AN EXPLORATORY STUDY OF DISTRICT HEALTH ADMINISTRATION IN HIMACHAL PRADESH

DISSERTATION SUBMITTED TO THE JAWAHARLAL NEHRU UNIVERSITY
IN PARTIAL FULFILMENT OF THE REQUIREMENTS
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MASTER OF PHILOSOPHY

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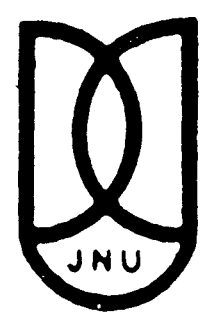

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CERTIFICATE

This is to certify that this dissertation "An Exploratory Study of District Health Administration in Himachal Pradesh" submitted by Sudhir Kumar, for the degree of Master of Philosophy, is his original work. It has not been previously submitted in part or full for any other degree of this or any other University.

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C O N T E N T S

A C K N O W L E D G E M E N T S

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(SUDHIR KUMAR)

I N T R O D U C T I O N

Introduction

Himachal Pradesh came into being on the 15th April, 1948, by the merger of some 20 odd tiny states. It had four districts in the beginning, i.e. Chamba, Mandi, Mahasu and Sirmaur, with an area of 27,007 square kilometres. In July, 1954, the neighbouring state of Bilaspur was integrated with the Pradesh, raising the number of districts to five and area to 28,175 sq. km. With the reorganisation of Punjab state in 1966, hilly districts of Kangra, Kullu, Lahaul and Spiti and Shimla were added to the Pradesh. It attained full fledged state hood on the 25th January, 1971.

Himachal Pradesh consists mostly of a hilly and mountaineous region, situated between 30^{o} 22' - 33^{o} - 12' N and 70^{o} 47' - 79^{o} 04' E. Physiographycally, it is situated in the heart of the western Himalayas, surrounded by the states of Jammu & Kashmir (North), Uttar Pradesh (south - east). Haryana (south), Punjab (west) and forms India's border with Tibet. It emerged as the eighteenth state of the Indian Union, with an area of 55,673 sq. km. and has a population of 5,111,079 according to provisional population statistics, 1991.[1]

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1. Census of India, Provisional Population totals, 1991, Series - I, Paper - I, Page - 3,Government of India.

According to quick estimates, the per capita income of the state in 1988-89 stood at Rs. 3,614 while at the National level it was Rs. 3,835. Only 8.70 per cent of the total population is urbanised in the state, while the percentage at the national level is 25.72. The rest of the population lives in rural areas and is generally engaged in agriculture.

Socio - cultural characteristics

The state is dominated by Hindu population. The other religious groups found in Himachal Pradesh are Muslims, Sikhs and Buddhists. The scheduled castes and scheduled tribes constitute 29.2 per cent of the total population as against the national average of 22.65 per cent. The caste system still prevails in the rural areas.

Table No. 1 Demographic and socio-economic indicators (1991).

Demographic and socio-economic indicators	Himachal Pradesh	India
Total population	5,111,079	843,930,861
Male population	2,560,894	437,597,929
Female population	2,550,185	406,332,932
Decennial population growth 1981-91		
Absolute growth	830,261	160,606,764
percentage growth	+19.39	+23.50

contd..

Density of population (per sq.km)	92	267
Sex ratio (female per thousand males)	996	929
Literacy rate (Total)	63.54%	52.11%
Male literacy rate	74.57%	63.86%
Female literacy rate	52.46%	39.42%
Schedule Caste*	24.62%	15.75%
Schedule Tribe*	4.61%	6.90%

* For the year 1989-90

Source : Census of India, provisional population totals, 1991, series 1, paper I & II, Govt. of India

The above table shows that the state is favourably placed with regard to literacy in both males and females. Himachal Pradesh's population growth rate is slow in comparison to the National growth rate. Also its sex ratio is far better than the national average.

The literacy ratio in the state has improved considerably. From 7.1 per cent at the time of independence, it has reached 63.54 per cent in 1991. The rapid increase in the literacy ratio is probably because of the British influence on its one time summer capital. It was better equipped in the sense that it had better institutions and awareness about the problems among the people. Even after independence, the tourist influx kept the capital of the state in a constant contact, but the villages still are not much changed. It has also brought

change in urban life. This had resulted in some special features in the state and particularly in Shimla district. It is probably because of all this, that the state literacy ratio is better than National literacy ratio.

Only 8.70 per cent of the total population is urbanised as against 26.72 per cent at the National level. Except for a few towns, there is hardly any urban life in the hills, though of late urbanisation is a fast growing trend. Joint family structure still dominates in the state. The people of Himachal Pradesh have strong religious faith and have lot of temples, that is why it is some times called land of Gods. The state has a rich cultural heritage with lot of traditional art forms, dances, music and folk lores. More characteristics of agrarian society are found in Himachal Pradesh.

Economic Conditions

Agriculture as primary occupation is predominant in the State. 76 per cent of the population is dependent on agriculture, although only 11 per cent of the total geographical area is available for cultivation. This means that agricultural land is over burdened and the maximum number of the villagers are agricultural labourers. Wheat, Barley and Maize are the important crops. Himachal Pradesh has emerged as a glass house for the country in respect of seed potatoes and vegetable seeds. Horticulture is quite

developed because of favourable geographical conditions and subsidies granted by the government of Himachal Pradesh.

Forests cover 38.30 per cent of the land out of the total geographical area. About 25 per cent of the state revenue comes from the forests. Five lakh people are employed in forest related employment. The industries are not fully developed and are generally related to agro-based products and woollen garments. This is because of the difficult terrain and lack of transport and communication. All this makes the cost of production very high therefore, unprofitable. The lack of infrastructure is determinant of all social, economic and cultural characteristics of Himachal Pradesh. Only those areas of the state are developed which are very well connected by roads and where infrastructural facilities are available. In the field of hydel power the state has progressed a lot. Out of 16,807 villages in the Pradesh, 15,776 were electrified by 1986.

Geographical features

Himachal Pradesh has 12 districts. There are 3 divisions, 42 sub-divisions. 66 Tehsils, 28 sub-tehsils and 69 community development blocks. The number of villages is 18,721 out of which 16,807 villages are inhabited and 1914 are uninhabited.

The state is almost wholly mountaineous with altitudes ranging between 350 to 7000 metres above the sea level. The climatic conditions accordingly vary from the semi tropical to semi-arctic. Similarly the soil pattern differs throughout the state. Himachal Pradesh is a state of rivers and springs. Himachal Pradesh has a diversified and rich flora and fauna because of the existence of a variety of climates and a wide range of altitudes. A variety of medicinal plants and herbs are found.

Tourism

From the economic point of view, tourism is specially important in the development of a state like Himachal Pradesh. It is a catalyst to economic growth and earning of foreign exchange. Tourism occupies an important place in the economy of Himachal Pradesh. Together with horticulture, forestry and hydel power, tourism is a major economic activity in the Pradesh for creating income and employment opportunities. In Himachal Pradesh Tourism offers the greatest scope for development because its geographical location and topography bestows upon the state all that a visitor looks for in nature. The state has now over 20 major tourist centres. With the increasing terrorism in Jammu and Kashmir, the importance of Himachal Pradesh as a tourism centre has gone up. This has resulted in a increase in the tourists numbers and therefore

cash inflow. Consequently also the facilities and infrastructures have been improved to meet the demands. This has also resulted in employment generation and further economic growth.

Health in Himachal Pradesh

Himachal Pradesh has different geographical conditions, so it also has a different set of health problems. The people of Himachal Pradesh are sturdy and adept in living in hills. Generally, the health problems faced by the people are of different character. There are unusually large number of orthopaedics cases. It is a problem for the people to avail the services in cases of gynaecology and preventive care service like immunisation, M.C.H. and family planning.

It is difficult for the people in rural areas to frequent the health centres because they are generally not located in the centre of the catchment area but located near roads or places where transportation facilities are available. In cases of diagnostic complications and emergencies, it becomes even more problematic for the rural people, because the health centres are not equipped with proper equipments and skilled doctors to look after these

patients and the district hospitals are far away and chances of admittance grim. Transportation facilities are not adequate. In winters some areas of the State are cut off completely from other adjoining areas due to heavy snow fall and landslides. In this duration health care services are not available.

These problems also act as hurdles for the health administration in providing health care services. Some areas are inaccessible because roads and means of transportation are not available. The cost of providing services are high and the finances are limited. This severely curtails the efficiency and efficacy of the health services.

Health Infrastructure

In Himachal Pradesh, Health and Family Welfare Department is providing health care services through a net work of 39 civil hospitals, 18 community health centres, 17 rural hospitals (up-graded PHCs), 190 primary health centres, 191 civil dispensaries, 1851 sub centres and 46 maternity and child health centres. The health institutions are as follows:

Table No. 2 The various health institutions providing services in Himachal Pradesh

(as on 31-3-1990)

Type of Institutions	No. of Institutions
Allopathic Institutions	
Teaching hospitals	2
District hospitals	12
Referral Hospitals	4
Civil Hospitals	39
Community Health Centres	18
Rural Hospitals (up-graded PHC)	17
Primary Health Centres	190
Civil dispensaries	213
Tuberculosis Institutions	
Hospitals	2
District T.B. Clinics/centres	11
T.B. Sub clinics	6
T.B. Survey-cum-domiciliary treatment centre	1
Leprosy Institutions	
Hospitals	8
Leprosy clinics/sub clinics	76
S.E.T. centres	15
District centres/clinics	11
Units	
Other Institutions	
Dental clinics	53
X-ray clinics	94
Eye and E.N.T. clinics	11
M & CW centres	46
Medical college	1
Radio Therapy unit	1
Female Health workers Training School	9
Male Health workers Training School	4
General Nursing course Training Centre	3

contd..

Ayurvedic Institutions	
Ayurvedic college	1
Ayurvedic Research Institute	1
Ayurvedic nature cure unit	1
Ayurvedic Hospitals	5
Ayurvedic Dispensaries	522
Unani Dispensaries	
Homeopathic dispensaries	2
Beds Available	7958

Source: Directory, 31 March, 1991, Department of Health and Family Welfare, Himachal Pradesh

Table No. 3 District wise number of Hospitals, Primary Health Centres (P.H.Cs), Community Health Centres (C.H.Cs), Rural Hospitals (RHs).

Districts	General Hospital	Community Health centres	Rural Hospital	Primary Health centres	Civil Dispen-saries	Sub Centres	Total
Bilaspur	1	-	1	11	14	95	122
Chamba	3	1	3	18	13	156	194
Hamirpur	1	2	1	10	11	136	161
Kangra	7	3	3	31	38	383	465
Kinnaur	2	2	1	6	2	35	48
Kullu	1	1	1	11	7	95	116
Lahaul & Spiti	1	1	1	4	8	29	44
Mandi	3	4	2	28	22	279	338
Shimla	11	2	1	31	32	219	296
Sirmaur	4	-	1	16	15	139	175
Solan	4	1	1	14	22	164	206
Una	1	1	1	10	12	119	144
H.P.	39	18	17	190	196	1849	2309

Source : Government of Himachal Pradesh, Shimla, Annual Report, Health and Family Welfare Directorate, 1989-90

Table No. 4 Block wise population, Number of Gram Panchayats and Medical Institutions in Shimla

District/ Block	Population 1981 census (rural)	Number of Gram panch-ayats	No. of Medical Institutions (as on 31-3-90)					
			General Hospitals	CHC/up-graded PHC/ rural Hospital	P.H.C.	Civil dispen-sary	Sub Centre	Total
Shimla	4,30,755	288	11	3	31	32	219	296
Kasumpti-seoni	92,893	57	4	-	3	15	58	80
Theog	55,610	42	1	-	3	5	28	37
Kumarsain	35,560	24	1	1	3	3	20	28
Rampur	62,093	36	2	1	6	1	30	40
Jubbal	55,966	45	1	1	5	5	27	39
Rohru	39,859	22	1	-	3	1	19	24
Chhohar	33,364	25	-	-	4	-	14	18
Chaupal	55,410	37	1	-	4	2	23	30

Source : Annual Report, Directorate of Health and Family Welfare, Government of Himachal Pradesh, Shimla (as on 31st march, 1990)

The state has remained cut out from the Nation and has been isolated because of its mountaineous terrain and therefore inaccessible. This has also posed a great problem in the development of infrastructures. The medical services has also to face this adverse situation and over come it to serve the rural population. The geographical features of Himachal Pradesh has had a bearing on the socio-cultural and economic characteristics of the state.

As compared to other states of the plains of the Indian Union, Himachal Pradesh belongs to the group of Hill states. Therefore, it elicits special interest in the study of the health services of the state. It becomes essential to study the ways and means by which the district health administration over comes these problems and supervises the primary health care units.

REVIEW OF LITERATURE

The Health Survey and Development (Bhore Committee, 1946) Committee[1] felt that both the curative and preventive health services were totally inadequate. The Committee opined that the hospitals and dispensaries for providing medical relief to the people, particularly in the rural areas, were insufficient and quality of such services was very poor. The Committee recommended that :

a) No individual should fail to secure adequate medical care because of inability to pay for it.

b) Health services should provide all consultant laboratory and institutional facilities for proper diagnosis and treatment.

c) The health programme must start from the very beginning, lay special emphasis on preventive work.

d) As much medical relief and preventive health-care as possible should be provided to the vast rural population of the country. Health services should be placed as close as possible to the people in order to ensure the maximum benefits to the communities to be served. The unit of health administration should, therefore, be made as small as is compatible with practical considerations.

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1. Government of India : Health Survey and Development Committee (Bhore Committee) Report, Vol.I-IV, Delhi, 1946.

e) Health consciousness should be stimulated by providing health education on a wide basis as well as by providing opportunities for the individual participation in local health programme.

Health Survey and Planning Committee[2] (Mudaliar committee, 1959-61) recommended to start mass campaign of certain diseases like tuberculosis, small pox, cholera, leprosy and filariasis. Paramedical personnel should be given further necessary training in other diseases, in order to, make them multipurpose personnel and allocate them to urban and rural centres. These should be one Auxiliary nurse midwife for every 5000 population and Auxiliary health worker for double that population. Integration of medical and health services should not be postponed.

The study group on Hospitals[3] (Ajit Prasad Jain Committee, 1966) recommended that the total bed strength at the primary health centre should be raised from six to ten. It suggested that by 1976 at least one of the sub-centres in the block should be raised to the status of Primary Health Centre to reduce the burden of the existing Primary Health Centre. The lady doctor for the family planning work at the

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2. Government of India : Report of the Health Survey and Planning Committee (Mudaliar Committee), Ministry of Health, 1959-61, New Delhi.

3. Government of India : Report of the Study Group on Hospitals (Ajit Prasad Jain Committee, 1966), Ministry of Health, Family Planning and Urban Development, New Delhi.

Primary Health Centre should always be in addition to the lady medical officer on health side. The laboratory technician at the Primary Health Centre should be utilized to undertake sample of stool, urine and blood tests of the patients attending the Primary Health Centre. The Committee suggested that one of the existing allopathic dispensaries should be upgraded in any block or which do not have any Primary Health Centre. Accommodation facilities should be provided to the doctors. There is a need for the setting up of an out-patient department and emergency services, special hospitals, T.B. Clinics, Mental Hospitals to the status of the Primary Health Centre.

