informal interviews, and observation of the **ongoing** activities at the sub-centres, and the primary health centre. The information **thus** collected has been used in the course of discussion to make the study more objective.

### 1.7 LIMITATION OF THE STUDY:

This study ~~is~~ basically limited to only one primary health centre in the district, based on which no firm generalization can be made regarding the functioning ~~of~~ other primary health centres in the district. However it is hoped that the study, by providing a critique of the working of a rural primary health centre would assist ~~the~~ planners, and administrators in making these centres, effective instruments in achieving the objectives as envisaged in the National Health Policy document.

CHAPTER II  
ORGANIZATION OF MEDICAL AND HEALTH SERVICES  
IN ANDHRA PRADESH

In this chapter an attempt has been made to analyze how the functions of the primary health care organization are differentiated and coordinated at different levels with greater emphasis on intradepartmental coordination. It would be appropriate to begin such an analysis at the lowest level, that is, the sub-centre, and proceed upwards to the directorate level. But before that let us very briefly look at the organization of medical and health services in Andhra Pradesh.

Health being a state subject falls within the domain of the state government. At the state level there are broadly two wings: (i) the Health Secretariat which provides the policy, and planning directions, and (ii) the Directorate which provides the necessary technical inputs into the various medical and health care programmes.

The Health Secretariat plays an important role by formulating policies pertaining to medical care, medical education, public health, and other matters related to health based on the information provided by the different directorates of medical and health services, and in turn communicates the formulated policies, and decisions to the directorates for implementation from time to time.

The Health and Medical Care Services are supervised, and controlled by the different directorates as follows :

(i) Directorate of Medical Education oversees the functioning of medical colleges and the teaching hospitals in the State;

(ii) Directorate of Institute of Preventive Medicine and Food Control, has the functions to provide the laboratory facilities and quality control of food commodities;

(iii) Directorate of Indian Medicine Systems and Homeopathy, looks after the provision of medical and health care services through Ayurveda, Unani, Homeopathy and other Indian systems;

(iv) Directorate of Drugs Control and Administration, controls the quality of drugs, issues licences for the manufacture and sale of drugs;

(v) Employees' State Insurance (ESI) services, provides protection against loss of wages due to inability to work on account of sickness, maternity and disablement, and payment of insurance money of the persons who die as a result of employment injury. The scheme also provides medical care to the insured persons and their family members;

(vi) Andhra Pradesh Vaidya Vidhana Parishad (Commissionerate of Medical Services) oversees the functioning of non-teaching hospitals which include the district hospitals, area hospitals, community hospitals, speciality hospitals, and dispensaries;

(vii) Directorate of Health provides the bulk of medical and health services in the state for **the** prevention and control of locally endemic diseases, and provision of curative services, particularly in rural **areas**; and

(viii) Directorate of Family Welfare is responsible for the Family Welfare and Immunization Programmes in addition to Maternal and Child Health Programme.

The bulk of the primary health care services are provided under the technical guidance and supervision of the above two directorates (vii & viii). We shall therefore start the analysis at the sub-centre and move upwards to the directorate level.

#### 2.1. ORGANIZATION AT THE SUB-CENTRE :

At the sub-centre level there are two main functionaries namely, the Multipurpose Health Workers (male and female) catering to a population of above 5000 scattered in three to five villages. Previously the workers used to look after only one health programme under the Uni-purpose Health Workers Scheme. After the introduction of the Multipurpose Scheme, the Health Workers are supposed to provide integrated ~~health~~ services to the population they were serving. Provision of integrated health services means that the Health Workers are given the responsibility of implementing all programmes and not just one programme. The duties of

the men and women Health Workers are similar except for the additional work of Maternal and Child Health **Programme** which is entrusted only to women Health Workers. For further details see Appendix VI : 108-124, The women Health Workers guide and supervise the work of the Dais, while the men Health Workers guide and supervise the work of the Village Health Guides.

In a given sub-centre area both the male and female Health Workers are supposed to coordinate their activities to achieve the programme targets. But these Health Workers rarely coordinated their day-to-day activities as most of them did not live in the sub-centre village (seven out of ten women Workers and all four men Workers). One reason why Health Workers did not reside in the sub-centre village was because residential accommodation was not available at all sub-centre villages, and where available was more accessible to the women workers rather than the men workers. At times even when residential accommodation was available the Health Workers preferred to stay away either because of personal problems or other personal interests. Secondly, coordination of activities between the two workers was also lacking because they were supervised individually by men and women **Multipurpose** Health Supervisors who reported directly and individually to the Medical Officer in-charge of the Primary Health Centre (PHC). It was only at the PHC that all workers meet once a month.



The organizational structure was such that the men and women Workers were considered independent entities working in a given sub-centre area and serving the same population, This was further reinforced by the allotment of targets for different programmes which were not given to a particular sub-centre area but were rather given to individual Workers. This approach obviously leads not to cooperation and coordination but to confrontation and unhealthy competition among the men and women workers. Sometimes Workers were also not able to coordinate their activities because of their social background differences like religion, and differences in sex. Another major problem in this PHC was that there are only four men Workers in place of the required number of ten Workers. This also made coordination very difficult. Enough men Workers have not been selected partly due to shortage of personnel and partly because of insufficient budget allocation to meet the salary expenditure of the men Workers. It was only during family planning camps, intensive immunization camps and epidemics that they were seen together. My own deeper feeling was that there was very little motivation in the Workers, and therefore were not committed to the cause of working together. ~~Given~~ Even these problems no concerted effort was made on the part of the Workers, their immediate Supervisors and Medical Officers to buildup a spirit of teamwork which was the very basis of providing integrated health care to all those in need. As a

result the men and women Workers continued to work independently in the same villages, for the same population and for the same programmes and objectives.

At the village level, two functionaries, namely, the Village Health Guides, and Dais are supposed to assist the men and women Health Workers in implementing the primary health care programmes.

The Village Health Guides (selected from the village community) are supposed to cover a population of one thousand spread over one or two villages. They should assist the male Health Workers in identifying fever cases, and collection of bloodsmears. In the meanwhile, they should also provide presumptive treatment and help the Health Workers in spraying of DDT. They should chlorinate public water sources and educate the community regarding the spread of communicable diseases, and provide treatment for minor ailments. For further details regarding the Health Guide's job duties see Appendix VI : 108-124.

The Dais help the women Workers by bringing antenatal cases to the sub-centres once a week. They conduct most of the deliveries in the villages as many of the Health Workers do not reside in the sub-centre villages. They also sometimes provide postnatal care, and motivate eligible couples to undergo sterilization.



The village level functionaries have an important role to play in the village, however it was found that their potential was not being fully exploited (by the PHC staff) for the implementation of primary health care programmes. Since they are selected from within the village community, these functionaries would have a better rapport with the villagers as compared to the other staff (who are not locally recruited). Therefore enlisting their cooperation and support would prove very useful,

## 2.2. ORGANIZATION AT THE SECTOR LEVEL :

Above the Multipurpose Health Workers and below the Medical Officers and other Primary Health Centre staff are the sector Multipurpose Health Supervisors (male and female). The Health Supervisors are expected to cover a population of 30,000 in which there are four to six sub-centres each with one male and female Health Worker. The duties of the men and women Supervisors are similar except for the additional work of Maternal and Child Health Programme which is entrusted only to the women Supervisors (see Appendix VI : 108-124).

The men and women Supervisors are supposed to coordinate their activities and also coordinate their activities with those of the Health Workers **including** the Health Guides and Dais. However, it was found that they rarely coordinated their activities. This was because the men Supervisors supervise the work of the men Workers,

and the women Supervisors the work of women Workers only, Secondly, many of the Supervisors (seven out of nine) do **not**, live at the sector headquarters due to lack of proper **accomodation** and facilities for their family. Coordination of activities between the Suprevisors and Workers was also lacking to a large extent. Although in terms of social background differences the gap between them is minimal they were not close to each other. This was because Supervisors were also assigned targets for sterilization cases along with the Workers. This practice was leading to unhealthy competition between them resulting in improper supervision and coordination of activities at the sub-centre level. Sometimes without the knowledge of the Health Workers, the Supervisors seek the help of Dais or Village Health Guides to get family planning cases. This resulted in a conflict between the Supervisors and Health Workers thereby affecting the coordination of their work. Supervisors usually visit the sub-centre village once a week on the day antenatal clinic is conducted and rarely visit other villages in their jurisdiction. They usually visit other villages only if there are cases to motivate for family planning operation, or during intensive immunization camps or during epidemics and mass media campaigns. ~~The~~ men and women Supervisors generally meet only during the monthly meetings at the Primary Health Centre. Although the Health Supervisors form an important link between the Medical Officers and the **Heal th** Workers their

involvement in the programme implementation was very unsatisfactory,

2,3, ORGANIZATION AT THE PRIMARY HEALTH CENTRE :

Each Primary Health Centre (PHC) has three Medical Officers, one regular Medical Officer, one Medical Officer in-charge of the Family Welfare Programme, and a third Medical Officer in-charge of the Village Health Guides Scheme. The Medical Officer in-charge of the Family Welfare Programme is designated as the in-charge Medical Officer of the Primary Health Centre for all administrative purposes. The Government of India is contemplating to abolish the Village Health Guides Scheme in a phased manner, and as a first step in the process, the post of the third Medical Officer is being abolished in some Primary Health Centres. Consequently, the regular PHCs henceforth will have only two Medical Officers (Refer figure, 2.1 : 67).

In the Primary Health Centre under study all the three Medical Officers were present. All were equal in rank, yet the in-charge Medical Officer was considered senior as compared to the other two Medical Officers because of the drawing and disbursement ~~po~~**ters**. The in-charge Medical Officer represents the PHC at the meetings held at the district and **mandal** level. Rest of the work like preventive and **promotive work**, curative **work**, and supervision of Health Workers at the sub-centre level

is supposed to be shared equally by all of them (see Appendix VI :108-124). However, this does not **always** happen, and the existing organizational structure has created problems of interpersonal relationships. Since administrative powers and authority are vested only with the in-charge Medical Officer, the other two Medical Officers felt that they were not able to effectively supervise the work of the Health Workers and were not able to take any action against them. They feel that they should also be given certain administrative powers at par with the in-charge Medical Officer. In the existing set up they feel helpless, and hardly showed any interest in the implementation of the various programmes at the village level.

On the other hand, the in-charge Medical Officer thinks that she has to bear the entire burden of running the Primary Health Centre, and was overworked as compared to the other Medical Officers. At the **sametime** she was not willing to delegate authority to the other two Medical Officers as she alone is answerable if something goes wrong. She had the feeling that authority vested in one Medical Officer was better as it would ensure better compliance to rules, and **procedures** by all the personnel.

Another area of conflict between the in-charge and the other Medical Officers was with regard to

transport facility, and availability of drugs and vaccines, The transport that was available at the Primary Health Centre was generally used by the in-charge Medical Officer, and was not shared with the other Medical Officers. According to the in-charge Medical Officer, it was not possible to share the vehicle with the other Officers because of the meagre budget allocation for the purpose. The vehicle was generally used when she had to go on field visits or to attend district level meetings or sometimes to bring patients for sterilization operations, and also to transport operated cases to their respective villages. Therefore, given the budgetary constraints the vehicle cannot be used by all the Medical Officers. Similarly, drugs and vaccines supplied to the PHCs were not always as per the indents submitted to the district health authorities. Only those drugs and vaccines which were available at the district headquarters were distributed to all the PHCs in the district, and hence had to be used judiciously so that they were available in times of need at the Primary Health Centre as well as the sub-centres. Drugs meant for six months cannot be utilized in three months according to the in-charge Medical Officer.

Given all these problems the in-charge Medical Officer always tried to keep herself apart from her colleagues. As a result there was hardly any communication and coordination of work between them. The district

authorities usually do not intervene and leave the matter to the Medical Officers themselves, In case problems get aggravated, and the performance of the Primary Health Centre is affected then transfer of one of the Medical Officers is considered as the only resort.

In the revised administrative set up (1985-1990) where Mandals have been formed, Mandal Primary Health Centres (MPHCs) catering to a population of 30,000 have been established, Each Mandal Primary Health Centre has only one Medical Officer assisted by a host of paramedical personnel just as in the case of other Primary Health Centres. They include, a Multipurpose Health Extension Officer -formally the Block Extension Educator, one Community Health Officer, Pharmacist, Lab Technician, Senior Assistant, Staff Nurse, Computer. Multipurpose Health Supervisor, Multipurpose Health Worker, Driver and Class IV employees. For further details regarding the job duties see Appendix VI: 108-124. In this kind of a set up the above discussed problems would be taken care of to some extent.

The in-charge Medical Officer is supposed to reside in the quarter provided near the PHC. However, in this study it was found that neither the in-charge Medical Officer nor the other Medical Officers resided in the quarter. They preferred to live in the city as two of them were engaged in private practice (doctors working in PHCs are not supposed to have private practice as they are paid non-



practicing allowance), The district authorities seem to ignore this fact, since they themselves indulged in private practice, As a result none of the doctors were available at the PHC after 1 P.M. Since they were not available, the supporting staff too were not available. The Pharmacist, for example, always came late to work, and would be the first one to leave on the pretext that she had to travel a long distance. The in-charge Medical Officer never bothered to take any disciplinary action as she herself would not follow the rules and regulations prescribed for her.

The discussion so far had been with reference to the coordination of activities within the PHC. However, there were other agencies outside the Primary Health Centre with which the Medical Officers had to coordinate their work. One of the agency was the Village Panchayat comprising of the elected leaders of the village. They wield considerable power and influence over the people and hence enlisting their cooperation is essential especially during immunization camps, family planning camps, and during epidemics. None of the Medical Officers were in touch with the village leaders. They find it difficult to communicate with them because of the differences in their social and educational background. Also as the village leaders are politically active the Medical Officers liked to keep away in order to avoid any kind of confrontation, and political interference in their work.

The other agencies with which the Medical Officers had to keep in touch included the Mandal Development Officer (MDO) and his staff; other developmental programme officers and workers. In the study it was found that some contact was maintained with the Mandal Development Officer and his staff, and not with other officers. This contact was maintained because the Medical Officers needed help during family planning camps, immunization camps, epidemics, and for organizing medical aid during fairs and festivals. They also needed the MDO's help in communicating with the village leaders, especially the Village Presidents. However, the Medical Officers were not very happy with the way the MDO and his staff respond. According to them timely help was never provided by the Mandal Office. On the contrary the Mandal Development Officer and his staff felt that the Medical Officers were not sensitive to the problems involved in making arrangements, as they also need to follow certain rules and procedures. The Medical Officers being professionally qualified considered themselves to be superior to the MDO thus making communication difficult. The fact that all the three Medical Officers were women made things even more difficult.

The in-charge Medical Officer was **considered** most passive and one who did not take any interest in the programmes nor strived to maintain a close liaison with the revenue department according to the Mandal Development



Officer. According to him the Medical Officers keep absenting themselves from work very often, and have no control over the Supervisors nor the Workers. According to the MDO, there are a lot of complaints from the villagers (who have undergone tubectomy) that there was no follow up of the operated cases, and no postoperative care provided. The performance figures of the various programmes according to him are highly exaggerated, and very little is being done on a routine basis especially with regard to family planning, and immunization programmes.

#### 2.4 DISTRICT LEVEL ORGANIZATION OF MEDICAL AND HEALTH SERVICES :

At the district level the District Medical and Health Officer (DMHO) is responsible for the implementation of all the national, and state health schemes, and for administering the medical institutions in the district except those under the control of Director of Medical Education, Commissioner. Andhra Pradesh Vaidya Vidhana Prasihd (APVVP), and University of Health Sciences. The DMHO works under the technical, and supervisory control of the Director of Health with regard to implementation of all health programmes except family welfare, ~~for~~ which the Director of Family Welfare is the supervising officer. Thus the DMHO is answerable to the Director of Health, as well as Director of Family Welfare.

The DMHO ~~is~~ assisted by one Additional DMHO in-charge of Family Welfare Programme, and two Deputy ~~DMHOs~~ **in-charge** of a revenue division for overall supervision. The DMHO ~~is~~ also assisted by individual programme officers at the district level like the District **Tuberculosis** Control Officer, District Leprosy Officer, (both civil surgeon cadre), District Malaria Officer, Administrative Officer, District Public Health Nursing Supervisor, and Statistical Officer.

~~The~~ DMHO thus has to play an important role in the coordination, and implementation of all programmes within the district, and forms an important link between the Director of Health, Regional Director, and all the medical institutions under his control, and supervision.

~~However~~, based on the informal interviews with some of the district level officers the organizational setup that exists does not seem to be as flexible as it appears.

~~If~~ we look at the organizational setup at the district level, one finds that the DMHO has a large span of control because of the centralized authority within the organization as compared to the second level officials, namely the Additional DMHO, Deputy DMHOs, and Programme Officers. Although the second level officials are given the role of supervision, they do not perform this function because of lack of clearly

~~across~~ any ~~discrepancies~~ with regard to achievement of target\* they cannot initiate action without the approval of the **DMHO**. This inturn depends on whether there exists a congenial relationship between the second level officials, and the **DMHO**. Therefore ~~mere~~ delegation of duties without accompanying delegation of authority does not serve any purpose. The Additional **DMHO**, and Deputy **DMHOs** function more as a technical staff assistants to the **DMHO**. The **DMHO's** work is mostly confined to signing bills, sanctioning of leave, effecting transfers, and sometimes attending to the personal problems of the staff/ Even simple matters like sanctioning of leave which can be handled by the lower level officials have to travel up the hierarchy, thereby causing unnecessary delay. Only sometimes the Deputy **DMHOs** sanction casual leave of the **PHC** Medical Officers, and pass the travelling allowance bills of the **PHC** staff. '

The ~~second level~~ officials thus act more as informers or communicators by keeping the Medical officers of the **PHCs** informed about possible transfers, visits of state level officials, and circulars received from the directorate. They also send reminders to the Medical Officers whenever there is a delay in receiving statistical reports from the **PHCs**. Since they are not given any powers to initiate action, these officials do not supervise the work of the **PHC** Medical Officers. However sometimes they try to solve the interpersonal problems among the staff at the **PHC** during their visits.

**Except** for the District Tuberculosis **Office**, **offices** of the District Malaria Officer, and Special Officer leprosy control are not located in the premises of the District Medical and Health Office. As a result these officers interact with the DMHO less frequently, (as they are relatively more independent) as compared to the other officials.

The district malaria office is headed by the District Malaria Officer (DMO) with a para-medical background. He is the drawing, and disbursing authority for all the workers recruited under the National Malaria Eradication Programme (NMEP), and therefore we find that some of the Multipurpose Health Workers get their pay from the district malaria office. Malaria clinics have been opened in all the **PHCs** which are serving as fever treatment depots, and drug distribution centres. Apart from the DMOs; there are Assistant DMOs, Malaria Supervisors, Malaria Surveillance **Inspectors**, and Malaria Surveillance Workers. The lab technicians in the **PHCs** also work under the supervision of the DMO. However the lab technicians complain that there are no facilities like running water, lab attenders, and proper microscopes for testing. According to them the in-charge **PHC** Medical Officer hardly takes any interest in solving the problems. Between the Medical Officer, and the DMO there seems to be a communication gap as one belongs to the medical profession, and the other belongs to the paramedical profession. There hardly

~~seems~~ to exist any coordinated effort between the two ~~with~~ regard to the programme implementation.

The district tuberculosis **office** has a District Tuberculosis Officer (DTO) drawn from ~~medical~~ background, one Medical officer in-charge of the tuberculosis clinic, two treatment organizers, one lab technician, one lab attender, ~~one~~ radiographer, six BCG technicians, one dark room assistant, and other administrative **staff**. The tuberculosis programme was implemented in the district only since October 1980, and at the PHCs there is no staff controlled by the DTO. All the staff are controlled by the DMHO, and DMO.

The BCG technicians, and treatment organizers go to the field, and train Multipurpose Health Workers in administration of BUG vaccine, and also help in organizing BCG camps. Some of the PHCs in the district do not have lab. technicians while ~~some~~ others do not have the ~~facilities~~ to examine the sputum, and they send the sputum for examination to the district level, where a treatment card is prepared, indexed, and sent to the PHC Medical Officers for further treatment. There are ten regular PHCs, two ~~mandal~~ PHCs (MPHCs), and fourteen civil hospitals in **Ranga Reddy** District where the tuberculosis programme is being implemented, and every centre is adequately being supplied with antituberculosis drugs according to the DTO. The DTO like the **DMO** feels that the PHC Medical Officers do not take interest in treatment of patients or ~~in~~ implementing the programme. According to

them, this 1m on# of the reasons why patients are discontinuing treatment at PHCs.

There are three leprosy control units in the district, and each is headed by a Medical Officer, one Physiotherapist, four Non-medical Supervisors; twenty Non-medical Assistants, and other supporting staff. At present there is no separate post of District Leprosy Officer in the district because the post has been converted to that of Special Officer Leprosy, and attached to the Directorate of Health. This has resulted in lack of supervision of the leprosy work in the district according to the DMHO. The Non-Medical Supervisors, and Non-medical Assistants consider detection of cases as the most difficult task, and consider this as the main reason for not achieving the desired results.

Thus the programme officers are neither fully part of the District Medical and Health Office nor are complete; independent, and this is reason why coordination of the different activities becomes difficult. Although integration of the various health programmes has been attempted with the introduction of the Multipurpose Scheme, integration at the district level has not been achieved fully, and as a result vertical supervision of each of the programmes is continued. Unless integration is brought about at the district level one cannot expect supervision to be effective. Because of these problems, the need is being felt at the higher levels to



them, this is one of the reasons why patients are **discontinuing** treatment at **PHCs**.

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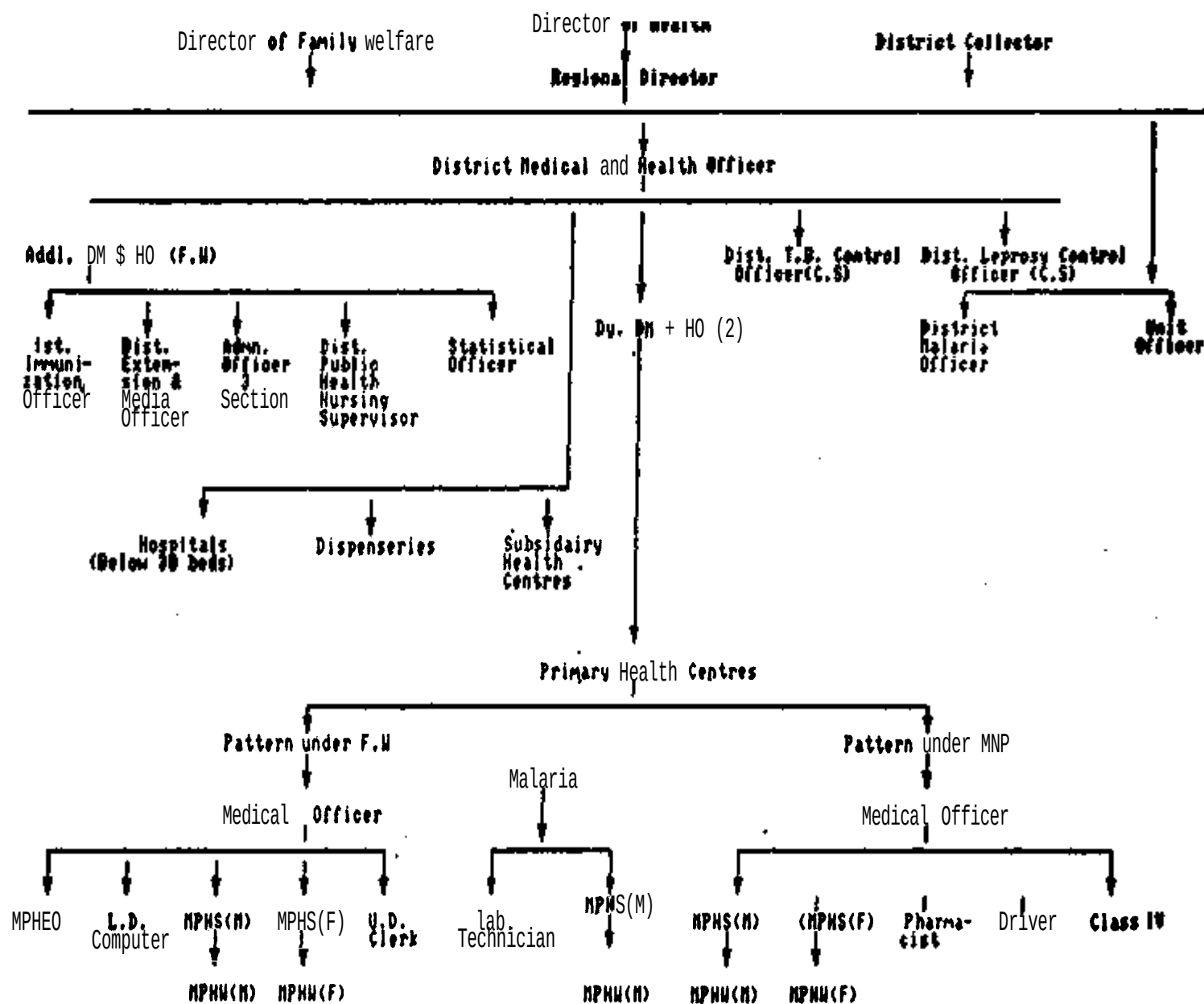
**redesignate** th# **post of** th# **DMHO** a\* Chief Medical Officer **so** that all Health and Family Welfare **Programmes** are under a unified **charge**, and control leading to a better coordination of **activities**. **The** programme officers would be his staff officers who would report to him the progress of their programmes, and assist him in supervision, and control.

Figure 2.i shows the organization of the medical and health services at the district level.



Figure 2.1 :

Organization of Medical and Health Service\* at the District Level.



Source : Directorate of Wealth and Directorate of Family Welfare, Hyderabad.

The District Collector and his revenue **subordinates** are expected to provide support to the medical and health activities in the district. The District Collector's help is required for acquiring land for construction of **PHCs**, sub-centres and hospitals, and the revenue officials **are** responsible for reporting the outbreak of epidemics. During religious fairs and festivals medical relief is provided in close consultation with the revenue officials as they are the ones incharge of fairs and festivals. During epidemics the District Collector assumes an important role, and provides the legal basis for mass inoculations, disinfecting work etc.

After the formation of Panchayat **Raj Institutions**, all development departments, including medical and health were answerable to the **Zillaparishads** at the district level. According to the **M.T. Raju** Committee Report (1967) the District Collector was made the chairman of the District Development Board, and also continued as Chairman of all the standing committees of the **Zilla** Parishad. (Ham **Reddy, G.** 1977: 11). Since the District **Collector** is the head of all development departments in the district, the **DMHO** works under his administrative jurisdiction. Though the various heads of the development departments are answerable to the Zilla Parishad, the latter cannot take any administrative action against them as they are under the administrative control of the District Collector, and technical, and supervisory control of their respective parent departments (**Muttalib, H.A.,**

1973: 5-9).

Based on the recommendations made by the Vengal Rao Committee, and Narsimham Committee, the Government of Andhra Pradesh amended the Panchayat Raj Act more or less on the Maharashtra pattern, wherein all the development departments including medical and health would be brought under the control of the Zilla Parishad, (Ram Reddy, G, 1977: 181-182). However this was not implemented, and the District collector holds away over the regulatory as well as developmental activities in the district.

In Andhra Pradesh, the PHCs were functioning under the administrative control of the Panchayat Samithis until 1980. But since 1980, they have been made independent of the Panchayat Samithis because of political interference, and other administrative problems. Thus the department of medicine and health is no more under the control of the Zilla Parishad, and Panchayat Samithi but rather under the control of the District Collector, and its parent department.

Having described the organization of the medical and health services at the district level let us now look at the medical and health care facilities in Ranga Reddy district.

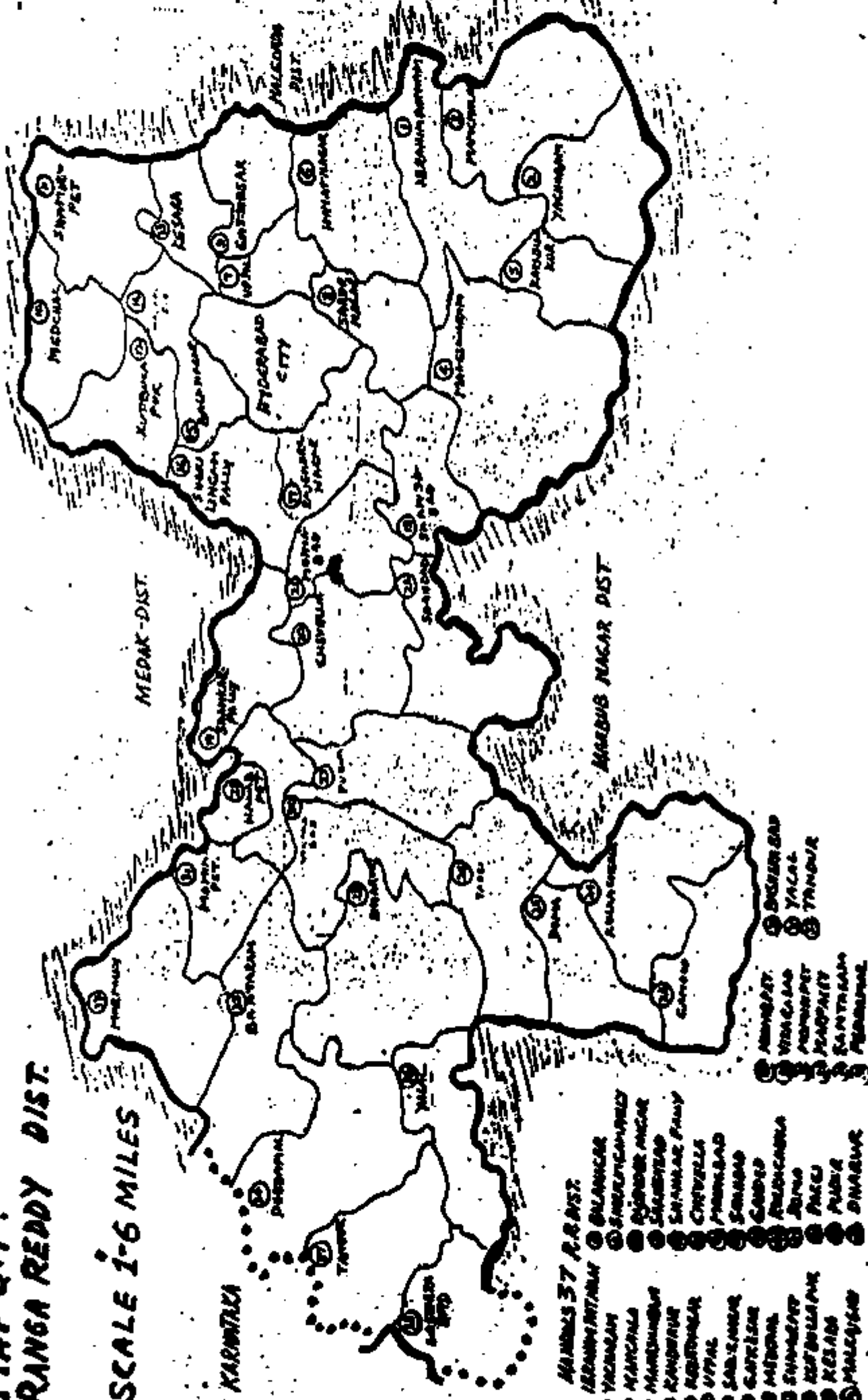
### 2,3.1 **Medical and Health Care facilities in R.N. District:**

Ranga Neddy district where this study was conducted is one of the backward districts of the **Telegana** region of Andhra Pradesh. **It** has a population of 15,62,062 (Census, 1981), and an area of 5,493 **sq.km.** **It** has 949 inhabited divisions and, thirtyseven **mandals** (Map:2.1).

**The** district has a network of 46 institutions under the control of the Director of Health. **It** has 12 hospitals with a bed strength of 536, 31 **PHCs** with a bed strength of 156, 247 sub-centres, and four subsidiary Health centres with a bed strength of 10 (Map 2.2).

# MAP 2.1: RANGA REDDY DIST.

SCALE 1-6 MILES



## MANDALS 37 R.R. DIST.

1. IZZATNAGAR
2. YACHANALLU
3. MARICHALLA
4. MARICHANALLU
5. RANGIREDDY
6. RANGIREDDY
7. RANGIREDDY
8. RANGIREDDY
9. RANGIREDDY
10. RANGIREDDY
11. RANGIREDDY
12. RANGIREDDY
13. RANGIREDDY
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26. RANGIREDDY
27. RANGIREDDY
28. RANGIREDDY
29. RANGIREDDY
30. RANGIREDDY
31. RANGIREDDY
32. RANGIREDDY
33. RANGIREDDY
34. RANGIREDDY
35. RANGIREDDY
36. RANGIREDDY
37. RANGIREDDY

[illegible]

GOVT. CIVIL HOSPITAL +  
PRIMARY HEALTH CENTRE ▼  
MANDAL P.H.C. ●  
RURAL HEALTH CENTRE ◎  
MANDAL BOUNDARY —

**GOVT. CIVIL HOSPITAL** **+**

**PRIMARY HEALTH CENTRE**

**MANDAL P.H.C.**

**RURAL HEALTH CENTRE** 

**MANDAL BOUNDARY**



Out of the 31 old PHCs, two of them have been upgraded, and have a bed strength of 30 each, while the remaining PHCs (8) including a Rural Health Centre (RHC) have six observation beds. The newly created mandal PHCs (MPHCs) however have only two observation beds. Among the 21 MPHCs, three of them are static PHCs, that is, they are functioning merely as dispensaries. There are 92 doctors working in all the medical institutions in the district. After the Andhra Pradesh Vaidya Vidhana Parishad (APVVP) was formed, two hospitals in the district having a bed strength of more than 30 have been transferred to APVVP.

Of the 31 PHCs in the district, the old PHCs (10) are housed in the government buildings with power, and water supply facilities. All the 10 PHCs have an operation theatre, however they have only one residential quarter for the in-charge Medical Officer. Only a few PHCs have quarters for the paramedical staff, and that too only for the supervisory cadre. The rest of the staff live in rented buildings.

In terms of accommodation at the old PHCs, it is highly inadequate because the government has not been able to construct buildings even in cases where land was available. This is attributed mainly to lack of funds, and delay in sanctioning funds. Even the buildings constructed are not being properly maintained. The remaining 21 MPHCs are all functioning in rented buildings, and are highly ill equipped,

with inadequate facilities for both the patients as well as the staff. The MPHCs are functioning more like dispensaries rather than centres expected to meet the health needs of the community. Only the old PHCs have a vehicle, and the budget allotted for drugs is Rs.30,000/- per PHC and Rs.2000/- per sub-centre per annum. However this is considered as highly inadequate. Most of the old PHCs do not even have the basic diagnostic facilities, equipment, and furniture.

Apart from hospitals, PHCs, subsidary health centres, there are four dispensaries; two urban family welfare centres; one tuberculosis clinic; four dental clinics; one leprosy rehabilitation centre; one ophthalmic unit; seven private nursing schools, and two postpartum units.

Tables 2.1 and 2.2. show the position of the staff at the PHCs proper, sector level, and sub-centre level.



Table %.

Position of staff at **PHCs proper.**

| Sl. NO.    | Name of the PHC | Civil Assistant Surgeons (CAs) |     |     | Multipurpose Health Extension Officer |     |     | Staff Nurse |      |      | Senior Assistant |      |      | L.D. Computer |      |      | Pharmacist |      |      | Lab Technician |      |      | Driver |      |      | Attenders |      |      | Total |
|------------|-----------------|--------------------------------|-----|-----|---------------------------------------|-----|-----|-------------|------|------|------------------|------|------|---------------|------|------|------------|------|------|----------------|------|------|--------|------|------|-----------|------|------|-------|
|            |                 | S IP V                         |     |     | S IP V                                |     |     | S IP V      |      |      | S IP V           |      |      | S IP V        |      |      | S IP V     |      |      | S IP V         |      |      | S IP V |      |      |           |      |      |       |
|            |                 | (3)                            | (4) | (5) | (6)                                   | (7) | (8) | (9)         | (10) | (11) | (12)             | (13) | (14) | (15)          | (16) | (17) | (18)       | (19) | (20) | (21)           | (22) | (23) | (24)   | (25) | (26) | (27)      | (28) | (29) |       |
| (Old PHCs) |                 |                                |     |     |                                       |     |     |             |      |      |                  |      |      |               |      |      |            |      |      |                |      |      |        |      |      |           |      |      |       |
| 1.         | Dona            | 3                              | 2   | 1   | 2                                     | 1   | 1   | 1           | -    | 1    | 1                | 1    | -    | 1             | 1    | -    | 1          | 1    | -    | 1              | 1    | -    | 1      | 1    | -    | 2         | 2    | -    | -     |
| 2.         | Rayanagar       | 3                              | 3   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | 1             | 1    | -    | 1          | 1    | -    | 1              | 1    | -    | 1      | 1    | -    | 2         | 2    | -    | -     |
| 3.         | Maheshwaran     | 3                              | 3   | -   | 2                                     | -   | 2   | 1           | -    | 1    | 1                | 1    | -    | 1             | 1    | -    | 1          | 1    | -    | 1              | 1    | -    | 1      | 1    | -    | 2         | 2    | -    | -     |
| 4.         | Nominpet        | 4                              | 4   | -   | 2                                     | 1   | 1   | 1           | -    | 1    | 1                | 1    | -    | 1             | 1    | -    | 1          | 1    | -    | 1              | 1    | -    | 1      | 1    | -    | 2         | 2    | -    | -     |
| 5.         | Peddahal        | 3                              | 3   | -   | 2                                     | 1   | 1   | 1           | 1    | -    | 1                | 1    | -    | 1             | 1    | -    | 1          | 1    | -    | 1              | 1    | -    | 1      | 1    | -    | 2         | 2    | -    | -     |
| 6.         | Podur           | 3                              | 3   | -   | 2                                     | 1   | 1   | 1           | -    | 1    | 1                | 1    | -    | 1             | 1    | -    | 1          | 1    | -    | 1              | 1    | -    | 1      | 1    | -    | 2         | 2    | -    | -     |
| 7.         | Shamirpet       | 4                              | 4   | -   | 2                                     | 1   | 1   | 5           | 4    | 1    | 1                | 1    | -    | 1             | 1    | -    | 2          | 2    | -    | 2              | 1    | 1    | 1      | 1    | -    | 3         | 3    | -    | -     |
| 8.         | Shankarpally    | 3                              | 3   | -   | 2                                     | 1   | 1   | 1           | 1    | -    | 1                | 1    | -    | 1             | 1    | -    | 1          | 1    | -    | 1              | 1    | -    | 1      | 1    | -    | 2         | 2    | -    | -     |
| 9.         | Yacharan        | 4                              | 4   | -   | 2                                     | 2   | -   | 8           | 3    | 2    | 1                | 1    | -    | 1             | 1    | -    | 2          | 2    | -    | 2              | 1    | 1    | 1      | 1    | -    | 3         | 3    | -    | -     |
| 10.        | Narsingi        | 3                              | 3   | -   | 2                                     | 2   | -   | 1           | 1    | -    | 1                | 1    | -    | 1             | 1    | -    | 1          | 1    | -    | 1              | 1    | -    | 1      | 1    | -    | 2         | 2    | -    | -     |
| (New PHCs) |                 |                                |     |     |                                       |     |     |             |      |      |                  |      |      |               |      |      |            |      |      |                |      |      |        |      |      |           |      |      |       |
| 11.        | Balanagar       | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | 1    | -    | 1              | 1    | -    | -      | -    | -    | 1         | 1    | -    | 1     |
| 12.        | Bantaram        | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | 1    | -    | 1              | 1    | -    | -      | -    | -    | 1         | 1    | -    | 1     |
| 13.        | Ganded          | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | 1    | -    | 1              | -    | 1    | -      | -    | -    | 1         | 1    | -    | 1     |
| 14.        | Kandukur        | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | 1    | -    | 1              | -    | 1    | -      | -    | -    | 1         | 1    | -    | 1     |
| 15.        | Keesara         | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | 1    | -    | 1              | 1    | -    | -      | -    | -    | 1         | 1    | -    | 1     |
| 16.        | Kulkacherla     | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | -    | 1    | 1              | 1    | -    | -      | -    | -    | 1         | 1    | -    | 1     |
| 17.        | Manchal         | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | -    | 1    | 1              | 1    | -    | -      | -    | -    | 1         | 1    | -    | 1     |
| 18.        | Moinabad        | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | 1    | -    | 1              | 1    | -    | -      | -    | -    | 1         | 1    | -    | 1     |
| 19.        | Manabpet        | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | 1    | -    | 1              | 1    | -    | -      | -    | -    | 1         | 1    | -    | 1     |
| 20.        | Qutbullapur     | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | 1    | -    | 1              | 1    | -    | -      | -    | -    | 1         | 1    | -    | 1     |
| 21.        | Saroornagar     | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | 1    | -    | 1              | 1    | -    | -      | -    | -    | 1         | 1    | -    | 1     |
| 22.        | Sarilingpally   | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | -    | 1    | 1              | 1    | -    | -      | -    | -    | 1         | 1    | -    | 1     |
| 23.        | Uppal           | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | 1    | -    | 1              | 1    | -    | -      | -    | -    | 1         | 1    | -    | 1     |
| 24.        | Yalal           | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | -    | 1    | 1              | 1    | -    | -      | -    | -    | 1         | 1    | -    | 1     |
| 25.        | Aloor           | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | -    | 1    | 1              | 1    | -    | -      | -    | -    | 1         | 1    | -    | 1     |
| 26.        | Siddalur        | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | -    | 1    | 1              | 1    | -    | -      | -    | *    | 1         | 1    | -    | 1     |
| 27.        | Gingertly       | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | -    | 1    | 1              | 1    | -    | -      | -    | -    | 1         | 1    | -    | 1     |
| 28.        | Bandamir        | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | -    | 1    | 1              | 1    | -    | -      | -    | -    | 1         | 1    | -    | 1     |
| 29.        | Tangator        | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | -    | 1    | 1              | -    | 1    | -      | -    | -    | 1         | 1    | -    | 1     |
| 30.        | Chengal         | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | -    | 1    | 1              | -    | 1    | -      | -    | -    | 1         | 1    | -    | 1     |
| 31.        | Mahadab*        | 1                              | 1   | -   | 1                                     | 1   | -   | 1           | -    | 1    | 1                | 1    | -    | -             | -    | -    | 1          | -    | 1    | 1              | -    | 1    | -      | -    | -    | 1         | 1    | -    | 1     |

Source % District Medical and Health Office, R. R. District.

**Table 2.8\***

Position of staff at Sector and Sub-centre level.

| Sl. WO.     | Name of PHC          | Number of Sectors | Multipurpose Health Supervisors(Men) |     |     | Multipurpose Health Supervi- sors (Women) |     |     | Number of Sub- Centres | Multipurpose Nealtb Nor- ker (Mem) |      |      | Multipurpose Nealtb Nor- ker (Women) |      |      |
|-------------|----------------------|-------------------|--------------------------------------|-----|-----|-------------------------------------------|-----|-----|------------------------|------------------------------------|------|------|--------------------------------------|------|------|
|             |                      |                   | S                                    | IP  | V   | S                                         | IP  | V   |                        | S                                  | IP   | V    | S                                    | IP   | V    |
|             |                      |                   |                                      |     |     |                                           |     |     |                        |                                    |      |      |                                      |      |      |
| (1)         | (2)                  | (3)               | (4)                                  | (5) | (6) | (7)                                       | (8) | (9) | (1#)                   | (11)                               | (12) | (13) | (14)                                 | (15) | (16) |
| (Old PHCs)  |                      |                   |                                      |     |     |                                           |     |     |                        |                                    |      |      |                                      |      |      |
| 1.          | Dona                 | 3                 | 5                                    | 5   | -   | 2                                         | 2   | -   | 1#                     | 9                                  | 4    | -    | 1#                                   | 1#   | -    |
| 2.          | Hayatnagar           | 2                 | 7                                    | 7   | -   | 2                                         | 2   | -   | 11                     | 4                                  | 4    | -    | 11                                   | 11   | -    |
| 3.          | Maheshwarani         | 3                 | 3                                    | 3   | -   | 1                                         | 1   | -   | 9                      | 4                                  | 4    | -    | 9                                    | 9    | -    |
| 4.          | Mominpet             | 4                 | 3                                    | 3   | -   | 2                                         | 2   | -   | 17                     | 6                                  | 6    | -    | 17                                   | 17   | -    |
| 5.          | Peddani              | 3                 | 6                                    | 6   | -   | 1                                         | 1   | -   | 11                     | 5                                  | 5    | -    | 11                                   | 11   | -    |
| 6.          | Podur                | 3                 | 4                                    | 4   | -   | 2                                         | 2   | -   | 8                      | 5                                  | 5    | -    | 8                                    | 8    | -    |
| 7.          | Shamirpet            | 6                 | 6                                    | 6   | -   | 4                                         | 4   | -   | 20                     | 8                                  | 8    | -    | 20                                   | 20   | -    |
| 8.          | Shankarpally         | 4                 | 3                                    | 3   | -   | 3                                         | 3   | -   | 12                     | 10                                 | 1#   | -    | 12                                   | 12   | -    |
| 9.          | Yacharam             | 4                 | 4                                    | 4   | -   | 3                                         | 3   | -   | 14                     | 5                                  | 5    | -    | 14                                   | 14   | -    |
| 1#.         | Narsingi             | 4                 | 3                                    | 3   | -   | 2                                         | 2   | -   | 4                      | 3                                  | 3    | -    | 4                                    | 4    | -    |
| (New MPHCS) |                      |                   |                                      |     |     |                                           |     |     |                        |                                    |      |      |                                      |      |      |
| 11.         | Balanagar            | 3                 | 2                                    | 2   | -   | -                                         | -   | -   | 2                      | 3                                  | 3    | -    | 2                                    | 2    | -    |
| 12.         | Bantaram             | 2                 | 1                                    | 1   | -   | 2                                         | 2   | -   | /                      | 4                                  | 4    | -    | 7                                    | 7    | -    |
| 13.         | banded               | 2                 | 2                                    | 2   | -   | 1                                         | 1   | -   | 4                      | 2                                  | 2    | -    | 4                                    | 4    | -    |
| 14.         | Kandukur             | 1                 | 1                                    | 1   | -   | 1                                         | 1   | -   | 7                      | 1                                  | 1    | -    | 7                                    | 7    | -    |
| 15.         | Keesara              | 1                 | -                                    | -   | -   | 1                                         | 1   | -   | 6                      | -                                  | -    | -    | 6                                    | 6    | -    |
| 16.         | Kulkacherla          | 2                 | -                                    | -   | -   | -                                         | -   | -   | 5                      | 2                                  | 2    | -    | 5                                    | 5    | -    |
| 17.         | Manchal              | 2                 | 1                                    | 1   | -   | 1                                         | 1   | -   | 6                      | -                                  | -    | -    | 5                                    | 5    | -    |
| 18.         | Moinabad             | 1                 | 2                                    | 2   | -   | -                                         | -   | -   | 3                      | 2                                  | 2    | -    | 3                                    | 3    | -    |
| 19.         | Nawabpet             | 2                 | 1                                    | 1   | -   | -                                         | -   | -   | 4                      | 3                                  | 2    | 1    | 4                                    | 4    | -    |
| 20.         | Outbullapur          | 2                 | 1                                    | 1   | -   | 2                                         | 2   | -   | 11                     | 2                                  | 2    | -    | 11                                   | 11   | -    |
| 21.         | Sarooranagar         | 2                 | 1                                    | -   | 1   | 1                                         | 1   | -   | 5                      | 2                                  | 2    | -    | 5                                    | 5    | -    |
| 22.         | Serilingan-<br>pally | 1                 | -                                    | -   | -   | -                                         | -   | -   | 3                      | 1                                  | 1    | -    | 3                                    | 3    | -    |
| 23.         | Uppal                | 2                 | 1                                    | 1   | -   | -                                         | -   | -   | 5                      | 2                                  | 2    | -    | 5                                    | 5    | -    |
| 24.         | yalal                | 2                 | 2                                    | 2   | -   | 2                                         | 2   | -   | 5                      | 4                                  | 4    | -    | 5                                    | 5    | -    |
| 25.         | Aloor                | 2                 | 1                                    | 1   | -   | 2                                         | 2   | -   | 6                      | 2                                  | 2    | -    | 6                                    | 6    | -    |
| 26.         | Siddalur             | 2                 | 2                                    | 2   | -   | 2                                         | 2   | -   | 7                      | 2                                  | 2    | -    | 7                                    | 7    | -    |
| 27.         | Gingurthy            | 1                 | 1                                    | 1   | -   | 1                                         | 1   | -   | 4                      | 1                                  | 1    | -    | 4                                    | 4    | -    |
| 28.         | Dandunaila-<br>ran   | 2                 | 1                                    | 1   | -   | 2                                         | 2   | -   | 6                      | 2                                  | 2    | -    | 6                                    | 6    | -    |
| 29.         | langatoor            | -                 | -                                    | -   | -   | -                                         | -   | -   | -                      | -                                  | -    | -    | -                                    | -    | -    |
| 30.         | chenagoual           | -                 | -                                    | -   | -   | -                                         | -   | -   | -                      | -                                  | -    | -    | -                                    | -    | -    |
| 31.         | Mahendrabad          | -                 | -                                    | -   | -   | -                                         | -   | -   | -                      | -                                  | -    | -    | -                                    | -    | -    |

Source : District Medical and Health Office, H.R. District.

Thus\* it can **be seen** from **the tables 2.1** and **2.2** that **as** far as the position of Medical Officers, and Multipurpose Health Extension Officers in PHCs is concerned, it is satisfactory, as all posts sanctioned have been filled up. However the position of the paramedical staff in PHCs is most **unsatisfactory**. For example, there are five PHCs where lab technicians posts have not been **filled** up., Except for the women Multipurpose Health Workers there is a shortage of men workers in all the PHCs. To relieve the burden of the Medical Officers from supervisory functions, the posts of Health Supervisors were created in the PHCs, however it can be seen that the number of posts sanctioned is far below the requirement.

The government should realize that by merely increasing the number of PHCs, the goal of attaining 'Health for All by 2000' can never be achieved. **Instead** the government should recruit enough numbers of paramedical personnel of all categories (for the existing institutions), and also provide the necessary infrastructure (physical facilities, and staff quarters) to enable them to perform their job well.

Having discussed the medical and health care facilities in Ranga **Reddy** district, let us now look at the organization at **the** level.

## **2.5. Directorate of Health:**

The Directorate of Health provides the bulk of medical and health services in the state. The main objectives of the department are, prevention and control of locally endemic diseases, and provision of curative services, particularly in rural areas.

The objectives of prevention, and control of locally endemic diseases is sought to be achieved through the implementation of the following programmes:

### **(i) National Malaria Eradication Programme:**

The programme is a centrally sponsored scheme with 50% central assistance, and the objective of the programme is to prevent morbidity, and mortality due to Malaria.

The state has a state malaria unit; 22 district malaria units; 6 zonal malaria units; 275 sub-malaria units, and 8 urban malaria units through which the National Malaria **Eradi-**cation Programme is carried out.

### **(ii) National Leprosy Eradication Programme:-**

This is a centrally sponsored programme with 100% central assistance. The main objectives of the programme **is** to eradicate leprosy by 2000 A.D. through early detection, and treatment of cases. The state has achieved phenomenal

success in this programme, and all the **districts** have been covered by the **multidrug** therapy programme. There has been a reduction in the prevalence rate from 18 to less than 2 per 1000 population.

The state has 94 leprosy control units; 23 district leprosy units, 164 survey, education, and training centres, 51 temporary hospitalization wards, 3 sample survey cum **assessment** units, 6 training centres, 1 leprosy control project, 1 leprosy rehabilitation and promotion unit, 1 model **leprosy** control unit, 91 urban leprosy clinics, and 1 supervisory medical urban unit.

(iii) **School Health programme:-**

Andhra Pradesh has been implementing the School Health Programme throughout the state since 1986, and the programme is extended to all the primary schools in the state. The Overseas Development Administration has agreed to provide an assistance of **Rs.1755.95** lakhs during the Eighth Plan. The School Health Programme is a state scheme, and the programme is being implemented utilizing the existing medical and health infrastructure in the state.

(iv) **National Tuberculosis Control Programme:-**

This programme is centrally sponsored **with** 50% central assistance. Tuberculosis (**T.B**) continues to be a major public health problem in the state. It is estimated that 10 lakhs of persons are suffering from the disease of which, **2.5**

lakh cases are infectious.

The main objectives of the programme are to detect **T.B.** cases among the patients attending the out-patient department in all the health institutions; provide domiciliary treatment to the detected cases, and prevention of disease by Bacillus **Calmette** Guérine (B.C.G.) vaccination.

There are 23 district T.B. Control units in the state and the programme is implemented in most of the peripheral health institutions including some of the **mandal** primary health centres.

(v) **National Filariasis Control Programme:-**

This programme is also centrally sponsored with 60% central assistance. The main aim of the programme is to control transmission of filariasis through detection and treatment of filaria cases. There are 28 urban filaria control units; 4 filaria clinics, 2 filaria survey units; 1 **detection-cum-treatment** centre, and 1 regional filaria training centre.

(vi) **National Guineaworm Eradication Programme:-**

This is a centrally sponsored programme with 100% central assistance, and the objective of the **programme** is to eradicate the **disease** by the end of 1990-91. This disease is prevalent only in 6 district of the state, namely, **Kurnool,**



**Mahboobnagar, Cuddapah, Ananthapur, Prakasam, and West Godavari.** Only one post of Technical Officer is sanctioned at the Directorate of Health under this programme.

(vii) **National Programme for the Control of Blindness:-**

This is a centrally sponsored scheme with 100% central assistance, and the objective of the programme is to bring down the incidence of blindness from 1.4% to 0.3% by 2000 A.D.

During the Seventh Plan period, 150 primary health centres were upgraded in the state, and one post of **Ophthalmic Assistant** for each primary health centre was created to attend minor ailments at peripheral level. Four district mobile units were established at Cuddapah, **Vizianagaram**, Nellore and **Nizamabad**, and these units have been provided with staff, and supplied with vehicles, and equipment. Three eye banks have been established at **Kurnool**, Guntur and **Visakhapatnam**.

(viii) **National Goitre Control Programme:-**

To combat the problem of endemic goitre in the tribal areas of the state, distribution of iodized salt at subsidised rates is being carried out in Visakhapatnam, Bast Godavari, Adilabad districts. This programme was started in Andhra Pradesh during 1987-88 with 100% central assistance. The scheme was included in the state plan from 1990-91 onwards.

The aim of this programme is to promote awareness of goitre, and its prevention among the people living in endemic areas through distribution of iodized salt at subsidized rates. There is a goitre cell in the Directorate of Health with one Technical Officer, one Deputy Statistical officer, and one Junior Assistant.

(ix) **National Sexually Transmitted Diseases (STD) Control Programme:-**

This programme was started in the state during 1984-85 with the establishment of a regional S.T.D. centre in Osmania Medical College, Hyderabad. This is a centrally sponsored scheme with 100% central assistance.

The main objectives of the programme are to assess the incidence levels of S.T.D. in vulnerable sections of population like pilgrim centres, tourist spots, industrial slums, ports and tribal areas in the states of Andhra Pradesh and Madhyapradesh and secondly, to train medical, and para-medical workers in the diagnosis, and treatment of S.T.D. cases through the regional S.T.D. training centre.

The staff of regional **survey-cum-mobile** unit, and regional S.T.D. reference laboratory, **Osmania** Medical College, Hyderabad are part, and parcel of this **programme**.



The Minimum Needs Programme in relation to health ~~aims~~ **at**, providing basic medical and health facilities **for the** people living in rural **areas**. The Minimum **needs Programme** which is implemented as a state plan programme **is** designed for the development of the infrastructure of the department by establishing new primary health centres **(PHCs)**, upgradation of 26% of primary health **centres**, to the level of 30 bedded community health centres **(CHCs)**, anti construction of buildings for primary health centres, community health centres and staff quarters.

At present there are 1268 primary health centres, **115** community health centres, and 8327 sub-centres in the state. During the Seventh Plan period (1986-90) ~~706~~ PHCs as against a target of 700 PHCs, 116 CHCs as against a target of 116 CHCs, and ~~1765~~ sub-centres as against a target of 4036 sub-centres were established.

The targets for establishing PHCs, CHCs and sub-centres during **Eighth Plan** are not yet communicated by the Government of India. It is proposed to establish 167 new PHCs and 2 CHCs during 1990-91. It is also proposed to create 116 posts of Civil Surgeon Specialists in CHCs, and provide additional staff, and equipment to 11 upgraded PHCs during **1990-91** under the Minimum Needs Programme.

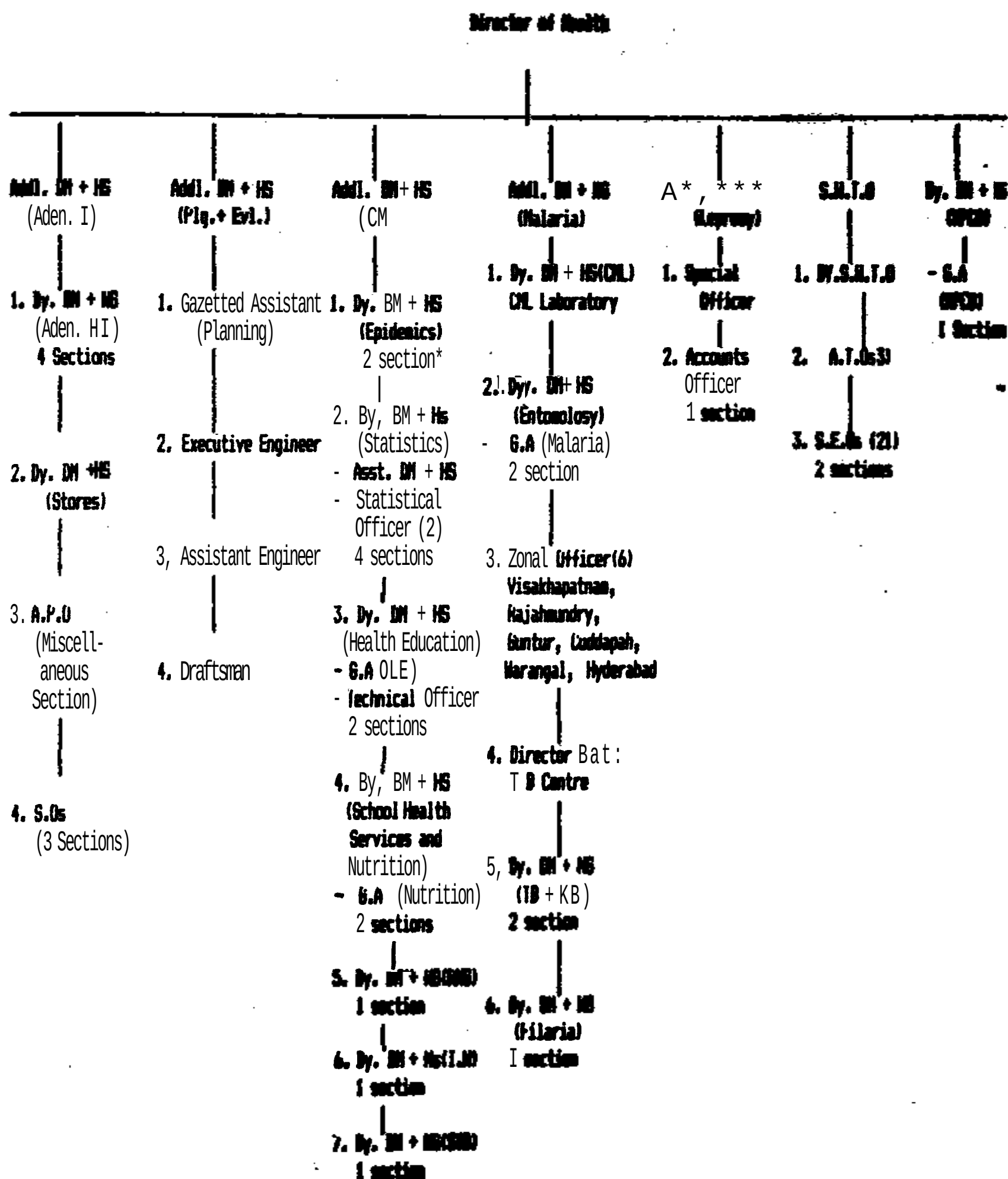
The expenditure under Minimum **Needs** Programme during the Seventh Plan was **Rs.4948.14 lakhs** as **against** an outlay of **Rs.5684.17** lakhs., The outlay for 1990-91 was **Rs.800.00** lakhs. The proposed outlay for **Eighth Plan (1990-95)** under MNP is **Rs.9892.28** lakhs.

An amount of **Rs.325.00** lakhs was allotted to **A.P. Health** Medical and Housing Infrastructure Development Corporation during **1990-91** for construction of PHC buildings, staff quarters, etc. An amount of **Rs.47.10** lakhs was allotted to the Chief Engineer (Buildings) for spillover capital works.

The Directorate of Health, functions under the supervision, and control of the Director of Health **who** is assisted by five Additional Directors of Medical and Health Services. They in turn are assisted by Deputy Directors, Gazetted Assistants, Special Officers, and other supporting staff. Figure 2.2 shows the organization of the Directorate of Health as on 31.3.91.

Figure 2.4 :

## Organization of the Directorate of Health

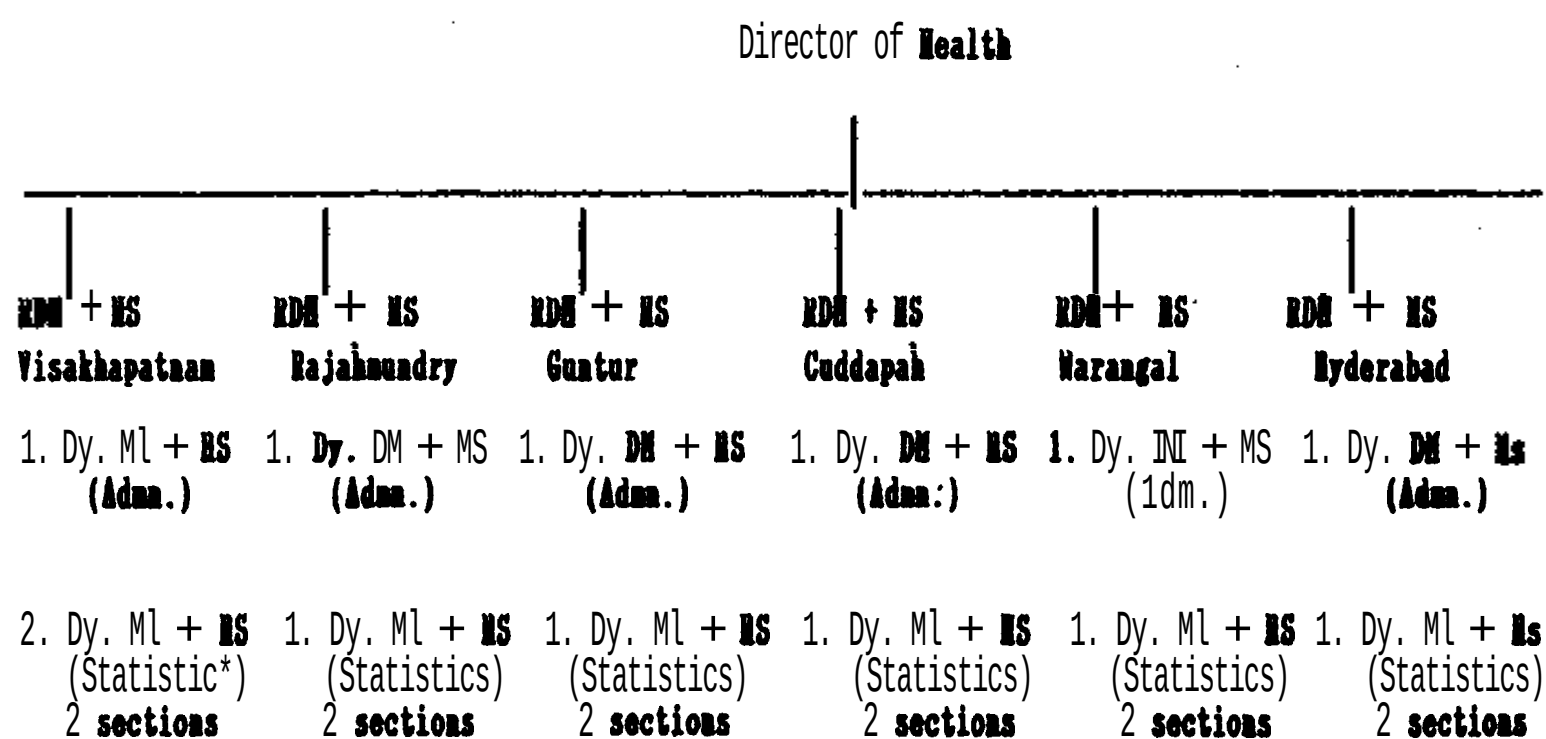


Source : Directorate of Health, Hyderabad, Andhra Pradesh.

At the zonal level below the Director of Health **are** the six Regional Directors of Medical and Health **Services**. Figure **2.3** shows the organizational setup at the zonal or Regional **level**.

Figure 2.3 :

### Organizational setup at the Regional Level



Source : Directorate of **Health**, Hyderabad, Andhra **Pradesh**.

**The posts** of the Regional Director\* were **created** under the six point formula for the smooth functioning of the administration. **The** Regional Director is of the same rank as an Additional Director of Medical and Health Services. He is responsible for the medical and health administration in the region. All medical institutions, except those under the control of the **APVVP**, and the Directorate of Medical Education, function under his direction, and control. He deals with all service matters of all the non-gazetted officials covered by the zonal scheme under the six-point formula, which include departmental transfers, postings, and disciplinary action relating to the zone. He is also responsible for the implementation of all plan, non-plan, and national schemes, under the medical and health department, and compilation of statistical data within the zone. Each **Regional** Director is assisted by two Deputy Directors, one for administration, and the other for statistics in each zone. The District Medical and Health Officer, the Additional District Medical and Health Officer, District Leprosy Officer, District Tuberculosis Control Officer, District Malaria Officers function under his control.

**Inspite** of the regional setup there is inadequate decentralization of power, and in several instances the approval of the Director of Health has to be obtained. This has resulted in inadequate supervision, and control of the health institutions in the state.

**Table 2.3.** shows the number of government hospitals, dispensaries, **PHCs**, MM. units under the control of the Director of Health as on 31.3.90.

Table 2.4 shows the distribution of population, number of **PHCs**, sub-centres and health personnel district wise.

Table 2.5 shows the number of beds in government and local body institutions, doctors and nurses in government service in the districts as on 01.04.1987, and population served by each. This part of the information was not available upto date as it was not compiled by the directorate (statistical wing).



Table 2.3 :

Statement showing the number of Hospitals, Dispensaries, **PHCs** and **MM** units in **A.P. as** on 31-3-90.

| Sl.         | District      | hospitals |     |      |      | Dispensaries |     |      |      | PHCs |      | units<br>No | Total |      | Doctors |
|-------------|---------------|-----------|-----|------|------|--------------|-----|------|------|------|------|-------------|-------|------|---------|
|             |               | Bo:       |     | Beds |      | Bo:          |     | Beds |      | No   | Beds |             | Total |      |         |
|             |               |           |     |      |      |              |     |      |      |      |      |             |       |      |         |
|             |               | R         | U   | R    | U    | R            | U   | R    | U    | No   | Beds | Bo          | Beds  |      |         |
| (1)         | (2)           | (3)       | (4) | (5)  | (6)  | (7)          | (8) | (9)  | (10) | (11) | (12) | (13)        | (14)  | (15) | (16)    |
| 1.          | Srikakulam    | 2         | 2   | 58   | 12   | 10           | -   | -    | -    | 54   | 244  | 2           | 70    | 314  | 106     |
| 2.          | Vizainagaram  | 3         | 4   | 32   | 61   | 4            | 1   | -    | -    | 47   | 226  | 6           | 65    | 319  | 104     |
| 3.          | Visakhapatnam | 8         | 3   | 76   | 48   | 6            | 1   | -    | -    | 56   | 272  | 6           | 80    | 396  | 126     |
| 4.          | E. Godavari   | 6         | 9   | 45   | 164  | 27           | 2   | -    | -    | 62   | 310  | 2           | 108   | 519  | 184     |
| 5.          | W. Godavari   | 3         | 4   | 48   | 62   | 3            | 1   | -    | -    | 57   | 262  | 5           | 73    | 372  | 134     |
| 6.          | Krishna       | 3         | 5   | 70   | 88   | 6            | -   | -    | -    | 57   | 284  | 1           | 72    | 442  | 128     |
| 7.          | Guntur        | 1         | 3   | 20   | 51   | 4            | -   | -    | -    | 63   | 282  | 1           | 71    | 353  | 130     |
| 8.          | Prakasham     | 3         | 3   | 27   | 47   | 4            | -   | -    | -    | 67   | 300  | 2           | 79    | 374  | 137     |
| 9.          | Nellore       | 5         | 5   | 65   | 83   | 3            | -   | -    | -    | 57   | 296  | 2           | 72    | 442  | 125     |
| 10.         | Caittoor      | 1         | 2   | 5    | 48   | 2            | -   | -    | -    | 72   | 322  | 1           | 78    | 375  | 142     |
| 11.         | Cuddapah      | 1         | 3   | 5    | 33   | 1            | -   | -    | -    | 57   | 258  | 1           | 63    | 296  | 126     |
| 12.         | Ananthapur    | 3         | 4   | 46   | 64   | 2            | 2   | -    | 6    | 68   | 319  | 1           | 80    | 435  | 152     |
| 13.         | Kurnool       | 4         | 6   | 52   | 88   | 8            | -   | -    | -    | 64   | 270  | 1           | 83    | 410  | 148     |
| 14.         | Mahaboobnagar | 7         | 7   | 82   | 175  | -            | -   | -    | -    | 64   | 326  | 2           | 80    | 583  | 165     |
| 15.         | Kanga Reddy   | 8         | 4   | 488  | 48   | -            | -   | -    | -    | 34   | 186  | -           | 46    | 722  | 92      |
| 16.         | Medak         | 1         | 2   | 10   | 55   | 1            | -   | -    | -    | 51   | 255  | -           | 55    | 320  | 98      |
| 17.         | Nizamabad     | 3         | 2   | 44   | 40   | -            | 1   | -    | -    | 36   | 220  | -           | 42    | 304  | 76      |
| 18.         | Adilabad      | 4         | 2   | 74   | 30   | 1            | -   | -    | -    | 52   | 266  | 6           | 65    | 370  | 120     |
| 19.         | Karimnagar    | 4         | 6   | 70   | 65   | 3            | -   | -    | -    | 58   | 337  | 1           | 72    | 472  | 130     |
| 20.         | Warangal      | 2         | -   | 52   | -    | -            | -   | -    | -    | 57   | 290  | 1           | 60    | 342  | 101     |
| 21.         | Khammam       | 8         | 7   | 61   | 108  | -            | -   | -    | -    | 46   | 218  | 4           | 65    | 387  | 105     |
| 22.         | Nalgonda      | 2         | 4   | 20   | 193  | -            | -   | -    | -    | 65   | 294  | -           | 71    | 507  | 122     |
| 23.         | Hyderabad     | -         | 4   | -    | 56   | -            | 4   | -    | -    | -    | -    | -           | 8     | 56   | 98      |
| State Total |               | 82        | 91  | 1450 | 1619 | 85           | 12  | -    | 6    | 1243 | 6035 | 45          | 1558  | 9110 | 2849    |

Source : Directorate of Health, Andhra Pradesh.

