AN ANALYSIS OF FUNCTIONING OF THE RURAL HEALTH TRAINING CENTRE - NAJAFGARH

BY

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To
My Parents

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CERTIFICATE

The work embodied in this dissertation entitled "An analysis of functioning of the Rural Health Training Centre, Najafgarh" is original to the best of my knowledge and has been carried out at the Centre of Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University, New Delhi. This work has not been submitted in part or full to this or any other university for any other degree or diploma.

DATED : 17.7.91 (JAYAPALLI BAPURAJ VIJAYSHRI)

We recommend this dissertation to be placed before the examiners for further evaluation.

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"Medicine is a social science and politics is medicine on a large scale." [Vichrow 1849]

Dedicated to - "The Hundreds and Millions of the oppressed who have been 'Target' of Motivational Manipulation, Victim Blaming and Social Marketing."

[Dedication of the book, Social Sciences and Health Services Development in India, Sociology of formation of an Alternative Paradigm by D. Banerji (1986)]

There are three kinds of lies, lies, damned lies and statistics. [Mark Twain]

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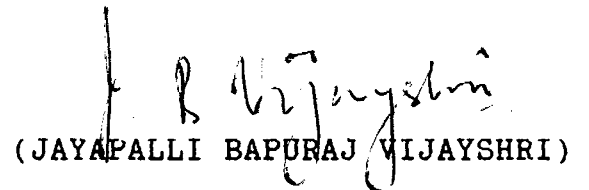

DATED (JAYAPALLI BAPURAJ VIJAYSHRI)

LIST OF ABBREVIATIONS USED

1.	ANM	AUXILLIARY NURSE MIDWIFE
2.	VHG	VILLAGE HEALTH GUIDE
3.	LHV	LADY HEALTH VISITOR
4.	MPW(F)	MULTI PURPOSE WORKER (FEMALE)
5.	RHTC	RURAL HEALTH TRAINING CENTRE
6.	PHC	PRIMARY HEALTH CENTRE
7.	CHC	COMMUNITY HEALTH CENTRE
8.	RCA	RESEARCH CUM ACTION
9.	MCD	MUNICIPAL CORPORATION OF DELHI
10.	GOI	GOVERNMENT OF INDIA
11.	MOHFW	MINISTRY OF HEALTH AND FAMILY WELFARE
12.	DGHS	DIRECTORATE GENERAL OF HEALTH SERVICES
13.	OPD	OUT PATIENT DEPARTMENT
14.	MCH	MATERNAL AND CHILD HEALTH

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CHAPTER - I

INTRODUCTION

HEALTH, HEALTH PROBLEM, HEALTH SERVICES CONCEPTUALISED

Health is a sensitive concept related to the very existence of people. It is based on the thin edge of 'being' or 'not being'. It is not just the mere absence of disease and global well being in order to work. Health is intricately related to the psyche and context of living of peoples.

A health problem is not just a manifestation of disease conditions in uncontrollable dimensions rather it is a manifestation of certain limitations in the very way of living of people. Limitations emanating from the economic, political, social and ecological ramifications complex and fragile in nature. Complex due to inter-linkages and fragile due to inequalities based within them. The outcome of these health problems are populations caught in the viscious circle of poverty and disease struggling to exist. Any effort to combat health problems would hence be linked to the social environment in the given time frame and this struggle to exist.

The health services as they exist in today's age can said to be one of the efforts to combat health problems. A health services system defined would be all organised efforts in dealing with health problems with the essentialities of scientific knowledge, technology and manpower.

It would be logical to conclude from the above conceptualisations that it is essential to understand the health services system in the relation to the above elucidated social environment to arrive at a global understanding or analysis of the health culture of people.[1,2,3]

HEALTH SERVICES RESEARCH - NATURE AND NECESSITY

Health services research has gained importance over time. This is so because the health services have failed to improve the health status of a mass of people despite high technological and huge manpower infrastructures. Even where health services have reached the people, barriers have come up for its utility and accessibility.[4,5]

The WHO has also indicated the importance of the health services research. A technical paper on this subject indicates the problems of this field viz. :

1. Complexity of health services organisation to be studied.
2. Lack of importance given by planners and decision makers to health services research.
3. Lack of interdisciplinary approach.[6]

The above leading to the present crisis in the form of total lack of data/knowledge bank on health services systems. Hence leading to blanks whenever there is an introspective evaluation on the gigantic failures of organised manual and resource exercises to deliver health services to people.

PERSPECTIVE TO THE PRESENT STUDY

The present study has the basic objective of an analysis of the functioning of a Rural Health Training Centre.

This study can said to be broadly based in the field of health services research.

The above objective does not envisage a generalistic technical qualitative analysis but aims at an analysis of the organization and the functioning of the centre over time through both secondary and primary data sources.

The present study cannot be said to be evaluative in nature rather it is a portrayal of insights arrived at after the analysis of the functions of the organization under study.

The chosen Rural Health Training Centre situated at Najafgarh, with its rich historical background can said to be a bird's eye view on the existing health services system in India.

Its dualistic functions of training facilities for health manpower and preventive and curative health services for nearby community provides an unique field area. An analysis of its functions based on preceeding conceptualisations is aimed at.

NOTES

Ideas taken from[1,2,3]

1. MIILER, H. (1973) : Medicine and Society, Science and English Policy Series

2. BANERJI, D. (1985) ; Health and Family Planning Services in India. An Epidemological Socio Cultural and Political Analysis New Delhi, Lok Paksh

3. QADEER, I. (1985) ; Health Services System in India - An Expression of Socio-Economic inequality, social Action, July

4. QADEER, I. (1990) : Beyond Medicine : An Analysis of Health Status of People Think India, vol. 2, no. 1 Jan-March.

(A comment on the negligible role of health services system in India in conjunction with the disease structure of mortality rates prevailing in India. Mortality rates had started declining before the establishment of health services in India. Death causes due to so-called tropical diseases remain so inspite of health services).

5. BANERJI, D. (1990) : A Socio-Cultural Political and Administrative Analysis of Health Policies and Programmes in India in the Eighties : A Critical Approach, Chapter Eleven, 123-130, New Delhi, Century Prints.

6. WHO SEARO (1988) : The concept of Health Services Research New Delhi, WHO SEARO.

A PERSPECTIVE AND REVIEW OF LITERATURE

A. RURAL HEALTH SERVICES AND PRIMARY HEALTH CARE IN INDIA - THE WHAT ? HOW ? AND WHY ?

NATURE :

The Rural Health Services in India is a huge infrastructure of manpower and resources trying to reach out to the very depths of the country, the village level. Figure - 1 is the diagrammatic representation of the health services system.