Kartar Singh Committee[4] (1973) recommended for multi-purpose worker's scheme. All the basic health services for a target population of 5000 are to be delivered by one female and male worker. The doctor who is incharge of the primary health centre should have the overall charge of all the supervisory and health workers in his area.

An evaluation study conducted by the Government of

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4. Government of India : Committee on Multi-purpose workers under Health and Family Planning Programmes (Kartar Singh Committee) Report, Ministry of Health and Family Planning, New Delhi, 1973.

Andhra Pradesh[5] in 1973 on the working of the Primary health centres, has pointed out a number of inadequacies in achieving the objectives of the Primary health centres and made a number of recommendations on the powers and functions of the medical officers, the role of Block Development Officers, importance of training and the necessity of providing conveyance to the field staff.

The Srivastava Committee[6] (1974) suggested the following measures :

"A nationwide network of efficient and effective services suitable for our conditions, limitations and potentialities should be evolved.

Steps should be taken to create bands of para-professionals or semi-professional health workers from the community itself to provide simple protective, preventive and curative services which are needed by the community.

Between the community and the primary health centre, there should be two cadres of health workers and health assistants.

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5. Government of Andhra Pradesh, "Evaluation Study on the working of the Primary health centres in Andhra Pradesh", Government Secretariat Press, Hydrabad, 1973.

6. Government of India : "Report of Study Group on Medical Education and Support Manpower (Srivastava Committee), D.G.H.S., New Delhi, 1974.

The Primary health centres should be provided with an additional doctor and a nurse to look after the maternal and child health services.

The possibility of utilising the services of senior doctors at the medical college, regional, district or taluka hospital for brief periods at the Primary health centre should be explored.

The Primary health centre as well as taluka, tehsil, district, regional and medical college hospitals should develop direct links with the community around them, as well as with one another within a total referral services complex.

The Government of India should constitute under an Act of Parliament a Medical and Health Education Commission for co-ordinating and maintaining standards in medical and health education on the pattern of University Grants Commission." (Government of India "Report of Study Group on Medical Education and Support Manpower (Srivastava Committee), D.G.H.S., New Delhi, 1974).

The Alma Ata Declaration[7] enjoined the concept of primary health care, which advocated among other things,

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7. World Health Organisation and UNICEF (1978) : "Primary Health Care : Report of the International Conference on Primary Health Care", Alma-Ata, USSR, Ganeva, WHO.

community self reliance and involvement in health service decision making. National health administrators were asked to provide integrated health services-curative, preventive, promotive and rehabilitative-to those who have had little or no access to health care. According to Banerji (Banerji, D.,(1991) "After Alma Ata", 'Health Action', June, issue-I, P.3) this requires considerable political, administrative and technological inputs and more important, is a sustained effort and a great deal of patience. However, during the 1980's a number of vertical initiative were undertaken by International agencies in an effort to divert attention away from the lack of basic survival needs. He explains at length elsewhere, how this concept of self reliance and democratisation of the health services has been manipulated by the ruling classes by using their economnic and political muscle, to impose their technocentric programme on the third world (Banerji, D (1987), "The Alma Ata Declaration on Primary Health Care and After unpublished, CSMCH, SSS, JNU).

In "A Survey of Research in Public Administration"[8] brought out by the Indian Council of Social Science Research during, 1975, makes it clear that only macro studies in the sphere of health have been undertaken,

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8. Kulkarni, V.M., "A Survey of Research in Public Administration, Indian Council of Social Science Research, New Delhi, Allied publishers.

that too on a peace meal basis. The survey reveals the necessity to undertake micro studies.

Goel[9] has done lot of work in the sphere of health care administration. He has written four books. In all these books he has emphasized the significance of health and how such an important aspect could not receive proper attention of the Central and State Governments. He stressed the need for designing a sound administrative system that helps to achieve the objective of health policy and recommended that those who are responsible for delivery of health care must be subjected to proper training courses.

Sethi[10] identified the problem areas in the sphere of health as : low priority for health, poor health consciousness, the poor made to pay for the rich, iniquitous health structure and insignificant global commitments. He advocated for decentralised health-care and national focus for health programmes.

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9. a. Goel, S.L., "Health Care Administration"
   i) "Ecology, Principles and Modern Trends", 1980
   ii) "Policy-Making and Planning", 1981
   iii) "Levels and Aspects", 1981
   b. Goel, S.L., "Public Health Administration", Sterling Publisher Pvt. Ltd., New Delhi, 1984.

10. Sethi, J.D., "Health and Development - A new focus", Indian Journal of Public Administration, vol. XXVI, No.3, July-Sep, 1980.

Murali Manohar and Rameshwaram[11] pointed out the reasons for the medicos not willing to serve in the rural areas because of their urban culture and their integration with modern medicine. They advocated for appointment of village health workers on the lines of Chinese barefoot doctors.

A study has been done by Dr. D. Banerji[12] in eleven primary health centre villages and 8 non primary health centre villages. The major findings among other things were demand for western medical care services, poor images of ANM/LHV in accessibility of hospital staff and facilities. The findings according to Dr. Banerj,i have two implications that are of far reaching significance.

1) "That there is considerable felt need for all types of health and family planning services. The task before health administrators is that of taking suitable steps to meet these un met felt needs; and

2) There is considerable unused capacity in the existing health services of the country. The task here is that of mobilising this unused capacity to meet the already existing unmet felt needs for health services.

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11. Murali Manohar, K. and Rameshwaram, G., "Why medicos dislike serving in villages", Kurukhshetra, Vol.XXIX, No.13, May 1-15, 1981.

12. Banerji, D. (1982) : "Poverty, Class and Health Culture in India", vol. 1, New Delhi, Prachi Prakashan.

Mere quantitative additions to the existing structure of health services will amount to subsidisation of in efficiency and waste, at a time when the available resources are so scares".

Srinivasan[13] stressed that health care is one of the most important of all human endeavours to improve the quality of life of the people and commented on the inadequacies of the health care services.

Maya Reddy[14] pointed out that shortage of drugs at the primary health centres is the end result of improper utilisation of scarce resources. The author indicated that two sets of factors predominate and create an artificial shortage of essential drugs. These are standardized budget allocations for the purchase of drugs and standardized distribution of items to the various primary health centres.

Virmani[15] undertook a study on the various aspects

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13. Srinivasan, S., "How adequate are our Health-care Services?", Kurkhshetra, Vol.XXXII, No.3, December, 1983

14. Maya Reddy, "Drug Shortage in Primary Health Centres, The Indian Journal of Social Work, Vol.XLIV, No.3, Oct, 1983.

15. Virmani, B.R., "Female Health Worker and Health Care Services", The Indian Journal of Social Work, Vol. XLV, No.1, April, 1984.

of female health workers, job profile, personnel and administrative policies having a bearing on their performance and their acceptance by the community. To improve the performance standards of the health workers, he suggested for modification of existing personnel policies.

Satyanarayana Rao[16] commented on the absence of uniform policy on health, defective administrative structure, the problem of co-ordination and accountability, non-association of specialists in the policy formulation and pleaded largely for improving the internal organisation of the eight large teaching hospitals in the state.

Summing up

The problems in the sphere of health care have been studied by various authors, committees and research scholars. They have by and large succeeded in identifying various problems and much more so the shortcomings inherent in the health policies and the administrative structure, procedures and practices.

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16. Satyanarayana, Rao. A.V., "Public Health Administration in Andhra Pradesh, Aleem, M.A. (Ed.) Allied Publishers Pvt. Ltd., New Delhi, 1985.

The review of the studies done so far and the literature available, shows that the family planning, has been studied in depth and the rest of the aspects like health care, in rural areas, hospitals, maternity and child health care services, sanitation, water supply, drugs, health administration have also been covered. Despite all this, the number of studies conducted on Himachal Pradesh is negligible. Especially, no studies on health or health administration, have been under taken on Shimla District of Himachal Pradesh.

THE STUDY

Upliftment of the health standards of the people living in the villages, through the National health programmes is the main task of the district health administration and its peripheral units. It is an uphill task of organizing and providing the people with preventive, curative promotive and rehabilitative services. There are several inherent difficulties of this sector like being considered as a consumption sector and the resulting impediments of lack of funds, manpower and infrastructure. Especially, the health services takes a different dimension when it comes to be related to a hilly and remote state like Himachal Pradesh. Remote in the sense of social contact and communication and transportation, resulting in handicap in implementation of the various National health programmes. Reaching the sparsely located villages and towns is in itself a determinant factor. All these obstacles make the task of the district health organisation in the state even more tough to accomplish.

In this study, effort has been made to understand how the district health administration in Himachal Pradesh is functioning because of its a-typical nature. It becomes essential to see whether the administrative principles and procedures are being observed or not. All this necessitate a comprehensive study of the district health administration.

Objectives of the Study

i) The first objective of the study is to understand the functioning of the district health organisation and its units, linkages between the district organisation and its units and the various administrative procedures with its various ramifications.

ii) The second objective of the research is to study whether the increased emphasis on primary health care approach is reflected in the district health organisation or not.

iii) Attempt will also be made, to see whether there is understanding about the primary health care, national health programmes and social problems among the health care staff.

The district health organisation will be studied with the purpose of understanding its functioning, administrative lacunas and problems in achieving efficiency. The ways and methods through which the district organisation and the field staff interacts. Communication motivation and delegation of authority in the district health organisations will also be studied. By the uses of questionnaires the opinion of the staff at the district and in the field will be studied.

Lately, there has been lot of emphasis on the primary health care approach. The study will also see whether this emphasis is being shown by the district health administration and its units at the implementation level or not. The awareness of the personnel to the health and various social problems will also be studied.

Selection of the Area of the Study

Shimla district of Himachal Pradesh was selected as the field area of the study because it is a hilly state, with cold climate and tough geographical terrain. So also, it has a different set of problems, which distinguishes it from the other states of the Nation Himachal Pradesh has twelve districts and Shimla district was chosen for the study because being the district in which the state capital is located it has better facilities available. Although even now there are areas in the district which are inaccessible still it is better than the other districts. Therefore, it would be like looking at the best, which the state can provide.

Shimla district has twenty four primary health centres. Initially it was planned to study at least 50% of the primary health centres and at least one primary health centre from each of the eight blocks but because of heavy snowfall and blockage of roads due to landslides, visits

only to nine primary health centres could be made. These primary health centres were selected randomly and on the basis of accessibility and convenience. Similarly, two sub centres under each of the eight primary health centres were visited but it was possible only to collect information from thirteen of them as most of the other sub centres had closed down or the workers were not coming at all. The teaching hospital (Indira Gandhi Medical College, Shimla) was also included in the study because several cases of referral were being sent regularly from the primary health centres to the teaching hospital directly.

Methodology

The following methods were used for collecting the data:

i) Analysis of records and documents

ii) Observations

iii) Interviews

Analysis of records and documents

Records and documents were collected from various sources i.e.,

i) Directorate of Health Services, Himachal Pradesh, Shimla.

ii) Directorate of Economics and Statistics, Himachal Pradesh, Shimla

iii) Office of the Chief Medical Officer, Deen Dayal Upadhyay Hospital, Shimla

iv) Various primary health centres visited by the researcher.

Together information about the number of institutions, their location, number of staff and various other basic facts related with the study. These official documents were studied to get the official picture of the health services and where ever possible it was compared with the actual conditions in the primary health centres and sub centres. It helped a lot in finding out discrepancies between the official documents and the actual reality. Especially this method helped a lot in finding the difference between the number of primary health centres, sub centres and the number of staff as shown in the official records and in reality.

Observation

During the visits to the hospitals, (Teaching hospital and district hospital) the primary health centres and sub centres careful observation was made of the infrastructural facilities, of the various units the services being provided and the over all state of affairs of the district hospital and other peripheral units. This helped in getting a complete and realistic picture of the health administrative system.

Observations were made through out the course of the field study. In the process of the research, interview schedules were administered to the doctors and the field staff this necessitated a visit to all these places. These occasions were also used to observe the building of the hospital/unit its location (especially the primary health centres and the sub centres) accessibility, the facilities which were available and were being provided. This also gave a chance to see whether the staff was really working or absent.

Interviews

Separate interview schedules[1] were prepared to interview and systematically collect information from:

i) The district health administrators
ii) Doctors of the District hospital
iii) Doctors of the primary health centres
iv) Medical Superintendent of the Teaching hospital (Indira Gandhi Medical College, Shimla)
v) Doctors of the Teaching hospital
vi) Workers of the sub centres

The questions were mainly pertaining to the National health programmes, administrative procedures,

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1. Appended in appendix 1-6

personnel motivation, primary health care approach and other similar informations which would enhance our understanding about the functioning of the district health organisation. The questions were generally open end questions requiring qualitative information.

As it turned out later, that most of the doctors were too busy to be interviewed, but instead they offered to fill up the interview schedules. So most of the information collected through the schedules was actually filled in by the doctors themself. Only after getting back the schedules, when certain columns/questions were found unanswered, that again these questions were put to the doctors verbally by the researcher. This way it was possible to conduct only a few interviews.

Data Collection

Data was collected mainly from the official records and documents (secondary data) and by administering interview schedules (primary data) . The secondary data are mainly pertaining to the number of institutions, their locations, number of staff available and special facilities available in these institutions etc. The main sources of secondary data were the Directorate of Health and Family Welfare, the office of the Chief Medical Officer and all the Primary Health Centres and sub centres.

Statistics related to demographic and socio-economic indicators were collected from the Directorate of Economic and Statistics, Himachal Pradesh, Shimla. All the statistics collected was used in the form of tables or otherwise.

Primary data were collected by interviewing the doctors and other health staff at the various levels of health organisation hierarchy. Interview schedules were administered and all the required data were collected and tabulated.

Data Analysis

Secondary data were taken from the documents, reports and Directory of the Directorate of Health services and used primarily for getting the facts such as number of institutions (i.e. primary health centres and sub centres), there locations staff available etc. This statistics was used to compare with the existing institutions in the district, to get the true picture.

Primary data were collected through interview schedules. Since, different schedules were used for the district hospital, district health administration, teaching hospital, primary health centres and sub-centres, therefore, different set of tables were prepared for each of them. All the responses were tabulated and the other qualitative data

were used as such to draw inferences. The tabulation was carefully done so that its qualitative content was not lost. All the tables were very carefully studied and analysed to get at the conclusion.

PROCESS OF DATA COLLECTION

For conducting the field work of the study the investigator sought permission from the Director, Health Services. When the investigator went to meet the Director, he could not meet the Director for the first five days as the Director was on tour. Despite the researchers regular visits, he could not meet the Director, because the Director, was always either meeting the Secretary, Health or the Health Minister. So, the researcher had to give his application to the P.A. of the Director, who some how got it sanctioned, from the Director. Still, the Director himself, refused to give an interview or fill up the schedule. The deputy Director, also refused to be interviewed or to fill up the schedule. Ultimately, the researcher met and requested the Asstt. Director, who was incharge of the Immunisation Mission, Himachal Pradesh who himself being a research scholar, offered to fill up the schedule.