Table 2.4

Distribution of **Population**, Health **Services**, and Health Personnel - District Wise as on **31-3-91**.

| Sl. No.      | Name of the District | Population      | No. of P.R.Cs | No. of H.Os | No. of Sub-centres | No. of A.B.Ms | No. of M.W(M) | No. of M.S(F) | No. of M.S(M) | Ang. Workers | C.M.G       | T.B.As |
|--------------|----------------------|-----------------|---------------|-------------|--------------------|---------------|---------------|---------------|---------------|--------------|-------------|--------|
| (1)          | (2)                  | (3)             | (4)           | (5)         | (6)                | (7)           | (8)           | (9)           | (10)          | (11)         | (12)        | (13)   |
| 1.           | <b>Srikakulam</b>    | <b>1959352</b>  | 54            | 94          | 367                | 379           | 431           | 63            | 109           | 278          | <b>1924</b> | MA     |
| 2.           | <b>Vizianagaram</b>  | 1804196         | 50            | 29          | 426                | 179           | 139           | 38            | 58            | 237          | <b>986</b>  | 1068   |
| 3.           | <b>Visakhapatnam</b> | 2576474         | 42            | 75          | 338                | 376           | 425           | 102           | 190           | <b>797</b>   | 1636        | 2671   |
| 4.           | <b>East Godavari</b> | 3701040         | 62            | 131         | <b>517</b>         | 635           | 514           | 116           | 261           | 571          | 2221        | MA     |
| 5.           | Nest Godavari        | 2873958         | 62            | 45          | 393                | 466           | 395           | 74            | 110           | 423          | 2250        | 3062   |
| 6.           | Krishna              | 3048463         | <b>57</b>     | 118         | 428                | 461           | 328           | 85            | 116           | 429          | 1926        | 1310   |
| 7.           | Guntur               | 3434724         | 67            | 90          | 459                | 388           | 489           | 79            | 115           | 346          | 2350        | MA     |
| 8.           | Prakasam             | <b>2329571</b>  | 66            | 141         | 419                | <b>488</b>    | 337           | 85            | 101           | <b>758</b>   | 2067        | 1046   |
| 9.           | Nellore              | 2014879         | 57            | <b>103</b>  | 377                | 422           | 281           | 49            | 66            | 810          | 1581        | 2048   |
| 10.          | Chittoor             | 2737316         | 72            | 130         | 317                | <b>505</b>    | 344           | 104           | 101           | 493          | 1947        | 2404   |
| 11.          | Cuddapah             | 1933304         | 48            | 94          | 345                | 378           | 192           | 80            | 68            | 560          | 1599        | 2111   |
| 12.          | <b>Ananthapur</b>    | 2548012         | 66            | 60          | 415                | 441           | 170           | 66            | 107           | 688          | <b>1795</b> | 2896   |
| 13.          | Kurnool              | 2407299         | 64            | 66          | <b>470</b>         | 368           | 332           | 46            | 83            | 733          | 1632        | 1928   |
| 14.          | Warangal             | 2300295         | 57            | 62          | 366                | 333           | 406           | 54            | 90            | 300          | 968         | MA     |
| 16.          | Khammam              | <b>1751574</b>  | 66            | <b>55</b>   | 377                | 497           | 323           | 63            | 74            | 512          | 348         | -      |
| 16.          | <b>Karimnagar</b>    | 2436323         | 58            | 51          | 288                | 232           | 344           | 63            | 90            | 691          | 1707        | -      |
| 17.          | Adilabad             | 1639003         | 44            | 52          | 355                | 172           | 239           | 46            | 98            | <b>525</b>   | 431         | -      |
| 18.          | Mahaboobnagar        | 2444619         | 64            | 52          | 354                | 362           | 344           | <b>55</b>     | 99            | 609          | 1231        | 48     |
| 19.          | <b>Rangareddy</b>    | 1582062         | 34            | 80          | 339                | <b>275</b>    | 159           | <b>45</b>     | <b>57</b>     | 468          | <b>782</b>  | 896    |
| 20.          | <b>Hyderabd (U)</b>  | 2260702         | 34            | 17          | --                 | <b>50</b>     | 0             | 34            | 100           | -            | -           | -      |
| 21.          | Medak                | 1807139         | 51            | 95          | 406                | 272           | 230           | 45            | 78            | 463          | 1537        | 1702   |
| 22.          | <b>Nizamabad</b>     | 1679683         | 34            | 66          | 282                | 200           | 135           | 68            | 69            | 811          | 1046        |        |
| 23.          | Nalgonda             | 2279685         | 59            | 124         | 227                | 434           | 170           | 66            | 101           | 549          | 1952        |        |
| <b>Total</b> |                      | <b>53549673</b> | 1268          | 1830        | 8266               | 8273          | 6726          | 1626          | 2341          | 12041        | 33835       | 22293  |

Source : Directorate of Family Welfare, Andhra Pradesh



Table 2!. 5 :

Beds in Government and Local **Body** Institutions and Doctors **and** Nurses in government service in the districts as on **1-4-1987**, and population served by each.

| Sl.<br>No. | District             | Beds          | Doctors      | Nurses       | Population served by one |               |               | No. of hospital<br>beds per nurse |
|------------|----------------------|---------------|--------------|--------------|--------------------------|---------------|---------------|-----------------------------------|
|            |                      |               |              |              | Bed                      | Doctor        | Nurse         |                                   |
| (1)        | (2)                  | (3)           | (4)          | (5)          | (6)                      | (7)           | (8)           | (9)                               |
| 1.         | <b>Srikakulam</b>    | 738           | 157          | 125          | 2,812                    | 13,220        | 16,604        | 5.9                               |
| 2.         | <b>Vizainagaram</b>  | 429           | 146          | 84           | 4,512                    | 13,259        | 23,046        | 5.0                               |
| 3.         | <b>Visakhapatnam</b> | 2,398         | 430          | 391          | 1,640                    | <b>6,763</b>  | 7,438         | 6.2                               |
| 4.         | <b>E. Godavari</b>   | <b>11,773</b> | 536          | 329          | 2,300                    | 7,609         | 12,397        | 5.3                               |
| 5.         | <b>W. Godavari</b>   | 830           | 190          | 166          | 3,832                    | 16,739        | 19,159        | 4.9                               |
| 6.         | <b>Krishna</b>       | 1,473         | 215          | 270          | 2,301                    | <b>15,762</b> | 12,551        | 5.5                               |
| 7.         | <b>Guntur</b>        | 1,854         | 487          | 356          | 2,048                    | <b>7,796</b>  | <b>10,665</b> | 5.2                               |
| 8.         | <b>Prakasham</b>     | 588           | 139          | 115          | 4,389                    | 18,567        | 22,442        | 5.9                               |
| 9.         | <b>Nellore</b>       | 1,098         | 209          | 191          | 2,051                    | 10,777        | 11,792        | 5.9                               |
| 10.        | <b>Chittoor</b>      | 1,572         | 422          | 339          | 1,925                    | <b>7,170</b>  | 8,925         | 4.6                               |
| 11.        | <b>Cuddapah</b>      | 777           | 153          | 171          | <b>2,769</b>             | <b>14,063</b> | 12,583        | 4.4                               |
| 12.        | <b>Ananthapur</b>    | 1,039         | 190          | 218          | <b>2,708</b>             | 14,808        | 12,906        | 4.6                               |
| 13.        | <b>Kurnool</b>       | 1,431         | <b>402</b>   | 323          | 1,864                    | <b>6,637</b>  | 8,260         | 4.3                               |
| 14.        | <b>Mahaboobnagar</b> | 838           | 177          | 162          | 3,292                    | 15,588        | 17,031        | 5.3                               |
| 15.        | <b>Kanga Reddy</b>   | <b>766</b>    | 106          | 132          | 2,444                    | 17,662        | 14,183        | 5.9                               |
| 16.        | <b>Nedak</b>         | 5,802         | 1,021        | <b>1,164</b> | 451                      | 2,562         | 2,247         | 5.0                               |
| 17.        | <b>Nizamabad</b>     | 724           | 158          | <b>163</b>   | 2,783                    | 12,754        | 12,363        | 4.3                               |
| 18.        | <b>Adilabad</b>      | 732           | 143          | 150          | <b>2,605</b>             | 13,333        | 12,711        | 4.9                               |
| 19.        | <b>Karimnagar</b>    | 752           | 148          | <b>161</b>   | <b>2,466</b>             | 12,532        | 11,520        | 4.5                               |
| 20.        | <b>Warangal</b>      | 787           | 170          | 169          | <b>3,464</b>             | <b>16,032</b> | 16,131        | <b>4.6</b>                        |
| 21.        | <b>Khammam</b>       | <b>1,346</b>  | 317          | 265          | 1,905                    | 8,087         | 9,674         | 5.0                               |
| 22.        | <b>Balgonda</b>      | 637           | 139          | 124          | 3,118                    | 14,289        | 16,017        | 5.0                               |
| 23.        | <b>Hyderabad</b>     | 805           | 186          | 185          | 3,182                    | 13,770        | 13,845        | 4.2                               |
| Total      |                      | 29,189        | <b>6,241</b> | <b>5,753</b> | 2,048                    | <b>9,568</b>  | 10,380        | 5.1                               |

Source : Director of Health, Andhra Pradesh.

## 2.6 Directorate of ~~F~~amily Welfare:

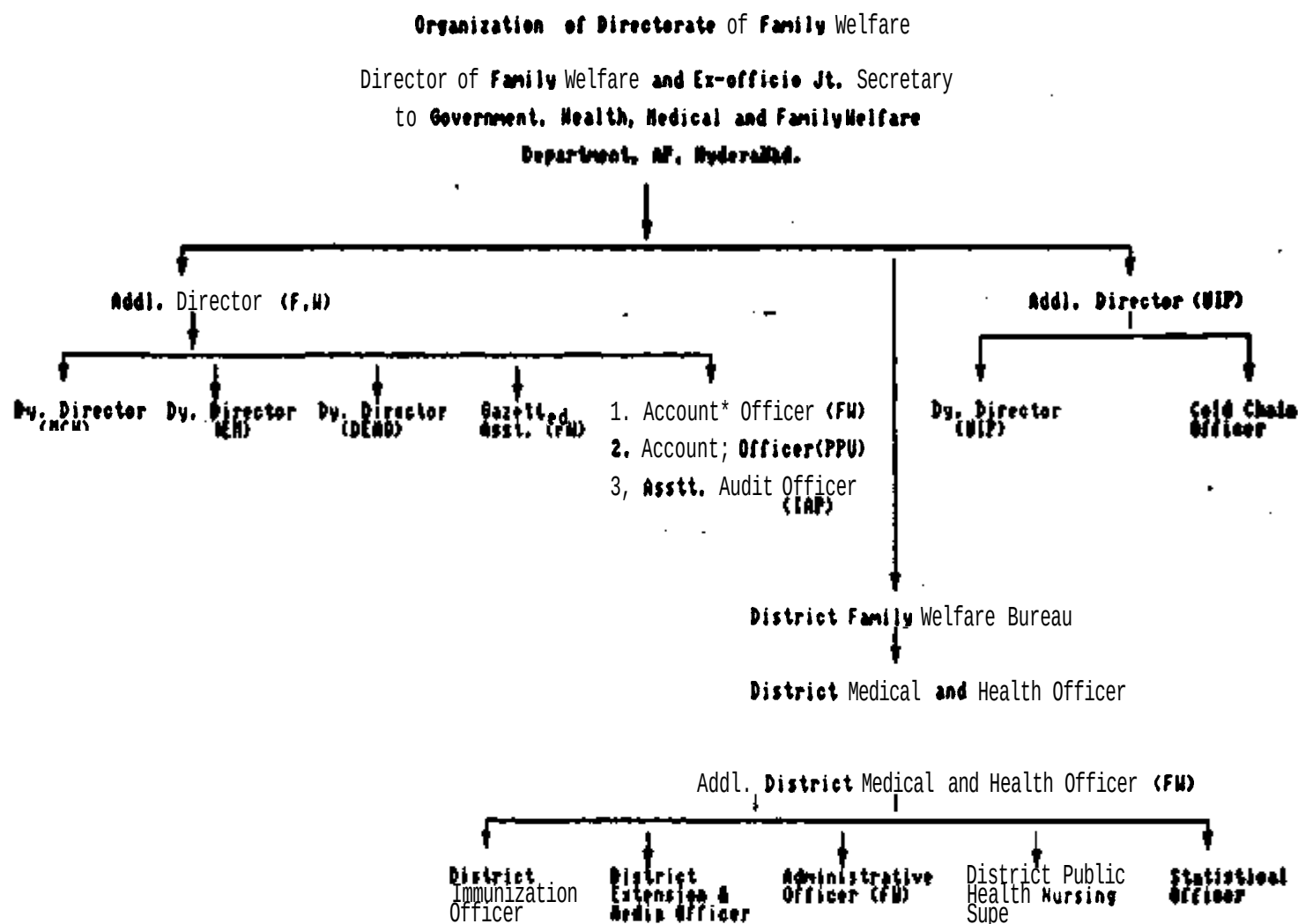
The Family Welfare Programme is a centrally sponsored scheme with 100% central assistance. The programme is implemented through the State Family Welfare Bureau at the state headquarters headed by the Director of Family Welfare, and Ex-Officio Joint Secretary to Government, Health, Medical and Family Welfare Department. The Director is responsible for monitoring, and evaluating the performance in respect of Family Welfare, and Immunization Programmes, in addition to Maternal and Child Health Programme. Further all correspondence with respect to the implementation of the programmes and supply logistics are maintained at the state level. The Director of Family Welfare is assisted by two Additional Directors, one in-charge of Family Welfare (FW) and the other in-charge of Universal Immunization Programme (UIP): four Deputy Directors in-charge of UIP, Maternal and Child Health (MCH), Demography (DEMO), and Mass Education Media (MEM), and other supporting staff.

At the district level, the Family Welfare Programme is implemented by the District Family Welfare Bureau headed by the Additional District Medical and Health Officer who is under the administrative and technical control of the District Medical and Health Officer. There are 23 such District Family Welfare Bureaus in the state.

There are **437 Rural** Family Welfare Centres, located **in PHCs** and 195 Urban Family Welfare Centres attached to hospitals, voluntary organizations, and local bodies. **In** addition there are **8,974** sub-centres in the state at the rate of one sub-centre for every 5000 population in plain areas, and one for 3,000 population in tribal, and hilly areas, through which family welfare services are rendered.

Figure 2.4 shows the organization of the Directorate of Family Welfare in the state, and table 2.6 shows the position of the staff at the state, district and sub-district levels.

Figure 2.4 :



Source : Directorate of Family Welfare, Andhra Pradesh,  
 Hyderabad.

"table 2. 6:

Position of staff at the Directorate, District  
and Sub-district **level**.

**Directorate Level:**

|                                                          |    |
|----------------------------------------------------------|----|
| 1. Director of Family Welfare                            | 1  |
| 2. Addl. Director of Medical and Health<br>Service (FW)  | 1  |
| 3. Addl. Director of Medical and<br>Health Service (UIP) | 1  |
| 4. Deputy Director (MEM)                                 | 1  |
| 5. Deputy Director (MCH)                                 | 1  |
| 6. Deputy Director (DEMO)                                | 1  |
| 7. Deputy Director (UIP)                                 | 1  |
| 8. Assistant Director (Technical)<br>Offset Press        | 1  |
| 9. Gazetted Assistant (Inspection Officer<br>of Stores)  | 1  |
| 10. Accounts Officers                                    | 2  |
| 11. Assistant Audit Officers                             | 3  |
| 12. Health Extension Officer                             | 1  |
| 13. Social Scientist                                     | 1  |
| 14. Statistical Officers                                 | 2  |
| 1b. Non-Gazetted staff                                   | 62 |
| 16. Off-set press                                        | 33 |

**District and Sub District Level:**

|                                                                  |         |
|------------------------------------------------------------------|---------|
| 1. District Family Welfare Bureau                                | 22      |
| 2. Regional Health and Family Welfare<br><b>Training</b> Centres | 4       |
| 3. Urban Family Welfare Centres                                  | 195     |
| 4. Rural Family Welfare Centres                                  | 437     |
| 5. Sub-centres                                                   | 8,9Y4   |
| 6. Village Health Guides                                         | 34,450  |
| Y. <b>Traditional</b> birth attendants                           | 4b,450. |

Source: Directorate of Family Welfare, A.P. Hyderabad.

Under the Family Welfare **Programme**, the following schemes are being implemented:

**(i) Family Planning:**

The objective of the programme is to achieve a birth rate of 21 per 1000, death rate of 9 per 1000 population, infant mortality rate of 60 per 1000 births, and a net reproduction rate of one by 2000 A.D. By the end of 1988 Andhra Pradesh had a birth rate of 26.8/1000 population; death rate of 9.9/1000 population and infant mortality rate of 82/1000 live births. As on 1-4-90, there were 114 lakh eligible couples (estimated) in the state, and of these 44% are protected through one or the other methods of contraception. Since the implementation of the programme till the end of 1989-90, Y1.3 lakh sterilizations were performed, and 13.6 lakh IUDs were inserted. However, according to the authorities the unprecedented cyclone in the coastal districts in



May 1990 has caused a serious set back in the implementation of the Family Welfare Programme in the state.

**(ii) Universal Immunization Programme (UIP):**

This scheme is being implemented in all the 23 districts. The programme envisages the prevention of six diseases namely diphtheria, whooping cough, tetanus, polio, tuberculosis, and measles, among infants, and protecting pregnant woman against tetanus. The Government of India had provided the necessary infrastructural facilities for the maintenance of cold chain of **vaccines**, and in addition created posts of District Immunization Officers, Statistical Officers, and **Refrigerator** Mechanics to strengthen, and monitor the programme in a **systemtic** way.

**(iii) Oral Rehydration Therapy (ORT):**

The programme aims at the replacement of body fluids lost due to diarrhoeal diseases affecting children. This aim is achieved by creating awareness among the people through health education imparted by Health Workers, Village Health Guides, and other paramedical staff. The staff have been trained to recognize the severity of dehydration, and supplementation of fluids by providing oral rehydration salt packets, and timely referral to the nearest **PHCs** or hospitals.

**(iv) Training of Multipurpose Health Workers (Men and Women):-**

The training for the men workers is being imparted at four **Regional** Family Welfare **Training** Centres regularly for a period of one year. In addition the training centres also provide inservice training to medical, and paramedical staff ranging from two weeks to six weeks. Recently six new schools have been sanctioned to impart training to the men workers. At present ~~7067~~ posts are sanctioned out of which only 6528 posts have been filled. According to the present requirement nearly 3000 more men **workers** are required. The reason for the shortage is that as far as expenditure for training, and stipend paid to them is concerned, the entire burden is borne by the Government of India, but once the workers are recruited, and selected it is the state's responsibility to pay salaries etc., and because of inadequate funds the government is not able to recruit the required number of men **workers**.

In Andhra Pradesh, there are 140 training institutions for the women workers, (12 government institutions, 18 grant-in-aid, and 110 private institutions). These institutions are imparting training to ~~5,600~~ women workers for a period of 18 months. The women workers are appointed at the sub-centres to carryout the services under Maternal and child Health, Family Planning, Oral **Rehydration** Therapy, and **Immu-**nization Programme.



(V) **Training of Village Health Guides (VHGs):**

Under this scheme one VHG is appointed for every 1000 population, and is given training for a period of three months at the PHC. There are 34,450 VHGs in the state who are paid an honorarium of Rs.50/- per month, and provided with medicines worth Rs.50/- per month. However the scheme has been found to be ineffective, and the government is planning to abolish it in a phased manner. Right now the post of Medical Officer under this scheme has been abolished, and medicines are also not being provided to the VHGs. However they are being paid Rs.50/- honorarium, so that they assist the Multipurpose Health Workers in programme implementation.

(vi) **Training Programme for Dais:** -

Under this programme the traditional birth attendants (Dais) are trained for a period of one month at the PHC to conduct safe home deliveries. Nearly 45,000 Dais have been trained in the state till now since the inception of the programme.

(viii) **Mass Education and Media Activities:-**

Mass education and media activities are aimed at promoting the Family Planning Programme, and the adoption of the small family norm. The programme also educates the people on the importance of immunization, oral rehydration therapy, and

maternal and child health services. The means used include, television, radio, posters, audio and video cassettes, traditional forms of entertainment besides person to person communication.

**(viii) Postpartum Programme:-**

There are 83 **Postpartum** units in the state, in teaching hospitals, district hospitals, and taluk hospitals. The aim of these units is to create a sense of acceptance of small family norm, and to provide the necessary services for the pregnant women.

**(ix) National Training Programme (IPPVL):-**

**Government** of India sanctioned under the India Population Project, a training programme in the state with the help of world Bank. The National Training Programme aims at improving the efficiency of health personnel by imparting training to the medical, and paramedical staff by identifying the gaps in their knowledge and skills to be used in the implementation of national programmes like Family Welfare Programme, Universal **Immunization** Programme (**UIP**), Maternal and Child Health Programme (**MCH**), Oral **Rehydration** Therapy (**ORT**) etc., and to enhance the service delivery system in which the trained worker will operate. For this purpose the following institutions are proposed to be established.

- a) State **Institute** of Health and Family Welfare which would act as an apex institute.

- b) Regional **Training** Centres, four for men, and four for women at the regional level ( Hyderabad, **Kurnool**, **Guntur** and **Visakhapatnam**).
- c) District Training Teams, one at each district headquarters.
- d) Field practice, and demonstration areas one each attached to the district training teams to impart practical training to the trainers at **PHC**, and sub-centre level.

To improve the service delivery system, it is proposed to construct 400 sub-centre buildings, replace 173 vehicles at **PHC** level, provide equipment to **PHCs**, and sub-centres, and provide delivery **kits** to **Dais**. The Government of India has allocated **Rs.1.37** lakhs for the year 1990-91 subject to supplementation of additional budget if required.

Thus it can be seen from the above description that the bulk of medical and health services are provided by the Directorate of Health, and Directorate of Family Welfare. In addition to the eight directorates, there is a State Health Transport Organization (**SHTO**) which looks after the maintenance and repairs of **1638** vehicles belonging to the Director of Family Welfare, Director of Health, Director of Medical Education, Commissioner of **APVVP**, Director of **Insurance** Medical Services, Director of Indian Medicine, and Director of Institute' of Preventive Medicine. There are 214 **ambu-**

lances under different programmes in the fleet of the SHTO.

The structure of the organization consists of one central workshop and administrative office at Hyderabad, four regional workshops at Warrangal, Cuddapah, Vijayawada and Visakhapatnam, and twenty mobile workshops located in each district.

In this chapter we have analyzed the organization structure of the primary health care organization with special emphasis on coordination of activities at different levels. Although the health policy envisages an integrated approach in the implementation of the services at the grassroot level, the present structure reflects functional specialization in the form of individual programme officers and additional directors incharge of specific programmes like family welfare, malaria, leprosy etc. This is because the various departments at the higher levels are still functioning independently as it was under the uni-purpose scheme and no attempt has been made to integrate the work of all the departments. This kind of a setup is only leading to problems of coordination and integration shortfalls between different departments, and distortion of priorities for the grassroot level workers due to lack of unified command.

## CHAPTER III

### PROFILE OF PERSONNEL

#### SOCIAL BACKGROUND, SELECTION AND TRAINING

An attempt has been made in this chapter to examine the social background, selection, training, transfers, and orientation of the functionaries towards their job.

Social background of the members was examined with the assumption that differences in social background could have an impact on the inter-personal relationships and teamwork in the organization. The differences could create problems of communication leading to improper coordination of activities, thereby affecting the overall performance.

Social background broadly measured in terms of their personal attributes, caste, religion, nativity, marital status and educational qualifications gives an indication of homogeneity or heterogeneity of PHC personnel as well as the village level functionaries.

### 3.1 PERSONAL ATTRIBUTES:

#### 3.1.1 Age and Sex:

Table 3.1 :

Distribution of functionaries by age and sex.

| Sl. No. | Age<br>(in years) | Category of personnel |       |                                 |       |                             |       |                       |                |
|---------|-------------------|-----------------------|-------|---------------------------------|-------|-----------------------------|-------|-----------------------|----------------|
|         |                   | Medical Officer       |       | Multipurpose Health Supervisors |       | Multipurpose Health Workers |       | Village Health Guides | Dais (trained) |
|         |                   | Men                   | Women | Men                             | Women | Men                         | Women |                       |                |
|         |                   | N=0                   | N=3   | N=7                             | N=2   | N=4                         | N=10  | N=30                  | N=24           |
| (1)     | (2)               | (3)                   | (4)   | (5)                             | (6)   | (7)                         | (8)   | (9)                   | (10)           |
| 1.      | 20 - 29           | -                     | 2     | -                               | -     | -                           | 3     | -                     | -              |
| 2.      | 30 - 39           |                       | -     | 1                               | -     | -                           | 6     | 1 8                   | 4              |
| 3.      | 40 - 49           |                       | -     | -                               | 6     | 1                           | 4     | 1                     | 6              |
| 4.      | 50 - 59           |                       | -     | -                               | 1     | 1                           | -     | 1                     | 8              |
| 5.      | 60 - 69           |                       | -     | -                               | -     | -                           | -     | -                     | 3              |
| 6.      | 70 & Above        | -                     | -     | -                               | -     | -                           | -     | -                     | 3              |
| Total   |                   | -                     | 3     | 7                               | 2     | 4                           | 10    | 30                    | 24             |

The above table shows that all the three Medical Officers are women, and also young in age. Six out of the seven men Supervisors, and one of the two women Supervisors belong to the age group 40-49 years, while one of the men Supervisor's, and one women Supervisor are above 50 years of age.



Six out of the ten woman **Workers** belong to the **age** group 30-39 years, while three of them are below **30** years of age, **and** one above 40 years of age. **In** contrast all the men Workers are above 40 years of age.

Thus it shows that the women Workers are relatively young when compared to the men Workers. **This** can be attributed to the fact that women Workers are being recruited on a regular basis unlike the men Workers. As already discussed in Chapter II, men Workers are not being recruited due to lack of funds.

As for the village level functionaries , eighteen out of the thirty Health Guides are below 40 years of age, while eleven of them are above 40 years but below **50** years, and only one of them is above **50** years of age. **fourteen** out of twenty four Dais (trained) are above 40 years of age, and ten of them are below **50** years.

### 3.2 SOCIAL BACKGROUND:

The social background of the functionaries was studied in terms of their religion, caste, marital status, and nativity.

### 3.2.1 **Religion:**

All Medical Officers, six out of seven men Supervisors, and one of the two women Supervisors, and all the Health Guides and Dais are Hindus. One male Supervisor is a Muslim and one female Supervisor is a Christian. One half of the women Workers (b) are Hindus, and the other half are Christians. However, three out of four men Workers are Muslims, and only one male Worker is a Christian. There are no Hindu men Workers.

### 3.2.2 **Caste:**

Two of the Medical Officers belong to the dominant castes (Kamma and Reddy), and the third belongs to a Schedule Caste. Six, out of the seven men Supervisors belong to the Other Castes including Muslims and the Christians. While only one belongs to the Backward Caste. Both the women Supervisors belong to Backward Castes. Three out of the four men Workers belong to Other Castes, including Muslims and Christians, and one belongs to the Backward Caste. Six out of the ten women Workers belong to the Backward Castes, while three belong to Other Castes, and one belongs to the Schedule Caste. Nineteen out of the thirty Health Guides belong to the Backward Castes, while eight of them belong to Other Castes, and three belong to the Schedule Castes.



### 3.2.3 Marital Status:

All the functionaries in this study are married with children ranging from 2 to 6.

### 3.2.4 Nativity:

All Medical Officers belong to Hyderabad, that is, they are predominantly urban oriented. Seven out of the nine Supervisors, and eleven out of the fourteen Workers belong to Ranga Reddy district (rural), and the remaining two Supervisors, and three Workers belong to other districts of the state. However it can be seen that all functionaries have practically migrated to Hyderabad because of their job, and also their childrens' education.

The Health Guides and Dais belong to their respective villages.

Since most of the PHC functionaries are local people, they prefer to continue working in this particular PHC as long as they can. As it can be seen further, most of them have been serving in the PHC for more than four years. Most of them have their own business or agricultural lands in the nearby villages. Hence being in this PHC enables them to do their job as well as look after their personal interests.

### 3.3. EDUCATIONAL QUALIFICATIONS:

Education is an important variable in determining how

tha personnel **perceive**, and parform their duties in an organization. Table 3.2 shows tha distribution of respondents according to their educational qualifications.

Table 3.2 :

Distribution of functionaries by educational qualifications :

| Sl. Educational<br>No. Qualifi-<br>cations |                                  | Category of personnel |                                       |       |                                   |       |      | Village<br>Health<br>Guides | Dais<br>(trained) |
|--------------------------------------------|----------------------------------|-----------------------|---------------------------------------|-------|-----------------------------------|-------|------|-----------------------------|-------------------|
|                                            |                                  | Medical<br>Officer    | Multipurpose<br>Health<br>Supervisors |       | Multipurpose<br>Health<br>Workers |       |      |                             |                   |
|                                            |                                  |                       | Men                                   | Women | Men                               | Women |      |                             |                   |
|                                            |                                  |                       |                                       |       |                                   |       |      |                             |                   |
|                                            |                                  | N=3                   | N=7                                   | N=2   | N=4                               | N=10  | N=30 | N=24                        |                   |
| (1)                                        | (2)                              | (3)                   | (4)                                   | (b)   | (6)                               | (Y)   | (8)  | (9)                         |                   |
| 1.                                         | MBBS                             | 3                     | -                                     | -     | -                                 | -     | -    | -                           | -                 |
| 2.                                         | Degree/<br>Diploma               | -                     | 1                                     | -     | 1                                 | -     | -    | -                           | -                 |
| 3.                                         | PUC/Inter-<br>mediate            | -                     | 2                                     | -     | 3                                 | 2     | 5    | -                           | -                 |
| 4.                                         | HSC/SSC/<br>Matric               | -                     | 4                                     | 1     | -                                 | 8     | 9    | -                           | -                 |
| 5.                                         | Middle or<br>Secondary<br>School | -                     | -                                     | -     | -                                 | -     | 12   | -                           | -                 |
| 6.                                         | Primary<br>School                | -                     | -                                     | 1     | -                                 | -     | 4    | -                           | -                 |
| 7.                                         | Illiterate                       | -                     | -                                     | -     | -                                 | -     | -    | -                           | 24                |
| Total                                      |                                  | 3                     | Y                                     | 2     | 4                                 | 10    | 30   | 24                          |                   |

In terms of the educational qualifications, it can be seen that four out of seven men Supervisors, and one women Supervisor have passed high school. Similarly eight out of the ten women Workers have also acquired high school qualifications. However, the men Workers are slightly better qualified in that three out of four have acquired intermediate degree.

Twelve of the Health Guides passed middle/secondary school, and nine of them passed high school. However all the Dais are illiterate.

All the three Medical Officers are planning to do their **postgraduation**. Frankly speaking none of the them seem to be interested in their job, and are working in the PHC as they have no choice. The Government of **A.P.** has made it compulsory for all doctors (seeking government job) to work in PHCs for a minimum period of two years. Thus the doctors have no choice but to work in the PHC. Also the Medical Officers are not oriented to work in rural areas as their curriculum lays more emphasis on curative, and specialized services which are **basically** urban oriented.

The same applies to the other categories of personnel working in the **PHCs**, i.e., Supervisors and **Workers**. They are **basically recruited on the basis of educational qualifications**

required for the purpose. **The** limited educational qualifications which they have acquired does not gear them up to serve in rural areas. **It** is only because of economic compulsions, and job security that they happen to take up this job.

Looking at the career patterns of the **PHC** personnel studied **intervals** of their period of unemployment if any, and the different jobs held before joining this service, it was found that half of the functionaries were unemployed for sometime after their formal education. One Medical Officer was unemployed for six years, while four out of nine Supervisors, eight out of fourteen Workers were unemployed for a period of 2 to 6 years.

**Regarding** the different jobs held by the functionaries, it is found that none of the doctors held any other job prior to this service. Five of the men Supervisors held different jobs as - revenue inspectors, junior auditors, and teachers. Similarly, three out of the four men Workers also worked as teachers, and clerks in private establishments while some had their own business. Thus it can be seen that the men Supervisors, and Workers held jobs totally unrelated to the present job. However, half of the women Workers have worked in private medical clinics, and nursing homes before joining this service. **This** is because the women Workers are basically qualified in nursing, while the men workers, and supervisors are not, and have been recruited as vaccinators under the

small pox eradication programme, for which they were given some training.

### **3.4 RECRUITMENT OF PERSONNEL:**

As already discussed in chapter 1, to ensure that the expectations placed by the organization on the personnel are fulfilled, various formal mechanisms like recruitment, selection, and training are used.

Recruitment involves finding manpower, and encouraging potential employees to seek jobs in any organization. The personnel working in the PHC belong to different cadres, and hence are recruited by different agencies (See table 3.3).

**Table 3.3 :****Recruitment of Primary Health Centre Staff**

| Sl. No. | Designation                                     | Service to which they belong             | Recruiting Authority              | Appointments, Transfers and postings | Mode of Recruitment |
|---------|-------------------------------------------------|------------------------------------------|-----------------------------------|--------------------------------------|---------------------|
| (1)     | (2)                                             | (3)                                      | (4)                               | (5)                                  | (6)                 |
| 1.      | Medical Officer                                 | A. P. Medical Services                   | A.P. Public Service Commission    | Director of Health                   | Direct              |
| 2.      | Community Health Officer                        | A.P. Public Health Sub-ordinate services | Regional Director                 | Regional Director                    | By Promotion        |
| 3.      | Multipurpose Health Extension Officer           | -do-                                     | -do-                              | -do-                                 | By Promotion        |
| 4.      | Multipurpose Health Supervisors (Male & female) | -do-                                     | -do-                              | -do-                                 | By Promotion        |
| 5.      | Upper Division Clerk                            | A.P. Ministerial Services                | -do-                              | -do-                                 | By Promotion        |
| 6.      | Multipurpose Health Workers (Male & female)     | A.P. Public Health Sub-Ordinate Service  | District Medical & Health Officer | District Medical & Health Officer    | Direct              |
| 7.      | L.D. Computer                                   | -do-                                     | -do-                              | -do-                                 | Direct              |
| 8.      | Lab Technician                                  | -do-                                     | -do-                              | -do-                                 | Direct              |
| 9.      | Pharmacist                                      | Medical and Health Service               | District Selection Committee      | -do-                                 | Direct              |
| 10.     | Driver                                          | A.P. Public Health Sub-ordinate Service  | -do-                              | -do-                                 | Direct              |
| 11.     | Voluntary Workers                               | -                                        | Medical Officer                   | Medical Officer                      | Direct              |
| 12.     | Village Health Guides                           | -                                        | -do-                              | -do-                                 | Direct              |

Source : Directorate of Health, Andhra Pradesh.

The Medical Officers at the **PHC** belong to the State Medical Service, and are recruited by the **A.P.Public** Service



Commission. Depending on the vacancies, the **APPSC** conducts periodical selection for the cadre of Assistant Civil Surgeons in the state. Generally the Directorate of Health fills the vacancies by making temporary appointments without reference to the **APPSC**. However appointments made on a temporary basis are usually regularized by the APPSC at a later point of time. All the three Medical Officers in this study have been appointed on a temporary basis, and are yet to be regularized. A number of doctors working in PHCs in the state are awaiting regularization for a number of years, and this has become a major source of worry, and frustration for the doctors in the PHCs.

To avoid delay, and also reduce the burden at the Directorate level, the posts of **Regional** Directors were created. The Regional Director is entrusted with the service matters of all State Public Health Sub-ordinate Service employees working in the respective regions. He is also the recruiting authority for a number of posts like the Multipurpose Health **Extension** Officer, Multipurpose Health Supervisors (men and women) who belong to the **A.P.** Public Health Sub-ordinate Services. The **non-technical** posts at the PHCs upto the upper division clerk (Senior Assistant) are also under the recruiting authority of the Regional Director (refer table 3.3).

The Multipurpose Health Workers (men and **women**), Lab

**Technicians, Computer** working in **PHCs** are recruited by the **District Medical** and Health Officer.

The Medical Officers of the **PHCs** can recruit the Village Health Guides, and Voluntary Workers. However in this study it was found that except for one Health Guide all others selected for training were those recommended by the village surpanch. The then **PHC** Medical Officers did not seem to have taken **an active** part in the selection process as they were basically required to recruit voluntary workers for training when the scheme was introduced in 19 YY (all Health Guides in the study were trained in the first three batches). As far as Dais are concerned, 63% were selected for training by the Health Supervisors, and 37% were selected by the Health Workers.

Recruitment is of two types - direct recruitment, and recruitment by promotion. Recruitment for the supervisory cadre is by promotion while for the others it is not so, that is, they are recruited directly. The men Workers, are promoted as Supervisors purely based on seniority unlike the women Workers who are promoted not only on the basis of seniority, but also on the basis of the training course which they have to undergo for a period of six months.

### 3.5 TRAINING OF PERSONNEL:

Once the selection process is completed the new employ-



e#, and the organization have to mutually **learn** to adjust to each other. Individuals try to develop careers within the organization, and organizations try to influence the development of the individual. In this process, training becomes an important instrument of socialization. Organizations use training to develop the necessary technical, and task skills that the employee will need to know to carry out his or her job effectively.

Training programmes (inservice) are important because they help the personnel to keep abreast of the new developments, and techniques to be adopted in the programme implementation. But how effective the in-service training programmes are depends on the nature of training, duration, and the facilities available. Let us see how the different categories of personnel have evaluated the training programmes (in-service) they have attended.

The Medical Officers at the **PHC** are neither given any **pre-service** training nor are they oriented to provide services which are preventive and **promotive** in nature. However there are inservice training programmes which they attend. All the three Medical Officers attended the training programme on the administration of **PHCs** at the **Rural** Health and Family Welfare Training Centre for a duration of one month. The programme according to them emphasized on imparting knowledge regarding programme **implementation**, and also to make them **managerially** sound with regard to administration, and ac-

counts. Two of the Medical Officers also attended the training on Medical Termination of Pregnancy (MTP) for **15** days, and also the Universal Immunization Programme (UIP), and Oral Rehydration Therapy (ORT) Programme for two days.

All the three Medical Officers were satisfied with the inservice training given to them, and found it useful.

Like the Medical Officers, the first line Supervisors also attended inservice training programmes. All of them attended two to four programmes each, the duration ranging from two days to two weeks. The training programmes attended by them included the Multipurpose Training Programme, Family Planning Training **Programme**, UIP programme, and training programme on Communicable Diseases.

Like the Medical Officers, seven out of the nine Supervisors found the training programmes useful, however two of them felt that in terms of the content, nothing new was being taught, and felt that emphasis should be more on imparting skills, rather than theory.

All the Health Workers attended inservice training programmes. Seven out of ten women Workers attended one to two programmes while the remaining three attended three to four programmes each. All men Workers attended four training programmes each.

All of them have attended the Multipurpose Training Programme, and the Family Welfare Programme. Three out of ten women Workers, and all men Workers in addition attended training programmes on **Immunization**, **ORT**, Management Information Evaluation Systems, Health Education, and Communicable Diseases.

Almost all Health Workers found the training programmes useful because the programmes emphasized on theory as well as practical knowledge. The men Workers felt that such training programmes should be organized atleast once a year so that they get a break from the routine, and also helps them in the **programme implmentation**. However, the women Workers feel that training programmes should be organized once in two years, to avoid repetition in the contents of the training programme. **Infact**, some of the women Workers were of the opinion that they are not able to use the skills they learn in the various training programmes because of poor infrastructural facilities at the sub-centres.

Not only do the PHC personnel undergo inservice training, they are also involved in the training of the village level functionaries, viz., the Health Guides, and Dais. The Dais are given one month's training at the PHC with an incentive of **Rs.300/-** plus a delivery kit, and the Village Health Guides are given three months training at the PHC, and are paid a stipend of **Rs.200/-** per month. Both these function-

**aries** found the training programme useful. The Dais found the training programme useful as they were taught to conduct deliveries in a more hygienic manner (for example, to cut their nails, and keep them clean before **delivery**, hands to be washed with soap, use of gloves, sterilizing the blade used to cut the umbilical cord, use of clean cloth, etc), and were also instructed on the different types of deliveries, and how they have to be handled. Most of the Health Guides (80%) also found the training useful as it not only helps in treating patients in the village but also helps in treating their family members including themselves. For some of the Health Guides the training has given them a sort of license for practising as Registered Medical Practitioners(RMPs). 20% , of the Health Guides felt that the training is not useful as no medicines are being given to them since the past eight to ten months.

In addition to the training programmes attended by the workers, they are supposed to receive **on-the-job** training from the Medical Officers, Supervisors and district level Programme Officers, during their visits to the sub-centres, and villages. However it was found that the Medical Officers and the District Officers hardly provided on-the-job training as they very rarely visit sub-centres, and other villages. On-the-job training was imparted only by the first line Supervisors which was not very much appreciated by the workers because they felt that their knowledge is very limited.

### **3.6 LENGTH OF SERVICE AND TRANSFER POLICIES:**

All Medical Officers have less than 5 years of service in the present job, while all Supervisors have a service of more than 10 years. Similarly the men Workers too have been in service for more than 10 years. However, half of the women Workers (5) have a service of less than 5 years, while four of them have a service of 5 to 10 years, and one of them has been in service for more than 10 years.

Thus it can be seen that majority of the women Workers are less experienced as compared to the men Workers. This is because the men Workers were recruited long ago under the uni-purpose scheme, and are now designated as Multipurpose Health Workers.

Coming to the village level functionaries all Health Guides have been working as voluntary workers for the past 8 to 10 years. Thirteen out of the twenty four Dais have been conducting deliveries for the past 19 years, while nine of them have been on the job since 3b years, and two of them have been conducting deliveries for the past 4b years. Since the Health Guides are voluntary workers, they have their own occupations to pursue. Fourteen out of the thirty Health Guides are engaged in business, while five of them are engaged in traditional caste occupations, and two of them are engaged in agriculture. An interesting feature worth noting

is that, the remaining nine Health Guides are **practicing** as **RMPs**. Some of the Health Guides are politically very active, and work as election volunteers also. Most of the Dais interviewed (15) work as agriculture labour, while six of them are engaged in agriculture, and three are engaged in business.

Generally, **the** number of transfers are associated with the length of service. Four out of the ten women Workers have no experience of transfers as it is their first appointment, and four of them have been transferred one to three times, and two of them have been transferred more than four times. However, half of the women Workers (5) have been in the present PHC for more than four years. Like the women Workers three out of the four men Workers have been transferred thrice, while one of them was transferred four to six times. Like the women Workers, three of the men Workers, have an experience of more than four years in this particular PHC. Likewise, seven out of nine Supervisors have been transferred more than four times, while two of them, have been transferred three to four times. However, **in terms** of experience in this PHC, all of them have been serving since more than four years.

Two of the Medical Officers joined service **immediately** after their graduation while the third joined service after a gap of six years. Two of them were transferred once, and for the third, it has been the first appointment. Two of the



Medical Officers have been in this PHC for more than four years, while the third has less than 4 years experience in this PHC.

**Thus** majority of all categories of functionaries have been in the PHC for more than 4 years.

Frequent transfers of personnel tends to hamper work in PHCs, firstly, because every PHC area differs from the other; and secondly the personnel have to get familiar with the area, the villages to be covered, the health needs of the community, and public health problems before actually getting down to work. Hence too frequent transfers might affect the performance of the functionaries.

Probing further into the question of transfers, the functionaries were asked to express their opinion regarding transfers. **Two** of the Medical Officers felt that there should be no transfers (though no reasons were cited), while the third Medical Officer felt that there should be transfers because, she feels that by working in the same place one's services are not given due recognition. The two Medical **Officers** who were against transfers were those having private practice in the city, and that could be one of the reasons why ~~they were~~ against transfers.

All the men Supervisors felt that there should be transfers, but preferred the transfers to be once in five

years, and not once in three **years**. However the women Supervisors were against transfers as they have already been transferred quite a number of times. They prefer to be retained in this **PHC** for some more time as their children are studying in the city. Half of the men and women Workers prefer transfers, while the other half do not. Because of domestic problems the women Workers are against transfers, also since most of them (seven), live in the city, they dislike transfers.

Some functionaries prefer **transfers because** they feel that at some point of time all Workers will get an opportunity to serve in well equipped **PHCs**, as well as in **PHCs** with poor infrastructure. Also there are some personnel who are more efficient in their work than some others, and if all the **efficient ones**, and the less **efficient** ones are retained in the same place then the services would not reach everyone. Some prefer transfers to avoid being harassed by corrupt officials. Some others feel that transfers help in gaining wider experience, knowledge, and ultimately help **in** performing their job well. **This** in turn would help **them** to gain recognition for their work. All those in favour of transfers however feel that the transfers should not be too frequent, and a worker should be retained in a place for at least five years. When the respondents were asked whether at any point of time they could not proceed on transfer, all of them said that they always proceeded on transfer. However informal



**interviews** did reveal that transfers were avoided through political **influence** of the local leaders, and district level officials.

### 3.7 **EMOLUMENTS:**

Income from salary is an **important** variable in determining how well a person performs his or her job. **Since** the PHC personnel are supposed to render services at the people's door step, it requires, devotion, and **commitment** on the part of the personnel. **The** personnel can render committed service only when their conditions of service are satisfactory. Table 3.4 shows the pay scales of the different categories of personnel working in the **PHC**.

Table 3.4 :

**Emoluments of the Primary Health Centre Staff.**

| S1.<br>No. | Designation                                        | Fay (in Rupees)                 |
|------------|----------------------------------------------------|---------------------------------|
| (1)        | (2)                                                | (3)                             |
| 1.         | Medical Officer                                    | <del>1810-70-2510-80-3230</del> |
| 2.         | Community Health Officer                           | <del>1380-60-1980-70-2750</del> |
| 3.         | Multipurpose Health<br>Extension Officer           | 1150-40-1510-50-2110            |
| 4.         | Multipurpose Health Supervisors<br>(Men and Women) | 1050-40-1450-45-1945            |
| 6.         | Multipurpose Health Workers<br>(Men and Women)     | 950-30-1250-35-1870             |
| 6.         | Staff Nurse                                        | <del>1150-40-1510-50-2110</del> |
| Y.         | Upper Division Clerk                               | 1100-40-1500-60-2060            |
| 8.         | Pharmacist                                         | <del>1010-35-1360-40-1800</del> |
| 9.         | Ophthalmic Assistant                               | 1010-35-1360-40-1800            |
| 10.        | L.D. Computer                                      | 910-30-1240-35-1625             |
| 11.        | Lab Technician                                     | 780-20-1000-25-1275             |
| 12.        | Driver                                             | <del>740-15-950-20-1150</del>   |
| 13.        | Attenders                                          | <del>740-15-950-20-1150</del>   |
| 14.        | Voluntary Workers                                  | 50                              |
| 1b.        | Village Health Guides                              | 50 (Honarorium)                 |

Source : G.O. Ms. No.288, Dated 17/11/86.  
Directorate of Health, Andhra Pradesh.

In the case of Supervisors, and Workers the pay scales are different, and the officer-in-charge of their salary payment are also different, and hence they feel that they should not work for all programmes. Among the functionaries it is the men Supervisors, and men Workers who expressed more dissatisfaction with regard to salaries drawn. Even though the Multipurpose Scheme was introduced long ago, some of the Workers and Supervisors were still drawing salaries as per the unipurpose scheme. The newly selected Workers and Supervisors draw slightly higher salaries as compared to those selected under the unipurpose scheme. This is causing a lot of resentment among them. Thus an attempt has to be made to bring about uniformity in the pay scales keeping in mind the educational qualifications, experience, and salaries drawn by them at present. This may also call for a merger of certain financial heads and procedures for accounting. This task once again requires interdepartmental coordination, and needs to be given a serious thought if the objectives of the PHC organization are to be realized. If the wages are not made uniform it is going to have a very negative impact on the morale of the personnel.

The Medical Officers however did not express any dissatisfaction regarding their salaries. This is because of the additional income they earn in private practice.

The Health Guides are paid Rs.50/- every month as honorarium. Although they have their own occupations , they still feel that they are not being rewarded suitably. According to them the honorarium should be increased from Rs.50/- per month to Rs.300-500 per month, while some of them felt that they should be recruited as full time workers with regular pay scales.

Like the Health Guides, the Dais (trained) too were unhappy with the honorarium they receive (Rs.1/- per antenatal case registered, and Rs.2/- per delivery conducted). Even this amount (Rs.3/-) is not being paid to them regularly due to paucity of funds. According to some Dais (40%) at least Rs.20/- to Rs.25/- should be paid for every delivery they conduct, while some others (16%) felt that Rs.100/- should be paid to them every month. The remaining 44% seemed to be highly dissatisfied, and claimed that they should be paid at least Rs.300/- per month. Since majority of the Dais (50%) are working as agriculture labour, and are engaged in agriculture (17%), they do not seem to be having a regular income. As a result they would like to receive some fixed remuneration from the government. because they consider themselves to be performing an important function in the village. Those involved in business (17%) were slightly

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 \* 47% of Health Guides are engaged in business. 23% are engaged agriculture, and 30% are practicing as RMPs.

better off as compared to those engaged in agriculture. and those working as agriculture labour, and hence were not as dissatisfied as the rest.

### 3.7 ORIENTATION OF THE FUNCTIONARIES TOWARDS THEIR JOB:

Orientation of the PHC personnel towards their job has been examined in terms of their personal preferences vis-a-vis the priorities laid down by the health department.

Highest priority (from the department's point of view) is accorded to family planning, followed by maternal and child health services, control of communicable diseases, medical relief, school health, health education and environmental sanitation. All Health Workers and Supervisors in the study identified themselves with the priorities set by the health department. However, it was not so with the Medical Officers who think that providing medical relief should be given the highest priority, followed by maternal and child health, family planning, control of communicable diseases and environmental sanitation. Health education and school health according to them should be given a low priority. This clearly shows that the Medical Officers were more interested in providing curative services rather than preventive services. This once again reflects the orientation of the medical education system which emphasises on curative services rather than preventive measures.

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Members of an organization usually weigh the advantages, and disadvantages of being in service in terms of their satisfaction with regard to the job, remuneration, promotions, colleagues, cooperation from villagers and facilities available. The respondents were therefore asked to identify two important advantages and disadvantages of being in this service.

All respondents said that the job offers security, and pension facility, and at the same time helps in rendering service to humanity.

On the negative side, the following response categories have been identified by the respondents:

- a) official interference;
- b) poor facilities, and working conditions;
- c) lack of promotional avenues, and
- d) frequent transfers.
- e) job is difficult because of too much workload.

Two of the Medical Officers identified categories (b) and (e) and the third Medical Officer identified (b) and (d). Five out of the nine Supervisors identified categories (b) and (c), while the rest (4) identified various combination of the above categories. Half of the women Workers (5) identified categories (b) and (c), while the other half identified categories (b), (e), and (c). AM the

men Workers (4) identified categories (b). (c). and (e).

Fixed and poor remuneration. too much of work load, lack of team work, lack of safety (for women Supervisors and Workers), lack of proper housing conditions, inadequate house rent allowance, travelling allowance. and lack of cooperation from the villagers due to traditional beliefs, customs and practices were some of the other disadvantages identified by the respondents. The Medical Officers in addition, also complained about indiscipline among the staff, and inability to have private practice. as other disadvantages of the job. even though two of them are engaged in private practice. Of all the respondents the men Supervisors, and Workers seem to be in general more dissatisfied than the women Workers, and Supervisors. By and large all categories of personnel considered their job as a difficult one involving a lot of effort without commensurate rewards.

In terms of their personal attributes. social background, educational qualifications. and income. there are considerable differences between the Medical Officers. Supervisors and Workers. and the village level functionaries. All the Medical Officers have an urban background. while the other functionaries have a rural background. Also the Medical Officers have high professional qualifications as compared to the other functionaries who are mostly educated upto high school. In terms of the caste. majority of the Medical



Officers belong to dominant castes as compared to the functionaries who mostly belong to the backward castes.

It was found that some of these differences especially in terms of their religious composition and sex of the members did impose certain constraints on the interpersonal relationships, team work, and coordination of activities. This obviously had a bearing on the performance of the workers at the grassroot level. Differences in terms of their caste composition did not have much impact on their interrelationships.

## CHAPTER IV

### WORK LOAD AND PROGRAMME WISE PERFORMANCE

During the last forty years, sizeable investments have been made in creating a network of infrastructural facilities all over the country to deliver medical, and health care services to the masses. It is therefore important to see that the existing infrastructure is energized to yield maximum benefits, if the goal of 'Health For All by 2000' is to be achieved. The achievement of this goal depends not only on utilizing the existing infrastructural facilities, but also on how well the employees perform their duties in their individual capacities, and as members of their respective teams.

In this chapter an attempt has been made to study the workload, and programme wise performance of the men and women Workers, Health Guides, and Dais with regard to health and family welfare activities. The performance of these three categories of personnel is being studied as they are the ones who render services at the grassroots level. Their performance will be discussed individually as their job functions vary. An attempt has also been made in this chapter to study the target setting practices of the personnel as their performance is judged based on the achievement of targets for various primary health care programmes.

#### 4.1 WORKLOAD OF THE PRIMARY HEALTH CENTRE PERSONNEL:

The expected duties of the various staff working in the primary health centre, has been discussed in detail

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#### 4.1 WORKLOAD OF THE PRIMARY HEALTH CENTRE PERSONNEL:

The expected duties of the various staff working in the primary health centre, has been discussed in detail

in ~~appendix~~ **V1**. However it needs to be seen how much time **is** actually being spent by them on the various tasks they have to perform.

#### 4.1.1 ~~Time spent on~~ **various** activities:

The PHC Medical **Officers** are supposed to divide the PHC area among themselves on a geographical basis and take responsibility for all the activities under Health and Family Welfare Programmes in their respective areas. Nevertheless the ultimate responsibility lies with the in-charge Medical Officer.

The Medical Officers were asked to spell out the time they spent on different tasks, **in** a week. According to them ~~50%~~, of their time is spent on curative services, while **15%** is spent on family planning work, and the remaining **35%** of the time is spent on administrative work, and supervision. All the Medical Officers spend relatively less time in supervising Workers in the field. The in-charge Medical Officer on the pretext of administrative work hardly supervises the work of the Workers, while the other two do not supervise on the pretext that no vehicle is available.

As far as the Supervisors are concerned, more than ~~60%~~ of their time (in a week) is spent on supervising the Family Planning Programme. The women Supervisors spend the remaining time on Maternal and Child Health and **Immunization** Pro-

gramme, while the men Supervisors spend the remaining time supervising other national programmes like Malaria Eradication, **immunization**, School Health, and **Environmental** Sanitation. The thrust of supervision is on the Family Planning Programme followed by Maternal and Child Health and Malaria Eradication.

As far as the Workers are concerned, each of them is expected to cover a population of 5,000. The men Workers have to visit every family in their area once a fortnight, and record his visit on the main entrance to the house, and perform functions he is assigned (see **appendix VI**). Similarly, the women Worker is supposed to visit all households where there are cases for antenatal, and postnatal care, and infants, once a week, and carry out the functions assigned to her (see **appendix VI**). In this study it has been found that six out of the ten women Workers cover a population of less than 5,000, while the rest (4) cover population of more than 5,000. On the other hand the men Workers cover a population of 14,000 to 17,000 instead of the stipulated 5,000. This is because there are only four men Workers for the entire **PHC** area covering eleven sub-centres. Similarly in terms of number of villages covered by the Health Workers, it was found that half of the women Workers (5) cover three to four villages each, while the other half (5) cover six to seven villages. The men Workers cover twelve to sixteen villages each, this is once again because there are only four of them.

All the Village Health Guides, and Dais approximately cover a population of 1000 to 1500 each. In terms of the number of villages covered, most of them (83%) cover only one village, while the remaining 17% cover more than one village. This is because some villages have a population of less than five hundred.

#### 4.1.2 ~~Distance travelled from place of stay to place of work, time spent on travel, and mode of transportation:~~

Distance to be covered from place of stay, to place of work, amount of time taken to travel, and mode of transportation are also important factors to be taken into account while considering the work load of the **personnel**,

Though the three Medical Officers live in city, the distance they travel from place of stay to the **PHC** varies. The in-charge Medical Officer lives 15 **kms.**, away, and spends an hour on travelling, while the other two live **40Kms** away from the **PHC**, and approximately spend around three to four hours on travelling. Two of the three Medical Officers travel only by bus, while the in-charge sometimes **travels** by bus, and sometimes uses the **PHC** vehicle. While going on field tours, the Medical Officers come to the **PHC** first, and then visit villages. Except the in-charge Medical Officer, the other two travel by bus. All villages under the **PHC** are located within a range of 3 Kms to 20 Kms from the **PHC**.



However the Medical Officers <sup>#</sup> very rarely go on field visits.

Except for one male, and one female Supervisor, the rest commute from the **city**. **The** average distance they travel (one way) ranges from 10 to 1b **kms** which means they spend approximately two, to two and half hours every day travelling. The women Supervisors travel by bus to their respective sub-centres, while the men Supervisors sometimes travel by bus, and sometimes use a moped. All Supervisors said they are on tour, for twenty four days in a month.

All Health Workers, are supposed to maintain residential accom<sup>m</sup>odation at their headquarters, unfortunately offi<sup>m</sup>cial accom<sup>m</sup>odation is available only in four sub-centres. ~~These~~ very sub-centres were observed to be highly illequipped without minimum **infrastructure** facilities like water, and electricity. In this study we find that seven out of the ten women Workers, and all men Workers live in the city as they have children studying in high schools, junior and degree colleges.

In terms of the distance they travel from **place** of stay to sub-centre village and other villages, it has been found that all men Workers travel a distance of 15 Kms to **30** Kms to reach their respective villages, and they approximately spend two to three hours everyday on travel. They travel by bus to villages where bus facility is available, and go by walk to villages which do not have bus facilities. These

villages are located 1 Km to 4 Km from the nearest bus stop. ~~The~~ women Workers travel a distance of 6 to 25 Kms from their place of stay to their respective villages, and approximately spend one to two and half hours everyday on travel. The women Workers travel by bus to their respective sub-centres and other villages, and where there is no bus facility they go by walk. ~~The~~ women Workers living in the sub-centre villages travel lesser distance, and also spend less amount of time on travel as compared to the Workers living in the city. The distance travelled by the men Workers, and the amount of time spent by them is more as compared to the distance travelled by the women Workers, and the time spent on travelling. This is because the men Workers cover more number of villages as compared to the women Workers (as they are only four men Workers). Since the men and women Workers stay at different places, and travel at different times it is difficult to see that they are able to coordinate their activities in the villages. Also coordination of activities becomes difficult as the number of sub-centres, and villages to be covered by the Workers differs. Since the Health Guides, and Dais reside in the villages they hardly spend any time on travelling, excepting for those 17% who cover more than one village, which they usually travel by walk or by a bicycle.



Given the workload, it was found that all Health Workers feel that their job is difficult. So is the case with the women Supervisors. Four out of the seven men Supervisors do not think that the job is easy, while three of them do not find the job difficult. The Medical Officers would not openly say that the job is difficult or challenging, but all of them seem to be trying for a posting in the city. They seem to be totally disinterested in the job, especially the in-charge Medical Officer who considers the job as a big headache.

#### 4.2 **PERFORMANCE OF WOMEN WORKERS:**

The women Workers are supposed to perform their job in areas like maternal and child health, family planning; immunization, training of local Dais, control of **communicable** diseases, treatment of minor ailments, health education, and maintenance of records. However, Workers perform only those duties which their superiors lay emphasis on, that is, they identify themselves with the priorities set by the **DMHO**, the Medical Officer in-charge, and their immediate Supervisors.

Table 4.1:

Distribution of Health Workers by number of job duties performed, **N=10**

| Sl. No. | Job Duties                       | Number of performing workers | Number of non-performing workers | Total workers |
|---------|----------------------------------|------------------------------|----------------------------------|---------------|
| (1)     | (2)                              | (3)                          | (4)                              | (5)           |
| 1.      | Family Planning                  | 10                           | --                               | 10            |
| 2.      | Maternal and Child Health (MCH)  | 10                           | --                               | 10            |
| 3.      | Immunization                     | 10                           | --                               | 10            |
| 4.      | Control of communicable diseases | 6                            | 4                                | 10            |
| 5.      | Health Education                 | 10                           | --                               | 10            |
| 6.      | Treatment of minor ailments      | 4                            | 6                                | 10            |

The above table shows that, all the Workers mostly concentrate on the **Family** Planning Programme, Maternal and Child Health Programme, and **Immunization** programme. They also impart health education to the villagers. However some of the Workers do not involve themselves in the control of communicable diseases as they feel it is the responsibility of the men Workers. Most of them also do not treat patients for minor ailments because the necessary medicines are not

available. **They** usually refer the cases either to the **PHC** or to the government hospital depending on the seriousness of the problem.

In terms of the field visits, and duties they have to perform all Workers are supposed to maintain an advance tour diary for the month. However, it is not strictly followed because of family planning camps, supervision by senior officials from the district office, and sometimes personal reasons like illness, and social obligations.

Let us now take a look at the programme wise performance of the women Workers.

#### 4.2.1 **Family Planning Performance:**

The family planning performance can be assessed by comparing the percentage of eligible couples already covered by some family planning method (either temporary or permanent), and the percentage of eligible couples yet to be covered. The number yet to be covered would be target group for the Workers. Therefore the number of eligible couples contacted, yet to be contacted, and the number of couples actually motivated by the worker during the last one year (against the target set) will tell us whether the worker is performing her job satisfactorily or not.

The number of eligible couples per 1000 population is estimated at 170-180, as per the estimates of the Directorate of Family **Welfare**. **The** total number of eligible couples per

sub-centre works out between ~~850-900~~.

Table 4.2 :

Distribution of Health Workers by number of **Eligible** Couples registered, **N=10**

| Sl.No. | Number of eligible couples registered | Number of workers |
|--------|---------------------------------------|-------------------|
| (1)    | (2)                                   | (3)               |
| 1.     | Less than 400                         | 5                 |
| 2.     | 400 - <del>500</del>                  | 3                 |
| 3.     | More than 600                         | 2                 |
| Total  |                                       | 10                |

Thus the table shows that Workers have not registered all the eligible couples in their areas. Since most of them (Y) do not live at the sub-centres, updating of registers has been completely neglected. Moreover, the Supervisors, and Medical Officers do not check to see whether the registers have been updated, and hence the lapse.

In terms of the number of eligible couples already protected by various methods, it was found that most of them are protected by way of sterilizations (table 4.3).

Table 4.3

Distribution of Health Workers **by** number of eligible **couples**  
**protected by various Family Planning methods. N = 14**

| 81.<br>No. | Number of<br>couples<br>protected<br>by steri-<br>lization | Number<br>of<br>health<br>workers | Number<br>of<br>couples<br>protected<br>by IUDS | Number<br>of<br>health<br>workers | Number<br>of<br>couples<br>protected<br>by oral<br>pills | Number<br>of<br>health<br>workers |
|------------|------------------------------------------------------------|-----------------------------------|-------------------------------------------------|-----------------------------------|----------------------------------------------------------|-----------------------------------|
| (1)        | (2)                                                        | (3)                               | (4)                                             | (5)                               | (6)                                                      | (7)                               |
| 1          | 50 - 75                                                    | 5                                 | 5- 10                                           | 6                                 | 5 - 10                                                   | 5                                 |
| 2          | 100 - 150                                                  | 5                                 | More than<br>15                                 | 4                                 | More than<br>10                                          | 5                                 |
| Total      |                                                            | 10                                | Total                                           | 10                                | Total                                                    | 10                                |

When compared to the number of couples already covered by way of sterilization, the number of couples covered by intrauterine devices (IUDS) is negligent. Six of the Workers said that only 5 to 10 cases are protected by **IUDS**, while four of them said that more than 15 cases are protected by IUDS. The number of eligible couples covered by oral pills **is** also less as compared to those covered by sterilisations, and follows the same pattern as that of IUDS. However no record was available with the women Workers to assess the coverage of condom users.

In terms of the number of eligible couples yet to be covered, one half of the Workers said that they have to cover ~~250-~~ 300 eligible couples, while the other half said that they have yet to cover 350-400 couples (table 4.4).

Table 4.4 :

Distribution of Health Workers by number of eligible couples yet to be covered or protected, **N** = 10

| Sl. No. | Number of eligible couples to be covered or protected | Number of health workers |
|---------|-------------------------------------------------------|--------------------------|
| (1)     | (2)                                                   | (3)                      |
| 1.      | 250 - 300                                             | 5                        |
| 2.      | 350 - 400                                             | <b>5</b>                 |
| Total   |                                                       | 10                       |

Thus it can be seen that the number of eligible couples registered, those already covered by the various methods, and the number of eligible couples yet to be covered shows that the data available is not reliable. **It** can be well assumed that the eligible couple registers have not been updated.

The Workers generally contact eligible couples based on the information provided by the trained Dais. The Dais inform the Health Workers about the deliveries they conduct as they are paid at the rate of **Rs.2/-** per delivery. **The** Health Worker records this information, and **inturn** uses **this**



information to visit the nursing mothers on the pretext of providing postnatal care, but with an ulterior motive of persuading the mother to accept sterilization. This aspect  
\*  
came to light while interviewing the Dais.

Before actually getting down to work, the Health Workers are first, and foremost supposed to conduct a household survey of the entire area within their jurisdiction. From this, information regarding the number of eligible couples, number of infants, number of children of varying age groups are identified, and separate registers are maintained. However, none of the sub-centres had the household registers updated, and the Workers were relying on the local Dais for information.

Coming down to the actual performance during 1988-89, half of the Workers contacted 100 eligible couples, while three contacted 130 to ~~150~~ couples, and the remaining two Workers contacted more than ~~150~~ eligible couples. However all eligible couples contacted were not willing to accept any family planning method. When one looks at the actual number of eligible couples motivated during the year for different methods, performance figures show that sterilizations preceed all other methods.

For the Family Planning Programme the district authorities fix targets for the **PHCs** based on the population of the

area, facilities available, and previous achievements. The target for the various methods in turn gets divided among the Workers. In the PHC under study the Supervisors are also given targets. However **this** is leading to unhealthy competition among the Supervisors, and Workers thus straining their relationship. According to the Workers sterilization cases are literally grabbed from them by their Supervisors (women).

Performance regarding sterilizations for the year **1988-89** shows that only two Workers out of ten have achieved more than 50% of their targets while the rest motivated less than 50% of the targets given to them (**table 4.5**). As **far** as IUD's are concerned, none of the Workers have motivated even 50% of the target for the entire year. **Table 4.5** shows the performance of the workers with regard to IUDs. Regarding distribution of oral pills, all the women Workers achieved more than 50% of their targets however, according to them only 5 to 15 women per sub-centre are regular users. None of the Workers have any performance to show with regard to the distribution of nirodh. The Workers generally do not interact with the men in the villages. Moreover it is only the men Workers, and the Health Guides who distribute nirodh.



Table 4.5:

Performance of the women Workers with regard to **Sterilizations, IUDs, and Oral pills, for the year 1988-89.**

| Sl. No. | Respondent | Sterilizations  |                      | IUDs            |                      | Oral pills      |                      |
|---------|------------|-----------------|----------------------|-----------------|----------------------|-----------------|----------------------|
|         |            | Target (Annual) | Achievement (Annual) | Target (Annual) | Achievement (Annual) | Target (Annual) | Achievement (Annual) |
| (1)     | (2)        | (3)             | (4)                  | (b)             | (6)                  | (7)             | (8)                  |
| 1.      | A          | 84              | 64<br>(76.0)         | <del>60</del>   | 21<br>(35.0)         | 240             | 138<br>(58.0)        |
| 2.      | B          | 84              | 56<br>(67.0)         | 60              | 28<br>(47.0)         | 240             | 174<br>(73.0)        |
| 3.      | C          | 84              | 37<br>(44.0)         | 60              | 22<br>(37.0)         | 240             | 148<br>(62.0)        |
| 4.      | D          | 84              | 18<br>(21.0)         | 60              | 25<br>(42.0)         | 240             | 132<br>(55.0)        |
| 5.      | E          | 84              | 36<br>(42.0)         | 60              | 29<br>(48.0)         | 240             | 153<br>(64.0)        |
| 6.      | F          | 84              | 27<br>(32.0)         | 60              | 12<br>(20.0)         | 240             | 163<br>(68.0)        |
| 7.      | G          | 84              | 30<br>(36.0)         | 60              | 14<br>(23.0)         | 240             | 170<br>(71.0)        |
| 8.      | H          | 84              | 29<br>(36.0)         | 60              | 11<br>(18.0)         | 240             | 158<br>(66.0)        |
| 9.      | I          | 84              | 31<br>(37.0)         | 60              | 9<br>(15.0)          | 240             | 102<br>(43.0)        |
| 10.     | J          | 84              | 19<br>(23.0)         | 60              | 8<br>(13.0)          | 240             | 164<br>(68.0)        |

(Figures in brackets indicate percentage achievement of target.)

**According** to the women Workers the most acceptable family planning method is sterilization (tubectomy) followed by **nirodh**, and oral pills. **IUDs** are considered most unpopular owing to their side effects.

Apart from providing family planning services, **MTP** is also done at the PHC, however the number of MTP cases are very few, and range from one to four per year for each Worker.

When the Workers were asked to assess the Family Planning Programme, majority (8) said that they are '**somewhat satisfied**' while the rest (2) said they were '**satisfied**' (table 4.6).

Table 4.6

Distribution of Health Workers according to their assessment of the Family Planning Programme, N= 10

| S1.No. | Level of Satisfaction     | Number of<br>Health Workers |
|--------|---------------------------|-----------------------------|
| (1)    | (2)                       | (3)                         |
| 1.     | Somewhat <b>satisfied</b> | 8                           |
| 2.     | Satisfied                 | 2                           |
| Total  |                           | <b>10</b>                   |

According to the Workers there are ~~50-100~~ eligible couples in every sub-centre area who resist family **planning**, because of the fear of side effects, and desire for more number of children.

4.2.2 **Performance with regard to Maternal and Child Health Services:**

The other programme in which the women Workers take an active part is the Maternal and Child Health Programme. **The** programme includes, registration of pregnant women, provision of antenatal care, conducting deliveries, provision of postnatal care, and immunization of infants, and children.

The Workers register most of the pregnant women in their area. This is usually done when women come to the antenatal clinic or through information provided by the Dais. Six out of the ten Workers have registered 100 to **125** cases, while two have registered more than 12b cases, but less than 150 cases, and the remaining two have registered more than 1b0 cases (table 4.Y).

Table 4.7:

Performance of the Women Workers with regard to Maternal and Child Health Care for the year 1988-89.

| Sl. No. | Resp-<br>dent | Number<br>of<br>antenatal<br>regist-<br>end | Number<br>of<br>antenatal<br>mothers<br>provided<br>with 3<br>medical<br>checkups | Tetanus toxoid<br>(first dose) |               | Tetanus toxoid<br>(Second dose) |               | Iron & Folic acid<br>tablets (#.5*) |               | minor<br>of<br>delive-<br>ries<br>regist-<br>ered | Number of<br>deliveries<br>conducted<br>by the<br>health-<br>worker | Number of<br>mom*<br>provided<br>postnatal<br>care | Number of infants<br>provided Iron &<br>Folic acid (0.1mg) |               |
|---------|---------------|---------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------|---------------|---------------------------------|---------------|-------------------------------------|---------------|---------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------|---------------|
|         |               |                                             |                                                                                   | Target                         | Achievement   | Target                          | Achievement   | Target                              | Achievement   |                                                   |                                                                     |                                                    | Target                                                     | Achievement   |
| (1)     | (2)           | (3)                                         | (4)                                                                               | (5)                            | (6)           | (7)                             | (8)           | (9)                                 | (10)          | (11)                                              | (12)                                                                | (13)                                               | (14)                                                       | (15)          |
| 1.      | A             | 156                                         | 142                                                                               | 192                            | 135<br>(70.0) | 192                             | 109<br>(57.0) | 192                                 | 142<br>(74.0) | 149                                               | 28                                                                  | 124                                                | 180                                                        | 139<br>(77.0) |
| 2.      | B             | 161                                         | 136                                                                               | 192                            | 112<br>(58.0) | 192                             | 90<br>(47.0)  | 192                                 | 136<br>(71.0) | 142                                               | 72                                                                  | 121                                                | 180                                                        | 153<br>(85.0) |
| 3.      | C             | 122                                         | 99                                                                                | 192                            | 78<br>(41.0)  | 192                             | 60<br>(31.0)  | 192                                 | 99<br>(52.0)  | 97                                                | 2                                                                   | 54                                                 | 180                                                        | 97<br>(54.0)  |
| 4.      | D             | 103                                         | 78                                                                                | 192                            | 63<br>(33.0)  | 192                             | 43<br>(22.0)  | 192                                 | 78<br>(41.0)  | 83                                                | 1                                                                   | 55                                                 | 180                                                        | 53<br>(29.0)  |
| 5.      | E             | 141                                         | 129                                                                               | 192                            | 114<br>(41.0) | 192                             | 69<br>(46.0)  | 192                                 | 129<br>(67.0) | 122                                               | 54                                                                  | 73                                                 | 180                                                        | 117<br>(65.0) |
| 6.      | F             | 119                                         | 109                                                                               | 192                            | 85<br>(48.0)  | 192                             | 85<br>(44.0)  | 192                                 | 109<br>(57.0) | 99                                                | 7                                                                   | 71                                                 | 180                                                        | 92<br>(51.0)  |
| 7.      | G             | 108                                         | 81                                                                                | 192                            | 66<br>(34.0)  | UK                              | 51<br>(27.0)  | 192                                 | 81<br>(42.0)  | 76                                                | 13                                                                  | 80                                                 | 180                                                        | 75<br>(42.0)  |
| 8.      | H             | 135                                         | 104                                                                               | 192                            | 80<br>(42.0)  | 192                             | 75<br>(39.0)  | 192                                 | 104<br>(54.0) | 102                                               | 4                                                                   | 73                                                 | 180                                                        | 100<br>(56.0) |
| 9.      | I             | 110                                         | 90                                                                                | 192                            | 79<br>(41.0)  | 192                             | 67<br>(35.0)  | 192                                 | 90<br>(51.0)  | 90                                                | 13                                                                  | 75                                                 | 180                                                        | 50<br>(33.0)  |
| 10.     | J             | 120                                         | 86                                                                                | 192                            | 61<br>(32.0)  | 192                             | 41<br>(21.0)  | 192                                 | 86<br>(45.0)  | \$ 1                                              | 1                                                                   | 51                                                 | 180                                                        | 51<br>(28.0)  |

(Figures in brackets indicate percentage achievement of target.)