FIGURE - 1 : HEALTH SERVICES SYSTEM IN INDIA

MINISTRY OF HEALTH AND FAMILY WELFARE

* DIRECTORATE GENERAL OF HEALTH SERVICES

CENTRAL COUNCIL OF HEALTH

STATE MINISTRY OF HEALTH AND FAMILY WELFARE

* STATE DIRECTORATE OF HEALTH SERVICES

* DISTRICT (CMO)
* TEHSIL
* BLOCK
* P.H.C. (MO)
* SUBCENTRE (MPW)

NOTE : * indicates supported by hospitals, dispensaries, research and training institutes.

The network of health services aims at providing primary health care based on the principle of equitable distribution, community participation, intersectoral co-ordination, appropriate technology and consisting of :

1. Education of health problems and measures of prevention and control.
2. Promotion of food supply and proper nutrition.
3. An adequate supply of safe water and basic sanitation.
4. Maternal and Child Health care including family planning.
5. Immunization and control of endemic diseases.
6. Prevention and control of endemic diseases.
7. Appropriate treatment of common diseases and,
8. Provision of essential drugs.[1]

The beneficiary being the smallest unit of population in the villages is reached through the network of Primary Health Centres with the aid of village health workers (multipurpose workers) and community representatives (village health guides). This whole exercise is Government funded. The policy underlying is hence based on the state policy priorities which are influenced by global trends encompassing medicine and health.

Table - 1 presents the comparative quantitative data on primary health care in rural India at All India and Delhi levels.

TABLE - 1

PROGRESS OF PRIMARY HEALTH CARE IN INDIA

TABLE - 1a : BASIC DATA

		DELHI	INDIA
1.	TOTAL AREA AS PER 1981 CENSUS (Km^2)	1483.0	327213.0
2.	TOTAL RURAL AREA AS PER 1981 CENSUS (Km^2)	891.1	3143240.9
3.	TOTAL PROJECTED POPULATION FOR 1990	89,10,000	82,19,92,800
4.	RURAL PROJECTED POPULATION FOR 1990	4,45,500	59,94,729
5.	RURAL INFANT MORTALITY RATE	-	102
6.	RURAL DEATH RATE	8.3	12.0
7.	RURAL BIRTH RATE	30.6	33.1
8.	NO. OF INHABITATED VILLAGES	214	5,88,651
9.	NO, OF DISTRICTS	1	446
10.	NO. OF BLOCKS	5	5,134

TABLE - 1b : HEALTH INFRASTRUCTURE (RURAL)

		DELHI	INDIA
1.	NO. OF HOSPITALS	1	3099
2.	NO. OF COMMUNITY HEALTH CENTRES	INA	1852
3.	NO. OF PRIMARY HEALTH CENTRES	8	20,532
4.	NO. OF SUBCENTRES	42	1,30,392
5.	NO. OF DISPENSARIES	84	13,029
6.	NO. OF ANM/HWF TRAINING SCHOOL	2	347
7.	LHV PROMOTIONAL SCHOOL	1	45

TABLE - 1c : HEALTH MANPOWER (RURAL)

		DELHI	INDIA
1.	DOCTORS IN POSITION AT PHC	6	20175
	VACANT POSTS	-	4157
2.	BLOCK EXTENSION EDUCATORS	3	5591
	VACANT POSTS	-	517
3.	HEALTH ASTT. (M) IN POSITION	41	24504
	VACANT POSTS	7	2154
4.	HEALTH ASTT. (F) IN POSITION	48	17714
	VACANT POSTS	4	3998
5.	HEALTH WORKERS (M) IN POSITION	192	82315
	VACANT POSTS	8	6827
6.	HEALTH WORKER (F) IN POSITION	89	120560
	VACANT POSTS	13	11531
7.	MIDWIVES NURSES IN POSITION	16	13867
	VACANT POSTS	1	2582
8.	TRAINED DAIS	180	600606
	VACANT POSTS	-	-
9.	VILLAGE HEALTH GUIDES	1NA	327
	VACANT POSTS	-	-

TABLE - 1d : NORMS FOR RURAL HEALTH SYSTEM IN INDIA

1.	POPULATION COVERED BY SUBCENTRE	3000 - 5000
2.	POPULATION COVERED BY PHC	20,000 - 30,000
3.	POPULATION COVERED BY CHC	1 LAKH
4.	NO. OF SUB CENTRES/PHC	6
5.	NO. OF PHC/CHC	4
6.	TRAINED VILLAGE HEALTH GUIDE	1 FOR EACH VILLAGE
7.	TRAINED DAI	1 FOR EACH VILLAGE
8.	POPULATION SERVED BY HEALTH WORKER (M) (F)	3000 - 5000

SOURCE -

COMPILED FROM - GOI, DGHS, CBHI "Rural Health Statistics in India June 90 (New Delhi : MOHW, 1990).

NOTE - INA stands for Information not available.

The health sector is both centrally and state sponsored in India, however health is a state subject constitutionally. Tables 2 and 3 portray the investments towards health and family welfare since the first five year plan.

TAABLE - 2

PATTERN OF INVESTMENT ON HEALTH, FAMILY WELFARE AND WATER SUPPLY ETC. (PLAN OUTLAY) IN DIFFERENT PLAN PERIODS IN PUBLIC SECTOR CENTRE STATES AND UTS.

(Rs. in Crore)

S.NO. 1	PLAN PERIOD 2	TOTAL OUTLAY 3	HEALTH 4	FAMILY WELFARE 5	SUB TOTAL 6
1.	First Plan (1951-56) actuals	1,960.0 (100)	65.2 (3.3)	0.1 (-)	65.3 (3.3)
2.	Second Plan (1956-61) actuals	4,672.0 (100)	140.8 (3.0)	5.0 (0.1)	145.8 (3.1)
3.	Third Plan (1961-66) actuals	8,556.5 (100)	225.9 (2.6)	24.9 (0.3)	5.0 (3.1)
4.	Annual Plan (1966-69) actuals	6,625.4 (100)	225.9 (2.6	24.9 (0.3)	250.8 (2.9)
5.	Fourth Plan (1969-74) actuals	15,778.8 (100)	335.5 (2.1)	278.0 (1.8)	613.5 (3.9)
6.	Fifth Plan (1969-74) actuals	39,426.2 (100)	760.8 (1.9)	491.8 (1.3)	1,252.6 (3.2)
7.	1979-80 actuals	12,176.5 (100)	223.1 (1.8)	118.5 (1.0)	341.6 (2.8)
8.	VI Plan Outlay	97,500.0 (100)	1,821.0 (1.9)	1,010.0 (1.0)	2831.0 (2.9)
9.	1980-81 actuals	14,832.4 (100)	269.6 (1.8)	141.9 (0.9)	411.5 (2.8)
10.	1981-82 actuals	18,219.9 (100)	346.5 (1.9)	183.9 (1.0)	530.4 (2.9)

(Table 3 contd..)