Having sought the permission of the Director, Health services, the investigator approached the Chief Medical Officer, of Shimla District, for his response and permission. The permission was granted but he refused to be interviewed or to fill up the schedule, giving the excuse that he was very busy. He asked his subordinate, the District Health Officer, to fill up a schedule on his behalf and later on he signed on it.

In the Chief Medical Officers' Office, there were only three programme officers, i.e. T.B., Health Officer and Family Planning. The Leprosy Programme and the Immunisation programme is looked after by the District Health officer. The researcher went in person to meet and request all the four district health officers i.e. C.M.O., D.H.O., D.F.P.O. and D.T.B.O. (Chief Medical Officer, District Health Officer, District Family Planning Officer and District T.B. Officer) to give him some time. So that he could get their responses. As they were all very busy and could not be interviewed, they offered to fill up the schedules themself. It took ten days time to collect the response from these officers.

Then the researcher met the doctors of the District hospital, Shimla (Deen Dayal Upadhyay Hospital). He visited all the departments of the hospital and requested the doctors for an interview. The doctors said that they were busy and could not be interviewed but they offered to fill up the schedule. Some of the doctors took the schedule and lost them several times. Even after taking several copies of the interview schedule, they did not give their response. There was a seventy per cent loss of schedules. Those who returned the interview schedules left questions unanswered and when requested to give a response they said that they did not like it (the questions).

Then the researcher visited the primary health centres in Shimla district. There are eight blocks in Shimla District i.e.

i) Rampur

ii) Theog

iii) Chaupal

iv) Jubbal

v) Rohru

vi) Chhohar

vii) Kasumpti-seoni

viii)Kumarsain

out of which, he was able to visit five blocks i.e. Theog, Jubbal, Rohru, Kasumpti - Seoni and Kumarsain. There are twenty five Primary Health Centres in Shimla district (although the 1991 Directory of the Directorate of health and family welfare shows 31, but as this directory came out in 1992, the study was planned according to 1990 directory). The investigator visited nine primary health centres i.e. Matiana, Balag (Theog Block), Kiari, Kalbog (Jubbal Block), Tikker (Rohru Block), Baragaon (Kumarsain Block) Dhami, Seoni and Mashobra (Kasumpti Seoni Block).

All these Primary Health Centres were located at a distance and reaching them was quite a problem especially with the oncoming snows. There were huge traffic blocks and twice, the investigator was cut out from the rest of the nation by heavy snow falls. He had to even push buses along

with fellow passengers to get it out of ice slush. To top it all, after facing all these hardships when he reached the primary health centres, the doctors were sometimes not present.

The first primary health centre that the investigator visited was Mashobra. Officially there were four doctors including a Block Medical Officer (Block Medical Officer is a senior doctor under whose supervision all the other doctors of the block work. Every block has a Block Medical Officer), who was a lady doctor. The researcher could not meet the Block Medical Officer because she had gone away on leave. Out of the remaining three two were absent. The doctor whom he met told him that the doctors who have political approach are arrogant and do not visit the primary health centre. They also use their approach to get better posting at the cities.

The most important feature that the investigator noticed in the primary health centres is that despite being full fledged primary health centres most of them had only one doctor and inadequate staff. Even in the primary health centres where there were more than one doctors only one was found present/working and the rest were absent. The second important feature was the large number of sub centres under one primary health centre. The Chart shown at primary health centre, Mashobra showed 52 sub centres under it

(although the directory of the Directorate of Health and Family Welfare, 1990 gives a different picture i.e. it shows a proper balance between the number of primary health centres and the sub centre that is 3 primary health centres and 42 sub centres in all).

The infrastructure at most of the primary health centres were not adequate and where it was adequate (example: Primary Health Centre, Matiana) it was not put to use. Lot of rooms were left vaccant and had become pegions abode. Most of the sub centres had only one worker. The percentage of male workers was more than double of the multi-purpose female workers. Therefore, it became a problem to get proper representation from female workers. The conditions of the sub centres was not good and the workers were mostly absent as it happened in most of the cases. Most of the workers that the investigator could meet was made possible only through the primary health centre camps and not in the sub centres.

The doctors of the primary health centres were very busy and therefore, they refused to gives an interview but instead took the interview schedule and offered to fill it up. In this process the researcher lost several schedules. Even after several visits some doctors did not give their response. The researcher, visited 9 primary health centres but got responses only from eight primary

health centres. Only at the primary health centre, Matiana the researcher got two responses back from one primary health centre, may be because the doctors were husband and wife. The response of the doctors were mixed. Some of the doctors confidently pointed out the drawbacks in the health administration, where as some of the doctors were hesitant. Only a few doctors filled up the schedule.

Questions like:

i) We keep hearing about the primary health care approach. what is it?

ii) What is the role of primary health centres in primary health care approach?

iii) What role do you prescribe for the people in the planning and implementation of their health care?

iv) It is said that in India 50% of the population is living below the poverty line. Being an intelligent citizen of the country you may be reflecting on this fact?

   a) In your opinion what are the reasons for the majority of the people being poor?

   b) What is poverty line and where does it exist?

v) 80 per cent of the Indian population lives in the villages. What are the implications for the health field?

were disliked by the doctors and most of them did not give response to the questions. Later, when the investigator questioned them about these questions, they refused to reply, which made the investigator feel that they did not know the answers. However, these questions are of much social relevances and a proper understanding of these

will improve the efficiency of the doctors.

Another feature that the investigator found was that Shimla being the capital of the state had the district hospital as well as the state hospital which is also a teaching hospital. Cases were referred to the teaching hospital directly from the primary health centres bypassing the district hospital. Also in the cases, where proper attention was not given to the patients at the district hospital, the patients were shifted to the teaching hospital.

This necessitated, that the researcher conduct a study in the teaching hospital also. Therefore, he had to seek the permission of the Medical Superintendent and the Director, medical Education. The Medical Superintendent granted the permission, but refused to give an interview. He took a interview schedule and instead of filling it up himself, gave it to the deputy medical superintendent to fill up. It seemed that the medical superintendent was afraid to commit himself in writing. The deputy medical superintendent also did not fill it up himself but got the responses typed on the schedule. This shows the bureaucracy instilled among the personnel (leading administrators) of the health services. The Director of Medical Education also seemed afraid because he refused to be interviewed or to fill up the schedule. Neither, he gave permission to contact and interview the interns and the registrars. The

reasons that he gave was that there are good students and bad students and he was not sure, what they would give in, as their response. Also he said that he had to protect the image of the institution.

The Director, Medical Education issued a letter[1] from his office, allowing the researcher to question only the head of departments (so that the researcher could get only those responses that he wanted i.e. official version). It seems that the Director thought that the students were on the war path and would not answer properly to the investigators questions. It turned out so, that the head of the departments were not present in their office and the investigator could not meet them, despite regular visits. Therefore, he was forced to interview the young interns and registrars, without the permission of the Director. The response rate was very good (close to 70%).

Problems faced in data collection

The problems faced in data collection were as follows :

i) Lot of time was lost in getting permission for conducting the research, as most of the Chief Executives i.e. Directors of Health & Family Welfare and Medical

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1. Appended in appendix No. 7

Education, the Chief Medical Officer were either on tour or busy attending meetings. The study was delayed by almost a month which limited, the number of primary health centres and sub-centres that the researcher could cover.

ii) Visiting the rural areas was a major problem because of three reasons :

a) heavy snow fall and road blocks in the area;

b) although the distances were not very much but due to the terrain and the snow it took a lot of time to cover the area; and

c) intense cold made it a big problem for the researcher to stay in the village.

iii) One major problem faced by the researcher, was that of meeting the doctors. Being the winter season most of the doctors were on leave and due to the shortage in staff the remaining doctors were very busy providing services. Under such circumstances, it was a tough problem to convince the doctors to give interviews. Most of the doctors refused to give interviews, but later, on persistent requests, they agreed to fill up the interview schedules.

iv) Incomplete responses was another problem. The doctors left a lot of questions unanswered. So, the researcher had to visit them again and again to get their responses. Despite that, some of the doctors refused to reply.

v) Lot of time was lost in finding out and meeting the multi-purpose health workers (Male & female) because most of the time they were not available at the sub-centres. So the investigator had to wait for them at the primary health centre on camp days to get their responses.

Despite these hurdles/problems the researcher was able to complete the study in time.

PRESENTATION OF DATA

The data thus collected, has been presented in this Chapter. It has been dealt with, in a simple manner. The schedules of the various levels of the district health organisation have been presented separately i.e. the schedules of the district health administrators, district hospital, primary health centres have been presented separately. The responses coming from each level has been further sub divided again in different categories, so as to simplify the understanding. The questions pertaining to different aspects such as administration, referral system, national programmes have been given under separate sub-headings.

The responses which are uniform, are presented in a statement form and where they are diverse there they are presented in the form of tables. The percentage of the frequency of a response has been given just to make it possible to give a clear picture.

PRESENTATION OF THE RESPONSES FROM THE DISTRICT HEALTH ADMINISTRATORS

Out of the total of eight district health administrators, whom the researchers met, only four

responded to the schedule. The administrators who responded to the schedules are the Asstt. Director (in-charge, Immunisation mission, Himachal Pradesh), Chief Medical Officer, Shimla District, District Health Officer and District Tuberculosis Officer (DTBO). The officers who did not respond were, the Director, Health and Family Welfare, two Deputy Directors of Health and Family Welfare and the District Family Planning Officer.

National Programmes

Maternal and Child Health Care:

3 out of 4 respondents felt that 60% of the female population of the district got pre and post natal care services under the Maternal and Child health care programme. They also agreed that areas like Dodra Kawar of Rohru Sub-division and Kashapath and Pandra-Beesh of Rampur Sub-division were still out of the reach of health services and the people there go without health care. The reason mentioned for it was, that it remained cut off from the rest of the district for long periods because of heavy snowfall.

Table No.1: Measures suggested by district health Administrators for further improving the efficiency of MCH programme.

S.No.	Responses	Total
i)	Opening up more institutions in the District	2
ii)	Making trained manpower available in all institutions	2
iii)	Strengthening of specialised services at sub-divisional level	2
v)	Better utilisation of Indigenous dias/VHG's	2
vi)	Posting of Health Workers in all Sub-centres	1
vii)	Better training to birth attendants	1
viii)	Creating awareness among the people	1
ix)	No response	1

Number of respondents : 4

Several suggestions were given by the district health administrators for further improving the efficiency of the programme. They included, opening up of more institutions in the district, increasing the number of trained manpower, improving the referral system and better utilisation of indigenous dais/Village health guides.

Family Planning:

3 out of 4 respondents felt that family planning programme was being preferred over the other national programmes. 2 respondents believed in having family

planning targets and 1 believed that there should be targets but not in the terms in which they were. The district health administration was involved in organising family planning camps. It was felt, that all the components of family planning programmes, should be emphasized and not merely sterilization to make the programme effective and also that it should become an integral component of primary health care. They also felt that efforts were required to make it a people movement.

Immunisation Programme:

3 respondents said that under the immunisation programme, cold chains were maintained to keep the vaccines effective.

Table No.2: Measures suggested by district health administrators for further improving the efficiency of Immunisation programme.

S.No.	Responses	Total
i)	Making vaccines available at more sites for convenience	2
ii)	Seeking cooperation of other departments in extending coverage	2
iii)	Adopting campaign approach in inaccessible areas	2
iv)	Providing health education	3
v)	Systematising of the services	1
vi)	No response	1

Most of the respondents felt that by providing health education, the efficiency of the immunisation programme could be improved. Other measures suggested by them included, making vaccines available at more places of convenience, seeking cooperation of other departments in extending coverage and adopting campaign approach in inaccessible areas.

Tuberculosis Control Programme:

Two respondents said that tuberculosis was a problem in Shimla district whereas the remaining two gave no responses.

Table No.3 Per cent of tuberculosis patients getting full course of treatment.

S.No.	Responses	Total
i)	60-80 per cent	1
ii)	10-12 per cent	1
iii)	No response	2

One respondent said that 60 to 80 per cent of the T.B. patients were getting full course of treatment, whereas another said that only 10-12 per cent got full course of treatment. The rest of the respondents did not reply to the question. Two respondents felt that the T.B. Control programme could be made more effective and the rest did not respond.

Leprosy Control Programme :

Three respondents out of four said that leprosy was a problem in Shimla district, the remaining respondent did not give any response. Majority of the district health administrators said that DDS was given as a treatment for leprosy. Only one respondent said that multi drug treatment was given.

Table No. 4: Measures suggested by the district health administrators for further improving the efficiency of leprosy control programme.

Response	Total
i) Opening of more Treatment Centres	2
ii) Involvement of Primary health care staff in detection and treatment	2
iii) Health Education	3
iv) No response	1

Most of the respondents said that health education could help a lot in improving the efficiency and efficacy of the programme. Opening of more treatment centres was also a suggestion put forward. They suggested that the primary health care staff should also be involved in detection and treatment of the cases.

Referral System :

All the respondents were dissatisfied with the referral system. They said that the referral system was not even much talked about. they also said that the referral system existed only in theory.

Promotion of Team Effort:

Table No.5: Methods used to promote group/team effort among the personnel as mentioned by district health administrators.

Response	Total
i) System is based on team work	2
ii) By providing Orientation Training	1
iii) By maintaining personal Rapport	1

Two district health administrators said that the system was based on team work. The other responses were team work was encouraged through orientation training and personal rapport. To the question, "how does the district health administration show appreciation of a good job done by a workers? The response was that the rewards and appreciation was given only for family planning work (100 per cent). 3 respondents felt that there were problems among the physicians and the technical staff.

Interaction between District Health Administration and Primary Health Centres

Table No. 6: The response of the district health administrators to the question whether they consult the primary health centres in matter of planning in:

Issues	Yes	No
i) Budget	0	4
ii) Drug distribution	3	1
iii) Target Setting	1	3
iv) Improving Efficiency	4	0
v) Overall Functioning	4	0

All the respondents said that the district health administration did not consult the primary health centres in matters of budgeting. 3 respondents said that in matters of drug distribution, the primary health centre was consulted. Again, three respondents said that primary health centres were not consulted in matters of target setting. 100 per cent respondents said that the primary health centres were consulted for improving efficiency and overall functioning. This shows that all the areas of freedom and authority have been taken away from the primary health centres and only responsibilities are given.

On the issue of preparation of budget 3 respondents said that budget comes readymade from the directorate. The major heads of expenditure enumerated by the district health administrator were medical, primary

health and family welfare.

Table No. 7: The various ways of interaction between the district health administration and primary health centres as enumerated by the district health administrators.

Responses	Total
i) Regular meetings held in CMO office attended by block medical officers	4
ii) Monthly meetings held at block level attended by field staff and district administration representatives.	3
iii) Regular tours	2
iv) Officers attending FP/EPI camps	2

The majority of respondents said that the method of interaction was predominantly, through meetings organised in chief medical officers office and block medical officers, office, attended by all concerned. The other ways of interaction are regular tours conducted by the district health administration staff and officers attending the various camps at primary health centre level.

Primary health care approach :

On the question of relevance of primary health care approach in India, the district health administrators said, that it was very relevant because India endeavoured to achieve "health for all" by 2000 AD with this approach. Only one respondent did not respond to the question.

Table No. 8: Salient features of Primary health care approach as enumerated by district health administrators.