The women Workers are supposed to provide antenatal services to all pregnant women who have been registered. Antenatal services include medical checkup, provision of tetanus toxoid vaccine, and distribution of iron and folio acid tablets.

Half of the women <sup>(5)</sup>Workers have provided the first medical checkup for 75 to 100 pregnant women, while two of them provided the first checkup to more than 100 but less than 125 women, and remaining (3) have provided the first checkup to more than 126 women. The Workers also said they provided the second, and third medical checkup for the same number of pregnant women.

The women living in the sub-centre villages come more often for checkups as compared to women from other surrounding villages according to the Health Workers. Some women come as many as 6 to 9 times for checkup during their entire term.

Most of the Workers (6) have administered the first dose of tetanus toxoid (TT) vaccine to 60 to 80 pregnant women which amounts to only 31% to 42% of their target (table 4.7). Three of the Workers covered 90 to 115 pregnant women, and the remaining one Worker covered more than 130 pregnant women amounting to 47% to 59%, and 70% of their target. Regarding the second dose of TT vaccine, five women Workers

covered 40 to 70 pregnant women, (21% to 36% target achievement), while four Workers covered 70 to 90 pregnant women, and one Worker covered more than 100 pregnant women (39% to 47% and 57% target achievement). Thus it can be seen that the performance regarding administration of TT vaccine is poor in most of the sub-centres excepting in one sub-centre. The reason is that this particular sub-centre is located in the PHC premises, and the clinic is conducted regularly once a week under the guidance of the Health Supervisor, whereas in the other sub-centres, antenatal clinics are not conducted regularly. Sometimes there are problems of shortage regarding vaccines, and medicines however it is not a **frequent** phenomenon, and cannot be taken as a reason for poor performance by the Workers,

**Regarding the distribution of iron and folic acid tablets (0.5 mg),** it was found that all women who came for antenatal checkup were given 30 to 60 iron and **folic acid tablets** (see table 4.7).

**The** women Workers generally register deliveries conducted by the trained Dais as they hardly conduct any deliveries, excepting for those Workers living in the sub-centre village\*. Six out of the ten women Workers have registered 60 to 99 deliveries, while the rest (4) registered more than 100 deliveries in their area.



As a rule the women Workers have to conduct 60% of the total deliveries in their area but on the contrary it was found that only two Workers conducted **50** to 75 deliveries for the year 1988-89 while the rest conducted only 1 to 20 deliveries (see table 4.7). The number of deliveries **conducted** by the Dais outnumber those conducted by the Workers because most of the Workers live in the city, and are not available in the village to perform this function. The villages have both trained as well as untrained Dais who perform this function, however no record is available regarding the number of deliveries conducted by the untrained Dais.

In case of any complication, the women Workers, and Dais refer the cases to the government hospital in the city (Koti hospital, government aternity hospital, Malakpet hospital). Cases are not **referred** to the **PHC** as doctors are not available round the clock.

Once a woman has delivered a child, every Health Worker is supposed to make atleast three postnatal visits at her house. **Postnatal** services include advice on immunization for the infant; health and nutrition education; treatment of minor problems like pain in the abdomen, general weakness, and sterilization for couples with two or more children. When considering the registration of women provided with postnatal care it was found that eight Workers registered **50** to **75** cases, while two registered more than 120 cases. **12**

practice postnatal services are provided by and large to those women who are willing to undergo sterilization. The Health Workers hardly visit other mothers in postnatal states. In case of any postnatal complication, the Health Workers refer the case to the Medical Officer at the **PHC**.

With regard to the distribution of iron and folio acid tablets (0.1 **mg**) to infants it was found that six Workers registered 50 to 99 infants, while three of them registered 100 to 150 infants, and only one Worker registered more than 150 infants (table 4.7).

Another component of the MCH programme **is** the immunization of the infants and children below five years of age. For this purpose the Health Workers are supposed to maintain registers of children below one year (infants register), and children of one to five years of age (table 4.8).



Table 4.8

Distribution of Health Workers by number of children registered (below one year, and one to five years), **N=10**

| S1.<br>No. | Number of children<br>registered<br>(below one year) | Number of<br>health<br>workers | Number of<br>children<br>registered<br>(one to five<br>year) | Number of<br>health<br>workers |
|------------|------------------------------------------------------|--------------------------------|--------------------------------------------------------------|--------------------------------|
| (1)        | (2)                                                  | (3)                            | (4)                                                          | (5)                            |
| 1.         | Less than 100                                        | 3                              | 0                                                            | 3                              |
| 2.         | 100 - 150                                            | 5                              | Less than 150                                                | 2                              |
| 3.         | More than 150                                        | 2                              | More than 200                                                | 5                              |
|            | Total                                                | 10                             | Total                                                        | 10                             |

The number of infants per 1000 population is estimated at 26 to 27 given the crude birth rate, and infant mortality rate. Accordingly every sub-centre area (5000 population) should have 130 to 135 children below one year. Given that six Workers cover a population of less than 5000, and four cover more than 5000, the number of children registered (below one year) seems to be more **orless** satisfactory. However, the number of children registered (one to five years) by the Workers is highly unsatisfactory. Since the thrust of the Immunization Programme is on immunisation of infants (that is, children below one year) for which the Health Workers are made accountable, they seem to be totally neglecting the registration, and immunization of children of one to five years of age. Once again this shows that no

efforts are being made on the part of the Workers, and Supervisors in getting the registers updated.

Performance of the women Workers with regard to immunization of infants (below one year) for the year 1988- 89 are available. Regarding BCG vaccine, only four Workers achieved more than 75% of their targets while three of them have achieved 50 to 75% of their target. The remaining three Workers achieved less than 50% of their target (see table 4.9).

Table 4.9:

Performance of women Health Workers with regard to number of children (below one year) immunized during 1988-89.

| Annual target of each worker = 180 |            |                |               |               |               |               |               |               |               |
|------------------------------------|------------|----------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| Sl. No.                            | Respondent | BCG            | DPT           |               |               | POLIO         |               |               | Measles       |
|                                    |            |                | I             | II            | III           | I             | II            | III           |               |
| (1)                                | (2)        | (3)            | (4)           | (5)           | (6)           | (7)           | (8)           | (9)           | (10)          |
| 1.                                 | A          | 168<br>(93.0)  | 45<br>(26.0)  | 48<br>(27.0)  | 68<br>(38.0)  | 40<br>(22.0)  | 47<br>(26.0)  | 56<br>(31.0)  | 60<br>(28.0)  |
| 2.                                 | B          | 110<br>(61.0)  | 82<br>(46.0)  | 66<br>(37.0)  | 64<br>(30.0)  | 82<br>(46.0)  | 66<br>(37.0)  | 54<br>(30.0)  | 63<br>(36.0)  |
| 3.                                 | C          | 141<br>(78.0)  | 99<br>(66.0)  | 58<br>(32.0)  | 102<br>(67.0) | 99<br>(55.0)  | 58<br>(32.0)  | 102<br>(57.0) | 163<br>(86.0) |
| 4.                                 | D          | 101<br>(56.0)  | 93<br>(62.0)  | 86<br>(48.0)  | 70<br>(39.0)  | 93<br>(52.0)  | 86<br>(48.0)  | 70<br>(39.0)  | 96<br>(53.0)  |
| 6.                                 | E          | 147<br>(82.0)  | 65<br>(36.0)  | 49<br>(27.0)  | 74<br>(41.0)  | 66<br>(36.0)  | 49<br>(27.0)  | 74<br>(41.0)  | 101<br>(66.0) |
| 6.                                 | F          | 81<br>(45.0)   | 59<br>(33.0)  | 32<br>(18.0)  | 59<br>(33.0)  | 59<br>(33.0)  | 32<br>(18.0)  | 59<br>(33.0)  | 84<br>(47.0)  |
| 7.                                 | G          | 124<br>(69.0)  | 47<br>(26.0)  | 43<br>(24.0)  | 69<br>(38.0)  | 47<br>(26.0)  | 43<br>(24.0)  | 69<br>(38.0)  | 142<br>(79.0) |
| 8.                                 | H          | 152<br>(84.0)  | 137<br>(76.0) | 146<br>(81.0) | 112<br>(62.0) | 137<br>(76.0) | 146<br>(81.0) | 111<br>(62.0) | 112<br>(62.0) |
| 9.                                 | I          | 76<br>(42.0)   | 53<br>(29.0)  | 38<br>(21.0)  | 33<br>(18.0)  | 63<br>(29.0)  | 38<br>(21.0)  | 33<br>(18.0)  | 100<br>(66.0) |
| 10.                                | J          | 40<br>(22.0)   | 14<br>(6.0)   | 7<br>(4.0)    | 23<br>(13.0)  | 14<br>(8.0)   | 7<br>(4.0)    | 23<br>(13.0)  | 16<br>(9.0)   |
| Total                              |            | 1140<br>(63.3) | 694<br>(38.6) | 573<br>(31.8) | 664<br>(36.9) | 689<br>(38.3) | 572<br>(31.8) | 651<br>(36.2) | 916<br>(60.9) |

(Figures in brackets indicate percentage achievement of target.)

Table 4.9:

Performance of women Health Workers with regard to number of children (below one year) immunized during 1988-89.

Annual target of each worker =180

| Sl. No. | Respondent | BCG            | DPT           |               |               | POLIO               |               |                      | Measles             |
|---------|------------|----------------|---------------|---------------|---------------|---------------------|---------------|----------------------|---------------------|
|         |            |                | I             | II            | III           | I                   | II            | III                  |                     |
| (1)     | (2)        | (3)            | (4)           | (5)           | (6)           | (7)                 | (8)           | (9)                  | (10)                |
| 1.      | A          | 168<br>(93.0)  | 45<br>(25.0)  | 48<br>(27.0)  | 68<br>(38.0)  | 40<br>(22.0)        | 47<br>(26.0)  | <b>56</b><br>(31.0)  | 50<br>(28.0)        |
| 2.      | B          | 110<br>(61.0)  | 82<br>(46.0)  | 66<br>(37.0)  | 54<br>(30.0)  | 82<br>(46.0)        | 66<br>(37.0)  | 54<br>(30.0)         | 63<br>(35.0)        |
| 3.      | C          | 141<br>(78.0)  | 99<br>(55.0)  | 58<br>(32.0)  | 102<br>(57.0) | 99<br>(55.0)        | 58<br>(32.0)  | 102<br>(57.0)        | 153<br>(85.0)       |
| 4.      | D          | 101<br>(66.0)  | 93<br>(52.0)  | 86<br>(48.0)  | 70<br>(39.0)  | 93<br>(52.0)        | 86<br>(48.0)  | 70<br>(39.0)         | <b>95</b><br>(53.0) |
| 5.      | E          | 147<br>(82.0)  | 65<br>(36.0)  | 49<br>(27.0)  | 74<br>(41.0)  | <b>65</b><br>(36.0) | 49<br>(27.0)  | 74<br>(41.0)         | 101<br>(66.0)       |
| 6.      | F          | 81<br>(45.0)   | 59<br>(33.0)  | 32<br>(18.0)  | 59<br>(33.0)  | <b>59</b><br>(33.0) | 32<br>(18.0)  | 59<br>(33.0)         | 84<br>(47.0)        |
| 7.      | G          | 124<br>(69.0)  | 47<br>(26.0)  | 43<br>(24.0)  | 69<br>(38.0)  | 47<br>(26.0)        | 43<br>(24.0)  | 69<br>(38.0)         | 142<br>(79.0)       |
| 8.      | H          | 152<br>(64.0)  | 137<br>(76.0) | 146<br>(81.0) | 112<br>(62.0) | 137<br>(76.0)       | 146<br>(81.0) | <b>111</b><br>(62.0) | 112<br>(62.0)       |
| 9.      | I          | 76<br>(42.0)   | 63<br>(29.0)  | 38<br>(21.0)  | 33<br>(18.0)  | <b>53</b><br>(29.0) | 38<br>(21.0)  | 33<br>(18.0)         | 100<br>(56.0)       |
| 10.     | J          | 40<br>(22.0)   | 14<br>(8.0)   | 7<br>(4.0)    | 23<br>(13.0)  | 14<br>(8.0)         | 7<br>(4.0)    | 23<br>(13.0)         | 16<br>(9.0)         |
| Total   |            | 1140<br>(63.3) | 694<br>(38.6) | 573<br>(31.8) | 664<br>(36.9) | 689<br>(38.3)       | 572<br>(31.8) | <b>651</b><br>(36.2) | 916<br>(50.9)       |

(Figures in brackets indicate percentage achievement of target.)

Regarding administration of first dose of DPT and Polio, it was found that most of the Workers (6) achieved 20% to less than ~~50%~~ of their targets, while only one of them achieved more than 75% of the target. Two of them achieved 50 to 55% of their target, and the **remaining** one Worker achieved less than 20% of the target.

As for the second dose of DPT and Polio administered, only one Worker achieved more than 75% of the target while five of them achieved 25% to less than 50% of the target, and the remaining four Workers achieved less than 25% of the targets. Similarly for the third dose of DPT and Polio only two Workers achieved 50% to 75% of their targets while the remaining achieved less than 50% of their targets.

Regarding administration of measles vaccine, two of the Workers have achieved more than ~~75%~~ of their target while four of them achieved 50 to 75% of the targets, and the remaining four Workers achieved less than 50% of their targets.

In the case of **BCG**, and measles vaccine, majority of the Workers have achieved more than 50% of their targets while in the case of DPT and Polio majority have achieved less than 50% of their target. Table 4.9 shows that the number of children immunized for BCG is more **as** compared to

children immunized for **DPT**, polio and measles. The coverage for **BCG** seems to be better because of two **reasons**. First, after delivery the mothers along with the infants generally visit the sub-centre or the PHC at least once because of some health problem, and this gives the Health Workers an opportunity to immunize the child for BCG. Secondly, when Health Workers go on house visits to motivate nursing mothers for family planning they generally administer the BCG vaccine, with the result the coverage tends to be better. **In** the case of other vaccines (DPT, polio, measles) the infants have to be brought to the sub-centre for immunization. These vaccines are not administered during house visits, and the mothers generally tend to postpone bringing the infants for immunization as they are busy with their work, or the child is sick or because of the fear of side effects, resulting in low coverage of infants for DPT and polio vaccines. **It is** also noticed that among the three doses of DPT and polio, the coverage for the first dose is better as compared to the second, and third doses. This again can be attributed firstly, to mothers not being aware of the need for the second and third doses, or mere postponement because of heavy work or because the child is sick, and secondly, negligence on the part of the Health Workers. The Health Workers are equally responsible for the low coverage as they neither conduct regular home visits nor update their registers, and also do not educate the mothers regarding immunization, and its importance. On the other hand they complain about inadequate staff, lack of cold storage, and **non-availability** of **vaccines**.



**Regarding** their assessment of the **Immunization Programme**, only three Workers said that they are '**somewhat** satisfied', while four of them said they were '**not** satisfied', and three of them expressed a '**high** level of **dissatisfaction**'.

Apart from providing family planning and maternal and child health services, the Workers also treat minor ailments during their visits to the villages or at the **sub-centres** depending on the availability of medicines. They also chlorinate wells in their villages during the rainy season. 117 wells were chlorinated during 1988-89 in the entire **PHC** area. The Workers also provide oral rehydration salts whenever available to children suffering from diarrhoea. However they should notify the Medical Officer of any abnormal increase in cases of diarrhoea, fever with rigors, and fevers with jaundice. In case of fevers with rigors the Worker should take the blood smear, and administer presumptive treatment, and also inform the men Workers, for further action. However, none of the women Workers collect any blood smears nor administer presumptive treatment but refer the cases to the **PHC**. Similarly the Workers neither participate in the National Tuberculosis Eradication Programme, nor maintain any record of the number of tuberculosis, and leprosy patients in their area.

The Workers impart health education to the women by talking to them either at the sub-centre or during home

visits which is very rare. They occasionally organize group discussions, and demonstration of wall posters and charts. The Workers generally participate in programmes (films, video shows, cultural programmes on health) organized by the district authorities. However these are organized once in four to six months depending on the availability of budget. The health education programmes so conducted also call for the involvement of the formal, and informal leaders of the villages so that whatever is conveyed makes an impact on the masses.

With a view to improve the health standards of the primary school children in the state a scheme known as 'Telugu Chiranjeevula Sukhibhavam' was launched in 1986 by the then Chief Minister of Andhra Pradesh. This scheme is being implemented utilizing the existing medical and health infrastructure. The aim of the scheme is to promote the health of primary school children, prevention of diseases, early detection, and treatment of illness backed up by referral service. For this purpose teachers have been trained to identify problem cases, and medical checkups are provided by the Medical Officers, and Multipurpose Health Supervisors atleast once a year covering all primary schools within their jurisdiction. The Medical Officers should also provide treatment of acute, and minor illnesses, and refer cases to specialists whenever necessary, and regular immunization is to be carried out by the Multipurpose Health Workers. There are



32 primary schools within the jurisdiction of the PHC area, having a total of 78 trained teachers, and a total strength of 6883 pupils (3979 boys and 2904 girls). However for the year 1988-89, only 20 out of the 32 primary schools were covered, with 3,676 children, out of which 287 children were treated at the PHC, and 141 children were referred to the **specialists**. The most common problems **identified** included vitamin deficiencies like 'A', 'B', 'C', 'D', and iron; allergic disorders, and respiratory tract infections, scabies, diarrhoeal disease including dysentery, and lameness due to poliomyelitis in childhood.

The women Workers do not participate in the School Health programme, and have no performance to show regarding immunization of school children. The whole programme seems to be lagging behind, and no active role is being played by the Medical Officers of the PHC.

- The discussion regarding the performance of the women Workers, shows that though they are supposed to perform a host of duties, they are mainly concentrating on the Family Planning and Maternal and Child Health Programmes; their performance with regard to these two programmes is really not upto the **mark**. **Except** for the provision of antenatal care, their performance with regard to family planning, and immunization is far from satisfactory and calls for a lot more effort on their part. The biggest handicap is that most Workers do not live at the sub-centres but commute from the

city. As a result the Workers hardly get any time for performing their job. They are irregular in conducting clinics, and hardly go on house visits unless they have cases for family planning motivation. Since most of them do not live in the villages they are not able to develop good rapport with the villagers, the formal, and informal leaders.

#### 4.3 PERFORMANCE OF MEN WORKERS:

The men Workers perform similar functions like women Workers except that they are exempt from conducting antenatal checkups, and deliveries. Like their counterparts they too take up only the duties suggested as important by their superiors. (Table 4.10).

Table 4.10

Distribution of Health Workers by number of job duties performed,

N = 4

| Sl.<br>No. | Job duties                                   | Number of per-<br><b>forming</b> workers | Number of<br>non-perform-<br>ing Workers | Total    |
|------------|----------------------------------------------|------------------------------------------|------------------------------------------|----------|
| (1)        | (2)                                          | (3)                                      | (4)                                      | (5)      |
| 1.         | Family planning                              | <b>4</b>                                 | -                                        | <b>4</b> |
| 2.         | National Malaria<br>Eradication<br>Programme | <b>2</b>                                 | <b>2</b>                                 | 4        |
| 3.         | <b>Immunization</b>                          | <b>2</b>                                 | <b>2</b>                                 | <b>4</b> |
| 4.         | Chlorination of<br>wells                     | <b>2</b>                                 | 2                                        | <b>4</b> |

When asked about their duties, two of them said that they concentrate on family planning, malaria eradication, and chlorination of wells, while the other two, concentrate only on family planning, and immunization. When asked why it was so, they said that due to heavy work load they were unable to perform other duties. Two of the Workers were originally recruited as Basic Health Workers, and two as Vaccinators. Although they were later trained as Multipurpose Health Workers, they still continue to perform duties as Basic Health Workers, and Vaccinators, as there are only four Workers for the entire PHC area. Also as they are made accountable for the family planning, malaria eradication, and immunization of children, they concentrate only on these

**programmes.**

All the Workers maintain an advance tour diary for the month. However since the number of sub-centres, and villages to be covered by each Worker are more they are unable to follow the tour programme as per schedule.

Let us now look at the programme wise performance of the men Workers.

#### 4.3.1 Family Planning Performance:

The men Workers, unlike the women Workers, do not maintain any information regarding the number of eligible couples, number of **couples** protected by various methods, number of couples contacted, and yet to be contacted. They depend for information on the women Workers, and the Village Health Guides. The Workers have some performance to show with regard to sterilizations, and **condoms**, and have no performance to show with regard to **IUDS**, and oral pills.

For sterilizations, the annual target for each Worker is 48, however, all the Workers have achieved **less** than **50%** of the targets (see table 4.11) with regard to **condoms**, two of them motivated 67% of their target, while the remaining two motivated 72% of their target (table 4.11). •

Table 4.11

Performance of Men Workers with regard to **sterilizations**, and condoms during 1988-89.

| Sl. No. | Respondent | Annual target for Sterilization | Total achievement for the year | Annual target for condoms | Total achievement for the year  |
|---------|------------|---------------------------------|--------------------------------|---------------------------|---------------------------------|
| (1)     | (2)        | (3)                             | (4)                            | (5)                       | (6)                             |
| 1.      | A          | 48                              | 11<br>(23)                     | 12,000                    | 8037<br>(67)                    |
| 2.      | B          | 48                              | 12<br>(25)                     | 12,000                    | <del>8006</del><br>8606<br>(67) |
| 3.      | C          | 48                              | 19<br>(40)                     | 12,000                    | 8672<br>(72)                    |
| 4.      | D          | 48                              | 17<br>(35)                     | 12,000                    | 8634<br>(72)                    |

(Figures in brackets indicate percentage achievement of target)

According to the Workers, the most acceptable method is tubectomy followed by condoms, oral pills, **IUDs**, and vasectomy. The Workers assess the Family Planning Programme 'as somewhat satisfactory', and consider illiteracy, and fear of side effects as the main reasons why people are not accepting family planning methods.

4.3.2 **Performance of the Workers with regard to the National Malaria Eradication Programme (NMEP):**

Apart from Family Planning Programme, importance is also given to the Malaria **Er**adication Programme. Under this programme the Workers are supposed to visit all houses in their jurisdiction twice a month to identify fever cases, collect blood smears, and provide presumptive treatment if necessary. Only two Workers have some performance to show. Each worker is supposed to collect 200 blood smears per month or 20 to 40 per week. The number of blood smears collected by the Workers varied from 131 to 244 per month. **The** collection exceeds 200 blood smears during June, July, and August. According to the Workers all fever cases are given presumptive treatment, and the blood smears collected during the first, and second fortnight are given to the lab technician at the PHC for testing. Since there is only one lab technician at the PHC, it takes a minimum of 8 to 10 days to get the reports. In terms of **the** number of positive cases **iden-**tified, only one Worker identified three positive cases, while the other did not identify any positive cases, for the year 1988-89. For the positive cases radical treatment **was** given by the Worker, and focal spraying of DDT **was** done with the help of the district authorities. **Informal** discussion\* with the Workers revealed that sometimes the positive slides are destroyed at the PHC as it involves a cumbersome **proce-**



**dure**, of sending of the positive slide to the District Malaria Office for testing and making arrangements for the follow up action. According to the Workers whenever a positive case is identified, radical treatment is given, and the matter ends there without any follow up action.

The men Workers complained of too much of work load and suggested recruitment of more Workers. According to them most of their time is spent in malaria work and immunization, and are unable to concentrate on the **Family** Planning Programme, resulting in poor performance.

#### 4.3.3 Performance of the Workers with regard to the Immunization Programme:

Another important activity undertaken by the men Workers is immunization. The Workers do not maintain separate registers of the number of children below one year of age, and of children above one year up to five years of age, but depend on the information recorded by the women Workers. Only two Workers are involved in this programme. The annual immunization target (for children below 1 year) for each worker is 360. Regarding **BCG** vaccine, both Workers have achieved more than 100% of their target. With regard to the DPT and polio, one worker achieved more than 100% of his target for all the three doses, while the other achieved, **86%** of the target for the first dose, 90% for the second dose, and above 100% for the third dose. With regard to measles,

one Worker achieved more than ~~100%~~ of the target, while the other achieved less than 60% of the target **(table 4.12)**.

Table **4.12** :  
 Number of children immunized (below one year) by the Health Workers during **1988-89**.  
 Annual target of each worker = 360.

| Sl. Respon- |     |       | DPT   |       |       | FOLIO |       | MEASLES |       |
|-------------|-----|-------|-------|-------|-------|-------|-------|---------|-------|
| No. dent    |     | BCG   |       |       |       |       |       |         |       |
|             |     |       | 1     | II    | III   | 1     | II    | III     |       |
| (1)         | (2) | (3)   | (4)   | (6)   | (6)   | (7)   | (8)   | (9)     | (10)  |
| 1.          | A   | 403   | 308   | 324   | 483   | 308   | 324   | 483     | 740   |
|             |     | (112) | (86)  | (90)  | (134) | (86)  | (90)  | (134)   | (206) |
| 2.          | B   | 630   | 872   | 578   | 626   | 872   | 678   | 626     | 166   |
|             |     | (176) | (242) | (161) | (146) | (242) | (161) | (146)   | (46)  |

(Figures in brackets indicate percentage achievement of target).

The performance of the two Workers with regard to immunization can be termed as very good, however the other two Workers have no ~~performance~~ to show with regard to immunization.

Apart from Family Planning, Malaria Eradication, **and**



Immunization, the other national programme for which the Workers are supposed to work is the National Tuberculosis Control Programme. The Workers are supposed to identify, and collect at least 10 sputae per month. However none of the Workers collect any sputae but refer the cases to the PHC, or the TB hospital in the city. For the year 1968-89, the PHC collected sputae for examination from **466** patients. Since there are no facilities for testing, the slides are sent to the District Tuberculosis Office for examination. For the year **1988-89** no positive case of tuberculosis has been identified. However there are **50** patients taking regular treatment at the **PHC**, (33 men and 17 women). Most of these patients are working as labourers in stone quarries, and a cotton mill situated near their villages. Since the Workers do not participate in the Tuberculosis Control Programme, they have no performance to show.

The other activity where the men Workers are involved is chlorination of wells. Once again only two Workers chlorinate wells. Each of the Worker has chlorinated **10-15** water sources during 1988-89. Since most villages have protected water supply, chlorination is not done on a regular **basis**. **It** is usually undertaken during the rainy season, or during **epidemics**.

In addition the men Workers, like the women Workers, take part in Health Education Programmes organised by the

district authorities. Borne of them participate in the School Health **Programme** especially during intensive immunization **camps**. However **performance** of the Workers **for** these activities is not recorded as their involvement is minimal.

The men Workers like the women Workers are also supposed to perform a host of duties (**see appendix VI**). However, their concentration is on Family Planning Programme, National Malaria Eradication Programme, and **Immunization** Programme. Their performance with regard to sterilizations is minimal although with regard to condoms it is somewhat satisfactory. The generally poor performance of the men Workers can be attributed to the heavy work load as there are only four Workers covering eleven sub-centres.

Even though the Workers are designated as Multipurpose Health Workers, and have acquired the necessary training they still seem to be following the uni-purpose pattern where, the Basic Health Workers (**BHW**) were responsible for the malaria work, and the Vaccinators (recruited under the small pox eradication programme) were responsible for the immunization work. The performance of two Workers with regard to collection of blood smears, and administration of presumptive treatment is satisfactory. However the number of positive cases identified for the entire year 1988-89 does not seem to be satisfactory as malaria is rampant in the area. This calls for greater attention from the supervisory staff, and the Medical Officers of the **PHC**. The performance of the two

Workers with regard to immunization of infants is very satisfactory.

Like most women Workers, the men Workers also live, and commute from the city spending a great deal of time on travelling. As a result they are not able to spend enough time to perform their duties. They hardly have any rapport with the villagers, including the Village Health Guides, and the women Workers, as a result they are not able to coordinate tasks, and be of mutual help to each other.

#### 4.4. PERFORMANCE OF THE VILLAGE HEALTH GUIDES:

The village Health Guides are voluntary Workers, and hence it is difficult to see to what extent they are involved in the health care activities in their villages. The Health Guides are basically meant to treat minor ailments, and assist the Health Workers in the implementation of the Family Welfare, and other National Health Programmes.

#### 4.4.1 Treatment of minor ailments and referral:

Table 4.13

Distribution of Village Health Guides by number of patients treated per day for minor ailments, **N=30**.

| Sl.No. | Number of Patients treated | Number of Health Guides |
|--------|----------------------------|-------------------------|
| (1)    | (2)                        | (3)                     |
| 1      | 0                          | 4<br>(13.0 )            |
| 2.     | Less than five             | 17<br>( 57.0 )          |
| 3.     | 5 - 10                     | 5<br>(17.0 )            |
| 4.     | More than 10               | 4<br>( 13.0 )           |
|        | Total                      | 30<br>( 100.0 )         |

(Figures in brackets indicate percentage).

The reason why some of the Health Guides do not treat any patients or treat only a few patients is because medicines are not being supplied to them for the past eight to ten months. Hence they do not have any performance to show in this regard. Those treating more than five, and ten patients per day are the ones who are practicing as Registered Medical Practitioners.

Whenever there are complicated cases, the Health Guides are supposed to refer them to the PHC, but on the contrary, **it**.was found that they refer the cases to private medical practitioners or to the government hospitals in the city, because they feel that the cases are not properly treated at the PHC. Only 5 to 10 cases have been referred to the PHC during 88-89 by the Health **Guides**.

#### 4.4.2 Involvement of the Health Guides in the Malaria Eradication Programme:

The Health Guides are supposed to identify fever cases, collect blood smears, start presumptive treatment, and inform the Health Worker. However in this study it was found that the Health Guides identify fever cases, and provide treatment only if medicines are available with them. They generally inform the Health Worker about the cases, but do not collect any blood smears. All of them have **identified** 24 to 40 cases for the year 1988-89.

The Health Guides also involve themselves in **identify-**ing diarrhoea cases (table 4.14).

Table 4.14 :

Distribution of village Health Guides by number of diarrhoea cases identified during 1966-69, **N=30**.

| Sl.No. | Number of diarrhoea cases identified | Number of Health Guides |
|--------|--------------------------------------|-------------------------|
| (1)    | (2)                                  | (3)                     |
| 1.     | Less than 50                         | Y<br>( 23.0 )           |
| 2.     | 50 - 70                              | 20<br>( 67.0 )          |
| 3.     | More than 70                         | 3<br>( 10.0 )           |
| Total  |                                      | 30<br>(100.0 )          |

(Figures in brackets indicate percentage).

In case of epidemics the Health Guides generally inform the Health Workers and the PHC Medical Officers, and help in **chlorination** of wells in their area.

#### 4.4.3 Involvement of Health Guides in Maternal and Child Health Programme:

None of the Health Guides really involve themselves in the **MCH** Programme but only advice the pregnant women to go for antenatal checkups. Their involvement in the **Immunisation** Programme is also very poor, and help the Workers only



during **immunization** camps by bringing the children for **immu-**  
nization.

#### 4.4.4 **Involvement of Health Guides in the Family Planning Programme:**

The Health Guides are supposed to motivate cases for family planning (temporary and permanent). **Each Health** Guide has been given a target of two sterilization per month or twentyfour per year, however, it was found that none of them achieved more than 50% of their **targets**( table 4.1b).

**Table 4.1b :**

Performance of Village Health Guides with regard to **sterili-**  
zations for the year 1988-89, N = 30.

| Sl.No. | Number of cases motivated<br>for sterilization operation | Number of<br>health Guides |
|--------|----------------------------------------------------------|----------------------------|
| (1)    | (2)                                                      | (3)                        |
| 1.     | Less than 5                                              | 10<br>( 33.0 )             |
| 2.     | 5 - 9                                                    | 9<br>( 30.0 )              |
| 3.     | 10 - 12                                                  | 11<br>( 37.0 )             |
| Total  |                                                          | 30<br>( 100.0 )            |

(**Figures** in brackets indicate percentage)

The Health Guides do **not** motivate cases for **IUDs**. and oral pills as they are not very acceptable to the people.

However **since** they are depot holders for condoms they supply condoms to the **users**. 50% of the Health Guides have **11-15** regular **users**, while 30% have 5-10 **users**, and 20% have less than 5 regular **users**.

The Village Health Guides would have provided an excellent link between the **villagers**, and the Health Workers provided there was good rapport between them, and medicines were available on a regular basis. According to the Health Guides, the Health Workers are not regular in visiting villages, and conducting clinics, while the Health Workers say that the Health Guides never bother to come, and help them in conducting clinics, home visits, or during immunization of children. According to the Health Workers, the Health Guides are mostly not available in the village as they are always away on some work. **Though** the scheme is a voluntary one, the Health Guides do not take it in **that** spirit, but expect to be promoted as Health Workers in the future. Because of this attitude on their part, and **non-**availability of a regular supply of medicines, has rendered the scheme obsolete.

#### **4.5 PERFORMANCE OF THE DAIS (TRAINED):**

The Dais like the Health Guides are also voluntary Workers, and considered important persons in terms of their contribution to the village (see **appendix vi**).



4.6.1 **Number of deliveries in the village and number of deliveries conducted by the Dais:**

The number of deliveries expected per 1000 population amounts to 28 to 30 given the crude birth rate in the area. Therefore in villages with more than 1000 population, the Dai should be aware of more than 30 deliveries in her village. This awareness would show as to how active the Dais are in villages. Majority (50%) are aware of more than 30 deliveries, while 30% are aware of 15 - 30 deliveries, and 20% are aware of less than 15 deliveries. Thus it shows that most of them are quite active, and seem to have a good rapport with the villagers.

Some of the Dais in the villages are more popular than some others, and this has an impact on their performance. The Dai's popularity generally depends on her nature, skills, experience, and also the reputation of her ancestors, as the profession is generally handed over from one generation to the other. All these would have a bearing on the number of deliveries the Dai actually conducts.

The Dais are also responsible for getting the pregnant women registered for antenatal care. However they do not generally provide antenatal care as they feel that it is the Health Worker's responsibility. Registration of antenatal cases is done because they are paid, one rupee per **every case** registered.

Table 4.16 :

Distribution of Dais (trained) by number of antenatal **cases** registered, during **1988-89**, **N** = 24.

| Sl.No. | Number of <b>antenatal</b><br>cases registered | Number of<br>Dais |
|--------|------------------------------------------------|-------------------|
| (1)    | (2)                                            | (3)               |
| 1.     | 10 - 29                                        | 10<br>( 42.0 )    |
| 2.     | 30 - 49                                        | 11<br>( 46.0 )    |
| 3.     | 50 and above                                   | 3<br>(12.0 )      |
| Total  |                                                | 24<br>(100.0)     |

(Figures in brackets indicate percentage)

When asked whether antenatal services are reaching all pregnant women, the Dais were of the opinion that antenatal services do not reach everyone as the Health Workers are not regular in conducting antenatal clinics.

Regarding the number of deliveries the Dais actually conducted for the year **1988-89**, it was found that 42% of them performed ten to twenty nine deliveries, while 46% conducted thirty to thirtynine deliveries, and 12% conducted more than fifty deliveries. The number of deliveries conducted is the same as the number of antenatal cases registered (see table 4.16).

Some of the Dais are more popular as compared to others, and hence we find the differences in the number of deliveries conducted. Since many of the women Workers (Y) do not live at the sub-centres, most of the Dais (63%) conduct deliveries without their help, while **20%** took the help of the Health Workers for less than eight deliveries, and **17%** took the help of the Health Supervisors for ten to fifteen deliveries, as the cases were slightly complicated.

In case of complicated deliveries majority of the Dais (80%) refer the cases to the ~~Government~~**Maternity** Hospital, ~~Koti~~ Hospital, or ~~Malakpet~~ Hospital as Health Workers are also not available.

In terms of the postnatal services provided, the Dais mainly advice the mothers regarding, the diet to be taken, immunization of infants, and importance of personal hygiene.

**4.4.2 Involvement of the Dais in the Family Planning Programme:**

Table 4.17:

Distribution of Dais by number of sterilization cases motivated during 1986-89, N=24

| Sl.No. | Number of cases motivated | Number of Dais |
|--------|---------------------------|----------------|
| (1)    | (2)                       | (3)            |
| 1.     | Less than 5               | 3<br>( 13.0 )  |
| 2.     | 5 - 10                    | 14<br>( 58.0 ) |
| 3.     | More than 10              | 7<br>( 29.0 )  |
| Total  |                           | 24<br>(100.0)  |

(Figures in brackets indicate percentage).

It was found that the women motivated by Dais were those having three or more children. This shows that Dais contribution towards the Family Planning Programme is not effective (so is the case with the women Workers). Also the Dais are unhappy with the remuneration they receive, that is, Rs.3/- for every registered delivery is not given to them regularly. The remuneration is given as, and when funds are available. Many of them expressed that their income from deliveries conducted is gradually decreasing because of

sterilizations. **They** feel that the government should pay them at least ~~Rs.300/-~~ per month as they are ones who conduct most of the deliveries without the help of the Health Workers. The Dais feel that the burden of conducting the deliveries is not shared by the Health Workers for which they are being paid, while on the other hand they are hardly paid anything as compared to the work they do. Given all these factors it can well be assumed that there could be a possibility of the Dais **demotivating** the women (target group) to undergo tubectomy. however this aspect needs to be probed into. The Dais are not involved in motivating cases for IUDs, and oral pills, and also do not involve themselves in the distribution of condoms.

The performance of the Dais regarding deliveries conducted, is quite satisfactory. The Dais form a vital link between the women Workers, and the villagers, hence the Workers rely to a great extent on information provided **by** them regarding identification of antenatal cases, number of deliveries conducted in the village, registration of infants, identification of eligible couples, and **so** on. Whenever Health **workers** go on **homevisits** the Dai\* accompany them though this is not a routine feature. **They** play an important role in getting **mothers** in antenatal **stage** registered, bringing them for **checkup**, and **persuade them** to **bring** their children for immunization. According **to the Health** Workers, the Dais are very **helpful**, unlike the Village **Health** Guides.

In this chapter an attempt has been made to study the programme wise performance of the various categories of personnel. Since the number of personnel interviewed in each category is small (the study being limited to only one PHC), and variations in performance are not very significant. no attempt has been made to correlate the performance of the various categories of personnel with their social background characteristics, recruitment and training: length of service and transfers; supervision and interpersonal relationships. This kind of an analysis would be more meaningful provided the sample size of each category of personnel was significantly large.

The performance of the Workers with regard to primary health care services was by and large very unsatisfactory. Performance was being shown only for those programmes and services where targets have been fixed. for example, family planning, antenatal care. immunization. detection and treatment of malaria, and chlorination of water sources. No performance has been recorded for other activities. Workers were providing only those services for which they were ranked and evaluated. So this brings us to the target setting practices.

#### 4.6 TARGET SETTING PRACTICES:

The targets for the various primary health care programmes were fixed based on the size of the population



served by the PHC, and its previous achievements. **The** targets for the PHC and the Village Health Guides **were** fixed by the District Medical and Health Office (DMHO). The targets of the PHC were in turn divided among the men and women Workers and Supervisors. The targets given to Village Health Guides were an additional figure. The Medical Officers of the PHC **were not** involved in selling of targets nor **were** they ranked in terms of the performance of the PHC. But since they are answerable for the programmes implemented at the PHC level they rely mostly on the Supervisors for achievement of targets.

At the PHC, the programme-wise performance for various programmes was supposed to be collected from the Workers at the time of the monthly meetings. However, it was found that only performance with regard to family planning achievement and that too sterilizations get attention while the other health programmes hardly get any attention.

Based on the information received, the Workers **were** ranked for individual programmes. At the PHC the men and women Workers were ranked individually and their combined performance was the performance of the PHC. Ranking of Workers was not only done for every month **based** on the monthly performance but was also done **with** regard to cumulative performance. While **collecting information** from Workers, no verification from Workers records was made. and most of the information is collected orally. **This is** because

the PHC was basically geared up to send the information to the DMHO rather than to provide feedback to its Workers.

The information collected programmewise as well as in a consolidated form is sent to the DMHO before the fifth of every month. The District Medical and Health Officer usually holds a meeting on the fifth of every month with all the Medical Officers working under his jurisdiction to discuss the performance of the PHCs, hospitals and other units, and problems encountered by them. However, according to the Medical Officers problems encountered in the field with regard to implementation were never taken seriously by the District Medical and Health Officer and no effort was made to sort out the problems.

The reports received by the DMHO are consolidated and sent to the concerned Additional Districts and Director of Health and Director of Family Welfare.

Targets as we have already mentioned were fixed depending on the past achievements. As the DMHO increases the targets, the PHC further inflates the performance figures (and sometimes gets the approval of the Medical Officers). Here inter-personal conflicts are maximum especially with regard to credit sharing. Very often, the family planning cases motivated by the Village Health Guides were credited to Workers, and the Supervisors take credit for cases motivated by Workers and Village Health Guides.



The men and women Workers who bear the major burden of target achievement were not happy with the targets given to them (especially with regard to Family Planning Programme) as they consider them to be too high. They were **also** not happy with the targets given to **Supervisors** as it creates interpersonal conflicts.

The pressure on target achievement was so high especially for some programmes that what was evaluated was not the actual performance of the Workers or the PHC but was only a clever manipulation of figures.

## CHAPTER V

### SUPERVISION AND SUPERVISORY STYLES AND LINKAGES WITH THE COMMUNITY

The policies, and programmes of a primary health centre can become effective only if they are known, understood, and put into practice by proper supervision. Supervision is always associated with **control**, delegation of authority, and evaluation.

Every organization to some extent develops, and uses systems of control to ensure that the activities of the personnel are oriented towards the goals of the organization, that the personnel assigned to carry out the job duties are actually performing their job, and that efficient coordinating mechanisms are developed, and followed to achieve the goals. For this purpose various formal **mechanisms** are used (See Chapter I:87-91), and one such mechanism **is** effective supervision, and supervisory practices in an organization.

Problems in supervision could be attributed to **the** inability on the part of the Supervisors to maintain a **participative** or consultative type of supervision. Supervisors who are considered an **important** link in the chain of **the** organization sometimes hesitate to allow the workers to participate in solving **problems**, and taking certain decisions. They generally seek to preserve a neutral zone **in the**

decision making process out of fear that they will lose control if participation is encouraged. This is because supervision is closely linked with control, and delegation of authority rather than interpersonal relationships. Supervisors must therefore realize that consultative supervision necessitates effective downward as well as upward communication. This kind of a supervision can take place only if there exists a good interpersonal relationship between the Workers, and their Supervisors. Consultative supervision thus not only encourages ideas from subordinates but also helps in keeping the latter informed about the policies, **programmes**, and the changes resulting from time to time.

Supervision in any organization can be classified as technical supervision, and administrative supervision. In the primary health centre, however the personnel do not tend to make any distinction between the two types of supervision. The first line Supervisors generally look into technical as well as administrative aspects. The technical aspects include the capability of Workers in terms of their skills and knowledge, while the administrative aspects include how the Worker is performing his or her job in terms of population coverage, target **achievement**, and maintenance of records.

All personnel in the primary health **centre**, excepting the Multipurpose Health Workers are involved in **supervision**, and are supposed to be on tour for twenty four days in

month. **Since** Workers perform their duties in their individual capacity and also as members of a team, effective supervision and guidance from the first line Supervisors, Medical Officers and District Officers becomes imperative. Thus in this chapter an attempt has been made to look into aspects of supervision, and supervisory styles practiced by the Supervisors and also, the linkages between the health **personnel**, and the community.

#### 5.1 FREQUENCY OF VISITS BY SUPERVISORS:

**The** Health Workers are directly under the supervision of the multipurpose Health Supervisors followed by the Medical Officers, and District Officers. **It** was found that the **PHC** Medical Officers, and District Officers rarely visit the Workers in the field, however they are supervised by the first line Supervisors once a week or once in two weeks. Majority of the women Workers (8) said they are supervised once a week, while one of them said that an\* **is supervised** once in two weeks, and the other one said that **she** is supervised more than once a week.

Table 5.1

Distribution of women workers by frequency of visits by Supervisors, N=10.

| Sl.No. | Frequency of Visits<br>by Supervisors | Number of women<br>workers |
|--------|---------------------------------------|----------------------------|
| (1)    | (2)                                   | (3)                        |
| 1.     | More than once a week                 | 1                          |
| 2.     | Once a week                           | 6                          |
| 3.     | Once in two weeks                     | 1                          |
| Total  |                                       | 10                         |

The visits of the women Supervisors is mostly confined to the sub-centres according to the women Workers, and they visit other villages only if there are any cases for family planning motivation. On the contrary the women Supervisors said that they visit the sub-centres as well as the villages once a week. However it was found that the Supervisors visits are mostly confined to the sub-centre, and the village where it is located.

The men Workers on the other hand are supervised only once in two to three weeks. According to them, the men super-

visitors visit only the sub-centre village, and very rarely visit other **villages**. Like the women Supervisors the men Supervisors also said that they visit the sub-centre village as well as other villages once a week.

The Medical Officers rarely visit the sub-centres, and other villages according to all the Workers. They come and supervise work in villages only during epidemics, and health camps. However all Workers meet the Medical Officers once a week or once in two weeks at the primary health centre. This fact has not been denied by the Medical Officers. The District Officers also very rarely visit the villages.

## 5.2 AMOUNT OF TIME SPENT BY THE SUPERVISORS:

Visits to the sub-centres or the villages by the Supervisors is in itself not sufficient, the amount of time they spend with the Workers is an important factor to be taken into consideration. According to ~~the~~ women Workers, **Supervisors** spend around two hour\* during th# **visits**. made on tn# antenatal clinic days. According to the men Workers **their** Supervisors spend only about an hour\* time in connection, generally with the ongoing routine programmes. In **case** of an immunization camp or a sterilization camp or an epidemic the Supervisors spend more than two **hours**. **The Supervisors** however said that they spend one to two hours during routine trips while they spend more time during **camps**. Similarly ~~the~~ Medical Officer\* spend one to two **hours** depending on ~~the~~



programme. Such occasions are **ofcourse** rare. The District Officers hardly spend an **hour's** time during their visits to the villages.

### 5.3 TASKS SUPERVISED:

According to the women Workers the tasks supervised by their immediate Supervisors include: **a)target** achievements under different programmes with special emphasis on family planning, b) monitoring and inspection of stocks, records, registers etc., c) examination of antenatal cases, d) immunization of infants, e) postnatal cases as required, and f) occassional discussion of personal problems of the field.

Similarly the tasks **supervised** by the Medical Officers, and District Officers include : a) supervision **ot** family planning work (target achievements), and b) checking of the records, and the stock position. However the quality of the work done by the Workers **is** not given much importance **by** the senior **Supervisors**.

According to the men Workers, the Supervisor\* check a) the blood smear collection register **b)** immunization register, c) daily **dairy**. d) family planning target achievements, **and** e) stock position. According to them, only family **planning** work is given importance **folloed** by others. Thus it can **be** seen that more emphasis is being placed **on the** quantity of

work turned out rather than the quality of work. Since most of the programmes are target oriented, with incentives attached, it is but natural that the focus is on quantity rather than quality of service **provided**. Likewise the **Medical** Officers, and District Officers also said that they insist on the quantity of work rather than quality because of the pressures being exerted on them by the directorate.

b.4 TYPE OF INSTRUCTIONS **GIVEN** BY THE SUPERVISORS:

Apart from frequency of supervision; amount of time spent by the Supervisors; tasks **supervised**, the type of instructions, and guidance given is also important **for effective** supervision.

**Instructions** could be **oral** or written. It was found that all Workers received only oral instructions from **their** immediate Supervisors. Sometimes the Workers receive written instructions from the Medical **Officers**, and the District Officers. But, these **instructions** are rarely taken **seriously**. According to the Workers, generally such **instructions** are more or less repetitive injunctions a general **kind**, and act only as **reminders**.

As far as satisfaction regarding the guidance from first line Supervisor\* **is** concerned, it was found **that** many of **the Workers** were not **satisfied**. According to them **Supervisors** only give instructions but do not provide timely help.



and **guidance**. According to the **Workers**, essential drugs are not supplied **regularly**, vehicles are not provided to bring cases for operation to the health **centre**, and to transport operated patients back home. Moreover the Workers face **harassement** from the **Supervisors** with regard to family planning cases motivated by them, that is, some cases motivated by the Workers are shown as cases motivated by the Supervisors. The Supervisors on the other hand said that enough help and guidance is provided to the Workers, and it is the Workers who do not follow the instructions, provided by them.

#### 5.5 RECOGNITION FOR GOOD PERFORMANCE AND REPRIMANDS FOR POOR PERFORMANCE:

Recognition for good performance motivates the Worker to perform even better while reprimands for poor performance act as a disciplinary measure pressurising the worker to improve his or her performance. Recognition for good performance is usually given **interns** of cash prizes, merit certificates, increments, promotion, and fewer transfer\* while reprimands include **warnings** which are **oral.issue** of memo#, transfers, stoppage of **increments**, and delayed promotion\*.

Level of **satisfaction** with "recognition for **work**" can be judged from the answer\* to the question in **this** regard. Only one woman Worker \*aid that reward i\* '**always**' given for good performance. While **three** \*aid that encouragement **comes**

only 'sometimes', and three others said that recognition was given **very rarely**. . The remaining Workers **(3)** said that due recognition is never given even when the Workers perform to their best of **ability**. Similarly three of the men Workers said that recognition is given sometimes while the remaining one Worker said that recognition is never given for good work done.

According to the Medical Officers, and first line Supervisors due recognition is always given provided Workers perform well. According to them most of the Workers are poor performers, and hence **do** not deserve recognition.

According to the Medical Officers, and Supervisors indiscipline seems to be the most negative aspect among the Workers. Absenteeism, lack of commitment, not reporting on time, and not being available in the field are some of the most common problems they encounter with the Workers. **When-** ever Workers performance is below average or poor they are generally given an oral warning, for a minimum of three **times** after **which** a memo is issued followed by a transfer, **and** stoppage of **increments**. **In** thl\$ health centre, **warnings**. **memos**. and transfers do not seem to make **much** impact on **the** Workers as they find **ways**. and means to overcome the cri\$\*. The ways and means include approaching union leaders, political **leaders**. and directorate **officials** to tide over tae crisis. **In** this primary health centre, four of tae women workers have been given a warning regarding their **performance**

(MCH and FP), and two of them have been issued **memos**. **Two** others were transferred to this primary health centre on grounds of poor performance from another health **centre**. **In** the case of men **Workers**, all of them were given warnings for poor performance with regard to family planning target **achievements**.

5.6 AMOUNT OF TIME SPENT BY THE WORKERS AND SUPERVISORS AT THE PRIMARY HEALTH CENTRE MEETINGS:

All Workers, and Supervisors attend the monthly meetings held at the primary health **centre**. **In** terms **of** the time spent at the meetings, it was found that **the** men Workers spend not more than an hour. **The** monthly meetings seem to be more of a farce rather than occasions when **Workers** performance is properly evaluated, administrative matters, and problems discussed, and appropriate decisions taken. No serious effort is made by the **in-charge** medical officer to find out why a particular Worker's performance **is** poor, whether drugs available are adequate, and whether they are encountering any problems in the **field**. **It** was found that the in-charge Medical Officer, and the other Medical **Officers** were only passive participants.

According to the **Workers**, except for family planning target **achievements** nothing else is discussed **in the** monthly meetings. **The** Medical **Officers**, and their immediate **supervi-**

sors never discuss problem faced by them, and if at all some **one** voices her or his problem nothing is done to solve **it**. **This** is the reason why none of the Workers find the monthly meetings really **useful**.

The Medical Officers and Supervisors on the other hand **find** the monthly meetings useful because they feel that they help in guiding the Workers in the right **direction**,. according to them the Workers' performance with regard to various activities are evaluated, and discussed at the meetings, and a plan of action for the subsequent month is also chalked out. **Instructions** if any from the **District Officers** are communicated to the Workers during the meetings.

As already mentioned, the monthly meetings are a mere farce as the researcher herself witnessed the proceeding of six monthly meetings held at the health centre. Except for "family planning target achievement", performance with regard to other activities or programmes was not discussed. No plan **or** action was chalked out, no guidance was given nor individual problems discussed. Circulars from the district office were communicated but there was no discussion on them. **It is** sad to note that the in-charge Medical Officer, and Supervisors did not discuss the progress of much vital on going programmes as Maternal and Child Health (**MCH**). Immunisation, and Control of Communicable Diseases. The monthly **performance** of the Workers with regard to these programmes is handed over to the **Computer** for compilation.

Although the Health Workers are **not** formally **given** any supervisory role, they are **supposed** to interact, and provide **help**, and guidance to the village level Workers, namely, the Health **Guides**, and the local Dais for effective programme implementation.

5.7 **RELATIONSHIP BETWEEN VILLAGE HEALTH GUIDES AND PRIMARY HEALTH CENTRE PERSONNEL:**

For effective implementation of the programmes at the village level, interaction between the Health Guides, Workers and Supervisors is very essential. When asked how often they meet women Workers only 13% of the Health Guides said that they meet them once a week, and **67%** said they meet them only sometimes, 10% said they meet them rarely, and another 10% said they never meet them (table 5.2).

Table 6.2:

Distribution of Village Health Guides by frequency of meetings with the women Workers,  $N = 30$

| 81.<br>No. | Frequency of<br>meetings | Number of<br>health Guides |
|------------|--------------------------|----------------------------|
| (1)        | (2)                      | (3)                        |
| 1.         | Once a week              | 4<br>(13.3)                |
| 2.         | Sometimes                | 20<br>(66.7)               |
| 3.         | Rarely                   | 3<br>(10.0)                |
| 4.         | Never                    | 3<br>(10.0)                |
| -          | Total                    | 30<br>(100.0)              |

(Figures in brackets indicate percentage)

According to the Health Guides, the women Workers mostly visit the sub-centre villages as compared to the other villages, and hence they do not get an opportunity to meet them often. The Health Guides frequently in contact with field staff usually happen to live in the sub-centre village where the sub-centres are located. Thus it shows that except for a few Health Guides the remaining do not maintain much contact with the women Workers. However the Health Guides meet the men Workers more often as compared to the women Workers. This could be due to the fact that the men Workers are involved at the stage of the initial training of the health Guides. Also both the categories are completely



**male**, and there is therefore the possibility of male boia **bonie** developing between members of two categories of **personnel**. This could be one of the reasons why Health Workers (**men**) also request the Health Guides to help them identify cases interested in adopting family planning.

The factor of sex based **friendships**, and interactions appears to be a factor of some significance also in the case of the Health Guides relationship with the men and women Supervisors. Majority of the Health Guides (75%) said that they only occasionally meet the women Supervisors, while **25%** said that they never meet them. As in the case of men Workers, the Health Guides meet the men Supervisors more frequently, as compared to the women Supervisors.

In terms of the amount of **time** they spend **with** the Workers, and Supervisors it was found that majority of the Health Guides (71%) spend less than half an hour **everytime** they meet. Since a majority, of them hardly meet the Workers, and Supervisors the latter can hardly depend on them for **implemeting** the various programmes.

On the question of "**help** received by the **Workers**" it was found that only the men Workers seek the help of the Health Guides **in** motivating family planning **cases**, **chlorination** of wells, and during immunisation camps. Sometimes **the** Health Guides depending on the **instructions** given by the **men**

Workers, and Supervisors, send family **planning** cases directly to the **primary** health centre without informing the women Worker. This is resented by the women Workers since they feel that the family planning work is their exclusive preserve.

Regarding the **Health** Guides visits to sub-centres, it was found that 13% visit the sub-centre every week irrespective of the Health Workers visit, while 17% occasionally visit the sub-centre, and the remaining 70% very rarely visit the sub-centres. However all of them visit the primary health centre once a month to collect their honorarium. Though a monthly meeting for the Health Guides **is** called for in the first week of every month, hardly any one turns up.

The Health Guides scheme has become obsolete as there is hardly any interaction between them, and the Workers. Though they have been recruited on a voluntary **basis** yet they feel that they are not being rewarded sufficiently. According to some of them the honorarium should be increased from **Rs.50** per month to **Rs.300** to **500** per month, while some others feel that they should be recruited as full time Workers with regular pay scales. The Health Guides also expressed profound dissatisfaction regarding the supply of medicines to **them**. **For** the past eight to ten months none of **them** have received any medicines from the **PHC**. **Even** prior to that period, medicines were supplied once in four or six **months**. **According** to them the medicines supplied are not sufficient, and **some-**



times expired drugs are allotted to them for distribution.

When the **PHC** personnel were asked to assess the performance of the Health Guides, they all expressed high levies of **dissatisfaction**, and felt that the scheme should be done away with as they really do not serve any purpose. According to them most of them are not available in the villages (that is, when the personnel visit the villages), and even those who are available do not cooperate, and follow instructions. The Health **Guides** are mostly away from the village because many of them are engaged in business. Also there seems to be no motivation to work as none of them are receiving any medicines, and there is no cooperation or interaction **what so** ever between them and **the** official Workers and **Supervisors**.

Apart from the Health Guide\*, every **sub-centre** area ha\* one trained Dal who **is** recruited aa a voluntary worker to **assist** the women Workera, or their routine field **trips**. According to the **PHC** peraonnel they are far more **helpful** aa compared to the Health **Guides**.

Thua **it** can be aeen that among the **various PHC** peraonnel **it is** only the Health Workera, and **Supervisors who meet** the Health **Guides** occasionally during their **visits to the villages**. Though **50%** of **the** Health Guide\* have **said** that they spend **sometime** on **health** and family welfare **activities**. their performance on the **whole** 1\* very **poor**. boat of **them do**

not keep in touch with the Health Workers, and are mostly not available in the village. We too had to make several trips to the villages to contact the Health Guides. Since medicines are not being supplied to them even treatment of minor ailments is not being undertaken in the villages. Only those villages where health Guides are functioning as **IMPs** (30%), treatment of minor ailments is being undertaken for a fee.

Most of the Health Guides expressed dissatisfaction with their job and the honorarium being paid to them. They appear to have offered their services assuming that in due course they may become permanent Health **Workers**. It seems the Health Guides were **not** properly oriented to the scheme. **Again** right persons were not recruited, we feel that for the job, middle aged men or women residing permanently **in** the village and having their respective occupations in the village should have been given this job. **Instead**, it was found that those who were **in** the good books of the **Sarpanch**, and known to the local Health Supervisors were brought **in** as Health Guides.

#### 5.6 RELATIONSHIP BETWEEN THE DAIS AND PRIMARY HEALTH CENTRE PERSONNEL:

Like the Health Guides, the **Dais** are also village level workers performing certain important **functions**. ~~therefore some~~ amount ~~of~~ supervision is done by **the women Workers**. and Supervisors with regard to their work.

Unlike the Health Guides the Dais meet the women Health Workers more often. When asked how often the women Workers meet them, majority (83%) said that they meet them once in a week or once in two weeks without fail, and **everytime** they meet they spend about one to one and a half hours together. The remaining Dais (17%) said that the women Workers meet them only sometimes, and that too for a very short while. **On** the other hand, the men Workers meet the Dais less often. Thus it can be said that the Dais are more **closely** associated with the women Workers because of the nature of their work. One important point to be noted at this juncture **is** that all **Dais** operating **in** the villages are not yet trained. **In** most of the **villages** a certain proportion (1b to 20%) of deliveries are still being conducted by untrained **Dais** who generally do not cloaely **associate themselves** with the women Workera. This **means** that the client population aerved by theae Dala (untrained) **is** at a greater **risk** than thoea who are being served by trained Dala. Therefore **it** ia high time that training la **imparted** to **all** Dala irreapectlve of the **size** of population they aerve, **firstly** becauae the people have to depend on them aa moat of the health Workera ao not live at the **sub-centres**, and aecondly. because the health **Workers** themselves rely heavily on the **information provided** by the Dala with regard to antenatal caaea. caaea for family planning **motivation**, and **immunization of infants**. and children.

With regard to the relationship between Dais, and Supervisors, it was found that the women Supervisors meet the Dais more often than the men Supervisors. Sometimes the Dais send sterilization cases to the women Supervisors without the knowledge of the women **Workers**, resulting in a clash **between** the two. **It** has been found that **17%** of the Dais took the help of the women Supervisors for conducting ten to fifteen deliveries during the year **1988 -1989**. Thus we find that some of the Dais are more closely associated with the women Supervisors rather than the women Workers.

**Regarding** supervision of Dais it was found that only **those** women Workers living in the sub-centre villages (3) sometimes **assisted**, and supervised the deliveries conducted by **13%** of the **Dais**, while the remaining **87%** of the Dais say that the women Workers generally help during the postnatal care provided by them. Since seven out of ten Health Workers do not supervise the deliveries **conducted**, no supervision with regard to the use of delivery kit **is** undertaken. Only **42%** of the Dais use the kit 'always', while **29%** use **it** only sometimes', and the remaining **29%** **never** use **it**. The **reason** for the **inadequate** use the kit **is** that **its** contents are not replenished on a regular **basis**. **Again** because the **instru-**ments in many of the kits are worn out or **rusted**, the kit **is** often not in a condition to be workable.

The Dais most of the time restrict their work to their

native village, and sometimes also provides their services to clients living in the nearby villages. However they do visit the **PHC** along with their clients during family planning operations. The Dais accompany their clients so that they can claim the fee for motivation. There are instances when the women Supervisors take away the money paid for motivation because the Dais are not present at the **PHC**. The Dais also visit the **PHC** to collect their honorarium. Thus we find that a majority of the Dais (67%) visit the health centre once **in** two to three weeks, while 21% visit once a month, and 12% visit once in two months.

When asked to assess the performance of the **Dais**, the health centre personnel consider the Dais very helpful as compared to the Health Guides. According to them, most of the Dais (**85%**) cooperate, and **generally** follow **instructions** given to them. However such **is** not the case with untrained Dais. This could be because there is not enough rapport between **them**. and the Health **Workers**.

**The** Dais on the other hand are not at all happy with the honorarium paid to them (**Rs.1** per **antnatal** case **regis-tered**. and **Rs.2** per delivery conducted). **Even this** amount according to them, and the **in-charge** Medical Officer, is not being **paid** regularly due to lack of funds. Whenever the district authorities release some amount under **this head**, **it** is divided among all the trained Dais working under **the** jurisdiction of the primary health centre. According to **some**

**Dais (40%)** at least **Rs.20** to **Rs.25/-** should be paid for every delivery conducted, while some others **(16%)** expressed that at least **Rs.100/-** per month should be paid, while the remaining **(44%)** felt that they should be paid at least **Rs.300/-** per month as most **or** the **deliveries** are conducted by them.

Regarding the remuneration they receive from their **clients**, it was found that **for** each delivery they receive **Rs. 20** to **50 cash**, and some **grain**. The remuneration usually varies with the socio-economic status of the client, as well as **the** sex of the **child**. **The** rewards **received** from the **well** to do are more satisfy **ing** as compared to those received from the **poor**. Also **the** reward **is** more satisfy **ing** **if it is a** male **child rather** than a **female child**. Since **the** poor are unable to pay them **immed i ate l y** after delivery, **the Dais feel that** **the** government **shou l d** pay **them** some **regu l ar** amount every **month**.

**Discussion** on **supervision** and **supervisory** styles at different levels shows that **it is highly unsatisfactory**. **Except for** one male **and** one female **supervisor**, all oth#r# do not maintain their sector **headquarters**. They **live in the city** **and spend** most of **their time in** commuting, leaving **very** little time for supervision. **The** woman Supervisors visit **the** sub-centres once a wee\* during antenatal clinic **days**, and supervise the examination of antenatal cases, immunization **of** **infants**, and family planning target achievements. **They** hardly



spend a couple of hours at the **sub-centre**. The men Supervisors visit the sub-centres only once in two **weeks**, but do not supervise any of the activities or records of the Workers. Therefore at the monthly meetings we find that excepting for family planning performance, performance with regard to other activities is not submitted. **It** is only during the end of the year that performance figures for the other activities are "produced". **Even** at the sub-centres it was found that none **of** the Workers were maintaining proper records of the work done. **This** is but to be expected since the Supervisors hardly spend any time looking into the aspects of record keeping. **They** also never bother to visit the households, and cross check whether **they** have been receiving services or not. All that they are interested is in "target **achievement**" as they will be taken to task by the district authorities for not fulfilling targets. Most of the women Workers consider their Supervisors as authoritarian and **dictatorial**, however the men Workers do not think so. They seem to have a more congenial relationship **with** their Supervisors. The reason for the friction between the women **Workers**, and Supervisors **is** due to the competition with regard to family planning **cases**. Since Supervisors are also given targets in **this PHC**, it **is** leading to an unhealthy competition between them **and** the **workers**, **inturn affecting** their **relationship**. What **one** finds **is** that there is no consultative supervision operating between these two **categories**, which is clearly manifested in the performance of the Workers. **The** problem is that even **the** Medical officers are passive **participants**, and **there is**

practically no supervision by **them in** the field. **Given** the kind of supervision, it is but natural for the performance of the Workers **to** be below average.

#### **LINKAGES BETWEEN THE HEALTH PERSONNEL AND THE COMMUNITY:**

The village community **exhibits** elements of unity and **diversity in** terms of **its** '**caste**', '**class**' and '**power**' composition, often resulting in different types of relationships and patterns of **interaction** between units.

**Previously**, efforts **in** development planning focussed on the rural leadership which belonged to the dominant group and which was also powerful **in its** own right. The focus was on the village leadership because **it** was assumed that any change that **is** being **introduced** has to be first, acceptable to the leaders, and only then can **it** become acceptable to the **others**. However, since certain aspects of development are directly related to poverty alleviation, the dominant groups are not **interested in** these programmes unless these help bolster their power **bases**. the development programmes which relate to strengthening of the infrastructure **of** the community have some indirect pay **offs**. in the shape of **contracts**. **The** benefits are usually cornered by the caste/class **elites**. **However**. subsequent changes brought about **in** the economic, political and administrative structures, have tended to shift the emphasis from involving leaders to the involvement of the



people (**eg. NIKD**) in the rural areas. Thus the democratic institutions helped creating new institutions, and **non-governmental** organizations who believe in the concept of involving not so much the leaders but the poorer segments of the village **community** in the implementation of various **programmes**.

Now it is within this given social structure of the villages that the primary health centre personnel have to operate, and implement programmes meant for the people. For effective implementation of programmes, the health personnel have to involve, not only the village leaders, and local revenue officials, but also other **organizations** like the Manila Mandais, and Youth Clubs. Apart from them, some of the village elders and local private medical practitioners also **have** to be brought in. Without the participation of the above organizations, village elders, and others, no programme can be a **success**. For organising a vibrant, successful programme, the health personnel especially the health workers, and Supervisors have to **interact**, and establish rapport with a large number of people and seek their help and **involvement**.

When asked about the number of **manila mandais** in their villages, eight of the ten women workers said that **there were** such organizations (in **fact 17** in the eight village\*). **The** other two said that there were no **manila** mandais in **their**

area. When we asked the eight Health Workers that had **mahila** mandals whether they attend the meetings held there, only one Worker said that she attended their **meetings**. She explained that when some information had to be communicated **regarding** antenatal **care, immunization, sterilization** camps or during **epidemics**, she found it expedient to go to these **meetings**. According to the women **Workers**, the mahila mandals are not **active**, and **consists** of a handful of members belonging to the dominant group in the **village**. Also many of the Worker\* do not get along with the mahila **mandal Presidents, Vice Presidents, and Secretaries**. The reason **is these** member\* are closely associated with the voluntary organization operating **in** the area (Family planning **Association** of India), and refer cases to be operated to the voluntary Worker\* rather than the **PHC Worker\***. **This** result\* in a cla\*h between the Health Workers, and the members of the mahila **mandals**. According to the **members**, the ca\*ea \*ent to the **PHC** are not taken good care of. and hence they refer them to the voluntary organizations. **It has** been **observed** that the voluntary **organiza-**tion has e\*tabll\*hed very good rapport with **all** the **important** members in the village, **resulting** in better performance a\* compared to the performance of the official health worker\* **especially** with regard to the **Family Manning Programme**. A\* compared to the number of **mahila mandals**, there are 36 **yuvak** manual\* (**youth club\***) operating in **the villages**. The **men** worker\* **sometimes** make use of **these** whenever **the need arises**. The **yuvak mandal\*** (27) on the **whole** are relatively **more** active a\* **compared** to **the mahila mandal\***. **The men workers**

use these mandals for communicating information regarding various health camps, and measures to be taken during village festivals. They also impart health education to the youth. The Workers attend the meetings only sometimes because of their tight schedule.

Thus it can be stated that the **mahila** mandals, and **yuvak** mandals though present are really not active enough to enable the Workers and Supervisors to make use of them on a regular basis. Many of them in fact merely exist on paper. Since these organizations are **inactive**, the Health Workers, and Supervisors have to rely on the village leaders or elders (Sarpanch, panchayat members, and other prominent persons), school teachers, and local private practitioners for help. Their help **is** sought during family planning **camps**, **immunization** camps, other **health camps**, for the control of communicable diseases like gastroenteritis. Help from school teachers is taken to **identify** children with **deficiencies**, and for immunization **purposes**. Help from private practitioners **is** sought **for identifying** fever cases, giving injections to women during delivery **time**, motivating cases for family planning, and treatment of minor ailments.

**All** the Workers said they meet the village leaders or elders once in two weeks during their visits to the **villages**. **When** asked whether they get adequate support, and help from them only six out of **the** ten women **workers**, and **two** out of

the four men Workers replied in the affirmative , while the remaining Workers said that the village leaders provided **very** little **help**. **All** the Supervisors maintained contacts with the village **leaders**, as their support, and help was needed during family planning, **immunization**, and other health **camps**. But according to them help was not always available as the leaders were often not available in the village during their **visits**. The **village** leaders belonged to the dominant land owning groups, who were economically well off, and had established **business else where**. **This** could be one of the **reasons** why they were not **available in the village**, most of the **time**.

None of the **Medical Officers maintained** any contact with the village leaders except for the in-charge Medical **Officer** who sometimes approached the leaders for help during **epidemics**, and sterilization camps. Since most of the leaders were political figures the Medical **Officers** try to keep away from them out **of fear** so that they may not seek favour **beyond** their **capacity**. however it was found that the leader\* sometimes sought the help of the **PHC personnel** by referring cases (relatives and friends) for treatment.

**54**

## CHAPTER VI

### SOCIODEMOGRAPHIC PROFILE OF THE BENEFICIARIES

#### 6.1 LOCATION OF VILLAGES, SIZE OF SETTLEMENTS AND AMENITIES AVAILABLE IN THE MANDAL:

An attempt has been made in this chapter to study the sociodemographic profile of the beneficiaries. Examining the social background characteristics of the beneficiary households would tell us who the users of these services are as they are essentially meant for the socially and economically backward sections of the community.

The primary health care services are meant to be delivered at the village level. Therefore, the location of villages vis-a-vis the health centres, size of settlements and amenities available would show whether the centres are physically accessible to the beneficiaries. Therefore an attempt has also been made to study the profile of the villages.

The study as we know has been confined to one PHC located in Hayatnagar mandal of Ranga Reddy district, Andhra Pradesh. The mandal has a total number of fortyone villages - thirty five inhabited, and six uninhabited villages. The PHC caters to the population living in these thirtyfive inhabited villages. Table 6.1 shows the number of inhabited villages according to population range, and amenities available in Hayatnagar mandal.

**Table 6.1:**

Village\* according to population range and amenities available in **Hayathnagar** Mandal.

| Sl. No. | Population Range | Number of inhabited Villages in each range | Primary Schools | Secondary Schools | High Schools | public transport facility | Post and Tele-graph | Approach by pucca road | Power Supply  | Mater Supply  |
|---------|------------------|--------------------------------------------|-----------------|-------------------|--------------|---------------------------|---------------------|------------------------|---------------|---------------|
|         | (1)              | (2)                                        | (3)             | (4)               | (5)          | (6)                       | (7)                 | (8)                    | (9)           | (10)          |
| 1.      | - 499            | 6<br>(17.1)                                | 2<br>(33.3)     | -                 | -            | 2<br>(33.3)               | -                   | 2<br>(33.3)            | 6<br>(100.0)  | 6<br>(100.0)  |
| 2.      | 500 - 1999       | 20<br>(57.0)                               | 17<br>(85.0)    | 6<br>(30.0)       | 1<br>(5.0)   | 18<br>(90.0)              | 9<br>(45.0)         | 18<br>(90.0)           | 20<br>(100.0) | 20<br>(100.0) |
| 3.      | 2000 - 4999      | 8<br>(22.8)                                | 7<br>(87.5)     | 6<br>(75.0)       | 4<br>(50.0)  | 8<br>(100.0)              | 8<br>(100.0)        | 8<br>(100.0)           | 8<br>(100.0)  | 8<br>(100.0)  |
| 4.      | 5000 +           | 1<br>(2.9)                                 | 1<br>(100.0)    | 1<br>(100.0)      | 1<br>(100.0) | 1<br>(100.0)              | 1<br>(100.0)        | 1<br>(100.0)           | 1<br>(100.0)  | 1<br>(100.0)  |
| TOTAL   |                  | 35<br>(100.0)                              | 27<br>(77.1)    | 13<br>(37.1)      | 6<br>(17.1)  | 29<br>(82.9)              | 18<br>(51.4)        | 29<br>(82.9)           | 35<br>(100.0) | 35<br>(100.0) |

(Figures in brackets represent percentage)

Source: Mandal Census Hand Book, 1985

Government of Andhra Pradesh.