S.NO.	PLAN PERIOD	TOTAL OUTLAY	HEALTH	FAMILY WELFARE	SUB TOTAL
1	2	3	4	5	6
11.	1982-83 actuals	21,282.9 (100)	386.9 (1.8)	288.3 (1.4)	673.2 (3.2)
12.	1983-84 actuals	25,087.5 (100)	470.2 (1.9)	382.9 (1.5)	853.1 (3.4)
13.	1984-85 actuals	29,878.0 (100)	-	-	942.0
14.	Total Sixth Plan (1980-85)	109,291.7 (100)	-	-	3412.2 (3.1)
15.	Seventh Plan (1985-90) Outlay	180,000.0 (100)	3392.9 (1.9)	3256.3 (1.8)	6649.2 (3.7)
16.	1985-86 actuals	33,059.9 (100)	579.9 (1.8)	479.8 (1.4)	1059.7 (3.2)
17.	1986-87 actuals	39,149.0 (100)	579.9 (1.8)	479.8 (1.4)	1059.7 (3.2)
18.	(1987-88 (R.E.)	43,677.9 (100)	773.0 (1.8)	572.9 (1.3)	1345.9 (3.1)
19.	1988-89 outlay	49,817.9 (100)	868.1 (1.7)	600.0 (1.2)	1468.1 (2.9)

Note : Figures in bracket indicate % of total (Col. 3)

R.E. - Revised Estimate

Source - Planning Commission in GOI, DGHS, CBHI "Health Information India" (1989) (New Delhi : MOHFW, 1989, Table 1.1)

TABLE - 3

5th, 6th, 7th PLAN OUTLAYS ON HEALTH AND FAMILY WELFARE

(CENTRE + STATE/UTS)

(Rs. in crore)

S.NO.	HEALTH PROGRAMME	1974-79 SUB TOTAL	1974-79 %	1980-84 SUB TOTAL	1980-84 %	1985-90 SUB TOTAL	1985-90 %
1.	Minimum Needs for rural health	120.30	17.65	576.96	31.84	1096.35	33.67
2.	Control of Communicable diseases	268.17	39.32	524.00	28.92	1012.67	29.85
3.	Hospitals & Dispensaries						
4.	Medical Research & Education	293.19	43.11	720.09	39.74	1283.87	37.8
5.	Traditional Systems of Medicine & Homeopathy						
6.	Others						
	TOTAL	681.66	100.00	1812.06	100.00	3392.89	100.00
	FAMILY WELFARE	491.80 (ACTUALS)		1010.00		3256.29	

Source - Planning Commission

The facts which emerge out of an analysis of tables 2 and 3 are :

1. There are two heads of investments health and family welfare in the plans (table 2).

2. Since 1951 on an average a meagre 3% has been alloted of the total outlay to above heads (table 2).

3. A large chunk of investment goes into the establishment of urban based curative medical research, training and services institutes, and reviving traditional systems of medicines.

4. This trend was tried to be checked by the minimum needs for rural health investment from the 5th plan, however the percentage of investment remains meagre towards this head (table 3).

5. Despite heavy investments control of communicable diseases remains a bad investment due to lack of a back up health services system (table 3).

The prece ding analysis was based on pure quantitative secondary data source, the qualitative analysis of health services have been done by various authors, refer 2,3,4,5. The central findings of these studies accentuate the following facts:

1. Western system of medicine[6] has found acceptance and is sought after in India's rural populace.[2,3]

2. The health service system providing this western medicine is however not reaching the poorest of poor.[2,3,4]

3. Health efforts are directed towards symptoms, not the actual cause of health problems as they undermine the socio-economic and political factors.[4,5]

The analysis which follows takes into account how the rural health services came to be what they are, as the National

Health Policy document [7] published by the Government of India (1982) has described :

1. Health Services are based on adopted health manpower policies and established through curative centres based on western models.

2. High emphasis on curative approach has led to the neglect of the preventive, promotive and rehabilitative aspects of health care.

3. Hospital based disease and cure oriented approaches benefit only the urban elite.

4. There is a cultural gap between the people and health care personnel due to a lop sided policy in training and development of personnel.

5. Community involvement, hence becomes imperative at all levels of need identification, implementation and management of various health and related programmes.

Almost a decade earlier a WHO study conducted in 1975 in collaboration with the UNICEF identified the major areas in which health services of developing nations were ailing. These areas were as follows[8] :

1. Problem of broad choices and approaches :

- Lack of clear national health policies and poor linkage of health services.

- Lack of clear priorities.
- Opposition to changes in the social aspects of health policy
- Inadequate community involvement in providing health care.
- Inappropriate training of health personnel.

2. Problems of resources :

- Inadequacy and maldistribution of resources of health services.
- Non utilization of actual and potential resources.
- Restricted use of primary health services.
- The rising cost of health services.

3. Problems of general structure of health services :

- Lack of effective planning machinery.
- Weak development of health system concept.

4. Technical weaknesses :

- Inadequate health education.
- Lack of basic sanitation.
- Deficiencies of communication and transport.
- Lack of adequate health information.

EVOLUTION :

To understand how the rural health services in India took shape to what they are today, one has to go back to the history of community health in India.

It would not be wrong to say that the present rural health services in India took shape due to a vision steeped in

nationalistic fervour. The written documents of the Sub Committee of National Health, National Planning Committee (1948) and the Health Survey and Development Committee (1946) portray the vision.[9,10]

The reports[9,10] are documents giving an accurate and precise account of the conditions of the public health services systems existing in the pre-independence India. The reports indicated the following :

(i) Poor socio-economic status of populace in India characterised by poverty, malnutrition, high mortality and diseases.[9]

(ii) Poorly structured health services system in India providing scattered health care to the rural populace.[10]

(iii) The elitist imperialist ethos of the existing administrative health services system serving only the colonial rulers and the Indian rich.[10]

(iv) The lack of social orientation in the field of public health and medicine.[10]

(v) Loss of Indian indigenous system of medicine to the masses due to colonial propagation of western medicine and subsequently the loss of royal patronage towards the former.[9]

To the above picture facts which can be added are :

(i) The public health measures were inadequate except where and when there were epidemics.[10]

(ii) The services being provided were by inadept Indian medical service personnel selected by the British Indian Army.[11]

The 'Bhore Committee'[10] report is perhaps the best blue print on the establishment of primary health care system in the world -

The spirit of the committee still calls out for the individual's right to comprehensive health care, preventive units, the primary health centres given by social physicians and propagated by political leaders in co-operation with the people.