Responses	Total
i) Primary health care is essential health care	3
ii) It is first contact care	3
iii) It is socially acceptable and economically viable	3
iv) It involves community participation	3
v) It depends upon a technology which is affordable, available and acceptable	3
vi) No response	1

Three respondents gave a very accurate picture of primary health care approach. They said that primary health care is essential health care, based on first contact. It involves community participation and is socially acceptable and economically viable. One respondent did not answer the question.

Table No. 9: Opinion of the district health administrators, whether primary health care approach takes a different dimension in the hilly area of Shimla district.

Responses	Total
i) Different parameters are to be adopted e.g. sub centre for smaller population then 5000	2
ii) Better community participation	2
iii) More intersectoral coordination	2
iv) More training facilities/opportunities	2
v) Not precisely	1
vi) No response	1

Two respondents said that the primary health care approach took a different dimension in the hilly area of shimla district. They said that different parameters had to be adopted for example: Sub-centre for smaller population than the fixed norm of 5000. They said that in the hilly areas better community participation was required. Also, more inter sectoral coordination and more training facilities/opportunities were required in hilly areas. One respondent did not agree that the primary health care approach took a different dimension. The remaining respondent did not respond.

Three out of four respondent said that reforms had been brought about in the organisation, keeping in view, the primary health care approach. One did not respond.

Table No. 10: The reforms that have been brought about in the organisation, keeping in view, the primary health care approach.

Responses	Total
i) Better infrastructure development	2
ii) More human resource development	2
iii) Inservice reorientation of staff	2
iv) Opening of sub centre and community health centres for less population	1
v) No response	1

Most of the respondents said that there had been several reforms in the organisation. Most important ones are, better infrastructure, human resource development, reorientation of staff and expansion of the organisation. However, all these reforms are part of the overall organisation growth.

Table No. 11: Suggestions put forward by district health administrators for further improving the health organisation, in consonance with the objectives.

	Responses	Total
i)	Better Supervision at all levels	2
ii)	More coordination with agencies specially at village level	2
iii)	Due modifications are made when needed	1
iv)	no response	1

For further improvement in the organisation the respondents have suggested better supervision at all levels and better coordination with agencies at village level. One of the respondents has said that due modifications are made whenever needed. One respondent did not respond.

Dissemination of information :

Table No : 12 : Methods that have been adopted to disseminate information to the masses about :

i) Food & nutrition ii) Water cleanliness

iii) Sanitation iv) MCH care

v) Immunisation vi) Education.

	Responses	Total
i)	Distribution of printed material	3
ii)	Health education talks	2
iii)	Film shows by mass media unit	3
iv)	Orientation training	2
v)	Through personal counselling to patients	3
vi)	Service camps	2
vii)	no response	1

Most of the respondents said that distribution of printed material, film shows by mass media unit and personal consulting were the most common method of information dissemination to the masses.

Peoples Participation in Health Care :

Three respondents opined that people should take active part in planning and implementation of health services. Whereas one respondent said that people have no

direct role , but their opinion as raised through their representatives should be considered.

General Awareness :

When the district health administrators were asked, "It is often said that doctor as a team leader, In your opinion who are the members of the health team ?" the administrators came up with a long list of the para medical workers. The list runs as follows :-

Table No. 13 : Members of the health team as enumerated by the district health administrators.

	Responses	Total
i)	Doctors	2
ii)	Pharmacist	2
iii)	Staff nurse	2
iv)	Auxiliary staff	2
v)	Anaesthesist	2
vi)	O.T. Astt.	2
vii)	Labsman	2
viii)	Health educators	3
ix)	Health supervisor	3
x)	Health worker	3
xi)	VHG/Dai	3
xii)	Private practitioner	1
xiii)	Village level leaders	1
xiv)	Anganwadi workers	1
xv)	ICDS supervisors	1
xvi)	All the paramedical staff	1

The list is almost exaustive It has also included the private practitioners and the village level leaders in its list of "health team" members.

Table No. 14 : Duties of the health team as mentioned by the district health administrators.

Responses		Total
i)	Curative services	2
ii)	Preventive services	2
iii)	Promotive services	2
iv)	To provide health care	1
v)	To coordinate and help implement the programme	1

Two of the respondents have included curative, preventive and promotive services in the duties of the health team. Whereas, the other have given a very general reply.

Different response were given for the wide spread poverty, when they were asked "why the majority of the people were poor?" They are as follows.

Table No. 15: Reasons for the majority of the people being poor.

	Responses	Total
i)	Imbalance between resources and population	3
ii)	Unemployment	2
iii)	Illiteracy/Ignorance	3
iv)	Out dated technology	2

v)	Poverty is a vicious circle (lack of capital)	2
vi)	Lack of Industrialisation	1
vii)	Majority dependent on agriculture	1
viii)	Our set up	1

Illiteracy and population explosion were the major reasons, as enumerated by respondent, of wide spread poverty. Unemployment, lack of capital and out dated technology were also mentioned as causes for poverty.

Two respondents said that Rs. 152/month for urban areas and Rs. 131.80/month for rural areas was the demarcation line or line of poverty, below which all were considered below the poverty line. One respondent said that Rs. 6400 or less annual income are categorised as below the poverty line. One respondent did not respond.

Table No. 16: Implications of a huge rural population for the health field.

	Responses	Total
i)	Contact between community & Health services becomes less	2
ii)	Delivery of services becomes difficult	2
iii)	Management of epidemics, emergencies requires lot of time	2
iv)	Health manpower reluctant to go to the rural areas	2
v)	The problem is out reach	1
vi)	Should create a village oriented health care structure	1

The district health administrators said that the contact and services between the rural population & health services becomes less. Management of cases, epidemics and emergencies became a problem. Also manpower problem would arise.

PRESENTATION OF THE RESPONSES FROM THE DISTRICT HOSPITAL

The response rate in the district hospital was 27.27%. Only 3 out of the 11 doctors, whom the researcher met and talked, responded to the schedule. The loss rate was around 72%.

Referral system:

100% respondents said that cases were referred from the PH C to the District Hospital. 2 out of them said that these referred patients got preference in treatment at the district hospital, the rest said that no preference was given. The doctors said that only complex cases, requiring investigations & needing surgical intervention were referred. Emergency cases were also referred. When asked about their opinion, about the referral system, two doctors gave vague reply, whereas one doctor said that referral system was not adequate.

Drugs Supply:

The respondents said that the drugs were bought by the chief medical officer and supplied to them. Two doctors

said that only Brand named drugs were given to them, the remaining doctor said that both brand named and generic drugs were given to them. 100% respondents said that life saving drugs were kept at the district hospital and that it was indented to sister 1/C and used as and when required. They also said that the drugs were not adequate for their requirements.

Personnel :

Table No. 1: The staff working in the district Hospital as enumerated by the doctors.

	Responses	Total
1)	M.O. Office Incharges	1
ii)	Male MOs	1
iii)	Female MOs	1
iv)	Pharmacists	1
v)	Matron	1
vi)	Ward Sister	1
vii)	Staff Nurse	1
viii)	Trained midwifes	1
ix)	Class IV	1
x)	Sweepers	1
xi)	Clerical Staff	1
xii)	dont have adequate details	1
xiii)	no response.	1

Number of respondents : 3

2 of the respondents did not have any information about their staff and did not respond to the question. Only one doctor was able to tell some thing about it. When asked, whether it was the full sanctioned staff, 2 doctors said yes and one said no. On the question of adequacy of the staff, again two doctors said that the staff was adequate and one doctor said it was not. The respondents did not know whether there was any post going unfilled or not Their responses were vague.

Motivation :

Table No. 2: The methods used by doctors at district hospital to promote group/team effort among the personnel.

	Responses	Total
i)	By group discussion	1
ii)	By appreciation	1
iii)	By frequent department meeting	1

It seemed that each doctor adopted his/her own way of promoting team effort. Different responses were received from each doctor. When asked, how they showed appreciation of a good work done by a worker, the answers were.

Table No. 3: Appreciation shown to the worker for a good work done, by the doctors

	Responses	Total
i)	No Provision	1
ii)	Verbally	1
iii)	Certificate of appreciation	1
iv)	Complimentary gifts	1

However, it became amply clear, at later stages, that certificate of appreciation and complimentary gifts etc. were given only for family planning work. Therefore,only response no. 1 and 2, seem to be honest.

On being asked, whether there were some problems between the physicians and the technical staff, 2 doctors said no and one doctor said that there were so many problems and it happens many times.

Preparation of Budget :

Two respondents said that they did not prepare budget and that it was prepared by the Chief medical officer. The third respondents gave a response enumerating the basis of preparation of budget, i.e. on the basis of bed strength, number of patients and status of institution. Two respondents said that the funds provided was not adequate.

Only one doctor said that it was best know to the CMO. Asked whether, there were any other source of funds, most of the doctors said no. Similarly on the issue of the various heads of expenditure 2 doctors did not respond and the third said that it was best known to the CMO. Two respondents said that there were rules and regulations governing expenditure, the third doctor said that it was known only to the CMO.

Primary Health Care approach:

Two respondents said that primary health care approach meant taking care of preventive aspect of health. It also included nutrition, family planning, MCH and immunisation under its ambit. The third response was vague. On being asked about the relevance of primary health care approach to India, two doctors gave a vague reply and only one said it was very relevant in reducing infant mortality and promote family welfare. Response to the question, whether the district hospital played a key role in primary health care approach, the response was simply yes (100%) . Similarly, they responded by simply saying yes, when asked whether the primary health care approach took a different dimension in the hilly areas of Shimla district.

Asked about organisational reforms in consonance with the objectives (i.e., primary health care approach) two doctors gave vague response whereas one doctor said that there were no reforms brought about in the organisation.

Table No. 4: Suggestions put forward for further improvement in the organisation, by district hospital doctors.

	Responses	Total
i)	By providing technical Staff & equipment at all institutions.	1
ii)	Not at present	1
iii)	No response	1

This shows, how vague the doctors are, in their responses. Providing technical staff and equipments, is a necessity, only after this, we can consider further improvement.

Dissemination of Information:

Table No. 5: The various methods that the doctors have adopted to disseminate information to the masses about :

i) Food & Nutrition ii) Water cleanliness

iii) Sanitation iv) MCH

v) Immunisation vi) Education

	Responses	Total
i)	By charts	2
ii)	By orientation classes/sessions	1
iii)	Visiting homes.	2
iv)	Anganwadi workers	1
v)	Mass Media	1
vi)	Para Medical staff	1
vii)	Public Health procedures	1
viii)	Best known to MO & programme officer	1

These are all regular methods of information dissemination. However, the last response, is very intriguing. The doctors are passing the buck around and trying to shift responsibilities on others.

General awareness

The question "what role do you prescribe for the people in the planning and implemention of their health care ?" went mostly unanswered. What ever responses came were all vague.

Table No. 6 : Members of the health team as enumerated by the doctors of the district hospital.

	Responses	Total
i)	M.O. 1/c	2
ii)	M.O. Male	1
iii)	M.O. Female/Lady	1
iv)	Pharmacist	1
v)	Matron	1
vi)	Ward Sister	1
vii)	Staff nurse	1
viii)	Trained midwifes	1
ix)	Class four	1
x)	Sweeper	1
xi)	Clerical Staff	1
xii)	Paramedical Staff	1
xiii)	No responses	1

Two doctors gave inadequate/no response simply, by saying paramedical staff or not replying at all. Only one doctor gave a full list. 2 doctors said that the duties of the health team is to provide health care services. The third doctor did not respond.

Table No. 7: Reasons for the majority of the people being poor, as mentioned by the doctors

	Responses	Total
i)	Defective policies	1
ii)	Vested interest	1
iii)	Illiteracy	3
iv)	lack of implementation	1
v)	Malnutrition	1
vi)	Over population	1
vii)	Lack of motivation	1
viii)	Lack of awareness of health	1

Maximum doctors mentioned illiteracy as the major cause of poverty. Defective policies, vested interest and lack of implementation are different sides of the same problem. One of the regular reasons was population explosion. When asked about poverty line, all the doctors did not answer the question. There was no response to the question, "80% of the Indian population lives in the rural areas. What are the implications for the health field ?"

PRESENTATION OF THE RESPONSES FROM THE PRIMARY HEALTH CENTRE

The researcher visited nine primary health centres and met twelve doctors and requested them for an interview. But most of the doctors refused to give an interview, as they were busy, but offered to fill up the schedules. The response rate was 75% (9/12)

NATIONAL PROGRAMME

Maternal and Child Health Care :

100% respondents said that maternal and child health care programme is supervised by female health supervisors. 88.8%, 44.4% and 33.3%, doctors said that MCH was supervised by Medical Officer, ANMs and Female Health Worker, respectively. Respondents even included Male Health Supervisor as responsible for supervising the MCH programme. All the respondents said that pre and post natal care services were handled by the ANMs, FHWs and FHS (Auxiliary Nurse and Midwife, Female Health Worker and Female Health Supervisor, respectively) by enrolling the cases and providing with MCH services. Clinical services are also provided, wherever needed.

Table No.1: The support given by the primary health centre to the Auxiliary Nurse and Midwives.

Responses	Total
i) T/D Kits	8
ii) Medicines	4
iii) Vaccines	2
iv) First Aid Kit	3
v) Orientation Training	1
vi) Meetings to sort out problems	1

Number of Respondents : 9

Most of the respondents enumerated all type of kits and medical equipments and facilities which were given to the ANM, to help in her services. Only one respondent said that meetings were held to sort out the problems, faced by the ANMs, which was a very positive step towards, bolstering the morale of the workers, for better services.

On the question of supervision of the ANMs 88.8% of the respondents said that ANMs were supervised by Female Health Supervisors and Medical Officers. 11.1% respondents said that male health worker, doctors and block medical officers were responsible supervision of the ANMs. It is supervising how they could include Male Health Worker, as one responsible for supervising the Auxiliary Nurse Midwives. It shows their ignorance.

44.4 per cent respondents said that if a difficult case came up, they referred it to the district hospital and 55.5 per cent said that it depended on the case.

Table No. 2 : Measures suggested by the Primary Health Centre Doctors, for further improving the efficiency of MCH programme.

Responses	Total
i) Orientation Training	6
ii) Increase in staff	2
iii) Health Education	2
iv) More Kits	1
v) Improvement in Infrastructure	1
vi) Better Facilities for Staff	3
vii) Stop Political Interference	1
viii) No response	1

The most prominent suggestions are orientation training (66.6%), Better facilities for the Staff (33.3%), increase in Staff and health education (22.2%). More kits and improvement in infrastructure are not important suggestions, because it is questionable, whether we lack in these facilities.

Family Planning :

Most of the doctors said that the family planning programme was organized through family planning camps. Only 44.4% respondents said that along with family planning camps regular services were provided at the PHC level and also through multi purpose workers. 100% respondents said that they had fixed targets to achieve in the family planning programme. The major criteria for deciding the targets for the workers was population and area covered by the worker.

However, how the targets were divided in the hierarcy, was not mentioned by the doctors.

Table No. 3 : The various rewards given by the PHC for achieving the family planning targets.