The **mandal** is located fourteen kilometres away from Hyderabad enroute national highway number nine connecting Hyderabad, and Vijayawada. It is surrounded by Nalgonda district on the east; **Ibrahimpatnam** mandal on the south; **Saroornagar** mandal on the west, and **Uppal** mandal on the north.



The **mandal** has a population of **53,889** according to the **1981** census of which, men comprise **27,785**, and women **26,104**. Out of the total population **9,989** belong to the Scheduled **Castes**, and **379** belong to the Schedule **Tribes**. The working population forms **42.7%** of the total population of which 12% are agricultural labourers, and 11% are cultivators. The remaining 19.7% belong to other categories like those engaged in household industry, factory **workers**, business, government **service**, teachers, traditional caste occupations, artists etc. The **mandal** has a total literacy rate of 24.4%.

The **mandal** has a total geographical area of **67,145** acres of which only 42% constitutes cropped area. The principal crops include paddy, jowar and castor. Vegetables and grapes are also grown as these are supplied to the markets in the city on a regular basis. Though two rivers - Musi and a tributary of **Bhima** river traverse the district, they are not used for irrigation purposes because of the rights created for Hyderabad city water supply, and irrigation rights to Musi projects in Nalgonda district. Therefore the main source of water for irrigation is ground water, and lakes.

Regarding educational facilities, the **mandal** has twentyseven primary schools, thirteen secondary schools, and six high schools.

**Thirtyone** villages **in** the **mandal** are connected with pucca roads, and public transport system is in operation in these villages. Eighteen villages also have postal facilities. **Two** villages have commercial banking facilities, and two villages have cooperative banking facilities . Apart from these amenities, in nine villages **311** pucca houses have been constructed for the economically weaker sections, and in eight villages land has been distributed to the poor for construction of houses.

As far as medical facilities are concerned, apart from the primary health centre there is one ayurvedic hospital, and one homeopathy dispensary. All villages in the mandal have protected drinking water supply, and electricity. Table 8.2 shows study villages according to their population size, location vis-a-vis sub-centres and **PHC**, and amenities available.



Table 6.2:  
Study villages according to their population size, location vis-a-vis the sub-centre, primary health centre, and amenities available.

| Sub-centre | Name of the Village | Population size | Bomber of house-holds | Distance from sub-centre (Kms) | Distance from PHC (Kms) | Maintenance of head quarters by health worker | Availability of pucca road | Availability of public trans- | Availability of health facility other than sub-centre | Availability of PHCs & MLAs | Educational facilities  |                           |                      | Power Supply | Drinking Water Supply |
|------------|---------------------|-----------------|-----------------------|--------------------------------|-------------------------|-----------------------------------------------|----------------------------|-------------------------------|-------------------------------------------------------|-----------------------------|-------------------------|---------------------------|----------------------|--------------|-----------------------|
|            |                     |                 |                       |                                |                         |                                               |                            |                               |                                                       |                             | Primary School facility | Secondary School facility | High School facility |              |                       |
| (1)        | (2)                 | (3)             | (4)                   | (5)                            | (6)                     | (7)                                           | (8)                        | (9)                           | (10)                                                  | (11)                        | (12)                    | (13)                      | (14)                 | (15)         | (16)                  |
| A          | 1. Peddalahberpet   | 3367            | 616                   | -                              | 3                       | yes                                           | yes                        | yes                           | no                                                    | yes                         | yes                     | yes                       | yes                  | yes          | yes                   |
|            | 2. Pasmanala        | 1445            | 236                   | 6                              | 3                       | -                                             | yes                        | yes                           | no                                                    | yes                         | yes                     | no                        | no                   | yes          | yes                   |
|            | 3. Kalanagar        | 310             | 63                    | 3                              | 6                       | -                                             | no                         | no                            | no                                                    | yes                         | no                      | no                        | no                   | yes          | yes                   |
| B          | 1. Taranatipet      | 2462            | 422                   | -                              | 6                       | no                                            | yes                        | yes                           | no                                                    | yes                         | yes                     | yes                       | yes                  | yes          | yes                   |
|            | 2. Gowrelly         | 1757            | 301                   | 3                              | 9                       | -                                             | yes                        | yes                           | no                                                    | yes                         | yes                     | no                        | no                   | yes          | yes                   |
|            | 3. Bacharam         | 1317            | 293                   | 4                              | 10                      | -                                             | yes                        | yes                           | no                                                    | yes                         | yes                     | no                        | no                   | yes          | yes                   |
|            | 4. Soddipally       | 181             | 36                    | 18                             | 12                      | -                                             | yes                        | yes                           | no                                                    | yes                         | no                      | no                        | no                   | yes          | yes                   |
| C          | 1. Bandlaravirala   | 2000            | 220                   | -                              | 15                      | no                                            | yes                        | yes                           | no                                                    | yes                         | yes                     | yes                       | no                   | yes          | yes                   |
|            | 2. Chinnaravirala   | 400             | 80                    | 2                              | 17                      | -                                             | no                         | no                            | no                                                    | yes                         | no                      | no                        | no                   | yes          | yes                   |
|            | 3. Guvvalady        | 250             | 50                    | 3                              | 18                      | -                                             | no                         | no                            | no                                                    | yes                         | no                      | no                        | no                   | yes          | yes                   |
|            | 4. Kavadiipalli     | 1816            | 296                   | 6                              | 9                       | -                                             | yes                        | yes                           | no                                                    | yes                         | yes                     | yes                       | no                   | yes          | yes                   |
|            | 5. Kali Jaguda      | 650             | 100                   | 8                              | 11                      | -                                             | yes                        | yes                           | no                                                    | yes                         | yes                     | no                        | no                   | yes          | yes                   |

Source: Mandal Census Hand Book, 1985, and  
Andhra Pradesh Road Transport Corporation.

| Sub-centre | Name of the Village | Population size | Number of house-holds | Distance from sub-centre (Kms) | Distance from PBG (Kms) | Maintenance of head quarters by health worker | Availability of pucca road | Availability of public trans- | Availability of government health facility other than sub-centre | Availability of PMPs & RMPs | Educational Facilities |      |      | Power Supply | Drinking Water Supply |
|------------|---------------------|-----------------|-----------------------|--------------------------------|-------------------------|-----------------------------------------------|----------------------------|-------------------------------|------------------------------------------------------------------|-----------------------------|------------------------|------|------|--------------|-----------------------|
| (1)        | (2)                 | (3)             | (4)                   | (5)                            | (6)                     | (7)                                           | (8)                        | (9)                           | (10)                                                             | (11)                        | (12)                   | (13) | (14) | (15)         | (16)                  |
| 'A'        | 1. Pedda Amberpet   | 3367            | 616                   | -                              | 3                       | yes                                           | yes                        | yes                           | no                                                               | yes                         | yes                    | yes  | yes  | yes          | yes                   |
|            | 2. Pasmanala        | 1445            | 236                   | 6                              | 3                       | -                                             | yes                        | yes                           | no                                                               | yes                         | yes                    | no   | no   | yes          | yes                   |
|            | 3. Kalanagar        | 310             | 63                    | 3                              | 6                       | -                                             | no                         | no                            | no                                                               | yes                         | no                     | no   | no   | yes          | yes                   |
| 'B'        | 1. Taramatipet      | 2482            | 422                   | -                              | 6                       | no                                            | yes                        | yes                           | no                                                               | yes                         | yes                    | yes  | yes  | yes          | yes                   |
|            | 2. Gowrelly         | 1757            | 301                   | 3                              | 9                       | -                                             | yes                        | yes                           | no                                                               | yes                         | yes                    | no   | no   | yes          | yes                   |
|            | 3. Bacharam         | 1317            | 293                   | 4                              | 10                      | -                                             | yes                        | yes                           | no                                                               | yes                         | yes                    | no   | no   | yes          | yes                   |
|            | 4. Saddipally       | 181             | 36                    | 18                             | 12                      | -                                             | yes                        | yes                           | no                                                               | yes                         | no                     | no   | no   | yes          | yes                   |
| 'C'        | 1. Bandlaravirala   | 2000            | 220                   | -                              | 15                      | no                                            | yes                        | yes                           | no                                                               | yes                         | yes                    | yes  | yes  | yes          | yes                   |
|            | 2. Chinnaravirala   | 400             | 80                    | 2                              | 17                      | -                                             | no                         | no                            | no                                                               | yes                         | no                     | no   | no   | yes          | yes                   |
|            | 3. Guvvalady        | 250             | 50                    | 3                              | 18                      | -                                             | no                         | no                            | no                                                               | yes                         | no                     | no   | no   | yes          | yes                   |
|            | 4. Kavadiipalli     | 1816            | 296                   | 6                              | 9                       | -                                             | yes                        | yes                           | no                                                               | yes                         | yes                    | yes  | no   | yes          | yes                   |
|            | 5. Kalijaguda       | 650             | 100                   | 8                              | 11                      | -                                             | yes                        | yes                           | no                                                               | yes                         | yes                    | no   | no   | yes          | yes                   |

Source: Mandal Census Hand Book, 1985, and

Andhra Pradesh Road Transport Corporation.

The table shows that out of the twelve study villages, four villages have a population less than ~~500~~, while five villages have a population of 600 - 1999, and three villages, have a population of 2000 - 4999. In terms of the location of the sub-centres (SC) vis-a-vis the primary health centre (PHC), sub-centre 'A' is three kilometres away from the PHC, and has three villages under its jurisdiction. SC 'B' is located six kilometres away from the PHC, and has four villages under its jurisdiction, and sub-centre 'C' is located fifteen kilometres away, and has five villages within its jurisdiction. Among all the sub-centres of the PHC, sub-centre 'C' is the most remote, and is situated near the border of Ranga Reddy, and Nalgonda districts.

As far as maintenance of sub-centres is concerned, only SC 'A' is being maintained, while in the case of SC 'B' and 'C' the Health Worker visits the sub-centre only once a week or sometimes once in two weeks to conduct antenatal clinics. The women Health Worker in-charge of SC 'B' lives near the primary health centre village, and covers a distance of eight kilometres (one way) from her place of residence, to the sub-centre. The Health Worker in-charge of SC 'C' lives in the city, and covers a distance of thirtythree kilometres (one way) from her place of stay to the sub-centre. This Health-Worker spends a considerable amount of time on travel thereby reducing the time spent in the village or at the sub-centre.



Th# reason why the Health Worker is maintaining the **headquarters** at SC 'A' may be because she has been recruited only three years **ago**, and this happens to be her first posting. Her husband is **unemployed**, and since she is herself **young**, and has no **children**, and other family responsibilities, she **is**, able to reside at the **SC headquarters**. In the case of the Health Worker of **SC 'B'**, she has put in twenty-three years of service, and is keen on seeking **reemployment** in the city itself in order spend more time with her family (her husband is a government employee currently working in the city, and her children attend college). Moreover this Health Worker really does not have anything to look forward to as she herself said once that there are no chances of any promotion, and that she has to retire as a Health Worker. Given her personal problems, the job of a Health Worker does not provide the necessary **motivation to** work. Similarly the Health Worker in-charge of SC 'C' has put in nine years of service. Because of her commitment towards her husband who works for the **state** police, and young children attending school she prefers to live in the city, and commute daily to **work**.

As far as transport facilities are concerned, only two villages under SC 'A', and three villages under SC 'C' have public transport system. However all villages in SC 'B' have public transport system.

**In** terms of availability of other government **medical** facilities (apart from sub-centre), none of the villages have any other government medical facilities, however, all villages have a minimum of two to three Registered Medical Practitioners (**RMPs**) who are either living in the village or visit the village once in two or three days. **These** visits depend on the number of villages they cover, and their popularity.

As far as educational facilities are concerned, eight out of the twelve villages, have government primary schools while four villages have secondary schools, and two villages have high schools. Other amenities available we should mention (i) power and protected drinking water supply (all the villages), (ii) pucca roads (nine villages), postal facilities (seven villages). However none of the twelve villages have any commercial banking or cooperative banking facilities.

## 6.2 **SOCIODEMOGRAPHIC PROFILE OF THE BENEFICIARY HOUSEHOLDS:**

The **sociodemographic** profile of the beneficiary households has been studied **in terms** of their religion; caste composition; type of family; household size; age and sex composition; educational qualifications; occupation; income; and their housing conditions. These are discussed in the sub-sections below:

#### 6.2.1 **Religious composition of the households:**

Majority of the households interviewed (**95.6%**) are **Hindus**, while **3.8%** of them are **Muslims**, and only **0.6%** are **Christians**.

#### (3.2.2. **Caste Composition:**

A sizeable proportion of the households (**56%**) belong to the 'Backward Castes' like Gouds, Gollas, **Padmasali**, including service castes like Barbers (**Mangali**), **Dhobis** (Chakali), **Blacksmiths**, Goldsmiths, Carpenters, (Vishwakarma Brahmins), etc. **28.5%** belong to the 'Scheduled Castes', who include **Malas** and Madigas, and **15.5%** belong to 'Other Castes' like Kapus, **Reddys**, **Kammas**, **Balijs**, including Muslims, and Christians. Thus the households covered in the three sub-centre areas predominantly belong to backward castes, and scheduled castes.

#### 6.2.3 **Type of family:**

In terms of the social grouping it was found that majority of the households (**58.9%**) belong to nuclear families which include husband, wife and their offsprings, while **30.8%** belong to extended families wherein members of a third generation such as spouses parents or members of the same generation such as spouse's brother or an additional wife reside. Only **10.3%** of the households belong to joint families where there are two or more nuclear families living together.

#### **6.2.4 Size of the households:**

Majority of the households (62.1%) have three to six members living in one household; while 31.4% have seven to ten members, and only 6.5% have more than ten members living in their households.

#### **6.2.5 Age and Sex composition of the households:**

Table 6.3 shows the distribution of the household members in terms of their age and sex.

Table 6.3:

**Distribution** of household **members in** terms of their age and sex,  
**N = 3035.**

| Sl.<br>No. | Age Group<br>(in Years) | Sex                   |                       | Total Number of<br>Males and Females |
|------------|-------------------------|-----------------------|-----------------------|--------------------------------------|
|            |                         | Males                 | Females               |                                      |
| (1)        | (2)                     | (3)                   | (4)                   | (5)                                  |
| 1.         | 2 Years and below       | 304(50.2)<br>(20.2)   | 301(49.8)<br>(19.7)   | 605(100.0)<br>(19.9)                 |
| 2.         | 2+ - 6                  | 200(48.5)<br>(13.3)   | 212(51.5)<br>(13.9)   | 412(100.0)<br>(13.6)                 |
| 3.         | 7 - 14                  | 264(51.0)<br>(17.5)   | 254(49.0)<br>(16.6)   | 518(100.0)<br>(17.1)                 |
| 4.         | 15 - 59                 | 711(49.3)<br>(47.1)   | 730(50.7)<br>(47.8)   | 1441(100.0)<br>(47.5)                |
| 5.         | 60 and above            | 29(49.2)<br>(1.9)     | 30(50.8)<br>(2.0)     | 59(100.0)<br>(1.9)                   |
| Total      |                         | 1508(49.7)<br>(100.0) | 1527(50.3)<br>(100.0) | 3035(100.0)<br>(100.0)               |

(Figures in brackets indicate **percentage**.)

The above table shows that the total number of males and females in each age group is more or less the same. We find that the working age group amongst the surveyed population (16 to 69 years age group) constitute **(47.5%)**. The number of dependents (above 60 and below 16 years) far out number them (62.6%). The dependency ratio in this case being **110.6\***.

$$\begin{aligned}
 & \text{Population under 15 years + population 60 years and above} \\
 * \text{ Dependency Ratio} &= \frac{\text{Population under 15 years + population 60 years and above}}{\text{Ratio population aged 15 - 59}} \times 100 \\
 &= \frac{1535}{1379} = 110.6
 \end{aligned}$$



6.2.6 Composition of members by Marital Status:

Table 6.4 shows the distribution of household members in terms of their marital status.

Table 6.4:

Distribution of household members by Marital Status,

N = 3036

| Sl. No. |                       |  | Marital Status |  | Total           |
|---------|-----------------------|--|----------------|--|-----------------|
| (1)     | (2)                   |  |                |  | (3)             |
| 1.      | Married               |  |                |  | 1233<br>(40.6)  |
| 2.      | Unmarried             |  |                |  | 1688<br>(55.6)  |
| 3.      | Widowed               |  |                |  | 110<br>(3.6)    |
| 4.      | Divorced or Separated |  |                |  | 4<br>(0.1)      |
| Total   |                       |  |                |  | 3035<br>(100.0) |

(Figures in brackets indicate percentage.)

The above table shows the marital status of the surveyed population. The target group for family planning activities is drawn from the married population.

#### 6.2.7 Literacy by educational levels:

**Education** is one important variable which determines the utilization of existing health services. However the number of persons having some formal education is depressingly low as can be seen from the table. Table 6.6 shows the distribution of household members according to their level of education.

**Table 6.6:**

Distribution of household members by Level of **Education**,

**N** = 2430

| Sl. No.      | Level of Education                      | Male                  | Female                | Total                  |
|--------------|-----------------------------------------|-----------------------|-----------------------|------------------------|
| 1.           | Illiterate                              | 691(41.2)<br>(57.4)   | 988(58.8)<br>(80.6)   | 1679(100.0)<br>(69.1)  |
| 2.           | Balwadi                                 | 19(41.0)<br>(0.7)     | 13(69.0)<br>(1.1)     | 22(100.0)<br>(0.9)     |
| 3.           | Primary School<br>(Class 1 to IV)       | 329(64.6)<br>(27.3)   | 181(36.6)<br>(14.8)   | 610(100.0)<br>(21.0)   |
| 4.           | Secondary School<br>(Class V to VII)    | 83(72.8)<br>(6.9)     | 31(27.2)<br>(2.6)     | 114(100.0)<br>(4.7)    |
| 6.           | Matric/High School<br>(Class VIII to X) | 66(84.6)<br>(6.6)     | 12(16.4)<br>(1.0)     | 78(100.0)<br>(3.2)     |
| 6.           | Intermediate<br>(Class XI & XII)        | 19(100.0)<br>(1.6)    | -                     | 19(100.0)<br>(0.8)     |
| 7.           | Degree/Diploma                          | 7(87.6)<br>(0.6)      | 1(12.6)<br>(0.1)      | 8(100.0)<br>(0.3)      |
| <b>Total</b> |                                         | 1204(49.6)<br>(100.0) | 1226(60.6)<br>(100.0) | 2430(100.0)<br>(100.0) |

(Figures in brackets indicate **percentage**.)

Table 6.6 shows that majority of the household members

(69.1%) are **illiterate**. A higher percentage of women are illiterate. It is **interesting** to note that while the lower educational levels beginning with illiteracy, and balwadi amongst whom the female population predominates, every successive level of education **beginning with** the primary school shows a successive increase in the percentage of men, and decrease in the percentage of women.

Table 6.6:

Age and Sex wise distribution of household members by Level of Education, **N** = 2430

| Sl. No.      | Level of Education                             | Age and Sex      |           |                  |                 |                  |                 |              |                |                    |                    |
|--------------|------------------------------------------------|------------------|-----------|------------------|-----------------|------------------|-----------------|--------------|----------------|--------------------|--------------------|
|              |                                                | 2+ - 6 years     |           | 7 - 14 years     |                 | 15 - 59 years    |                 | 60 and above |                | Total              |                    |
|              |                                                | Male             | female    | Male             | female          | Male             | female          | Male         | females        | Male               | Females            |
| (1)          | (2)                                            | (3)              | (4)       | (5)              | (6)             | (7)              | (8)             | (9)          | (10)           | (11)               | (12)               |
| 1.           | <b>Illiterate</b>                              | <b>135(19.5)</b> | 162(16.4) | 70(10.1)         | 112(11.3)       | 456(66.3)        | 664(69.2)       | 26(4.1)      | 30(3.0)        | 691(100.0)         | 966(100.0)         |
| 2.           | <b>Balwadi</b>                                 | 9(100.0)         | 9(69.2)   | -                | <b>4(30.8)</b>  | -                | -               | -            | -              | 9(100.0)           | <b>13(100.0)</b>   |
| 3.           | Primary School<br>(class 1 to IV)              | <b>56(17.0)</b>  | 41(22.7)  | 163(50.0)        | 120(66.3)       | 109(33.1)        | 20(11.0)        | 1(0.3)       | -              | 329(100.0)         | 181(100.0)         |
| 4.           | Secondary School<br>(Class V to HI)            | -                | -         | 29(35.0)         | <b>17(54.8)</b> | 54(65.1)         | 14(45.2)        | -            | -              | 63(100.0)          | 31(100.0)          |
| 5.           | <b>Matric/High School</b><br>(Class VIII to X) | -                | -         | 2(3.0)           | 1(8.3)          | 64(97.0)         | 11(91.7)        | -            | -              | 66(100.0)          | <b>12(100.0)</b>   |
| 6.           | <b>Intermediate</b><br>(Class XI & HI)         | -                | -         | -                | -               | <b>19(100.0)</b> | -               | -            | -              | 19(100.0)          | -                  |
| 7.           | <b>Degree/Diploma</b>                          | -                | -         | -                | -               | <b>7(100.0)</b>  | <b>1(100.0)</b> | -            | -              | <b>7(100.0)</b>    | 1(100.0)           |
| <b>Total</b> |                                                | 200(16.6)        | 212(17.3) | <b>254(21.9)</b> | 254(20.7)       | 711(59.1)        | 730(59.5)       | 29(2.4)      | <b>30(2.5)</b> | <b>1204(100.0)</b> | <b>1223(100.0)</b> |

(Figures in brackets indicate percentage.)

The table compares male, female literacy level **in** term\* of age. From the table it is obvious that while there has been a preference for male literacy; as far as the older generations are concerned, illiteracy was the norm about a generation ago. The 15-59 age group is nearly 59% literate as compared to above 60 age group. More than 50% of those educated upto primary school belong to 7-14 years age group. This is an indicator of the changing attitude towards education of children.

**1f** we look at the educational level of the heads of households, it can be seen that 80% of them are illiterate, and 11% had their primary school education, b% had their secondary school education, while 4% passed high school. Only 1%, and 0.4% passed intermediate, and bachelor's degree.

### 6.2.8 Occupation of the households:

Table 6.7:

Distribution of households according to their predominant Occupation, **N** = 477

| Sl. No. | Occupation                   | Sub-centre           |                             |                      | Total                       |
|---------|------------------------------|----------------------|-----------------------------|----------------------|-----------------------------|
|         |                              | 'A'                  | 'B'                         | 'C'                  |                             |
| (1)     | (2)                          | (3)                  | (4)                         | (5)                  | (6)                         |
| 1.      | Agriculture                  | 4(12.9)<br>(2.6)     | 7(22.6)<br>(4.5)            | 20(64.5)<br>(11.7)   | 31(100.0)<br>(6.5)          |
| 2.      | Agriculture labour           | 56(31.5)<br>(37.1)   | 62(34.8)<br>(40.0)          | 60(33.7)<br>(35.1)   | <b>178(100.0)</b><br>(37.3) |
| 3.      | Business                     | 16(24.6)<br>(10.6)   | 26(40.0)<br>(16.8)          | 23(35.4)<br>(13.5)   | 65(100.0)<br>(13.6)         |
| 4.      | Government Service           | 13(65.0)<br>(8.6)    | 1(5.0)<br>(0.6)             | 6(30.0)<br>(3.5)     | 20(100.0)<br>(4.2)          |
| 5.      | Urban skilled occupation     | 13(52.0)<br>(8.6)    | 11(44.0)<br>(7.1)           | 1(4.0)<br>(0.6)      | 25(100.0)<br>(5.2)          |
| 6.      | Urban unskilled occupation   | 13(36.1)<br>(8.6)    | 5(13.9)<br>(3.2)            | 18(50.0)<br>(10.5)   | 36(100.0)<br>(7.5)          |
| Y.      | Traditional caste occupation | 36(29.5)<br>(23.8)   | 43(35.2)<br>(27.7)          | 43(35.2)<br>(25.1)   | 122(100.0)<br>(25.6)        |
| Total   |                              | 161(31.7)<br>(100.0) | <b>155(32.5)</b><br>(100.0) | 171(35.8)<br>(100.0) | 477(100.0)<br>(100.0)       |

(Figures in brackets indicate percentage).

The above table shows the predominant occupation of the

households. **Irrespective** of the sub-centres, it is found that **37.3%** of the households depend on agriculture labour for their livelihood; followed by **25.6%** who depend on traditional caste occupations like, barbers, **dhobis**, weavers, carpenters, blacksmiths, artists, toddy tapping, and **potmaking**. About 13.6% of the households are engaged in business such as poultry, dairy, groceries, vegetable vending, and clothiers, while **7.5%** are engaged as dailywage labourers in stone quarries (urban unskilled occupation). About **5.2%** of the households are engaged as lorrydrivers, autodrivers, mechanics, masons and electricians (urban skilled occupation),. Only 4.2% depend on government jobs.

**If** we look at each of the occupations sub-centre wise, it can be seen that majority of those engaged in agriculture belong to sub-centre '**C**' followed by sub-centre '**B**' and '**A**'. This is because sub-centre '**C**' is far away from the city, and is located in the interior where people mostly live on agriculture, and work as agricultural labourers or engage in traditional occupations supporting the agricultural economy. Similarly greater number of households in sub-centre '**B**' and '**C**' are engaged in business than in sub-centre '**A**'. This is because sub-centre '**A**' is closer to the city, and is located on the national highway number 9, as against sub-centre '**B**' and '**C**'. As compared to sub-centres '**B**' and '**C**' majority of those working in government service belong to sub-centre '**A**'. Once again this could be because of its location, and easy



accessibility to the city. When one looks at **those** engaged **in** urban unskilled occupation, **50%** of them belong to sub-centre 'C'. This is because of the stone quarries located around these villages. As far as households engaged in agriculture labour, and traditional caste occupations is concerned, they are more or less evenly distributed in all the three sub-centres.

Though the above table shows the predominant occupations of the **households**, it has been **found** that no household really depends entirely on one **occupation**. but rather on a combination of occupations in order to make ends meet. For example, if the husband or head of the household is engaged in business, or agriculture, the wife or other members work as agricultural labourers, For instance in households where the predominant occupation is agriculture labour, they still depend, to some extent, on agriculture as most of them hold some extent of land ranging from half an acre to three acres.

### 6.2.9 Income distribution of the households:

Table 6.6:

Distribution of respondents by **Income**, N = 477

| Sl. No. | Income (per month) in Rs.                     | Sub-centre           |                      |                      | Total                 |
|---------|-----------------------------------------------|----------------------|----------------------|----------------------|-----------------------|
|         |                                               | 'A'                  | 'B'                  | 'C'                  |                       |
| (1)     | (2)                                           | (3)                  | (4)                  | (5)                  | (6)                   |
| 1.      | < 500<br>(lower economic group)               | 18(17.6)<br>(.11.9)  | 41(40.2)<br>(26.5)   | 43(42.2)<br>(25.1)   | 102(100.0)<br>(21.4)  |
| 2.      | 500 - 999<br>(lower middle economic group)    | 99(36.8)<br>(65.6)   | 80(29.7)<br>(51.6)   | 90(33.5)<br>(52.6)   | 269(100.0)<br>(56.4)  |
| 3.      | 1000 - 1499<br>(middle economic group)        | 22(26.5)<br>(14.6)   | 31(37.3)<br>(20.0)   | 30(36.1)<br>(17.5)   | 83(100.0)<br>(17.4)   |
| 4.      | 1500 - 1999<br>(higher middle economic group) | 7(70.0)<br>(4.6)     | 1(10.0)<br>(0.6)     | 2(20.0)<br>(1.2)     | 10(100.0)<br>(2.1)    |
| 5.      | 2000 and above<br>(higher economic group)     | 5(38.5)<br>(3.3)     | 2(15.4)<br>(1.3)     | 6(46.1)<br>(3.5)     | 13(100.0)<br>(2.7)    |
| <hr/>   |                                               |                      |                      |                      |                       |
|         | Total                                         | 151(31.7)<br>(100.0) | 155(32.5)<br>(100.0) | 171(35.8)<br>(100.0) | 477(100.0)<br>(100.0) |

(Figures in brackets indicate percentage.)

Irrespective of the distribution of households sub-centrewise, a sizeable proportion of them (56.4%) in the study earn a total income of **Rs.500** to 999 per month (lower middle economic group), followed by 21.4% who earn less than Rs.500 per month, and can be termed as economically backward. About 17.4% of the households earn **Rs.1000** to 1499 per month



(middle economic group,) and 2.1% earn **Rs.1500** to 1999 per month and can be termed as those belonging to the higher middle economic group. Only **2.7%** of the households belong to the higher economic group earning **Rs.2000** and above per **month**.

The economic class structure of the three sub-centres varies to some **extent**, while the lowest income group seems to be smaller in sub-centre 'A'. **It is** of equal importance in sub-centres 'B' and 'C' this is however to some extent **compensated** by the higher presence of next income group (lower middle) where the percentage of this group is considerably higher in 'A', compared to sub-centres 'B' and 'C'. The higher middle, and higher economic groups are also more in sub-centre 'A' as compared to B and 'C'. From our own personal observation supported by earlier data we can say that the higher economic households consists of agriculturists found particularly in sub-centre 'C', and government servants found particularly in sub-centre 'A'. Subcentre 'B' on the whole shows lower presence of upper income households as it is neither easily accessible to the city nor does it have a larger number of better off agriculturists. **The** accessibility of sub-centre 'A' to the city seems to have given an added advantage to the households in sub-centre 'A'.

#### 6.2.10 **Housing Conditions:**

The housing conditions of the households have been studied in terms of the type of houses they live **in**, number of **rooms**, and civic **amenities**, which **include**, source of lighting, source of drinking **water**, and availability of latrine facilities.

For the purpose of the study the classification of houses have been based on the materials used for construction. Three types of houses have been **identified** - pucca, semipucca, and kutcha. Pucca houses are those built with materials such as granite, bricks, cement, wood, and tiles; while semipucca houses are those built with, a combination of materials such as granite, bricks, mud, and with thatched roofs; and kutcha houses are those built with mud, and thatched roofs. Table 6.9 shows the distribution of respondents according to the type of housing, and number of rooms.

Table \*.9:

Distribution of respondents according to type of **housing**, and number of rooms, **N** = 47Y

| Sl. No. | Sub-centre | Type of housing |                  |                 | Total             | Number of rooms  |                 |                 | Total             |
|---------|------------|-----------------|------------------|-----------------|-------------------|------------------|-----------------|-----------------|-------------------|
|         |            | Pucca           | Semipucca        | Kutcha          |                   | 1 - 2            | 3 - 4           | More 4          |                   |
| (1)     | (2)        | (3)             | (4)              | (5)             | (6)               | (7)              | (8)             | (9)             | (10)              |
| 1.      | 'A'        | 44(29.1)        | 91(8*.3)         | <b>16(10.6)</b> | 151(1**.*)        | 86(57.*)         | 42(27.8)        | 23(15.2)        | <b>151(100.0)</b> |
| 2.      | 'B'        | 19(12.3)        | <b>107(69.0)</b> | 29(18.7)        | 155(1**.*)        | 77(49.7)         | 43(27.7)        | <b>35(22.6)</b> | 155(1**.*)        |
| 3.      | 'C'        | 22(12.9)        | 117(68.4)        | 32(18.7)        | 171(1**.*)        | 9*(52.6)         | <b>37(21.6)</b> | 44(25.7)        | 171(1**.*)        |
| Total   |            | 85(17.8)        | <b>315(66.0)</b> | 77(18.1)        | <b>477(100.0)</b> | <b>253(53.0)</b> | 122(25.8)       | 1*2(21.4)       | <b>477(100.0)</b> |

(Figures in brackets indicate percentage.)

The table shows that majority of the households (66%) live in **semi-pucca** houses, while 16.1% live in kutcha houses, and only 17.8% live in pucca houses. In terms of the **number** of rooms in a household, **53%** live in houses with one or two rooms, while **25.6%** live in houses consisting of three or **four** rooms, and 21.4% live in houses which have more than **four rooms**. Table **6.10** shows the distribution of households according to their income, and type of housing, and number of **rooms**.

Table 8.10:

Distribution of respondents according to income, type of housing and number of rooms, **N = 477**.

| Sl. No. | Income<br>Rs. | Type of housing |           |          | Total      | Number of rooms |           |           | Total      |
|---------|---------------|-----------------|-----------|----------|------------|-----------------|-----------|-----------|------------|
|         |               | Pucca           | Semipucca | Kutcha   |            | 1-2             | 3-4       | Above 4   |            |
| (1)     | (2)           | (3)             | (4)       | (5)      | (6)        | (7)             | (8)       | (9)       | (10)       |
| 1.      | < 500         | 20(19.6)        | 28(27.5)  | 54(52.9) | 102(100.0) | 92(90.2)        | 1#(9.8)   | -         | 102(100.0) |
| 2.      | 500 - 999     | 37(13.8)        | 211(78.4) | 21(7.8)  | 269(100.0) | 138(51.3)       | 84(31.2)  | 47(17.5)  | 269(100.0) |
| 3.      | 1000 - 1499   | 19(22.9)        | 62(74.7)  | 2(2.4)   | 83(100.0)  | 19(22.9)        | 24(28.9)  | 40(48.2)  | 83(100.0)  |
| 4.      | 1500 - 1999   | 5(50.0)         | 5(50.0)   | -        | 10(100.0)  | 3(30.0)         | 1(10.0)   | 6(60.0)   | 10(100.0)  |
| 5.      | 2000 & above  | 4(30.8)         | 9(69.2)   | -        | 13(100.0)  | 1(16.7)         | 3(23.1)   | 9(69.2)   | 13(100.0)  |
| Total   |               | 85(17.8)        | 315(66.0) | 77(16.1) | 477(100.0) | 253(53.0)       | 122(25.6) | 102(21.4) | 477(100.0) |

(Figures in brackets indicate percentage.)

If one looks at the distribution of households **in terms** of their income, and type of housing, it is found that majority of the economically backward households **(52.9%)** live in kutcha houses, while **27.5%** live in **semi-pucca** houses, and 19.6% live in pucca houses. The pucca houses are constructed by the government for the economically weaker sections of the population. Majority of the lower middle, and middle economic groups (78.4% and **74.7%**) live in **semipucca** houses, while only 7.8% and 2.4% live in kutcha houses. Those living in

puooa **houses** comprise **13.8%** and **22.9%**. All those belonging to the higher **middle**, and higher economic groups, live only in **semipucca** and pucca houses.

As far as income, and number of rooms in a household is concerned, it was found that higher percentage of the economically backward and lower middle income households live in houses with one or two rooms, while a higher percentage of middle, higher middle, and higher income households live in houses with bigger **accomodation** (houses having more than four **rooms**).

As far as civic amenities are concerned, 61.4% have electricity in their houses, while 38.6% use kerosene lamps to light their homes. As far as drinking water supply is concerned, all villages have borewells, some of which, are connected to an overhead tank from where safe drinking water is supplied to the households. **It** was found that 99.2% use only this water source, while 0.6% use water from surface wells. **This** is only in the smaller settlements which have only one or two borewells for the entire village. Water from open dug wells is used only when the borewells are not in working condition. With regard to availability of sanitary latrine facility, it was found that only 23% of the households have latrine facility in their houses, while majority (YY%) do not have this facility. There are open drains flowing on either side of the roads in practically all the villages leading to highly unsanitary living conditions. The

problem **is** that waste from all houses is let out **on** the road thereby creating these drains. In some villages these drains pass by the borewells thereby increasing chances of contamination of the water source. Table below shows the distribution of households according to type of housing and civic amenities.

Table 6.11:

Distribution of respondents **by** type of housing, and civic amenities, **N** =477.

| Sl. No.       | Type of housing | Source of <b>Lighting</b> |           | Total      | Latrine facility |               | Total      |
|---------------|-----------------|---------------------------|-----------|------------|------------------|---------------|------------|
|               |                 | <b>Electricity</b>        | Kerosene  |            | Available        | Not Available |            |
| (1)           | (2)             | (3)                       | (4)       | (5)        | (6)              | (7)           | (8)        |
| 1. Pucca      |                 | 51(60.0)                  | 34(40.0)  | 85(100.0)  | 39(45.9)         | 46(54.1)      | 85(100.0)  |
| 2. Semi Pucca |                 | 236(74.9)                 | 79(25.1)  | 315(100.0) | 70(22.2)         | 245(77.8)     | 315(100.0) |
| 3. Kutchha    |                 | 6(7.8)                    | 71(92.2)  | 77(100.0)  | -                | 77(100.0)     | 77(100.0)  |
| Total         |                 | 293(61.4)                 | 184(38.6) | 477(100.0) | 109(22.9)        | 368(77.1)     | 477(100.0) |

(Figures in brackets indicate **percentage**.)

The above table shows that 60% of pucca houses, and 74.9% of the **semipucca** houses have electricity. Only 7.8% of the kutchha houses have **electricity**, as majority (92.2%)



use only kerosene lamps to light their homes. As far as sanitary latrine facility is concerned, none of the kutcha houses: 77.8% of semipucca houses, and 54.1% of the pucca houses possess any latrine facility. Less than 50% pucca houses, and 22.2% semipucca houses have latrine facility. This fact highlights the need for proper sanitation facilities, combined with health education for the villagers.

In the chapter an attempt has been made to study the location of villages vis-a-vis the sub-centres and the PHC, size of settlements, availability of amenities in the mandal, and the social background of the households under study.

Two of the sub-centres ('A' and 'B') are more accessible (geographically) to the beneficiaries as compared to SC 'C' because of better public transport facility. In some cases the PHC is more accessible as compared to the S(s (the SCs are not properly located). The SCs are also not functionally accessible as two of the Workers do not reside there, and necessary medicines and vaccines are not available at all times. Apart from the SCs no other government health facility is available in these villages. However, there is no dearth of PMPs and RMPs on whom the people depend for treatment of minor ailments.

The social background of the beneficiaries shows that majority of them belong to the 'backward castes' and 'schedule castes' who are not very literate. Most of them work as agriculture labour, and depend on their traditional caste occupations and agriculture. Majority of them earn less than Rs.1000/- per month, and their housing conditions especially in terms of sanitation is extremely poor.

## CHAPTER VII

### OUTREACH AND UTILIZATION OF PRIMARY HEALTH CARE SERVICES AS PERCEIVED BY THE BENEFICIARIES.

Seeking help is one of the strategies, people resort to when faced with crisis, and illness, is no exception. Illness is differently perceived among different cultures, and that determines most of the **behaviour** or action taken for treatment. We should first differentiate between illness behaviour, and health behaviour. Illness behaviour is any activity, undertaken by a person who falls ill, it also includes his definition of his state of health, and finally his discovery of a suitable remedy. Health behaviour on the other hand is any activity undertaken by a person believing **himself/herself** to be healthy; his/her behaviour oriented towards preventing disease or detecting it at symptomatic stage.

The likelihood that an individual will engage in a particular kind of health behaviour is basically a function of two variables - (i) the perceived amount of threat, and (ii) the attractiveness or value of the behaviour. The amount of threat depends on (a) the importance of health matters to the individual, (b) the perceived susceptibility to the disease in question; (c) the perceived seriousness of the consequences of the contemplated action which **in turn** depends on the perceived probability that the action will lead to the desired preventive, and ameliorative results, and the unpleasantness or "cost" of taking the action compared



with taking no action, and suffering the consequences (**kasl** and cobb, **1968:246-66, 531-41**).

Mechanic (**1978**) has worked out a general theory of help seeking behaviour by identifying ten variables affecting the response to illness

- ( i) visibility and recognizability of signs and symptoms;
- ( ii) the extent to which the symptoms are perceived as **serious**;
- (iii) the extent to which symptoms disrupt family, work, and other social activities;
- ( iv) the frequency of the appearance of the signs and symptoms, their persistence or their frequency of recurrence;
- ( v) the tolerance threshold of those who are exposed to signs and symptoms;
- ( vi) available information, knowledge, and cultural assumptions;
- (vii) basic needs that lead to denial;
- (viii) competing possible interpretations that can be assigned to the symptoms once they are recognized;
- ( ix) needs competing with illness responses;
- ( %) availability of treatment sources, physical proximity, and psychological, and monetary costs of taking action. The use of help, and the choice among possible alternative facilities depends on the relative accessibility of the facilities to the person. The greater the barriers to a particular facility, the more likely is that some other source of help will be chosen or some

competing definition of the situation will be **applied**. Barriers to care include, economic costs, time, effort, and **convenience**. Factors such as the necessary distance to **travel**, periods of day in which services are **provided**, and acceptability of the facilities from which such services are distributed affect receptivity to them (**Mechanic, 1978: 249 - 286**).

Health services are broadly divided into curative, preventive, and **promotive** services, and the use of preventive services is regarded as an indicator of the level of sophistication at which the public, and health services interact in order to prevent, cure and palliate disability.

**The** acceptance or rejection of any health measure depends on the interplay of the beneficiaries; the providers who are the agents or instruments, and other social factors. **The** beneficiaries must first, and foremost recognize the seriousness of the **problem**, and should be predisposed to take action. **He/She** should have the knowledge, and belief in the desired action, and feel that his/her social group approves of the desired action. **He/She** must define the desired act as expected, and appropriate for fulfilling his/her role obligation. Also the desired act must produce the desired result, and must be convenient, and accessible without too much **of** effort, and must fit into the individual's regular routine as much as possible, and the beneficiaries must have some posi-

tive previous experiences with the desired action or measure  
(Suchman E.A, 1967 : 197-209).

Thus the acceptance of a particular health measure depends on a constant interplay of three factors, namely, the **beneficiaries**, **providers**, and social or environmental factors.

Whenever beneficiaries or clients approach a Health Worker they come with an image of the Health Worker's role, and the way it should be performed. This image reflects the societal definition of the Health Workers **role**, and expectations as well as conceptions formed by the beneficiaries from prior experience or from hearing about experiences of other **people**. It is in this frame of reference that the beneficiaries attempt to evaluate the Health Workers performance. The extent to which the Health Worker can meet these expectations, may play an important part in the beneficiaries conformity to his/her treatment, and likelihood of return visits. The providers and beneficiaries operate within different assumptive worlds, and frequently lack awareness of the extent to which their assumptions are different. The success of this relationship is mainly based on the extent the two share common frames of reference.

The sub-centre or **PHC** is a place where integrated health care services such as **curative**, **preventive**, and **promotive** are provided to the beneficiaries, and serves as a **focal**

point from which health services radiate into the area covered by the sub-centre or **PHC**. This objective is achieved by **providing** the following services - **(i)** treatment of minor ailments; **(ii)** maternal and child health **care**; **(iii)** family **planning**; **(iv)** control of communicable **diseases**; **(v)** school health; **(vi)** health **education**; and **(vii)** environmental **sanitation**, with the help of one resident **Multipurpose** Health Worker (**male** and **female**) for each sub-centre **area**.

In this chapter, we are primarily concerned with the perceptions of the beneficiaries regarding the outreach, and utilization of the health centre services. Outreach is demonstrated by the services being taken to the doorstep of the beneficiaries. The services supposed to be provided by the health centre under this category include the following - **(i)** antenatal care, **(ii)** **deliveries**, **(iii)** postnatal care **(iv)** post operative care **for** persons who have undergone family planning operations, and **(v)** detection of malaria cases.

By utilization we mean the extent to which the general population is availing the various services being provided by the health centre headquarters or **PHC**. The services provided by the health centre under this category include - **(i)** treatment of minor **ailments**. **(ii)** antenatal **care**. **(iii)** deliveries, **(iv)** immunization of children, **(v)** family **planning** operations, and **(vi)** **treatment** of communicable diseases like

**malaria, and tuberculosis.**

Before discussing the outreach **and** utilization of the Primary health care services, let us first discuss the frequency of visits to villages by the health personnel.

**Y . 1 FREQUENCY OF VISITS BY HEALTH PERSONNEL:**

As **most** of the **PHC** personnel do not reside in the villages, let us take a look at the perceptions of the beneficiaries regarding frequency of visits to villages by the various health personnel. The health personnel include, the Medical Officers, the **Extension Educator**, Multipurpose Health Supervisors (men and women), and Multipurpose Health Workers (**men and women**).

The respondents were asked, 'How often the above personnel visit the villages?'

Table 7.1:

Distribution of respondents by frequency of visits by health personnel, N=447

| Sl. No. | Category of health personnel | Frequency of visits |                   |              |                    |           | Stays in tillage | Total    |
|---------|------------------------------|---------------------|-------------------|--------------|--------------------|-----------|------------------|----------|
|         |                              | once a week         | once in two weeks | once a month | once in two months | Rarely    |                  |          |
| (1)     | (2)                          | (3)                 | (4)               | (5)          | (6)                | (7)       | (8)              | (9)      |
| 1.      | Medical Officers             | -                   | -                 | -            | -                  | 439(92.0) | 38(8.0)          | -        |
| 2.      | Extension Educator           | -                   | -                 | -            | -                  | -         | 477(100.0)       | -        |
| 3.      | Health Supervisors (me*)     | -                   | 9(1.9)            | 197(41.3)    | 140(29.4)          | 95(19.9)  | 36(7.5)          | -        |
| 4.      | Health Supervisors (women)   | -                   | 34(7.1)           | 300(62.9)    | 53(11.1)           | 7#(14.7)  | 20(4.2)          | -        |
| 5.      | Health Workers (me*)         | 2(0.4)              | 39(8.2)           | 150(31.4)    | 96(20.1)           | 170(35.6) | 20(4.2)          | -        |
| 6.      | Health Workers (women)       | 18(3.8)             | 175(36.7)         | 134(28.1)    | 23(4.8)            | 34(7.1)   | 3(0.6)           | 90(18.9) |

(Figures in brackets indicate percentages)

The Medical Officers are supposed to visit each sub-centre area at least once a fortnight on a fixed day not only to check the work of the staff, but also to provide curative services. The Extension Educator is supposed to supervise the work of field workers in the area of education, and motivation, and is supposed to be on tour for twenty four days in a month with a minimum of one night halt in every field worker area.



Although the Medical Officers, and **Extension** Educator have said that they visit all the villagers **in** their jurisdiction once a **month**, the responses do not substantiate what they **say**.

The Multipurpose Health Supervisors (**men** and **women**) are supposed to visit each sub-centre at least once a week on a **fixed** day to **observe**, and guide Health Workers in their day to day activities, and carry out supervisory homevisits in the area of the Health Workers. However, according to the respondents, the Supervisors visits are roughly once a month. There is a certain association between the perceived visits, and distance from sub-centres (table 7.2 and Y.3)

Table 7.2:

Distribution of respondents by distance between ~~sub-centre, and other~~ villages, and frequency of visits by Health Supervisors (women), ~~N~~ = 447

|         |                                   | Frequency of visits |                       |                               |          |         |                        |
|---------|-----------------------------------|---------------------|-----------------------|-------------------------------|----------|---------|------------------------|
| Sl. No. | Distance from Sub-centre (in kms) | once in two weeks   | once a month          | <del>once</del> in two months | Barely   | No idea | Total                  |
| (1)     | (2)                               | (3)                 | (4)                   | (6)                           | (6)      | (7)     | (8)                    |
| 1.      | Sub-centre village                | 31(13.2)            | <del>179</del> (76.5) | 11(4.7)                       | -        | 13(5.6) | <del>234</del> (100.0) |
| 2.      | 2 - 4                             | -                   | 68(54.7)              | 8(7.5)                        | 36(34.0) | 4(3.8)  | 106(100.0)             |
| 3.      | 6 - 7                             | 3(3.0)              | 63(63.0)              | 27(27.0)                      | 6(6.0)   | 1(1.0)  | 100(120.0)             |
| 4.      | 8 kms and above                   | -                   | -                     | 7(18.9)                       | 28(76.7) | 2(5.4)  | <del>37</del> (100.0)  |
| Total   |                                   | 34(7.1)             | 300(62.9)             | 63(11.1)                      | 70(14.7) | 20(4.2) | 477(100.0)             |

(Figures in brackets indicate percentages)



Table 7.3:

**Distribution** of respondents by distance between **sub-centre**, and other **villages**, and frequency of visits by Health Supervisors (men), **N** = 447

|         |                                   | Frequency of visits |              |                    |          |         |            |
|---------|-----------------------------------|---------------------|--------------|--------------------|----------|---------|------------|
| Sl. No. | Distance from Sub-centre (in kms) | once in two weeks   | once a month | once in two months | Rarely   | No idea | Total      |
| [1]     | (2)                               | (3)                 | (4)          | (6)                | (6)      | (7)     | (8)        |
| 1.      | Sub-centre village                | 9(3.9)              | 116(49.6)    | 77(32.9)           | 12(6.1)  | 20(8.6) | 234(100.0) |
| 2.      | 2 - 4                             | -                   | 40(37.7)     | 26(23.6)           | 36(34.0) | 5(4.7)  | 106(100.0) |
| 3.      | 5 - 7                             | -                   | 41(41.0)     | 38(38.0)           | 16(16.0) | 5(5.0)  | 100(100.0) |
| 4.      | 8 kms and above                   | -                   | -            | -                  | 31(83.8) | 6(16.2) | 37(100.0)  |
| Total   |                                   | 9(1.9)              | 197(41.3)    | 140(29.4)          | 95(19.9) | 36(7.6) | 417(100.0) |

Figures in brackets indicate percentages)

When we compare the tables 7.2 and 7.3 it can be seen that the performance of women Supervisors - as seen in their village visits-is far better as compared to the men Supervisors. The respondents mentioned bi-monthly visits of the two categories of the Supervisors as follows (11.1% for women, and 29.4% for men Supervisors). As one would expect the distance from the sub-centre is a negative factor for the Supervisors involvement in the field work. This is born out in both the tables given above. However, the Supervisors visit to villages 2-4 kms. away from the sub-centre are lower in frequency as compared to the village located 6-7 kms away.

**The** reason for this is that most of the villages located % to 4 **kms** away do not have public transport system.

**If** we look at the responses of the households with regard to availability of **transport** facility, all respondents living in villages without transport facility have said that Supervisors visit them rarely. According to them, the Supervisors come only during immunization camps, or to motivate cases for family planning. Supervision by the Health Supervisors is not as per given norms.

**The** Multipurpose Health Workers (men and women) are posted at sub-centres, and have to **cover** a population of 5,000. They are supposed to reside in the sub-centre village, and visit villages within its jurisdiction at least once a week (see chapter **II**). Among the three sub-centres covered for this study, only at sub-centre 'A' does the Health Worker (women) reside, while at sub-centre '**B**' and '**C**' no one resides. None of the Health Workers (men) reside in the sub-centre villages. **It** was found that workers mostly visit villages once in two weeks or bi-monthly. Once again we find an association between the perceived visits, and distance from sub-centres just as in the case of the Supervisors (table 7.4 and 7.5).

Table 7.4:

Distribution of respondents by distance between **sub-centre**, and other villages, and frequency of visits by Health Workers (women), **N** = 447

| Sl. No.       | Distance from Sub-centre (in kms) | Frequency of visits |                   |              |                    |          | Stays in village | Total               |
|---------------|-----------------------------------|---------------------|-------------------|--------------|--------------------|----------|------------------|---------------------|
|               |                                   | once a week         | once in two weeks | once a month | once in two months | Rarely   |                  |                     |
| (1)           | (2)                               | (3)                 | (4)               | (5)          | (#)                | (7)      | (#)              | (10)                |
| 1. Sub-centre |                                   |                     |                   |              |                    |          |                  |                     |
|               | Tillage                           | -                   | 144(61.5)         | -            | 4-                 | -        | -                | 90(38.5) 234(100.0) |
| 2.            | 2 - 4                             | -                   | 2(1.*)            | ##(#4.2)     | 1#(*.4)            | 23(21.7) | 3(2.8)           | - 106(100.0)        |
| 3.            | & - 7                             | 18(18.0)            | 29(29.0)          | 53(53.0)     | -                  | -        | -                | 100(100.0)          |
| 4.            | 8 kms and above                   | -                   | -                 | 13(35.1)     | 13(35.1)           | 11(29.7) | -                | - 37(100.0)         |
|               | Total                             | 18(3.8)             | 175(36.7)         | 134(28.1)    | 23(4.1)            | 34(7.1)  | 3(0.6)           | 90(18.9) 477(100.0) |

(Figures in brackets indicate percentages)

Table 7.5:

Distribution of **respondents** by **distance** between **sub-centre**, and other villages, and frequency of visits by Health Workers (men), **N** = 44'

| Sl. #0.       | Distance from Sub-centre (in kms) | Frequency of visits |                   |              |                    |                | Total   |            |
|---------------|-----------------------------------|---------------------|-------------------|--------------|--------------------|----------------|---------|------------|
|               |                                   | once a week         | once in two meets | once a month | once in two months | Barely No idea |         |            |
| (1)           | (2)                               | (3)                 | (4)               | (5)          | (6)                | (7)            | (8)     | (*)        |
| 1. Sub-centre |                                   |                     |                   |              |                    |                |         |            |
|               | Tillage                           | 2(0.9)              | 27(11.5)          | 78(33.3)     | 44(18.8)           | 68(29.1)       | 15(6.4) | 234(100.0) |
| 2.            | 2 - 4                             | -                   | 4(3.8)            | 41(38.7)     | 20(18.9)           | 39(36.8)       | 2(1.9)  | 106(100.0) |
| 3.            | 5 - 7                             | -                   | 8(8.0)            | 31(31.0)     | 23(23.0)           | 38(38.0)       | -       | 100(100.0) |
| 4.            | 8 kms and above                   | -                   | -                 | -            | 9(24.3)            | 25(67.6)       | 3(8.1)  | 37(100.0)  |
| Total         |                                   | 2(0.4)              | 39(8.2)           | 154(31.4)    | 96(21.1)           | 170(35.6)      | 20(4.2) | 477(100.0) |

(Figures in brackets indicate percentages)

Most of the Health Workers too, like the Supervisors rarely visit the villages without transport facility. The work performance of the Health Workers is only slightly better than the women Supervisors, and considerably better than the men Supervisors. The fact that they do not stay in the village results in lower frequency of visits, and is not as per the norms set.

The frequency of visits by the men and women Workers, and Supervisors differs because of the nature of duties. As the women Workers, and Supervisors are in-charge of the Mater-

nal and Child Health Programme (MCH), their visits to the villages are relatively more frequent as compared to the visits by the men Workers, and Supervisors. Although the men Workers and Supervisors are **in-charge** of the centrally sponsored schemes like National Malaria Eradication Programme, National Tuberculosis Control Programme, Universal Immunization Programme. School Health, Environmental Sanitation, they do not spend much time on these activities as they do not consider them to be very important. The authorities at the higher levels (state and district) do not give as much importance to such activities as Control of Communicable Diseases, Environmental Sanitation, School Health as compared to MCH, and family Planning Programme. Also given the fact that the number of men Workers in the PHC is highly inadequate, the result is that the outreach of services is very poor. Except for the men Supervisors in-charge of Family Welfare Programme, those in-charge of the Immunization Programme, Malaria Eradication Programme, and Tuberculosis Control Programme, hardly go on field visits.

## 7.2 **OUTREACH COMPONENTS:**

Perceptions regarding the outreach of services will be discussed below:

### 7.2.1 **Antenatal Care:**

Out of the total number of **respondents(477)**, only fifteen of them said that antenatal care was provided at their homes during the last one **year**. **The** antenatal care included, general checkup of the pregnant women, administration of tetanustoxide vaccine, and iron and **folic** acid tablets. The women were also advised to take nutritious **food**. The coverage of pregnant women at their homes by the Health Workers is very poor. Most of the Health Workers provide antenatal services only at the antenatal clinics. As most of them do not live in the villages, they hardly go on house **visits**, unless there is a case to motivate **for family** planning, or there is some other personal advantage.

### 7.2.2 **Deliveries:**

Only four out of the total respondents (4YY) said that the woman Health Worker conducted deliveries at their homes. Even though the Health Workers are supposed to conduct **50%** of the total deliveries in their area, they hardly conduct any deliveries as seen from the data. These four respondents belong to the village (sub-centre '**A**') where the Health Worker resides. Thus, inspite of the Health Worker residing in the sub-centre village hardly any deliveries are being conducted by her. Most of the deliveries in the villages are conducted by the **Dais(trained)** (81%).



### 7.2.3 **Postnatal Care:**

After delivery, the women Health Workers are supposed to make atleast three postnatal **visits**, and provide care to all nursing mothers. Postnatal services include, general checkup of mother and child; immunization for the new bom; treatment of minor problems if any; health education, and advice on family planning. **36%** of the respondents said that the Health Worker provided postnatal care at their homes during last one year. The outreach for postnatal care is better as compared to the outreach with regard to antenatal care, and deliveries.

According to the respondents, the Health Workers visited the mothers during the first two weeks after delivery. The mothers and infants were checkedup, and the mothers were given iron and **folic** acid tablets. They were also told to bring the infants, to the **sub-centre/PHC** for immunization, and were strongly adviced to undergo tubectomy.

In this study it was found that on the pretext of providing postnatal care the women Health Workers, actually go to motivate cases for family planning operations. The postnatal visits are confined to houses where couples have more than three or four children. **It** is only after the third or fourth delivery that the Health Worker visits them, and tries to motivate them to undergo tubectomy. Women who had

their **first** or second child were never provided any postnatal services, unless they showed some interest in family **planning**. The respondents were generally unhappy with postnatal services provided, and in case of any problem they either visit a private practitioner or the government hospital.

#### Y.2.4 **Post Operative Care:**

**The** Health Workers are supposed to provide post operative care to all women who have undergone tubectomy operations. However, it was found that only, nine out of the total respondents (1Y0) who reported as having undergone tubectomy, received post operative care. The **others(161)** were not attended upon. This confirms the above perception that the Health Workers are interested only in family planning cases. Once a person undergoes the operation they do not even bother to provide post operative care. This is the reason why most of the people lack faith in the Health Workers.

#### Y . 2 . 5 **Detection and Treatment of Malaria:**

The Health Workers (men) are supposed to visit all houses in their jurisdiction once a fortnight to **identify** cases suffering from recurring fever, and collect their blood smear for examination. At the same time they are supposed to provide presumptive treatment to control the fever. Only



twentyeight out of the total **respondents(477)** reported that the Health Worker visited the\* during the last one year, and collected blood smear fro\* members suffering with recurring **fever**. **They** also said that the worker administered presumptive treatment.

According to the **respondents**, the Health Workers (**men**) do not actually visit each and **every house**. **They** usually come to **village**, stop at one place (**usually** a tea **shop**), and ask passers by if any one in the village is suffering from **fever**. Sometimes he picks up a /cycle from one of his friends in the **vi l l a g e**, and **goes** around asking passers by on the road if anyone is suffering from fever. Based on this information, **he** then visits the house to check for **fever cases**, and **collect** blood **smears**. **Incase** the passers by are not able to provide information about fever cases, he just leaves the village assuming that there are no fever cases, and that no one is suffering from malaria.

The reason why Health Workers behave in this manner, could be because of the heavy work load. There are four men Workers for the entire **PHC** area. Out of these four, two are in-charge of malaria work, and two are in-charge of immunization work. Since only two of them are in-charge of malaria work, one cannot expect them to visit every house once a **fortnight**.

**Thus** it can be seen that the outreach of primary health care services is extremely poor. This is because most of the Health Workers do not reside in the sub-centre villages, nor are they regular in their visits. All that they are interested in is family planning cases, and all their other activities centre around it.

### **7.3 UTILIZATION OF PRIMARY HEALTH CARE SERVICES:**

Having discussed the outreach of services, let us now discuss the utilization of primary health care services as perceived by the beneficiaries. Utilization of services will be broadly discussed in two ways - (i) **in terms** of sub-centre/PHC users; users of other services, and non users; and (ii) by comparing utilization of the **sub-centre/PHC** services in relation to other variables, **namely, sub-centre**; frequency of visits by Health Workers; distance between sub-centre and other villages; availability of public transport facility; caste; income; and education of the respondents head of households.

#### **Y.3.1 Utilization by sub-centre/PHC users, user of other services, and non-users:**

**Table** Y.6 shows the distribution of respondents by sub-centre/PHC users, users of other services (for various purposes). and non-users of **services**.

Table 7.6:

**Distribution of respondents by sub-centre/PHC users, users of other services, and non-users, N = 477.**

| Sl. No. | Purpose                    | Sub-centre or PHC users | Users of Other Services |                                      |                                 |                         |           | Total    | Numbers and Percentage |
|---------|----------------------------|-------------------------|-------------------------|--------------------------------------|---------------------------------|-------------------------|-----------|----------|------------------------|
|         |                            |                         | Government hospital     | Private nursing home, clinic, or PHC | Registered Medical Practitioner | Indigenous practitioner | MS others |          |                        |
| (1)     | (2)                        | (3)                     | (4)                     | (5)                                  | (6)                             | (7)                     | (8)       | (*)      | (10) (11)              |
| 1.      | Treatment of minor ailment | 146(30.6)               | 61(12.8)                | 40(8.4)                              | 212(44.4)                       | 18(3.8)                 | -         | -        | 477(100.0) -           |
| 2.      | Antenatal Care             | 285(59.7)               | 114(23.9)               | 78(16.4)                             | -                               | -                       | -         | -        | 477(100.0) -           |
| 3.      | Deliveries                 | 5(1.0)                  | 56(11.7)                | 42(8.8)                              | -                               | -                       | 316(66.2) | 58(12.2) | 477(100.0) -           |
| 4.      | Immunization:              |                         |                         |                                      |                                 |                         |           |          |                        |
|         | A) BOG                     | 51(57.3)                | 20(22.5)                | 18(20.2)                             | -                               | -                       | -         | -        | 89(100.0) 388(81.3)    |
|         | B) DPT & OPY (I)           | 57(53.3)                | 15(14.0)                | 35(31.8)                             | -                               | -                       | -         | -        | 107(100.0) 370(77.6)   |
|         | C) DPT & OPY (II)          | 44(49.4)                | 13(14.6)                | 32(36.0)                             | -                               | -                       | -         | -        | 89(100.0) 388(81.3)    |
|         | D) DPT & OPY (III)         | 32(46.4)                | 12(17.4)                | 25(36.2)                             | -                               | -                       | -         | -        | 69(100.0) 400(85.6)    |
|         | E) Measles                 | 3(37.5)                 | 1(12.5)                 | 4(50.0)                              | -                               | -                       | -         | -        | 8(100.0) 100(20.9)     |
| 5.      | family Planning Operation  | 127(74.7)               | 25(14.7)                | 18(10.6)                             | -                               | -                       | -         | -        | 170(100.0) 337(70.4)   |
| 6.      | Treatment of Malaria       | 3(5.4)                  | 1(1.8)                  | -                                    | 52(92.8)                        | -                       | -         | -        | 56(100.0) 421(88.3)    |
| 7.      | Treatment of Tuberculosis  | 3(21.4)                 | 2(14.3)                 | 9(64.3)                              | -                               | -                       | -         | -        | 14(100.0) 403(84.7)    |

(Figures in brackets indicate percentage) \* Indicates percentage to the total respondents

#### **7.3.1.1 Treatment of minor ailments:**

With regard to treatment of minor ailments most of the respondents have said that they use the services of the Registered Medical Practitioners (**RMPs**), as they are more accessible as compared to the Health Workers. Also the necessary medicines are available with them while, no medicines are available with the Health Workers to treat minor ailments. It is only at the PHC that minor ailments are treated as the supply of medicines is slightly better. People living nearer to the PHC utilize its services, while the rest depend on **RMPs**, government hospitals, private medical practitioners, and indigenous practitioners.

#### **7.3.1.2 Antenatal Care:**

Higher percentage of respondents have said that they use the sub-centre/PHC services for antenatal care (see table 7.6). This is because these centres are mostly meant to provide **Family** Welfare Services, of which antenatal care is an important component. The antenatal care provided at these sub-centres/PHC mainly includes, services such as, checking of foetal position, administration of tetanus toxoid vaccine, distribution of iron and **folic** acid tablets, and advice on nutritional requirement, and personal hygiene. Among the users of the sub-centre/PHC for antenatal care, **94.7%** said that they received two doses of tetanustoxide vaccine, and

thirty to sixty iron and folio acid tablets. The remaining 5.3% did not receive any services. When asked why they did not receive tetanus toxide injection, and iron **tablets**, all that they could say was that the Health Worker did not administer. This could be either because there was no **vaccine**, and iron tablets available, or the pregnant women did not attend the antenatal clinic regularly. It was observed that the tetanus toxide vaccine, and iron and **follic** acid tablets were generally available, as storage is not a problem. As far as advice on nutrition, and personal hygiene is concerned, 83.2% of the respondents said they were advised on nutrition, while ~~65.3%~~ said said that they were advised on personal hygiene. All those who come for antenatal checkups are not advised on nutritional requirement, and personal hygiene, as most of them are poor, and belong to the lower castes who cannot afford to take nutritious food, and maintain personal hygiene.

#### 7.3.1.3 Deliveries:

Since Health Workers are not available at the sub-centres we find most of the deliveries being conducted at home. Respondents who said that they used the government hospital, and the **PHC** for the purpose did so, because of complications in delivery. The well to do used the services of the private nursing home.

Majority of respondents (81%) used the services of the trained Dais, while 12.8% used the services of the untrained Dais, and 3% used the services of an elderly person from the family. Only 1.9% used the services of the women Health Supervisor, and 1.2% used services of the women Health Worker. The reason why respondents prefer the Dais is because they are from the village community, and are available round the clock unlike the Health Workers.

#### Y . 3 . 1 . 4 Immunization of Children:

Children below one year of age are supposed to be immunized for - (i) Bacillus **Calmette Guérine (B.C.G)**; (ii) Diphtheria, whooping cough (Pertussis) and Tetanus (D.P.T), and Oral Polio Vaccine (O.P.V); and (iii) Measles Vaccine. However in rural areas we find that vaccinations are not carried out on a regular basis, and usually the child attains an age of one and half to two years by the time he/she is immunized for all the diseases. Therefore an attempt has been made here to study the immunization details of children aged eleven to **twentyfour** months. **If** a child is immunized for all the diseases mentioned above, one can consider the child to be fairly well protected. **Immunization** details of the older children in the household have not been recorded as the mothers were unable to recollect information regarding the vaccines, and place of immunization.



Table 7.6 shows that less than 26% of **the** respondents (total users) have said that their children **are immunized for** BCG, DPT, polio, and measles, while more than **75%** have said that their children are not immunized. The reasons **include** unaware of the need for immunization (96%), fear of **side** effects (78%), and lack of faith in immunization (32%) (Because of multiple responses the percentages do not add). Among the users, a higher percentage utilised the **sub-centre/PHC** for immunization of children. A lower percentage of respondents utilised the **sub-centre/PHC** and government hospital for the second and third dose of DPT and OPV. This is because the mothers were busy with their work, and were also unaware of the need for the second, and third dose of DPT and OPV, and measles vaccine. Only eight respondents out of the entire sample (477) got their children (below two years) immunized fully, that is, the children were **immunized** against BCG, DPT and OPV (three doses) and Measles.

Even though the women Health Workers are supposed to immunize infants, and children regularly at the **sub-centres**, they do not do so as no cold storage facilities are available. Usually the men Health Workers carry out the immunization at the sub-centres, and other villages. According to majority of the respondents (**64.4%**), their visits are rare. **In fact** 24% of the respondents had no idea about their visits. 9% said they visit once in two months, and only 2.3% said they visit once a month. The reason for the rare visits is because only two out of the four Health Workers (men) carry

out immunizations ~~in~~ the entire **PHC** area. Hence it is not possible for them to visit every village once a week. At the **PHC**, children are immunized once a week, as cold storage facility is available. This is the reason why more number of respondents used the **PHC** rather than the sub-centre for immunization of children.

On the whole it can be said, that the utilization of immunization services in the villages is very poor, with more than **75%** of non-users. This calls for a sincere effort on the part of the Health Workers to educate the villagers in this regard.

During the course of discussion with some of the respondents, it was found that they believed, children will be affected by polio, if immunized against polio. Ten such cases of children affected by polio have been identified in the study. When this was discussed with the Health Workers, they said, that when children develop fever after immunization, the parents out of anxiety take them to a private medical practitioner or an **RMP** for treatment. The treatment according to the workers might have resulted in an adverse reaction, causing the problem.

When the Health Workers were asked whether they inform the mothers or parents regarding the side effects of immunization, they said they generally do so at the time of ~~immuni-~~



zation. However, the respondents said that the Health Workers never informed them about the side effects. The Workers, therefore, have to make sincere efforts to clear misconceptions- 'that immunization against a disease could cause the disease'. The villagers have to be educated regarding the importance of immunization for various diseases, and side effects if any, in order to make the programme a success.

#### 7.3.1.5 Family Planning:

Before discussing the utilization of family planning services, let us first discuss the opinion of the respondents regarding the ideal number of children in a family. The opinion regarding ideal number of children in a family reflects to a certain extent the attitude of the respondents towards the concept of family planning. When the respondents were asked, 'what is the ideal number of children in a family?', majority (54.9%) have said that there should be four children per family (two girls and two boys). 32.3% consider three children as the ideal (two boys and one girl), and 12.8% consider only two children (one girl and one boy) as the ideal. The respondents prefer two or three children because they can look after the children well, while those who prefer four children do so because of the fear of infant mortality. These respondents also consider more number of children as an asset, as the children start earning from the age of eight or ten years.

Thus it can be seen that a large number of **respondents** in the study still prefer to **have** more number of children. **These** respondents belong to the economically backward, and lower middle income groups who are also **illiterate**. Also many of the women who have undergone sterilization operation were those having four or more than four **children**. This **confirms** the preference for more number of children, and also shows that the Health Workers are not making enough effort to convince couples, with two children to adopt the permanent method of family planning.

Majority of the respondents who reported sterilization used the services of the **PHC (75%)**.

On the whole it can be said that the **utilization** of family planning services in the **villages** is **poor, with 64.4%** of non-users. **The** reason for not using the services include - the desire to have more number of children (**60%**); fear of operation (**20%**); and non-cooperation from the **spouse(20%)**. Once again this calls for an increased effort on the part of Health Workers, and Supervisors in implementing the programme .

#### **Y.3.1.6 Control of Communicable diseases:**

Services are provided only for malaria eradication, and control of tuberculosis at the **PHC**. No services are provided at the sub-centres. **56** respondents in the study reported as

having suffered from malaria during the past one year. However only three of them used the **PHC** for this purpose. At the **PHC** blood smears were **collected**, and the patients were administered presumptive treatment. However they were not informed of the blood smear report. The remaining respondents(52) used the services of the **RMPs**, and one respondent stated to have used the government hospital services.

15 respondents reported that they had one member in the household who is suffering tuberculosis. However only fourteen are taking treatment. Out of these fourteen only three of them are using the **PHC** services, while the rest visit the private medical practitioners or the government hospital. The reason why most of them do not use **PHC** is because, the Health Supervisor in-charge of dispensing drugs for tuberculosis is not available most of the time. He is supposed to be present at the **PHC** on particular day in the week to dispense medicines. However, he is not regular, and the patients have to make repeated trips. Because of this situation many of the patients discontinue **treatment**, and there is no way of tracing them. Although Health Workers on their field trips are supposed to collect sputae for examination from suspected **cases**, they do not do so, as there are no facilities to examine the sputae at the **PHC**. Because of this problem the Workers are not involved in the programme, and are unable to identify the defaulters.

Utilization of **sub-centre/PHC** services **with** regard to the two communicable diseases is very low.

Apart **from** providing services **for** treatment of minor ailments, maternal and child health care, **immunization**, family planning, and control of communicable diseases, the **PHC** is also responsible for - (i) provision of school health services to children in all government primary schools; (ii) environmental sanitation in the villages, and **(iii)** health education to the villagers.

Only eight of the twelve villages covered, had government primary schools where school health services are provided. Only **30%** of the respondents were aware of the routine medical checkup conducted in the schools. **The** respondents could not recollect any other services provided to their children. One Medical Officer, and one Health Supervisor are supposed to cover all government primary schools in their jurisdiction once in six months. **They** are supposed to examine all children, and identify cases needing treatment, and refer them to specialists if necessary. They are also supposed to organize immunization camps, eye camps, and dental camps at least once a year. However no such camp was organized during the past one year. Only a routine medical **check-**up of children was done, and that too, only once in \* whole years time.

Both environmental sanitation, and health education are being given **very** low **priority**. According to the **respondents**, chlorination of drinking water sources is done only during the rainy season because of the high incidence of cholera, and gastroenteritis. Chlorination, according to them is never done on a regular basis. **The** men Workers, and Village Health Guides are responsible for this activity, but hardly anyone seems to take interest. Action is taken only when there is an epidemic. The respondents have complained about insects, and worms in the water they collect for household use.