A similar call has been sounded world wide also in Alma Ata declaration of Primary Health Care 1978 which is :

Essential health care made universally accessible to individuals and acceptable to them through their full participation and at a cost the community and country can afford.[1]

The next part of this analysis briefly takes into account why even after having such a sound beginning through Bhore committee's Long and short plans of establishment, the primary health centres network as it stands today fails to carry across primary health care to large numbers of people in rural India.

There are however numerous other studies to prove the contrary i.e., primary health care had reached quite a few people and it was the inhibition of the people which was withholding them from using the services.[12,13,14]

These health behavior studies are the earliest on the time dimension of health research in India. The shift now is towards a critical understanding of the very dynamics of the limitations of health care and the social structure underlying in India.

The above trend can said to have reached articulation in form of the ICSSR - ICMR report by the study group on an Alternative Strategy for health services in India (1981).

This report recommended an integrated developmental approach towards health, aided by health services rooted in the community decisions of needs and carried forward by community representatives.[15]

PROBLEMS :

The first Primary Health Centre was established at Najafgarh in 1952, Since then there has been a steady establishment of primary health centres and sub centres since the first plan period. See table 4.

TABLE - 4

ESTABLISHMENT OF PRIMARY HEALTH CENTRES AND SUBCENTRES SINCE THE FIRST PLAN

PLAN PERIOD	PHC'S	SUBCENTRES
First Plan	725	
Second Plan	2,565	
Third Plan	4,631	
Inter Plan		
1967	4,793	17,521
1968	4,946	21,539
1969	4,919	22,826
Fourth Plan	5,283	33,509
Fifth Plan	5,484	47,112
Sixth Plan	7,284	84,590
Seventh Plan * June 1990	20,532	1,30,392

Source : 601, DGHS, CBHI
"Health Information India" (1988)
(New Delhi : MOHFW, Table 9.1)
* Rural Health Statistics.

However Primary Health Care eludes many. This is so because of the following factors.[16]

1. The health policies are used as political tools by international health agencies and national governments of member states to dominate a mass of people in the third world countries. Illustrations of this would be :

a. Population Numbers Problem pointed out by groups of people of the first world like Club of Rome. This has led to drastic population control measures in the third world like that of the family planning programme in India and other inadequate environmental policies.[17]

b. Domination of western cultural idioms of individuality and self participation leading to chaotic community participation schemes in the third world such as the CHV scheme of India. Community reliance remaining a distant dream due to politico-economic control by elite castes of the health sector.[18]

c. The selective approaches towards health like GOBI-FFF, leading to medico technological revolutions aiding political gains through immediate gains of lessened mortality rates.[19]

2. Role of health professionals in Primary Health Care remains a paradox of poor working conditions and lessened commitment to work. It also portrays a lack of social interest on the part of health professionals and a class characteristics of professional social control of people.[20]

3. The undermining of the felt needs of the people leading to almost a distorted understanding of health problems of people.[21]

4. The role of vertical organisation and horizontal integration of health services, is a matter that has been hindering the steady expansion of health services in India. So much so

that various committees had to be set up since the 1960's to integrate the various functions of the health services whenever it was necessary. The major programmes being that of malaria control, family planning and other communicable disease control programmes except that of tuberculosis control.[22]

This constant change has effected the quality of services rendered. In a final pitched attempt the Multipurpose Workers Scheme has been launched to integrate health manpower and infrastructure at all service levels in India. However, this has also largely failed due to (a) Inadequate implementation (b) Emphasis on Family Planning Work (c) Variations at State levels.[23]

All these factors will be discussed in detail in conjunction with the findings of the present study.

The present study is based on the preceding perspective and is aimed at arriving at an insight as to how a primary health unit which was established as a model and training unit for the present health centre network evolved over time. This study also questions its relevance in the present tunes through a brief socio-psychological analysis of the functioning of the Rural Health Training Centre, Najafgarh.

B. REVIEW OF LITERATURE

A brief review of literature is presented to describe studies similar to the context of the present study. Such studies classically have been termed as Primary Health Centre Studies.

1. The most representative study in this category of studies is the one entitled, `Functional Analysis of Health Needs and Services.´ Conducted at the Narangwal Rural Health Research Centre (197Ø).[24] The study, based on a methodology linking needs to health research available, had two fold purposes of community needs and attitudes identification and the study of health care delivery system. A functional matrix of thirteen functions was tested on a village - PHC population through secondary surveys, village profiles and interviews. This attempt took into account the community need factors, however this research was limited in development of a methodology as it failed to establish linkages between the community needs and the health services.

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2. Analysis of quality of services rendered by primary health centres has been the topic of many a research studies.[25,26,27,28]

   Salient features emerging out of these studies are :

(a). Non participicitant observation.

(b). Time - Motion evaluations of the functions given out by the health functionaries.

(c). Qualitative analysis of the structural amenities in the Primary Health Centre.

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The studies hence totally lack the 'Community Factor' of analysis and give out the technicalities of unused or misused resources and the slackness of the staff to give out the resources only.

These studies are based on a typical PHC's and do not take into account regional differences prevailing. They also undermine policy issues such as decision making.

3. Special mention is necessary of the dissertation research work conducted out in the Najafgarh Block area. The findings of the most representative of such exercises are :

i. Mis-utilization of resources at the Najafgarh, PHC.[30]

ii. Good services rendered through the MCH/FW clinics at the Najafgarh, PHC.[30]

iii. Gaps in knowledge of community health workers/village health guides in basic areas of nutrition and communicable diseases,[29, 31] so also for dais trained at the Najafgarh, PHC.[30]

iv. Emphasis on family planning work at all levels.[30,31]

v. Lack of representation from lower castes in the VHG scheme.[31]

These research exercises are restricted to :

a. Time -Motion analysis of services at Najafgarh PHC.

b. Scheme Evaluation without emphasis on community perceptions.

c. Organizational analysis devoid of policy considerations.

d. These studies demonstrate only the evaluations of a set of functionaries and do not take all participants into

consideration. There is also a tendency of not taking into account the critical historicity of the centre and linking it to the present anomalies of the functions and services of the centre, i.e., the search of relevance of the centre through time.

4. The guiding study for the present project is a longitudinal sociological study of 19 Indian villages by Banerji (1982). This study is an intensive investigation into the village culture alongwith the health culture prevailing in the villages. This study throws light on the dismal status of primary health centres delivering primary health care to the rural populace.[2]

In a recent publication the author comments upon the inaccessibility of the primary health care to the lower economic groups in the villages. Through interviews, surveys and secondary sources the author has developed a methodology to study the health culture prevailing in the 19 representative villages. He indicates through this methodology how technocentric western medicine does not meet the felt needs of people. The author comments upon the socio-cultural background of meaning and perception of health problems and commodification of medical and other services.[32]

This unique study based on an integrated approach to the health services and prevailing socio-cultural system helps to understand the health status of people in a global perspective.