Responses	Total
i) Favorable Reports in ACRs	8
ii) Prize Distribution (Cash & kind)	9
iii) Certificates	6
iv) Medals and Shield	2
v) Momentoes	1
vi) Punishments (no punishment)	9

There are many rewards for family planning work. Prizes, certificates and favourable comments in the Annual Confidential Reports are given to workers . There are no punishments for failing to achieve the targets.

100 per cent respondents said that family planning programme was given preference over other programmes. Health education and better transportation facilities were the two important suggestions given by the doctor for further improvement of family planning programme.

Immunisation Programme :

The immunisation programme was organised through immunisation camps (100%) and through regular immunisation facilities at the PHC (66.6%). The vaccines were kept effective through cold chains (100%) (i.e. vaccine

carriers/ice box).

Table No. 4: Measures suggested by the Primary Health Centre Doctors to further improve the universal immunisation programme.

Responses	Total
i) Health Education	1
ii) Transportation Facilities	4
iii) Improve Refrigeration Facilities	5
iv) Better Facilities at PHC & SC	1
v) No response	2

Major suggestions put forward, included improvement of refrigeration facilities, transportation facilities. 2 doctors did not respond to the question.

Tuberculosis Control Programme:

88.8% doctors said that tuberculosis was not a problem in Shimla district. Only one respondent said that it was a rare disease. The most important methods of T.B. case detection as enumerated by the doctors were sputum examination (88.8%), X-ray examination (88.8%). The other methods were clinical (22.2%) symptoms (11.1%) and one of the doctors did not respond to the question. 88.8% doctors said that T.B. patients were not treated at the PHC.

Leprosy Control Programme

All the respondents said that leprosy was not a

problem in Shimla district. 66.6% doctors said that leprosy patients did not come to the PHC for treatment, 22.2 per cent said that they did come and 11.1 per cent did not respond. For leprosy case detection, 66.6 per cent doctors said that clinical test were undertaken, 44.4 per cent said physical examination was done.

Multi drug treatment was considered effective by 55.5 per cent doctors in terms of cost and cure and single drug treatment by 33.3 per cent. One respondent said that multi drug treatment was better in terms of cure and single drug treatment in terms of cost, for leprosy.

Referral System :

100 per cent respondents said that patients were referred from the PHC to the district hospital. 66.6 per cent said that the referred patients got preference in treatment at the district hospital 22.2 per cent said they did not get preference and 11.1 per cent said they got preference sometimes. On being asked, which type of cases were referred to the district hospital, the doctors said complex cases which could not be handled at the PHC level or which required further investigations.

55.5 per cent respondents said that the referral system was not satisfactory and that it required further improvement. 44.4 per cent said that it was good.

Drug Supply :

On the question of supply of drugs 100 per cent respondents said that they got it from the district hospital. One of the respondents, also said that drugs were procured from the state hospital which proved wrong on further investigation. 100 per cent respondents said that the drugs were not purchased, but supplied to them. 55.5 per cent doctors said that drugs were given only to the poor and needy patients, whereas 44.4 per cent said that it was given to all the patients.

88.8 per cent doctors said that both brand named and generic drugs were supplied to them and only one doctor said that generic drugs were supplied to the PHC. 100 per cent respondents said that life saving drugs were provided to them and that they were used whenever required. They also said that drugs were not adequate for their requirements.

Personnel :

66.6 per cent doctors said that the personnel available at the PHC were not adequate. Only 33.3 per cent said that personnel were adequate in numbers. 77.7 per cent doctors said that there were several posts going vacant. 22.2 per cent said that no post was going unfilled.

Motivation :

Table No.5: Methods used by the PHC doctors in promoting group/team effort among the personnel.

Responses	Total
i) By Encouraging	3
ii) By Teaching	2
iii) By Organising Meetings	5
iv) By personal Contact	3
v) By Motivation	1
vi) By Discussion	3
vii) By Delegation of Authority & Responsibility	1
viii)Appreciation of Work	1

All the doctors used their own method of encouraging the personnel and promote group/team effort. Only organising meetings and delegation of authority and responsibility were the two official ways of promoting group/team effort.

Table No. 6 : The various ways adopted by the doctors at PHC level to show appreciation of a good work done by a worker.

Responses	Total
i) Certificates and consolation prizes in family planning prize distribution	2
ii) Good comment/remark in the ACRs (help in Promotion)	7
iii) Appreciation (personal)	4

Good comments/remarks in the Annual Confidential Report was the most favourite method of showing appreciation

(77.7%), second came personal appreciation (44.4%).

100 per cent respondents said that there were no problems between the physicians and the technical staff.

Decision Making Process :

Table No. 7 : Does the district health administration consult the primary health centre in matters of planning in.

		Responses	Total
i)	Budget	Yes	0
		No	9
ii)	Drug Distribution	Yes	0
		No	9
iii)	Target Setting	Yes	1
		No	8
iv)	Improving Efficiency	Yes	6
		No	3
v)	Overall Functioning	Yes	6
		No	3

In matters of budget, the district health administration did not consult the PHC (100%). Similarly, in drug distribution also the PHC was ignored (100%). In target setting, only one respondent said that the PHC was consulted whereas, the others said that the PHC was not consulted (88.8%). In improving efficiency and overall functioning, 66.6% respondents said that the PHC was consulted whereas the rest said that PHC was not consulted.

Budget Preparation :

88.8 per cent respondents said that the budget was not prepared by them and that it was prepared by the BMO or at the district level. 11.1 per cent did not respond to the question. 77.7 per cent respondents said that the budget provided to them was not adequate. 11.1 per cent said that it was not known to him and 11.1 per cent did not respond to the question. 100 per cent respondents said that there was no other source of funds other than government funds.

The various heads of expenditure were not known to the doctors (100%). They said only the block medical officer knew about the expenditures. 77.7 per cent respondents said that there were rules and regulations governing expenditure and two respondents do not answer the question. This shows that in budgetary matters and expenditure the doctors have no role to play and they take less interest in it.

Problem faced by Doctor :

Table No. 8: Problem faced by Doctor working in the PHC

Responses	Total
i) Education for Children	8
ii) Transportation Facilities	7
iii) Accommodation Facilities	3
iv) Lack of Staff in PHC	1
v) No Extra Benefit as we also work on holidays	1
vi) Interference from Politicians	1
vii) Low Standard of Life	1
viii) Monetary Problems	1
ix) Social problems	4
x) Lack of facilities	2
xi) Cold Zone	1

Education for children, transportation facilities and social problems were the main problems indicated by the doctors (88.8%, 77.7% and 44.4% respectively). Primary health centres should be located in such areas, that these problems do not arise. Some of the problems are however, very critical and need to be dealt immediately. When asked what measures they would suggest for making any improvement in their life pattern, they said that all the above mentioned problems should be removed.

Interaction between the district health administration and primary health centres. :

Out of the various ways of interactions, between the district health administration and the primary health centres, the most important ones and regularly put to use, were meetings (88.8%) followed by discussions (22.2%) and through block medical officer (11.1%)

Primary health Care Approach :

Only, 44.4 per cent respondents gave answer to the question on primary health care approach. They said that it was preventive, promotive and curative services at the doorstep and in the form acceptable to the people. One respondent said that it was basic care. 44.4 per cent respondent did not respond to the question. A look at all the responses showed that the doctors were not very clear

about the primary health care approach. Similarly, when asked what was the role of PHC in primary health care approach, 77.7% said it was critical but they could not substantiate the answer. It showed their ignorance. Two respondents did not answer the question.

66.6% respondents said that primary health care approach took a different dimension in the hilly areas of Shimla district, 33.3% said it did not. 88.8 per cent respondent doctors said that no reforms had been brought about in the organisation, keeping in view the primary health care approach. Only 11.1 per cent said that reforms had been brought about, for example, more stress on preventive care like immunisation and MCH was given.

Table No. 9: Suggestions for further improvement in the organisation as put forward by PHC doctors.

Responses	Total
i) Health Education to be Provided	2
ii) Facilities should be increased	3
iii) Referral System Should be Improved	3
iv) Infrastructure should be Improved	1
v) Better Transportation Facilities	1
vi) Better perks to the Staff	1
vii) No Response	2

Several important suggestions were given to improve the health services. 33.3 per cent doctors suggested that the referral system should be improved. They also said that facilities should be increased. Health education was

one suggestion that was given everywhere. Better transportation, infrastructure and perks are common suggestions.

Dissemination of Information :

Table No.10: The various methods, that have been adopted to disseminate information to the people about:

i) Food and Nutrition ii) Water Cleanliness
iii) MCH iv) Immunization
v) Education.

Responses	Total
i) Health Education by Individual Approach	7
ii) Camps for People	3
iii)By Importing Training to Health Workers	1
iv) T.V. programmes	3
v) Radio Talks	1
vi) Educational Charts	8

Educational Charts and Health Educational by individual approach were the most common method of information dissemination used by the doctors at the PHC level. Camps for people were also organised for providing the people information about food and nutrition, water cleanliness etc.

General Awareness :

Variety of responses were given, by the doctors, when they were asked, that what role they prescribe for

people in the planning and implementation of their health care. 22.2 per cent doctors said that they should give their suggestions for improvement. Another 22.2 per cent doctors said that people should take active part. 33.3 per cent gave vague response and 22.2 per cent did not respond to the question.

Table No. 11: The members of the health team as enumerated by doctors of the PHC

Responses	Total
i) Nurses	4
ii) FHS	2
iii) Technicians	4
iv) Radiographers	1
v) Pharmacists	1
vi) CHVs	1
vii) Social Workers	1
viii)FHWs	1
ix) MHWs	1
x) MHS	1
xi) Opinion Leaders	1
xii) All the Health Staff	5
xiii)Doctors	1

A majority of the respondents (55.5%) simply wrote, "all the health staff". This shows either they avoided elaborating or they did not take interest. In the same way they wrote that the duties of the health team was to provide health care which is a very simple reply. What was expected was a comprehensive explanation of the duties of the health team.

Table No. 12: The reasons for the majority of the people being poor as mentioned by the PHC doctors.

Responses	Total
i) Majority of People are Uneducated	9
ii) Unplanned Families	2
iii) Lack of proper Leadership	1
iv) Lack of Capital	2
v) Lack of Infrastructure	2
vi) Political Interference	3
vii) Lack of Enterprenueral Skills	1

100 per cent respondents said that illiteracy was the major cause of poverty followed by political interference, lack of capital, infrastructure and unplanned families (33.3%, 22.2%, 22.2% and 22.2% respectively).

Except one doctor, all others did not answer the question, "what is poverty line and where does it exist?" Even this doctor gave a definition of poverty line and could not tell about where it exists. His definition is "This is a line between the people i.e. the one who do not have the basic amenities of life and on the other side the rest.

Table No. 13: Implications of a huge rural population for the health field.

Responses	Total
i) It means more challenge	1
ii) Inability to serve the masses therefore need to improve by organisational reforms and motivation to personal	2
iii) More efforts	2
iv) Better training to doctors to cope up with situation	1
v) More infrastructure required	1
vi) Vague response	1
vii) No response	1

No clear trends emerged in this question. All the responses were different. Some doctors felt that it meant more efforts (22.2%) some said that it was a handicap and that reforms had to be brought about along with better motivation for the people to be able to serve the rural populations. Some doctors also wanted better training to the doctors, so that they could cope up with the situation.

PRESENTATION OF RESPONSES FROM THE SUB CENTRES

After visiting 18 sub centres, it was possible only to meet 14 health workers out of which 11 were male health workers and 3 were female health workers.

Maximum respondents were locals from the sub centre area only, except a few, who came from distant places as far as 12 kilometers. Maximum workers cover the area under the sub centre, on foot.

Maternal and Child Health Programme :

Questions concerning the maternal and child health programme were put to the female health workers only. When asked how much area/population, they had been able to provide with, pre and post natal care, 66.6% said "as much as possible" only 33.3% said, "all the area".

Table No. 1: Pre and post natal care services given to the expectant mothers by the ANMs

Responses	Total
i) Immunisation	3
ii) Vitamins, Iron and Folic Etc.	3
iii) Education	1
iv) Contraceptives & Preventive Measures	2
v) Help	2
vi) Check and Monitoring	1

Number of Respondents: 3

100 per cent workers said that immunisation, Vitamins, Iron, Folic etc. were given to the expectant mothers. 66.6 per cent said that contraceptives and preventive measures and what so ever help required was given. Check and monitoring was also done. The interesting thing was that, education was also given to the expectant mothers, to cope up with the situation.

The female health workers said that there was no area left that they had not covered (100%). Whenever, needed they also referred cases to the PHC. 66.6 per cent workers said that the referred patients did not always get preference in treatment. 33.3 per cent said that referred patients got preference.

Malaria Programme :

54.54 per cent health workers said that they had no role to play in malaria case detection. 45.45 per cent

said that their role in case detection was to just give medicine as precaution. 27.27 per cent did not respond to the question. The malaria prevention measures that they took were spraying (81.81%) telling people about preventive measures (45.45%) and giving medicines (27.27%). The only service they gave to the malaria patient was to give chloroquin (100%).

Family Planning Programme :

100 per cent respondents said that they had to achieve a fixed target during a fixed time span. They also said that they had to give preference to the family planning programme work over other programmes. When asked whether the work could be done in a better way, 64.28 per cent workers said 'no', 28.59 per cent said 'yes' and 7.14 per cent said 'don't know'.

Table No. 2: The rewards and Punishments for achieving Family planning targets.

Responses	Total
i) Certificates	14
ii) Momentoes	3
iii) Cash Prizes	13
iv) Award to PHC	2
v) Prize	3
vi) No Punishment	6

Number of Respondents : 14

The most common method of rewarding the workers was certificates (100%) and cash prizes (92.8%) 42.85 per cent said that there were no punishments for failing to achieve the targets.

Immunisation Programme :

100 per cent respondents said that in the difficult terrain of Shimla district, the vaccines were kept effective through vaccine carriers.

Tuberculosis Control Programme :

64.28 per cent workers said that they had no role to play in the treatment of T.B. patients. 35.71 per cent workers did not respond to the question. When asked about the procedures of case detection, 42.85 per cent said that they did not know, 50 per cent did not respond to the question and 7.14 per cent said that the T.B. cases were referred. 35.71 per cent workers did not know, what per centage of the patients were taking full course of treatment. 64.28 per cent did not respond.

Leprosy Control Programme :

On the question of their role in detection of leprosy cases 35.71 per cent workers said 'no role', 21.42 per cent workers said 'that cases of leprosy do not occur' and 42.85 per cent workers did not answer the question. When

asked how they helped a leprosy patient 71.4% did not answer, 14.28% said that there were no Leprosy case, 7.14% said no role and 7.14% said "donot know".

Referral System :

Fourteen out of fourteen respondents said that, cases were referred from the sub centre to the primary health centre. 64.28 per cent workers said that these referred patients got preference in treatment, 28.57 per cent said, 'sometimes' and 7.14 per cent did not respond to the question.

Table No. 3: The type of cases that are referred to the Primary Health Centre from the sub centre.

Responses	Total
i) All cases	6
ii) Most of the Cases	2
iii) Difficult Cases	2
iv) Doctors do it	2
v) Patients themselves go	2

There was no fixed criterion, for referring cases to the PHC. Some workers said that all the cases were referred, some said that most of the cases were referred. Only a few said that difficult cases were referred. Workers also said that, now patients themselves go to the PHC. Vague response such as doctors do it, was also given. 71.42 per cent workers said that the referral system worked, 28.57 per cent said that it did not work always.