According to the respondents, health education sessions are organized rarely, that is, once in six months. The topics discussed relate mostly to family planning, antenatal care, and immunization of children. Topics like nutrition education, personal hygiene, and sanitation are never touched upon. According to the respondents, the health education sessions are nothing but a campaign for the family planning **programme**.

Thus it can be seen that the sub-centres, and **PHC** mostly provide services in the area of family welfare, and to some extent services for communicable diseases like malaria, and tuberculosis.

Y . 3 . 2 ~~Utilization of sub-centre/PHC services in relation to~~  
other variables:

Having discussed the utilization of services in terms of **sub-centres/PHC** users; users of other **services**(for various purposes); and **non-users**, let us now discuss utilization of **sub-centre/PHC** services in relation to other variables, namely, (i) sub-centre, (ii) frequency of visits by Health Worker (female), (iii) distance between sub-centres and other villages, (iv) availability of transport facility, (v) caste, (vi) income, and (vii) education of the respondents head of households.

Utilization of services in relation to these variables has been **studied** with the assumption that, **utilization** is better in sub-centres where the Health Workers reside\* and vice versa. In our sample only one Health Worker **resides** at the sub-centre village. Hence, frequency of Health Workers visits, especially the women Workers, is considered **important** because higher the frequency of visits, higher would be the utilization of services. Distance between **sub-centres**, and other villages, and availability of transport facility is also considered important as it is assumed that utilization is better in **sub-centre** villages vis-a-vis other villages located away from the sub-centres. **It** is also assumed that mostly the schedule castes, and backward castes utilize **these** services. **The** economically backward, and lower middle income



groups, and households with illiterate heads utilize the services as compared to the higher economic group, and households with literate heads.

Y.3.2.1 ~~Sub-centre wise Utilization of services:~~

Table 7.7:

Percentage distribution of respondents by sub-centre, and **utili**  
**zation** of sub-centre/PHC services \*.

| Sl. No.         | Sub-centre | Services provided at sub-centre/PHC |                |            |              |              |               |                |         | Family Planning Operation |
|-----------------|------------|-------------------------------------|----------------|------------|--------------|--------------|---------------|----------------|---------|---------------------------|
|                 |            | Treatment of minor ailments         | Antenatal care | Deliveries | Immunization |              |               |                | Measles |                           |
|                 |            |                                     |                |            | BCG          | DPT & OPV(I) | DPT & OPV(II) | DPT & OPV(III) |         |                           |
|                 |            | N=477                               | N=477          | N=477      | N=89         | N=107        | N=89          | N=69           | N=8     | N=170                     |
| (1)             | (2)        | (3)                                 | (4)            | (5)        | (6)          | (7)          | (8)           | (9)            | (10)    | (11)                      |
| 1.              | A          | 28.5                                | 69.5           | 2.0        | 81.0         | 68.8         | 64.3          | 62.5           | 50.0    | 81.3                      |
| 2.              | B          | 30.3                                | 60.0           | 0.6        | 45.0         | 59.0         | 51.6          | 43.5           | 50.0    | 71.4                      |
| 3.              | C          | 32.7                                | 50.9           | 0.6        | 35.7         | 33.3         | 33.4          | 31.0           | -       | 72.9                      |
| All Respondents |            | 30.6                                | 59.7           | 1.4        | 57.3         | 53.3         | 49.5          | 46.3           | 37.5    | 74.7                      |

\* For details see Appendix V      **Tables 7.1 to 7.11**

The table shows an association between the **sub-centres**, and utilization of various services. Utilization of sub-centre/PHC for antenatal care, **immunization** of children, and

family planning operations is higher in sub-centre 'A'. This is because the women Worker resides in the sub-centre village. The use of the sub-centre/PHC for treatment of minor ailments is low in all the three sub-centres **because**, medicines are generally not available at the **sub-centres**, and one has to go all the way to the PHC for getting **treated**. This is the reason why most of the people use the services of the **RMPs**. People mostly **residing** in the PHC village or villages nearby, use the PHC for treatment of minor ailment. However, a slightly higher percentage of respondents from sub-centre 'C' utilize the sub-centre/PHC for treatment of minor ailments. This is because sub-centre 'C' is not easily accessible, and other treatment sources are not available in the near vicinity.

Thus by and large it can be said that utilization of services is better in sub-centres where Health Workers reside, as compared to the sub-centres where no Health Workers reside.



### 7.3.2.2 Frequency of visits by women Health Workers, and

cas:

Table 7.8:

Percentage distribution of respondents by frequency of visits by Health Workers (women) and utilization of sub-centre/PBC services \*.

| Sl. No.         | Frequency of Visits | Services provided by the sub-centre/PNC |                |            |              |              |               |                |         | Family Planning Operation |
|-----------------|---------------------|-----------------------------------------|----------------|------------|--------------|--------------|---------------|----------------|---------|---------------------------|
|                 |                     | Treatment of minor ailments             | Antenatal care | Deliveries | Immunization |              |               |                |         |                           |
|                 |                     |                                         |                |            | BCG          | DPT & OPV(I) | DPT & OPV(II) | DPT & OPV(III) | Measles |                           |
| (1)             | (2)                 | (3)                                     | (4)            | (5)        | (6)          | (7)          | (8)           | (9)            | (10)    | (11)                      |
|                 |                     | N=477                                   | N=477          | N=477      | N=89         | N=107        | N=89          | N=69           | N=8     | N=17                      |
| 1.              | Once a Week         | 55.6                                    | 77.8           | -          | 50.0         | 66.7         | 66.7          | 66.7           | -       | 85.7                      |
| 2.              | Once in two Weeks   | 32.0                                    | 62.3           | 1.7        | 57.6         | 48.6         | 46.4          | 50.0           | 25.0    | 60.0                      |
| 3.              | Once a Month        | 28.4                                    | 57.5           | -          | 33.3         | 36.0         | 30.0          | 23.5           | -       | 52.9                      |
| 4.              | Once in Two Months  | 56.5                                    | 47.8           | -          | 50.0         | 50.0         | 50.0          | 50.0           | -       | 60.0                      |
| 5.              | Rarely              | 29.4                                    | 35.3           | -          | -            | 54.5         | 50.0          | 28.6           | 100.0   | 81.8                      |
| 6.              | No idea             |                                         |                |            | 100.0        | 100.0        | 100.0         |                | -       | -                         |
| 7.              | Stays in village    | 28.8                                    | 68.9           | 2.2        | 66.1         | 70.3         | 65.2          | 50.0           | 50.0    | 77.8                      |
| All Respondents |                     | 30.8                                    | 59.7           | 1.7        | 57.3         | 53.3         | 49.5          | 44.3           | 37.5    | 74.7                      |

\* For details see Appendix V

Tables 7.12 to 7.22

**Utilization** of services is higher in villages where **Health** Workers frequently visit, that **is**, once a week, and once in two **weeks**, and **ofcourse** in villages where the Health Workers **reside**. However it is interesting to note that a higher percentage of respondents who perceive the Health Workers visits as 'once in two **months**' have utilized the services of the health centre. These respondents mostly belong to the economically backward group who mostly depend on the Health Worker.

**7.3.2.3 Distance between sub-centre and other villages,  
and Utilization of services:**

Table 7.9:

Percentage distribution of respondents by distance between sub-centre and other villages, and utilization of sub-centre/PHC services\*.

| Services provided by the sub-centre/PHC |                                   |                             |                |            |              |              |               |                |         |                           |
|-----------------------------------------|-----------------------------------|-----------------------------|----------------|------------|--------------|--------------|---------------|----------------|---------|---------------------------|
| Sl. No.                                 | Distance from Sub-centre (in km*) | Treatment of minor ailments | Antenatal car* | Deliveries | Immunization |              |               |                |         | Family Planning Operation |
|                                         |                                   |                             |                |            | BCG          | DPT & OPV(I) | DPT & OPV(II) | DPT & OPV(III) | Measles |                           |
| (1)                                     | (2)                               | (3)                         | (4)            | (5)        | (6)          | (#)          | (7)           | (\$)           | (#)     | (1#)                      |
|                                         |                                   | N= 477                      | N=477          | #477       | N=89         | N=167        | N=89          | N=69           | N=8     | N=170                     |
| 1.                                      | Sub-centre Village                | 27.8                        | 61.8           | 1.7        | 72.5         | 58.3         | 55.1          | 56.7           | 33.4    | 86.1                      |
| 2.                                      | 2 - 4                             | 22 \$                       | 47.1           | -          | 29.8         | 47.4         | 37.5          | 28.6           | -       | 60.9                      |
| 3.                                      | 5 kms and above                   | 41 \$                       | 66 #           | #7         | 47 \$        | 46 4         | 45 #          | 38 9           | 100 #   | #57                       |
| All Respondents                         |                                   | 30 6                        | 59 7           | 1 #        | 57 3         | 53 3         | 49.5          | 46 3           | 37.5    | 74.7                      |

\* for details see Appendix V Tables 7.23 to 7.33

The table does not show a significant association regarding distance between sub-centre and other villages and utilization. A higher percentage of respondents living in the sub-centre villages, and those living away from the sub-

centre village (IS km .and beyond) are **utilizing** the **se** the health **centre**. Respondents living 2-4 km away sub-centre reported low utilization. This is **because** most of the **vil lages** in this range do not have public **transport** system.

#### 7.3.2.4 **Availability of transport facility and utilization of services:**

Table 7.10:

Percentage distribution of respondents by availability and **non-**availability of transport facility and utilization of **sub-oen-**tre/PHC **services\***.

| Services provided by the sub-centre/PHC |                    |                             |                |            |              |              |               |                |         |                           |
|-----------------------------------------|--------------------|-----------------------------|----------------|------------|--------------|--------------|---------------|----------------|---------|---------------------------|
| Sl. #0.                                 | Transport Facility | Treatment of minor ailments | Antenatal care | Deliveries | Immunization |              |               |                |         | Family Planning Operation |
|                                         |                    |                             |                |            | BCG          | DPT & OPV(I) | DPT & OPV(II) | DPT & OPV(III) | Measles |                           |
| (1)                                     | (2)                | (3)                         | (4)            | (5)        | (6)          | (7)          | (8)           | (9)            | (10)    | (11)                      |
|                                         |                    | #477                        | #477           | #477       | B: # \$      | B: 107       | B: 89         | # \$ #         | #4      | B: 170                    |
| 1.                                      | Not Available      | 30.6                        | 33.3           | -          | .            | .            | .             | .              | .       | 73.3                      |
| 2.                                      | Available          | 30. #                       | 61. 9          | 1.1        | 60#          | a* 4         | 51.7          | 49.2           | 37.&    | 74.\$                     |
|                                         | ill Respondents    | 30. \$                      | 59.7           | 1 #        | 57 3         | 533          | 4#.'5         | 46.3           | 37.â    | 74.7                      |

\* For details see Appendix V **Tables 7.34 to 7.44**

There is an association between the availability of transport facility, and utilization of antenatal **services.**

and immunization of children. A certain percentage of utilization of antenatal services is reported from villages without transport facility, while no utilization is reported with regard to immunization of children. Utilization with regard to family planning services is more or less similar in villages with, and without transport facility. **This** once again shows that Health Workers visit villages without transport facility to motivate cases for family planning.

Thus more than the distance between sub-centres and other villages, availability of transport facility seems to be a crucial factor in the utilization of services.

**7.3.2.5 Caste composition of the respondents and utilization of services:**

Table 7.11: .

Percentage distribution of respondents by caste and utilization of sub-centre/PHC services\*.

| Services provided by the sub-centre/PHC |                 |                             |                |            |              |              |               |                |         |                           |
|-----------------------------------------|-----------------|-----------------------------|----------------|------------|--------------|--------------|---------------|----------------|---------|---------------------------|
| Sl. No.                                 | Caste           | Treatment of minor ailments | Antenatal care | Deliveries | Immunization |              |               |                |         | Family Planning Operation |
|                                         |                 |                             |                |            | BOG          | DPT & OPV(I) | DPT & OPV(II) | DPT & OPV(III) | Measles |                           |
| (1)                                     | (2)             | (3)                         | (4)            | (5)        | (6)          | (7)          | (8)           | (9)            | (10)    | (11)                      |
|                                         |                 | N=477                       | N=477          | N=477      | N=69         | N=107        | N=69          | N=69           | N=6     | #:171                     |
| 1.                                      | Schedule Castes | 36.0                        | 77.2           | 2.2        | 85.0         | 66.6         | 75.0          | 7#.#           | -       | #4.1                      |
| 2.                                      | Backward Caste; | 31.1                        | 55.4           | 0.7        | 53.1         | 4#.1         | 44.#          | 44.#           | 50.0    | 72.4                      |
| 3.                                      | Other Castes    | 20.0                        | 43.2           | -          | 40.0         | 53.3         | 40.1          | 30.1           | -       | \$1.3                     |
|                                         | All Respondents | 30.6                        | 59.7           | 1.#        | 57.3         | W.3          | 49.5          | 46.3           | 37.5    | 74.7                      |

\* For details see Appendix V

Table\* 7.45 to 7.55

The health centre services are generally meant for everyone living in the area. However, since the economically well off can afford to get themselves treated by private medical practitioners, the health centre services, which are



free, are mostly utilized by the poor, many of whom belong to the schedule castes, and backward castes.

**7.3.2.6 Income of the respondents, and utilization of services:**

Table 7.12:

Percentage distribution of respondents by income and utilization of sub-centre/PHC services\*.

| Sl. No. | Income (in Rs.) | Services provided by the sub-centre/PHC |                |            |              |              |               |                |         | family Planning Operation |
|---------|-----------------|-----------------------------------------|----------------|------------|--------------|--------------|---------------|----------------|---------|---------------------------|
|         |                 | Treatment of minor ailments             | Antenatal care | Deliveries | Immunization |              |               |                | Measles |                           |
|         |                 |                                         |                |            | BCG          | DPT & OPV(I) | DPT & OPV(II) | DPT & OPV(III) |         |                           |
| (1)     | (2)             | (3)                                     | (4)            | (5)        | (6)          | (7)          | (8)           | (9)            | (10)    | (11)                      |
|         |                 | =                                       | =              | =          | =            | =            | =             | =              | =       | =                         |
|         |                 | N=477                                   | N=477          | N=477      | N=69         | N=107        | N=69          | N=69           | N=0     | N=170                     |
| 1.      | < 500           | 34.3                                    | 65.7           | 1.0        | 44.4         | 76.2         | 56.7          | 85.7           | 100.0   | 89.3                      |
| 2.      | 500 - 999       | 35.3                                    | 65.8           | 1.1        | 73.5         | 58.4         | 53.7          | 50.0           | 66.6    | 81.3                      |
| 3.      | 1000 - 1499     | 16.9                                    | 42.2           | 1.2        | 45.7         | 45.8         | 34.8          | 35.7           | -       | 55.9                      |
| 4.      | 1500 - 1999     | 20.0                                    | 40.0           | -          | 20.0         | -            | -             | -              | -       | -                         |
| 5.      | 2000 and above  | -                                       | 15.4           | -          | 15.7         | 33.4         | 33.4          | 40.0           | -       | 50.0                      |
| <hr/>   |                 |                                         |                |            |              |              |               |                |         |                           |
| 114     | Respondents     | 30.5                                    | 55.7           | 1.1        | 57.3         | 53.3         | 49.5          | 46.3           | 37.5    | 74.7                      |

\* For details see Appendix V Tables 7.56 to 7.66

Once again it is the economically backward, and lower

middle **income** groups who are utilizing the health centre **services**.

Y . 3 . 2 . Y **Education of respondents head of households and utilization:**

Table 7.13:

**Percentage** distribution of education of respondents head of households and utilization of sub-centre/PHC **services\***.

| Sl. No.                | Level of Education | Services provided by the sub-centre/PHC |                |            |             |              |               |                |         | Family Planning Operation |
|------------------------|--------------------|-----------------------------------------|----------------|------------|-------------|--------------|---------------|----------------|---------|---------------------------|
|                        |                    | Treatment of minor ailments             | Antenatal care | Deliveries | Imaamiation |              |               |                | Measles |                           |
| (1)                    | (2)                | (3)                                     | (4)            | (5)        | BCG         | DPT & OPV(I) | DPT & OPV(II) | DPT & OPV(III) | (10)    | (11)                      |
|                        |                    | N:477                                   | N=477          | N=477      | N=89        | N=107        | N=89          | N=69           | N=8     | N=170                     |
| 1. Illiterate          |                    | 32.6                                    | 63.7           | 1.3        | 65.5        | 63.3         | 58.2          | 54.0           | 75.0    | <b>80.0</b>               |
| 2. Primary School      |                    | 34.0                                    | 52.0           | -          | 40.0        | 45.4         | 50.0          | 46.2           | -       | 71.4                      |
| 3. Secondary School    |                    | 19.0                                    | 42.9           | -          | 50.0        | 50.0         | 40.0          | 33.3           | -       | 72.7                      |
| 4. High School & above |                    | 5.3                                     | 30.8           | -          | 66.7        | 50.0         | 50.0          | 50.0           | -       | <b>40.0</b>               |
| <b>All Respondents</b> |                    | 30.6                                    | 59.7           | 1.0        | 57.3        | 53.3         | 49.5          | 45.3           | 37.5    | 74.7                      |

\* for details see **Appendix V** **Tables 7.67 to 7.77**

The health centre services are **mostly** utilized by the



respondents whose head ~~of~~ households are illiterate, and those educated upto primary, and secondary school. ~~Irrespec-~~ tive of the of the education of heads of households all respondents in the study are utilizing the immunization services provided by the health centres.

Thus the sub-centre/PHC services are mostly utilized by the poor, who are illiterate, and also belong to the schedule castes, and backward castes.

Apart from the sub-centre/PHC services there are also some voluntary organizations providing health care services to the villagers. The voluntary organizations operating ~~in~~ the area are - (i) The Family Planning Association of India (FPAI); (ii) National Association for the Blind (NAB); (iii) Systematic Action for Village Evaluation (SAVE); and (iv) ~~Shramik~~ Vidhyapeet. The most popular among the four is the ~~FPAI~~, which seems to be doing a good job of involving the community in various - (i) educational activities (opening of adult education centres, balwadis for children etc); (ii) developmental activities (providing housing, water and electricity facilities, health care services, pesticides for poor farmers etc); (iii) socio-cultural activities (organizing folk songs and dramas, sports, competitions for women in housekeeping, rangoli etc); and (iv) income generating activities (shoe making, soap making, vegetable vending etc).

Their health activities include, organising general health checkups, well baby shows, eye camps, diabetes detection camps, dental camps, immunization camps, cancer detection camps, and distribution of vitamin tablets, and supply of nutrition supplements to children.

The Health Workers of the **YPAI** have a better rapport with the **villagers** ( as they are locally recruited), as compared to the Health Workers of the **PHC**, as a result their services are also being utilized by the villagers. But the **PHC** workers hardly coordinate their activities with those of the voluntary workers. If at all any coordination exists, it is only during the family planning camps. Coordination of activities will help resolve the problem of duplication of **services**.

Apart from the voluntary organizations, there are a number of **Registered Medical Practitioners (RMPs)** operating in the villages. Every village has atleast two to three **RMPs**, who are either living in the village, or visit the village once in two days. They mostly provide treatment for minor ailments. It is interesting to note that some of the village Health Guides (30%) are also working as **RMPs**. although, majority (**74%**) of the respondents said that they do not utilize the services of the Health Guides. 26% utilise their services as **RMPs**.

In this chapter, an attempt has been made to study **the**

extent of outreach, and utilization of **sub-centre/PHC** services by the beneficiaries. Excepting for antenatal care, family planning, to some extent immunization of children, and control of communicable diseases like malaria and tuberculosis, no other programmes are being implemented seriously. Given this kind of a situation, it is but natural that most people do not use the sub-centre/PHC services for other purposes excepting those mentioned above. The sub-centres do not even provide medical relief to people suffering from minor ailments as no medicines are available. As most of the Health Workers do not reside in the sub-centre villages, the people hardly find them of any use.

This calls for a sincere effort on the part of technocrats, and bureaucrats to provide the necessary **infrastructure** at the sub-centres, so that they are within **the** reach of those, for whom it is meant. **If** proper services are provided at the periphery it would not only benefit the people in the villages, but would also go a long way in reducing the burden on the government hospitals in the towns, and cities. At the same time it also prevents people from being exploited by the unscrupulous private practitioners or **KMPs**, and helps **in** achieving the goal of providing primary health care to all.

## CHAPTER VIII

### CONCLUSION

The concept of primary health care and the PHC was first presented by the Bore Committee in **1946**. The PHC then was structured to be relatively simple and a small unit meant for the provision of both curative and preventive services. Over the years it was subject to many changes in terms of new programmes and shifting priorities based on the recommendations of various committees. The most significant changes included. (i) the expansion of PHC and sub-centre network in rural areas, (ii) functional integration of work of the personnel at PHCs, and (iii) selection of health volunteers from the rural community for every one thousand population.

In spite of all these changes at the grassroot level the health situation as prevalent during the early **80's** constituted a cause for serious concern. It was in **1983** that the National Health Policy was evolved pledging its commitment to the goal of 'Health for All by the year **2000**' through the universal provision of comprehensive primary health care services at the door steps of the people ensuring their full participation. The new policy aimed at raising the health status of the people by coordinating health and all health related programmes, and restructuring the health services on the **preventive**, promotive, and rehabilitative aspects of health care **following** certain broad approaches as

discussed in chapter I : 8-10. However experience in the **last** two decades has shown that the performance of the PHCs is **still** far from satisfactory, and that they have failed to achieve the purpose for which they were established. It was in this context that the objective of the study - namely to 'gain insights into the role and potential of the PHC as an instrument of the National Health Policy' was taken up. This holistic evaluation has been done in the light of - the existing organization structure, and organization processes such as selection, training procedures, **programmewise** performance evaluation and target setting **practices**, supervision, supervisory practices, etc. Besidethe social background of the employees and their linkages with the community were also discussed to illustrate the performance of the PHC. The **sociodemographic** profile of the beneficiaries and their perceptions regarding the outreach and utilization of primary health care services were also discussed in chapters VI and VII.

Some of the important findings emerging out of this study are discussed below :

#### 8.1 **Organization** Structure :

At the village level, the Village Health Guides (VHG) and the Dais with the full participation of the community are not only supposed to project the health needs of the people but also involve themselves in the provision of primary health care services. However, there hardly exists any

interaction between these two functionaries. The **VHGs** generally work under the guidance of the male Workers. and the Dais (trained) under the guidance of the women Workers. This guidance is confined to family **planning**, maternal child health services, and services pertaining to treatment of malaria and gastroenteritis.

At the sub-centre level there are two **functionaries**, namely, the male and female Multipurpose Health Workers. They are supposed to reside at the sub-centre and coordinate all their activities in the villages. **However**, it was found that these Workers functioned as individual entities (see chapter II:49-51). Were they functioning in a coordinated fashion, the impact of their work would have been more effective.

At the sector level there is one male and female Multipurpose Health Supervisor. They like ~~the~~ Workers, are supposed to coordinate their work at the sub-centres and villages. However, they also rarely coordinate with each other (see chapter II:52-53).

At the PHC there are three Medical Officers along with some supporting staff (see chapter II:54-57). It was found that there was hardly any cooperation between them. It was also noticed that there was constant friction between the **in-**charge Medical Officer and the other two Medical Officers as a result of overlap of duties. The subordinate Medical Officers lacked administrative authority and this **was** a



source of their disaffection. The Medical Officer **incharge** was reluctant to equally share the available resources such as drugs and the use of vehicle. The friction between the Medical Officers resulted in poor supervision of services at the grassroot level.

The incharge Medical Officer is supposed to reside in the quarters provided near the **PHC**. However, neither the in-charge nor the other Medical Officers reside in the quarter. They prefer to live in the city where they engage in private practice (Doctors working in PHCs are not supposed to have private practice as they are paid non-practicing allowance). The higher authorities at the district level seem to ignore this fact as they themselves indulge in private practice see chapter II:57-58).

The Medical Officers are not only responsible for coordinating work at the PHC and **sub-centres** but have also to seek the help of other agencies to coordinate work in the villages. These include the Village Panchayat - comprising of the village leaders; the Mandal Development Officer (MDO) and his **staff**; and Voluntary Organizations operating in the area. The Medical Officers generally maintain contacts with the MDO and his staff but not with the village leaders. The cooperation of the MDO is necessary while conducting family planning camps, immunization camps. **massmedia activities**. during epidemics, and while conducting training programmes. The MDO and his staff have greater influence on the village elite groups, and are better equipped and more resourceful **in**

solving problems as compared to the Medical Officers. The Medical Officers to some extent coordinate their work with the Family Planning Association of India, a voluntary organization operating in the area. This cooperation is once again to enlist support for the Family Planning Programme.

The District Medical and Health Officer is responsible for implementing all primary health care programmes in the district. He is assisted by an Additional District and Medical Health Officer, Deputy District Medical and Health Officers, individual Programme Officers and other supporting staff. However, it was found that all powers were vested with the District Medical and Health Officer and powers have not been delegated to the Additional and Deputy District Medical Health Officers. Their role has thus been reduced to that of the facilitators. This results in the lack of coordination of work at the district office, and supervision at the PHC and sub-centre levels (see chapter II:60-62). Although integration of the various health programmes has been attempted with the Multipurpose Health Workers Scheme at the grassroot level, for its success it was essential **that** the supervisory functions were integrated. However this has not taken place at the district and the Directorate levels. As a result Workers are performing only some tasks and not **others**, and the Supervisors are supervising only some **programmes**, and not all the others.



There also exists a communication gap between the individual Programme Officers and the Medical Officers of the **PHC**. This is because the Medical **Officers** feel they are answerable only to the District Medical and Health Officer and not to the individual Programme **Officers**, and hence do not bother about instructions given by the Programme Officers. Secondly, the individual Programme Officers do not have sufficient powers to question the Medical Officers, and lastly some of the Programme Officers come from a **para-medical** background (see chapter II:62-66).

The District Medical and Health Officer is not only responsible for all the health programmes in his district but is also supposed to coordinate the work of his department with other health related sectors like nutrition, **education**, housing, pharmacueticals, and rural development. However, it was found that all departments work independently with little or no coordination at the district level. The Integrated Rural Development Programme, the Minimum Needs **Programme**, the **20-point** programme have been formulated to improve the **quality** of life through all round **socioeconomic** development in rural areas. Although the health policy stresses the need for intersectoral coordination of health and all health related sectors the health programmes are not infact thus coordinated. The coordination does, however, exist **in** the field of Family Planning Programme.

At the directorate level the structure once again reflects functional specialization in the form of Additional Directors for each of the major programmes like family welfare, immunization and control of communicable diseases (see chapter II:78-101).

## 8.2 Social background, selection and training of the employees :

Social background of the members broadly measured in terms of their religion, caste, nativity, and educational qualifications show considerable differences (see chapter III:105-110). It was noticed that persons belonging to Christian denominations irrespective of their formal status seemed to have better rapport with one another, and some amount of team work was noticed among them. Differences in terms of their caste did not have much impact on their interrelationships.

There are considerable differences in terms of the educational background of the personnel. At one end of the continuum are the Medical Officers with high professional qualifications while at the other end are the Dais who are illiterate. Inbetween are the Supervisors, Workers and Village Health Guides whose qualifications range from the primary school to intermediate education levels. The differences in educational qualifications between the Supervisors and Workers is not significant and majority of them have matriculation qualifications. However, the men

Supervisors and Workers seem to be slightly better qualified than their women counterparts (see chapter **III:107-110**).

Although our health policy stresses the need for selecting the right persons for the right job, the state government has not **followed** this, and persons without the required qualifications, expertise and aptitude for work in rural areas have been selected. None of the Medical Officers have qualifications in Public Health or Social and Preventive Medicine. They are working in the health centre because the government made it compulsory for all doctors (seeking government jobs) to work in PHCs for a minimum period of two years after which their services will be **reguralized**. The men Supervisors and Workers were those initially selected as **vaccinators** during the smallpox eradication **programme** and as malaria workers during the malaria eradication **programme**, and are now designated as **Multipurpose Health Supervisors and Multipurpose Health Workers**. Also the recruiting of personnel for different posts is not done by one agency as shown in table 3.3 (see chapter **III:112**) and each category of personnel are recruited by a different authority.

After selection, the employees are sent for training. Some of the functionaries felt that nothing new is being taught and that the same thing gets repeated **in** every training programme. They felt that the emphasis should be more on practical skills rather than on theory. The men Workers found the training programmes useful and felt that

**they** should be organized **at least** once a year so that they get a break from the routine. Some of the women Workers were of the opinion that they were not able to use the skills they learn in the various training programmes because of the poor infrastructural facilities at the sub-centres. Very little on-the-job training is provided to the Workers. The training provided by the Multipurpose Health Supervisors is not appreciated by the Workers as they feel that the Supervisors knowledge is very limited. This could be because there is not much variation in the educational levels of the Supervisors and Workers, and secondly Supervisors are none other than Workers who by virtue of promotion have become Supervisors. It is obvious that only a few amongst them with native abilities as good communicators can make good trainers. The Medical Officers, and district level Supervisors do not provide any on-the-job training to the Workers (see chapter III:115-119).

The PHC personnel undergo inservice training and are also involved in the training of Village Health Guides (VHG), and Dais selected from the community. The functionaries found the training programme useful as they were taught things which they were not aware of.

The policy emphasises the provision of continuous **training** for the village level workers. and recommends uninterrupted supplies of drugs, and material for health education. However. in this study it was found that the workers received training initially when the scheme **was**

introduced thereafter no reorientation training was given to them. They are also not receiving the regular supply of drugs and material for health education. The policy also states that there should be large scale transfer of knowledge, and simple technologies to the **village** level workers. Except for a medical kit and a delivery kit (supposed to be replenished regularly) no other technologies are provided to these **workers**.

Transfers of employees show that the number of transfers are associated with their length of service. In this PHC it was found that most of them have been working for more than four years continuously by either getting their transfer orders cancelled or by getting the orders kept in **abeyance**. Since the PHC is located nearer to the city the employees try their level best to be retained in this MIC (see chapter III:119-123).

Income from salary is an important variable in determining how well a person performs his or her job. The men Workers and Supervisors recruited under the **uni-purpose** scheme expressed high levels of dissatisfaction due to lack of uniformity in pay scales. The village level functionaries too were not happy with the honoraria they receive, and feel that they deserve a better share. The Health Guides feel that their honoraria should be increased from Rs.50/- per month to Rs.300-500 per month. The Dais usually receive **Rs.1/-** per antenatal case registered and Rs.2/- for every delivery

conducted. However this amount is not being paid to them regularly due to paucity of funds. They feel that they deserve much more as they conduct almost all the deliveries in the **villages**.

On the whole the personnel feel that although the job offers security and helps in rendering services to **humanity**, there are several drawbacks. They feel\* dissatisfied with their job because of poor working and living conditions, lack of promotional avenues, too much of work load. and differences in salary.

### 8.3 Workload, programmewise performance and target setting practices :

In the P11C it was found **that all** categories of personnel were spending more than 60% of their time on family planning work followed by the provision of maternal and child health services, and detection and treatment of malaria. The reason why some programmes and services were **given** more importance as compared to others was because of - (i) the existing organization structure which was allowing only vertical supervision of the individual programmes rather than supervision of **all** programmes, and (ii) evaluation of Workers based on the targets fixed for certain programmes.

As far as the work-load is concerned, **it** is related to the beneficiary population covered by Workers. There were considerable differences as each of the men Workers covered



more than 14,000 population as compared to the stipulated norm of 5000 population per Worker. This was due to shortage of men Workers. Women Workers not **living** at the sub-centres spent considerable amount of time **travelling** thus reducing the amount of time spent in villages and sub-centres (see chapter IV:132-137).

The performance of the women Workers (as **seen** in chapter IV:139-146) with regard to the Family Planning Programme is far from satisfactory. The Workers attribute **the** poor performance to the resistance they encounter from the people, but the actual problem is that workers have not been able to buildup the necessary rapport with the villagers. This came out of our interviews with the beneficiaries.

Their performance with regard to antenatal services is fairly good (see chapter IV:147-150).

The women Workers are supposed to conduct 50% of the deliveries in their area, however most of the deliveries are conducted by the Dais. Only Workers staying in the village where the sub-centre is located have conducted more number of deliveries. The Workers also do not provide postnatal services to all mothers. In the area of family planning, women undergoing **tubectomy** do not normally receive post operative care.

Information flow from the grass root level to the sub-centre **is** unsystematic since no registers are maintained as they ought to be. No registers are maintained by the women

Workers listing the number of infants, and children below five years. Performance of women Workers with regard to immunization of infants is available, while performance with regard to children aged one to five years is not available. The performance with regard to the administration of **BCG** vaccine is better as compared to DPT and Polio and Measles vaccine (see chapter IV:153-158).

Apart from providing family planning and maternal and child health services the women Workers treat patients for minor ailments only if medicines are available. Hence they have no performance to show in this regard. They also have little to show with regard to control of communicable diseases. However, they do provide oral rehydration salts, whenever available, to children suffering from diarrhoea. They impart health education to the women either at the sub-centres or during home visits which is very rare. They very occasionally organize group discussions and demonstrations with the help of district **massmedia** officials. They sometimes chlorinate wells during epidemics but take no interest in other aspects of environmental sanitation. The women Workers also do not participate in the School Health Programmes.

The performance of the women Workers on the whole is far from satisfactory, as they perform only a few duties on a continuing basis.



The men Workers like their women counterparts are involved only in the Family Planning, Immunization, and Malaria Eradication Programmes, and sometimes they undertake 'chlorination of wells' (see chapter IV:161-163).

The performance of the men Workers with regard to family planning programme varies from method to method thus as regards sterilizations it is very poor but with regard to distribution of condoms is satisfactory. Similarly in relation to malaria control their performance is satisfactory (see chapter IV:163-170).

The village level functionaries (Health Guides and Dais) are also important members of the health team. The Health Guides have no performance to show with regard to the number of patients treated for minor ailments, malaria or gastroenteritis as no medicines are being provided to them for the past eight to ten months (see chapter IV:170-172). Their role has been reduced to that of informers. Their performance with regard to sterilizations is **poor**, but act as depot holders for the distribution of condoms (see chapter IV:174-175).

In this study it was found that most of the Health Guides were working in far off places and were hardly available for a few hours in the villages. The Health **Guides** do not consider themselves as voluntary workers and expect to be promoted as Health Workers in due course of time. Not choosing the right persons, and **non-availability** of medicines

has rendered the scheme ineffective.

Unlike the Health Guides, the Dais (trained) are relatively more active as they perform an important function within the community. They conduct almost all the deliveries in the villages (most women Workers are not residing at the sub-centres). They help in registration of antenatal cases, deliveries, and the new born. Their performance with regard to the Family Planning Programme is not effective as they generally motivate only those women who have more than three or four children. Most of them expressed unhappiness with the Family Planning Programme as their source of income (from deliveries) is gradually decreasing (see chapter IV:176-180). One important aspect that needs attention is that all Dais in the villages were not trained, and only one Dai for every thousand population has been trained. There were instances where a large village had more than four Dais out of which only one or two were trained. As a result a sizeable proportion of deliveries are still being conducted by untrained Dais. One of the main objective of the Family Welfare Programme is to reduce infant mortality rate but with a sizeable proportion of deliveries being conducted by the untrained Dais it is not possible to reduce the infant mortality rate.

Another important aspect that needs attention is that the trained Dais are not using the delivery kit provided to them as some of the items are lost, and items like soap, blade, and cotton, are not replenished. The Workers never

supervise the deliveries conducted by the Dais as a result the kit is never used. The Workers are more dependent on the Dais rather than the **Dais** being dependent on them. This is the reason why Dais are considered an important link between the community, and the health personnel. On the whole the performance of the Workers, and **village** level functionaries is not very satisfactory.

An important aspect of the health policy is the establishment of a well worked out referral system to provide adequate expertise at the various levels of the organization setup nearest to the community depending upon the actual needs and problems of the area. However, it was found that there was absolutely no referral system operating. All cases needing referral were asked to go to the government hospitals in the city or private nursing homes bypassing the PHC and the Rural Health Centre (RMO). This is **done because** the PHC and the RHC are poorly equipped.

#### 8.4 Supervision, supervisory practices and linkages with the community :

For the health care delivery system which operates at three levels, namely, the PHC, the sub-centre and the village, effective supervision and communication at all levels is absolutely essential. The district **officials**, and all PHC personnel excepting the Multipurpose Health Workers are involved in supervision.

Supervision is inadequate at all levels of the organization (see chapter V:187-190). Not only is **periodical** supervision inadequate, the supervision also shows lack of interest on the part of Supervisors to provide technical help, and encourage Workers to perform well. Because of undue emphasis on family planning target achievements, Supervisors lay greater stress on the Family Planning Programme rather than other programmes. While the recorded quantity of work increases the quality of services remains uncertain.

No interest is taken by the Supervisors to check the records and registers at the sub-centres, and whether **supplies** are available. The records maintained by the Workers do not lend to proper evaluation of the quantity or quality of work. Some centres did not even have basic registers like the household register, infants register, and eligible couples register, and where they were **available**, were not upto date. The Workers do not feel the need to update them as they receive information from the Dais.

Workers in general are dissatisfied **with** the guidance and help provided by their Supervisors because they indulge in inspection type of supervision rather than supportive and instructive type of supervision. Their relationship is characterized more by **conflict** and confrontation rather than cooperation because of allotment of family planning targets to Supervisors (see chapter V:191-192).

The Health Workers are supposed to submit monthly reports for the various programmes at the monthly meeting held at the **PHC**. However it was found that except for family planning achievements no other programme achievements are submitted by the Workers during the meetings. Achievements with regard to other activities like number of antenatal cases treated, number of deliveries registered, registration of postnatal cases, number of infants, and children immunized, etc. are submitted only once in three to four months, the authenticity of which is doubtful. For example, in the case of sterilization achievements, it was found that even though some of the Workers did not achieve any target for the month yet performance for the month was shown. This was witnessed by the researcher herself. Therefore the figures submitted really do not indicate the actual performance. How can then one account for such discrepancies, and false reports? Who should be made responsible for this? How can one put an end to such false reporting? These are some of the questions which need to be given a serious thought.

No effort is made by the Medical Officers (especially the incharge) during the **PHC** monthly meetings to find out why a particular Worker's performance is low or whether he or she is encountering any problems in the field. and whether sufficient and necessary drugs and vaccines are available on a continuous basis. No plan of action for the coming month is chalked out, and no guidance is provided to the Workers.

If there are any circulars from the District Medical and Health Office they are communicated to the Workers without any discussion on them.

Supervision therefore at different levels is highly unsatisfactory with overriding **emphaiss** given to the supervision of Family Planning Programme. No attention is paid to the **maintainence** and upkeep of records and registers. No household visits are conducted to cross check whether services are reaching the people.

Community participation is the corner-stone of the National Health Policy as it provides for a continuous dialogue between the providers and beneficiaries (see chapter V:208-211). It was found that the Manila Mandals and Youth Clubs were not really active and **the** Workers and Supervisors do not attend any of their meetings. This is because they do not get along with the office bearers of these organizations. However they make use of these organizations only when information regarding immunization camps, family planning camps, and **massmedia** activities have to be communicated to the **villagers**. Generally the personnel keep in touch w&th the **village** leaders, school teachers, and local practitioners for help during camps, and epidemics. On the whole the Health Workers and Supervisors do not maintain sufficient linkages with the villagers.



#### 8.5 Sociodemographic profile of the beneficiaries :

The social background of the beneficiaries shows that majority of them are Hindus and belong to the 'Backward Castes' and 'Schedule Castes' who are mostly illiterate and economically backward. Their families are predominantly nuclear with an average size of three to six members per household (see chapter VI:219-231). There are less number of working people and more number of dependents. Among the working population most of them work as agriculture labour followed by their traditional caste occupations, and belong to the lower middle and lower economic groups.

The location and amenities available in the villages show that the sub-centres are geographically not accessible to all villages because some have no pucca roads and public transport system. In some cases the PHC is more accessible (geographically) as the villages are located nearer to it with good transport facility (see chapter VI:216-219).

All of them have access to safe drinking water facility. However, environmental sanitation is extremely poor. One finds that there are open drains flowing **all** over the village along the houses and near the wells where drinking water is **collected**. The people in the villages are living in extremely unhygienic conditions. No effort is made by the PHC personnel **especially** the Health Workers to educate the\* regarding disposal of wastes. and **environmental** sanitation.

#### 8.6 Outreach and utilization of primary health care services as perceived by the beneficiaries :

According to the beneficiaries the Health Workers do not visit all villages regularly, and usually visit the sub-centre village more often. The outreach of services is very poor and very few households were provided services at their homes (see chapter VII:243-255). According to the beneficiaries the Workers and Supervisors visit their homes not to provide services but to motivate them to undergo tubectomy.

For treatment of minor ailments and fevers, villagers mostly use the services of the Registered Medical Practitioners as neither Workers nor medicines are available at the sub-centres. Utilization of the sub-centres for the immunization of infants is very poor with more than 75% nonusers. Very low utilization has also been observed with regard to treatment of communicable diseases like malaria, and tuberculosis. On the whole outreach and utilization of services was **extremely** poor in all villages, and most of the people visit private medical practitioners or government hospitals in the **city**. Utilization was better in villages where the Health Worker was residing, and where transport facility was available. However among the users, utilization was higher among the Schedule Caste and Backward Caste groups who are mostly **illiterate**, and economically backward. Although the policy stresses the need that high priority be given to high risk groups. and



underprivileged segments of the population in remote areas, the quality and quantity of services being provided to them is very poor (see chapter VII:257-279).

To overcome some of the problems, the following are a series of steps which if implemented may lead to much needed improvements :

1) At the village level, the health functionaries, namely, the Health Guides and the Dais have to be mobilized by the Workers and Supervisors to ensure full participation of the community, and to provide basic health services to the people. While recruiting Health Guides, care should be taken to select the right kind of persons. Persons who are in their middle ages and are permanent residents of the village (having their own occupation) and who are oriented towards serving the community on a voluntary basis would be the best choice. Since one can expect them to be a part of the village, have enough energy, yet may still have sufficient motivation to learn new things. They would also be more acceptable to the community. The **Rs.50/-** honorarium given to the present set of village guides is not a sufficient **recompence** for the work they are supposed to perform. Also care should be taken to provide the necessary drugs for treating minor ailments, and material for health education on a regular basis. In this connection we must mention that some of the voluntary organizations have developed very effective training and communication kits for the Village Health Guides. In Maharashtra, district **Jankhed**, the Arole's have a

readily available stock of these kits. This could be adapted for every district. It is only then that the scheme would make some sense. Also care should be taken to supervise their work (by the PHC personnel) so that **drugs** and medicines provided for use are not diverted for any other purpose.

All Dais in the community should be trained irrespective of the population they serve. Atleast this way one can ensure that to some extent deliveries are conducted in a more hygienic way. Also care should be taken to see that they use the delivery kit, and items in the kit are regularly revised and replenished. It should be made compulsory on the part of the Workers to supervise atleast 50% of the total deliveries conducted by the Dais.

The Dais (trained) are considered an **important** link between the **village** community and Health Workers. The government therefore could make use of their services (for the Family Planning Programme) by paying them sufficient remuneration of **Rs.200/-** to Rs.250/- per month. They can **be** trained not only to conduct deliveries but also motivate eligible couples with two children to adopt the permanent method of family planning. In this manner the government to a certain extent can ensure the success of the Family Planning **Programme**.

The village level functionaries in this study received training only once when the schemes were initially **launched**. **This** is totally insufficient and there is a need for a system

which **ensures** continuous training **as** most of these functionaries are either illiterate (in the case of Dais) or have studied upto matriculation (as in the case of Health Guides). Training given once in two or three years coupled with adequate supervision would ensure the provision of adequate services at the village level. However, this would call for a total reorientation of the purpose of the **PHC**. The staff at the PHC, today are primarily engaged in providing curative services to small town local people. Their time should be equally divided into providing continuous training to the village level workers.

2) At the sub-centre level, first and foremost, enough number of men Workers have to be recruited, and the district authorities have to see to it that all Workers reside at the sub-centres. Because Workers are not residing at the sub-centres they have not been able to develop good rapport with the villagers who include not only the beneficiaries, but also the village leaders, elders, school **teachers**, **private** medical practitioners, **RMPs** and other voluntary organizations operating in the area, resulting in poor performance.

The sub-centres are the weakest link in the **whole chain** of the health organization. Out of ten working sub-centres only four of them have men Workers although there are women Workers in all the sub-centres. These sub-centres do not function because of the following reasons - i) they are not supervised, ii) they are inadequately staffed, and have no drugs to distribute, and iii) the Health Workers are not

local residents and therefore do not have local roots. My observation was that only those sub-centres functioned where the Workers stayed within the village. Unless this is ensured the existence of sub-centres is a total waste of resources. It would be far better if the local communities would be organized and given complete **responsibility** to run these sub-centres. If the Health Worker is answerable to the village president it is more likely that she/he will be available for the people.

The excuse given by the Workers was invariably that they were not given **accommodation**. If the responsibility was handed over to the village community they would ensure accommodation for the Health Workers.

Sub-centres have to be properly equipped **with** the necessary furniture, equipment, medicines and **vaccines**. In this study it was found that lack of proper infrastructural facilities at the sub-centres was one of the major reasons why people were not using the services.

The targets to be achieved for the various **programmes** should not be given to the individual Worker\* but to the sub-centre area with clear responsibility located **with** the Supervisor as it **will** ensure cooperation among the Workers. The performance of the sub-centres therefore should be made the responsibility of the Supervisor. Also both the Workers (**male** and female) should be supervised by one Supervisor and not two Supervisors as is being done at present. **This** once

again **will** help in coordination of work and prevent **duplication** of services as both Workers will be working in the same **villages**, for the same population, and towards the same **objectives**.

3) At present there is a clear distinction between male and female Supervisors. This should be given up. The Supervisors at present are responsible for four or five sub-centres. Instead each of them should be made to supervise only two sub-centres which should include the work of both the men and women Workers. Also Supervisors have to be relieved of rigid target achievements, since these do not reflect the realities on the ground. Instead a decentralized system based on peoples needs and under the overall **accountability** to the peoples representatives, at the grass roots level, should take care of the performance of the system.

Another important aspect that needs to **be given** attention is the development and training of the health personnel. It was found in the study that **the** Workers were not really oriented to the people, and the element of human touch was missing. This calls for regular training programmes (atleast once in two years) which are oriented to the people. It was found that the Supervisors were indulging **in** an inspection type of supervision rather than supportive and instructive type of supervision. Therefore the training programmes for Supervisors should lay greater **emphasis** on the supervision and supervisory styles of the personnel **as this**

would remarkably improve the performance of the sub-centres and the **PHC**.

4) At the **PHC** one finds that the **Medical** Officers are inexperienced, and are not oriented to provide preventive and **promotive** services in rural areas. Even the training (in-service) provided to them in rural health and administration of **PHCs** does not seem to have helped in any way as reflected in the performance of ~~the~~ **PHC**. They feel that they are over qualified for the job and are basically oriented towards curative practice. The present system of making the **PHC** posting compulsory for doctors seeking jobs in government service is actually ruining the system, and this practice should be done away with. Therefore there is a need for restructuring the health care delivery system at ~~the~~ **PHC** with Medical Officers trained specifically to provide rural health **services**, with an accent on-public health or social and preventive medicine, and health education. These Medical Officers would have a better understanding of the priorities and the rural health setup. This is possible only by the creation of a Rural Medical Service which will be exclusively responsible for rural areas.

The personnel thus recruited should not only serve the masses at the **PHC**, and sub-centre level but, should also act as intermediaries between the district level functionaries, and the community. They should be made responsible for the training, and supervision of the Health Supervisors. Health Workers, and village level workers (**Dais** and Health



Guides). The training, implementation and monitoring of health services at the peripheral level should be made their responsibility.

These Medical Officers should be provided with additional incentives in terms of better living **conditions**. high non-practicing allowance to ensure their stay in the PHC **village**. Also each PHC should have only one Medical Officer to avoid overlap of duties and conflicts. For this **purpose**, the size of the population to be covered by each PHC should be reduced to 25000, with five sub-centres under each PHC. This will ensure better supervision of work at **the** sub-centres as **well** as the village level.

Coordination with regard to the other agencies (Mandal Development Officer and his staff, and other Development Officers) within the vicinity of the PHC area has to be improved as provision of primary health care **services is** not an individual effort but is a group effort involving the entire community. This also helps in preventing **duplication** of services.

5) In this study it was found that the District Medical and **Health** Officer had a large **span** of control **as** compared to the second level officials, namely, the Additional District Medical and Health Officer. Deputy District Medical and Health Officers, and Programme **Officers** who are given the role of supervision. They do not perform their role due to lack of delegated authority. Therefore mere **delegation** of

duties without accompanying delegation of authority does not serve any purpose. This is the reason why supervision from the district level is poor. This centralized authority within the organization should be decentralized, and sufficient power should be given to the second level officials so that they are able to perform the role given to them. Also officials from district level should spend more time on supervision of PHCs and sub-centres should also be actively involved in the training the Medical Officers, Supervisors, and Workers.

Another problem of **intradepartmental** coordination is with regard to the location of offices. Except for the District Tuberculosis Office, the offices of the District Malaria Officer and Special Officer Leprosy are not located in the District Medical and Health Office. As a result these **officers** interact with the District **Medical** and Health Officer less frequently and continue with the vertical supervision of the individual programmes carried out by the staff recruited under these programmes. This **is** the reason why only some programmes are being supervised and not others.

At the district level all health and family welfare activities should be consolidated into a single office **with** the District Medical and Health officer (DMHO) as **the** head. The DMHO should be redesignated as Chief District Medical Officer, and the officers below should **be** designated as District Medical **Officers**, and given adequate **powers**. **This**



will **not** only result in job satisfaction, **but** also in better coordination of activities.

In the study it was found that coordination of health and all health related departments is grossly lacking and whatever coordination exists is confined only to the Family Planning Programme. This is because of over emphasis on the **Family** Welfare Programme and also partly because the medical and health departments have not been made accountable to the Village Panchayats and the **Zilla** Parishad.

Payscales of the Workers recruited under the vertical programmes or specific areas such as Malaria Eradication, Leprosy etc., should be made equal with those recruited under the **Multipurpose** Scheme as it is causing a great deal of resentment among the personnel. Uniformity in paycales should be brought about keeping in mind the educational qualifications, workers experience and the **salaries** drawn by them at present. This may call for a merger of certain financial heads and procedures for accounting and auditing.

6) The study shows that among all the primary health care programmes, the Family Planning Programme has been given overriding emphasis, and all energies of the employees are channelled into it at the cost of other programme\*. **This is** because of the target oriented approach based on **which** Workers are evaluated, and rewarded. **This target oriented** approach should be done away with **as it** acts \*\* a **deterrent** to the **primary health** care approach and people perceive **the** role

of **Health** Workers not as Health Workers, but as Family Planning Workers. If we ensure efficient, and effective delivery of primary health care services to the needy in the **villages**, the aim of spreading the **small** family norm becomes **easier**.

7) The reporting system regarding performance from the sub-centres to the district level should be **streamlined**, and suitable mechanisms devised to check authenticity of the data submitted by the Workers. Oneway of doing it is to check the sub-centre records maintained by the **Workers**, and also by cross checking this information at the village level from the beneficiaries. This would act as a **mechnism** of control, and also help in the proper planning and organization of **services**. External evaluation of programmes should be done as it would ensure **effective** delivery of services to **the** needy in the **villages**.

8) The study shows that the referral services at the sub-centres, and PHC are very poor, **therefore**, organized backup of referral services needs to be strengthened. The **services** at Rural Health Centres and District Hospitals should **be** improved to enable the personnel to refer cases. Since these organizations are not properly equipped the Workers send the cases to the hospitals in the city. This is the reason why hospitals in the city are overcrowded.

The above sugessted steps are by no means **complete**, but they emphasise the need to reorganize the existing health

care system, and mobilize the existing manpower, and other resources to the **optimal** level **without** wasting time to make primary health care **fully** operational. The **PHC** studied by us, according to the District Medical and Health Office, was supposed to be the best performing in the district. On the contrary, our findings show that the PHC is actually not performing **well** and has problems of coordination and integration at the various levels of the organization structure. Unless drastic steps are taken to correct the deficiencies of the system the objective of 'Health for All by 2000 AD' can never be achieved.

## BIBLIOGRAPHY

1. Anderson, O.W. (1972) : Patterns of Use of Health services, In, Freeman, H.K, and Keeder, L.G., Hand Book of Medical Sociology. New Jersey: Prentice - Hall.
2. Banerji, D (1976) : Formulating An Alternative Rural Health Care System For India: Issues and Perspectives. New Delhi : centre of Social Medicine and Community Health Jawaharlal Nehru University.
3. Banerji, D (1984) : Poverty, class and Health Culture. New Delhi: Prachi Prakashan.
4. Banerji, D (1985) : Health and Family Planning Services in India - An Epidemiological, Socio-cultural and Political Analysis and a Perspective. New Delhi: Lok paksh.
5. Banerji, D (1988) : Trends in Public Health Practice in India - A plea for a new public health. Paper presented at the thirty **second**. annual conference of the Indian Public Health Association, Hyderabad, February **6-7**.
6. Banerji, D (1989) : Class Inequalities and Unequal Access to Health Services in India. In, Social Action. **July-September, vol.39, NO.3** : 21b - 228.
7. Barnard, C.I (1938) : The Functions of the Executive. Cambridge, Mass : Harvard University Press.

8. Blau, P.M. (1965) : \_\_\_\_\_ of Bureaucracy.  
Chicago : University of Chicago Press.
9. Blau, P.M., and Scott, W.R (1962) : Formal Organizations. San Francisco : Chandler.
10. Blau, P.M., and Scott, W.R (1963) : Formal Organizations: A Comparative Approach. London : Routledge and Kegan Paul.
11. Bose, A., and Desai, P.B (1983) : Studies in Social Dynamics of Primary Health Care. Delhi : Hindustan publishing Corporation.
12. Bose, A (1983) : The community Health Worker Scheme: An Indian Experiment. In, Morley, D. Rhode, et.al., (ed.), Practicing Health For All. England : Oxford University Press.
13. Bose, A (1987) : For whom The Target Tolls? - A Critique of Family Planning Incentives. Cash Awards and Targets: Presidential Address. XII Annual conference of the Indian Association for the Study of Population. Allahabad, Allahabad University.
14. Caplow, T (1964) : Principles of Organization. New York : Harcourt, Brace and World.
15. Chuttani, C.S., et.al (1976) : Factors Responsible for **Under-utilization** of Primary Health Centres - A community Survey in three States of India. In, Journal of Health Administration. vol. IX, No.3: 229-237.

16. Dandare, **M.P.** (1985) : **The Community Health Volunteer - a change agent : A Case Study of the Vadu Community Health Volunteer Project, In, Journal of Family Welfare, June, 31(4) : 17-21.**
  
17. David, **L.H.**, and Narayana, **G** (1985) : **Management Needs Assessment USAID Area Development Project, Maharashtra. Administrative Staff College of India, Hyderabad.**
  
18. Devi, Manjula (1986) : **Awareness and utilization of government health services in Gulbarga (district) TIPS (Mimeo).**
  
19. Dutt. **P.R** (1962) : **Rural Health Services in India. New Delhi: Central Health Education Bureau, Directorate General of Health Services, Ministry of Health and Family Welfare.**
  
20. Dutta, Praphulla (1955) : **Rural Health and Medical Care in India. Ambala : Army Educational Stores.**
  
21. Etzioni, **A** (1961) : **A Comparative Analysis of Complex Organizations. Glencoe, Ill : Free Press.**
  
22. Etzioni, **A** (1964) : **Modern Organizations. Englewood cliffs. N.J. : Prentice-Hall Inc.**
  
23. Gandotra, **M.M.**, et.al(198Y) : **Multipurpose Health Workers Scheme in Gujarat : An evaluation. In, The Journal of Family Welfare. Vol. **XXXIV**. No.2.**



24. Gaum, J.M., et.al. (1936) : The Frontiers of Public Administration. Chicago : University of Chicago Press.
25. Ghosh, S (1983) : Primary Health Care for Developing Countries. In, Indian Paediatrics, April, 20(4) : 235-42.
26. Government of Andhra Pradesh (1960) : Third Five Year Plan. Department of Planning and Local Administration, Hyderabad.
27. Government of Andhra Pradesh (1969) : Fourth Five Year Plan. Department of Planning and Cooperation, Hyderabad.
28. Government of Andhra Pradesh (1970) : Fourth Five Year Plan. Telangana (1969-1974). Planning and Cooperation Department, Hyderabad.
29. Government of Andhra Pradesh (1971) : Evaluation Study on the Working of the Primary Health Centres in Andhra Pradesh. Evaluation study No:49. The Evaluation Wing of the Planning and Cooperation Department, Hyderabad,
30. Government of Andhra Pradesh (1973) : Fifth Five Year Plan Draft Outline. Planning and Cooperation Department, Hyderabad.
31. Government of Andhra Pradesh (1976) : Review of Progress - Fourth Five Year Plan (1969-74). Finance and Planning (Planning Wing) Department, Hyderabad.

32. Government of Andhra Pradesh (1980) : Sixth Five Year Plan. Volume II. Finance and Planning (Planning Wing) Department, Hyderabad.
33. Government of Andhra Pradesh (1984) : Medical and Health Care Services in Andhra Pradesh : A Review. Report prepared for the Department of Finance and Planning by Centre for Economics and Social Studies, Hyderabad.
34. Government of Andhra Pradesh (198b) : Evaluation Report on Primary Health Centres with attached Non-allopathic Clinics in Andhra Pradesh. Evaluation Study Report No.66. the Evaluation Wing of the Finance and Planning Department, Hyderabad.
35. Government of Andhra Pradesh (1988) : Seventh Five Year Plan. Volume II. Finance and Planning Department, Hyderabad.
36. Government of Andhra Pradesh (1988) : Seventh Five Year Plan - Midterm Appraisal. Finance and Planning Department, Hyderabad.
37. Goel, S.L (1981) : Health Care Administration : Policy Making and Planning. New Delhi: Sterling Publishers.
38. Goel, S.L. (1981) : Health Care Administration : Levels and Aspects. New Delhi: Sterling Publishers.
39. Government of India (1946) : Report of the Health survey and Development Committee. Delhi : Ministry of Health.



40. Government of India (1948) : Report of the National Planning Committee. Delhi : Ministry of Health.
41. Government of India (1952) : The First Five Year Plan. Planning Commission, New Delhi.
42. Government of India (1956) : The Second Five Year Plan. Planning commission, New Delhi.
43. Government of India (1961) : The Third Five Year Plan. Planning Commission, New Delhi.
44. Government of India (1962) : Report of the Health Survey and Planning Committee (Volume I and II), New Delhi : Ministry of Health.
45. Government of India (1968) : The Fourth Five Year Plan. Planning Commission, New Delhi.
46. Government of India (1973) : Report of the Committee on Multipurpose Workers under Health and Family Planning Programmes. New Delhi : Ministry of Health and Family Planning.
47. Government of India (1974) : The Fifth Five Year Plan. Planning commission, New Delhi.
48. Government of India (197b) : Report of the Group on Medical Education and Support - Man Power. New Delhi : Ministry of Health and Family Planning.

49. Government of India (1977) : Family Welfare Programme: A Statement. New Delhi: Ministry of Health and Family Welfare.
50. Government of India (1981) : Report on the Working Group on Health for All by A.D. 2000. New Delhi: Ministry of Health and Family Welfare.
51. Government of India (1983) : National Health Policy. New Delhi: Ministry of Health and Family Welfare.
52. Government of India (1983) : Health Statistics of India. Directorate General of Health Services, New Delhi: Ministry of Health and Family welfare.
53. Government of India (1985) : The Seventh Five Year Plan. Planning Commission, New Delhi.
54. Government of India (1986) : Job Responsibilities of Staff of the Primary Health Centre: 11-31. Rural Health Division, Ministry of Health and Family Welfare.
55. Government of India (1988) : Health Information India. Directorate General of Health Services, New Delhi: Ministry of Health and Family Welfare.
56. Government of India (1990) : Draft Approach to the Eight Five Year Plan. Planning Commission, New Delhi.
57. Government of Orissa (1983) : Management of Health and Family Welfare Services - Report on Department of Health and Family Welfare. Prepared by the Administration Staff College of India, Hyderabad.

58. Gross, B.M (1968) : Organizations and their Managing, New York: Free Press.
59. Herman, J.B., and Hulin, C.L (1972) : Studying Organizational Attitudes from Individual and Organizational Frames of Reference. In, Organizational Behaviour and Human Performance, 8: 84-108.
60. ICMR (1980) : National Conference on Evaluation of Primary Health Care Programmes - Summary Report, New Delhi.
61. ICMR (1989) : Evaluation of Quality of Maternal and Child Health and Family Planning Services at Primary Health Centres and Suggested Strategies for their Improvement - Summary Report, February Division of Human Resource Development research, New Delhi.
62. ICSSR - ICMR (1981) : Health For All - an Alternative strategy. Pune: Indian Institute of Education.
63. IIM, Ahmedabad (1985) : Public Systems Group Study of Facility Utilization and Programme Management in Family Welfare Bihar, September.
64. IIM, Ahmedabad (1985) : Public Systems Group Study of Facility Utilization and Programme Management in Family Welfare Madhya Pradesh. September.
- 8b. IIM, Ahmedabad (1985) : Public Systems Group Study of Facility Utilization and Programme Management in Family Welfare Uttar Pradesh. September.

- 66 . IIPS (1982) : Report on the Base-line survey on Fertility, Mortality and related factors in Bihar. International Institute for Population Sciences, Bombay;
67. IIPS (198b) : Base-line Survey on Fertility, Mortality and Related Factors in Maharashtra. International Institute for Population Sciences, Bombay and Department of Sociology, Marathwada University, aurangabad.
68. Indira Kapoor (1989) : Factors Responsible for Low Utilization of Health and Family Welfare Services in India. In, Basantibala, J. et.al, (ed.); Health and Family Welfare Services in India. New Delhi: Ashish publishing House.
69. Jeffery, Rogers (1986) : Issues in the Political Economy of Health in India. Paper presented at the seminar on Health For All: Concept and Reality Bombay, November 15-16
70. Jorapur, P.B (1979) : Problems in Implementing Family Planning Programmes: A study of Medical and Para-medical Personnel. Nutrition, Health and Family Planning in Karnataka. A Study of ICDS. Tirupati: Sri Venkateshwara University.
71. Karan Singh (1976) : The National Population Policy Statement. New Delhi: Ministry of Health and Family Welfare.

72. Kasi, S.V., and Cobb, M.D., et.al(1966) : Health Behaviour, Illness Behaviour and Sick Role Behaviour. In, Archives Environmental Health. Volume. 12, February.
73. Kast, F.E., and Rosenzweig, J.E(ed.)(1979) : Organization and Management: A Systems and Contingency Approach. Tokyo: McGraw Hill, Kogakusha Ltd.
74. Katz, D., and Kahn, R.L (1966) : The Social Psychology of Organizations. New York: John Wiley and Sons.
75. Lakshamma, T (1989) : Under Utilization of Maternal and Child Health and Family Planning Services - A case study of Andhra Pradesh. In, Basantibala, J.et.al.,(ed.), Health and Family Welfare Services in India. New Delhi: Ashish Publishing House.
76. Linton, R (1936) : The Study of Man. New York: Appleton Century.
77. Litterer, J.A (196b) : The Analysis of Organizations. New York: John Wiley and Sons.
78. Litterer, J.A (1973) : The Analysis of Organizations. 11<sup>th</sup>(ed.). New York: John Wiley and Sons, Inc.
79. Maru, R.M (1983) : The Community Health Volunteer Scheme in India: An Evaluation. In, Social Science and Medicine, 17 (19): 14YY-83

80. Maurya, K.N (1989) : An Analysis of Causative Factors **Responsible** for Low **Utilization** of Health and Family Welfare Services. In, **Basantibala, J.et.al.,(ed.), Health and Family Welfare Services in India**. New Delhi: Ashish Publishing **House**.
81. Mechanic, D (1978) : **Illness Behaviour**. In, Mechanic, D. **Medical Sociology** II(ed.). New York: the Free Press.
82. Merton, R.K (1940) : Bureaucratic structure and Personality. In **Social Forces**, 18.
83. Merton, R.K (1957) : **Social Theory and Social Structure**. New York: the Free Press.
84. Meyer, H.H.,et.al(1965) : Split Roles in Performance Appraisal. **Harvard Business Review**, 43(1) : 123-129.
85. Misra, B.D., et.al(1982) : **Organization for Change: A Systems Analysis of Family Planning in Rural India**. New Delhi: Radiant Publishers.
86. Mouii, A.S. chandra., et.al (1982) : Distance as a variable influencing the Delivery of Maternal and Child Health and Family Planning services. In, **Journal of Institute of Economic Research**, XVI : 26-37.
87. Muttalib, M.A (1973) : **Development Administration in Rural Government for Agricultural Production - An Approach in Comparative Administration**. Hyderabad: Osmania University.



88. Naik, J.P (1977) : An Alternative System of Health Care Services in India. New Delhi: All led Publishers.
89. Nirmala Murthy (1986) : Family Planning Programme: Lessons **from** Management Interventions. Vikalpa (A Journal for Decision Makers), volume, II, No.3, July-September, IIM, Ahmadabad.
90. Oommen, T.K (1985) : Health and society in India: Towards a Sociological understanding. In, Relevant Sociology, volume II, No.1.
91. Park, J.E. and Park, K (1979) : Text Book of Preventive and Social Medicine. Jabalpur: Banarasidas Bhancot.
92. Parsons, T (1951) : Towards a General Theory of Action. Cambridge, Mass: Harvard University Press.
93. Parsons, T (1952) : Social System. London: Tavistock publications Ltd.
94. Parsons, T (1956) : Suggestions for a Sociological Approach to the Theory of Organizations. In, Administrative Science Quarterly. 1:63-85, 225-39.
95. Parsons, T (1960) : Structure and Process in Modern Societies. Glencoe. ill: free Press.
96. Pannikar, P.G.K (1976) : Health Care Delivery System in India: Alternative Approaches. In, Economic and Political Weekly, volume XI. No.22.

97. Pannikar, P.G.K (1979) : Resources not the Constraints on Health **improvement: A** case study of Kerala. In, **Economic and Political Weekly**, volume XIV: 1803-1609.
98. Pannikar, P.G.K. and Soman, C (1984) : **Health Status of Kerala: Paradox of Economic Backwardness and Health Development.** Trivandrum, Centre For Development Studies.
99. Porter, L.W., et.al (1975) : **Behaviour in Organizations.** Singapore: McGraw Hill, Inc.
100. Porter, L.W., and Steers, R.M (1973) : Organizational Work and Personal Factors in Employee Turnover and Absenteeism. In, **Psychological Bulletin**, 80: 151-176.
101. Presthus, R.V (1958) : Towards a theory of **organizational** behaviour. In, **Administrative Science Quarterly**, 3.
102. Qadeer, I (1977) : Reshaping Health Services: A note on draft plan on rural health services. In, **Economic and Political Weekly**, volume XII: 926-928.
103. Qadeer, I (1985) : Health Services System: An Expression of **Socio-Economic** In equalities. In, **Social Action**, volume 35, July-September.
104. Raghavender Rao. D (1975) : **Public Health Services in Andhra Pradesh**. Hyderabad: Andhra Pradesh Academy of Sciences.



105. **Ram, Eric, R., and Dutta, B.K (1976)** : A study of the utilization of primary health **centre** and sub-centre health services by the rural people of Miraj **taluka, Maharashtra. In, Indian Journal Of Public Health. XX** : 134-143.
106. **Ram, Raghu, N.V (1971)** : **Health Administration and Policy Development.** Hyderabad: **Ramalakshmi** printers and publishers.
107. **Ram Reddy, G (1977)** : **Patterns of Panchayat Raj in India. Madras: Macmillan Co.**
108. **Rao, T. V (1984)** : **Human Dynamics in Management of Population Programme.** Paper presented at the **ICOMP** Biennial Conference, Tunis, 15-17 May, (edited by) Ellen Sattar, **Kuala Lumpur, Malaysia.**
109. **Reddy, P.H., and Narayana, C (1978)** : **Report of the Health and Family Welfare Programme Personnel - A Study in Job Satisfaction.** Population project, **Karnataka.**
110. **Reddy, P.H (1980)** : Resources not the constraint on health improvement: A comment. In, **Economic and Political Weekly.** volume XV: 123-124.
111. **Reddy, P.H., et.al (1983)** : **Health and Family Welfare Status of people: Report on Base-line Survey.** Bangalore: Population Centre (**Mimeo**).

112. Reddy, P.M (1989) : Utilization of Maternal and Child Health and family Welfare services in Andhra Pradesh. In, Basantibala, J. et.al,(ed.), Health and Family Welfare Services in India. New Delhi: Ashish publishing House.
113. Rosenstock, M. I (1961) : . Why people use health services. Milbank Memorial Fund Quarterly, volume 44: 94-127.
114. Sarbin, T.R (1959) : Role Theory. In Glindze's, Hand Book of Social Psychology, Volume 1. Cambridge, Mass: Addison Wesley.
115. Schein, E.H (1968) : Organizational Socialization and the Profession of Management. In, Industrial Management Review, 9 :1-16.
116. Schein, E.H (1970) : Organizational Psychology (second edition). Englewood Cliffs, N.J.: Prentice-Hall.
117. Schneider, B (1972) : Organizational climate: Individual differences and Organizational realities. In, The Journal of Applied Psychology. 56: 211-217.
118. Scott, W.G., and Mitchell, T.R (1972) : Organizational Theory (Revised Edition), Richard, D. Irwin, Inc., Homewood, Ill.
119. Shah, M.H (1989) : Factors Responsible for Low Performance of family Welfare Programme. In, basantibala, J. t.al,(ed.), Health and Family Welfare Services in India. New Delhi: Ashish publishing House.

120. Sholapurkar, M.V., et.al (1963) : Utilization of Institutional Health Care Facilities by the Target Groups in Rural Karna-taka. Population Centre (Mimeo).
121. Sills, D.L (1957) : The Volunteers. Glencoe, Ill: Free Press.
122. Silverman, D (1970) : The Theory of Organizations. London : Heinemann.
123. Simon, H.A (1952) : Comments on the Theory of Organization. In. American Political Science Review, 46.
124. Srinivasan, S (1987) : Management of Rural Health Care. In, Social volume 17, No.1.
125. Steers, R.M (1971) : The Concept of Organizational Goals: A research review. Unpublished manuscript, Graduate School of Administration, University of California, Irvine. In, Porter, L.W., et.al. Behaviour in Organiza-tions. Singapore: McGraw-Hill.
126. Strother, G. B (1963) : Problems in the Development of a Social Science of Organiza-tion. In, H.J. Leavitt (ed.), The Social Science of Organi-zations. Englewood Cliffs, N.J. : Prentice-Hall.
127. Suchman, E.A (1963) : Sociology and the field of Public Health. New York: Russel Sage foundation.

128. Suchman, E.A (1967) : Preventive Health Behaviour: A model for research on community health **campaigns**. In, **The Journal of Health and Social Behaviour**, 8(3), September.
129. Talwar, P.P., and Bhandari, S.C (1987) : **Health and Family Welfare Services in Rural Areas of Madhya Pradesh - An Assessment of Quality**. Paper presented at the ORG workshop on quality of Health and Family Welfare Services provided by Primary Health Centres and Sub-Centres in Rural India, 24th April.
130. Thompson, J.D (1967) : **Organizations in action**, New York: McGraw Hill.
131. Tosi, H.L., et.al (1970) : Setting Goals in Management by **Ojectives**. In, **California Management Review**, 12(4): 70-78.
132. WHO-UNICEF (1978) : **Primary Health Care**. Report of the international Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September.
133. Yoder, D (1956) : **Personnel Management and Industrial Relations**. Englewood Cliffs, N.J.: Prentice-Hall, Inc.
134. Yoder, D (1959) : **Personnel and Policies II** (ed), New York: Prentice-Hall. Inc.
135. Zald, M.N (1963) : Comparative Analysis and Measurement of Organisational goals: The case of correctional institutions for **delinquents**. In. **Sociological Quarterly**, 4: 206-230.

