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Reasons for Under-Utilization of Health Services—A Case Study of a PHC in a Tribal Area of Bihar'

Introduction

DURING the last thirty years, Indian health and family welfare programme has grown manifold. A review of the financial outlays for the programme indicates a steep rise in the expenditure in successive five year plans. The number of primary health centers (PHCs), which constitute the nucleus of public health delivery system in rural India, had increased to 5,691 by 1982. Apart from this, now there are 57,638 sub-centers under the Family Welfare Programme. Thus, on the whole there has been a considerable increase in the infrastructure in terms of men and material. However, the achievements in reducing infant and maternal mortality and promotion of contraception, particularly in rural areas are not impressive and are not in proportion to the quantum of inputs pumped into the programme. The infant mortality has remained almost stationary during the last decade and was estimated to be as high as 127 in 1982. Maternal mortality is also shockingly high and is reported to be around five per thousand births. Performance of the Family Planning Programme is also not encouraging and only 23 per cent of the eligible couples had been effectively protected by 1982. The scenario thus presented is somewhat discouraging and is a source of considerable concern to the policy makers and programme administrators.

At a number of national forums, now questions are being raised as to what factors are responsible for the low performance of the programme? Why, as various studies indicate, the public health services have failed to reach people? What changes or interventions are required and at what level to improve the

•The fadings presented in the article are those of authors and do not necessarily reflect the views of the Operations Research Group.

functioning of the programme? The available literature on health and family planning, which has grown in volume over the last three decades has however, failed to pin-point specific bottlenecks of the programmes, A quick review of available studies reveals that most of these concentrate more on beneficiaries, leaving the problems of providers untouched. However, some of the recent studies have focussed their attention on providers, their functioning and their interaction with client.[1],[2]-*[1] These studies have made a good beginning and have succeeded in capturing some crucial information on functioning of the PHC. However, as all these studies were carried out at macro level, using sample survey method, they did not provide qualitative information, which could be useful in understanding the mechanism of the functioning of PHC at micro level.

There is now growing realization of the need for in-depth case studies of PHC to understand the functioning and interaction among the PHC staff inter se and between them and the community at large. Our attempt is in this direction.

Data

The present study is part of a major ORG study to understand the fuuctioning of health and family welfare services in three states namely Bihar, Gujarat and Kerala. While in Bihar the performance of health and family planning programme was poor, in Gujarat and Kerala it is better. In each of these states, in-depth studies of the functioning of 3 to 4 PHCs, were conducted and compared. To understand the health seeking behaviour of people and their interaction with public and private health personnel, a large scale household survey was also conducted. The detailed findings are not presented here. We confine our discussion here only to the functioning of Mirpur PHC* located in the district of Santhal Paragana, a tribal area in the southern part of Bihar. To collect data, a trained social scientist stayed in the selected ;PHC village for one month and collected the necessary information by participant observation and in-depth interviews of doctors, other PHC staff and members of the community at large. A number of visits were also made to sub centers of the PHC to understand their functioning. The reference period for the study is the last quarter of 1982.

The Mirpur Block

The Mirpur Block falls in Pakur sub-division of the district of Santhal Paragana. According to 1981 Census, the PHC covers about 47,000 population spread over 1B villages. The total number of households in the PHC area was 8,725 and average density was 279 person per sq km.

*Mirpur **is a fictitious** name.

45 per cent of the total population belonged to scheduled tribe and 5.4 per cent to scheduled castes. About 60 per cent of the total population belonged to non-worker or unemployed categories. 20.4 per cent of the total population was literate. Tar surfaced roads in the whole block measured only 11 km. The rest are kutcha and were not motorable during rainy season. Hills and rivers make the accessibility of villages still more difficult Buses were available only on the main road. Out of the 118 villages in the block, only seven had post office and only one village had telegraph facility. Only seven villages in the block were electrified. The main sources for drinking water were wells and ponds. Thus the Mirpur block is one of the least developed area in Bihar.

The Mirpur PHC

The public health infrastructure of Mirpur block consisted of a PHC and eight sub-centers. Of the S sub-centers, 5 were for health and the remaining three for Only family welfare services. The distance of the sub-centres from PHC ranged between 2 km to 22 km with mean distance 10.1 km (S.D. = 5.7). The PHC was headed by a doctor designated as MO incharge (MO1). Apart from MOI, three doctors were posted at PHC, to assist him in health and family welfare work. Among the paramedical staff, Block Extension Educator (BEE) and Lady Health Visitor (LHV) were the supervisory staff for family planning, while Sanitary Inspector and LHV (Health) were responsible for supervising the health staff.