The above brief review of limited number of studies indicates the importance of the `community factor´ in health service systems research.

NOTES

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CHAPTER - III

OBJECTIVES DESIGN AND METHODOLOGY OF THE PRESENT STUDY

NOTE ON THE RHTC, NAJAFGARH

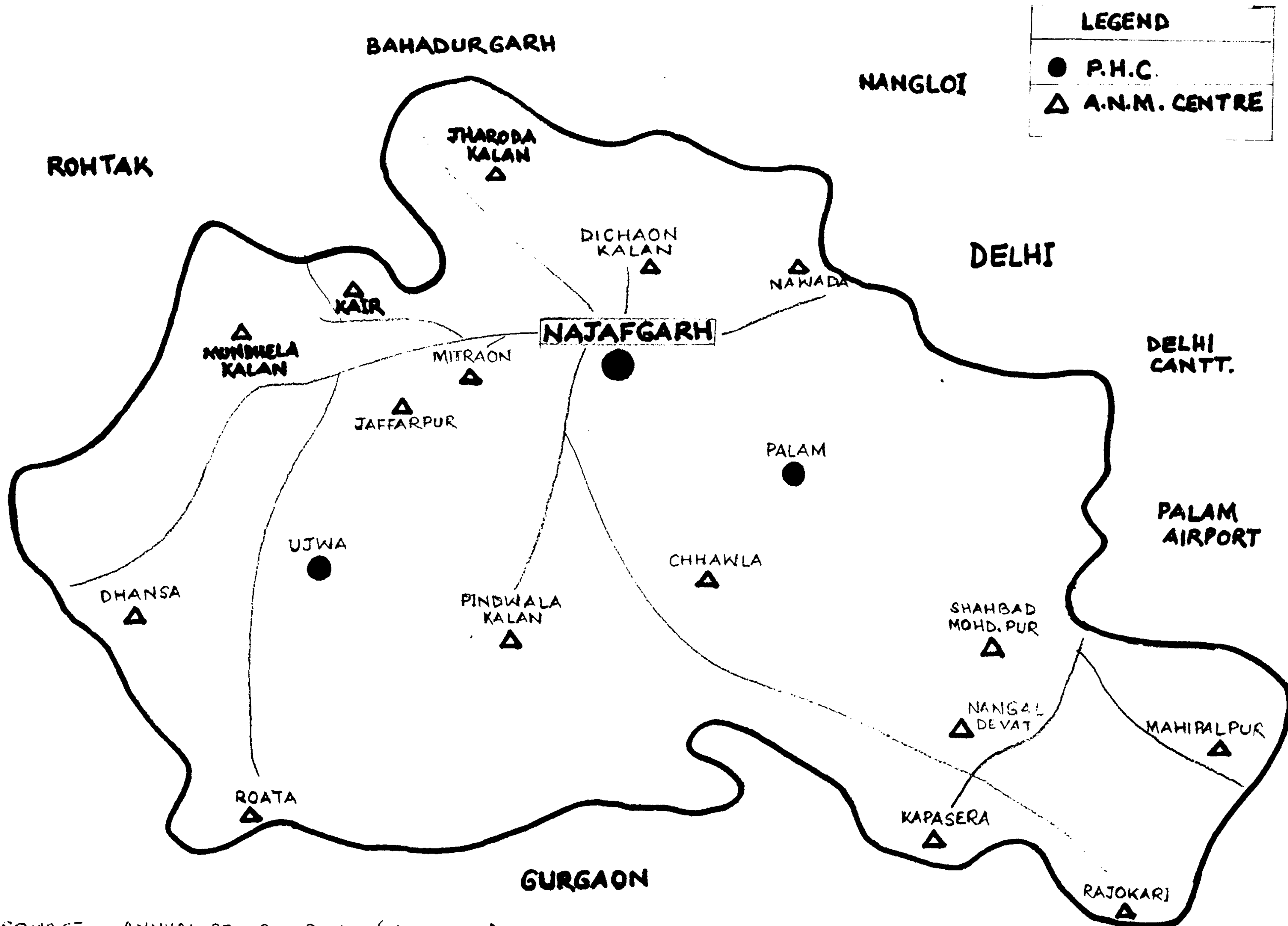
The Rural Health Training Centre, Najafgarh holds the distinction of being a model demonstration cum training unit since the year, 1937 and being the first established Primary Health Centre of independent India. Till the present it can be said that this centre has stood and witnessed the series of changes in health concepts, policies and plans of the Indian rural health efforts given by the foreign funding agencies and the Directorate of Health, New Delhi.

1. Services to a rural block area (rural West Delhi) providing preventive and curative health care to 71 villages through a network of three Primary Health Centres and sixteen sub centres (population of around four lakhs, 1.5 lakhs in the townships of Palam and Najafgarh). City referral services are provided by the Safdarjung and Sucheta Kriplani Hospitals, New Delhi to this PHC area.

2. Training of health manpower viz. auxiliary nurse midwives (ANM), nursing students, dais (traditional birth attendants) internship students of the M.B.B.S. course and the LHV promotional training programme.

3. Research studies conducted on the field area in the areas of health and family welfare issues from time to time.

FIGURE-2 FIELD AREA : R.H.T.C. NAJAFGARH



SOURCE - ANNUAL REPORT, RHTC (1989-1990)

The RHTC Najafgarh, hence can be said to be a unit providing health care services, training and research facilities. Figure 2 gives a geographical location of the RHTC Najafgarh field area.

The present study is an attempt to analyse the organizational functioning of the RHTC from its inception to the present status.

OBJECTIVES OF THE PRESENT STUDY

1. Study of the organizational functions through the three basic aims of the RHTC viz., services, training and research. An analysis of the health manpower, resource structure and policy issues attached to the three basic aims over time.

2. Generation of information about the problems which are faced by the functionaries giving out the functions and the beneficiaries receiving them.

3. To establish through 1 and 2 and the organizational relevance of the RHTC Najafgarh in the present times.

RATIONALE OF THE PRESENT STUDY

The rationale behind the study is to understand the discrepancy which exists between the theoretical ideal at policy levels and the practical reality at the implementation level in fulfilling the aims of any institution in this case the Rural Health Training Centre, Najafgarh.

Though based in an area with heavy urban inputs the RHTC, Najafgarh, has a historical value and the question asked, whether it has proven to be a beacon light to the existing rural health services network of India or not?, as it was purpoted to provide.