Drug Supply :

92.85 per cent (13/14) health workers from the sub centre said that drugs were supplied from the primary health centre. Only one respondent said that they got the supply of drugs from the teaching/state hospital i.e. Indira Gandhi Medical College.

Table No. 4: Type of Drugs supplied to the sub centre.

Response	Total
i) All the types required	5
ii) Vaccines	6
iii) Chloroquin	6
iv) Mala D & N	2
v) Nirodh	3
vi) Iron	7
vii) Folic	7
viii) Bandage	3
ix) Chlorine	3
x) Vitamins	5
xi) ORS	1
xii) No response	1

The workers enumerated all the drugs, vaccines, first aid etc., that they got from the PHC. 35.7 per cent simply said that all the required drugs etc. were provided by the primary health centre. Rest of them gave elaborate list of drugs etc.

57.14 per cent health workers said that the drugs were adequate, whereas 42.85 per cent said that the drugs were not adequate for their requirements.

Personnel

8 respondents out of fourteen said that there was only one worker in the sub centre. Five said there were two workers and one workers did not respond to the question. 57.14 per cent respondents said that the number of workers was adequate and 42.85 per cent said that it was not. 92.85 per cent respondents said that there were not community health volunteers under their sub centre. Only one worker said that there were CHVs under his sub centre.

Interaction between PHC and the sub centre :

There was no set procedure of giving orders and directions to the workers. However, the majority of orders came from the block medical officers. Even doctors gave directions to the sub centre workers.

Table No. 5: The methods through which the health workers inform their superiors.

Response	Total
i) Report on the Camp day	7
ii) By filling Tables	1
iii) Monthly progress Report	10
iv) By Reporting to Superiors	1
v) Through Meetings	2

Monthly progress report was the most regular method of reporting progress. However, verbal reporting was

also done on the camp day, when the doctors visited the sub centre.

Motivation :

64.28 per cent workers said that, rewards were given only for family planning work. 14.28 per cent workers said that, certificates were given for good work.

100 per cent respondents said that the workers were not consulted by the primary health centre in matters of functioning/working. 64.28 per cent workers said that they were never consulted in any matter. 35.71 per cent workers did not respond to the question at all.

Table No. 7: The problems faced by the workers working in the sub centres.

Responses	Total
i) Educational Problems	9
ii) Transportation	7
iii) Accommodation	5
iv) Politics	1
v) Bad Roads	1
vi) Less Pays	6
vii) Lesser Facilities	3
viii) Isolation From Family	1
ix) Cold Weather	3
x) Lack of Staff/Workers	2
xi) No. Problems	1
xii) Security	1

The major problems faced by the workers were education for children (64.28%) transportation (50%)

monetary problems (42.85%) and accommodation problems. There was also a worker who said he had no problems. The suggestions, they gave, to remove all the problems were generally vague. They simply said that all these problems should be removed. They said schools should be opened, more pay should be given etc. One respondent said that hard decisions have to be taken to remove these problems.

PRESENTATION OF RESPONSES FROM THE STATE/TEACHING HOSPITAL

The response rate at the State/teaching hospital was seventy per cent. The investigator met 10 doctors (registrars and interns) out of which 7 doctors responded to the interview schedule.

Referral System :

100 per cent respondents said that they receive a lot of referred cases in the hospital. Four out of seven respondents said that the referred patients got preference in treatment, two said that the patients did not get preference and one said 'not always'. 100 per cent doctors said that they gave treatment to those patients also, who came without a referral.

Table No.1: Type of cases referred to the teaching hospital

Responses	Total
i) Difficult cases which cannot be managed	2
ii) cases of tertiary care	1
iii) Those which cannot be diagnosed at primary Health Centre	3
iv) All type of cases	1

Number of respondents: 7

Generally, only those cases were referred to the State/teaching hospital, which could be managed or diagnosed at the lower levels.

Table No.2: Opinion of the doctors of the teaching hospital about the referral system.

Responses	Total
i) Defective	4
ii) Indispensable	1
iii) Satisfactory	1
iv) Useless	1

The opinion of the doctors of the state/teaching hospital about the referral system was not good. Only one doctor said that the referral system was indispensable. Four respondents said that it was defective and one said it was useless.

Drug Supply :

When asked, "how do you get drugs?", three doctors said that they got it from the hospital store. The rest of the responses were from private chemists, government supply to hospitals and through medical suprintendent. Six out of seven doctors said that the drugs supplied to them was not adequate.

Primary Health Care Approach :

Table No.3: Salient features of primary health care approach as enumerated by the teaching hospital doctors.

Responses	Total
i) To provide comprehensive care	1
ii) Preventive, Promotive Curative	1
iii) Essential Health care	3
iv) Universally avilable and Acceptable	3
v) Affordable to People	3
vi) People Participation	1
vii) Vague response	2

In response to the question of relevance of primary health care approach, most of the respondents said that it was very relevant, because India has a large rural population and to cater to its health needs, the primary health care approach was essential.

100 per cent respondents said that primary health care approach took a different dimension in the Hilly areas. However only 3 respondents out of seven explained it further. They said that it took a different dimension because hilly areas have difficult terrain/inaccessible areas, peculiar social and cultural traits and similar other problems, so the coverage of the population becomes a problem.

Four respondents out of seven said, that reforms had been brought about in the organisation keeping in view, the primary health care approach. Two doctors said that no reforms had been brought about and one respondent did not answer the question. However, no one was able to clearly tell, what were the reforms which have been brought about. All the four of them gave vague responses. Asked for further suggestion for improvement of the organisation, most of them wanted expansion of health care facilities, equal emphasis on all the national programmes, better facilities to the staff and workers and better training to the workers. They also said that the peripheral system should be strengthened.

Table No. 4: Members of the "health Team" as enumerated by the Doctors of Teaching Hospital.

Responses	Total
i) Nurses	4
ii) Male Health Worker	5
iii) Female Health Worker	6
iv) Village Health Guide	5
v) Trained Dais	1
vi) Doctor	4
vii) Male Health Supervisor	2
viii)Female Health Supervisor	2
ix) Social Worker	1
x) Block Development Staff	1
xi) Occupational Therapist	1
xii) Anganwadi Workers	1
xiii)Irrelevant Response	1

The list of the members of health team is a long one, including almost every one. However, only four responses were satisfactory.

Table No. 5: Duties of the Health Team as pointed out by the doctors

Responses	Total
i) To provide health care services	6
ii) To educate people	3
iii) To Provide preventive, promotive and curative service	1
iv) Survelliance	1
v) Family Planning Service	1

Six respondents simply said, that the duty of the health team was to provide health care services. 3 respondents said that the duties include educating people. Two respondents included preventive, promotive and curative services in the list of services. Only one respondent said that survelliance was also a responsibility of the health team.

General Awareness:

Table No. 6: Reasons for the majority of the people being poor.

Responses	Total
i) Defective social system	2
ii) Excessive Bureaucratisation	1
iii) Corruption	4
iv) Lack of political will to alleviate poverty	1
v) Inadequate exploitation of vast natural resources.	1
vi) Lazy, non-enterprising people	1
vii) Gross over population	3
viii) Lack of education	2
ix) Ignorance of the people	1

Corruption, over population, illiteracy and defective social system were the major reasons enumerated by the doctors for the mass poverty in India. Three respondents did not respond to the question on poverty line. Two respondents said that poverty line is a statistical measure. One respondent said that it was a arbitrary line, indicating the minimum standard of life of an individual. Another doctor said that poverty line is related to the GNP of a country and the per capital income.

Table No. 7: Implications of a vast rural population for the health field.

Responses	Total
i) Services have to be rural oriented	2
ii) Lack of propes infrastrucure	1
iii) Major chunk of health budget should be allocated to rural areas	1
iv) More medical specialists for rural areas	1
v) Service should be concentrated in villages	1
vi) Vague response	1

Doctors feel that the services should be rural oriented and more resources should be allocated to the rural areas. Also that, more medical specialists should be deputed to the rural areas.

Table No. 8: Suggestions given by the doctors for over all improvement of the medical services.

Responses	Total
i) Education to generate awareness	2
ii) Family Planning	1
iii) To make it a autonomous organisation	1
iv) No political interference	2
v) More funds to health care system	1
vi) Instilling a sense of duty in health care personnel	1
vii) Better facilities to health staff	3
viii)No response	1

Three doctor felt that more facilities should be provided to the health staff. Two respondents. felt that education should be provided to generate awareness among the masses. They also suggested that political interference should be stopped.

Dissemination of Information :

Table No. 9: The various methods used to disseminate information to the masses about:

a) Food & Nutrition
b) Sanitation
c) Water Cleanliness
d) MCH
e) Immunisation
f) Education

Responses	Total
i) Audio-Visual methods	2
ii) Group discussion	2
iii) Personal counselling	4
iv) Through education only	2
v) Media	1
vi) No response	1

The most famous method for the dissemination of information was personal counseling, followed by Audio-Visual methods and group discussions.

National Health Programmes

Maternal and Child Health programme :

Table No. 10: Salient features of MCH programme as mentioned by the doctors of teaching hospital.

Responses	Total
i) To teach expectant mothers about motherhood	4
ii) Identify high risk & preventive remedial measure	4
iii) Treat the nutritional problems of pregnancy	4
iv) Immunisation of Children	4
v) Safe Conducting of delivery	4
vi) Family planning	1
vii) No Response	1

Fairly accurate picture of the MCH programme was given by the doctors. They mentioned almost all the characteristics of the programme, like teaching expectant mothers about mother hood, identifying high risk and preventive remedial measures, safe delivery, Immunisation etc.

Table No. 11: Percentage of people benefitting from MCH programme.

Responses	Total
i) Cannot comment/difficult to assess	3
ii) 100% in Urban and 60-70% in rural areas	2
iii) 80-90%	1
iv) No response	1

Three respondents said, that they could not comment as it was difficult to assess. Two respondents said that 100 per cent in urban areas and 60-70% per cent in rural areas were benefiting from the programme.

Family Planning Programme:

Table No. 12: Salient features of the Family Planning Programme

Responses	Total
i) Telling people about the importance of small family	5
ii) Methods and guidance for family planning	4
iii) Improving health of mothers and children	2
iv) No response	2

Five respondents said that under the family planning programme, the people were told about the importance of small family. Four doctors said, that they told people about methods and guidance for family planning. Two respondents did not answer the question.

Table No. 13: Suggestions for making family planning programme effective.

Responses	Total
i) Providing sex education in schools	4
ii) Providing method and facilities in a better way	3
iii) Intensive health education	3
iv) Greater incentives for sterilisation	1
v) No response	1

Four respondents said, that sex education should be provided in schools. Providing methods and facilities for family planning in a better way and intensive health education were suggested by three respondents.

Immunisation Programme :

Table No. 14: Opinion of doctors of the state hospital about the immunisation programme

Responses	Total
i) Efficacy of Immunisation is doubtful	1
ii) A very good & effective programme	5
iii) No response	1

Five respondents said that immunisation programme was very effective. However, one of the respondent felt that efficacy of immunisation is doubtful.

Table No. 15: Percentage of people being benefitted from the immunisation programme

Responses	Total
i) Very few	1
ii) A large number of people	4
iii) 60-70%	1
iv) No response	1

Most of the respondents (four) said that immunisation programme was benefiting a large number of people.

Leprosy Programme :

Six out of seven respondents said that there was a leprosy control programme in Himachal Pradesh. One respondent did not respond to the question.

Table No. 16 : Main components of Leprosy Control Programme

Responses	Total
i) Health education	4
ii) Early case detection and Treatment	5
iii) To provide multi-drug therapy	4
iv) Follow up	2
v) Rehabilitation	4
vi) No response	2

Five respondents said, that early case detection and treatment were the most important component of Leprosy control programme. Four respondents included health education, multi-drug therapy and rehabilitation, as components of Leprosy Control Programme. Only two respondents said that follow up was also important. Two doctors did not respond.

Five doctors said that multi drug treatment was better than single drug treatment, because there was no chance of relapse and resistant. Two doctors did not answer the question.

Tuberculosis Control Programme :

Table No. 17: Main elements of the T.B. Control Programme. --

Responses	Total
i) Early detection via tests	5
ii) Proper Treatment	6
iii) Vaccination	1
iv) Rehabilitation	2
v) Education	2
vi) Follow up	1
vii) Survelliance	1
viii)Maintenance of Records	1
ix) no response	1

Proper treatment, early detection via test and follow up were the important elements pointed out by six five and one doctors respectively. Rehabilitation, vaccination, survelliance and education were also mentioned.

Table No. 18: Percentage of people benefiting from T.B. Control Programme

Responses	Total
i) Not many	2
ii) Lot of people	3
iii) Don't Know	1
iv) No response	1

Three doctors said that a lot of people were benefitting from this programme. However, two respondents said that not many people were benefitting.

THE PRESENTATION OF THE RESPONSE OF MEDICAL SUPRINTENDENT (TEACHING HOSPITAL)

Referral System :

The Medical Suprintendent said that as many as 25% of the patients coming to the hospital were referred cases. He said that preference in admission was given to the referred patients. Treatment was also given to the patients who came without a referral. When asked about the type of cases referred to the teaching hospital, the Medical Superintendent said that complicated surgical and medical

cases such as head injuries, trauma etc. were referred for which the facilities are not available elsewhere. He gave a very vague answer, when asked about his opinion on the referred system.

Drug Supply :

The Medical Superintendent said, that the drugs were supplied through the state civil supplies corporation, Himachal Pradesh, from the Government of India undertakings and the rest of the drugs were purchased as per the rate contract of the controller of stores, Himachal Pradesh. He said that, the drugs supplied to the hospital was adequate. He further said that, there was no provision to supply drugs to other hospitals and PHCs in the state from the teaching hospital, as the drugs were supplied to them by the concerned districts.

Budget Preparation

The Medical Superintendent said that the budget was prepared on an annual basis, keeping in view the actual expenditure in the previous year, reflecting ten per cent increase every year. A supplementary budget was also prepared. He said that the funds provided, were not adequate.

Primary Health Care Approach :

When the Medical Superintendent was asked, about Primary Health Care approach and its relevance in India he did not respond to the later question and gave a vague response to the former. He said that the Primary Health Care included opening of PHCs, SCs, upgradation of PHCs into CHCs training of health worker, immunisation etc. He also said that, primary health care approach is one of the aspects of the "Health for All" by 2000 AD in India.

He said that, primary health care approach took a different dimension in the hilly areas because of difficult terrain. He said that, one sub centre was opened for only a population of 3000 instead of 5000. When asked, "keeping in view the Primary Health Care Approach were there any reforms which were brought about in the organisation, the Medical Superintendent said that being a curative institution it did not pertain to it.

General Awareness :

The Medical Superintendent was unable to tell about the members of the health team. He said that it pertains to PSM Deptt. Indira Gandhi Medical College, Shimla. This shows his ignorance. The reason that he gave for the majority of people being poor, was that our economy was predominantly agriculture based. Unemployment and

population growth were the other reasons given. On the question of poverty line he said that, families whose income is below 6000 per annum, are below the poverty line. He said that the implications of the masses living in rural areas on health field were illiteracy, poverty, Ignorance and disease. Which is a very irrelevant response. The Medical Superintendent was satisfied with the performance of the hospital and said that there was no need for further improvement.