At sub-center level, each of the 5 health sub-centers was provided with one Health Worker (HW), one ANM, and one Sweeper-cum-Scrvant. However, each of the family planning sub-centers was run by an ANM alone.

Findings

The findings of the study have been divided into three parts. The first part deals with the performance of the PHC in terms of number of patients who were served by the PHC, their waiting time, their interaction with doctors and other PHC staff etc. These findings are based on the observation on eight consecutive days at PHC. Apart from that, the secondary data available in PHC records were also used to assess the performance of the PHC. The second part presents a more detailed analysis of the functioning of the PHC in terms of various inputs both in human and material resources, supervision etc. Finally, the third part deals with the community perception about the functioning of PHC and the credibility of the PHC among its users.

Performance in Health Care

Dailyturnoutofpatientsandtheircharacteristics.Duringthe8consecutiveNo2 1987 DemographyIndia179

days of observation, altogether 213 patients came to the **PHC.** This shows that average daily turnout of patients was about 27. An analysis of the last five years records kept at PHC also showed that the average daily turnout of patients was 25. This average seems to be considerably lower than the corresponding averages for Gujarat (69/day) and Kerala (84/day). Knowing that the mortality and morbidity levels in Bihar are higher than in Gujarat and Kerala, the low turnout of patients at PHC only indicates that in Mirpur PHC **area,** the people seek medical help from other sources. Mirpur PHC is perhaps not an isolated case. A similar exercise in another PHC of the same district (i.e. Sanihal Paragana) revealed a lower turnout of only 17 patients per day (Table 1).

TABLE l-AVERAGE DAILY TURNOUT OF PATIENTS AT SELECTED PHCs IN THREE STATES OF INDIA

		Average daily turnout of patients		
		Bihar	***Gujarat***	***Kerala***
PHC	**1**	**27**	**36**	**136**
	2	**17**	**60**	**50**
	3	**36**	**65**	**72**
	4	**30**	**158**	**S3**
Wt. Average number of		**27.5**	**69.0**	**84.0**

An analysis of the characteristics of the patients revealed that out of 213 patients, about 48 per cent were children (0-14 years). The proportion of female patients was lower in all the age groups except in the older age group (45+ years), (Table 2). It indicates that perhaps female generally do not get proper treatment in their childhood as well as during their reproductive age span (15-44 years). Proportion of females in total patients was however higher (56.8 per cent) than that of males (43.2 per cent). Most of the children were accompanied by women; only a few by males. While 45 per cent of the total population in the PHC area belonged to scheduled tribes, their proportion among the patients was only 17. This indicates that majority of tribal population do not care to go to PHC for their treatment.

Most of the patients (71 per cent) excluding children aged 0-5 years were illiterate and 63 percent of them had family income less than Rs. 200 per month (mean family income Rs. 220 (S.D. = 184). The average family size was around 5.7 (S.D. — 2.8). This shows that the patients who availed the PHC service belonged to the poorest class; and they could not afford private medical services.

TABLE 2—SELECTED CHARACTERISTICS OF THE PATIENTS

Characteristics	*Male*	*Female*	*All*
Age			
0—4	25.0	21.5	23.0
5-14	305	20.7	24.9
15-44	37.0	35.5	36.2
45-f	7.5	22.3	15.9
All Ages	43.2	56,8	1000
Caste & Religion			
Hindu (other than SC/ST)	42.4	57.6	53.7
Muslims	41.0	58.9	34.3
Scheduled Tribe	60-0	40.0	7-0
Education			
Illiterate	—	—	70.5
Literate	—	—	29.5
Total V	92	121	213

Distance travelled. An analysis of the distribution of patients according to the distance travelled to seek treatment at PHC reveals that about 49 per cent of the 213 patients came from a distance upto one km, about 29 per cent between 1 to 3 km, and the remaining about 22 per cent had covered more than 3 km to reach the PHC (Table 3). Thus the main "catchment area" of the PHC fell within a radius of about 3 km from it. An analysis of the mode of transport used by the patients to reach the PHC revealed that almost all (97.7 per cent) patients had come on foot. Only two patients out of 213 used bus,