DESIGN OF THE PRESENT STUDY

The planned study was based on a set design of intensive field work and collection of data through secondary sources of documents. Figure 3 gives a diagramatical representation of the study design.

FIGURE - 3

DESIGN OF THE STUDY

RHTC - FUNCTIONING
- RELEVANCE

HISTORICAL REVIEW	PRESENT STATUS
SOURCE	SOURCE
= interview with Dr. P.R. Dutt (ex-officer in-charge RHTC, Najafgarh)	= Interviews with Beneficiaries, RHTC PHC Services Personnel Trainers Trainees
= Official Documents	Administrative Officer Medical Officer-in-charge PHC Najafgarh Officer-in-charge, RHTC
	= Official Documents

CONSOLIDATED VIEWS ANALYSIS

The design of the study hence is based predominantly on qualitative analysis only and there is quantitative analysis backing where and when available.

METHODOLOGY OF THE PRESENT STUDY

TOOLS used :

1. Secondary Source : Official documents viz. annual reports of the RHTC, Ministry of Health, the available research reports and text books on the community health.

2. Primary Source : Case structured open ended interviews with various categories of people with the RHTC (see design). The use of this tool required the following steps.

a. Rapport Formation.

b. Collection of preliminary data of the demographic status of the individual.

c. Structured questioning through open ended interview schedule (Refer appendix for the schedules).

d. Consolidation of the data from the interviews.

PROCEDURE OF DATA COLLECTION AND SAMPLE :

The data collection procedure can be divided into four phases :-

PHASE - 1

(a). Collection of secondary source of data to establish the historical necessity and evolution of the RHTC.

(b). Interview with Dr. P.R. Dutt, ex-officer in-charge to authenciate the above exercise and to get a first hand view through his invaluable experiences at the RHTC.

(c). Permission sought from the Directorate of Health , New Delhi to conduct the field work at RHTC, Najafgarh.

(d). Establishment of rapport with the officer-in-charge, RHTC, Najafgarh.

PHASE - 2

(a). Non participipitant observation at the RHTC administrative, training, PHC service areas at Najafgarh (This was done from PHASE 1 to PHASE 4).

(b). Structured open ended interviews with 150 beneficiaries of the OPD and MCH clinics of PHC, Najafgarh.

(c). Structured open ended interview with the services personnel the PHC, Najafgarh.

(d). Structured open ended interviews with the trainees and trainers of the RHTC Najafgarh.

PHASE - 3

(a). Structured open ended interviews with the administrative personnel RHTC, Najafgarh.

(b). Structured open ended interviews with the officer-in-charge RHTC, Najafgarh.

(c). Collection of vital statistics about the Najafgarh block.

PHASE 1-4 serve the objectives number 1, PHASE 2-4 serve the objective number 2 of the present study.

Sample :

The sample characteristics are discussed in detail in Chapter V, however it is important to note that the beneficiaries chosen were the ones who had a minimum contact of 1 year the RHTC Najafgarh. The functionaries interviewed were the ones present at the centre, so also for the trainees.

CHAPTER - IV

A HISTORIC NOTE ON RHTC NAJAFGARH

CHANGING ETHOS OF THE RHTC NAJAFGARH

Taking a historical stance to the field project under study has been a difficult task. History is often forgotten and kept in a shadow of dust of the past, however a historical analysis is very essential as it leads one back to the very roots of endeavour and gives insight about activities in the past and present.

PHASE 1 - THE NEED

THE BACKGROUND

The very roots of the RHTC Najafgarh as it stands today would date back to the year, 1937[1]. The picture in the background would be a country in the midst of its intense independence struggle reaching the climax of freedom but coupled with problems associated with the socio-economic degradation by the colonial rule. A population effected by famine (mostly man-made) and disease caught in a vicious cycle of `poverty-disease´ as described by C.E.A. WINSLOW.

Establishment :

It is ironical to note that the present centre was established with the aid of neo-imperialists in 1937. It being a part of parcel-aid given by the International Health Board of the Rockefeller Foundation in its endeavours of country health work.

The foundation's aid expanded towards control and survey of hook worm to malaria control to sanitation activities spread over the southern province.[2,3]

In order to reach more populations of the rural areas, a need was felt by the Health Boards to establish centres for training, personnel and demonstrating health enhancement activities. Various experiments of social reformers in India like that of Tagore's Shanti Niketan were incorporated in the Foundation's activities and policies at these centres.

This need was felt as far back as in 1920's and subsequently resulted in the establishment of seven demonstration rural health units in India modelled after U.S.A. county health centres.

These centres were established in :

1. NAJAFGARH (Delhi) [13.7.1937 date of establishment]
2. LUCKNOW (Uttar Pradesh)
3. RAMNAGARA (Karnataka)
4. POONAMLLEE (Tamil Nadu)
5. NAYATTINAKARA (Kerala)
6. SINGUR (West Bengal) [1931 1st to be established]
7. SIRUR (Maharashtra)[1]

The international pressures underlying these establishments was the recommendation, to give out health care through primary rural units by the following councils and conferences :

1. Council of Medical and Allied under Lord Dawson of Penn in 1920.

2. European Conference on Rural Hygiene in Geneva, 1931
3. Inter Government Conference of the Far East countries on Rural Hygiene in Bandung, 1937.

Policy :

On an average financial aid from the Rockefeller Foundation ranged from $ 1000 to $ 20,000 annually for the decade of 1927-37. The Najafgarh unit received a grant of $ 31,350 in 1937.[3,4]

Financial assistance from the Foundation stopped in 1942 for the unit and it came under the control of the then Government of India.[1]

Apart from financial aid the Rockefeller Foundation can said to have propagated world wide trends of Public Health through its experts. The trends indicated the following characteristics which echoed in the Najafgarh unit also :

1. Disease control and Health promotion.
2. Germ Theory and external control of factors related to disease.
3. Medication for control of diseases.
4. Training of health personnel.[6]

In the Indian context the trends of health promotion and cure, based on the western scientific rigour can said to have been more of a curse than a blessing. The philosophy of the funding agency might have been humanitarian, but portrayed a dilemma of being instrumental in bringing in a way of life foreign to the existing culture in India disregarding the felt needs of the people.[7]

PHASE 2 - THE EVOLUTION

Background :

The formulation of the health policy of India as has been discussed has its roots in the Bhore Committee Report of 1946, a blue print on guidelines for health endeavours adequate to Indian conditions. As the league of Nations in 1931 had recommended. The Bhore Committee suggested the establishment of health centres for providing integrated curative and preventive services.

The community Development Programme started in 1951 by the independent Indian Government can said to be a landmark for the health services of India.

As off the First Five Year Plan, this programme envisaged a multifaceted multipronged developmental plan for rural India incorporating the maxim of self reliance and organised efforts towards common goals as elaborated by Leavell (1956).