Dissemination of Information :

The Medical Superintendent said that, charts demonstration, lectures and health workers were the main instruments of dissemination of information, about food and nutrition, water cleanliness, sanitation, MCH, immunisation and education.

Voluntary Contributions :

The Medical Superintendent said that, there were other sources of fund also. He said that, hospital welfare was maintained to help the poor patients and contributions for this were given by volunteers.He also said that, there were provisions for accepting these donations. These contributions were made in cash form.

NATIONAL PROGRAMMES

Maternal and Child Health Care Programme :

The Medical Superintendent said that the "MCH programme is an important component of family welfare programme. It is aimed at improving the health of mothers and children under the programme. The care of mothers and immunisation of the children is undertaken. In his opinion nearly eighty per cent of the people were benefitted from the programme.

Family Planning Programme :

The Medical Superintendent said that "the family planning programme is aimed at motivating the people to accept small family norm". It is being implemented in the state on the voluntary basis. To fulfill the objectives of this national programme, the health department is soliciting the cooperation of other departments, voluntary organisations and public representatives. He suggested that, family planning should be made compulsory for eligible couples.

Immunisation Programme

The Medical Superintendent said that "under the programme, the immunisations of mothers and children with T.T., DPT, DT, BCG, Polio, Measles and Typhoid is also under taken. This programme is being carried out in the state

through a network of all the alopathic institutions. This programme is aimed at achieving universal immunisation and hundred per cent coverage of eligible infants with BCG, DPT, OPV, and measles. He said that nearly 80 per cent of people were benefitted from this programme.

Tuberculosis Programme :

The Medical Superintendent said that, the programme was aimed at erradicating T.B. from the country by detecting new cases and giving them institutional/domiciliary treatment. In his opinion majority of people were benefitting from the programme.

Leprosy :

The Medical Superintendent said that, there was a leprosy control programme in Himachal Pradesh. He could not explain the main components of the programme. He said that it was being carried out and supervised by Director Health Services. He did not respond to the question about his opinion on the multi drug treatment and single drug treatment.

D I S C U S S I O N

DISCUSSION

The encounters with the doctors and workers proved to be an interesting affair. While some of them, really gave a vivid picture of the in's and out's of the health service system, there were a few who did not respond at all. The answers varied from a simple yes to elaborative and reasoned one's. On the whole, the questionnaire session provided the researcher with ample information, so as to arrive at some definite and concrete conclusions.

Referral System:

At all the levels of the hierarchy, of the District health services, the doctors referred patients from the lower levels to higher levels. However, all the referred patients, did not get preference in treatment. Treatment was also given to those patients who came without a referral. Doctors at all the levels were dissatisfied with the referral system. The district health administrators went to the extent of saying that referral system existed only in theory. This shows their helplessness and inability to do anything to improve the system. To restore the referral system to its stipulated status, the doctors should give preference to the referred patients and should discourage those patients who come without a referral from the peripheral areas.

Drug distribution :

Drug's were supplied from the district hospital to the periphery units. The respondents at the various levels, were unanimous about the inadequacy of drugs Except the medical superintendent of the state/teaching hospital who said that drugs were adequate (The responses for the M.S of the State hospital was filled up by the Deputy Medical Superintendent) In the absence of drugs, all the national programmes and efforts put to, implement them would be sheer wastage.

Budget :

Doctors and health workers were not involved in the process of budget preparation. Prepared Budget was provided at all levels. This severely curtails the role of budget as a tool of management for growth. Since, the budget makers are not the real budget users, the intricacies of proper balance, emphasis and economy would not be clear to them. It also fails in context of accountability.

Except the CMO, BMO and the Medical Superintendent of the teaching hospital, no other doctor was aware of the various heads of expenditure, which again shows excessive centralisation.

Only at the State/teaching hospital there was a provision to accept donations from the general public for the sake of the hospital and the poor patients. Donations are a precious source of funds which should be tapped.

Personnel :

The staff was inadequate at all levels, especially at the primary health centres and sub-centres. Instead of four doctors at each PHC, only one doctor was working/appointed at most of the PHCs. At most of the sub-centres, only one multi-purpose male/female worker was deputed. In such circumstances, the incessant demand for expansion of the infrastructure seems to be futile. For a PHC and SC to give proper performance, at least the stipulated staff should be appointed.

Motivation :

Meetings, discussions and verbal appreciation were used as methods of motivation by the doctors. For, the family planning programme work, of course, the health administration gave cash prizes, certificates and also favourable remarks in the ACR's (Annual confidential reports) This has given undue emphasis on one programme, resulting in the ignorance of other programmes by the workers.

National Programme :

The incidence of tuberculosis was negligible in the district. Leprosy was also not a problem in the district. MCH programme was not being in implemented properly, because the sub-centres (most of them) had only one health worker, male or female. If only male health worker is working in the SC then MCH programme could not be handled properly and if only a female health worker, then she would be over burdened with all the programme's works especially the family planning programme (from which she is benefitted). Support to the ANM's was given only in the form of kits, medicines, first aid box etc.

Family planning programme was given maximum preference, at the cost of other programmes. Targets were set and accepted at all the levels by the personnel. Rewards were give for family planning work only.

Primary Health Care Approach :

The concept of the primary health care approach, was not very clear among the doctors. Only, the district health officer and a few doctors were able to give a clear picture of the approach. Although, all of them said that the approach was very relevant in Indian context, but they could not substantiate it.

Organisational Reform :

The reform process was not undertaken in the district health services in Shimla district. The response given by the doctors were vague or relating to organisational growth. The significance of reforms was not understood by the doctors. Some of them even said that, reform does not pertain to the health institutions.

People's Participation :

Although, lady doctors talked about people's participation they were not clear, how people could contribute in health care. The respondents gave vague responses. They could not foresee any relevant role for the people except giving suggestions.

Interaction between the Various levels of the district health care organisation:

The ways of interaction between the various levels of the district health care organisation was limited only to meetings, which was seldom used. The higher levels of the health institutions (in the hierarchy) rarely consulted the PHC's and sub-centres in matter's of budget preparation, drug distribution and target setting.

General awareness :

Illiteracy, population explosion, corruption, agriculture based economy and political interference were the major causes of poverty as enumerated by the doctors. However, only a few doctors were able to tell exactly about the poverty line. Most of the doctors did not respond at all, to the question.

The implications of a huge rural population on health services were a big mainly challenge, need for rural orientation and more infrastructure. The respondents said it mainly meant, more out reach, staff and infrastructure, and funds earmarked for the rural areas.

Problems faced by the personnel of the PHCs and Sub Centres:

The main problems, encountered by the doctors and workers posted in the PHCs and Sub-centres were education for children, lack of transportation facilities, social isolation and cold zones. These problems were peculiar to Shimla district, as it constitutes of hilly areas only. Most of the PHCs and Sub-centres were located in interiors of the district and these problems could be overcome by development only.

Suggestions put forward by the doctors for further improvement:

Health education to the people was the most important suggestion put forward by the doctors. It is strange, that whenever, the doctors were asked for suggestions for the improvement of the national programmes or the health care system, they said that health education should be provided to the people. They did not suggest any measures for the improvement of the organisation. Increased in infrastructure, was also demanded, but when the existing infrastructure was not fully utilised how could the increase infrastructure be put to use.

The demand for more staff is genuine. Rural orientation of the health services was suggested, which if taken, would be a much appreciated step.

S U M M A R Y

SUMMARY

The objective of this study was to look into the various aspects of district health administration and primary health care in Shimla district of Himachal Pradesh. In this study, attempt was made to see that; how far the administrative procedures were followed, to enhance the efficiency and efficacy in providing health care. It included a study of the district health administration, district hospital, primary health centres and sub centres and interviews of doctors and workers at all these levels, to know the response of the personnel to these issues.

Issues relating to the implementation of national health programmes were also studied. It also focuses on the referral system, budgetary process, drug situation etc. For this purpose eight primary health centres and thirteen sub centres were visited. (although eleven primary health centres and eighteen sub centres were visited, it was only possible to get responses from eight primary health centres and thirteen sub centres.)

The national health programmes are very important for the health service system. If they are not implemented properly, then no other intervention can succeed in bringing up the health status of the people. Presently, it is only the family planning programme which is given due emphasis, whereas the other national programmes are sidelined.

However, if the other sectors of health remain weak, family planning programme alone cannot bring about the desired changes. Therefore, there should be a balanced approach to the attainment of a healthy society.

There is lot of centralisation of power. Authoritarian decision are taken, which adversely effects the morale and motivation of the personnel. Target setting, planning, budget preparation and decisions relating to drug distribution are taken at the top level. This severely effects the commitment of the workers and the doctors because until and unless they take part in these activities, they will not feel bound towards making it a success.

The interaction between the various levels of health service system are very formal and restricted. It is a limitation and hinders in free articulation of ideas and also the feed back of the services. Rewards are given only for family planning programme, which is not fair. This encourages, disproportionate efforts, of the workers to the various programmes.

A major failure, of the health services, is its inability to follow the referral system strictly. If the referral system breaks down, then the whole, primary health care approach fails. The referral system when used properly, it streamlines the organisation and divides the burden of health care properly.

A N N E X U R E S

ANNEXURE 1

INTERVIEW SCHEDULE (District Health Administration)

Research Topic : An Exploratory study of District Health Administration in Himachal Pradesh.

Name of the Respondent :

Designation :

Age :

Salary drawn :

Place of working :

Marital Status :

Number of Children :

Years of experience :

Shimla district has a difficult terrain and is different from most of the districts of Himachal Pradesh and the country in terms of geography and economy. I am, interested in knowing whether it has any bearing on the administration of the health services. Therefore, I would like to know about some aspects of health administration of the district and the functioning of National Health programmes.

1. M C H

i) How many people get pre and post natal care ?

ii) Are there places or areas which are difficult to reach and where the health services have not been able to provide MCH care services ?

iii) What measures would you suggest for further improving the efficiency of the programme?

2. Family Planning

i) Is Family Planning programme given preference over other programmes?

ii) Do you believe in Family Planning Targets ?

iii) Does the District Health Administration organise family planning camps?

iv) Do you think this programme could be made more effective?

3. Immunisation

i) Shimla district has a very difficult terrain. In such conditions, how are the workers able to keep the vaccines effective?

ii) What measures would you suggest for further improving the efficiency of the programme?

4. Tuberculosis

i) Is tuberculosis a problem in Shimla District?

ii) What percentage of TB. Patients get full course of treatment?

iii) Do you think that the T.B. control programme could be made more effective ?

5. Leprosy

i) Is leprosy a problem in Shimal District?

ii) What is the type of treatment given to the leprosy patients ?

iii) What measures would you suggest for further improving the efficiency of the programme ?

Que.2.a) What is your opinion about the referral system ?

b) Is the referral system in your organisation put to use or it is just a procedure much talked about ?

Que.3.a) How do you promote group/team effort among the personnel ?

b) How does the district health administration show appreciation of a good job done by a worker ?

c) Are there any problems between the physicians and the technical staff ?

Que.4.Does the district health administration consult the Primary health centres in matters of planning in :

i) Budget

ii) Drug distribution

iii) Target Setting

iv) Improving efficiency

v) Overall functioning

Que.5. How do you prepare your budget ?

Que.6. What are the various heads of expenditure in the district health administration ?

Que.7.The district health organisation has to take along it, all the primary health centres under it, and has to function unitedly and unidirectionally. What are the various ways of interaction between the district health administration and primary health centres ?

Que.8.What is Primary Health Care approach. What is its relevance in India ?

Que.9.Do you think that the Primary Health Care Approach takes a different dimension in the hilly areas of Shimla District ?

Que. 10.a)Keeping in view the Primary Health Care Approach, are there any reforms which have been brought about in the organisation ?

b) If yes, then what are they ?

c) Do you have any suggestions for further improving the organisation in consonance with the objectives?

Que.11 What are the various methods that you have adopted to disseminate information, to the masses about :

i) Food and nutrition

ii) Water cleanliness

iii) Sanitation

iv) MCH Care

v) Immunisation

vi) Education

Que.12 What role do you prescribe for the people in the planning and implementation of their health care?

Que. 13 It is often said that, "docter as a team leader".
a) In your opinion who are the members of the health team ?

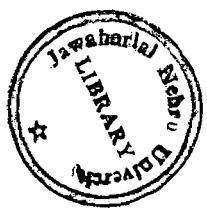
b) What are the duties of the health team ?

Que.14 It is said that in India 50% of the population is living below the poverty line. Being an intelligent citizen of the country, you may be reflecting on this fact.

i) In your opinion, what are the reasons for the majority of the people being poor ?

ii) What is poverty line and where does it exist ?

Que.15 80% of the Indian population lives in the villages. What are the implications for the health field ?



ANNEXURE 2

INTERVIEW SCHEDULE (District Hospital)

Research Topic : An Exploratory study of District Health Administration in Himachal Pradesh.

Name of the Respondents :

Designation :

Age :

Salary drawn :

Place of working :

Marital Status :

Number of Children :

Years of experience :

Shimla district has a difficult terrain and is different from most of the districts of Himachal Pradesh and the country in terms of geography and economy. I am, interested in knowing whether it has any bearing on the administration of the health services. Therefore, I would like to know about some aspects of health administration of the district and the functioning of National Health programmes.

Que.1 a) Does the primary health centre refer cases to the district hospital ?

b) Do the referred patients get preference in treatment at the district hospital ?

c) Generally, what type of cases are referred to the district hospital ?

d) What is your opinion about the referral system ?

Que.2 a) How do you get your supply of drugs ? Do you purchase drugs yourself or are they supplied to you ?

b) What type of drugs do you get :
i) Generic drugs ii) Brand named drugs

c) Does the district hospital store keep life saving drugs?

d) If yes, then what is the procedure of using it ?

e) Are the drugs adequate for your requirements ?

Que.3.a) What is the staff working in the district hospital? Please give in detail category and number ?

b) Is it the full sanctioned staff ?

c) Are the number of personnel available in the district hospital adequate ?

d) Is there any post going unfilled ?

Que.4.a) How do you promote group / team effort among the personnel ?

b) How do you show appreciation of a good work done by a worker?

c) Are there any problems between the physicians and the technical staff ?

Que.5a) How do you prepare your budget ?

b) Is the fund provided to you adequate ?

c) Are there any other source of funds, other than Govt. funds, for instance, do you get any donations from drug companies/rich people for the use of poor patients ?

d) Is there any provision for accepting these donations ?

e) If yes, do you get it in the form of :

i) Medicine iii) Cash

ii) Food iv) Equipments

Que.6.a) What are the various heads of expenditure in the district hospital ?

b) Are there any rules and regulations governing expenditure ?

Que.7.a) We keep hearing about primary health care approach what is it ?

b) What is its relevance to India ?

c) Do you think that the district hospital plays a key role in primary health care approach ?

Que.8.Do you think that the primary health care approach takes a different dimension in the hilly areas of Shimla district ?

Que.9.a) Keeping in view the primary health care approach are there any reforms which have been brought in the organisation ?

b) If so, what are they ?

c) Do you have any suggestions for further improvement ?