Time spent at the PHC. Observation on 50 patients, 10 on each day for 5 consecutive days, was made to estimate the total time spent at PHC by the patients to see the doctor. The selection of the 10 patients was done at random and at different hours of the working day. The analysis shows that on an average a patient had to wait for about 72 minutes (S.D. — 29.7) from his/her arrival at PHC for seeing the doctor (Table 4). The average time the doctor spent with the patient in examining and writing the prescription was only

TABLE 3—DISTRIBUTION OF PATIENTS ACCORDING TO THE DISTANCE OF THEIR RESIDENCE FROM PHC

Distance (In km)	*Malt*	*Female*	*Total*
Up to 1	45.7	51.3	48.9
1-3	30.4	28.1	29.1
3-5	4,3	6.6	5.6
5-8	10.9	6.6	8.4
8+	8.7	7.4	8.0
Total N	92	121	213
Mean	2.6	2.2	2.4
S.D.	2.8	2.6	2.7

TABLE 4—WAITING TIME OF PATIENTS AND MEAN TIME SPENT BY DOCTOR IN THEIR EXAMINATION

Nature of work	*Mean lime* (in minutes)	*S.D.*	*No. of observation*
Waiting for doctor	72.0	29.7	50
Examination by doctor	1.4	0.6	50
Taking medicine from compounder	1.7	0.6	50

TABLE 5—YEAR-WISE PERFORMANCE OF FAMILY PLANNING DURING 1977-1982 AT MIRPUR PHC

	1981-82		*1980-81*		*1979-80*		*1978-79*		*1977-78*	
	T.	*Ach.*	*T.*	*Ach.*	*T.*	*Ach.*	*T.*	*Ach.*	*T.*	*Ach.*
Sterilization	200	95	200	3	200	16	200	12	200	Nil
Male		14		3		16		12		—
Female		81		—		—		—		—
Loop	60	—	60	—	60	50	60	—	60	—
Copper-T		30		—		—		—		—
Conventional contraceptives		200*								
Condom (in pieces)		1942		3334		2694		2450		1650

*No. of users. T. = Target. Ach. = Achievement.

about 1.4 minutes (S.D. = 0.63) and the average time taken by the compounder to give the medicine was 1.7 minutes (S.D. = 0.6) The main cause of such a long waiting time was the late arrival of doctor at PHC. On all the eight days under observation, the doctor instead of starting work at 8 AM, always arrived between 11 to 11.15 AM.

For the waiting time there was no proper sitting arrangement for the patients. They sat on floor of the verandah outside the examination room. As soon as the doctor arrived, they gathered in the examination room and tried impatiently to get the doctor's attention. There was no queue system and hence some patients, who came later saw the doctor first.

Performance in MCH Care and Family Planning. During the entire stay of one month of the Investigator at the PHC none of the patients attending the PHC, had come for MCH or family planning care. During the month, the sub-centres together attended a total of 103 ante-natal and 44 post natal cases. Records on year-wise performance of MCH and family planning confirmed the consistantly low performance of the PHC in respect of these two aspects (Tables 5 and 6).

Where and what goes wrong. We now turn to the analysis of the functioning of the PHC in order to identify the factors responsible for the low level of its performance. The factors considered are the logistic supports in terms of human and material resources, quality of extension work, supervision, and the motivation of the workers for carrying out extension work.

Problems of Logistics

Availability of Doctors at PHC and Sub-centers. The PHC had four doctors. All of them were supposed to attend PHC for 4 days and in the remaining two days attend various sub centres. The allocation of duties was done one the basis of circular from the State Health Minister, dated 23.9.81 and letter from Civil Surgeon dated 20.10.81 setting weekly time table for each doctor.

However, for all practical purposes, only MOI was available at PHC. During the entire period of our stay at PHC (one month), we did not see any other doctor attending PHC except one who came only for few hours to meet MOI and to do some paper work. A probing on this revealed that one of the doctors was on study leave and the remaining two did not live in the PHC area at all. It was also reported that they were living in their home towni (about 150 km away from PHC) and were running their private practice. When the MOI was asked why those doctors were not attending the PHC, he could not give any satisfactory reason. However, it was reported later from various sources that the MOI was not interested in complaining against them, both because he did not want to antagonise them and also he feared that their staying in PHC area could affect his private practice adversely.