# A P P E N D I C E S

## APPENDIX I

### 1. INTERVIEW SCHEDULE FOR MEDICAL OFFICERS

#### A. Social-Characteristics :

1. Age (in years) : a) < 20, b) ~~20~~ - ~~29~~  
c) 30 - ~~39~~ d) 40 - ~~49~~  
e) 50 and above
2. Religion : a) Hindu, b) Muslim  
c) Christian
3. Caste : a) Schedule Caste  
b) backward Caste  
c) Other Caste
4. Nativity : a) Village b) Town c) City
5. Place of residence : a) PHC Village b) City
6. Marital Status : a) Married b) Unmarried  
c) Widowed d) Separated or Divorced
7. Educational : a) M.B.B.S b) M.D/M.S/  
Qualifications P.G. Diploma  
c) Any other (please specify)
8. After completing your education, have you ever been unem-  
ployed Y  
YES/NO , If Yes, specify period
9. Did you hold any other job/jobs before joining the present  
service Y  
YES/NO , If yes, please specify.
10. Length of service in the present job (in years)  
a) < 5 years b) 5 years, and above

#### B) Orientation towards 'Health for All by 2000 A.D'.

11. What in your opinion should be the principal aim(s) of a  
Medical Officer serving in a PHC?  
a)  
b)  
c)



12. What according to you is 'Health For All by 2000 A.D'?
13. Have you **ever** been transferred from one **PHC** to another Y  
 YES/NO , If yes, Number of times:
14. Have you any time tried to avoid a **transfer**?  
 YES/NO , If yes, state reasons :
15. Your opinion regarding transfers :  
 a) There should be transfers.  
 b) There should not be transfers. (Give reasons)
16. Training and opinion regarding inservice training programme:  
 Did you undergo any preservice training before taking up this job?  
 YES/NO , If yes,  
 a) Duration of training :  
 b) Institute where you were trained :  
 c) Year of training :
17. Did you attend any inservice training programme(s) ?  
 YES/NO , if yes,  
 a) Number of programmes :  
 b) Duration of training :  
 c) Institute where you were trained :  
 d) year of training :
18. What were the aim(s) of **the** training **programme(s)** which you attended?
19. Your satisfaction with the inservice training **programme(s)**:  
 a) Very satisfactory      b) Somewhat satisfactory  
 c) Not satisfactory      d) Highly dissatisfactory
20. Orientation towards Government service:
21. According to you, what are the two most important advantages of **being** in government **service**?

- a) Secure and pensionable job
- b) Can render service to **humanity**.
- c) Can establish contacts with other government officials.
- d) Any other (**please specify**),

22. What do you think are the two most important disadvantages of being in government **service**?

- a) Official interference
- b) Poor facilities and working conditions.
- c) Lack of promotional **avenues**.
- d) Frequent transfers.
- e) No private practice.
- f) Any other (please specify).

23. Which of the following services are given top priority from the organizations point of view, and what do you think should be given top priority (please rank in order)

| Services                              | Organizational<br>priorities | Personal<br>priorities |
|---------------------------------------|------------------------------|------------------------|
| -----                                 |                              |                        |
| a) Medical relief                     |                              |                        |
| b) Control of Communicable diseases   |                              |                        |
| c) <b>Environmental</b> sanitation    |                              |                        |
| d) Maternal and Child Health Services |                              |                        |
| e) Family Planning                    |                              |                        |
| f) School Health                      |                              |                        |
| g) Health Education                   |                              |                        |
| h) Collection of Vital statistics.    |                              |                        |

24. Workload and Supervision:

kindly give the actual distribution of work per **week**, for the following activities.

| Activity                       | Percentage of actual time<br>devoted |
|--------------------------------|--------------------------------------|
| -----                          |                                      |
| a) Medical <b>Relief</b>       |                                      |
| b) Administration              |                                      |
| c) Field Trips                 |                                      |
| d) Operations                  |                                      |
| e) Any other (please specify;. |                                      |

25. How often do you visit the sub-centres in your **jurisdiction**?



26. Your field trips are confined to :
- a) Sub-centre villages only
  - b) Sub-centre, as well as other villages
27. How much time do you spend on the supervision of the sub-centres and mode of **transportation**?
- Time spent during each trip:
- a) < 1 hour    b) 1 - 2 hours    c) more than 2 hours.
- Mode of transportation :
- a) Bus            b) Vehicle
28. Which of the following tasks do you supervise during your field **trips**?
- a) Maintenance of records
  - b) Stock position
  - c) **Target** achievement
  - d) **Problems** faced by the workers in implementing programmes
  - e) All the above
  - f) Any other (please specify)
29. What kind of instructions do you give the health **workers**?
- (a) Oral    (b) Written    (c) . Both
30. ~~Relationship with superiors, colleagues, and other workers:~~
- How would you characterize your relationship with the district level **administrations**?
- a) business like    b) authoritarian    c) Congenial
  - d) Counterproductive    e) Any other (please specify)
31. How would you characterize your relationship with the other Medical Officers in the **PHC**?
- a) **Professional** cooperation    b) Healthy **Professional** rivalry
  - c) Any other (please specify)

32. How often **do** the following personnel visit the **PHC**?
- | Category of personnel | Once a week | Once in two weeks | Once in a month | <b>Rarely</b> |
|-----------------------|-------------|-------------------|-----------------|---------------|
| a) Health workers     |             |                   |                 |               |
| b) Health supervisors |             |                   |                 |               |
| c) Health Guides      |             |                   |                 |               |
| d) Dais (trained)     |             |                   |                 |               |
33. Whenever workers visit the **PHC**, do they meet **you**?
- a) Yes, always    b) Sometimes    c) **Rarely**    d) Never
34. Do your staff cooperate on all matters and follow your instructions'/?
- YES/NO, If no, reasons :
- 3b. Is due recognition given to committed workers'/?
- a) yes, always    b) some times    c) never
36. How much time do you spend during the monthly meetings with your **workers**?
- a) < 1 hour    b) 1 - 2 hours    c) more than two **hours**.
37. What aspects do your discuss during the monthly meetings'/?
- a) **Target** achievements  
b) Action plan for the month  
c) Problems faced by the workers in the field  
d) Any other (please specify).
38. Do your workers find the meetings **useful**?
- YES/NO (state reasons)
39. What are the problems you encounter with your **staff**?
- a) Absenteeism  
b) Wot able to fulfil targets  
c) Lack of commitment.  
d) Lack of knowledge.  
e) Any other (please specify)

Relationship with local elite and other voluntary organization:

40. Do you maintain contacts with the village **leaders**?

YES/NO.

41. Do you get adequate support, and help from them **in times of need**?

YES/NO.

If yes, for what purpose do you seek their **help**?

42. Do you maintain contacts with the revenue officials, and other officials in the **mandal**?

YES/NO

43. Do they extend support whenever **needed**?

YES/NO

If yes, for what purpose do you seek their **help**?

44. Do you coordinate your activities with those of the voluntary organizations operating in your **area**?

YES/NO

If yes, what are the areas in which coordination is **sought**?

Assesment of the Primary Health Care activities and opinion regarding the outreach of services.

4b. How would you assess the following activities of **the PHC**?

| Activities | Satis<br>factory | Somewhat<br>Satisfactory | Not<br>satisfactory | <b>Highly</b><br>dis-<br>satisfactory |
|------------|------------------|--------------------------|---------------------|---------------------------------------|
|------------|------------------|--------------------------|---------------------|---------------------------------------|

- 
- a) Medical relief
  - b) Maternal and Child Health Services
  - c) **Family** planning
  - d) Malaria Era-dication

- e) Control of tuberculosis
- f) School Health
- g) Health Education
- h) Chlorination of water sources
- i) Maintenance of records and registers

46. Do you think that the services rendered by the **PHC** and sub-centres are reaching most of the people in the **villages**?

YES/NO, If no, state reasons:

47. Do you think, the **PHC** and sub-centres are **meeting** most of the needs of the people in the **villages**?

YES/NO, If no, state reasons:

## 2. INTERVIEW SCHEDULE FOR MULTIPURPOSE HEALTH SUPERVISORS

### A. Social-Characteristics:

1. Sex : a) Male b) **Female**
2. Age : a) < 20 b) 20-29 c) 30-39 d) 40-49  
e) 60 years and above
3. Religion : a) Hindu b) Muslim c) Christian
4. Caste : a) Schedule Caste b) backward Caste c) Other caste
5. Marital Status : a) Married b) Unmarried  
c) Widowed d) Separated/Divorced
6. Nativity : a) Village b) **Town** c) City
7. **Place** of residence : a) Sector headquarter b) **PHC** village  
c) City
8. Educational Qualifications :
  - a) Primary School
  - b) Secondary School
  - c) **SSC/MATRIC**
  - d) **Intermediate/PUC**
  - e) Degree/Diploma

9. After completing your education, have you ever been unemployed?  
 Yes/No  
 If yes, specify period
10. Did you hold any other job before joining the present service?  
 Yes/No  
 If yes, details of the job and number of years of service:
11. Details of present employment:  
 i) service in the present job:  
 ii) Population covered :

B. Orientation towards 'Health For All by 2000 A.D.'.

12. What according to you is 'Health For All by 2000' Y
13. What in your opinion should be the principal aim(s) of any Health Worker in our country?

C. Orientation towards government service:

14. According to you what are the three most important advantages of being in government service?
- a) Secure and pensionable job
  - b) Can render service to humanity
  - c) Can establish contacts with other government personnel
  - d) Any other
15. What do you think are the three most important disadvantages of being in government service?
- a) Official interference
  - b) Poor facilities and working conditions
  - c) lack of promotional avenues.
  - d) frequent transfers
  - e) Any other
16. have you ever been transferred from
- i) One PHC to another : Yes/No

If yes, number of times :

- a) 1-3 b) 4-6 c) 7-9 d) 10 times and above

17. Your opinion regarding transfers:

- a) there **shuld** be transfers  
b) there should not be transfers

(state reasons)

18. How would you **assess** the **following**? -

|                            | Level of satisfaction |                               |                       |                                        |
|----------------------------|-----------------------|-------------------------------|-----------------------|----------------------------------------|
|                            | Satis-<br>factory     | Somewhat<br>satisfa-<br>ctory | Not satis-<br>factory | Highly <b>dis</b><br>satisfac-<br>tory |
| a) Salary                  |                       |                               |                       |                                        |
| b) Promotions              |                       |                               |                       |                                        |
| c) Transfers               |                       |                               |                       |                                        |
| d) Working<br>conditions   |                       |                               |                       |                                        |
| e) Housing faci-<br>lities |                       |                               |                       |                                        |
| f) Travelling<br>allowance |                       |                               |                       |                                        |

19. **Training** :

Did you undergo any preservice training before your **posting**?

Yes/No

- If yes,      i) Duration of training :  
                 ii) **Institute** where you :  
                                         underwent training  
                 iii) Year of training :      :

20. What is the total number of inservice training **programmes** attended by you, and what are **they**?

- i) (a) 1      (b) 2      (c) 3      (d) 4      (e) more **than** four  
ii) Name of programmes attended :



21. Your opinion regarding the inservice training programmes you attended :

- a) Very Satisfactory.
- b) Somewhat satisfactory
- c) Not satisfactory
- d) Highly dissatisfactory

22. Have you ever been involved in the training of **personnel**?

Yes/No , If yes, category of personnel

- a) Health Workers (men)
- b) Health Workers (women)
- c) Health Guides
- d) Dais

E. Workload and Supervision :

23. Kindly give the actual time spent on supervision per week, for the following activities :

| Activity                                 | Percentage of actual time devoted |
|------------------------------------------|-----------------------------------|
| -----                                    | -----                             |
| a) Maternal and Child Health Care        |                                   |
| b) family <b>Planning</b>                |                                   |
| c) Control of Communicable Diseases      |                                   |
| d) Health Education                      |                                   |
| e) School Health                         |                                   |
| f) Environmental Sanitation              |                                   |
| g) Maintenance of records and registers. |                                   |

24. How often do you visit the **sub-centres**?

- a) Once a week
- b) Once in 2 weeks
- c) Once a month

25. Distance between place of stay and the **sub-centres** in your **jurisdiction**?

- a) 3-6 Kms
- b) 7-10 Kms
- c) 11-14 Kms
- d) 15 Km and above

26. 'Time spent on your routine trips to **the** sub-centres (travel time excluded), and mode of transportation used :

| 'Time spent during each trip<br>----- | Mode of transportation used<br>----- |
|---------------------------------------|--------------------------------------|
| (a) 1 hour                            | (a) <b>Walk</b>                      |
| (b) 1 - 2 hrs                         | (b) Bus                              |
| (c) 3 - 4 hrs                         | (c) Bicycle                          |
|                                       | (d) Motorcycle                       |

27. Your field trips are confined to :

- a) Sub-centre villages
- b) Sub-centre villages as well as other villages

28. Which of the following tasks do you **supervise**?

- a) Maintenance of records
- b) Position of targets achieved
- c) Deliveries conducted
- d) Antenatal Care
- e) Family Planning Programme implementation
- f) Spraying of DDT
- g) Chlorination of wells
- h) Collection of blood smears
- i) School Health
- j) Stock position
- k) **Immunization**
- l) Any other

29. What kind of instructions do you give **the** health **workers**?

- a) Oral            b) Written        c) **Both**

30. Do you maintain an advance tour dairy that **is** a **months** plan of visit to **villages**?

Yes/No

31. **Is** it always possible to follow the tour programme as per the **plan**?

- a) Yes, it is possible to follow
- b) No, it is not always possible to follow (state reasons)



**Relationship with superiors, colleagues, and other workers**

32. How would you characterize your relationship with your **superiors**?

- a) Business like
- b) authoritarian
- c) Congenial
- d) Counterproductive

33. How often do you meet the following personnel in the **field**?

| Personnel             | Once a week | Once in 2 weeks | Once in a month | Rarely | Never |
|-----------------------|-------------|-----------------|-----------------|--------|-------|
| -----                 |             |                 |                 |        |       |
| a) District Officers  |             |                 |                 |        |       |
| b) Medical Officers   |             |                 |                 |        |       |
| c) Extension Educator |             |                 |                 |        |       |

34. How much time do they spend during their **visits**?

| Personnel             | Time spent |         |                 |
|-----------------------|------------|---------|-----------------|
|                       | < 1 hr     | 1-2 hrs | more than 2 hrs |
| -----                 |            |         |                 |
| a) District Officers  |            |         |                 |
| b) Medical Officers   |            |         |                 |
| c) Extension Educator |            |         |                 |

35. Do they supervise the work done by **you**?

Yes/No

if yes, tasks supervised

- a) Checking records
- b) Stock position
- c) Targets achieved
- d) Problems faced during supervision and implementation of programmes
- e) Any other

36. During your visits to the sub-centres, do you get to meet the following **personnel**?

| Category of personnel | frequency |           |               |       |
|-----------------------|-----------|-----------|---------------|-------|
|                       | Always    | sometimes | <b>Rarely</b> | Never |

- a) Healthworkers (women)
- b) Healthworkers (men)
- c) Health Guides
- d) Dais (trained)

37. Is due recognition given for good **performance**?

- a) Yes, always
- b) Sometimes
- c) Never

38. Do you find the monthly meetings held at the **PHC**, useful'/?

- a) yes
- b) no
- If yes, in what way :
- If no, state reasons :

39. Do you meet your other colleagues in your **area**?

Yes/No

If yes, how often ?

- a) Once a week
- b) **Once** in 2 weeks
- c) Once a month
- d) **Rarely**
- e) Never

40. Do you visit the sub-centres together/  
res/No

If yes, how often?

- a) Once a week
- b) **Once** in 2 weeks
- c) Once a month
- d) **Rarely**
- e) Never

41. Do you find working together advantageous /  
Yes/No

If yes, in what **way**?

If no, why so'/?

42. Do you get adequate help, and cooperation from **the** following **personnel**?

personnel

- |                           |        |
|---------------------------|--------|
| a) health workers (women) | Yes/No |
| b) health workers (men;   | Yes/No |
| c) wealth Guides          | Yes/No |

d) Dais . Yes/No

If no, state reasons

43. Do they follow your instructions?

Yes/NO

If no, state reasons

44. What are the problems you encounter with the health workers?

- a) Not able to fulfil targets
- b) Lack of commitment
- c) Never available in the field
- d) Lack of proper knowledge
- e) Any other

G. Relationship with the local elite and other Voluntary Organizations:

4b. Do you maintain contacts with the village leaders?  
Yes/NO

i) If yes, do you get adequate support and help from them in times of need?  
Yes/No (please explain)

4b. Do you coordinate your activities with the activities of the voluntary organizations operating in your area?

Yes/No  
If yes, what are the areas in which coordination is sought?

H. Assessment of the Primary Health Care activities and opinion regarding the outreach services :

4/. how would you assess the following activities of the PHC?

| Activities                            | Satisfactory | Somewhat satisfactory | Not Satisfactory | Highly dissatisfactory |
|---------------------------------------|--------------|-----------------------|------------------|------------------------|
| a) Medical relief                     |              |                       |                  |                        |
| b) Maternal and Child health Services |              |                       |                  |                        |
| c) Family Planning                    |              |                       |                  |                        |
| d) Malaria Eradication                |              |                       |                  |                        |
| e) Control of Tuberculosis            |              |                       |                  |                        |
| f) School Health                      |              |                       |                  |                        |
| g) Health Education                   |              |                       |                  |                        |

- h) Chlorination of  
Water sources
  - i) Maintenance  
of records and  
registers.
- 

4d. Do you think, the **PHC/sub-centres** are meeting most of the  
needs of the people in your **area**?

Yes/No

If no, why do you think so?

4y. Do you think the services rendered by the **PHC/Sub-centres**  
are reaching all the villages in **Hayatnagar Mandal**?

Yes/No

If no, state reasons:

5d. Which of the following strata do you think are the main  
beneficiaries of the **PHC/Sub-centre services**?

- a) Lower Socioeconomic strata
- b) Middle Socioeconomic strata
- c) Upper Socioeconomic strata

## APPENDIX II

### INTERVIEW SCHEDULE FOR **MULTIPURPOSE HEALTH WORKERS**

#### A. Social Characteristics :

1. Name of the sub-centre :
2. Sex : a) Male b) Female
3. Age : a) < 20 years b) 20 - 29 years c) 30 - 39 years  
d) 40 - 49 years e) 50 years and above
4. Religion : a) Hindu b) Muslim c) Christian
5. Caste : a) Scheduled Caste  
b) Backward Caste c) Other Caste
6. Marital Status : a) Married b) Unmarried c) Widowed  
d) Divorced e) Separated
7. Nativity : a) Village b) Town c) City
8. Place of residence : a) Sub-centre Village b) city
9. Educational Qualifications :
  - a) Primary school
  - b) Secondary school
  - c) SSC/Matric
  - d) Intermediate/PUC
  - e) Degree/Diploma
10. Occupation of father :
  - a) Small/Marginal farmer
  - b) business
  - c) Government service
  - d) Private job
  - e) Any other
11. After completing your education, have you ever been unemployed?  
Yes/No  
If yes, specify period :
12. Did you hold any other job before joining the present service?  
Yes/No  
If yes, details of the job and number of years of service.
13. Service in the present job :  
(a) 1-2 years (b) 3-4 years (c) 5-6 years (d) 7-8 years  
(e) 9-10 years (f) above 10 years

B Orientation towards 'Health For All by 2000 A.D'.

14. What according to you is 'Health For All by 2000 A.D'?

15. What in **your** opinion should be the principal **aim(s)** of any health worker in our **country**?

a)

b)

C Orientation towards government service :

16. ~~According to you what are the~~ **three** most important advantages of being in **Government service**?

(a) Secure and pensionable job

(b) Can render service to humanity

(c) Can establish contacts with other government personnel

(e) Any other.

17. What do you think are the **three** most important disadvantages of being in **Government service**?

(a) Official **interference**

(b) ~~Poor~~ facilities and working conditions

(c) Lack of promotional avenues

(d) **Transfers**

(e) Any other

18. have you ever been **transferred**?

Yes/No

~~If~~ yes,

Number of times:

1a) 1-3 (b) 4-6 (c) 7-9 (d) 10 times and above

19. have you any time avoided a **transfer**?

Yes/No

~~If~~ yes, state reasons

20. Your opinion regarding transfers :

1a) there should be transfers

(b) there should not be transfers  
(give reasons)



21. How would you assess the following?

|  | Satisfactory | Somewhat satisfactory | Not satisfactory | Highly dissatisfactory |
|--|--------------|-----------------------|------------------|------------------------|
|--|--------------|-----------------------|------------------|------------------------|

- a) Salary
- b) Promotions
- c) Transfers
- d) Working conditions
- e) Housing facilities
- f) Travelling allowance

#### D Training

22. Did you undergo any preservice training before your posting?  
Yes/No

If yes,

- a) Duration of training :
- b) Institute where you underwent training :
- c) Year of training :

23. Number of inservice training programmes attended by you and what are they?

- i) (a) 1 (b) 2 (c) 3 (d) 4 (e) more than four

ii) Names of training programmes attended :

24. Your opinion regarding the following aspects of the inservice training programmes you attended:

|  | Satisfactory | Somewhat satisfactory | Not Satisfactory | highly dissatisfactory |
|--|--------------|-----------------------|------------------|------------------------|
|--|--------------|-----------------------|------------------|------------------------|

facilities provided  
at the training  
centre

Personnel involved  
in the training  
programme

Duration of training  
programme

25. Do you have any suggestions for improving the **training** programme?

- (a) Programme should impart more knowledge
- (b) Should lay more emphasis on practical training
- (c) Duration of training should be longer
- (d) There should be an increase in the stipend paid
- (e) Any other

26. Were you given any **on-the-job** training'/?

Yes/No

If yes,

i) Category of personnel involved in the training:

ii) Did you find it useful?

Yes/No

If yes, in what way:

If no, state reasons:

27. Have you ever been involved in the training of **personnel**?

Yes/No

If yes, category of **personnel**:

(a) Health Guides (b) Dais

**E** Workload and Supervision :

28. What are the job duties you **perform**?

- (a) Family planning (b) Antenatal care (c) Deliveries
- (d) Medical relief (e) health education
- (f) Control of communicable diseases
- (g) Sanitation and hygiene (h) School health
- (i) Immunization (j) Any other

29. Distance between place of stay and **sub-centre**?

(a) 1-2 km (b) 3-4 km (c) 5-6 km (d) more than 6 km

30. What is the total distance you have to travel to cover **the** villages in your **jurisdiction**?

(a) same village (b) 1-3 km (c) 4-6 km (d) 7-9 km  
(e) 10-12 km (f) more than 12 kms

31. Time spent on your routine trips to the villages (travel time excluded) and mode of transportation used:



Time spent per trip

Mode of transportation

- (a) 1-2 hrs
- (b) 3-4 hrs
- (c) 4-6 hrs
- (d) More than 6 hours

- (a) Walk
- (b) Bus
- (c) Bicycle
- (d) Motor cycle

32. Your field trips are confined to
- (a) Sub-centre village only
  - (b) Sub-centre village and other villages
33. How often do you visit your **villages**?
- (a) Once a week
  - (b) Once in 2 weeks
34. During your visit to the village, number of households you cover?
- (a) < 5
  - (b) 5-9
  - (c) 10-14
  - (d) 15-19
  - (e) 20 and above
35. Do you maintain an advance tour diary, that is, a month's plan of visit to **villages**?
- Yes/No
36. Is it always possible to follow the tour programme as per the plan?
- (a) Yes, it is possible to follow
  - (b) No, it is not always possible to follow (Reasons)
37. Do you supervise the work of the following **personnel**?
- (a) Health Guides
  - (b) Dais
- Yes/No
- If yes, tasks supervised:
- (a) Deliveries conducted
  - (b) Number of blood smears collected
  - (c) Stock position of drugs
  - (d) Use of the delivery Kit by the dais
  - (e) Any other

**Relationship with superiors, colleagues and other workers:**

38. How would you characterize your relationship with your superiors?

| Category of personnel | Business like | Authoritarian | Congenial | Counter productive | Any other |
|-----------------------|---------------|---------------|-----------|--------------------|-----------|
| a) Medical Officers   |               |               |           |                    |           |
| b) Extension Educator |               |               |           |                    |           |

- c) Health Supervisors (men)
- d) Health Supervisors (women)

39. How often do you meet the following personnel in the village?

| Personnel                     | Once a week | Once in 2 weeks | Once a month | Rarely | Never |
|-------------------------------|-------------|-----------------|--------------|--------|-------|
| a) District Officers          |             |                 |              |        |       |
| b) Medical Officers           |             |                 |              |        |       |
| c) Extension Educator         |             |                 |              |        |       |
| d) Health Supervisors (men)   |             |                 |              |        |       |
| e) Health Supervisors (women) |             |                 |              |        |       |

40. How much time do they spend with you during the visits'/?

| Personnel                     | Time spent |         |                 |    |
|-------------------------------|------------|---------|-----------------|----|
|                               | < 1 hr     | 1-2 hrs | More than 2 hrs | NK |
| a) District Officers          |            |         |                 |    |
| b) Medical Officers           |            |         |                 |    |
| c) Extension Educator         |            |         |                 |    |
| d) Health Supervisors (women) |            |         |                 |    |
| e) Health Supervisors (men)   |            |         |                 |    |

41. Do they supervise the work done by you?

Yes/No

What are the tasks supervised by your immediate supervisors?

- (a) Checking records
- (b) Stock position
- (c) Target achievement
- (d) Problems faced during implementation of tasks
- (e) Deliveries
- (f) DDT spraying
- (g) Chlorination of wells
- (h) Immunization
- (i) Any other

42. During your visits to the villages, do you meet the following **personnel**?

| Personnel         | Yes, always | Sometimes | Barely | Never |
|-------------------|-------------|-----------|--------|-------|
| (i) Health Guides |             |           |        |       |
| (ii) Dais         |             |           |        |       |

43. Is clue **recognition** given for good performane?  
 (a) Yes, always (b) Sometimes (c) **Rarely**  
 (d) Never (e) Any other

44. Whenever a worker is not **position** to **fulf il** the targets given to him/her, is any action **taken**?  
 Yes/No  
 (please explain)

45. Do you **find** the monthly meetings held at the **PHC, useful**?  
 (a) Yes (b) WO (c) **NK**  
 If yes, in what **way**?

If no, **state** reasons :

46. Can you recollect any instance(s) when you asked for help from **your** supervisor but were **refused**?

Yes/No/NK

If yes, could you cite a couple of instances :

47. Do you meet your other colleagues from the sub-centre area?  
 Yes/No  
 If yes, how often?

(a) Once a week (b) **Once** in two weeks  
 (c) Once a month (d) Never (e) **Rarely**

48. Do you visit the **village(s)** together?  
 Yes/No  
 If yes, how often?

(a) Unce a week (b) Unce in 2 weeks (c) One\* a month  
 (d) Never (e) **Rarely**

49. Do you seek any help from your **colleagues**?  
 Yes/No  
 If yes. in which of the following **areas** :

- (a) Family Planning (b) **Immunization**  
 (c) Health Education (d) School Health (e) Any other

50. Do you **find** working together advantageous?

Yes/No

If **yes**, in what **way**?

If **no**, why so?

b 1. Do you get, adequate help and cooperation from the following **personnel**?

(a) Health Guides Yes/No

(b) **Dais** Yes/No

If no, state reasons

b2. Do they follow your **instructions**?

Yes/No

If no, state reasons

#### G Programme wise Performance :

##### 1. Medical Relief:

53. How many patients do you see per day on an average **for** medical **relief**?

(a) < 5 (b) 5-10 (c) 11-15 (d) More than 15 patients

54. Whenever there is a complicated/emergency case where do you refer such cases to?

(a) PHC

(b) Nearest government Hospital

(c) **Private** nursing home

(d) Any other

55. Do you maintain any record of the referred **cases** to provide follow up services?

Yes/No

If yes, give reasons :

##### 2. Maternal and Child Health Care :

56. Do all expecting **mothers** register for antenatal care at your sub-centre?

Yes/No

If no, what do you think are the reasons

(a) Sub-centre far away

(b) inadequate facilities

(c) System of registration not known

(d) Local help available (**PHN/Dai**)

(e) Any other

57. Do the expecting mothers (**those registered**) come for regular antenatal check ups?  
Yes/No  
If **yes** (i) number of **women** provided **ANC at** your centre during the past one year :
58. Do you render antenatal services to mothers at their homes?  
Yes/No  
If **yes**, services **provided**:  
If **no**, **state** reasons :
59. What antenatal services do you **provide**?  
(a) **T** for the expecting mothers  
(b) Distribute **iron** and **folic** acid tablets  
(c) Provide nutrition education  
(d) Advise on personal hygiene and sanitation  
(e) Any other
60. Do you take care to identify high risk and abnormal pregnancies?  
Yes/No  
If **yes**, number of abnormal/high risk pregnancies registered during the past one year:
61. Number of deliveries conducted by you at your sub-centres during the past one year:
62. Do you maintain a record of deliveries conducted by trained dais?  
Yes/No  
If **yes**, number of deliveries conducted by the **dais** in the last one year in your area:
63. Whom do the people generally **prefer**?  
(a) yourself (b) Health supervisor (c) Dai  
(give reasons)
64. Are you satisfied **with** the facilities provided for **ANC** at your **centre**?  
Yes/No  
If **no**, **state** reasons
65. Do you provide any postnatal services to **mothers**?  
Yes/No  
If **yes**, services provided  
(a) Advise on **Family Planning**  
(b) **Immunization** schedule to be followed, **and** its importance for the child  
(c) **Health** and nutrition education  
(d) Weaning procedures  
(e) **Treatment** of minor **problems**

(f) Any other

If no, state reasons:

3 Family Planning (FP) :

66. Total number of eligible couples in your area: \_\_\_\_\_

Number of eligible couples contacted : \_\_\_\_\_

Number of eligible couples yet to be contacted: \_\_\_\_\_

67. Number of **eligible** couples protected by various family planning methods in your **area**?

- (a) IUDs
- (b) Oral Pills
- (c) Condoms
- (d) Tubectomy
- (e) Vasectomy

68. Number of eligible couples not accepting any family planning method in your area: \_\_\_\_\_

Reasons:

- (a) Fear of side effects
- (b) Superstition
- (c) Desire for more children
- (d) Any other

69. Do you depend on the Health Guides and Dais for information regarding eligible **couples**?  
Yes/No

70. Rank the following methods in terms of their **acceptability**:

- (a) IUDs
- (b) Oral pills
- (c) Condoms
- (d) Tubectomy
- (e) Vasectomy

71. Your assessment of the family **Planning Programme**

| Method               | Satisfactory | Somewhat satisfactory | Not Satisfactory | Highly dissatisfactory |
|----------------------|--------------|-----------------------|------------------|------------------------|
| a) Temporary methods |              |                       |                  |                        |
| b) Permanent methods |              |                       |                  |                        |



1± not satisfied, could you suggest ways of improving the family planning **performance**:

72. Total number of children (6 years and **below**) in your **area**:

73. Number of children immunized (**completely**) and number of children yet to be immunized for the **following**:

| Vaccine          |          | No. of children immunized | No. of children yet to be immunized |
|------------------|----------|---------------------------|-------------------------------------|
| 1. DPT           | I Dose   |                           |                                     |
|                  | II Dose  |                           |                                     |
|                  | III Dose |                           |                                     |
| 2. Polio         | I Dose   |                           |                                     |
|                  | II Dose  |                           |                                     |
|                  | III Dose |                           |                                     |
| 3. BCG           |          |                           |                                     |
| 4. Measles       |          |                           |                                     |
| 5. DPT (Booster) |          |                           |                                     |
| 6. Polio ( " )   |          |                           |                                     |
| 7. DT            |          |                           |                                     |

74. Number of children not immunized in your **area**: \_\_\_\_\_  
Reasons:

- (a) Fear of side effects
- (b) No faith in immunization
- (c) Vaccination not regular in his visits
- (d) Vaccine not available
- (e) Place of immunization too **far**
- (f) Mother too busy
- (g) Child ill
- (i) Any other

75. how often is vaccination carried out in your **area**?  
(a) Once a week (b) Once in 2 weeks (c) **Once** a month  
(d) Once in 2 or 3 months (e) **Rarely**

76. Do you encounter any problems in implementing **the** immunization **programme**?  
Yes/No  
**If** yes,  
la) Lack of cold storage  
(b) Lack of adequate staff  
(c) Vaccines not available  
(d) Any other

YY. Your assessment of the immunization **programme?**

- (a) Satisfactory
- (b) Somewhat satisfactory
- (c) Not satisfactory
- (d) Highly dissatisfactory

5 Control of communicable diseases :

78. What are the common communicable diseases prevalent in your area?

- (a) Malaria (b) Tuberculosis (TB) (c) Leprosy
- (d) Any other

79. Services provided in the case of malaria for the past one year:

- i) Number of cases suspected to be suffering from malaria in your area : \_\_\_\_\_
- ii) Number of smears collected: \_\_\_\_\_
- iii) Number of cases given presumptive treatment: \_\_\_\_\_

80. how long does it take to receive the reports from the lab?  
(a) 2-3 days (b) 4-5 days (c) 6-7 days (d) 8 days and above  
(e) Any other

Number of positive cases identified during the year: \_\_\_\_\_

81. how often is DDT sprayed?

- (a) Sprayed only when there is a positive case
- (b) Once in 2 to 3 months
- (c) Once in 6 months
- (d) Once a month
- (e) Once in 4-5 months
- (f) Any other

82. Present status of NM&P in your area:

- (a) Cases are on the increase and programme ineffective
- (b) Cases are on the decrease and programme effective
- (c) Programme effective but not given enough importance
- (d) Any other

83. Number of TB cases identified in your area during the past one year \_\_\_\_\_

84. Number of cases for which sputum was collected and examined: \_\_\_\_\_

85. Number of cases treated at:

- i) PHC: \_\_\_\_\_
- ii) District level : \_\_\_\_\_



86. **Present** status of the National **TB Control Programme**
- i) Cases are **on** the increase and programme **ineffective**
  - ii) Cases are on the decrease and programme effective
  - iii) Programme effective but not given enough importance

6. **School Health/Environmental Sanitation/Health Education**

87. Do you participate in the school health **programmes**?  
Yes/No

i) If yes, the number of schools you **cover**: \_\_\_\_\_

ii) services rendered : (a)  
(b)  
(c)

88. Do you chlorinate the wells and ponds in the **village**?  
Yes/No  
If yes,

Number of water sources

Frequency

(a) 1 - 2  
(b) 3 - 4  
(c) 5 - 6  
(d) More than 6

(a) Only when there is an epidemic  
(b) Once in more than 8 **months**  
(c) Once in 3-4 months  
(d) Once in 2 months  
(e) Once a month  
(f) More than once a month

89. Do you organize educational sessions for the people **in** your **area**?

Yes/No

i) If yes,

| Type of educational activity | Frequency | Type of aids used | Average attendance | Place where the activity is organized |
|------------------------------|-----------|-------------------|--------------------|---------------------------------------|
| 1. Group discussions         |           |                   |                    |                                       |
| 2. Meetings                  |           |                   |                    |                                       |
| 3. Individual or home visits |           |                   |                    |                                       |

1. **Group** discussions  
2. Meetings  
3. **Individual** or home visits

ii) Topics of discussion :  
(a) family Planning (b) Hygiene and Sanitation  
(c) Health education (d) **Importance** of Immunisation  
(e) Any other.

90. List of registers and records maintained

- i.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.

H Assessment of infrastructural facilities at the sub-centre:

91.

| Facilities                                | Batista-<br>ctory | Somewhat<br>satisfactory | Not sati-<br>sfactory | Highly dis-<br>satisfactory |
|-------------------------------------------|-------------------|--------------------------|-----------------------|-----------------------------|
| a) Location of<br>sub-centre              |                   |                          |                       |                             |
| b) Condition of<br>sub-centre<br>building |                   |                          |                       |                             |
| c) Equipment                              |                   |                          |                       |                             |
| d) Position of drugs                      |                   |                          |                       |                             |
| e) Storage facility                       |                   |                          |                       |                             |
| f) Toilet                                 |                   |                          |                       |                             |
| g) Water                                  |                   |                          |                       |                             |
| h) Electricity                            |                   |                          |                       |                             |

i Relationship with the local elite and other voluntary organizations:

92. Do you maintain contacts with the village leaders?

Yes/No

i) If yes, do you get adequate support and help from them in times of need?

Yes/No (please explain)

93. Do you have mahila mandals/youth clubs in your villages?

Yes/No

i) If yes. do you regularly attend the meeting\* held there?

Yes/No

ii) If yes. do you find such a gathering useful?

Yes/No

- iii) If yes, in what way?
- iv) If no, state reasons:

94. Are there any individuals (PMPs/RMPs) providing health care in your area?  
 Yes/No  
 If yes, did you at any time avail their services?  
 Yes/No  
 If yes, cite a couple of instances.

95. Are there any voluntary organizations providing health care facilities in your area?  
 Yes/No  
 If yes

- |    |                             |     |                   |
|----|-----------------------------|-----|-------------------|
| i) | Name of the organization(s) | ii) | Services rendered |
|    | -----                       |     | -----             |
|    | a)                          |     |                   |
|    | b)                          |     |                   |
|    | c)                          |     |                   |

96. Do you coordinate your activities with theirs?  
 Yes/No  
 If yes, cite a couple of instances:

J Orientation regarding outreach of Services:

97. Do you think, the PHC/Sub-centres are meeting most of the needs of the people in your area?  
 Yes/No  
 If yes, why do you think so?

98. Do you think the services rendered by the PHC/Sub-centres are reaching all the villages in Hayatnagar Mandal?  
 Yes/No  
 If no, state reasons:

99. Which of the following strata do you think are the main Beneficiaries of the PHC/Sub-centre services?  
 (a) Lower socio-economic strata  
 (b) Middle socio-economic strata  
 (c) Upper socio-economic strata

100. Any thing else you would like to discuss regarding the performance of the PHC services, and problems encountered by you:

### APPENDIX III

#### 1. INTERVIEW SCHEDULE FOR VILLAGE HEALTH GUIDES (VHGs)

##### A. Social Characteristics :

1. Name of the village :
2. Age : a) < 20 years b) 20 - 29 years c) 30 - 39 years  
d) 40 - 49 years e) 50 years and above
3. Religion : a) Hindu b) Muslim c) Christian
4. Caste : a) Scheduled Caste  
b) Backward Caste c) Other Caste
5. Marital Status : a) Married b) Unmarried c) Widowed  
d) Separated/Divorced
6. Educational Qualifications :
  - a) Primary school
  - b) Secondary school
  - c) SSC/Matric
  - d) Intermediate/PUC
  - e) Degree/Diploma
7. Details of present employment :  
(a) 1-2 (b) 3-4 (c) 4-5 (d) 5-6 (e) 6 years and above
8. Do you have any other occupation (other than being a VHGs)?  
Yes/No  
If yes,
  - (a) Agriculture (b) business
  - (c) Traditional Caste occupation (d) Any other
9. Income  
(a) < 500 (b) 500 - 100 (c) 1001 - 1500 (d) 1501 - 2000
10. Did you hold any other job before being selected as a VHGs?  
Yes/No  
If yes, details of the job

##### B. Recruitment and Training.

11. how did you come to know of the VHGs scheme?
12. Who selected you as a VHGs?
  - (a) Village Sarpanch (b) PHC Medical Officer (PHC MU)
  - (c) health Supervisor (MS)

13. Did you undergo any training programme?  
Yes/No  
If yes, i) Duration of training :  
ii) Place :  
iii) Year of training :
14. Which of the following personnel were involved in the training programme?  
(a) PHCMOs (b) HS
- 1b. Did you find the training programme **useful**?  
Yes/No  
If no, state reasons:
16. Were you given any reading material during or after **the** training **course**?  
Yes/No  
If yes,  
i) Do you find it useful : Yes/No  
ii) Do you refer to it in case of any **doubt**? : Yea/No
17. Your satisfaction with the training programme?

-----  
Satisfactory      Somewhat satisfactory      Not satisfactory      Highly **dis**-satisfactory

- a) **Personnel** involved in the training programme  
b) Duration of the training programme  
c) Stipend

18. If not satisfied, do you have any suggestions to **improve** the training programme/  
(a) **Programme** should impart more knowledge and **skills**  
(b) Duration of training should be longer  
(c) there should be an increase **in** the stipend **paid/hono**-rarium and regular payment  
(d) Any other

C **Performance:**

19. Which of the following services do you provide in the **vill**-lage?  
(a) Treatment of common ailments  
(b) identification of fever cases  
(c) **Chlorination** of **wells**  
(d) Distribution of condoms  
(e) Any other

20. How many patients do you see per day for medical **relief**?  
 (a) < 5 (b) 5-10 (c) 11-20 (d) more than 20
21. Do you provide any services to pregnant women?  
 Yes/No  
 If yes, i) Distribute **Iron & folic** acid tablets  
 ii) **Provide** Vitamin 'A' solution  
 iii) Provide **'T'** Vaccine  
 iv) Health and nutrition education  
 v) Any other
22. Do you help the **MPHWs** in the immunization **programmes**?  
 Yes/No  
 If yes, what type of help do you **render**?
23. Do you motivate cases for family planning?  
 Yes/No  
 If yes,
- | Method<br>----- | No. of cases motivated<br>----- |
|-----------------|---------------------------------|
| 1. Vasectomy    |                                 |
| 2. IUDS         |                                 |
| 3. Tubectomy    |                                 |
| 4. Oral Pill    |                                 |
| 5. Condoms      |                                 |
24. Do you maintain any **registers**?  
 Yes/No  
 If yes,  
 Name of registers .: a) **Stock register** for drugs  
 b) **Patients** register  
 c) Any other
25. How much time do you spend on health and family welfare# activities in a day on an **average**?  
 (a) < 1 hr (b) 1 to 2 hrs  
 (c) More than 2 hrs
26. What are the common ailments you **treat**?  
 (a) fever (b) **cold/coughs** (c) minor **injuries**  
 (d) Any other
27. where do you refer your cases'/  
 (a) Sub-centre (b) **PHC** (c) local private **practitioner**  
 (d) government hospital (e) Any other
28. How many cases did you refer to **the PHC** during the **last one year**?  
 (a) 0 (b) 1-99 (c) 100-199 (d) 200 and **above**



sub-centre: (a) 0 (b) 1-99 (c) 100 and above

29. Were the cases taken good care of?

At PHC: (a) yes, always (b) sometimes (c) never

At Sub-centre : (a) yes, always (b) **sometimes** (c) never

30. In case of an epidemic, for eg, diarrhoea/gastroenteritis in the village what steps do you **take**?

(a) try and treat the cases

(b) inform the health workers

(c) try and educate the villagers regarding the precautions to be taken, for eg, boiling water **before** drinking.

(d) advise ORT

(e) refer the case to PHC

(f) refer the case to government hospital

(g) take the help of the local PMP

(h) Any other

D Relationship with the PHC personnel :

31. How often do the following workers visit the **village**?

| Personnel | More than<br>once a<br>week | Once a<br>week | Once in<br>2 weeks | Once in a<br>month | Rarely |
|-----------|-----------------------------|----------------|--------------------|--------------------|--------|
|-----------|-----------------------------|----------------|--------------------|--------------------|--------|

a) PHCMOs

b) ~~EE~~

c) Health Supervisors  
(women)

d) Health Supervisors  
(men)

e) Health Workers  
(women)

f) Health Workers  
(men)

32. Do the workers meet **you**? (Sub-centre MPHWS)

(a) yes, always (b) sometimes (c) rarely (d) Never

33. Do they request you for any help?

Yes/No

i) If yes, area in which they seek help:

(a) ~~FP~~ (b) immunization (c) communicable diseases  
(d) MCH (d) any other

ii) Amount of time spent with you :

(a) < 1b mts (b) 15-29 mts (c) 30-59 mts  
(d) 1 hr (e) more than 1 hrs

34. How often do you visit the **sub-centre?**  
 (a) Once a week (b) Once in 2 or 3 weeks  
 (c) Once a month (d) Very rarely  
 (e) Occasionally (f) Never
35. How often do you visit the **PHC?**  
 (a) Once a month (b) Occasionally (c) **Rarely**
36. Are there any specific instances where you asked for help but were not provided by the sub-centre or **PHC staff?**  
**Yes/No/NR**  
 If yes, could you cite an instance:

**F Assessment of infrastructural facilities at the Sub-centre and Cooperation from other agencies:**

37. How would you assess the following:

| Facilities                          | Satisfactory | Somewhat satisfactory | Not satisfactory | highly dissatisfactory |
|-------------------------------------|--------------|-----------------------|------------------|------------------------|
| a) Location of Sub-centre           |              |                       |                  |                        |
| b) Condition of Sub-centre building |              |                       |                  |                        |
| c) <del>E</del> quipment            |              |                       |                  |                        |
| d) Lab facilities                   |              |                       |                  |                        |
| e) <del>P</del> osition of drugs    |              |                       |                  |                        |
| f) Storage facilities               |              |                       |                  |                        |
| g) Toilet                           |              |                       |                  |                        |
| h) Water                            |              |                       |                  |                        |
| i) Power                            |              |                       |                  |                        |

38. Do you get regular supply of **drugs?**  
**Yes/No**  
 If yes, are the drugs relevant and useful  
**Yes/No**  
 If no, could you give the names of the drugs which are not useful:  
 (a)  
 (b)  
 (c)
39. Do you think there is a **shortage of essential drugs given to you?**  
**Yes/No**  
 If yes, type of drugs : (a)  
 (c)



(d)

40. Do you have any storage problems for the drugs **received**?  
Yes/No
41. Do you get your monthly honorarium regularly?  
Yes/No  
If no, what do you think are the reasons for the delay?
42. Do you have youth **clubs/mahila** mandals in your village?  
Yes/No  
i) If yes, do they conduct regular meetings:: Yes/No  
ii) Do you attend the meetings: Yes/No  
iii) Are they helpful to you in any way : Yes/No  
If yes, in what **way**?
43. Do you maintain conacts with the village leaders?  
Yes/No  
If yes, do you get adequate support and help from them in times of need?  
Yes/No  
If yes, who are **they**? kindly furnish some information
44. Are there any individuals (**PMPs**) providing health care in yur **village**?  
Yes/No  
If yes, i) name(s) of the practitioners ii) Qualifications  
(a) (a)  
(b) (b)  
(c) (c)  
(d) (d)
- 4b. Did you at any time avail their services?  
Yes/No  
If yes, cite a couple of instances:
- 4b. Are there any voluntary organisations providing health care facilities in your **village**?  
Yes/No  
If yes,  
i) **Name(s)** of the organisation ii) **Services** rendered  
-----  
(a)  
(b)  
(c)  
(d)
- 4f. Did you at any time avail their services?  
Yes/No  
If yes. cite a couple of instances:

49. Your satisfaction regarding the following:

|                                                           | Satis-<br>fied | Somewhat<br>Satisfied | Not<br>Satisfied | Highly dis-<br>satisfied |
|-----------------------------------------------------------|----------------|-----------------------|------------------|--------------------------|
| a) Your job                                               |                |                       |                  |                          |
| b) Honorarium                                             |                |                       |                  |                          |
| c) <b>Recognition</b> and<br>Cooperation from<br>villages |                |                       |                  |                          |
| d) PHC personnel or<br>health workers                     |                |                       |                  |                          |
| e) Cooperation from<br>village leaders                    |                |                       |                  |                          |

50. Perception regarding outreach of services:

50. Do you think that the services rendered by the **PHC** and Sub-centres are reaching most of the people in the villages'/  
Yes/No  
If no, state reasons:

51. Do you think the **PHC** and sub-centres are meeting most of the needs of the people in your **area**?  
Yes/No  
If no, state reasons:

52. Which of the following strata do you think are the main beneficiaries of the **PHC/Sub-centre** services:

- (a) Lower socio-economic strata
- (b) Middle socio-economic strata
- (c) Upper socio-economic strata

53. Do all sections of the population utilize your **services**?  
Yes/No  
If no, which sections of the population utilize your services  
(a)  
(b)  
(c)

54. your assessment of the following services rendered **by the PHC/Sub-centres** in your area/village:

| Services   | Satisfa-<br>ctory | Somewhat<br>satisfac-<br>tory | Neutral | Not satis-<br>factory | Highly dis<br>satisfac-<br>tory |
|------------|-------------------|-------------------------------|---------|-----------------------|---------------------------------|
| a) Medical |                   |                               |         |                       |                                 |

- relief
- b) Immunization
- c) FP
- d) School health
- e) Environmental sanitation
- f) Control of communicable diseases
- g) ANC
- h) Deliveries
- i) PNC
- j) Health education

55. Do you have anything to add in regard to **specific** problems faced by **you**?

## 2. INTERVIEW SCHEDULE FOR THE DAIS (TRAINED)

### A. Social Characteristics :

1. Name of the village :
2. Age :
  - a) 20 - 29 years
  - b) 30 - 39 years
  - c) 40 - 49 years
  - d) 50 years and above
3. Religion :
  - a) Hindu
  - b) Muslim
  - c) Christian
4. Caste :
  - a) Scheduled Caste
  - b) Backward Caste
  - c) Other Caste
5. Marital Status :
  - a) Married
  - b) Unmarried
  - c) Widowed
  - d) Separated/Divorced
6. Level of Education :
  - a) Illiterate
  - b) Primary school
  - c) Secondary school
7. Number of years of experience as a Dai?
  - a) 1-19
  - b) 20-39
  - c) 40-59 years
  - d) 60 and above
8. Do you have any other occupation (other than Dais work)?  
yes/No  
If yes.
 

| Occupation             | income per month |
|------------------------|------------------|
| -----                  | -----            |
| (a) Agriculture labour | a) Rs. < 100     |
| (b) Agriculture        | b) Rs. 100 - 299 |

- (c) business
  - (d) Any other
  - c) Rs. 300 - 499
  - d) Rs. 500 & above
9. Numer of Dais in the village, including **yourself**?  
 (a) one (b) two (c) three (d) four and more
10. If you are the only one in the **village**, who was doing **Dais** work prior to your taking up this **work**?  
 (a) Own mother (b) sister (c) relative (d) some other in the village
11. If there is more than one **Dai** in the village do you compete with the others for delivery cases?/  
 Yes/No
12. Do all the groups in the village avail your services?/  
 Yes/No  
 If no, which groups are interested in your **services**?  
 (a) Lower socioeconomic group  
 (b) Middle socioeconomic group  
 (c) Upper socioeconomic group

#### **B Recruitment and Training.**

13. Who selected you for the Dai training **programme**?  
 (a) Health Supervisor (women)  
 (b) Health Supervisor (men)  
 (c) Health Worker (women;  
 (d) Health Worker (men)
14. i) Duration of training :  
 ii) Place of training :  
 iii) fear of training :
15. Which of the following personnel were involved in the training **programme**?  
 la; PHCMUs (b) Health Supervisor (women)  
 (c) Health Workers (women)
16. Did you find the training programme **useful**?  
 Yes/No  
 If yes. in what way:  
 If no. state **reasons**:

17. Do you find a change in the number of deliveries conducted before training and **after training?**

Yes/No

- i) If yes, number of deliveries conducted has increased
- ii) Number of deliveries conducted has decreased (please explain)

If no, state reasons:

18. Did you get any **on-the-job** training in your village while conducting **deliveries?**

Yes/No

If yes, who gave you the training

- (a) Health Supervisors (women)
- (b) Health Workers (women)

19. After the training, did you receive the delivery **kit?**

Yes/No

If yes, do you regularly use it

- (a) always (b) sometimes (c) Never

If no, state reasons:

- (a) No need to use
- (b) Not in working condition
- (c) Do not know how to use
- (d) Any other

20. Your satisfaction with the training **programme?**

-----  
Satisfactory      Somewhat satisfactory      Not satisfactory      highly dissatisfactory

- a) Personnel involved in the training programme
- b) Duration of the training programme
- c) Stipend

C Performance:

21. how many deliveries did you conduct during **the last** on# **year?**

- (a) < 10 (b) 10-29 (c) 30-49 (d) 50-69 (e) 70 and above

22. for how many of these deliveries did you **take the MFW's assistance?**

- (a) None (b) 1-6 (c) 7-12 (d) 13-18 (e) 19-24 (f) 25 and above

23. Do you **refer** cases to the **PHC**?  
 Yes/No  
 If yes, were they taken good care of at the **PHC**?  
 (a) yes, always (b) sometimes (c) never
24. Were the following services provided for the pregnant women whom you attended?  
 (a) Distribution of iron and **folic** acid tables: Yes/No  
 (b) Distribution of Vitamin '**A**' solution : Yes/No  
 (c) TT vaccinations : Yes/No  
 (d) Health and Nutrition education : Yes/No
25. Do you provide antenatal care **to** pregnant mothers?  
 Yes/No  
 If yes, services provided:
26. Suppose a pregnant woman comes to you with edema what will you do?  
 (a) **Reassure** her that nothing will happen  
 (b) Immediately take the patient or **refer** her to the **PHC/Sub-centre**  
 (c) **Refer** the patient to the private medical practitioner  
 (d) Take her to an indigenous practitioner  
 (e) Any other
27. Do mothers get postnatal care in your village?  
 If yes, what kind of PNC is given?  
 (a) General checkup of mother and child  
 (b) Treatment of minor problem  
 (c) Health and nutrition education  
 (d) **FP**  
 (e) **Immunization** of infants  
 (f) Any other
28. Do you provide any PNC to the nursing mothers?  
 Yes/No  
 If yes, services rendered :
29. Do you motivate cases for **FP**?  
 Yes/No  
 If yes,

| Method              | No. of cases <b>motivated</b> |
|---------------------|-------------------------------|
| -----               | -----                         |
| 1. <b>Vasectomy</b> |                               |
| 2. <b>IUDS</b>      |                               |
| 3. <b>Tubectomy</b> |                               |
| 4. Ural Pill        |                               |
| 5. Condoms          |                               |



1) " ~~Relationship with PHC personnel and other agencies:~~

30. How often do the following personnel visit the **village**?

| Personnel | More than<br>once a<br>week | Once a<br>week | Once in<br>2 weeks | Once in a<br>month | Barely |
|-----------|-----------------------------|----------------|--------------------|--------------------|--------|
|-----------|-----------------------------|----------------|--------------------|--------------------|--------|

- a) PHCMOs
- b) ~~EE~~
- c) Health Supervisors  
(women)
- d) Health Supervisors  
(men)
- e) Health Workers  
(women)
- f) Health Workers  
(men)

31. Whenever your sub-centre MPW (~~r~~) visits the villages, does she meet you?

- (a) yes, always (b) Some times (c) ~~Rarely~~ (d) Never

32. Does she request you for any helpY  
Yes/No

i) If yes, what type of help:

33. How much of time does she spend during her visit to youY

- (a) < 15 mts (b) 15-29 mts (c) ~~30-59~~ mta  
(d) 1-1 1/2 hr (e) more than 1 1/2 hra

34. Does she supervise the work done by youY

Yes/No

if yes, which of the following activities does she super-  
viseY

- (a) Conducting deliveries
- (~~b~~) Use of delivery kit
- (c) Sterilization of instruments
- (~~d~~) PNC
- (e) Any other

35. Do you visit the **sub-centre**?  
 Yes/No  
 If yes, how **often**?
- (a) Once a week
  - (b) Once in 2 or 3 weeks
  - (c) Once a month
  - (d) Very rarely
  - (e) Occasionally
  - (f) Never
36. Do you visit the **PHC**?  
 Yes/No  
 If yes, how often and for what **purpose**?
- |           |         |
|-----------|---------|
| Frequency | purpose |
| -----     | -----   |
- (a) Once in 2 weeks
  - (b) Once a month
  - (c) Once in 2 months
  - (d) Very rarely
  - (e) Any other
37. Can you recollect any specific **instance** when you asked **for** some help, but were not provided by the sub-centre or PMC:
- (a) Sub-centre : Yes/No/NK
  - (b) PHC : Yes/No/NK
- If yes, could you cite an instance :
38. Do you accept gifts from your **clients**?  
 Yes/No/NK  
 If yes, do you think that the rewards you get in the **form of** gifts is more remunerative than the honorarium you receiver  
 Yes/No/NK
39. Are there any individuals (Private Medical Practitioners) providing health care in your village?  
 Yes/No  
 if yes,
- |                                        |                           |
|----------------------------------------|---------------------------|
| i) <b>Name(s)</b> of the practitioners | 11) <b>Qualifications</b> |
| -----                                  | -----                     |
| a)                                     | a)                        |
| b)                                     | b)                        |
| c)                                     | c)                        |
| d)                                     | d)                        |
40. Did you at any time avail their services  
 Yes/No  
 If yes, when did you avail their service **and why**?
41. Did they at any **time** avail your **services**?  
 Yes/No  
 If yes, cite a **couple** of instances:



42. Are there any voluntary organizations providing health care facilities in your **village**?

Yes/No

If yes,

i) Name of the Organization                      ii) Services rendered

-----

a)

b)

c)

d)

43. Did you avail their services any **time**?

Yes/No

If yes, cite a couple of **instances**:

44. Do they at any time avail your **services**?

Yes/No

If yes, could you cite a couple of **instances**:

4b. Your satisfaction regarding the following:

-----

|  | Satis-<br>ried | Somewhat<br>Satisfied | Not<br>Satisfied | highly dis-<br>Satisfied |
|--|----------------|-----------------------|------------------|--------------------------|
|--|----------------|-----------------------|------------------|--------------------------|

a) Your job

b) Honorarium

c) Recognition and  
cooperation from  
villages

d) PHC personnel or  
health workers

e) Cooperation from  
village leaders

1) **Perceptions regarding outreach of services**

Do you think that the services rendered by **the PHC/Sub-**  
centre are reaching all the village\* in your ar#aY

Yes/No/NK

If no. state reasons:

47. Do you think the **PHC** and Sub-centres are meeting **most of the**  
needs **or** the people in your area:

Yes/No/NK

If no. state reasons

48. Which of the following strata do you think are **the main** beneficiaries of the **PHC/Sub-centre** services:

- (a) Lower socioeconomic strata
- (b) Middle socioeconomic strata
- (c) Upper socioeconomic strata

49. Your assessment of the following services rendered by the **PHC/Sub-centres** in your village:

| Services                            | Satisfac-<br>tory | Somewhat<br>satisfac-<br>tory | Neutral | Not satis-<br>factory | highly dis<br>satisfac-<br>tory |
|-------------------------------------|-------------------|-------------------------------|---------|-----------------------|---------------------------------|
| a) Medical relief                   |                   |                               |         |                       |                                 |
| b) Immunization                     |                   |                               |         |                       |                                 |
| c) FP                               |                   |                               |         |                       |                                 |
| d) School health                    |                   |                               |         |                       |                                 |
| e) Environmental sanitation         |                   |                               |         |                       |                                 |
| f) Control of communicable diseases |                   |                               |         |                       |                                 |
| g) ANC                              |                   |                               |         |                       |                                 |
| h) Deliveries                       |                   |                               |         |                       |                                 |
| i) PNC                              |                   |                               |         |                       |                                 |
| j) Health education                 |                   |                               |         |                       |                                 |

50. Do you have anything to add with regard to specific **problems** faced by your

## APPENDIX IV

### HOUSEHOLD INTERVIEW SCHEDULE

#### A. Socio-economic criteria: 42

1. Name of the village :
2. Religion : Hindu/Muslim/Christian
3. Caste : Schedule Caste/Backward Caste/Other Caste
4. Type of family : **Nuclear/Extended/Joint**
5. Household based data:

| Sl. No. | Relationship to the head of the household (start with the respondent) | Age | Sex | Marital* Status | Educational* qualifications | Occupational* onx | Income# |
|---------|-----------------------------------------------------------------------|-----|-----|-----------------|-----------------------------|-------------------|---------|
|---------|-----------------------------------------------------------------------|-----|-----|-----------------|-----------------------------|-------------------|---------|

#### \* Marital status:

- a) Married (M)
- b) Unmarried (S)
- c) Widowed (W)
- d) Separated or divorced (D)

#### \* Educational Qualifications

- a) Illiterate (1)
- b) Primary School (P)
- c) Secondary School (S)
- d) High School/Matric (H/M)
- e) Intermediate (Inter)
- f) Degree (D)

#### x Occupation # Income (in Rupees)

- |                           |                   |
|---------------------------|-------------------|
| a) Agriculture            | a) < 500          |
| b) Agriculture labour     | b) 500 < 999      |
| c) <b>Poddytapping</b>    | c) 1000 < 1499    |
| d) Government service     | d) 1500 < 1999    |
| e) Business               | e) 2000 and above |
| f) <b>urban skilled</b>   |                   |
| g) <b>Urban unskilled</b> |                   |

6. Housing Conditions:
- i) type of construction : a) **Pucca** b) **Semi pucca** c) **Kutcha**
  - ii) Number of rooms : a) 1 - 2 b) 3 - 4 c) 5 and above
7. Civic amenities :
- i) Source of lighting : a) **Electric** light  
b) Kerosene lamp  
c) Oil lamp
  - ii) Source of drinking water : a) **Protected** water supply  
b) surface well
  - iii) Latrine facility : a) Available  
b) Not available
8. in case of illness in the household, where do you generally seek help from?
- la) Let the illness subside on its own
  - (b) **Seek** the help of indigenous practitioner
  - (c) **Seek** the help of the private medical practitioner
  - (d) Go to sub-centre/health worker
  - (e) Go to PHC
  - (f) Go to nearby government hospital
  - (g) Go to a private nursing home
  - (h) Go to the chemist
  - (i) **Seek** help from neighbours
  - (j) Any other
9. Is there any person in your village who treats minor ailments (VHG)?
- Yes/No
- If yes, did you any time avail of his/her **services**?
- Yes/No
- If yes. purpose
- (a) fever
  - (b) cold and cough
  - (c) family planning
  - (d) any other
- If no, reasons
- (a) is not easily available
  - (b) is never available
  - (c) does not have the necessary **medicines**
  - (d) provides preferential treatment
  - (e) any other
10. How often do the following visit your **village**?

| Personnel | Once a week | Once in 2 weeks | Once a month | Once in 2 months | Rarely | Stay in village |
|-----------|-------------|-----------------|--------------|------------------|--------|-----------------|
|-----------|-------------|-----------------|--------------|------------------|--------|-----------------|

- a) PHC doctor
- b) BHI
- c) BKE
- d) HV
- e) HI
- f) ANM
- g) BHW

**B. Utilization and outreach of sub-centre/PHC services :**

**(i) Antenatal Care :**

- 1.1. Did the pregnant mother register for **ANC** at the PMC/Sub-centre?  
 Yes/No  
 If yes, did she go for regular checkups?  
 Yes/No  
 If yes, duration of pregnancy and number of visit\*

| Duration of Pregnancy | Number of visits |   |   |   |   |   |   |   |    |
|-----------------------|------------------|---|---|---|---|---|---|---|----|
|                       | 1                | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9+ |

- a) 1 - 3 months
- b) 4 - 5 months
- c) 6 - 7 months
- d) 8 - 9 months

**Reasons for not registering:**

- a) PHC/Sub-centre far away
- b) No faith in modern medicine
- c) System of registration not known
- d) inadequate facilities at PHC/sub-centre
- e) Staff discourteous
- f) better facilities available at the local private nursing home
- g) Local neip available (PHC and Dai)
- h) Any other

12. Was the expecting mother attended by any health worker at home?  
 Yes/No  
 If yes, a) Duration of pregnancy during the worker's visit: a) 1-3 months  
 b) 4-5 months\*  
 c) 6-7 months

d) 8-9 months

b) Number of visits :

13. During antenatal **checkups**, was the pregnant **woman** given any **injections?** (TT)

Yes/No

If **yes**, number of doses : (a) one  
(b) two  
duration of : (a) 1 - 3 months  
pregnancy (b) 4 - 5 months  
(c) 8 - 9 months  
(d) 8 - 9 months

14. Was the pregnant woman given any **tablets?** (Iron and folic acid)

Yes/No

If **yes**, number of tablets : (a) 30  
received (b) 60  
(c) 90

15. Was the pregnant mother advised on

(a) Nutritional requirement : Yes/No  
(b) Hygiene and Sanitation : Yes/No  
(c) Any other

(ii) **Deliveries** :

16. Where did you deliver your last **child?**

(a) at home (b) **PHC** (c) private nursing home  
(d) government hospital (e) Any other

17. In case of delivery was conducted at the **PHC**, who conducted the **delivery?**

(a) Medical Officer (b) Health Supervisor  
(c) health worker

18. In case of delivery at home, who conducted the **delivery?**

(a) Dai (trained) (b) Dai (untrained) (c) Health worker

19.

It **Dai**, conducted the delivery reasons:

(a) Dai is more familiar as she belongs to the village  
(b) She is available round the **clock**  
(c) **is** very experienced

20. If **ANM**, conducted the delivery **reasons:**

(a) Dai not available  
(b) **ANM** is better trained  
(c) More hygienic  
(d) Any other

21. Do you **think** there is any **difference** in the quality of services provided by the **Dai** and the **ANM?**

Yes/No



If yes, in what way,

22. Which of the two (Dai and Health worker) **do you think** the people prefer?

(a) Dai (b) **ANM**

(iii) Postnatal Care :

23. Did any health worker visit you after **delivery**?

Yes/No

i) If yes, duration of postnatal period during the worker's visit

fa) 7 - 15 days

(b) 1 - 2 months

(c) 3 - 4 months

(d) after 4 months

ii) Number of visits : a) 1 b) 2 c) 3 d) 4 e) more than 4 times

iii) Services provided

(a) **Instructions** regarding nutritional requirements for the mother and child

(b) General checkup of mother and child

(c) **Immunization** schedule to be followed and importance of immunization

(d) Advice on family planning

(e) Any other

(iv) Immunization :

24. Did you get your child **immunized**?

Yes/No

If yes, for which of the following is your child immunised:

| Vaccine | Age at which the child was immunized |            |            |              |           | Place of immunization |            |          |                |                |
|---------|--------------------------------------|------------|------------|--------------|-----------|-----------------------|------------|----------|----------------|----------------|
|         | 1-3 months                           | 4-6 months | 7-9 months | 10-12 months | 1-2 years | PHC centre            | Sub-centre | *t house | Govt. hospital | Private clinic |

SCG

DPT 1

DPT II

DPT III

Polio i

Polio ii

Polio iii

Measles

2b. If the child has been partially **immunized** or not immunized **reasons?**

- (a) Unaware of need to return for the **2nd/3rd/booster** dose
- (b) **Fear** of side effects
- (c) No faith in immunization
- (d) Place of immunization too far
- (e) Time of immunization inconvenient
- (f) **Vaccinator** does not come to the village
- (g) Mother too busy
- (h) Child **ill**,
- (i) Any other

26. How often does the vaccinator visit the **sub-centre?**

- (a) Once a week
- (b) Once in two weeks
- (c) Once a month
- (d) Once in 2 or 3 months
- (e) Very rarely
- (f) Never
- (g) Any other

(v) Family Planning:

27. What do you think is the ideal number of **children in a family?**

- (a) 1 (b) 2 (c) 3 (d) 4 (e) 5 (f) more than 4

**Reasons:**

28. Awareness of the methods available to those who plan to **limit** the number of **children** or to have enough interval between **children?**

Yes/No

if yes,

**Methods known**

- a) IUDs
- b) Oral Pills
- c) Condoms
- d) **Sterilization**

**Source of knowledge**

- a) **Spouse**
- b) friend
- c) Neighbour
- d) **Radio**
- e) **TV/Films**
- f) **Magazines**
- g) Health worker
- h) **Any** other

29. Are you or any of your family members currently practicing any spacing **method?**

Yes/No

1) if yes. method practised

- a) IUDs
- b) oral pills
- c) **Condoms**



ii) If using IUD :

**Place of insertion**

**Duration of use**

- a) PHC
- b) Sub-centre
- c) Govt. hospital
- d) Private Clinic
- e) Any other

- a) > 3 months
- b) 3 - 6 months
- c) Y - 10 months
- d) 11 month\* and above

iii) If using oral pills/condoms :

**Source of supply**

**Duration of use**

- a) Health worker
- b) Any other

- a) 3 month\*
- 1b) 3 - 6 months
- c) Y - 10 month\*
- d) 11 months and above

30. Did any one in your household undergo sterilization?

Yes/No

If yes,

**Place of sterilization**

- (a) Tubectomy
- (b) Vasectomy

- (a) PHC
- (b) Government Hospital
- (c) Private nursing home
- (d) Sterilization camp
- (e) Any other

31. Did the health worker visit you after the operation

Yes/No

32. Incentive received after the operation

- (a) Tubectomy - Cash :
- Kind :
- (b) Vasectomy - Cash :
- Kind :

(vi) **Control of Communicable diseases** :

(a) **Treatment of Malaria** :

34. Has anyone suffered from Malaria recently :

Yes/No

If yes, what did you do

- (a) went to the PHC/Sub-centre
- (b) consulted the health worker
- (c) went to the PMP
- (d) took medicine from the chemist
- (e) Any other

- 3b. If you went to the **PHC/consulted** the health **worker** :  
 (a) was your blood examined? Yes/No  
 (b) were you given any medicine ? Yes/No  
 (Presumptive treatment)
36. Were you informed of the blood smear **examination** report?  
 Yes/No  
 i) If tested positive, were you given **treatment**?  
 Yes/No  
 ii) Was **DDT** sprayed in your house and the surrounding **houses**?  
 Yes/No  
 If yes, how **often** was it **done**, and who did the spraying?  
 (a) only once (a) Health Worker  
 (b) twice (b) **Village** administration  
 (c) thrice (c) Any other  
 (d) more than thrice
- iii) Was the blood smear of the other members in the family  
 collected?  
 Yes/No
- (b) **Treatment of Tuberculosis** :
37. Is any one in your family suffering from **TB**? (Chronic cough)  
 Yes/No  
 If yes,  
 i) Are you currently taking **treatment**?  
 Yes/No  
 If yes, 

| <u>Source</u>             | <u>Duration</u> |
|---------------------------|-----------------|
| a) <b>PHC</b>             |                 |
| b) <b>Dist. TB Office</b> |                 |
| c) <b>Govt. hospital</b>  |                 |
| d) <b>PMP</b>             |                 |
| e) Any other              |                 |
- If no. state reasons:
- (vii) School Health Services
38. Are any health services provided to your children **in** the  
**school**?  
 Yes/No  
 If yes, services **provided**?  
 (a) **Routine** medical checkup  
 (b) **Immunization (TT and DT)**  
 (c) Distribution of vitamin tablets  
 (d) Any other
- (viii) Environmental sanitation:
39. How often are wells chlorinated in your **village**. and who  
 does the chlorination?

**How often**

**Who does the chlorination**

- a) More than once a month
- b) Once a month
- c) Once in two months
- d) Once in 3-4 months
- e) Once in 6 months
- f) Once in more than 6 months
- g) Never
- h) Only when there is an epidemic

- a) Village **administration**
- b) Health workers
- c) Village Health Guides
- d) Any other

40. Do health workers emphasize on hygiene and sanitation **or** their visits to the **village**?

Yes/No

If yes, on what aspects do they educate the villagers:

- (a) **Personal** hygiene
- (b) Disposal of **garbage** and preparation of compost pits
- (c) cleanliness of surroundings
- (d) Planting of trees
- (e) Any other

41. What are the **major** fairs and **festivals** that occur **in** your **villages**?

- a)
- b)
- c)

42. Was there any outbreak of disease and epidemics during **these** **periods**?

Yes/No

i) if yes, give details :

ii) how was the problem combated?

**(ix) Health Education:**

43. Do you have a **manila** mandal(s) **in** your **village**?

Yes/No

i) If yes. are you a member of the **manila** mandal?

Yes/No

ii) Do you regularly attend the meeting\* held at the **manila** mandal?

Yes/No

iii) If yes, do you find the meetings **helpful**?

Yes/No

If yes. in what **way**?

iv) If you do not attend the meetings state reasons:

44. Are educational sessions organised in your **village**?

Yes/No

i) If yes.

| Type of educational activity | Frequency | Type of aids used | Average attendance | Place where the activity is organised |
|------------------------------|-----------|-------------------|--------------------|---------------------------------------|
| 1. Groups discussions        |           |                   |                    |                                       |
| 2. Meetings                  |           |                   |                    |                                       |
| 3. Individual or home visits |           |                   |                    |                                       |

- ii) Topics of discussions :
- Hygiene and sanitation
  - importance of immunization
  - Nutrition Education
  - Family Planning
  - Any other

**C Awareness of voluntary organizations and others, and utilization of services :**

- 4a. Are there any voluntary organisations providing health care in the village?

Yes/No

If yes.

**Name of the organisations(a)**

**Services rendered**

a)

a)

b)

b)

c)

- 4b. Are there any individuals providing voluntary health care (other than the VHG) in your village?

Yes/No

- i) If yes, are they from the

**services rendered**

a) same village

a)

b) come from city

b)

c) Any other

c)

d)

- 11) Do you utilize the services they provide?

Yes/No

(Give reasons)

**D Perceptions regarding outreach**

**PHC/Sub-centre services :**

41. Do you think that the services rendered by the PHC/Sub-centre are reaching all the people in the village?

Yes/No

If no, why do you think so?

40. Which of the following strata do you think are the **main** **benef**iciaries of the **PHC/sub-centre** services?

- (a) Lower socioeconomic strata
- (b) Middle socioeconomic strata
- (c) Upper socioeconomic strata

APPENDIX V  
DEVELOPMENT OF NATIONAL HEALTH POLICY IN INDIA

1. Pre-Independence period:

Two of the earliest attempts to define a strategy for 'Health for All' were from India. The report of the Health sub-committee of the National Planning Committee (1948). and Health Survey and Development Committee (1946) also known as the Bhore Committee, are worth reviewing in this context.