Que.10 What are the various methods that you have adopted to disseminate information to the masses about :

i) Food and nutrition

ii) Water cleanliness

iii) Sanitation

iv) MCH

v) Immunisation

vi) Education

Que.11 What role do you prescribe for the people in the planning and implementation of their health care ?

Que.12.a) It is often said that "doctor as a team leader". In your opinion who are the members of the health team?

b) What are the duties of the health team ?

Que.13 It is said that in India 50% of the population is living below the poverty line. Being an intelligent citizen of the country you may be reflecting on this fact ?

a) In your opinion, what are the reasons for the majority of the people being poor ?

b) What is poverty line and where does it exist ?

Que.14 80% of the Indian population lives in the villages. What are the implications for the health field ?

ANNEXURE 3

INTERVIEW SCHEDULE (Primary Health Centre)

Research Topic : An Exploratory study of District Health Administration in Himachal Pradesh.

Name of the Respondent :

Designation :

Age :

Salary drawn :

Place of working :

Marital Status :

Number of Children :

Years of experience :

Shimla district has a difficult terrain and is different from most of the districts of Himachal Pradesh and the country in terms of geography and economy. I am, interested in knowing whether it has any bearing on the administration of the health services. Therefore, I would like to know about some aspects of health administration of the district and the functioning of National Health programmes.

1. MCH

a) How is the maternity and child health care programme supervised in this PHC ?

b) How are the pre and post natal care services handled ?

c) What is the support given to the ANM's by the PHC?

d) How are the ANM's supervised ?

e) If a difficult case comes up does the PHC handles it or it is referred to the district hospital ?

f) What measures would you suggest for further improving the efficiency of programme ?

2. Family Planning

a) How is the family planning programme organised ?

b) Do you have fixed target to achieve in a fixed time span ?

c) What is the criterion of giving targets to different type of personnel? Please give in detail, which worker gets how much of targets ?

d) What are the rewards and punishments for acheiving a target and for failing to do so ?

e) Is family planning programme given preferrence over other programmes ?

f) What are the measures that you would suggest for further improving the programme ?

3. Immunisation

a) How is the immunisation programme organised ?

b) Shimla district has a very difficult terrain, in such conditions, how are the workers able to keep the vaccines effective ?

c) What measure would you suggest for improving the programme ?

4. Tuberculosis

a) Is tuberculosis a problem here ?

b) What is the procedure of case detection ?

c) Are the T.B. patients treated by the PHC ?

d) Are the patients getting full course of treatment?

e) If not, why ?

f) What per cent are getting full course of treatment?

h) What measures would you suggest for further improving the programme?

5. Leprosy

a) Is leprosy a problem here ?

b) Do the leprosy patients ever come to the PHC for treatment ?

c) How are leprosy cases detected ?

d) In your opinion is the multi-drug treatment better or the single drug treatment, in terms of cure and costs ?

f) What are the measures that you would suggest for further improving the efficiency of the programme?

Que.2.a) Do you refer patients from the PHC to the district hospital ?

b) Do the referred patients get preference in treatment at the district hospital ?

c) Which type of cases do you refer to the district hospital ?

d) What is your opinion about the referral system ?

Que.3 a) How do you get your supply of drugs ?

b) Do you purchase drugs yourself or are they supplied to your ?

c) How are the drugs distributed? Are they given to every patient or to the poor patients only ?

d) What type of drugs do you get :

i) Generic drugs ii) Brand named drugs

e) Do you get life saving drugs ?

f) If yes, then what is the procedure of using them ?

g) Are the drugs adequate for your requirements ?

Que.4 a) Are the number of personnel available in the PHC adequate ?

b) Is there any post going unfilled ?

Que.5 a) How do you promote group/team effort among the personnel ?

b) How do you show appreciation of a good work done by a worker ?

c) Are there any problems between the physicians and the technical staff ?

Que.6.Does the District health administration consult the PHC in matters of planning in :

a) Budget

b) Drug distribution

c) Target setting

d) Improving efficiency

e) Overall functioning

Que.7 a) How do you prepare your budget ?

b) Is the budget provided to you adequate ?

c) Are there any other source of funds, other than govt. Funds, for instance, do you get any donations from drug companies/ rich people for the use of poor patients ?

d) Is there any procedure for accepting these donations ?

e) If yes, do you get it in the form of :

i) Medicine ii) Food

iii) Cash iv) Equipments

Que.8 a) What are the various heads of expenditure in the PHC ?

b) Are there any rules and regulations governing expenditure ?

Que.9 a) You have been working for quite some time. What are the problems faced by a person like you in the PHC ?

b) What measures would you suggest for making any improvement in your life pattern ?

Que.10 What are the various ways of interaction between the district health administration and the PHC ?

Que.11. a) We keep hearing about the Primary Health Care approach, What is it ?

b) What is the role of PHC's in Primary health care approach ?

Que.12 Do you think that the primary health care approach takes a different dimension in the hilly areas of Shimla district?

Que.13 a) Keeping in view the Primary Health care approach are there any reforms which have been brought about in the organisation ?

b) If yes, then what are they ?

c) Do you have any suggestions for further improvement ?

Que.14 What are the various methods, you have adopted to disseminate information to the people about ?

a) Food and nutrition

b) Water cleanliness

c) Maternal and child health care

d) Immunisation

e) Education

Que.15. What role do you prescribe for the people in the planning and implementation of their health care ?

Que.16 a) It is often said that "doctor as a team leader" In your opinion, who are the members of the health team?

b) What are the duties of the health team ?

Que. 17 It is said that in India 50% of the population is living below the poverty line. Being an intelligent citizen of the country you may be reflecting on this fact ?

a) In your opinion, what are the reasons for the majority of the people being poor ?

b) What is poverty line and were does it exist ?

Que.18 80% of the Indian population lives in the villages. What are the implications for the health field ?

ANNEXURE 4

INTERVIEW SCHEDULE (Sub-Centre)

Research Topic : An Exploratory study of District Health Administration in Himachal Pradesh.

Name of the Respondent :

Designation :

Age :

Salary drawn :

Place of working :

Marital Status :

Number of Children :

Years of experience :

Shimla district has a difficult terrain and is different from most of the districts of Himachal Pradesh and the country in terms of geography and economy. I am, interested in knowing whether it has any bearing on the administration of the health services. Therefore, I would like to know about some aspects of health administration of the district and the functioning of National Health programmes.

Que.1 a) Where do you live ?

b) How far is this place ?

c) How do you go to the villages/areas covered by the SC ?

Que. 2. MCH Programme

a) To what percentage of the population, you have been able to give pre and post natal care ?

b) What type of pre and post natal care services you give to the expectant mothers ?

c) Is there any area/population you have not been able to serve and why ?

d) Do you refer cases to the PHC ?

e) Do the referred cases get preference in treatment at the PHC ?

2. Malaria Programme

a) What is your role in malaria case detection ?

b) What are the malaria prevention measures that you take ?

c) What are the services that you give to the malaria patients ?

3. Family planning

a) Do you have fixed targets to acheive in a fixed time span ?

b) Do you have to give preference to the family planning programme over the other programmes ?

c) Do you think that the work could be done in a better way ?

d) What are the rewards and punishments for achieving the targets and for failing to do so ?

4. Immunisation Programme

a) Shimla district has a very difficult terrain. In such conditions how are you able to keep the vaccines effective ?

5. Tuberculosis Programme

a) What is your role in the treatment of T.B. patients ?

b) What is the procedure of case detection ?

c) What per centage of the patients are taking full course of treatment ?

6. Leprosy Programme

a) What is your role in detection of leprosy cases ?

b) How do you help out a leprosy patient ?

Que.2 a) Do you refer patients from the S.C. to the PHC ?

b) Do the referred patients get preference in treatment at the primary health centres ?

c) What are the type of cases that you refer to the PHC ?

d) Do you think that the referral system works or it is useless ?

Que.3 a) How do you get your supply of drugs ?

b) What type of drugs do you get?

c) Are the drugs adequate?

Que.4 a) How many workers are there in this Sub-centre?

b) Are they adequate?

Que.5 Are there any community health volunteers under this Sub-centre ?

Que.6 a) How do you get orders and from whom ?

b) How do you inform your superiors about the progress ?

c) Do you get any rewards for a good work done ?

Que.7 a) Does the Primary Health centre take any suggestion from you, concerned with the functioning/working ?

b) In what matters does it take your suggestions ?

Ques.8 a) What are the problems faced by you, working in this Sub-centre ?

b) How, do you suggest, these problems could be removed ?

ANNEXURE 5

INTERVIEW SCHEDULE (Teaching Hospital)

Research Topic : An Exploratory study of District Health Administration in Himachal Pradesh.

Name of the Respondent :

Designation :

Age :

Salary drawn :

Place of working :

Marital Status :

Number of Children :

Years of experience :

The Indira Gandhi Medical College is the largest hospital of the state. Being the largest State hospital and also a teaching hospital, it has considerable influence on the health administration of the State and Shimla district in particular. I am interested in knowing its role in the health administration system. Therefore, I would like to know about some aspects of health administration and the National health programmes.

Que.1.a) Do you get many cases referred to this hospital ?

b) Do the referred patients get preference in admission at the Indira Gandhi Medical College ?

c) Do you give treatment to the patients who come without a referral ?

d) Generally, what type of cases are referred to the state hospital ?

e) What is your opoinion about the referral system ?

Que.2.a) How do you get drugs ?

b) Are the drugs supplied to you adequate ?

Que.3.What is primary health care approach. What is its relevance in India ?

Que.4.Do you think that the Primary Health Care approach takes a different dimension in the Hilly areas ?

Que.5.a) Keeping in view the primary health care approach, are there any reforms which have been brought about in the organisation ?

b) If yes, then what are they ?

c) Do you have any suggestions for further improving the organisation in consonance with the objectives?

Que.6. It is often said that "doctor as a team leader"

a) In your opinion who are the members of the health team?

b) What are the duties of the health team ?

Que.7.It is said that in India 50% of the population is living below the poverty line. Being an intelligent citizen of the country you may be reflecting on this fact ?

a) In your opinion what are the reasons for the majority of the people, being poor ?

b) What is poverty line and where does it exist ?

Que.8. 80% of the Indian population lives in the villages. What are the implications for the health field ?

Que.9. What are the suggestions that you would like to give, for over all improvement of the medical services ?

Que.10 What are the various methods that you have adopted to disseminate information to the masses about :

a) Food and nutrition

b) Sanitation

c) Water cleanliness

d) MCH

e) Immunisation

f) Education

Que.11. National Health Programmes

i) Maternal and Child health programme

a) There is a national programme for maternal and child health. What are its salient features ?

b) How many people, in your opinion are benefitting from this programme ?

ii) Faminly Planning Programme

a) There is so much talk about family planning. What is it ?

b) Can you suggest ways for making family planning programme effective ?

iii) Immunisation programme

a) What is your opinion about the Immunisation programme ?

b) How many people in your opinion are benefitting from this programme ?

iv) Leprosy Programme

a) Is there a leprosy control programme in Himachal Pradesh ?

b) If yes, Then what are its main components ?

c) What is your opinion about the multi-drug treatment and the single drug treatment ?

v) Tuberculosis Programme

a) What are the main elements of the T.B. control Programme ?

b) How many people in your opinion are benefitting from this programme ?

ANNEXURE 6

INTERVIEW SCHEDULE (Teaching Hospital)

Director, Medical Education & Medical Suprintendent

Research Topic : An Exploratory study of District Health Administration in Himachal Pradesh.

Name of the Respondent :

Designation :

Age :

Salary drawn :

Place of working :

Marital Status :

Number of Children :

Years of experience :

The Indira Gandhi Medical College is the largest hospital of the state. Being the largest State hospital and also a teaching hospital it has considerable influence on the health administration of the State and Shimla district in particular. I am interested in knowing its role in the health administration system. Therefore, I would like to know about some aspects of health administration and the National health programmes.

Que.1. a) Do you get many cases referred to this hospital ?

b) Do the referred patients get preference in adminssion at the Indira Gandhi Medical College ?

c) Do you give treatment to the patients who come without a referral ?

d) Generally, what type of cases are referred to the state/teaching hospital ?

e) What is your opoinion about the referral system ?

Que.2.a) How do you get drugs ?

b) Are the drugs supplied to you adequate ?

c) Since, this is the largest hospital in the State, do you give drugs to other hospitals and primary health centres ?

Que.3. a) How do you prepare your budget ?

b) Is the fund provided to your adequate ?

Que.4. What is primary health care approach? What is its relevance in India ?

Que.5.Do you think that the primary health care approach takes a different dimension in the hilly areas ?

Que.6.a) Keeping in view the primary health care approach, are there any reforms which have been brought about in the organisation ?

b) If yes, then what are they ?

c) Do you have any suggestions for further improving the organisation in consonance with the objectives?

Ques.7. It is often said that "doctor as a team leader"

a) In your opinion who are the members of the health team?

b) What are the duties of the health team ?

Que.8.It is said that in India 50% of the population is living below the povery line. Being an intelligent citizen of the country you may be reflecting on this fact ?

a) In your opinion what are the reasons for the majority of the persons being poor ?

b) What is poverty line and where does it exist ?

Que. 9. 80% of the Indian population lives in the villages. What are the implications for the health field ?

Que.10. What are the suggestions that you would like to give for overall improvement of the medical services ?

Que.11. What are the various methods that you have adopted to disseminate information to the masses about :

a) Food and nutrition

b) Water cleanliness

c) Sanitation

d) MCH

e) Immunisation

f) Education

Que.12 a) Are there any other source of fund, other than govt. funds, for instance, do you get any donations from drug companies / rich people for the use of poor patients ?

b) If yes, then are there any provisions for accepting these donations ?

c) Do you get it in the form of :

i) Medicine ii) Food

iii) Cash iv) Equipments

Que.13 National programmes

i) MCH

a) There is a national programme for MCH. What are its salient features ?

b) How many people, in your opinion are benefitting from this programme ?

ii) Family planning programme

a) There is so much talk about the family planning Programme. What is it ?

b) Can you suggest ways for making family planning programme effective ?

iii) Immunisation

a) What is your opinion about the Immunisation programme ?

b) How many people in your opinion are benefitting from this programme ?

iv) Tuberculosis

a) What are the main elements of the T.B. control programme ?

b) How many people in your opinion are benefitting from this programme ?

v) Leprosy

a) Is there a leprosy control programme in Himachal Pradesh ?

b) If yes, then what are its main components ?

c) What is your opinion about the multi-drug treatment and the single drug treatment ?

ANNEXURE 7

Indira Gandhi Medical College,
Shimla-171001.

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Shri Sudhir Kumar, A research Scholar of Jawahar Lal Nehru University, New Delhi , intends to study of District Health Administration and Primary Health Care in Shimla District. He is having a questionarie for this purpose. The Heads of Department, Medicine,Orthopaedics, Eye ,ENT,Surge y, Paed etc. may please render necessary assistance to Shri Sudhir Kumar for filling up this quesiotionarie and provide necessary help. However the views expressed by the concerned Heads of Department will be personal opinion.

(V.K. Bhargava)
Director-Principal.

By Circulation
Heads of Department
concerned.

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