TABLE 6—YEAR-WISE PERFORMANCE OF MCH

Years	T.T.		D.P.T.		DT3-8 Yearn		Iron tabts. mothers		Iron tabts. children		Vit .A solution		Antenatal	Delivery
	T.	Ach,	T.	Ach.	T.	Ach.	T.	Ach.	T.	Ach.	T.	Ach.	Ach.	Ach.
1979-80	100	48	160	41	160	49	220	74	220	11	700	51	354	112
1980-81	80	26	300	Nil	230	17	220	59	220	21	600	335	488	114
1981-82	160	8	300	Nil	230	20	220	65	220	22	660	381	436	108

TABLE 7—STAFF POSITION AT MIRPUR PHC

Designation	*No. of positions sanctioned*	*No. of positions filled*	*No. of vacancies*
MO Incharge	1	1	Nil
Medical officers	3	3	Nil
B.E.E.	1	1	Nil
L.H.V.	2	1	1
Pharmacist/Compounder	1	Nil	I
Lab. Tech. (Malaria)	1	1	Nil
Clerk	1	Nil	1
Sanitary Inspector	1	1	Nil
Surveillance Inspector (Malaria)	1	1	Nil
Enumerator (smallpox)	1	1	Nil
ANMs	8	8	Nil
Trained Dal	2	2	Nil
Dresser	1	1	Nil
Vaccinator	3	3	Nil
B.H.W.	1	1	Nil
Sweeper-cum-servant	5	4	1
H.W.	4	4	Nil
Orderly	1	1	Nil
F.W.A.	1	1	Nit
M.W.A.	1	1	Nil
Surveillance workers	4	4	Nil
M.F.P.W.	3	Nil	3

F.W.A. = Female Ward Attendant. M.W.A. = Male Ward Attendant.

The MOI, who lives in PHC premises attended the PHC regularly. However, it was observed that MOI used to attend the PHC only after 11 AM. From morning till 11 AM., he attended the patients at his own residence privately. Taking the advantage of the permission given by the Bihar government to the doctors of PHC to do private practice after PHC clinic time, the doctors including MOI were interested in their private practice only. The patients who wanted to return their home early or could not afford to wait for long time at PHC preferred to consult MOI at his residence for private treatment. This was one of the main reasons for the low turnout of patients per day at PHC.

It was reported that non-availability of the lady doctor further discouraged female patients to seek treatment related to maternity and gynaecological problems. In such cases they preferred to go to a well equipped Missionary Hospital, located about one km from PHC, where lady doctors were always available to look after their needs. Absence of lady doctor also affected family planning programme as neither the tubectomy operations could be performed nor the IUD could be inserted at PHC. It is reported that during sterilization camps a lady doctor from district headquaters was called in.

Availability of Paramedical Staff and Workers Client Ratio. The staff position at Mirpur PHC is given in Table 7. Among the paramedical staff, the LHV post had fallen vacant about 5 years ago and one of the ANMs was promoted to this post as an acting LHV. Till the completion of the study no regular LHV was appointed. Apart from the post of LHV, three posts of male FP worker and one post of compounder were vacant. No specific reasons were given as to why the vacant posts were not filled yet. The absence of male family planning workers was affecting the extension work adversely in the PHC area. Referring to these vacant posts the BEE said : "We do not have male family planning workers, though the posts have been vacant, the appointments are not made by the government. It is physically not possible for us to cover the whole area assigned to us."

A similar view was expressed by MOT. Apart from emphasizing the need of male family planning workers, the doctor was of strong opinion that the area assigned to an ANM is too large, ranging between 6 to 18 villages with an average population of about 6,000. The coverage for other health staff like vaccinator (27 villages), basic health worker (15-20 villages), Surveillance workers (27-35 villages) etc. was much larger in terms of both number of villages and total population. The client/worker ratio for the PHC was inordinately high; it was physically *not* possible for the staff to cater to the needs of most people particularly with grossly inadequate transport and communication network.