The Changed Character :

Soon after the independence, the Najafgarh unit was incorporated into various programmes. Foremost being the establishment as the first Indian Primary Health Centre, by the then health minister Raj Kumari Amrit Kaur in 1949. It started functioning in 1952 for 27/72 villages providing curative and preventive services. The first PHC was a model unit for establishment of other PHC's.[1]

The Training Factor :

The training facet of the Najafgarh unit saw its inception as late as 1954. The training context was characterised by an orientation towards rural life though the PHC services and hence included culture, education, health and developmental inputs in an integrated fashion. These inputs were based on what is called the KSA factors of training which means that the trainees were given inputs to improve upon their knowledge, skill and attitudes (KSA) so that they would become carriers of a multifaceted developmental change in rural India. The trainees were usually extension health workers and block development officers.[1]

The training unit was founded by the Ford Foundation under its oversees development programmes with the aims of (1) Establishment of peace; (2) Strengthening of democracy and economy; (3) Education in democratic society; (4) Individual behaviour and human relations.[7]

The Environmental Sanitation Factor :

The year 1956 saw the start of the Research cum Action Project on Environmental Sanitation in which 95 villages were chosen. The Najafgarh, Singur and Poonamallee were chosen field areas. The aim of the project being installation and promotion of use of septic latrines in rural India. The project also aimed at testing/demonstrating organisational set up for the effective implementation of the above aim. The project at Najafgarh concluded in 1961. It was funded and propagated by the Ford Foundation.[7]

Upon trying to critically evaluate the RCA projects and setting up the training facet one can remark that these projects portrayed a complexity felt after of good aims (philosophically) but inadequate action primarily due to :

(a) Lack of finances.

(b) Lack of action plan.

(c) A typical top-down approach in policy making.

Going through a series of documents,[8,9] one finds that the lacuna is that only technical (design and location), administrative problems (like finance from the Community Development Programme etc.) and Personnel allocation (BDO/PHC,CMO) were tackled or looked into. It was assumed that the people have to accept the dictates of sanitation as propagated by the Health Educators through motivational manipulation. There was a total disregarded for the cultural factors. For example social stigmas attached to women who used the latrines etc.

The Maternal and Child Health Factor :

The MCH facet was perhaps the first to be started in the Najafgarh Field area. A health unit consisting of a doctor and public health nurse from the WHO was functional since the 1949. A mobile dispensary was also provided to expectant nursing mothers and children.[1]

This can be said to have expanded towards the following :

(a) A School Health Project (1956).

(b) A Family Planning Research Unit (1959).

The above were based at the PHC, Najafgarh functionally utilising its personnel and funded by the Directorate of Health Services and ICMR respectively.

In years to come the character of functions changed from MCH - Family Planning - Immunization as and when it were a policy at the decision making levels.

The Policy :

The Directorate of Health Services had taken over the functioning of the following units in the Najafgarh area in 1957 and redesignated it as the RHTC :

1. Najafgarh Health Unit (1949).
2. Primary Health Centre, Najafgarh (1952).
3. Primary Health Centre, Palam (1955).
4. Primary Health Centre, Ujwa (1955).
5. Najafgarh Orientation Training Centre (1954).

The policy at the Najafgarh Unit in this phase can be said to be based on experimentation which involved implementation of western ideas on the Indian population.

Initially as is seen in Ford Foundation annual reports (1951-1960), there was a cultural awareness whilst programmes were funded and formed but later a marked change is evident towards research and social marketing.[8]

The shifts in policies can said to have been primarily due to :

1. Social engineering phase of public health in the west (1960's).[4]
2. An open policy of aided countries to incorporate ideas of the west to get financial assistance and expertise from the International bodies like WHO, UNICEF and funding agencies like the Ford Foundation.[5]

The above analysis has been cross checked with Dr. P.R. Dutt (ex-officer-in-charge RHTC Najafgarh (1960-1968). Commenting upon the functioning, Dr. P.R. Dutt highlighted the following regarding the RHTC Najafgarh Field area and policies in the time frame discussed in the historical note i.e. phase 2.

1. The field area under study was a flood prone area leading to communicable diseases from time to time. The PHC's played a vital role in alleviating the problems created by the floods.
2. There were quite a few pioneer research studies held during this time, for e.g. :-

a. Establishment of expenditure on drugs per head in the field area.
b. Research cum Action project.

The Indian researchers were guided by work of researchers like John Grant of Ford Foundation.

3. The resources were always available at the field area, however there was a will to perform of the functionaries which solved problems of implementation. Community

Participation was very high through village talks and active participation in acute situations like epidemics.

4. Research cum Action project failed due to the weak health education and training programmes of the RHTC.
5. The MCH factor as discussed in the role was also the propogation of family planning sterialization procedures.
6. Politics was rampant between :

a. Administrators = Medical Personnel
b. Medical Personnel = Implementers
c. Implementers = Community

7. Favours were sought from politicians to gain ends like :

a. Promotions
b. Cencellation of orientation training criteria for internship.

8. There was no political will to change the status of the community, as health actions were used to gain individually rather than collectively.

In conclusion it can be stated that the need and evolution of the RHTC Najafgarh as a model unit was dogged by various paradoxes.

As can be inferred from the analysis the need was based for propagation of western medicine and the evolution was based on social engineering of givers to give and receivers to receive services based on an alien technology through artificially created a - cultural methods.

The question which arises is, whether such a paradoxical beginning has effected the growth of the RHTC unit considered a model unit for the Indian rural health services system?

NOTES

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1. RHTC Najafgarh Annual Report document (1989-1990) D.G.H.S., New Delhi.

2. DUTT, P.R. (1965), Rural Health Services.

3. Rockefeller Foundation, Annual Reports (1927-1928), (1937-1988).

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5. Ideas taken from :
BANERJI, D. (1985) Social Sciences and Health Services Development in India, " A sociology of formation of Alternative Paradigm' Lok Paksh, New Delhi.

6. A report on the conference held at New Delhi on 10-11 September (1956) (to discuss the social and cultural factors in Environmental Sanitation in Rural India), D.G.H.S.,New Delhi.

7. The Ford Foundation Annual Reports (1951-1961).

8. Rural Latrine Programmes (1961-1962), D.G.H.S., Ministry of Health, New Delhi.

9. Rural Latrine Programmes (1958-1961) Planning Research and Action Institute, Planning Department, U.P.

CHAPTER - V

FINDINGS OF THE PRESENT STUDY AND DISCUSSION

The following presentation is based on the facts generated by the methodology as described in Chapter III.