Though the National Planning Committee report was published in 1948, the National Planning Committee constituted by the Indian National Congress under the Chairmanship of Jawaharlal Nehru had considered the report of its sub-committee on National Health as early as 1940. even before the Bhore Committee was constituted. The report indicated a preventive approach to primary health care. and the major



**recommendations** put forward **include:**

- a) India should **adopt** a form of health organisation, in which both curative and preventive functions are **suitably** integrated;
- b) preservation and maintenance of the health of the people should be the responsibility of the state;
- c) as an immediate step, in order to meet special **conditions** prevailing in India, we recommend the training of a large number **of** health workers. These health workers should be given elementary training in practical, community and personal hygiene, first-aid, and simple medical treatment, stress being laid on the social aspects, and implications of medical and public health work;
- d) **There** should be one health worker for every thousand population\_\_\_\_\_ (**National** Planning Committee, **1946**: 224-225).

**The** idea **of** developing primary health centres as the focal point for providing comprehensive, curative and preventive health services **in** the rural areas **in** India was presented by the 'health Survey and **Development** Committee' (**1946**). The Committee felt that a **worker. in** whatever field he may be engaged, can only give his best **if** his physical condition is not impaired by any disability **resulting** from the absence of sound health, and asserted that a nation's **health, prosperity** and advancement, whether **in** the economic or **intellectual**

**sphere,** are conditioned by the state of its physical **well being,** and **therefore,** any expenditure on health is an **investment** for the **present,** and future of the country (GOI. 1946; Vol. II: 17-19).

The Committee recommended **that,**

"(i) No individual should fail to secure adequate medical care because of inability to pay for **it.**

(ii) The health programme **must,** from the **beginning,** lay special emphasis on preventive work, the creation and maintenance of a healthy environment.

(iii) The health service\* should be placed as close to the people as possible.

(iv) **It** is essential to secure the active cooperation of the people in the development of the health programmes, and the idea that the health of the individual **is his** own responsibility should be **inculcated"** (GOI. 1946; Vol. IV Summary:\*)).

The Committee also recommended an **integrated** approach with well **established infrastructure** for rural and urban health care along with a proper referral system (GOI. 1946; Vol. IV: 11). it **emphasized** an **intersectoral** approach to **health** services development which implied viewing health service\* in the context of socio-economic development (GOI. 1946; Vol. IV: 3-4).



Given the size and diversity of the **country**, the **Committee** recommended that health services should be a state subject. The centre was to provide the policy direction and some amount of financial assistance, and the states had full authority with respect to resource allocation, **location**, and administration of the various health institutions (**GOI, 1946: Vol IV: 19**).

Thus it can be seen that both the National Manning Committee of the Indian National **Congress**, and the Mhore Committee recognized the need for **improved** socio-economic conditions, and adequate provision of health services to promote better health among the people.

Based on the observations of the **Bhore** Committee, the allocation of funds for health services development were spelt out in the five years plans.

## 2. **Planning Period: 1951 - 1999 :**

Efforts during the **First**, and Second Plans **were concentrated** mainly in the areas of communicable diseases, expansion of medical and paramedical manpower, **self-** sufficiency in drugs and equipment, family **planning**, and other supportive services for raising the standard of health of the people (**GOI, 1952: 488-525; GOI, 1956:533-554**).

However, the outlays were inadequate to meet the requirements as some of the individual components acquired resources on a much larger scale than the total health sector outlays, for example, water supply, and sanitation. So, the government picked up programmes which were more manageable like, establishment of institutional facilities. Since then all efforts in the health sector have centered around this aspect (Health Statistics of India, 1963: 71).

The Government of India had appointed the Health and Planning Committee in 1959 to review the first and Second Five Year Health Plans, and to make recommendations for the future plans. In order to improve health care in rural areas, the committee recommended that further opening of the primary health centres on the existing pattern be discontinued, and instead called for an expansion, and strengthening of district hospitals, and introduction of mobile team\* of specialists to provide necessary supervisory, and consultancy services to the rural area\*. Regarding health personnel engaged in the mas\* campaign\* against certain communicable diseases, the committee felt that it was neither possible nor desirable to have separate agencies to deal with individual diseases, and suggested that health personnel should be trained to tackle all health problem\* in rural areas. that is, the committee emphasized the need to convert paramedical personnel recruited for individual programme\* to multi-purpose personnel (GOI, 1962: 15-20).

The Third Plan, launched in 1961 focussed its attention on the shortage of construction of **primary health centre** buildings and staff quarters, and inadequate **training** facilities for the different categories of **personnel in rural areas** (GOI, 1961: 651-679).

The Fourth Plan emphasized the need for **establishment** of necessary **infrastructure** for **speedy construction of buildings**, and effective performance of primary **health centres** by providing adequate **staff, drugs, and equipment** (GOI, 1968: 306-314).

The main emphasis during the **Fifth** Plan period was on:

- (i) expanding the network of medical **facilities** and health services in the **country**;
- (ii) increasing accessibility of health services **in rural areas**;
- (iii) correcting regional **imbalances** especially **between the** urban, and rural areas;
- (iv) intensification **of** national programmes **and** eradication of communicable diseases;
- (v) improvement of environmental sanitation;
- (vi) improvement in **the** quality **of** service\* **by providing the** necessary orientation and **training** to **medical. and** para medical personnel (GOI, 1974: 78-81).

In order to give a thrust to health services in the rural areas the Government introduced the **Minimum Needs** Programme during this plan period. The main ~~components~~ of the Minimum Needs Programme related to health **include:**

"(i) ensuring in all areas a minimum uniform availability of public health facilities, which would include **preventive** medicine, family planning, and the detection of early morbidity, and adequate arrangements for referring serious **cases** to an appropriate higher echelon;

(ii) supplying drinking water to villages suffering from chronic scarcity or having unsafe sources of water; and

(iii) carrying out environmental improvement of **slums**" (Bose. A: 1983: 30).

The position of the primary health centres and sub-centres, targets and achievements during the Fifth **Plan** is shown in table **5.1**.

Table 5.1 \*

Minimum Needs ~~Programme~~ **Progress and Achievement** during Fifth Plan

| Sl. No. | Items under Minimum Needs Programme                              | Position at the beginning of the Fifth Plan (1973-74) |                  |                       | Percentage Achieved |
|---------|------------------------------------------------------------------|-------------------------------------------------------|------------------|-----------------------|---------------------|
|         |                                                                  |                                                       | Target (1974-79) | Achievement (1974-78) |                     |
| (1)     | (2)                                                              | (3)                                                   | (4)              | (6)                   | (5)                 |
| 1.      | Primary health Centres (Numbers)                                 | 5,283                                                 | 101              | <b>117</b>            | 106.9               |
| 2.      | <del>Sub-centres</del> (Numbers)                                 | <del>33,509</del>                                     | 10,317           | <del>4,605</del>      | 44.8                |
| 3.      | Rural hospitals (Numbers)                                        | -                                                     | 1,293            | 315                   | 24.3                |
| 4.      | Backlog of construction of primary health centres (Numbers)      |                                                       |                  |                       |                     |
|         | a) <del>Dispensary buildings</del> with staff quarters (Numbers) | <del>602</del>                                        | 918              | 218                   | 23.7                |
|         | b) <del>Dispensary buildings</del> only (Numbers)                | 3,813                                                 | <del>552</del>   | 132                   | 23.9                |
|         | c) Staff quarters only (Numbers)                                 | 1,154                                                 | 3,211            | 591                   | <b>18.4</b>         |
|         | d) <del>Backlog</del> of construction of sub-centres (Numbers)   | 18,047                                                | 15,482           | 3,491                 | <b>22.5</b>         |

Source : Health Statistics of India, 1983 : 136.

Central Bureau of Health Intelligence.

Directorate General of Health Services.

Ministry of Health and family Welfare,

GOI, New Delhi.

Despite all effort\* by the **government** (during the subsequent plan periods) in providing health **care services** in rural **areas**, one finds that very little **emphasis has been placed** on the preventive and promotional **aspects** of health. Eventually the government recognized the **need** to **restructure** undergraduate medical education (which **relies** on **curative** methods and sophisticated **diagnostic aides**) to **suit** thm **needs** of the country with due emphasis on community health rather than institutional care. Thus came **into** being the report **of** the group on Medical Education and Support Manpower al\*o known as the **Srivastava** Committee, which submitted it\* r\*port **in 1975**.

The Committee recommended a nation **wide** network of efficient and effective **health** services for tn\* country; it "placed greater emphasis on **human** effort rather **than** on monetary **inputs**", and advocated **that** "health **services** should be provided within **the** community **itself**" (GOI, 1975: 2-11).

According to the Committee the quality of health **\*\*rv-** ices would improve by suitably trained, **para- professionals**, and Health Assistants whose **induction into** the **system** 1\* recommended on a **self-employment** b\*\*l\* to provide **simple**, preventive and curative **services** n\*sd\*d by tm\* **community**. The group envisaged that such **community** level **health workers** could be recruited from tn\* community **itself**, at **the same** time **emphasizing the** need for trained doctor\* both **for rural** \*\*



well as urban areas (GOI, 1975:11-26).

### 3. Planning Period: 1981-85:

The concept of primary health care has been **discussed** at the international level by the Alma Ata Conference **(1978)** and, at the national level, by the **ICSSR-ICMR** study group. According to the document, 'Health for All by ~~2000~~ A.D.' **means** - "The provision of a good and adequate health care **system** for all citizens, and especially for women and children, and poor, and underprivileged groups" (**ICSSR-ICMR, 1981: vii**).

The study group surveyed the health situation **in** India, and pointed out that the major causes of morbidity and mortality were diseases related to poor living conditions. While death rates had fallen since **independence** the average Indian was still prone to a host of communicable diseases which included tuberculosis, malaria, gastroenteritis, leprosy, **filaria**, etc (**ICSSR-ICMR, 1981:5**). As far as health services were concerned the committee observed that the existing services were overwhelmingly curative, and little progress has been made to develop and **integrate** the preventive and **promotive** aspects (**ICSSR-ICMR, 1981: 62**).

According to the report, "Health is a **function, not** only of medical **care**, but of the overall **integrated** development of society - cultural, **economic, educational, social**.

and political. Health also depends on a number of supportive services - nutrition, improvement in environment and health education" (ICSSR - ICMR, 1981: 213).

The proposal for introducing the community level health workers was made in April, 1975, and the scheme was officially launched in 1977 as a centrally sponsored, and funded scheme.

According to this scheme, a Community Health Worker is given training for a period of three months\*. He is taught the fundamentals of health services, hygiene, treatment of common infectious diseases and ailments, first aid, etc. He is expected to provide basic health care to a village or community with a population of 1,000, and also keep the Medical Officer in-charge of the primary health centre informed regarding the health status of the village or community. Apart from this training he is also given training in traditional systems of medicine, and is also instructed to maintain simple records. He is provided with a medical kit, and an honorarium for the services rendered to the community on a part-time basis (Bose, A. 1983: 38).

In 1978, the Planning Commission undertook a review of the performance in the health sector, and identified several drawbacks. According to the commission, our health care delivery system does not take into consideration the social, economic, ecological factors, conditions of work, etc..



secondly, it is concentrated mostly **in the urban areas**; thirdly, it is based on medical education system which orients the doctors not for the health of the people **but instead** for medical practice; and lastly, it undermines **the traditional** health care systems, and encourages the **use of drugs** (Bose, A, 1983: 35).

The ICSSR-ICMR report **suggests** that '**Health For All**' **cannot** be achieved through a linear expansion of the **existing** system or even by **tinkering** with **it**, through minor reform\*. The **committee** advocates nothing short of a radical change, and **calls** for a '**comprehensive** national policy on health' which becomes a collaborative and cooperative **responsibility** of individuals, families, local committee\*, and **state** apparatus **in** rendering the health **delivery** \*y\*tem more efficient and effective (ICSSR-ICMR, 1981: 211).

The report advocate\* that the goal of '**Health for all**' can only be achieved through a fully democratic prooea\*. "This new approach to health cannot be implemented la a centralized political \*y\*tem where expert\* **take** all the decisions for the **people**, and the **bureaucrats implement** them again for the people. **It 1\*, therefore, necessary** to abandon the existing centralised and **top-down** approach to the **organization** of health service\*, and create a new **system** of building from **below** with **community-based** health **services**" (ICSSR-ICMR, 1981:26).

Given the kind of lopsided development, and widespread disparity between the rich, and poor within the country one needs to question whether such a democratic, participatory health care system is really viable? The highly trained medical professional is not merely an individual but is a member of a group who acquires power not only by virtue of his/her knowledge but also, from the status he/she occupies within that group. It is this status that determines one's interest; and his/her professional commitment would not be the health of the people but rather the optimization of his/her interests as a member of that group. No result in the polarization of the professional on the one hand, and the clients/patients (especially the poor and illiterate) on the other hand, resulting in a wide communication gap between the two groups. As pointed out by an eminent social scientist, the first step in this case is to "launch a massive educational programme (not necessarily medical) for our healers so that they develop a qualitatively different role-commitment, and perception". and unless this is done no radical change can be expected (Gonsky, 1985:12). However, this in itself is not sufficient, and simultaneously, provision of universal primary education in which adequate health education is integrated has to be advocated to the underprivileged masses. However, the report agrees that very little is actually being done in this regard as the health care personnel do not have the aptitude, and training for the purpose.

The report suggests that the western oriented **model** of health care services which we are following today should be abandoned to be replaced by an alternative model. **Under the** new alternative model, "a new category of **personnel, the** Community Health Volunteers will be **introduced** who will be the main bridge between the community and the **services**" (ICSSR-ICMR, 1981: Xii) .

The pertinent question **is** whether these Community Health Volunteers are competent enough to provide adequate health care in the community? What we **really** need today **is** a band of trained health personnel with a rural **background**, and who are **willing** to **serve** th\* rural masses at the **same**time, serving as interm\*dlarls b\*tw\*\*n th\* train\*d **professionals**, and the community they ar\* to s\*rv\*.

The strategy advocated in th\* Sixth **Five Year** Plan was based on the recommendation of th\* working group on health also known as th\* **Kripa Narain** Committee, 1981. The plan document also conc\*d\*d that "**the infrastructure of sub-centres, primary health c\*nters, and rural hospitals built up in** the rural ar\*as touch\*s only a fraction of th\* rural population. Th\* conc\*pt of health **in its** totally **with** preventive and **promotive** h\*alth car\* **services in** addition to **curative**. is still to b\* mad\* op\*ratlonal. The plan **also** admits that the **involvement** of the people **is** almost **non-existent**". (bos\*. A, 1983: 39-40).

While spelling out **its** strategy, **the** plan **emphasized** that "..... horizontal and vertical linkages have to be established among all the interrelated programmes **like** protected water supply, environmental sanitation and **hygiene**, nutrition, education, family planning and maternity and child welfare". (**Bose. A. 1983: 40**). The plan makes a plea for restructuring, and reorienting the health care system for **attaining** the policy objectives by the Year 2000 **A.D.**

For the first time in **1983** an official document - National Health Policy (**NHP**) was approved by the Parliament. The policy was based on the recommendations made by the **ICSSR** - **ICMR** report (**ICSSR-ICMR, 1981**).

The policy starts with a caution that, the demographic, and health picture of the country still constitutes a cause for serious and urgent concern because of the high rate of population growth, high mortality rates among women, and children, exceptionally high and severe malnutrition, and continued high incidence of communicable, and non-communicable diseases for want of potable water supply, and basic environmental sanitation. Further poverty, and ignorance as contributing **factors** for the high incidence of disease mortality (**NHP, 1983: 34**).

"The existing situation has been largely engendered by the almost wholesale adoption of health manpower development

**policies**, and the **establishment** of curative **centres based on** the western **models, which** are inappropriate, and irrelevant to the real needs of our people, and the **socio-economic** conditions obtaining in the country. The hospital-based disease, and cure oriented approach towards the establishment of medical services has provided benefits to the upper crusts of society, specially those residing in the urban areas. **The** proliferation of this approach has been at the cost of providing comprehensive primary health care services to the entire population, whether residing in the **urban** or rural areas. **The** existing approach, instead of improving awareness, and building up self-reliance has tended to enhance dependency, and weaken the community's capacity to cope with its problems. . The prevailing policies with regard to the education, and training of medical and health personnel, at various levels, has resulted in the development of cultural gap between the people, and the personnel providing care. The various health programmes have, by and large, failed to involve individuals, and families in establishing a self-reliant community. Also, over the years, the planning process has become largely oblivious of the fact that the **ultimate** goal of achieving a satisfactory health status for all our people cannot be secured without involving the community in the identification of their health needs, and priorities as well as in the implementation, and management of the various health, and related programmes" (**NHP, 1983:35**).

While declaring that, India is committed to attaining

the goal of 'Health for All by the Year 2000 A.D.', the statement on NHP asserts that "its contours have been evolved within a fully **integrated** planning framework which seeks to provide universal, comprehensive primary health care services, relevant to the actual needs and priorities of the community, at a cost which the people can afford, **ensuring** that the planning, and implementation of the various health programmes is through the organized involvement, and participation of the community, adequately utilizing the services being rendered by private voluntary organizations active in the health sector" (NHP, 1983: 35-36).

The policy also envisages fulfilment of the goals set in the revised 20 - point programme which gives top priority, to the promotion of family planning as a peoples programme on a voluntary basis (NHP, 1983: 36). In view of securing a balanced growth of the population which is of vital importance, the policy feels the necessity to enunciate, separately a National Population Policy (NHP, 1983: 36-37).

Similarly, while appreciating that the effective delivery of **health** care services would depend upon the nature of education, training and appropriate orientation towards community health of all categories of medical and health personnel, and their capacity to function as an integrated team, the policy views it as of crucial importance that the entire basis, and approach towards medical and health **educa-**



tion, at all levels la reviewed in terms of national needs and priorities, and the training programmes restructured to produce personnel of varying grades of skills and competence, who are professionally equipped, and socially motivated to effectively deal with day-to-day problems within the existing constraints. Given this, the policy calls for the formulation of a separate National Medical and Health education Policy (NHP, 1983:37).

To put an end to what it calls the existing all round unsatisfactory situation, the statement underlines the urgent need for restructuring the health services around the following broad approaches:

(i) Provision of a well dispersed network of primary health care services with the organized support of volunteers, auxiliaries, para-medics, and adequately trained multi-purpose workers;

(ii) Large scale **transfer** of knowledge, simple skills, and technologies to Health Volunteers selected by the Communities, and enjoying their confidence;

(iii) Positive efforts to build up individual self-reliance and effective community participation;

(iv) Back-up support to primary health care through a well worked out referral system;

(v) Establishing a nation-wide chain of **sanitary-cum-epidemiological** stations to tackle the entire range of

poor health **conditions**;

(vi) full utilization of untapped **resources** through organized logistic, financial, and technical support to **voluntary** agencies active in the field;

(vii) Planned establishment of centres equipped to provide specialist treatment when necessary;

(viii) Special efforts, well coordinated programmes to be launched to provide **mental** health, medical care, and physical and **social** rehabilitation to the disabled;

(ix) First priority to be accorded to people living in tribal, hilly, and backward areas, and to populations affected by endemic diseases (**NHP, 1983: 38-41**).

While calling for the reorientation of the existing health personnel, the policy envisages a dynamic process of change and innovation in health manpower development ensuring the emergence of fully integrated bands of workers functioning within the health team approach (**NHP, 1983:41**).

The policy calls upon the states to take steps to dispense with the system of private practice by **doctors** in government service by paying appropriate compensatory non-practicing allowance, and also to take timely **decisions** regarding the availability and dispersal of private practitioners. it also calls for an organized integration of **the**



various **indigenous**, and other systems of medicine **into** the existing health care delivery system, especially with regard to the preventive, **promotive**, and public health objectives. The policy also stresses the **need** for a well planned, time bound attention to some of the supportive services like nutrition, prevention of food adulteration, maintenance of the quality of drugs, water supply and sanitation, environmental protection, **immunization**, maternal and child health services, school health, and occupational health services (NHP, 1983: 42-45).

Further, the policy calls for an integrated approach to health education, establishing an effective management information system, certain guidelines for making the medical industry responsive to meet the national requirements, strengthening of health insurance schemes, review of existing health legislation, building up of basic research with high priority accorded to applied, operational research for continuously improving the cost effective delivery of health services, setting up mechanisms needed to achieve **intersectoral** coordination of the various supportive services, and periodic monitoring and review of progress in the health field (NHP, 1983: 42-48).

The goals set for Health and Family Welfare **Programmes** by the policy are presented in table **5.2**.

Table 5.2:  
Goals for Health and family Welfare Programmes.

| 81.<br>No. | Indicator                                                            | Current<br>level | Goals |       |          |
|------------|----------------------------------------------------------------------|------------------|-------|-------|----------|
|            |                                                                      |                  | 1985  | 1990  | 2000     |
| (1)        | (2)                                                                  | (3)              | (4)   | (5)   | (6)      |
| 1.         | Infant mortality rate :                                              |                  |       |       |          |
|            | Rural                                                                | 136(1978)        | 122   | -     | -        |
|            | Urban                                                                | 70(1978)         | 60    | -     | -        |
|            | Total                                                                | 105(1978)        | 102   | 8Y    | below 60 |
|            | Perinatal mortality                                                  | 67(1976)         | -     | -     | 30 - 35  |
| 2.         | Crude death rate/Around                                              | 14               | 12    | 10.4  | 9.0      |
| 3.         | Pre-school child (1-6 years) mortality                               | 24(1976-77)      | 20-24 | 15-20 | 10       |
| 4.         | Maternal mortality rate                                              | 4-b(19Y6)        | 3-4   | 2-3   | below 2  |
| b.         | Life expectancy at birth (years)                                     |                  |       |       |          |
|            | Male                                                                 | 52.6(19Y6-61)    | 55.1  | 5Y.6  | 64       |
|            | female                                                               | 61.6(19Y6-81)    | 54.3  | 5Y.1  | 64       |
| 6.         | Babies with birth weight below 2000 gms(percentage)                  | 30               | 20    | 18    | 10       |
| Y.         | Crude birth rate                                                     | 35               | 31    | 2Y.0  | 21.0     |
| 8.         | Effective couple protection (percentage)                             | 23.6(march, 82)  | 3Y.0  | 42.0  | 60.0     |
| 9.         | Net Reproduction Kate (NRR)                                          | 1.48(1981)       | 1.34  | 1.1Y  | 1.0      |
| 10.        | Growth rate (annual)                                                 | 2.24(19/1-81)    | 1.90  | 1.66  | 1.20     |
| 11.        | Family size                                                          | 4.4(19Y5).       | 3.8   | -     | 2.3      |
| 12.        | Pregnant mothers receiving antenatal care (%)                        | 40-50            | 50-60 | 60-75 | 100      |
| 13.        | Deliveries by trained birth attendants (%)                           | 30-35            | 50    | 80    | 10k)     |
| 14.        | Immunization status (%) coverage)                                    |                  |       |       |          |
|            | TT (for pregnant women)                                              | 20               | 60    | 100   | 100      |
|            | TT(for school children)                                              |                  |       |       |          |
|            | 10 years                                                             | -                | 40    | 100   | 100      |
|            | 16 years                                                             | 20               | 60    | 100   | 100      |
|            | DPT(children below 3 yeras)                                          | 20               | Y0    | 80    | 80       |
|            | Polio (infants)                                                      | b                | b0    | Y0    | 85       |
|            | BUG (infants)                                                        | 60               | Y0    | 80    | 85       |
|            | DT(New school entrants b-6 years)                                    | 20               | 80    | 85    | 85       |
|            | Typhoid(New school entrants b-6 years)                               | 2                | Y0    | 85    | 85       |
| 1b.        | Leprosy - percentage of disease arrested cases out of those detected | 20               | 40    | 80    | 80       |
| 16.        | TB - percentage of disease arrested cases out of those detected      | b0               | 60    | 75    | 90       |
| 1Y.        | Blindness - Incidence of (%)                                         | 1.4              | 1     | 0.7   | 0.3      |

Source : NHP, 1983 : 49-50.

The National Health Policy is\* the latest, and the most comprehensive policy documents but, it is a mere repetition of the previous plan documents, and reports submitted by various committees (some of which have already been discussed), and the goals set are in no way better than what was recommended by the Bhore Committee in 1946.

Although the policy reiterates that India is committed to the goal of 'Health for All' there is ample evidence in the implementation of this policy that family planning programme has been given overriding emphasis at the cost of promoting primary health care, and moreover the policy calls for a separate National Population Policy thereby admitting its incomprehensiveness.

Secondly, the policy also calls for a separate National Medical and Health Education Policy thereby isolating the issues further from the existing bodies which are already dealing with medical education, like the Medical Council of India, Nursing Council etc.

Thirdly, the policy calls for a meaningful, and phased integration of the indigenous, and other systems of medicine with the modern system of medicine but, fail\* to show at what appropriate levels this could be done.

**Fourthly**, the policy **advocates** community **involvement** and **participation**, which is a myth given the kind of **social**, economic and political developments in the country, and the widespread disparities between the **haves**, and **havenots**.

Finally, the policy encourages the establishment of practice by private medical professionals, and non-governmental agencies with a view to reduce government expenditure, and to fully utilize untapped resources but, this will inevitably result in strengthening of the already existing health infrastructure in the urban areas as very few private doctors, and non-governmental agencies would like to invest in rural areas as it would not be commercially viable.

Thus it can be seen that **the** National Health Policy merely reiterates the status-quoist, and incremental approach of the ruling elite in the country. **It** will only serve the vested interests rather than the needy masses in the country.

In the Seventh Five Year Plan, primary health care is to continue as the main instrument of action to achieve the goal of '**Health for All by 2000 A.D.**' (GOI, 1985: 379). The strategy advocated in the Seventh Plan **incorporated** most of the suggestions made by various committees which looked into the working of the health sector pro-

**grammes.** The plan placed greater emphasis on **improvement** of the quality of **services, backed** by adequate **strengthen-**ing of infrastructural facilities and to establish **these** where they are not available in a coordinated, and integrated effort. **It** also recommended active community participation, and involvement of non-governmental organizations. Special emphasis has been given for training, and education of doctors, and paramedical personnel **(GOI, 198b: 379-386).**

Table **5.3** shows the year wise and plan wise increase in the establishment of primary health centres and sub-centres in the country.

Table 5.3 :

Establishment of Primary Health centres and **sub-centres** in **India**  
**since** First five Year Plan

| (1)                               | (2)            | (3)                |
|-----------------------------------|----------------|--------------------|
|                                   | <b>PHCs</b>    |                    |
| first Plan                        | 725            |                    |
| Second Plan                       | <b>2,565</b>   |                    |
| Third Plan                        | 4,631          |                    |
| <b>INTER-PLAN PERIOD 3 YERARS</b> | <b>PHCs</b>    | <b>Sub-Centres</b> |
| As on 31-3-1967                   | 4,763          | <b>17,521</b>      |
| As on 31-3-1966                   | 4,946          | <b>21,539</b>      |
| As on 31-3-1969                   | 4,919          | <b>22,826</b>      |
| <b>4 TH FIVE YEAR PLAN</b>        |                |                    |
| As on 31-3-1970                   | 5,015          | 23,627             |
| As on 31-3-1971                   | 5,112          | 28,489             |
| As on 31-3-1972                   | 5,183          | <b>28,167</b>      |
| As on 31-3-1973                   | 5,248          | 31,034             |
| As on 31-3-1974                   | 5,283          | 33,609             |
| <b>5 TH FIVE YEAR PLAN</b>        |                |                    |
| As on 31-3-1975                   | 5,293          | 33,616             |
| As on 31-3-1976                   | 5,328          | 34,088             |
| As on 31-3-1977                   | 5,380          | 38,110             |
| As on 31-3-1978                   | 5,400          | <b>38,115</b>      |
| As on 31-3-1979                   | 5,423          | 40,124             |
| As on 31-3-1980                   | 5,484          | 47,112             |
| <b>6 TH FIVE YEAR PLAN</b>        |                |                    |
| As on 31-3-1981                   | 5,740          | 51,406             |
| As on 31-3-1982                   | 5,851          | <b>57,975</b>      |
| As on 31-3-1983                   | 5,959          | 65,643             |
| As on 31-3-1984                   | 6,375          | 77,236             |
| As on 31-3-1985                   | 7,284          | 84,690             |
| <b>7 TH FIVE YEAR PLAN</b>        |                |                    |
| As on 31-3-1986                   | <b>12,934*</b> | 92,483             |
| As on 31-3-1987                   | <b>14,281*</b> | 1,01,649           |
| As on 31-12-1987                  | 14,609         | 1,02,674           |

Note : \* Includes subsidiary Health Centers also.

Source: Health Information India, 1988 : 141. **CBHI, DGHS,**  
 Ministry of Health and Family Welfare. **GOI, New Delhi.**



The Liabile **indicates an** increase in the number of primary health centres **established** between the First and the Third Plan period while it has decreased from **1967 onwards** to the end of Sixth Five Year Plan with a sudden increase during the Seventh Five Plan **period**. The decrease in the number **of** primary health centres, and sub-centres during the plan periods can be attributed to the reduced allocation of plan funds for health services in general as can be seen from table 5.4.

Table #.4:

**Pattern of Investment** on Health, family Welfare and Water Supply etc.  
(Plan outlays) in different Plan Periods in Public Sector -Centre, States and Union Territories.

| Sl. No.               | PERIOD | Total Plan Investment outlays (all heads of development) | Health  | Family Welfare | Sub-total | Water Supply and Sanitation |
|-----------------------|--------|----------------------------------------------------------|---------|----------------|-----------|-----------------------------|
| (1)                   | (2)    | (3)                                                      | (4)     | (5)            | (6)       | (7)                         |
| 1. First Plan         |        | 1,960.0                                                  | 65.2    | 0.1            | 65.3      | 11.0                        |
| (1951-56) actuals     |        | (100)                                                    | (3.3)   | (-)            | (3.3)     | (0.56)                      |
| 2. Second Plan        |        | 4,672.0                                                  | 140.8   | 5.0            | 145.6     | 74.0                        |
| (1956-61) actuals     |        | (100.0)                                                  | (3.0)   | (0.1)          | (3.1)     | (1.58)                      |
| 3. Third Plan         |        | 8,576.6                                                  | 225.9   | 27.0           | 252.9     | 106.7                       |
| (1961-66)             |        | (180.0)                                                  | (2.6)   | (0.3)          | (2.9)     | (1.2)                       |
| 4. Annual Plan        |        | 6,625.4                                                  | 140.2   | 82.9           | 223.1     | 102.7                       |
| (1966-69) actuals     |        | (100.0)                                                  | (2.1)   | (1.3)          | (3.4)     | (1.6)                       |
| 6. Fourth Plan        |        | 15,778.8                                                 | 335.5   | 285.8          | 621.3     | 468.9                       |
| (1969-74) actuals     |        | (180.0)                                                  | (2.1)   | (1.8)          | (3.9)     | (2.9)                       |
| 6. Fifth Plan         |        | 39,426.2                                                 | 780.8   | 497.4          | 1,258.2   | 1,091.6                     |
| (1974-79) actuals     |        | (100.0)                                                  | (1.9)   | (1.3)          | (3.2)     | (2.8)                       |
| 7. (1979-80) actuals  |        | 12,176.6                                                 | 223.1   | 116.2          | 339.3     | 387.6                       |
|                       |        | (100.0)                                                  | (1.8)   | (1.0)          | (2.8)     | (3.2)                       |
| 6. Sixth Plan         |        | 97,500.0                                                 | 1,821.1 | 1,010.0        | 2,831.1   | 3,922.0                     |
| (1980-85) outlay      |        | (180.0)                                                  | (1.9)   | (1.0)          | (2.9)     | (4.0)                       |
| 9. 1980-81 (actuals)  |        | 14,832.4                                                 | 269.6   | 140.9          | 410.5     | 517.48                      |
|                       |        | (100.0)                                                  | (1.8)   | (0.9)          | (2.8)     | (3.5)                       |
| 10. 1981-82 (actuals) |        | 18,210.9                                                 | 346.5   | 193.0          | 539.5     | 640.2                       |
|                       |        | (180.0)                                                  | (1.9)   | (1.1)          | (3.0)     | (3.6)                       |
| 11. 1982-83 (actuals) |        | 21,282.9                                                 | 386.9   | 288.3          | 675.2     | 729.6                       |
|                       |        | (180.0)                                                  | (1.8)   | (1.4)          | (3.2)     | (3.4)                       |
| 12. 1983-84 (actuals) |        | 25,087.6                                                 | 470.2   | 362.9          | 833.1     | 992.6                       |
|                       |        | (100.0)                                                  | (1.9)   | (1.6)          | (3.4)     | (4.0)                       |
| 13. 1984-85 (R. E)    |        | 30,232.1                                                 | 550.4   | 424.1          | 974.5     | 1,087.7                     |
|                       |        | (180.0)                                                  | (1.8)   | (1.4)          | (3.2)     | (3.6)                       |
| 14. Total Sixth Plan  |        | 1,09,645.8                                               | 2,015.5 | 1,429.2        | 3,444.7   | 3,977.6                     |
| (1980-85)             |        | (180.0)                                                  | (1.8)   | (1.3)          | (3.1)     | (3.6)                       |
| 16. Seventh Plan      |        | 1,80,000.0                                               | 3,392.9 | 3,256.0        | 6,648.9   | 6,522.5                     |
| (1985-90) outlay      |        | (180.0)                                                  | (1.9)   | (1.8)          | (3.7)     | (3.6)                       |
| 16. 1986-86 (actuals) |        | 33,059.9                                                 | 578.9   | 479.8          | 1,058.7   | 1,181.1                     |
|                       |        | (180.0)                                                  | (1.8)   | (1.4)          | (3.2)     | (3.6)                       |
| 17. 1986-87 (R. E)    |        | 40,260.7                                                 | 683.1   | 530.0          | 1,213.1   | 1,325.0                     |
|                       |        | (180.0)                                                  | (1.7)   | (1.3)          | (3.0)     | (3.3)                       |
| 18. 1987-88 outlay    |        | 44,696.4                                                 | 822.4   | 666.0          | 1,488.4   | 1,580.9                     |
|                       |        | (180.0)                                                  | (1.8)   | (1.3)          | (3.1)     | (3.5)                       |

Source : Health Information India, 1988 : 61 - 62.

CBHI, DGHS, Ministry of Health and Family Welfare, GOI, New Delhi



The **draft** approach to the ~~Eighth~~ <sup>h</sup> ~~Five~~ Year Plan (1990-1995) states that it will be impossible to achieve 'Health for All' by the year 2000 at the current rate of expansion of health **services**. It also agrees with the fact that health **delivery** system in rural areas is highly inadequate and **defective**, and stresses the need for health as an important component **for** the success of the **Family Planning Programme**. Based on past experiences, the approach paper suggests that the health delivery system should become a part of a package programme in which other social services such as education, and **women's** programmes are brought in (GOI, 1990:19).

The draft paper stresses the need to structurally modify the medical education system in order to make the health care system more effective. It calls for several reforms in the system, and suggests that medical professionals be trained, equipped and oriented to serve in rural areas through innovative medical schooling. The paper also states "that in both education, and health services provided by the public sector, there is a strong case, both on grounds of revenue, and equity, for the better-off sections **to** pay adequately for the services utilized by them" (GOI, 1990:19).

Thus the approach to the Eighth Plan does not seem to be any different from the approaches to the previous plan documents which we have had.

The constitution of India lays the burden of implementation of welfare programmes on the state governments, while the resources, and policy directive\* are provided by the central government. This coupled with varying degree\* of political commitment\* have resulted in variations between states in the implementation of medical, and health care services as evidenced by various indicators of health. The general impression that these indicators convey is that Andhra Pradesh lags behind many states, and in some case\*, behind the country's average performance (GOAP, 1984: 2-3).

In this context it would be appropriate to look at the policy developments (in the field of health ) in the State of Andhra Pradesh.

#### 4. ANDHRA PRADESH STATE HEALTH POLICY:

The Government of Andhra Pradesh has been broadly following the policies laid down by the centre with respect to medical and public health, with greater emphasis on the curative aspects of health care.

A state level working group on Medical and Public Health stressed that, "in a country where the general level of health is low due to malnutrition and other factors, any programme of development towards better health should lay greater emphasis on the curative side. Infact till the

general level of health ~~is~~ considerably raised by ~~an increase~~ in the standard of living, the curative aspect of health programmes will be all the more important" (GOAP, 1960:204). Towards this end, a programme for the provision of more medical facilities was initiated during the first Plan period.

Unhygienic environment, low resistance due to inadequate diet, lack of proper medical care, curative and preventive, besides lack of general health, and low economic status were some of the causes identified for the poor state of health. Thus during the first Plan period, programmes for health development were taken up with a view to remove some of these serious impediments to progress (GOAP, 1960:220).

At the end of the first Plan, 132 primary health centres were opened in the state, and it was proposed to open 200 more primary health centres by the end of the second plan (GOAP, 1960:205).

The objectives of the Second Five Year Plan included:

- (i) establishment of institutional facilities;
- (ii) development of technical manpower through appropriate training programmes, and employment of persons trained;
- (iii) family planning and other supportive programmes for raising the standard of health of the people.

An outlay of **Rs.185.63** lakha ~~-Rs.121.09 lakhs~~ for Andhra region, and **Rs.64.54** lakha for ~~Telangana~~ region, for **implementation** of the various public health programmes **was** proposed to fulfil the above objectives (GOAP, 1960:221-222).

Keeping in view the low priority accorded to social services in terms of financial allocation in the First and Second plan period, and the stress laid on the improvement of social services as a basic condition of development, greater emphasis was placed on health services development in the Third Five Year Plan.

During the Third Plan period, efforts were concentrated in the field of medical education by increasing the intake capacity in medical colleges, and creating adequate facilities for the training of para- medical personnel, but progress in medical care was dismal at the district, taluk and primary health centres level. (GOAP, **1969:146**).

According to the survey conducted by the Planning and Cooperation Department, GOAP in 1970, in the state, out of the 10,276 inhabited villages, only 24.1% have medical facility either government or private, located within the villages, while another 33.9% of the villages have this facility within a distance of five miles from the villages. the remaining 42% of the villages are further away from medical **facility**, beyond ten miles from the **villages**. the villages

with a larger population are somewhat better off with regard to **medical facility** than those with smaller population **size**. (GOAP, 1970:145).

The main objectives of the Fourth Plan were:

- (i) to expand medical **services**, particularly to those serving the rural areas;
- (ii) strengthen the district, and taluk headquarters hospitals;
- (iii) provision of specialized services in a decentralized manner so that a larger population could be served;
- (iv) to strengthen teaching hospitals, and expand the training programmes for medical, and para-medical personnel,
- (v) to expand the laboratory, and diagnostic services; and
- (vi) to give assistance to the Indian Systems of Medicine and Homeopathy (GOAF, 1969:146).

In order to achieve the above objectives an amount of **Rs.348.41** lakhs was provided for modern medicine in the medical sector but the expenditure incurred was only **Rs.299.94** lakhs amounting to only **86%**. The shortfall in expenditure was mainly due to the disturbed conditions in the state during **1969 to 1972**, and also due to not filling up of various posts on account of administrative problems. (GOAP, 1976:98).

A sum of Rs.136.41 lakh\* was provided for **implementing** the schemes of public health. The expenditure incurred worked out to Rs.143.53 lakhs **forming 105.2% (GOAP, 1976:107).**

In the approach document of the Fifth Five Year Plan, the National Development Council highlighted the rural-urban imbalance in the provision of health care services. **The** document also stresses that the traditional norms such as doctor-population, and bed-population ratio or percapita expenditure on health are not sufficient to overcome this imbalance, and that the norms during the Fifth Plan should be related to adequate extension of medical and health care services in the rural areas **(GOAP, 1973:419).**

Keeping in view the national approach as well as the needs of the state; in the Fifth Plan, it was proposed to expand the existing medical and health facilities, and also improve their quality. Emphasis was to be on provision of medical services in such a way that they were to be easily accessible to vulnerable sections of the population. **This** was to be achieved by identifying a hierarchy of service\*, and integrating all the medical and health services at each level in actual operation. **Improved** medical facilities especially at the lower level institutions for rural population, and health care received greater attention with **the** introduction of the Minimum Needs Programme during the **Fifth**



Plan period (**GOAP, 1980:341**).

At the end of the Fourth **Plan there** were 415 primary health centres functioning in the state along with **3,014** sub-centres including 1,245 sub-centres under the Community Development **Programme**, and **1,769** family planning **centres**. Thus no additional primary health centres were proposed in the Fifth **Plan**, and instead **it** proposed to strengthen the existing primary health centres by making provision for **medicines**, and taking up construction of buildings **for** the primary **health** centre staff. Out of the 41b primary health centres, 199 had no buildings, and 346 primary health centres had no quarters for the staff (**GOAP, 1980:205**).

When compared to the ideal bed-population ratio of 1:1000, and doctor-population ratio of 1:3,500, the available facilities in the state indicated considerable short falls. While on the one hand, there was a shortage of doctors in rural areas, on the other hand about 1200 and more medical graduates were being turned out by the medical colleges in the state every year (**GOAP, 1980:206**).

An outlay of **Rs.32.45** crores was proposed in the Fifth Plan for medical and health services in the state. **But**, subsequently in view of the paucity of resources, and larger allocation for irrigation and power schemes, the provision for medical and health was cut down to **Rs.15.91** crores **in the** revised Fifth Plan. While the allocation for medical serv-

ices were marginally increased, the major out was under public health in **respect** of the Minimum Needs Programme, which was revised at the national level. However, even the revised allocation was higher in relation to the Fourth Plan outlay by only **Rs.4.66** crores for Medical and Public Health Programmes (GOAP, 1980: 20Y).

During the Sixth Plan, the thrust was similar to the Fifth Plan which emphasized strengthening of district, taluk, teaching hospitals, and expansion of primary health **centres**. Emphasis was on the completion of the ongoing schemes to avoid backlog, and further escalations in estimated costs (GOAP, 1980:342).

An outlay of **Rs.2,500.00** lakhs was proposed for the medical sector in the Sixth **Plan**, and an amount of **Rs.1343.25** lakhs was provided for public health schemes, and centrally sponsored schemes (GOAP, 1980: 343-354).

Since in the field of medicine the state was considered backward, a huge stepup was contemplated in the Seventh Five Year Plan, and primary health care was the main instrument of action (GOAP, 1986:379).

In the revised administrative setup, **'Mandals'** were formed in place of taluks in **1985-86**. About **653 mandal** headquarters were covered by the existing primary health



**centres**, taluk **hospitals**, and other government **medical insti-**  
tutions, and the remaining **500** new **mandals** required medical  
**institutions**. Thus it was proposed to establish primary  
health centres or dispensaries during **1985-86** itself in all  
mandals which did not have medical facilities (GOAF,  
**1986:385**).

In terms of rural health **facilities**, the programme of  
upgrading all the existing 426 primary health centres into  
community health centres by providing **30** beds at each centre  
was proposed. It was also proposed to introduce health care  
system to cover all school going children (GOAF, **1988:101**).

In continuation of the earlier plans, and policies the  
Seventh Plan lay emphasis on the establishment of superspe-  
cialities in all teaching hospitals, at the same time, pro-  
posed strengthening of district, and taluk hospitals. As a  
policy it also contemplated to encourage private hospitals,  
and devise institutional mechanisms for attracting finances  
from non-resident Indians. Now this shift in policy towards  
privatization in health care can be attributed to the politi-  
cal change that had taken place in the state, that is, the  
emergence of a regional party whose members represent the  
dominant business class in the state.

The Planning Commission approved an outlay of  
**Rs.16,420.00** lakhs for the health sector during the Seventh  
Plan. The details of approved out-lays for, **the** Seventh

Plan, and 1985 and 1986, and 1986 and 1987 annual plans are as follows:

| Sl. NO. | Department                                     | Seventh Plan | Annual Plan |          |
|---------|------------------------------------------------|--------------|-------------|----------|
|         |                                                |              | 1985-86     | 1986-87  |
| 1.      | Medical Education                              |              |             |          |
| 2.      | Indian Medicine                                |              |             |          |
| 3.      | Drugs Control Administration                   |              |             |          |
| 4.      | Health + Family Welfare                        |              |             |          |
| a)      | Normal Public Health Schemes                   | 9,641.00     | 1,327.00    | 1,606.00 |
| b)      | 50% State share of centrally sponsored schemes |              |             |          |
| 5.      | Institute of Preventive Medicine               |              |             |          |
| 6.      | E S I (under labour)                           | 40.00        | 10.00       |          |
| 7.      | M N P                                          | 6,739.00     | 622.00      | 810.00   |
| Total   |                                                | 16,420.00    | 1,999.00    | 2,416.00 |

Source : GOAP 1988 : 101

The aim of any health policy is to bring about a planned change in the health status of the people. However developments in this direction over the past 42 years did not bring about any significant change in the health status of the people.

## APPENDIX VI

### DUTIES OF PRIMARY HEALTH CENTRE PERSONNEL

The gamut of **PHC** workers constitute a functional unit, and provide preventive, **promotive** and curative services to the people in rural areas. The PHC serves as a focal point from which supervisory control is exercised over various levels of workers. Specific job descriptions of the various personnel are described below:

#### (i) Medical Officers:

The PHC Medical Officers are responsible for providing direction, and guidance to **all health activities** radiating from their health centre. They should be familiar with their areas, the villages, community health needs. and public health problems. As already mentioned, in a regular PHC

there are three **Medical Officers**. The first is designated as in-charge **Medical Officer (Family Welfare)**, the second as **Medical Officer (Regular)**, and the third as Medical Officer (Village Health guides Scheme). **Though** their designations are different all of them perform similar functions **viz.**, curative, preventive, promotive work, and training. While the curative, preventive, and promotive work is shared by all the three, the training and administrative work is performed by the Medical officer in-charge who is also incharge of the Family Welfare Programme.

(a) Curative Work:

The Medical Officers should organize the out-patient department, and allot duties to the ancillary staff to ensure smooth running of the out-patient department. He/She should attend to cases referred by the sub-centre staff, and village level workers, and provide guidance to them in the treatment of minor ailments. He/She should cooperate with other institutions providing curative services in his area. He/She should visit each sub-centre in his/her area at least once **in** a fortnight to check the work of the **staff** as well as to provide curative services.

(b) Preventive and Promotive Work:

She/He should ensure that all the members of his/her team are fully conversant with the various Health, and Family Welfare programmes to be implemented in the area.

He/She should organize Maternal and Child Health Services (**antenatal, intranatal,** and postnatal care of **mothers,** and **infants**), plan and implement the **immunization Programme,** and ensure maximum possible coverage of the target population in the **PHC area.** **He/She** should ensure adequate supply of vaccines, their storage, maintenance of cold chain, and other items for the effective implementation of the **programme.**

**He/She** should organize, and conduct family planning camps, and ensure adequate supplies of drugs, educational material, and contraceptives required for the services.

**He/She** should be alert for early detection of malaria, tuberculosis, leprosy cases, and ensure complete, and regular treatment. **He/She** should also ensure proper maintenance of sanitation in the villages to prevent communicable disease and take necessary action in case of an epidemic in his/her area. **He/She** should keep close liaison with the development officials, community leaders, voluntary organizations in her/his area, and involve them to the best advantage **in** the promotion of health **programmes.**

(c) **Training** and Administrative Work:

**The** Medical Officer should organize training programmes under the guidance of the district health **authorities,** and health and family welfare training centres.

As head of the organization **she/he should** discharge all **financial** duties entrusted to **him/her**, and discharge day to day administrative functions pertaining to the **PHC**.

**He/She** should ensure to keep up-to-date inventory, and stock register of all the stores, and equipment supplied to the **PHC**, and get indents prepared **for** drugs **etc, sufficiently** in advance, and submit to the **DMHO**. **He/She** should scrutinize the programmes of his/her staff, and suggest changes if necessary to suit the priority of work.

**He/She** should conduct monthly staff meetings for evaluating the progress of work, and suggest steps to be taken for further **improvements**. **He/She** should ensure maintenance of the prescribed records at **PHC level**, and should receive reports from the periphery, get them complied, and submit them regularly to the district health authorities. **He/She** should attend the meetings of the Medical Officers at the district headquarters called by the **DMHO** to review the work done by the **PHCs** once a month.

Thus the efficient functioning of the **PHC** depends on the leadership qualities of the Medical Officer. However, the success of the primary health centre's **programmes** is not possible without the assistance of the headquarter staff in the **PHC** such as the Multipurpose Health **Extension** Officer, Senior Assistant, **Computer**, and others.



(ii) **Multipurpose Health Extension Officer:**

The Multipurpose Health Extension Officer functions under the technical supervision, and guidance of the Deputy District Extension Media Officer (**Dy.DEMO**), and District Extension Media Officer (**DEMO**). However he will be under the immediate administrative control of the in-charge Medical Officer.

He is responsible for providing support to all Health and Family Welfare **Programmes** in the **mandal**. He assists the in-charge Medical Officer in conducting training of Health Workers under various schemes. He is also **responsible** for organizing Mass Communication Programmes like film shows, exhibitions, and lectures with the help of **DEMO**.

He should supervise the work of field workers in the area of education and motivation, and be on tour for 16 days in a month. He should check the available stock of conventional contraceptives with the depot holders, and other functionaries. He should help the field-workers in winning over resistant cases, and dropout\*. He should organise population education, and health education sessions **in** schools and, for the village youth. He should prepare a monthly report on the progress of educational activities in the mandal, and send it to the **DEMO**.

**(iii) Pharmacist:**

The Pharmacist assists the Medical Officer to conduct the out-patient clinic, and manages the centre in the absence of the Medical Officer. His/Her main responsibility is to distribute tablets, and capsules to the patients as per the Medical Officers' prescription. He/She should maintain stock registers for medicines, drugs, and equipment, and is in overall charge of the medical stores in the PHC.

**(iv) Laboratory Technician:**

All PHCs have been provided with a post of lab technician or assistant. He works under the supervision of the in-charge Medical Officer. He should follow all the general laboratory procedures, and maintain the necessary records of investigations done, and submit them to the Medical Officer. He should indent for supplies for the laboratory through the Medical Officer, and ensure safe storage of materials received.

As a routine he is supposed to carry out examination of urine, stool, blood, sputum etc., however, in most of the PHCs, facilities are there only for collection of blood specimens by finger prick technique for the detection of malaria. He has to maintain records of slides examined by him, and must get the positive slides confirmed by the PHC Medical Officer. he must maintain daily progress, and output



register of blood **slide examinations**, and the backlog chart of pending radical treatment vis-a-vis collected slides.

(v) **Computer:**

The computer functions under the supervision, and **guid-**ance of the **PHC** Medical officer. He receives technical support, and guidance from the Statistical Assistant at the district level. He must keep close contact with all the Health Workers working for the primary health centre.

He is responsible for collecting information on various components of Health and Family Welfare Programme including mass education and media activities from the sub-centres. He scrutinizes, and consolidates the information collected for the entire **PHC** area.

He is required to compile the updated information regarding eligible couples, and child registers, and family planning acceptors in all the villages of the **PHC**. He is expected to prepare charts, and graphs depicting the progress of various Health and Family Welfare Programmes. He is required to carryout any other statistical functions assigned by the **PHC** Medical Officer.

(vi) **Senior Assistant:**

The Senior Assistant is **in-charge** of the entire office work of the **PHC**. Since the **PHC** staff work under different programmes sponsored by the central government with separate heads of **accounts**, he has to prepare separate pay bills, and travelling allowance bills. He is responsible for bringing the money required from the treasury on the Medical Officer's instructions. He has to also maintain registers regarding salaries, travelling allowance, and other expenditure incurred in the **PHC**.

(vii) **Multipurpose Health Supervisor (Male):**

A Health Supervisor (male) is expected to cover a population of ~~30,000~~ in which there are six **sub-centres**, each with one male Health Worker. The Health Supervisor is expected to help, and guide the male Health Worker in planning, and organizing various health activities. He should visit each Health Worker once a week to observe, and guide him in his day-to-day activities, and carryout supervisory home visits in his area.

He should coordinate his activities with those of the women Health Supervisor, other health personnel including the Village Health Guides, and Dais.

He should assist the Medical Officer of the PHC in conducting training programmes for various categories of health personnel. He should check at regular intervals the stores available at the sub-centres, and ensure timely placement of indents for procuring the supplies.

He should guide the Health Worker in proper maintenance of records, consolidating them, and submitting reports to the Medical Officer.

He should supervise the malaria work done by the workers, and give radical treatment to positive cases, supervise the spraying of insecticides during local spraying. He should be alert to the sudden outbreak of epidemics, and take remedial measures. He should help in maintaining environmental sanitation, and supervise the chlorination of water sources.

He should supervise the immunization of all children from one to five years. He should personally motivate resistant cases for family planning and assist the Medical Officer in organizing camps, at the same time, providing information on the availability of medical termination of pregnancy (MTP) services.

He should identify cases of malnutrition among infants, young children, and provide treatment and advice. He should

provide treatment of minor **ailments**, provide **first-aid** during **accidents** and emergencies, and refer cases beyond **his** competence either to the **PHC** or the nearest hospital. He should also carry out educational activities, and arrange group meetings with leaders, and involve them in spreading the message for various health programmes.

**(Viii) Multipurpose Health Supervisor (Female):**

Just as their male counterparts, the woman supervisors guide, and supervise the work of **the** women workers, and perform all the duties mentioned above.

In addition, she has to organize, and conduct training for Dais with the assistance of women workers. She should conduct weekly **MCH** clinics at each sub-centre with the assistance of the women Health Workers. She should personally motivate resistant cases for family planning, and should supervise the immunization of all pregnant women, and **infants**.

She should provide treatment of minor ailments, and refer cases beyond her competence to the **PHC** or the nearest **hospital**. She should carry out health **education** activities for **MCH**, family planning, nutrition and immunization. She should also organize, and conduct training of women leaders with the help of the women Health Workers.

(ix) **Multipurpose Health Worker (Male):**

Under the Multipurpose Scheme, one Health Worker (male), and one Health Worker (female) are posted at each sub-centre, and are expected ultimately to cover a population of **5000**. ~~The~~ men **workers** should visit each family in their jurisdiction once a fortnight, and identify fever cases, collect blood samples, and send them to the lab technician for testing. ~~In~~ the meanwhile they administer presumptive treatment. ~~In~~ case of positive cases the worker has to refer them to the Health Supervisor (male) for radical treatment. He should educate the community on the importance of blood smear collection, treatment, insecticidal spraying of houses, and other measures to control the spread of malaria.

He should identify cases of communicable diseases, and carryout control measures until the Health Supervisor (male) arrives. He should educate the community about the importance of **control**, and preventive measures against communicable diseases, and about the importance of taking regular, and complete treatment. He should chlorinate public water sources, and educate the community on environmental sanitation.

He should immunize children (**1-5** years) for **BCG**, **DPT**, and folio, and assist the Health Supervisor (male) in the immunization of school children.

He should utilize the information from the eligible couples register, and motivate them for family planning individually, and in groups. He should distribute conventional contraceptives to couples, and provide follow up services to the family planning acceptors. He should build rapport with satisfied acceptors, village teachers, and others, and utilize them for promoting the Family Welfare Programme. He should assist the Health Supervisor (male) in training the leaders in the community, and in educating, and involving the community in the Family Welfare **Programme**.

He should identify cases of malnutrition among pre-school children, and refer them to the **PHC**, and distribute iron and folic acid tablets to **pre-school** children, pregnant, and nursing mothers. He should educate the community about nutritious diet for mothers, and children.

He should provide treatment for minor ailments, and refer cases beyond his competence. He should attend, and participate in the staff meetings at the **PHC**, and coordinate his activities with the women Health Workers, and other health personnel like the Village Health Guide\*.

He should from time to time, survey all the families **in** his area, and collect general information about the village, prepare and maintain household register, and village register. From the information thus obtained he should prepare



**the** eligible **couples'** register with the help of the women worker, and maintain it up to date.

(X) **Multi-purpose Health Worker (Female):**

Under the Multipurpose Scheme, one Health **Worker(fe-** male), and one Health Worker (male) are posted at each sub-centre to cover a population of **5000**. However during the Yth plan the women Health Workers activities were limited to **350-560** families i.e., those households only where there are cases for antenatal, and postnatal care, and infants.

**The** women Health Worker should provide care to pregnant women throughout the period of pregnancy, and immunize them with tetanus toxide and, distribute iron and **folic** acid tablets. She should refer abnormal cases to the woman Health Supervisor or the **PHCs**. She should conduct atleast **50%** of the total deliveries in her area, and should supervise deliveries conducted by Dais, and assist them whenever needed. She should atleast make three post-natal visits for each delivery conducted in her area, and render advice regarding care of the mother, and the new born. She should educate **mothers** individually, and in groups for better family health, including MCH, family planning, nutrition, **immuniation**, control of communicable diseases, personal and environmental hygiene, and care of minor ailments.

She should utilize the **information** from the eligible couples, and child register for the family planning programme, and motivate, and distribute conventional contraceptives, and oral contraceptives to the **couples**. She should provide facilities for family planning acceptors, and also provide follow up services to women acceptors. She should build rapport with the acceptors, village leaders, Health Guides, Dais and **others**, and utilize them **for** promoting Family Welfare Programme. She should participate in **mahila mandal** meetings, and utilize such gatherings for educating women about the Family Welfare Programme at the **same time** informing them about the availability of **MTP** services.

She should identify cases of malnutrition among infants, young children, and give prompt advice, and treatment. She should distribute iron and folic acid tablets to nursing mothers, young children, and family planning acceptors, and also administer vitamin 'A' solution to **pre-school** children. She should immunize infants and children against **DPT**, poliomyelitis, measles, and tuberculosis.

She should **identify** cases of cholera, **gastroenteritis**, malaria, etc during her house visits, and notify **the** male Health Worker about them. She should register antenatal cases, infants, and women aged **15** to 44 years through **systematic** home visits, and at the clinic. She should **assist the** male Health Worker in preparing the eligible couple **register**.



and maintain it upto **date**. She should **prepare, and submit** the prescribed periodical **reports** in time to the **women Health Supervisor**.

The woman worker should also provide **treatment for** minor ailments, and coordinate her activities with the male **Health Worker**, and other health personnel including **the** Health Guides and **Dais**. She should participate as **a** member of the team in **camps**, and attend, and participate in staff meetings at the **PHC**.

(xi) **Village Health Guide (VHG):**

A **VHG** is expected to cover a population of 1000, and will receive technical guidance from the Health Worker (male).

He should identify fever cases, collect the blood **smears**, and send them **for examination**. He should administer presumptive treatment, and inform the Health Worker, and assist him in the spraying operation. He should educate the villagers on how to prevent malaria.

He should inform the Health Worker **in** case of an epidemic in the area, and educate the people about the prevention, and control of communicable diseases. He should chlorinate drinking water sources at regular intervals, **and** assist the workers in the immunization of infants, and children. **He**

should spread the message of family planning, and educate the people about the available methods, and act as a depot holder. He should **inform the** Health Worker of those couples who are willing to accept a family **planning** method, and also educate the community about the availability of **MTP services**.

He should advise the pregnant women to consult the women **Health Worker**, and encourage them to utilize the **facilities** made available to **them**. He should educate the community about nutritious diet for mothers, and children. He should provide emergency first aid, and treatment of minor **ailments**, and refer cases to the Health Worker or the **PHC**.

**(xii) Dai:**

The Dai is an important person in her village, and serves as a **link** between the families in her **village**, and the woman Health Worker. She should contact every pregnant mother, and see that she is registered at the sub-centre or **PHC**. She should ensure that every pregnant women in her area attends the antenatal clinic at least three times i.e., after the third month to confirm pregnancy; during the seventh month, and during the ninth month, and that every pregnant women is immunized against tetanus (two doses), and is given iron and **folic** acid tablets as prescribed. **In** case of an abnormality she should refer to the Health Worker or **Health Supervisor** or the **PHC**, and seek medical aid without delay.

When she receives a call for delivery she should use the kit. and observe aseptic techniques while conducting the **delivery**. She should see that her **kit** is always replenished, **clean**, and ready for use. During postnatal period if she finds any **complications** in the mother she should immediately inform the Health Worker or the PHC. She should try to ensure that all infants in her area are immunized with BCG, DPT and oral poliomyelitis vaccine. She should also motivate eligible couples in her area to use a contraceptive method or to undergo sterilization.

## APPENDIX VII

Table 7.1:

Sub-centre wise distribution of respondent\* by utilization of sub-centre/PHC for treatment of minor ailments, N = 477

| S1.<br>NO. | Sub-centre | Sub-centre/PHC<br>users | Users of other<br>services* | Total      |
|------------|------------|-------------------------|-----------------------------|------------|
| (1)        | (2)        | (3)                     | (4)                         | (5)        |
| 1.         | 'A'        | 43(28.5)                | 108(71.5)                   | 151(100.0) |
| 2.         | 'B'        | 47(30.3)                | 108(69.7)                   | 155(100.0) |
| 3.         | 'C'        | 56(32.7)                | 115(66.3)                   | 171(100.0) |
| Total      |            | 146(30.6)               | 331(69.4)                   | 477(100.0) |

(Figures in brackets indicate percentage).

\* Refer table 7.6 page 257

Table 7.2:

Sub-centre wise distribution of respondents by utilization of sub-centre/PHC for antenatal care, N = 477.

| S1.<br>NO. | Sub-centre | Sub-centre/PHC<br>users | Users of other<br>services* | Total      |
|------------|------------|-------------------------|-----------------------------|------------|
| (1)        | (2)        | (3)                     | (4)                         | (5)        |
| 1.         | 'A'        | 105(69.5)               | 46(30.6)                    | 151(100.0) |
| 2.         | 'B'        | 93(60.0)                | 62(40.0)                    | 156(100.0) |
| 3.         | 'C'        | 87(50.9)                | 84(49.1)                    | 171(100.0) |
| Total      |            | 285(59.7)               | 192(40.3)                   | 477(100.0) |

(Figures in brackets indicate percentage).

\*Refer table 7.6 page 257

Table 7.3:

Sub-centre wise distribution of respondents by place of delivery,

N = 477.

| Sl. NO. | Sub-Centre | Place of delivery |                   |                      |                     |          | Total                 |
|---------|------------|-------------------|-------------------|----------------------|---------------------|----------|-----------------------|
|         |            | At home           | PHC               | Private nursing home | Government hospital | house    |                       |
| (1)     | (2)        | (3)               | (4)               | (5)                  | (6)                 | (7)      | (8)                   |
| 1.      | 'A'        | 103(66.2)         | 3(2.0)            | 16(10.6)             | 16(9.9)             | 14(9.3)  | 151(100.0)            |
| 2.      | 'B'        | 106(67.7)         | 1(0.6)            | 12(7.7)              | 19(12.3)            | 18(11.6) | <del>155(100.0)</del> |
| 3.      | 'C'        | 106(63.2)         | 1(0.6)            | 14(8.2)              | 22(12.9)            | 26(16.2) | 171(180.0)            |
| Total   |            | 316(66.2)         | <del>5(1.0)</del> | 42(8.8)              | 66(11.7)            | 68(12.2) | 477(100.0)            |

(Figures in brackets indicate **percentage**).

Table 1.4 :

Sub-centre wise distribution of respondents by persons responsible for conducting deliveries at home, and the PHC, N = 321.

| Sl. NO. | Sub-Centre | Persons responsible for conduct of delivery |               |                   |               |                              | Total                 |
|---------|------------|---------------------------------------------|---------------|-------------------|---------------|------------------------------|-----------------------|
|         |            | Trained Dai                                 | Health Worker | Health Supervisor | Untrained Dai | Elderly person in the family |                       |
| (1)     | (2)        | (3)                                         | (4)           | (5)               | (6)           | (7)                          | (8)                   |
| 1.      | 'A'        | 66(61.3)                                    | 4(3.8)        | 3(2.8)            | 24(22.6)      | 10(9.4)                      | 106(100.0)            |
| 2.      | 3"         | 91(66.6)                                    | -             | 2(1.9)            | 13(12.3)      | -                            | <del>106(100.0)</del> |
| 3.      | 'C'        | 104(96.4)                                   | -             | 1(0.9)            | 4(3.79)       | -                            | <del>109(100.0)</del> |
| Total   |            | <del>260(81.0)</del>                        | 4(1.2)        | 6(1.9)            | 41(12.8)      | 10(3.12)                     | 321(100.0)            |

(Figures in brackets indicate percentage).

Table 7.5:

Sub-centre wise distribution of respondents by immunization of **chil-**  
dren for BCG, and place of immunization, **N** = 89.

| Sl.<br>NO. | Sub-<br>Centre | Place of immunization |          |                        |                   | Total            |
|------------|----------------|-----------------------|----------|------------------------|-------------------|------------------|
|            |                | Sub-centre            | PHC      | Government<br>hospital | Private<br>clinic |                  |
| (1)        | (2)            | (3)                   | (4)      | (5)                    | (6)               | (7)              |
| 1.         | 'A'            | 13(35.1)              | 17(46.9) | 9(10.8)                | 3(8.1)            | 37(100.0)        |
| 2.         | 'B'            | -                     | 11(46.8) | 9(37.6)                | 4(16.7)           | <b>24(100.0)</b> |
| 3.         | 'C'            | -                     | 10(36.7) | <b>7(25.0)</b>         | 11(39.3)          | <b>28(100.0)</b> |
| Total      |                | 13(14.6)              | 38(42.7) | 20(22.5)               | 18(20.2)          | 89(100.0;        |

(Figures in brackets indicate **percentage**).

Table 1.6:

Sub-centre wise distribution of respondents by immunization of **chil-**  
dren for DPT, and Polio (1 dose), and place of immunization, **N** = 107.

| Sl.<br>NO. | Sub-<br>Centre | Place of immunization |                 |                        |                   | Total             |
|------------|----------------|-----------------------|-----------------|------------------------|-------------------|-------------------|
|            |                | Sub-centre            | PHC             | Government<br>hospital | Private<br>clinic |                   |
| (1)        | (2)            | (3)                   | (4)             | (5)                    | (6)               | (7)               |
| 1.         | 'A'            | 10(31.3)              | <b>12(37.5)</b> | 2(6.3)                 | 8(26.0)           | 32(100.0)         |
| 2.         | 'B'            | 16(38.6)              | 8(20.6)         | 7(17.9)                | 9(23.1)           | 39(100.0)         |
| 3.         | 'C'            | 3(8.3)                | 9(26.0)         | 6(16.7)                | 18(60.0)          | 36(100.0)         |
| Total      |                | 28(26.2)              | 29(27.1)        | <b>15(14.0)</b>        | 35(31.8)          | <b>107(100.0)</b> |

(Figures in brackets indicate percentage).



Table 7.7:

Sub-centre wise distribution of respondents by immunization of children for DPT, and Polio (II dose), and place of immunization, N = 89.

| Sl. NO. | Sub-Centre | Place of immunization |          |                     |                | Total     |
|---------|------------|-----------------------|----------|---------------------|----------------|-----------|
|         |            | Sub-centre            | PHC      | Government hospital | Private clinic |           |
| (1)     | (2)        | (3)                   | (4)      | (5)                 | (6)            | (7)       |
| 1.      | A          | 7(25.0)               | 11(39.3) | 2(7.1)              | 8(28.6)        | 28(100.0) |
| 2.      | B          | 11(35.5)              | 5(16.1)  | 6(19.4)             | 9(29.0)        | 31(100.0) |
| 3.      | C          | 2(6.7)                | 8(26.7)  | 5(16.7)             | 16(60.0)       | 30(100.0) |
| Total   |            | 20(25.5)              | 24(27.0) | 13(14.6)            | 32(36.0)       | 89(100.0) |

(Figures in brackets indicate percentage).

Table 7.8:

Sub-centre wise distribution of respondents by immunization of children for DPT, and Polio (III dose), and place of immunization, N = 69.

| Sl. NO. | Sub-Centre | Place of immunization |          |                     |                | Total     |
|---------|------------|-----------------------|----------|---------------------|----------------|-----------|
|         |            | Sub-centre            | PHC      | Government hospital | Private clinic |           |
| (1)     | (2)        | (3)                   | (4)      | (5)                 | (6)            | (7)       |
| 1.      | A          | 6(20.8)               | 10(41.7) | 2(8.3)              | 7(29.2)        | 24(100.0) |
| 2.      | B          | 6(26.1)               | 4(17.4)  | 6(26.1)             | 7(30.4)        | 23(100.0) |
| 3.      | C          | 2(9.1)                | 6(22.7)  | 4(18.2)             | 11(60.0)       | 22(100.0) |
| Total   |            | 13(18.8)              | 19(27.6) | 12(17.4)            | 25(36.2)       | 69(100.0) |

(Figures in brackets indicate percentage).

Table 7.9:

Sub-centre wise distribution of respondents by immunization of children for measles, and place of immunization, N = 8.

| Sl. NO. | Sub-Centre | Place of immunization |         |                     |                | Total    |
|---------|------------|-----------------------|---------|---------------------|----------------|----------|
|         |            | Sub-centre            | PHC     | Government hospital | Private clinic |          |
| (1)     | (2)        | (3)                   | (4)     | (5)                 | (6)            | (7)      |
| 1.      | A          | 1(60.0)               | -       | 1(60.0)             | -              | 2(100.0) |
| 2.      | B          | -                     | 2(60.0) | -                   | 2(60.0)        | 4(100.0) |
| 3.      | C          | -                     | -       | -                   | 2(100.0)       | 2(100.0) |
| Total   |            | 1(12.6)               | 2(26.0) | 1(12.5)             | 4(60.0)        | 8(100.0) |

(Figures in brackets indicate percentage).

Table 7.10 :

Sub-centre wise distribution of respondents by sterilization, N = 477.

| Sl. NO. | Sub-Centre | Number of respondents who reported sterilization | Number of respondents who did not report sterilization | Total      |
|---------|------------|--------------------------------------------------|--------------------------------------------------------|------------|
| 1.      | A          | 48(31.8)                                         | 103(68.2)                                              | 161(100.0) |
| 2.      | B          | 63(40.6)                                         | 92(69.4)                                               | 166(100.0) |
| 3.      | C          | 69(34.6)                                         | 112(65.5)                                              | 171(100.0) |
| Total   |            | 170(36.6)                                        | 307(64.4)                                              | 477(100.0) |

(Figures in brackets indicate percentage).



**Table 7.11:**

Sub-centre wise distribution of respondents by place of **sterilization**, N = 170.

| Sl. NO. | Sub-Centre | Place of <b>sterilization</b> |                     |                      | Total                 |
|---------|------------|-------------------------------|---------------------|----------------------|-----------------------|
|         |            | PHC                           | Government hospital | Private nursing home |                       |
| (1)     | (2)        | (3)                           | (4)                 | (5)                  | (6)                   |
| 1.      | A          | 39(81.3)                      | 6(12.5)             | 3(6.3)               | <del>48(100.0)</del>  |
| 2.      | B          | 45(71.4)                      | 7(11.1)             | 11(17.5)             | 63(100.0)             |
| 3.      | C          | 43(72.9)                      | 12(20.3)            | 4(6.8)               | 59(100.0)             |
| Total   |            | 127(74.7)                     | 25(14.7)            | 18(10.6)             | <del>170(100.0)</del> |

(Figures in brackets indicate percentage).

**Table 7.12:**

**Distribution of respondents by frequency of visits by health workers (female), and utilization of sub-centre/PHC for treatment of minor ailments, N = 477.**

| Sl. No. | Frequency of visits | Sub-centre/PHC users | Users of other Services* | Total      |
|---------|---------------------|----------------------|--------------------------|------------|
| (1)     | (2)                 | (3)                  | (4)                      | (6)        |
| 1.      | Once a week         | 10(55.6)             | 8(44.4)                  | 18(100.0)  |
| 2.      | Once in two weeks   | 56(32.0)             | 119(68.0)                | 176(100.0) |
| 3.      | Once a month        | 38(28.4)             | 96(71.6)                 | 134(100.0) |
| 4.      | Once in two months  | 13(56.5)             | 10(43.5)                 | 23(100.0)  |
| 5.      | Rarely              | 10(29.4)             | 24(79.6)                 | 34(100.0)  |
| 6.      | No idea             | -                    | 3(100.0)                 | 3(100.0)   |
| 7.      | stays in village    | 19(26.8)             | 71(73.2)                 | 90(100.0)  |
| Total   |                     | 146(30.6)            | 331(69.4)                | 477(100.0) |

(Figures in brackets indicate percentage).

\* Refer table 7.6 page 257

**Table 7.13:**

Distribution of respondents by frequency of visits by **health** workers (female) and utilization of **sub-centre/PHC** for antenatal care, N = 4YY.

| Sl. No. | Frequency of visits | Sub-centre/PHC users | Users of other <b>Services*</b> | Total              |
|---------|---------------------|----------------------|---------------------------------|--------------------|
| (1)     | (2)                 | (3)                  | (4)                             | (5)                |
| 1.      | Once a week         | <b>14(77.8)</b>      | 4(22.2)                         | 18(100.0)          |
| 2.      | Once in two weeks   | 109(62.3)            | 66(37.7)                        | <b>175((100.0)</b> |
| 3.      | Once a month        | 77(57.5)             | 57(42.5)                        | 134(100.0)         |
| 4.      | Once in two months  | 11(47.8)             | 12(52.2)                        | 23(100.0)          |
| 5.      | Rarely              | 12(35.3)             | 22(64.7)                        | 34(100.0)          |
| 6.      | No idea             | -«                   | 3(100.0)                        | 3(100.0)           |
| 7.      | stays in village    | <b>62(68.9)</b>      | 28(31.1)                        | 90(100.0)          |
| Total   |                     | 285(59.7)            | 192(40.3)                       | 477(100.0)         |

(Figures in brackets indicate percentage).