Training. All the staff members working in PHC had received training requisite for meeting the appointment criteria. All the paramedical staff including

BEE except two ANMs and one LHV were non-matric. As regards training in family planning and extension work, out of 8 ANMs, only one ANM had attended one week orientation course. Similarly, only one ANM had attended a special MCH training. Among the supervisory staff (Doctor, BEE, SI, LHV), only one of the doctors and the BEE had received training in family planning work. About this problem, the MOI said that the training of his staff, particularly those of extension workers, was totally insufficient. He strongly felt that his paramedical staff, particularly the extension workers should be given orientation training so that they could perform their job efficiently. His comment was : none of the workers had requisite skill for performing family planning work and hence the programme was suffering. He added that none of the ANMs or LHV would be able to insert loop/copper-T. Most of them also had misconceptions about the family planning methods. As a result, out of the 16 workers who were contacted and interviewed only two of them were practicing family planning. One of the ANMs had attained menopause and two wanted to have an additional child. The remaining 11 (68.7 per ceat) had achieved their desired family size but were yet not using family planning method. On probing two of them said that they were using abstinence and the remaining 9 failed to give a satisfactory answer.

Supply of Medicine and Immunization Agents. Discussion with MOI and other PHC staff on supply of medicine and immunization agents revealed that medicines were supplied both as routine and on requisition from the district office. Generally there was not much lag between requisition and supply of medicine. However, it was reported that the supplies never coincided with their demand and need. MOI further added that there were many medicines which were commonly used but were mostly not available with the PHC. As an example he cited that penicillin was out of stock for the last two years. Anti-tuberculosis drug, though available at the time of interview, was reported to be in short supply perennially. Supply of immunization agents like TT, BCG, DPT and vaccination against cholera was always inadequate. As a practice, most of these medicines were kept at PHC to meet the demand on the spot and thus supply to sub-centers was always inadequate,

At the time of the study, out of the eight sub-centers, 6 sub-centers did not have TT in stock. Of course, it was available at PHC but for all practical purposes it was physically inaccessible for majority of the villages falling beyond 3 km from the PHC. Vaccine for polio was neither available at PHC nor at sub centers. According to MOI it was not supplied to PHC at all.

It was also observed that Ayurvedic drugs sent to PHC as a routine were never used as neither the doctors had any knowledge about these drugs nor the patients wanted to use them. Generally the patients believed in Allopathic drugs as they considered them "strong" and thus "could cure fast*'.

Supply of Contraceptives. PHC provides services for vasectomy, pills and

condom. At the time of study it was observed that condom and pills were available in stock and facilities for performing vasectomy were adequate. However, as mentioned earlier because of non-availability of lady doctor, tubectomy was not performed at PHC. IUD was in stock but services could not be offered because of the absence of lady doctor or any trained staff. One ANM, who was given training for one week for inserting IUD was not confident enough to do insertions.

As regards the facilities available for conducting tubectomy operations, apart from the lady doctor, anaesthesist was also not available at PHC. However, tubectomy operations were performed at PHC during camps organized once or twice in a year. To conduct these operations a lady doctor from district hospital was called with the necessary equipment. During camp, the PHC faced severe problem in accommodating the operated cases. The PHC had only six beds, hence during the camps all the rooms including patient wards and the corridors were used to accommodate tubectomised women. Commenting on this situation, the doctor said: "We have to stop attending all outdoor patients during family planning camps. All rooms are used for keeping the sterilised women. Beds are made on the floor. Rugs and bed sheets are borrowed from block Office."

During our stay at PHC, all the six beds had remained unused. The two rooms, which constitute the in-patient wards remained locked all the time. The rooms were not cleaned regularly and were full of dust. The indoor patients admitted during the study period were lying in the corridor and were using their own cots and bed sheets. Only for one day, the male ward was opened during this period to accommodate a constable who came to seek medical attention. In reply to an enquiry in this regard the MOI said: "The villagers do not like to remain in closed rooms. They prefer to be in open area and hence they keep their beds in the corridors."

However, cross check with the indoor patients revealed that the PHC staff did not want to offer these beds in order to avoid cleaning and maintenance of wards. The ward facilities were offered only to influential persons or government servants like constables.

Transportation. The PHC did not have any vehicle. This adversely affected the health and family planning programmes. Many sub-centers were far off and even if the doctor wanted to visit, he could therefore not do so. The communication network of the block as such is poor and the situation becomes worse during rainy season (see Table 8). Except the S.I. who uses his cycle, all of the extension workers, when interviewed reported that they carried out their field work on foot. In this regard the BEE said: "We can not cover far off places. Thus we can not contact many people. You can not expect us to cover all the areas on foot. In emergency cases we are quite helpless because we cannot bring or take patients anywhere. This is also true in case of

family planning. We cannot bring or take back a sterilized person. We are totally immobile."

TABLE 8—ACCESSIBILIFY OF SUB-CENTERS FROM PHC

Sub-Center	*Distance from PHC*	*Type of Road*	*Whether road can be used in all seasons*
S1	22	Pucca (10 km}+ Kutcha	**Not during rainy season**
S2	10	Kutcha	Yes
S3	12	Pucca (9 km) 4- Kutcha	Not during rainy season
S4	10	Kutcha	Not during rainy season
S5	10	Pucca	Yes
S6	8	Pucca (7 km) + Kutcha	Not during rainy season
S7	7	Pucca (3 km) + Kutcha	Not during rainy season
S8	2	Pucca	Yes

An interview with MOI also endorsed the views of BEE and he strongly felt that the lack of transportation was a serious bottleneck in the PHC'S work.

Extension Work

The extension work was poor. The LHV, who was responsible for supervising extension work of ANMs, was not herself interested in doing anything. Every week she was supposed to work for three days at PHC and the remaining three days in the field. However, during the entire period of observation, she was hardly seen working at PHC. It was reported by the doctor that she was an arrogant lady and he found it difficult to control her. We tried to meet her a number of times, but could meet her only at the end of our stay. When we asked her for the reasons for not attending PHC, she replied that she was always working, and added that it was only the BEE, being against her, was making false propaganda that she was not working. When we said that we also witnessed her not working at PHC, then she paused for a while and said she was all the time sick and moreover she had to look after her own child.

Our visits to sub-centers revealed that they were almost non-functioning. According to the programme, the ANM should open the sub-center everyday from 8 AM to 12 noon and she should go for extension work and distribution

of contraceptives in the afternoon. However, when we visited two consecutive days each of the two sub-centers, one of the centers was found locked on both the days, while the other sub-center was found open on one day. Informal talk with villagers revealed that the sub-centers were rarely open. However, the ANM claimed that most of the time they were in the field for extension work. The claim is rather unrealistic, when one looks into the last five years FP performance of the PHC (see Table 9). For example, in 1980-81, only three sterilizations were performed and 3334 pieces of condom were distributed. In 1981-82, a total of 95 sterilizations were performed. Apart from that 30 copper-T were inserted, 4 packets of OC and about 2000 pieces of condom were distributed. A scrutiny of the weekly reports of the worker revealed that during one month of observation, in all 92 pieces of condom were distributed by 2 ANMs. The discussion with supervisory staff on the family planning performance revealed that the jump in the number of sterilization from 3 in 1980-81 to 95 in 1981-82 was mainly because of the acute drought in the area. According to them many poor couples opted for sterilization to get the incentive money.

TABLE 9-YEAR-WISE EXTENSION WORK DONE DURING 1977-1981 BY MIRPUR PHC STAFF

Item	*1981*	*1980*	*1979*	*1978*	*1977*
No. of group meetings	138	—	3	—	—
Number of camps					
O.T.	8	—	—	—	~
Film Shows	—	—	—	—	—
Exhibitions	2	—	—	—	—

During our stay at PHC, only one orientation meeting was organized in the PHC village and was attended by about 50 local women. Dy. Mass Media Officer came from the Civil Surgeon office to address the meeting. We were informed that this was the first OT camps held during 1982.

Records of the extension work confirmed our observation that motivational efforts to provide family planning were negligible (see Table 9). During 1981, 138 group meetings, 8 OT camps and only 2 exhibitions were organized. In all the five years, no film show was held. The situation was still worse in 1980 and the preceding years, when hardly any group meetings, OT camps and film shows were organized.

A number of beneficiaries reported that no extension worker of PHC had ever visited them or their neighbours. One of the villagers sarcastically asked us: "is there any social worker in the PHC?"

Typical responses of the villagers on the availability of ANM or other extension workers were: "I do not know; we do not know that ANM is available to PHC; We do not approach ANM for attending delivery or for that matter any help, because we know that they would not come or help without charging money. If you do not pay enough, they would not do any work satisfactorily; see the problem is that doctor 'X' himself says, 'give some money, request her she will do your work' but the ANM asks more money, why should we depend on her?"