\* Refer table 7.6 page **257**

**Table 7.14:**

Distribution of respondents by frequency of visits by health workers(female), and place of delivery, N = 477.

| Sl. Frequency<br>NO. of visits |     | Place of delivery |        |                            |                        |                   | Total      |
|--------------------------------|-----|-------------------|--------|----------------------------|------------------------|-------------------|------------|
|                                |     | At home           | PHC    | Private<br>nursing<br>home | Government<br>hospital | Mother's<br>house |            |
| (1)                            | (2) | (3)               | (4)    | (6)                        | (6)                    | (7)               | (8)        |
| 1. once a week                 |     | 9(50.0)           | -      | 2(11.1)                    | 3(16.7)                | 4(22.2)           | 18(100.0)  |
| 2. once in two weeks           |     | 126(72.0)         | 3(1.7) | 11(6.3)                    | 18(10.3)               | 17(9.7)           | 176(100.0) |
| 3. once in month               |     | 87(64.9)          | -      | 11(8.2)                    | 17(12.7)               | 19(14.2)          | 134(100.0) |
| 4. once in two months          |     | 12(62.2)          | -      | 6(21.7)                    | 2(8.7)                 | 4(17.4)           | 23(100.0)  |
| 6. Barely                      |     | 23(67.6)          | -      | 1(2.9)                     | 6(14.7)                | 6(14.7)           | 34(100.0)  |
| 6. No idea                     |     | 2(66.7)           | -      | -                          | 1(33.3)                | -                 | 3(100.0)   |
| 7. Stay in village             |     | 67(63.3)          | 2(2.2) | 12(13.3)                   | 10(11.1)               | 9(10.0)           | 90(100.0)  |
| Total                          |     | 316(66.2)         | 6(1.0) | 42(8.8)                    | 66(11.7)               | 68(12.2)          | 477(100.0) |

(Figures in brackets indicate percentage).

**Table 7.15:**

**Distribution** of respondent\* by frequency of visits by health worker (female), and persons responsible for conducting deliveries at home, and the PHC, N = 321.

| Sl. NO. | Frequency of visits | Persons responsible for conduct of delivery |               |                   |               |                              | Total      |
|---------|---------------------|---------------------------------------------|---------------|-------------------|---------------|------------------------------|------------|
|         |                     | Trained dai                                 | Health Worker | Health Supervisor | Untrained Dai | Elderly person in the family |            |
| (1)     | (2)                 | (3)                                         | (4)           | (5)               | (6)           | (7)                          | (8)        |
| 1.      | once a week         | Y(YY.8)                                     | -             | -                 | 2(22.2)       | -                            | 9(120.0)   |
| 2.      | once in two weeks   | 119(92.2)                                   | -             | 3(2.3)            | 7(5.4)        | -                            | 129(100.0) |
| 3.      | once in month       | Y5(86.2)                                    | -             | 1(1.1)            | 11(12.6)      | -                            | 87(100.0)  |
| 4.      | once in two months  | 10(83.3)                                    | -             | -                 | 2(16.7)       | -                            | 12(100.0)  |
| 5.      | Barely              | 11(47.8)                                    | -             | -                 | 6(26.1)       | 6(26.1)                      | 23(100.0)  |
| 6.      | No idea             | 2(100.0)                                    | -             | -                 | -             | -                            | 2(100.0)   |
| Y.      | Stay in village     | 36(61.0)                                    | 4(6.8)        | 2(3.4)            | 13(22.0)      | 4(6.81)                      | 59(100.0)  |
| Total   |                     | 260(81.0)                                   | 4(1.2)        | 6(1.9)            | 41(12.8)      | 10(3.1)                      | 321(100.0) |

(Figures in brackets indicate percentage).

**Table 7.18:**

**Distribution of respondents** by frequency of visits of health workers (female), and immunization of children for **BCG**, place of **immunization**, **N = 89**.

| Sl. NO.               | Frequency of visits | Place of immunization |                     |                     |                      | Total     |
|-----------------------|---------------------|-----------------------|---------------------|---------------------|----------------------|-----------|
|                       |                     | Sub-centre            | PHC                 | Government hospital | Private clinic       |           |
| (1)                   | (2)                 | (3)                   | (4)                 | (b)                 | (6)                  | (Y)       |
| 1. once a week        | -                   |                       | 2(50.0)             | 2(50.0)             | -                    | 4(100.0)  |
| 2. once in two weeks  | 1(3.8)              | 14(63.8)              |                     | 6(19.2)             | 6(23.1)              | 26(100.0) |
| 3. once in month      | -                   |                       | 7(33.3)             | 7(33.3)             | 7(33.3)              | 21(100.0) |
| 4. once in two months | -                   |                       | 2(60.0)             | 2(60.0)             | -                    | 4(109.0)  |
| 5. Barely             | -                   | -                     |                     | 2(40.0)             | 3(60.0)              | 5(100.0)  |
| 6. No idea            | -                   | -                     | -                   | -                   | -                    | -         |
| Y. Stay in village    | 12(41.3)            | 13(44.8)              |                     | 2(6.9)              | 2(6.9)               | 29(100.0) |
| <del>Total</del>      | <del>13(14.6)</del> | <del>38(42.7)</del>   | <del>20(22.6)</del> | <del>18(20.2)</del> | <del>89(100.0)</del> |           |

(Figures in brackets indicate percentage).



**Table 7.17:**

Distribution of respondents by frequency of visits of health workers and immunization of children for DPT and POLIO (1 dose) and place of immunization, N = 107.

| Sl. No.      | Frequency visits   | Place of immunization |          |                     |                | Total             |
|--------------|--------------------|-----------------------|----------|---------------------|----------------|-------------------|
|              |                    | Sub-centre            | PHC      | Government hospital | Private clinic |                   |
| (1)          | (2)                | (3)                   | (4)      | (5)                 | (6)            | (7)               |
| 1.           | once a week        | -                     | 2(66.7)  | -                   | 1(33.3)        | 3(100.0)          |
| 2.           | once in two weeks  | 2(6.7)                | 16(42.9) | 6(17.1)             | 12(34.3)       | 36(100.0)         |
| 3.           | once in month      | 8(32.0)               | 1(4.0)   | 6(24.0)             | 10(40.0)       | 26(100.0)         |
| 4.           | once in two months | -                     | 2(50.0)  | -                   | 2(60.0)        | 4(100.0)          |
| 5.           | Rarely             | 6(64.6)               | -        | 1(9.1)              | 4(36.4)        | 11(100.0)         |
| 6.           | No idea            | 2(100.0)              | -        | -                   | -              | 2(100.0)          |
| Y.           | Stay in village    | 10(37.0)              | 9(33.3)  | 2(7.4)              | 6(22.2)        | 27(100.0)         |
| <b>Total</b> |                    | 28(26.2)              | 29(27.1) | 16(14.0)            | 36(31.8)       | <b>107(100.0)</b> |

(Figures in brackets indicate percentage).

**Table 7.18:**

Distribution of respondents by frequency of visits of health workers, and immunization of children for DPT and POLIO (II dose) and place of immunization, N = 89.

| Sl. Frequency<br>NO. of visits |          | Place of immunization |          |                        |                   | Total      |
|--------------------------------|----------|-----------------------|----------|------------------------|-------------------|------------|
|                                |          | Sub-centre            | PHC      | Government<br>hospital | Private<br>clinic |            |
| (1)                            | (2)      | (3)                   | (4)      | (5)                    | (6)               | (7)        |
| 1. once a week                 | -        |                       | 2(66.7)  | -                      | 1 (33.3)          | 3( 100.0)  |
| 2. once in two weeks           | 2(Y. 1)  | 11                    | (39.3)   | 4( 14.3)               | 11(39.3)          | 28( 100.0) |
| 3. once in month               | 5(25.0)  | 1(6.0)                |          | 6(30.0)                | 8(40.0)           | 20(100.0)  |
| 4. once in two months          | -        |                       | 2(50.0)  | -                      | 2(50.0)           | 4(100.0)   |
| b. Barely                      | 5(50.0)  | -                     |          | 1(10.1)                | 4(40.0)           | 10(100.0)  |
| 6. No idea                     | 1(100.0) | -                     |          | -                      | -                 | 1(100.0)   |
| 7. Stay in village             | 7(30.4)  | 8(34.8)               |          | 2(8.7)                 | 6(26.1)           | 23(100.0)  |
| Total                          |          | 20(22.5)              | 24(27.0) | 13(14.6)               | 32(36.0)          | 89(100.0)  |

(Figures in brackets indicate percentage).



**Table 7.19:**

**Distribution** of respondents by frequency of visits of health workers, and immunization of children for DPT and POLIO (III dose) anti place of immunization, N = 69.

| Sl. No. | Frequency of visits | Place of immunization |          |                     |                | Total     |
|---------|---------------------|-----------------------|----------|---------------------|----------------|-----------|
|         |                     | Sub-centre            | PHC      | Government hospital | Private clinic |           |
| (1)     | (2)                 | (3)                   | (4)      | (5)                 | (6)            | (7)       |
| 1.      | once a week         | -                     | 2(66.7)  | -                   | 1(33.3)        | 3(100.0)  |
| 2.      | once in two weeks   | 2(10.0)               | 8(40.0)  | 2(10.0)             | 8(40.0)        | 20(100.0) |
| 3.      | once in month       | 3(17.6)               | 1(6.9)   | 6(35.3)             | 7(41.2)        | 17(100.0) |
| 4.      | once in two months  | -                     | 1(60.0)  | 1(60.0)             | -              | 2(100.0)  |
| 5.      | Rarely              | 2(28.6)               | -        | 1(14.3)             | 4(57.1)        | 7(100.0)  |
| 6.      | No idea             | 1(100.0)              | -        | -                   | -              | 1(100.0)  |
| 7.      | Stay in village     | 6(26.3)               | 7(36.8)  | 2(10.6)             | 6(26.3)        | 19(100.0) |
| Total   |                     | 13(18.8)              | 19(27.6) | 12(17.4)            | 26(36.2)       | 69(100.0) |

(Figures in brackets indicate **percentage**).

**Table 7.20:**

**Distribution** of respondents **by** frequency of visits of health **workers**, and immunization of children for **measles**, and place of immunization, N = 8.

| Sl. Frequency<br>NO. of visits |     | Place of <b>immunization</b> |            |                                |                           | <b>Total</b> |
|--------------------------------|-----|------------------------------|------------|--------------------------------|---------------------------|--------------|
|                                |     | <b>Sub-centre</b>            | <b>PHC</b> | <b>Government<br/>hospital</b> | <b>Private<br/>clinic</b> |              |
| (1)                            | (2) | (3)                          | (4)        | (5)                            | (6)                       | (7)          |
| 1. once a week                 |     | -                            | -          | -                              | -                         | -            |
| 2. once in two<br>weeks        |     | -                            | 1(26.0)    | -                              | 3(75.0)                   | 4(100.0)     |
| 3. once in month               |     | -                            | -          | -                              | 1(100.0)                  | 1(100.0)     |
| 4. once in two<br>months       |     | -                            | -          | -                              | -                         | -            |
| 5. Rarely                      |     | -                            | 1(100.0)   | -                              | -                         | 1(100.0)     |
| 6. No idea                     |     | -                            | -          | -                              | -                         | -            |
| Y. Stay in<br>village          |     | 1(60.0)                      | -          | 1(60.0)                        | -                         | 2(100.0)     |
| Total                          |     | 1(12.5)                      | 2(26.0)    | 1(12.6)                        | 4(60.0)                   | 8(100.0)     |

(Figures in brackets indicate percentage).

**Table 7.21:**

Distribution of respondents by frequency of visits of health workers(female), and sterilization. N = 477.

| Sl. Frequency<br>NO. of visits | Number of<br>respondents<br>who reported<br>sterilization | Number of<br>respondents<br>who did not<br>report ste-<br>rilization | Total      |
|--------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------|------------|
| 1. once a week                 | 7(38.9)                                                   | 11(61.1)                                                             | 18(100.0)  |
| 2. once in two<br>weeks        | 63(36.0)                                                  | 112(64.0)                                                            | 175(100.0) |
| 3. once a month                | 51(38.1)                                                  | 83(61.9)                                                             | 134(100.0) |
| 4. once in two<br>months       | 10(43.5)                                                  | 13(56.5)                                                             | 23(100.0)  |
| 6 Barely                       | 11(32.4)                                                  | 23(67.6)                                                             | 34(100.0)  |
| 6. No idea                     | 1(33.3)                                                   | 2(66.7)                                                              | 3(100.0)   |
| 7. Stay in village             | 27(30.0)                                                  | 63(70.0)                                                             | 90(100.0)  |
| Total                          | 170(36.6)                                                 | 307(64.4)                                                            | 477(100.0) |

(Figures in brackets indicate percentage).

**Table 7.22:**

Distribution of respondents by frequency of visits of health workers (**female**), and place of sterilization, **N = 170**.

| Sl. NO. | Frequency of visits | Place of immunization |                     |                      | Total      |
|---------|---------------------|-----------------------|---------------------|----------------------|------------|
|         |                     | PHC                   | Government hospital | Private nursing home |            |
| (1)     | (2)                 | (3)                   | (4)                 | (5)                  | (6)        |
| 1.      | once a week         | 6(85.7)               | 1(14.3)             | -                    | 7(100.0)   |
| 2.      | once in two months  | 56(88.9)              | 1(1.6)              | 6(9.5)               | 63(100.0)  |
| 3.      | once a month        | 27 (52.9)             | 14 (27.5 )          | 10(19.6 )            | 51 (100.0) |
| 4.      | once in two months  | 8(80.0)               | 1(10.0)             | 1(10.0)              | 10(100.0)  |
| 5.      | Rarely              | 9(81.8)               | 2(18.2)             | -                    | 11 (100.0) |
| 6.      | No idea             | -                     | K 100.0)            | -                    | 1(100.0)   |
| 7.      | Stay in village     | 21(77.8)              | 5(18.5)             | 1(3.7)               | 27(100.0)  |
| Total   |                     | 127(74.7)             | 26(14.7)            | 18(10.6)             | 170(100.0) |

(figures in brackets indicate **percentage**) .

**Table 7.23:**

Distribution of respondents **by** distance **between** sub-centre and other **villages**, and utilization of **sub-centre/PHC** for treatment of minor **ailments**, N = 477.

| S1. No. | Distance from sub-centre | Sub-centre/PHC users | Users of other Services* | Total              |
|---------|--------------------------|----------------------|--------------------------|--------------------|
| (1)     | (2)                      | (3)                  | (4)                      | (5)                |
| 1.      | Sub-centre village       | <b>65(27.8)</b>      | 169(72.2)                | 234(100.0)         |
| 2.      | 2 - 4 Km                 | <b>24(22.6)</b>      | <b>82(77.4)</b>          | <b>106((100.0)</b> |
| 3.      | 5 Km + above             | <b>57(41.6)</b>      | 80(58.4)                 | 137(100.0)         |
| Total   |                          | 146(30.6)            | 331(69.4)                | 477(100.0)         |

(Figures in brackets indicate percentage).

\* Refer table 7.6 page 257

Table 24:

Distribution of respondents by distance between sub-centre and other villages, and utilization of **sub-centre/PHC** for antenatal care, N = 477.

| S1. No. | Distance from sub-centre | Sub-centre/PHC users | Users of other Service** | Total              |
|---------|--------------------------|----------------------|--------------------------|--------------------|
| (1)     | (2)                      | (3)                  | (4)                      | (5)                |
| 1.      | Sub-centre village       | 144(61.5)            | 90(38.5)                 | 234(100.0)         |
| 2.      | 2 - 4 Km                 | 50(47.1)             | 56(51.9)                 | <b>106((100.0)</b> |
| 3.      | 5 Km + <b>above</b>      | 91(66.4)             | 46(33.6)                 | 137(100.0)         |
| Total   |                          | 285(59.7)            | 192(40.3)                | <b>477(100.0)</b>  |

(Figures in brackets indicate percentage).

\* Refer table 7.6 page 257

**Table 7.25:**

Distribution of respondents by distance between sub-centre and other villages, and place of delivery, **N** = 477.

| Sl. NO. | Distance from sub-centre | Place of delivery |        |                      |                     |                 | total             |
|---------|--------------------------|-------------------|--------|----------------------|---------------------|-----------------|-------------------|
|         |                          | At home           | PHC    | Private nursing home | Government hospital | Mother's house  |                   |
| (1)     | (2)                      | (3)               | (4)    | (5)                  | (6)                 | (7)             | (8)               |
| 1.      | Sub-centre village       | 167(67.1)         | 4(1.7) | 21(9.0)              | 26(11.1)            | 26(11.1)        | <b>234(100.0)</b> |
| 2.      | 2 - 4 Km                 | 74(69.8)          | -      | <b>6(5.7)</b>        | 14(13.2)            | 12(11.3)        | <b>106(100.0)</b> |
| 3.      | 5 Km + above             | 86(62.0)          | 1(0.7) | 16(10.9)             | 16(11.7)            | 20(14.6)        | 137(100.0)        |
| Total   |                          | 316(66.2)         | 6(1.0) | <b>42(8.8)</b>       | 66(11.7)            | <b>58(12.2)</b> | 477(100.0)        |

(Figures in brackets indicate percentage).

**Table 7.26:**

Distribution of respondents by distance between sub-centre and other villages, and persons responsible for conducting deliveries at home and the **PHC**, **N** = 321.

| Sl. NO. | Distance from sub-centre | Persons responsible for conduct of delivery |               |                   |               |                              | Total             |
|---------|--------------------------|---------------------------------------------|---------------|-------------------|---------------|------------------------------|-------------------|
|         |                          | Trained Dai                                 | Health Worker | Health Supervisor | Untrained Dai | Elderly person in the family |                   |
| (1)     | (2)                      | (3)                                         | (4)           | (5)               | (6)           | (7)                          | (8)               |
| 1.      | sub-centre village       | 133(82.6)                                   | 4(2.6)        | 4(2.6)            | 16(9.9)       | <b>4(2.5)</b>                | 161(100.0)        |
| 2.      | 2 - 4 Km                 | 62(70.2)                                    | -             | 1(1.4)            | 16(20.2)      | 6(8.1)                       | <b>74(100.0)</b>  |
| 3.      | 5 Km + above             | 76(87.2)                                    | -             | 1(1.2)            | 10(11.6)      | -                            | <b>86(100.0)</b>  |
| Total   |                          | <b>260(81.0)</b>                            | 4(1.2)        | 6(1.9)            | 41(12.8)      | <b>10(3.1)</b>               | <b>321(100.0)</b> |

(Figures in brackets indicate percentage).



**Table 7.27:**

Distribution of **respondents by** distance between sub-centre and other **villages**, and children immunized for **BCG** and place of immunization, N = 89.

| Sl. NO. | Distance from sub-centre | Place of immunization |          |                     |                | Total     |
|---------|--------------------------|-----------------------|----------|---------------------|----------------|-----------|
|         |                          | Sub-centre            | PHC *    | Government hospital | Private clinic |           |
| (1)     | (2)                      | (3)                   | (4)      | (5)                 | (6)            | (7)       |
| 1.      | sub-centre village       | 12(23.5)              | 25(49.0) | 7(13.7)             | 7(13.7)        | 51(100.0) |
| 2.      | 2 - 4 Km                 | -                     | 3(20.0)  | 6(40.0)             | 6(40.0)        | 15(100.0) |
| 3.      | 6 Km + above             | 1(4.3)                | 10(43.6) | 7(30.4)             | 6(21.7)        | 23(100.0) |
| Total   |                          | 13(14.6)              | 38(42.7) | 20(22.5)            | 18(20.2)       | 89(100.0) |

(Figures in brackets indicate percentage).

**Table 7.28:**

Distribution of respondents by distance between sub-centre and other villages, and immunization of children for DPT and POLIO (I dose) and place of immunization, N = 107.

| Sl. NO. | Distance from sub-centre | Place of immunization |          |                     |                | Total      |
|---------|--------------------------|-----------------------|----------|---------------------|----------------|------------|
|         |                          | Sub-centre            | PHC      | Government hospital | Private clinic |            |
| (1)     | (2)                      | (3)                   | (4)      | (5)                 | (6)            | (7)        |
| 1.      | sub-centre village       | 12(20.0)              | 23(38.3) | 8(13.3)             | 17(28.3)       | 60(100.0)  |
| 2.      | 2 - 4 Km                 | 9(47.4)               | -        | 6(26.3)             | 5(26.3)        | 19(100.0)  |
| 3.      | 5 Km + above             | 7(26.0)               | 6(21.4)  | 2(7.1)              | 13(46.2)       | 28(100.0)  |
| Total   |                          | 28(26.2)              | 29(27.1) | 15(14.0)            | 35(31.8)       | 107(100.0) |

(Figures in brackets indicate percentage).

**Table 7.29:**

Distribution of respondents by distance between **sub-centre** and other **villages**, and immunization of children for DPT and POLIO (II dose) and place of immunization, **N** = 89.

| Sl. NO. | Distance from      | Place of immunization |          |                     |                | Total                |
|---------|--------------------|-----------------------|----------|---------------------|----------------|----------------------|
|         | sub-centre         | Sub-centre            | PHC      | Government hospital | Private clinic |                      |
| (1)     | (2)                | (3)                   | (4)      | (5)                 | (6)            | (7)                  |
| 1.      | sub-centre village | 9(18.4)               | 18(36.7) | 6(12.2)             | 16(32.7)       | <del>49(100.0)</del> |
| 2.      | 2 - 4 Km           | 6(37.5)               | -        | 6(31.3)             | 6(31.3)        | 16(100.0)            |
| 3.      | 6 Km + above       | 6(20.8)               | 6(26.0)  | 2(8.3)              | 11(46.8)       | 24(100.0)            |
| Total   |                    | 20(22.6)              | 24(27.0) | 13(14.6)            | 32(36.0)       | 89(100.0)            |

(Figures in brackets indicate percentage).

**Table 7.30:**

Distribution of respondents by distance between sub-centre and other villages, and immunization of children for DPT and POLIO (III dose) and place of immunization, **N** = 69.

| Sl. NO. | Distance from sub-centre | Place of immunization |          |                     |                | Total     |
|---------|--------------------------|-----------------------|----------|---------------------|----------------|-----------|
|         |                          | Sub-centre            | PHC      | Government hospital | Private clinic |           |
| (1)     | (2)                      | (3)                   | (4)      | (6)                 | (6)            | (7)       |
| 1.      | sub-centre village       | 7(18.9)               | 14(37.8) | 4(10.8)             | 12(32.4)       | 37(100.0) |
| 2.      | 2 - 4 Km                 | 4(28.6)               | -        | 6(36.7)             | 6(36.7)        | 14(100.0) |
| 3.      | 6 Km + above             | 2(11.1)               | 6(27.8)  | 3(16.7)             | 8(44.4)        | 14(100.0) |
| Total   |                          | 13(18.8)              | 19(27.5) | 12(17.4)            | 25(36.2)       | 69(100.0) |

(Figures in brackets indicate percentage).



**Table 7.31:**

**Distribution of respondents** by distance between sub-centre and other villages, and immunization of children for measles, and place of immunization, N = 8.

| Sl. NO. | Distance from sub-centre | Place of immunization |         |                     |                | Total    |
|---------|--------------------------|-----------------------|---------|---------------------|----------------|----------|
|         |                          | Sub-centre            | PHC     | Government hospital | Private clinic |          |
| (1)     | (2)                      | (3)                   | (4)     | (5)                 | (6)            | (7)      |
| 1.      | sub-centre village       | 1(12.5)               | 1(12.5) | 1(12.5)             | 3(37.5)        | 6(75.0)  |
| 2.      | 2 - 4 Km                 | -                     | -       | -                   | 1(12.5)        | 1(12.5)  |
| 3.      | 5 Km + above             | -                     | 1(12.5) | -                   | -              | 1(12.5)  |
| Total   |                          | 1(12.5)               | 2(25.0) | 1(12.5)             | 4(50.0)        | 8(100.0) |

(Figures in brackets indicate percentage).

**Table 7.32:**

Distribution of respondents by distance between sub-centre and other villages, and sterilization, N = 477.

| Sl. NO. | Distance from sub-centre | Number of respondents who reported sterilization | Number of respondents who did not report sterilization | Total      |
|---------|--------------------------|--------------------------------------------------|--------------------------------------------------------|------------|
|         |                          |                                                  |                                                        |            |
| 1.      | sub-centre village       | 79(33.8)                                         | 156(66.2)                                              | 234(100.0) |
| 2.      | 2 - 4 Km                 | 46(43.4)                                         | 60(56.6)                                               | 106(100.0) |
| 3.      | 5 Km + above             | 45(32.8)                                         | 92(67.2)                                               | 137(100.0) |
| Total   |                          | 170(35.6)                                        | 307(64.4)                                              | 477(100.0) |

(Figures in brackets indicate percentage).

**Table 7.33:**

Distribution of respondents by distance between sub-centre and other **villages** and place of sterilization, **N = 170**.

| Sl. NO. | Distance from sub-centre | Place of sterilization |                     |                      | Total      |
|---------|--------------------------|------------------------|---------------------|----------------------|------------|
|         |                          | PHC                    | Government hospital | Private Nursing home |            |
| (1)     | (2)                      | (3)                    | (4)                 | (5)                  | (6)        |
| 1.      | sub-centre village       | 68(86.1)               | 6(7.6)              | 5(6.3)               | 79(100.0)  |
| 2.      | 2 - 4 Km                 | 28(60.9)               | 11(23.9)            | <b>7(15.2)</b>       | 46(100.0)  |
| 3.      | 5 Km + above             | 31(68.9)               | 8(17.8)             | 6(13.3)              | 46(100.0)  |
| Total   |                          | 125(74.7)              | 26(14.7)            | 18(10.6)             | 170(100.0) |

(Figures in brackets indicate percentage).

**Table 7.34:**

Distribution of respondents by availability of transport facility, and utilization of **sub-centre/PHC** for treatment of minor ailments, N = 477.

| Sl. No. | Transport facility | Sub-centre/PHC users | Users of other Services* | Total      |
|---------|--------------------|----------------------|--------------------------|------------|
| (1)     | (2)                | (3)                  | (4)                      | (5)        |
| 1.      | Not Available      | 11(30.6)             | 26(69.4)                 | 36         |
| 2.      | Available          | <b>135(30.6)</b>     | 306(69.4)                | 441        |
| Total   |                    | 146(30.6)            | 331(69.4)                | 477(100.0) |

(Figures in brackets indicate percentage).

\* Refer table 7.6 page **257**

**Table 7.35:**

Distribution of respondents by availability of transport facility, and utilization of **sub-centre/PHC** for antenatal care, N = 477.

| Sl. No. | Transport facility | Sub-centre/PHC users | Users of other Services* | Total              |
|---------|--------------------|----------------------|--------------------------|--------------------|
| (1)     | (2)                | (3)                  | (4)                      | (b)                |
| 1.      | Not available      | 12(33.3)             | <b>24(66.7)</b>          | 36(100.0)          |
| 2.      | Available          | <b>273(61.9)</b>     | <b>168(38.1)</b>         | <b>441((100.0)</b> |
| Total   |                    | <b>285(59.7)</b>     | 192(40.3)                | <b>477(100.0)</b>  |

(Figures in brackets indicate percentage).

\* Refer table 7.6 page 257

**Table 7.36:**

Distribution of respondents by availability of transport facility and place of delivery, N =477.

| Sl. No. | Transport facility | Place of delivery |               |                      |                     |                 | Total             |
|---------|--------------------|-------------------|---------------|----------------------|---------------------|-----------------|-------------------|
|         |                    | At home           | PHC           | Private nursing home | Government hospital | Mother's house  |                   |
| (1)     | (2)                | (3)               | (4)           | (b)                  | (6)                 | (7)             | (8)               |
| 1.      | Not available      | 26(72.2)          | -             | 1(2.8)               | 4(11.1)             | <b>5(13.9)</b>  | 36(100.0)         |
| 2.      | Available          | <b>290(65.8)</b>  | <b>5(1.1)</b> | 41(9.3)              | 62(11.8)            | <b>53(12.0)</b> | 441(100.0)        |
| Total   |                    | 316(66.2)         | <b>5(1.0)</b> | <b>42(8.8)</b>       | <b>66(11.7)</b>     | <b>58(12.2)</b> | <b>477(100.0)</b> |

(Figures in brackets indicate percentage).

**Table 7.37:**

Distribution of respondents **by** availability of transport facility and, persons responsible for conducting deliveries at home and the **PHC**, **N** = 321.

| Sl. NO. | Transport facility | Persons responsible for conduct of delivery |               |                   |               |                              | Total             |
|---------|--------------------|---------------------------------------------|---------------|-------------------|---------------|------------------------------|-------------------|
|         |                    | Trained Dai                                 | Health Worker | Health Supervisor | Untrained Dai | Elderly person in the family |                   |
| (1)     | (2)                | (3)                                         | (4)           | (5)               | (6)           | (7)                          | (8)               |
| 1.      | Not available      | 16(67.7)                                    | -             | -                 | 6(19.2)       | 6(23.1)                      | <b>28(100.0)</b>  |
| 2.      | Available          | 246(83.1)                                   | 4(1.4)        | 6(2.0)            | 36(12.0)      | 4(1.4)                       | <b>295(100.0)</b> |
| Total   |                    | 260(81.0)                                   | 4(1.2)        | 6(1.9)            | 41(12.8)      | 10(3.1)                      | 321(100.0)        |

(Figures in brackets indicate percentage).

**Table 7.38:**

Distribution of respondents by availability of transport facility and immunization of children for **BCG** and place of immunization, **N** = 89.

| Sl. NO. | Transport facility | Place of <b>immunization</b> |                 |                     |                 | Total     |
|---------|--------------------|------------------------------|-----------------|---------------------|-----------------|-----------|
|         |                    | Sub-centre                   | PHC             | Government hospital | Private clinic  |           |
| (1)     | (2)                | (3)                          | (4)             | (5)                 | (6)             | (7)       |
| 1.      | Not available      | -                            | -               | 1(26.0)             | 3(76.0)         | 4(100.0)  |
| 2.      | Available          | 13(16.3)                     | <b>38(44.7)</b> | 19(22.4)            | <b>15(17.6)</b> | 86(100.0) |
| Total   |                    | 13(14.6)                     | 38(42.7)        | <b>20(22.5)</b>     | 18(20.2)        | 89(100.0) |

(Figures in brackets indicate percentage).

**Table 7.39:**

Distribution of respondents by **availability** of **transport facility** and immunization of **children** for DPT and POLIO (I dose) BCG place of **immunization**, N = 107.

| Sl. NO. | Transport facility | Place of <b>immunization</b> |                 |                     |                | Total      |
|---------|--------------------|------------------------------|-----------------|---------------------|----------------|------------|
|         |                    | Sub-centre                   | PHC             | Government hospital | Private clinic |            |
| (1)     | (2)                | (3)                          | (4)             | (6)                 | (6)            | (7)        |
| 1.      | Not available      | -                            | -               | 1(26.0)             | 3(76.0)        | 4(100.0)   |
| 2.      | Available          | 28(27.2)                     | 29(28.2)        | 14(13.6)            | 32(31.6)       | 103(180.0) |
| Total   |                    | 28(26.2)                     | <b>29(27.1)</b> | <b>15(14.0)</b>     | 36(32.7)       | 107(100.0) |

(Figures in brackets indicate percentage).

**Table 7.40:**

Distribution of respondents by availability of transport facility and immunization of children for **DPT** and POLIO (II dose), and place of immunization, N = 89.

| Sl. NO. | Transport facility | Place of immunization |          |                     |                 | Total            |
|---------|--------------------|-----------------------|----------|---------------------|-----------------|------------------|
|         |                    | Sub-centre            | PHC      | Government hospital | Private clinic  |                  |
| (1)     | (2)                | (3)                   | (4)      | (6)                 | (6)             | (7)              |
| 1.      | Not available      | -                     | -        | 1(26.0)             | 3(76.0)         | 4(100.0)         |
| 2.      | Available          | 20(23.5)              | 24(28.2) | 12(14.1)            | 29(34.1)        | <b>86(100.0)</b> |
| Total   |                    | 20(22.5)              | 24(27.0) | 13(14.6)            | <b>32(36.0)</b> | <b>89(100.0)</b> |

(Figures in brackets indicate percentage).

**Table 7.41:**

Distribution of respondents by availability of transport facility and immunization of children for DPT and POLIO (III dose), and place of immunization, N = 69.

| Sl. NO. | Transport facility | Place of immunization |          |                     |                | total     |
|---------|--------------------|-----------------------|----------|---------------------|----------------|-----------|
|         |                    | Sub-centre            | PHC      | Government hospital | Private clinic |           |
| (1)     | (2)                | (3)                   | (4)      | (5)                 | (6)            | (7)       |
| 1.      | Not available      | -                     | -        | 1(25.0)             | 3(75.0)        | 4(100.0)  |
| 2.      | Available          | 13(20.0)              | 19(29.2) | 11(16.9)            | 22(33.8)       | 65(100.0) |
| Total   |                    | 13(18.8)              | 19(27.6) | 12(17.4)            | 26(36.2)       | 69(100.0) |

(Figures in brackets indicate percentage).

**Table 7.42:**

Distribution of respondents by availability and non-availability of transport facility and immunization of children for measles and place of immunization, N = 8.

| Sl. NO. | Transport facility | Place of immunization |         |                     |                | Total    |
|---------|--------------------|-----------------------|---------|---------------------|----------------|----------|
|         |                    | Sub-centre            | PHC     | Government hospital | Private clinic |          |
| (1)     | (2)                | (3)                   | (4)     | (5)                 | (6)            | (7)      |
| 1.      | Not available      | -                     | -       | -                   | -              | -        |
| 2.      | Available          | 1(12.6)               | 2(26.0) | 1(12.6)             | 4(50.0)        | 8(100.0) |
| Total   |                    | 1(12.6)               | 2(26.0) | 1(12.6)             | 4(60.0)        | 8(100.0) |

(Figures in brackets indicate percentage).



**Table 7.43:**

Distribution of respondents by availability of **transport facility** and **sterilization**, N = 477.

| S1. Transport<br>No. facility | Number of<br>respondents<br>who reported<br>sterilization | Number of<br>respondents<br>who did not<br>report ste-<br>rilization | <b>Total</b> |
|-------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------|--------------|
| 1. Not available              | 15(41.7)                                                  | 21(58.3)                                                             | 36(100.0)    |
| 2. Available                  | 155(35.1)                                                 | 286(64.9)                                                            | 441(100.0)   |
| Total                         | 170(35.6)                                                 | 307(64.4)                                                            | 477(100.0)   |

(Figures in brackets indicate **percentage**).

**Table 7.44:**

Distribution of respondents by available of transport facility, and place of sterilization, N = 170.

| Sl. No. | Transport facility | Place of sterilization |                     |                      | Total      |
|---------|--------------------|------------------------|---------------------|----------------------|------------|
|         |                    | PHC                    | Government hospital | Private nursing home |            |
| (1)     | (2)                | (3)                    | (4)                 | (5)                  | (6)        |
| 1.      | Not Available      | 11(73.3)               | 4(26.7)             | -                    | 16(100.0)  |
| 2.      | Available          | 116(74.8)              | 21(13.5)            | 18(11.6)             | 155(100.0) |
| Total   |                    | 127(74.7)              | 25(14.7)            | 18(10.6)             | 170(100.0) |

(Figures in brackets indicate percentage).

**Table 7.45:**

Distribution of respondents by caste, and utilization of sub-centre/PHC for treatment of minor ailments, N = 477.

| S1.<br>NO. | Caste           | Sub-centre/PHC<br>users | Users of other<br>services* | Total      |
|------------|-----------------|-------------------------|-----------------------------|------------|
| (1)        | (2)             | (3)                     | (4)                         | (5)        |
| 1.         | Scheduled Caste | 49(36.0)                | 87(64.0)                    | 136(100.0) |
| 2.         | Backward Castes | 83(31.1)                | 184(68.9)                   | 267(100.0) |
| 3.         | Other Castes    | 14(20.0)                | 60(80.0)                    | 74(100.0)  |
| Total      |                 | 146(30.6)               | 331(69.4)                   | 477(100.0) |

(Figures in brackets indicate percentage).

\* Refer table 7.6 page 257

**Table 7.46:**

Distribution of respondents by caste and utilization of sub-centre/PHC for antenatal care, N = 477.

| S1.<br>NO. | Caste           | Sub-centre/PHC<br>users | Users of other<br>services* | Total      |
|------------|-----------------|-------------------------|-----------------------------|------------|
| (1)        | (2)             | (3)                     | (4)                         | (6)        |
| 1.         | Schedule Castes | 105(77.2)               | 31(22.8)                    | 136(100.0) |
| 2.         | Backward Castes | 148(55.4)               | 119(44.6)                   | 267(100.0) |
| 3.         | Other Castes    | 32(43.2)                | 42(56.8)                    | 74(100.0)  |
| Total      |                 | 285(59.7)               | 192(40.3)                   | 477(100.0) |

(Figures in brackets indicate percentage).

\* Refer table 7.6 page 257



**Table 7.47:**

Distribution of respondents by **caste** and place of delivery, **N = 477**.

| Sl. NO. | Caste           | Place of delivery |        |                      |                  |                | Total      |
|---------|-----------------|-------------------|--------|----------------------|------------------|----------------|------------|
|         |                 | At home           | PHC    | Private nursing home | Govern- hospital | Mother's house |            |
| (1)     | (2)             | (3)               | (4)    | (6)                  | (6)              | (7)            | (8)        |
| 1.      | Schedule Castes | 98(72.1)          | 3(2.2) | 8(5.9)               | 12(8.8)          | 16(11.0)       | 136(100.0) |
| 2.      | Backward Castes | 178(66.7)         | 2(0.7) | 25(9.4)              | 30(11.2)         | 32(12.0)       | 267(100.0) |
| 3.      | Other Castes    | 40(64.1)          | -      | 9(12.2)              | 14(18.9)         | 11(14.9)       | 74(100.0)  |
| Total   |                 | 316(66.2)         | 5(1.0) | 42(8.8)              | 56(11.7)         | 58(12.2)       | 477(100.0) |

(Figures in brackets indicate percentage).

**Table 7.48:**

Distribution of respondents by caste, and persons responsible for conducting deliveries at home, and the **PHC**, **N = 321**.

| Sl. NO. | Caste           | Persons responsible for conduct of delivery |               |                   |               |                              | Total      |
|---------|-----------------|---------------------------------------------|---------------|-------------------|---------------|------------------------------|------------|
|         |                 | Trained Dai                                 | Health Worker | Health Supervisor | Untrained Dai | Elderly person in the family |            |
| (1)     | (2)             | (3)                                         | (4)           | (6)               | (6)           | (7)                          | (8)        |
| 1.      | Schedule Castes | 79(78.2)                                    | -             | 4(4.0)            | 16(14.8)      | 3(3.0)                       | 101(100.0) |
| 2.      | Backward Castes | 146(81.1)                                   | 1(0.6)        | 2(1.1)            | 24(13.3)      | 7(3.9)                       | 180(100.0) |
| 3.      | Other Castes    | 36(87.6)                                    | 3(7.6)        | -                 | 2(6.0)        | -                            | 41(100.0)  |
| Total   |                 | 260(81.0)                                   | 4(1.2)        | 6(1.9)            | 41(12.8)      | 10(3.11)                     | 321(100.0) |

(Figures in brackets indicate percentage).

**Table 7.49:**

Distribution of respondents by caste and immunization of children for BCG place of immunization, SI = 89.

| Sl. NO.            | Caste | Place of immunization |          |                     |                | Total     |
|--------------------|-------|-----------------------|----------|---------------------|----------------|-----------|
|                    |       | Sub-centre            | PHC      | Government hospital | Private clinic |           |
| (1)                | (2)   | (3)                   | (4)      | (5)                 | (6)            | (7)       |
| 1. Schedule Castes |       | 4(20.0)               | 13(65.0) | 2(10.0)             | 1(5.0)         | 20(100.0) |
| 2. Backward Castes |       | 4(8.2)                | 22(44.9) | 14(28.6)            | 9(18.4)        | 49(100.0) |
| 3. Other Castes    |       | 5(25.0)               | 3(15.0)  | 4(20.0)             | 8(40.0)        | 20(100.0) |
| Total              |       | 13(14.6)              | 38(42.7) | 20(22.5)            | 18(20.2)       | 89(100.0) |

(Figures in brackets indicate percentage).

**Table 7.50:**

Distribution of respondents by caste, and immunization of children for DPT and POLIO (I dose), and place of immunization, N = 107.

| Sl. NO.            | Caste | Place of immunization |          |                     |                | Total      |
|--------------------|-------|-----------------------|----------|---------------------|----------------|------------|
|                    |       | Sub-centre            | PHC      | Government hospital | Private clinic |            |
| (1)                | (2)   | (3)                   | (4)      | (5)                 | (6)            | (7)        |
| 1. Schedule Castes |       | 4(22.2)               | 8(44.4)  | 3(16.7)             | 3(16.7)        | 18(100.0)  |
| 2. Backward Castes |       | 11(18.6)              | 18(30.6) | 10(16.9)            | 20(33.9)       | 59(100.0)  |
| 3. Other Castes    |       | 13(43.3)              | 3(10.0)  | 2(6.7)              | 12(40.0)       | 30(100.0)  |
| Total              |       | 28(26.2)              | 29(27.1) | 16(14.0)            | 36(31.8)       | 107(100.0) |

(Figures in brackets indicate percentage).

**Table 7.51:**

Distribution of respondents by **caste**, and **immunization** of **children** for **DPT** and **POLIO (II dose)**, and **place** of immunization, **N = 89**.

| Sl.<br>NO. | Caste              | Place of immunization |          |                        |                   | Total     |
|------------|--------------------|-----------------------|----------|------------------------|-------------------|-----------|
|            |                    | Sub-centre            | PHC      | Government<br>hospital | Private<br>clinic |           |
| (1)        | (2)                | (3)                   | (4)      | (5)                    | (6)               | (7)       |
| 1.         | Schedule<br>Castes | 2(16.7)               | 7(68.3)  | 2(16.7)                | 1(8.3)            | 12(100.0) |
| 2.         | Backward<br>Castes | 7(14.0)               | 16(30.0) | 9(18.0)                | 9(18.0)           | 50(100.0) |
| 3.         | Other<br>Castes    | 11(40.7)              | 2(7.4)   | 2(7.4)                 | 12(44.4)          | 27(100.0) |
| Total      |                    | 20(22.6)              | 24(27.0) | 13(14.6)               | 32(36.0)          | 89(100.0) |

(Figures in **brackets** indicate percentage).

**Table 7.52:**

Distribution of respondents by caste, and immunization of children for **DPT** and **POLIO (III dose)**, and place of **immunization**, **N = 69**.

| Sl.<br>NO. | Caste              | Place of immunization |          |                        |                   | Total     |
|------------|--------------------|-----------------------|----------|------------------------|-------------------|-----------|
|            |                    | Sub-centre            | PHC      | Government<br>hospital | Private<br>clinic |           |
| (1)        | (2)                | (3)                   | (4)      | (5)                    | (6)               | (7)       |
| 1.         | Schedule<br>Castes | 1(10.0)               | 6(60.0)  | 2(20.0)                | 1(10.0)           | 10(100.0) |
| 2.         | Backward<br>Castes | 6(13.2)               | 12(31.6) | 8(21.1)                | 13(34.2)          | 39(100.0) |
| 3.         | Other<br>Castes    | 7(33.3)               | 1(4.8)   | 2(9.6)                 | 11(52.4)          | 21(100.0) |
| Total      |                    | 13(18.8)              | 19(27.6) | 12(17.4)               | 26(36.2)          | 69(100.0) |

(Figures in **brackets** indicate **percentage**).

**Table 7.53:**

**Distribution** of respondents by caste, and immunisation of **childre** for measles and place of **immunization**, N = 8.

| Sl. NO. | Caste           | Place of immunization |         |                     |                | Total    |
|---------|-----------------|-----------------------|---------|---------------------|----------------|----------|
|         |                 | Sub-centre            | PHC     | Government hospital | Private clinic |          |
| (1)     | (2)             | (3)                   | (4)     | (5)                 | (6)            | (7)      |
| 1.      | Schedule Castes | -                     | -       | -                   | -              | -        |
| 2.      | Backward Castes | 1(16.7)               | 2(33.3) | 1(16.7)             | 2(33.3)        | 6(100.0) |
| 3.      | Other Castes    | -                     | -       | -                   | 2(100.0)       | 2(100.0) |
| Total   |                 | 1(12.5)               | 2(25.0) | 1(12.5)             | 4(50.0)        | 8(100.0) |

(Figures in brackets indicate percentage).

**Table 7.54:**

**Distribution** of respondents by caste, and sterilization, N = 4YY.

| Sl. NO. | Caste           | Number of respondents who reported sterilization | Number of respondents who did not report sterilization | Total      |
|---------|-----------------|--------------------------------------------------|--------------------------------------------------------|------------|
| 1.      | Schedule Castes | 34(25.0)                                         | 102(75.0)                                              | 136(100.0) |
| 2.      | Backward Castes | 105(39.3)                                        | 162(60.7)                                              | 267(100.0) |
| 3.      | Other Castes    | 31(41.9)                                         | 43(58.1)                                               | 74(100.0)  |
| Total   |                 | 170(35.6)                                        | 307(64.4)                                              | 477(100.0) |

(Figures in brackets indicate percentage).

**Table 7.55:**

Distribution of respondents by caste, and place of sterilization,  
N = 170.

| Sl.<br>No. | Caste           | Place of sterilization |                        |                            | Total      |
|------------|-----------------|------------------------|------------------------|----------------------------|------------|
|            |                 | PHC                    | Government<br>hospital | Private<br>nursing<br>home |            |
| (1)        | (2)             | (3)                    | (4)                    | (5)                        | (6)        |
| 1.         | Schedule Castes | 32(94.1)               | 2(5.9)                 | -                          | 34(100.0)  |
| 2.         | Backward Castes | 76(72.4)               | 13(12.4)               | 16(15.2)                   | 105(100.0) |
| 3.         | Other Castes    | 19(61.3)               | 10(32.3)               | 2(6.5)                     | 31(100.0)  |
| Total      |                 | 127(74.7)              | 25(14.7)               | 18(10.6)                   | 170(100.0) |

(Figures in brackets indicate percentage).

**Table 7.56:**

Distribution of respondents by income, and utilization of sub-centre/PHC for treatment of minor ailments, N = 477.

| Sl.<br>No. | Income<br>(in rupees) | Sub-centre/<br>PHC users | Users of other<br>Services* | Total       |
|------------|-----------------------|--------------------------|-----------------------------|-------------|
| (1)        | (2)                   | (3)                      | (4)                         | (5)         |
| 1.         | < 500                 | 35(34.3)                 | 67(65.7)                    | 102(100.0)  |
| 2.         | 500 - 999             | 95(35.3)                 | 174(64.7)                   | 269((100.0) |
| 3.         | 1000 - 1499           | 14(16.9)                 | 69(63.1)                    | 83(100.0)   |
| 4.         | 1500 - 1999           | 2(20.0)                  | 8(80.0)                     | 10(100.0)   |
| 5.         | 2000 and above        | 0                        | 13(100.0)                   | 13(100.0)   |
| Total      |                       | 146(30.6)                | 331(69.4)                   | 477(100.0)  |

(Figures in brackets indicate percentage).

\* Refer table 7.6 page 257

Table 7.57:

Distribution of respondents by **income, and** utilization of **sub-centre/PHC** antenatal care, N = 477.

| Sl. No. | Income (in rupees) | Sub-centre/PHC users | Users of other Services | Total                |
|---------|--------------------|----------------------|-------------------------|----------------------|
| (1)     | (2)                | (3)                  | (4)                     | (5)                  |
| 1.      | < 500              | 67(65.7)             | 35(34.3)                | 102(100.0)           |
| 2.      | 500 - 999          | 177(65.6)            | 92(34.2)                | <b>269((100.0)</b>   |
| 3.      | 1000 - 1499        | 35(42.2)             | <b>48(57.8)</b>         | <b>83(100.0)</b>     |
| 4.      | 1500 - 1999        | 4(40.0)              | 6(60.0)                 | 10(100.0)            |
| 5.      | 2000 and above     | <del>2(15.4)</del>   | <del>11(84.6)</del>     | <del>13(100.0)</del> |
|         | Total              | 285(59.7)            | 192(40.3)               | 477(100.0)           |

(Figures in brackets indicate percentage).

\* Refer table 7.6 page 257

Table 7.58:

Distribution of respondents by income, and place of **delivery**, N = 4YY.

| Sl. NO. | Income (in rupees) | Place of delivery |        |                      |                     |                 | Total             |
|---------|--------------------|-------------------|--------|----------------------|---------------------|-----------------|-------------------|
|         |                    | At home           | PHC    | Private nursing home | Government hospital | Mother's house  |                   |
| (1)     | (2)                | (3)               | (4)    | (6)                  | (6)                 | (Y)             | (8)               |
| 1.      | < 500              | Y4(72.6)          | 1(1.0) | 3(2.9)               | <b>13(12.7)</b>     | <b>11(10.8)</b> | <b>102(100.0)</b> |
| 2.      | 500 - 999          | 183(68.0)         | 3(1.1) | <b>25(9.3)</b>       | <b>25(9.3)</b>      | 33(12.3)        | <b>269(100.0)</b> |
| 3.      | 1000 - 1499        | <b>48(57.8)</b>   | 1(1.2) | 12(14.6)             | 13(16.7)            | 9(10.8)         | 83(100.0)         |
| 4.      | 1500 - 1999        | <b>6(60.0)</b>    | -      | 1(10.0)              | 2(20.0)             | 1(10.0)         | 10(100.0)         |
| 5.      | 2000 & above       | 6(38.6)           | -      | 1(7.7)               | 3(23.1)             | 4(30.8)         | <b>13(100.0)</b>  |
|         | Total              | 316(66.2)         | 6(1.0) | 42(8.8)              | <b>56(11.7)</b>     | <b>58(12.2)</b> | <b>477(100.0)</b> |

(Figures in brackets indicate percentage).



**Table 7.59:**

Distribution of respondents by income, and persons responsible for conducting deliveries at home, and the **PHC**, **N** = 321.

| Sl. NO. | Income (in Rs.) | Persons responsible for conduct of delivery |               |               |               |                              | Total                 |
|---------|-----------------|---------------------------------------------|---------------|---------------|---------------|------------------------------|-----------------------|
|         |                 | Trained Dai                                 | Health worker | Health worker | Untrained Dai | Elderly person in the family |                       |
| (1)     | (2)             | (3)                                         | (4)           | (5)           | (6)           | (7)                          | (8)                   |
| 1.      | < 500           | 64(85.3)                                    | -             | 2(2.7)        | 6(8.0)        | 3(4.0)                       | <del>75(100.0)</del>  |
| 2.      | 500 - 999       | 148(79.6)                                   | 2(1.1)        | 3(1.6)        | 26(14.0)      | 7(3.8)                       | <del>186(100.0)</del> |
| 3.      | 1000 - 1499     | 41(83.7)                                    | 1(2.0)        | 1(2.0)        | 6(12.2)       | -                            | <del>49(100.0)</del>  |
| 4.      | 1500 - 2000     | 3(60.0)                                     | 1(16.7)       | -             | 2(33.3)       | -                            | <del>6(100.0)</del>   |
| 5.      | 2000 & above    | 4(80.0)                                     | -             | -             | 1(20.0)       | -                            | <del>5(100.0)</del>   |
| Total   |                 | 260(81.0)                                   | 4(1.2)        | 6(1.9)        | 41(12.8)      | 10(3.1)                      | 321(100.0)            |

(Figures in brackets indicate percentage).

**Table 7.60:**

Distribution of respondents by **income**, and immunization of children for **BUG**, and place of immunization, **N** = 89.

| Sl. NO. | Income (in Rs.) | Place of immunization |                    |                     |                | Total               |
|---------|-----------------|-----------------------|--------------------|---------------------|----------------|---------------------|
|         |                 | Sub-centre            | PHC                | Government hospital | Private clinic |                     |
| (1)     | (2)             | (3)                   | (4)                | (5)                 | (6)            | (7)                 |
| 1.      | < 500           | -                     | 4(44.4)            | 4(44.4)             | 1(11.2)        | 9(100.0)            |
| 2.      | 500 - 999       | 10(20.4)              | 26(63.1)           | 6(10.2)             | 8(16.3)        | 49(100.0)           |
| 3.      | 1000 - 1499     | 3(16.0)               | <del>6(30.0)</del> | 7(36.0)             | 4(20.0)        | 20(100.0)           |
| 4.      | 1500 - 1999     | -                     | 1(20.0)            | 2(40.0)             | 2(40.0)        | 6(100.0)            |
| 5.      | 2000 & above    | -                     | 1(16.7)            | 2(33.3)             | 3(50.0)        | <del>6(100.0)</del> |
| Total   |                 | 13(14.6)              | 38(42.7)           | <del>20(22.5)</del> | 18(20.2)       | 89(100.0)           |

(Figures in brackets indicate percentage).

**Table 7.81:**

Distribution of respondents by **income**, and immunization of **children** for **DPT**, and **POLIO (1 dose)** and place of **immunization**,  
N = 107.

| Sl. NO. | Income (in Rs.) | Place of <b>immunization</b> |           |                     |                | Total       |
|---------|-----------------|------------------------------|-----------|---------------------|----------------|-------------|
|         |                 | Sub-centre                   | PHC       | Government hospital | Private clinic |             |
| (1)     | (2)             | (3)                          | (4)       | (5)                 | (6)            | (7)         |
| 1.      | < 500           | 11 (52.4)                    | 5 (23.8)  | 2 (9.5)             | 3 (14.3)       | 21 (100.0)  |
| 2.      | 600 - 999       | 9 (18.8)                     | 19 (39.6) | 5 (10.4)            | 15 (31.3)      | 48 (100.0)  |
| 3.      | 1000 - 1499     | 7 (25.9)                     | 4 (14.8)  | 6 (22.2)            | 10 (37.0)      | 27 (100.0)  |
| 5.      | 1600 - 1999     | -                            | -         | 2 (40.0)            | 3 (60.0)       | 5 (100.0)   |
| 6.      | 2000 & above    | 1 (16.7)                     | 1 (16.7)  | -                   | 4 (66.7)       | 6 (100.0)   |
| Total   |                 | 28 (26.2)                    | 29 (27.1) | 15 (14.0)           | 35 (31.8)      | 107 (100.0) |

(Figures in brackets indicate percentage).



**Table 7.62:**

Distribution of respondents by income and **immunization of children** for **DPT, POLIO (1 dose)**, and place of **immunization**,  
N = 89.

| Sl. NO. | Income (in Rs.) | Place of <b>immunization</b> |          |                     |                | <b>Total</b> |
|---------|-----------------|------------------------------|----------|---------------------|----------------|--------------|
|         |                 | Sub-centre                   | PHC      | Government hospital | Private clinic |              |
| (1)     | (2)             | (3)                          | (4)      | (5)                 | (6)            | (Y)          |
| 1.      | < 600           | 8(57.1)                      | 4(28.6)  | 1(7.1)              | 1(7.1)         | 14(100.0)    |
| 2.      | 600 - 999       | 7(17.1)                      | 15(36.6) | 4(9.8)              | 15(36.6)       | 41(100.0)    |
| 3.      | 1000 - 1499     | 4(17.4)                      | 4(17.4)  | 6(26.1)             | 9(39.1)        | 23(100.0)    |
| 5.      | 1600 - 1999     | -                            | -        | 2(40.0)             | 3(60.0)        | 5(100.0)     |
| 6.      | 2000 & above    | 1(16.7)                      | 1(16.7)  | -                   | 4(66.7)        | 6(100.0)     |
| Total   |                 | 20(22.5)                     | 24(27.0) | 13(14.6)            | 32(36.0)       | 89(100.0)    |

(Figures in brackets indicate percentage).

**Table 7.83:**

**Distribution of respondents by income and immunization of children for DPT, POLIO (III dose), and place of immunization, N = 69.**

| Sl. NO. | Income (in Rs.) | Place of immunization |          |                     |                | Total     |
|---------|-----------------|-----------------------|----------|---------------------|----------------|-----------|
|         |                 | Sub-centre            | PHC      | Government hospital | Private clinic |           |
| (1)     | (2)             | (3)                   | (4)      | (5)                 | (6)            | (7)       |
| 1.      | < 500           | 4(50.0)               | 3(37.6)  | 1(12.6)             | -              | 8(100.0)  |
| 2.      | 500 - 999       | 4(13.3)               | 11(36.7) | 4(13.3)             | 11(36.7)       | 30(100.0) |
| 3.      | 1000 - 1499     | 4(19.0)               | 4(19.0)  | 5(23.8)             | 8(38.1)        | 21(100.0) |
| 4.      | 1500 - 1999     | -                     | -        | 2(40.0)             | 3(60.0)        | 6(100.0)  |
| 5.      | 2000 & above    | 1(20.0)               | 1(20.0)  | -                   | 3(60.0)        | 6(100.0)  |
| Total   |                 | 13(18.8)              | 19(27.5) | 12(17.4)            | 26(36.2)       | 69(100.0) |

(Figures in brackets indicate percentage).

Table 7.64:

Distribution of respondents by income and immunization of children for measles, and place of immunization. \* = 8.

| Sl. NO. | Income (in Rs.) | Place of immunization |          |                     |                | Total    |
|---------|-----------------|-----------------------|----------|---------------------|----------------|----------|
|         |                 | Sub-centre            | PHC      | Government hospital | Private clinic |          |
| (1)     | (2)             | (3)                   | (4)      | (5)                 | (6)            | (7)      |
| 1.      | < 500           | -                     | 1(100.0) | -                   | -              | 1(100.0) |
| 2.      | 500 - 999       | 1(33.3)               | 1(33.3)  | 1(33.3)             | -              | 3(100.0) |
| 3.      | 1000 - 1499     | -                     | -        | -                   | 4(100.0)       | 4(100.0) |
| 4.      | 1500 - 1999     | -                     | -        | -                   | -              | -        |
| 5.      | 2000 & above    | -                     | -        | -                   | -              | -        |
| Total   |                 | 1(12.6)               | 2(26.0)  | 1(12.6)             | 4(60.0)        | 8(100.0) |

(Figures in brackets indicate percentage).

Table 7.65:

Distribution of respondents by income, and sterilization, N = 477.

| Sl. NO. | Income (in rupees) | Number of respondents who reported sterilization | Number of respondents who did not report sterilization | Total      |
|---------|--------------------|--------------------------------------------------|--------------------------------------------------------|------------|
| 1.      | < 600              | 28(27.5)                                         | 74(72.5)                                               | 102(100.0) |
| 2.      | 600 < 999          | 99(36.8)                                         | 170(63.2)                                              | 26*(100.0) |
| 3.      | 1000 < 1499        | 34(41.0)                                         | 49(59.0)                                               | 83(100.0)  |
| 4.      | 1600 < 1999        | 6(60.0)                                          | 5(50.0)                                                | 10(100.0)  |
| 5.      | 2000 and above     | 4(30.8)                                          | 9(69.2)                                                | 13(100.0)  |
| Total   |                    | 170(35.6)                                        | 307(64.4)                                              | 477(100.0) |

(Figures in brackets indicate percentage).

Table 7.66:

Distribution of respondents by **income** and place **of sterilization**

N = 170.

| Sl.<br>NO. | Income<br>(in Rs. ) | Place of sterilization |                        |                            | Total      |
|------------|---------------------|------------------------|------------------------|----------------------------|------------|
|            |                     | PHC                    | Government<br>hospital | Private<br>Nursing<br>home |            |
| (1)        | (2)                 | (3)                    | (4)                    | (5)                        | (6)        |
| 1.         | < 500               | 25(89.3)               | 3(10.7)                | -                          | 28(100.0)  |
| 2.         | 500 < 999           | 81(81.8)               | 11(11.1)               | 7(7.1)                     | 99(100.0)  |
| 3.         | 1000 < 1499         | 19(55.9)               | 8(23.5)                | 7(20.6)                    | 34(100.0)  |
| 4.         | 1500 < 1999         | -                      | 2(40.0)                | 3(60.0)                    | 5(100.0)   |
| 5.         | 2000 and above      | 2(50.0)                | 1(25.0)                | 1(25.0)                    | 4(100.0)   |
| Total      |                     | 127(74.7)              | 25(14.7)               | 18(10.6)                   | 170(100.0) |

(Figures in brackets indicate percentage).

Table 7.67:

Distribution of respondents by education of head of **households**, and utilization of **sub-centre/PHC** for treatment of minor ailments, N = 477.

| Sl.<br>No. | Level of<br>education    | Sub-centre/<br>PHC users | Users of other<br>*<br>Services | Total      |
|------------|--------------------------|--------------------------|---------------------------------|------------|
| (1)        | (2)                      | (3)                      | (4)                             | (5)        |
| 1.         | Illiterate               | 124(32.6)                | 256(67.4)                       | 380(100.0) |
| 2.         | Primary School           | 17(34.0)                 | 33(66.0)                        | 50(100.0)  |
| 3.         | Secondary School         | 4(19.0)                  | 17(81.0)                        | 21(100.0)  |
| 4.         | High School and<br>above | 1(3.8)                   | 25(96.1)                        | 26(100.0)  |
| Total      |                          | 146(30.6)                | 331(69.4)                       | 477(100.0) |

(Figures in brackets indicate percentage).

\* Refer table 7.6 page 257

**Table 7.68:**

**Distribution** of respondents by level of education of the head of households, and utilization of **sub-centre/PHC** for **antenatal** care, N = 4YY.

| <b>Sl. No.</b> | <b>Level of Education</b> | <b>Sub-centre/PHC users</b> | <b>Users of other Services*</b> | <b>Total</b> |
|----------------|---------------------------|-----------------------------|---------------------------------|--------------|
| (1)            | (2)                       | (3)                         | (4)                             | (5)          |
| 1.             | Illiterate                | 242(63.7)                   | 138(36.3)                       | 380(100.0)   |
| 2.             | Primary School            | 26(52.0)                    | 24(48.0)                        | 50((100.0)   |
| 3.             | Secondary School          | 9(42.9)                     | 12(57.1)                        | 21(100.0)    |
| 4.             | High School and above     | 8(30.8)                     | 18(69.2)                        | 26(100.0)    |
| Total          |                           | 285(59.7)                   | 192(40.3)                       | 4YY(100.0)   |

(Figures in brackets indicate percentage).

\* Refer table Y.6 page 251

**Table 7.69:**

Distribution of **respondents** by education of the head of **house-**  
**holds**, and **place of delivery**, N = 477.

| Sl. NO. | Level of Education    | Place of delivery |         |                      |                     |                | Total                 |
|---------|-----------------------|-------------------|---------|----------------------|---------------------|----------------|-----------------------|
|         |                       | At home           | PHC     | Private nursing home | Government hospital | Mother's house |                       |
| (1)     | (2)                   | (3)               | (4)     | (6)                  | (6)                 | (Y)            | (8)                   |
| 1.      | Illiterate            | 260(68.4)         | 5( 1.3) | 28(7.4)              | 44(11.6)            | 43( 11.3)      | <del>380(100.0)</del> |
| 2.      | Primary School        | 28(56.0)          | -       | 7(14.0)              | 9( 18.0)            | 6( 12.0)       | 60(100.0)             |
| 3.      | Secondary School      | 16(46.2)          | -       | -                    | 1(4.8)              | 4(19.0)        | <del>21(100.0)</del>  |
| 4.      | High School and above | 12(46.2)          | -       | 7(26.9)              | 2(7.7)              | 5(19.2)        | 26( 100.0)            |
| Total   |                       | 316(66.2)         | 5( 1.0) | 42(8.8)              | 56( 11.7)           | 58(12.2)       | 477( 100.0)           |

(Figures in brackets indicate percentage).



**Table 7.70:**

Distribution of **respondents** by education of the head of households, and persons responsible for conducting deliveries at **home**, and the **PHC**, **N** = 321.

| Sl. NO. | Level of Education    | Persons responsible for conduct of delivery |               |                   |               |                              | Total                 |
|---------|-----------------------|---------------------------------------------|---------------|-------------------|---------------|------------------------------|-----------------------|
|         |                       | Trained Dai                                 | Health Worker | Health Supervisor | Untrained Dai | Elderly person in the family |                       |
| (1)     | (2)                   | (3)                                         | (4)           | (6)               | (6)           | (Y)                          | (8)                   |
| 1.      | Illiterate            | 215(81.1)                                   | 2(0.8)        | 6(2.3)            | 34(12.8)      | 8(3.0)                       | <del>265(100.0)</del> |
| 2.      | Primary School        | 24(85.7)                                    | -             | -                 | 3(10.7)       | 1(3.6)                       | <del>28(100.0)</del>  |
| 3.      | Secondary School      | 12(75.0)                                    | 1(6.3)        | -                 | 2(12.5)       | 1(6.3)                       | 16(100.0)             |
| 4.      | High School and above | 9(75.0)                                     | 1(8.3)        | -                 | 2(16.7)       | -                            | 12(100.0)             |
| Total   |                       | 260(81.0)                                   | 4(1.2)        | 6(1.9)            | 41(12.8)      | 10(3.1)                      | 321(100.0)            |

(Figures in brackets indicate percentage).

**Table 7.71:**

Distribution of respondents by education of head of **households** and immunization of children for **BCG**, place of **immunization**,  
N = 89.

| Sl. NO. | Level of Education    | Place of immunization |          |                     |                | Total     |
|---------|-----------------------|-----------------------|----------|---------------------|----------------|-----------|
|         |                       | Sub-centre            | PHC      | Government hospital | Private clinic |           |
| (1)     | (2)                   | (3)                   | (4)      | (b)                 | (6)            | (7)       |
| 1.      | Illiterate            | 11(18.0)              | 29(47.5) | 13(21.3)            | 8(13.1)        | 61(100.0) |
| 2.      | Primary School        | -                     | 6(40.0)  | 4(26.7)             | 1(33.3)        | 15(100.0) |
| 3.      | Secondary School      | 2(33.3)               | 1(16.7)  | 1(16.7)             | 2(33.3)        | 6(100.0)  |
| 4.      | High School and above | -                     | 2(28.6)  | 2(28.6)             | 3(42.9)        | 7(100.0)  |
| Total   |                       | 13(14.6)              | 38(42.7) | 20(22.5)            | 18(20.2)       | 89(100.0) |

(Figures in brackets indicate percentage).



**Table 7.2:**

**Distribution of repondenta by education of head of households and immunization of children for DPT, and POLIO (1 dose). and place of immunization, N = 107.**

| Sl. NO. | Level of Education | Place of immunization |          |                     |                | Total      |
|---------|--------------------|-----------------------|----------|---------------------|----------------|------------|
|         |                    | Sub-centre            | PHC      | Government hospital | Private clinic |            |
| (1)     | (2)                | (3)                   | (4)      | (5)                 | (6)            | (7)        |
| 1.      | Illiterate         | 21 (30.9)             | 22(32.4) | 8( 11.8)            | 17(25.0)       | 68(100.0)  |
| 2.      | Primary School     | 5(22.7)               | 6(22.7)  | 4(18.2)             | 8(36.4)        | 22(100.0)  |
| 3.      | Secondary School   | 2(33.3)               | 1(16.7)  | 1(16.7)             | 2(33.3)        | 6(100.0)   |
| 4.      | High School        |                       |          |                     |                |            |
|         | and above          | -                     | 1(9.1)   | 2(18.1)             | 8(72.7)        | 11(100.0)  |
|         | Total              | 28(26.2)              | 29(27.1) | 15(14.0)            | 35(31.8)       | 107(100.0) |

(Figures in brackets indicate percentage).

**Table 7.3:**

Distribution of respondent\* by education of head of **households** and **immunization** of children for DPT, and POLIO ( 11" **dose**), and place of **immunization**, N = 89.

| Sl. NO. | Level of Education    | Place of immunization |          |                     |                | Total                  |
|---------|-----------------------|-----------------------|----------|---------------------|----------------|------------------------|
|         |                       | Sub-centre            | PHC      | Government hospital | Private clinic |                        |
| (1)     | (2)                   | (3)                   | (4)      | (5)                 | (6)            | (7)                    |
| 1.      | Illiterate            | 14(25.5)              | 18(32.7) | 8(14.5)             | 15(27.3)       | 55( <del>100.0</del> ) |
| 2.      | Primary School        | 5(27.8)               | 4(22.2)  | 2(11.1)             | 7(38.9)        | 18( <del>100.0</del> ) |
| 3.      | Secondary School      | 1(20.0)               | 1(20.0)  | 1(20.0)             | 2(40.0)        | 5( <del>100.0</del> )  |
| 4.      | High School and above | -                     | 1(9.1)   | 2(18.1)             | 8(72.7)        | 11( <del>100.0</del> ) |
| Total   |                       | 20(22.6)              | 24(27.0) | 13(14.6)            | 32(36.0)       | 89(100.0)              |

(Figures in brackets indicate percentage).

**Table 7/4:**

Distribution of **respondents** by education of head of **households** and **immunization** of children for DPT, and **POLIO (III dose)**, and place of immunization, N = 69.

| Sl. NO. | Level of Education    | Place of immunization |          |                     |                | Total     |
|---------|-----------------------|-----------------------|----------|---------------------|----------------|-----------|
|         |                       | Sub-centre            | PHC      | Government hospital | Private clinic |           |
| (1)     | (2)                   | (3)                   | (4)      | (5)                 | (6)            | (7)       |
| 1.      | Illiterate            | 9(20.5)               | 1b(34.0) | 8(18.2)             | 12(27.3)       | 44(140.0) |
| 2.      | Primary School        | 3(23.1)               | 3(23.1)  | 2(15.4)             | 6(38.6)        | 13(100.0) |
| 3.      | Secondary School      | 1(33.3)               | -        | -                   | 2(66.7)        | 3(100.0)  |
| 4.      | High School and above | -                     | 1(22.2)  | 2(22.2)             | 6(66.7)        | 9(100.0)  |
| Total   |                       | 13(18.8)              | 19(27.5) | 12(17.4)            | 26(36.2)       | 69(100.0) |

(Figures in brackets indicate percentage).

**Table 7.5:**

**Distribution of respondents** by education of **head** of households and immunization of children for measles, and place of immunization, N = 8.

| Sl. NO. | Level of Education    | Place of immunization |         |                     |                | Total    |
|---------|-----------------------|-----------------------|---------|---------------------|----------------|----------|
|         |                       | Sub-centre            | PHC     | Government hospital | Private clinic |          |
| (1)     | (2)                   | (3)                   | (4)     | (6)                 | (5)            | (7)      |
| 1.      | Illiterate            | 1(25.0)               | 2(50.0) | 1(26.0)             | -              | 4(100.0) |
| 2.      | Primary School        | -                     | -       | -                   | 1(100.0)       | 1(100.0) |
| 3.      | Secondary School      | -                     | -       | -                   | 1(100.0)       | 1(100.0) |
| 4.      | High School and above | -                     | -       | -                   | 2(100.0)       | 2(100.0) |
| Total   |                       | 1(12.6)               | 2(26.0) | 1(12.6)             | 4(60.0)        | 6(100.0) |

(Figures in brackets indicate percentage).

**Table 7.76 :**

**Distribution of respondents** by education of head of household, and **sterilization**, N = 477.

| Sl. NO. Level of Education | Number of respondents who reported sterilization | Number of respondents who did not report sterilization | Total      |
|----------------------------|--------------------------------------------------|--------------------------------------------------------|------------|
| 1. Illiterate              | 125(32.9)                                        | 255(67.1)                                              | 380(100.0) |
| 2. Primary School          | 21(42.0)                                         | 29(58.0)                                               | 50(100.0)  |
| 3. Secondary School        | 11(52.4)                                         | 10(47.6)                                               | 21(100.0)  |
| 4. High School and above   | 13(50.0)                                         | 13(50.0)                                               | 26(100.0)  |
| Total                      | 170(35.6)                                        | 307(64.4)                                              | 477(100.0) |

(Figures in brackets indicate percentage).

**Table 7.7.1**

**Distribution of respondents by education of head of household and place of sterilization, N = 170.**

| Sl. NO. | Level of Education    | Place of sterilization |                     |                      | Total      |
|---------|-----------------------|------------------------|---------------------|----------------------|------------|
|         |                       | PHC                    | Government hospital | Private nursing home |            |
| (1)     | (2)                   | (3)                    | (4)                 | (5)                  | (6)        |
| 1.      | Illiterate            | 100(80.0)              | 18(14.4)            | 7(5.6)               | 125(100.0) |
| 2.      | Primary School        | 15(71.4)               | 4(19.0)             | 2(9.5)               | 21(100.0)  |
| 3.      | Secondary School      | 8(72.7)                | 1(9.1)              | 2(18.2)              | 11(100.0)  |
| 4.      | High School and above | 4(30.8)                | 2(15.4)             | 7(53.8)              | 13(100.0)  |
| Total   |                       | 127(74.7)              | 25(14.7)            | 18(10.6)             | 170(100.0) |

(Figures in brackets indicate percentage).