Supervision

Three of the 8 sub-centers were for family planning and remaining 5, for health only. Health sub-centers were supervised by Sanitary Inspector, and LHV (health). The other three were run by ANMs and their supervision was done by BEE and LHV (family Planning). BEE was looking after the programme under the overall guidance of MOI, while LHV (FP) was immediate supervisor of ANMs (FP). Generally, the progress of work was reviewed by the doctor every month in the monthly staff meeting. Apart from that BEE and LHV were supposed to visit various field areas and sub-centers to help ANMs in their motivational work, if needed. However, our observation was that neither the doctor nor the supervisory staff were keen in supervising the work of the field workers. They rarely visited any sub-center. One of the ANMs of a sub-center whom we were able to contact only after three successive visits said : "I am posted at this sub-center for the last two years. So far no supervisor has visited me. I contact our supervisors only on Saturdays, when we visit PHC either to submit weekly report or to get medicine.'*

This sub-center, about 10 km away from the PHC, was connected by a kutcha road. The sub centers on pucca roads were occasionally (once in a month or less) visited by their immediate supervisors. Thus, with the increase of the inaccessibility, either due to long distance or poor communications, the supervision becomes almost negligible,

A review of the records indicates that during 1982 (from January to 22nd October) not a single staff meeting was held, whereas during 1981, 11 staff meetings were reported.

Not only the PHC doctor or supervisory staff but also the district officials were neglecting supervision of the programme. During the period of one month stay at PHC no district official visited PHC or sub center for supervision. Present CMO had not visited PHC even after ten months of the assumption of his office. It was reported that the present CMO was promoted to this post, after superseding some of his senior colleagues. They had challenged his promotion to higher authorities and at present CMO was busy most of the time lobbying his case at Patna, the state capital. The MOI commenting on the visits by the district officials to PHC said : "They come to PHC every year

only during January to March in connection with achievement of FP targets and to pressurise the staff to achieve the targets."

Our informal discussions with doctor and other supervisory staff revealt that there was a general belief among all the staff that the doctors or supervisor could not cause any harm to them and even if they made any written complaints against them, it could be nullified through political influence or by bribing the officials, A similar thinking prevailed even among the doctors and supervisory staff with respect to their higher authorities. As a consequence, generally, the supervisors at all levels had an apathetic attitude towards the programmes. Commenting on this MOI added ; "Supervisors, including me, do not have any power to award or punish workers. We can only ask the worker to give written explanation for his/her bad performance or at the most can stop his/her TA. We generally, even do not do that also to avoid personal enmity and because we know that such action would not help much." He further added : "The money paid as TA is not much (Rs. 75/-to BEE and **Rs.** 50/- to ANM). In fact, both the supervisors and workers try to avoid tours and field work because the TA is totally inadequate and nobody wants to spend money from his/her own pocket."

Motivation and Personal Background of Workers

The workers who were interviewed were not motivated to work in rural areas in general and in the present PHC in particular. As the PHC was located in a backward area, they did not have many of the essential facilities- Except the MOI and BEE none of them were provided with accommodation. Out of 17 workers about whom the background data was collected, 10 (58.8 per cent) were educated and brought up in urban area and hence were not interested in working in villages, At least 4 of them mentioned that they found it difficult to communicate with villagers because of language problem. Similarly, 9 were not interested in continuing there and had already moved their application for transfer. Commenting on this, an ANM who had applied for transfer added : "I am living in this PHC for the last two years. My husband is working in another district. My whole family life is disturbed. I have requested higher authorities to transfer me to that district. However, 9 months have already lapsed since I moved my application but so far no action has been taken. I am always in tension and trying for transfer. In such situation how can you expect from me to concentrate on work?"

Discussion

A detailed discussion with doctors, BEE, other PHC staff and the community at large, gave us an impression that the reasons for such a chaotic situation were deeply embedded in the socio-political structure in the block, district and the state as a whole. We feel that by providing a vehicle, posting a lady doctor,

recruiting few more extension workers and improving supervision will only contribute marginally to improve the performance of PHC. The problems, which are fundamental in nature, will remain unresolved. One of the senior officials admitted this fact by saying, "We provide everything to ANMs but they do not work. The problem is much serious to deal with. We can not take action against them. At every step, we are stuck up with political and bureaucratic interference. Many times, oral and written warnings were given to them. But what happened? If we take these issues more seriously, we will be transferred to some other PHC worse than the present one .. . The personal achievement of LHV (FP) for the last three years is nil. She hardly does any work but yet she survives. It is because she has strong backing in the district headquarters."

This explains the mechanism which is influencing the functioning of the whole PHC. The doctors are not in a position to punish or reward their staff. If any action is taken, that could be influenced and reversed through political connections and money. A number of PHC staff members openly commented : "When no body is working at any level, be it a Minister, or CMO, or any official, why should I work . .. When the people in the state capital or district headquarters are busy in making money, why should we sit idle! Otherwise, from where will we give the commission to the higher-ups? . . . What is there to worry, give some money, nothing will happen." This seems to be general logic in support of non-functioning and their apathetic attitude towards the whole issue.

As a result of the non-functioning of PHC and the eagerness on the part of the doctors to promote their private practices the community at large is at a loss. They have lost their faith in the health and family planning services of the government. Majority of the people seek health and maternity services from private sources. Even those who seek help from PHC doctor, they prefer to pay his fee at his residence and get the necessary advice rather than waiting for a long time at PHC. The triba] population preferred to go to the missionary hospital which was quite close to the PHC for medical services. As one of the tribal informant put it angrily: "Why should we go to PHC, where we get Pani (coloured mixture) and we have to wait for a long time to see the doctor? Government medicines are sold in the market to private doctors. Dr. 'X' of PHC once at his residence gave me medicine costing Rs 18 for my one year old child who had been suffering from dysentry. Even then the child was not cured. If you are short of even one rupee, the doctor will take the prescription and medicine back. He is a Chor (Thief). He has bought a new car by selling government medicines and doing private practice during PHC time."

To improve the overall functioning of PHC, it is essential, therefore, that the programme is seen in a broader framework and corrective measures are applied not only at the programme level but also at the general socio-political levels. The latter is much more crucial than the former. This calls for much

more serious committment to the cause by the political bosses and senior administrators. At programme level some of the following interventions could be useful:

(a) The private practice by the PHC doctors should be stopped by introducing a suitable non-practising allowance. This will improve their attendance at PHC and sub-centers.

(b) Immediate steps should be taken to decentralize the power structure so that the doctors and otner supervisory staff are enabled to suitably reward and punish their staff. This will go a long way in improving the supervision work at PHC.

(c) Steps should be taken either to provide better transport facilities to ANMs and supervisory staff or to reduce the area coverage by increasing manpower.

(d) The ANMs and the other extension workers should be given re-orientation training for FP work, including training in communication and motivational work. The ANM should also be given practical training for inserting lUDs.

(e) As far as possible a lady doctor should be posted and required facilities for conducting tubectomy and MTP should be provided at PHC.

(f) Immediate steps should be taken to provide proper accommodation to the staff at the place of work.

(g) Adequate supply of medicine and immunization agents should be ensured. In this regard, emphasis should be placed on adequate supply of medicines and immunization agents at sub-centers.

(h) The PHC has abandoned CHV schemes. Immediate action should be taken to revive this scheme and as far as possible female CHV should be trained under the revised and renamed scheme of Village Health Guide (VHG). Success of VHG will depend on right selection and regular supply of medicine. To attract female VHG, the venue of training should be shifted fromj PHC to sub-centers so that the normal life of the VHG during the training should not be disturbed.

(i) Attempt should be made to establish a loose but formal link with the PHC staff and other village practitioners in such a way that they should complement rather than compete with public health practitioners. Experiment in Bangladesh has shown that the rural practitioners could be effectively used in promoting family planning and taking MCH care (including immunization) at the door steps of the people.

(j) To make the people aware of the services available at PHC and sub-centers, free of cost hoardings with the facilities being offered at the centers written in the local language may be displayed.

As regards the non-programmatic parameters in the state particularly those related with the existing socio-political structure in the state not much can be discussed at this juncture except hoping that the political leaders and decision

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As regards the non-programmatic parameters in the state particularly those related with the existing socio-political structure in the state not much can be discussed at this juncture except hoping that the political leaders and decision

makers will take note of the situation. As mentioned earlier, the solution lies more in a serious political commitment to the cause and desire to implement the programme effectively, than only increasing the infrastructure in terms of men and material.

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