The section, Findings incorporates the views of beneficiaries and PHC service personnel interviewed at Najafgarh. These are further analysed through the rationalizations put forward by the administrative officer, officer-in-charge RHTC, and the medical officer in-charge, PHC Najafgarh.

The section, Discussion revisits the perspective put forward about the rural health in India in conjunction with the findings of the present study.

The above is supported by observations. All designations and names have been withheld for confidentiality. The presentation of data generated through interviews helps one to understand the day to day functions of the RHTC and throws light on the problems faced by all the groups of people in the system prevalent. All this leads to a conclusion about the relevance of the RHTC in the present times and comment on its status as a model unit.

FINDINGS

A. VIEW OF BENEFICIARIES AND PHC SERVICE PERSONNEL

Beneficiaries Profile :

Table - 5 presents demographic details of the beneficiaries interviewed (n = 150) at the OPD and MCH clinics at PHC Najafgarh.

TABLE - 5

DEMOGRAPHIC PROFILE : BENEFICIARIES

S.NO.	CHARACTERISTICS	FEMALES N=103		MALES N=47	
		NO.	%	NO.	%
I.	AGE (YRS.)				
1.	17-25	61	59	06	13
2.	26-34	19	19	28	60
3.	35-43	08	08	05	11
4.	44 & above	15	15	08	16
II.	PROFESSION GROUP				
1.	GOVERNMENT	-	-	11	23
2.	PRIVATE/BUSINESS	-	-	18	38
3.	SELF EMPLOYED/ AGRICULTURE	08	06	15	32
4.	LABOURER	15	13	03	06
5.	HOUSEWIVES	80	78	-	-
III.	ANNUAL INCOME (Rs./Month)				
1.	- - 750	23	22	09	19
2.	800 - 1550	-	-	20	43
3.	1500 - 2350	-	-	12	26
4.	2400 & above	-	-	06	12
5.	No Income (Dependent)	80	78	-	-

(table 5 contd.)

S.NO.	CHARACTERISTICS	FEMALES N=103		MALES N=47	
		NO.	%	NO.	%
IV.	ASSOCIATION WITH RHTC (YRS.)				
1.	1 - 5	49	48	16	34
2.	6 - 10	22	21	13	28
3.	11 - 15	17	17	08	17
4.	15 & above	15	15	10	21
V.	CAUSE OF VISIT TO RHTC				
1.	WELL BABY CLINIC	25	24	-	-
2.	ANTE NATAL CLINIC	23	22	-	-
3.	OPD/CONSOLATION	32	31	31	66
4.	FAMILY WELFARE	23	22	09	19

Table - 5 depicts as follows :

1. Majority of the beneficiaries interviewed were women, (n = 103). On an average they were housewives belonging to the age group of 17-25 yrs., showing preference for the OPD services and the Well Baby Clinic at the PHC. They had contact of 1-5 yrs. with the PHC.
2. This sample includes a few women labourers whose earnings were upto Rs. 750 per month and they usually attended the OPD
3. The men (n = 47) were mostly self employed or in private service of the age group of 26-34 yrs. and belong to the income bracket of Rs. 880-1550 per month. They preferred the OPD consultations and had contact of 1-5 yrs. with PHC.
4. Family Welfare function was also quite sought by both men and women.

It is important to note that beneficiaries had come from the villages near Palam and Ujwa PHC's area also (refer to figure -2) to get services from the PHC, Najafgarh.

Salient Features of Interview Data generated from the Beneficiaries

1. When asked about the service, available at the PHC's majority of the beneficiaries were of the opinion that the following services were given :

a. Immunization for children and pregnant women.

b. Sterilization procedures of tubectomy and vasectomy.

c. Treatment for common cold, fever, diarrhea, infections and injuries etc. (drugs availability).

d. Referral of men to Safdarjung Hospital.

e. Referral of women to Sucheta Kriplani Hospital.

f. Indoor Patients services.

None mentioned the (1) ANM services at the subcentres (2) Preventive actions of health education, sanitation and school health project given out by the PHC, as claimed by its staff.

2. When asked about the quality and nature of the services complaints poured out. These were :

a. Non availability of drugs essentially given to the OPD patients.

b. The `referral roulette´ played by PHC and Hospital doctors.

c. Non availability of emergency services at all times.

d. No lady doctor available.

e. Lack of expertise on the part of M.B.B.S. student trainees.

f. Callousness and private practice by certain doctors.

g. Only 3-4 hrs. of OPD/MCH time and lack of propagation of calendar of clinics of the PHC.

3. No meaningful suggestions for improvement came up from the beneficiaries and usually turned into pleas and petitions. Most of them came up with this helplessness as they considered themselves too `Chota´ or poor to fight the authorities.

Only a few men of the upper income bracket who knew about the D.G.H.S., came up with an action plan of improvement through an unified attempt by Najafgarh residents by filing a written complaint to the D.G.H.S. about PHC.

4. Talking about services with beneficiaries, who had long association with PHC that one could make out that the field area under study had been one with heavy resource inputs. The beneficiaries reported basic reasons for the dismal conditions prevailing as follows :

a. Mis-utilization of resources like drugs and transport facilities by all the officials concerned.

b. Increasing populations in and around Najafgarh.

c. Lack of `international `(Phirangi Log)´ aid, as *given* earlier by the funding agencies.

Services Personnel Profile :

Figure - 4 presents the organizational set up at PHC Najafgarh.

FIGURE - 4

ORGANIZATION AT PHC NAJAFGARH

officer-in-charge

(C.M.O.)

	Medical Officer - Incharge (1)
OFFICER CADRE	Senior Medical Officers (4) (2)*
	Junior Medical Officers (1)
MIDDLE CADRE	Family Welfare Extension Educators (2) (1)*
	Sanitary Inspector (1) (vacant)

NON OFFICER CADRE

OPD	MCH	INDOOR PATIENTS DEPTT.
Pharmacist (1)	Public Health Nurses (3) (2)*	Staff Nurses (3) (2)*
Dresser (1)	LHV (1)	LHV (2) -
Lab Asst. (1)	ANM (3)	Midwife (1) -
	School Health ANM (1)	

LASS IV CADRE	CLERICAL STAFF	SUBCENTRES
Sweepers (3) (2)*	Clerk (2) -	ANM (8) (4)*
Ward Boys(2) (1)*	Store Officer (2) -	LHV (2) -
Ayahs (2) (1)*		VHG (6) -
Medicine Carrier (1)		Trained dais (4) -
Driver (1)		
Malis (3) (2)*		

Note : * no. interviewed.

- could not be interviewed.

As is seen from the figure - 4, the organisation of the PHC, Najafgarh is based on the old pattern prevalent in the 1960's after the inception of the Family Planning Programme. The staff is surplus and role ambiguity is prevalent, especially in the non-official cadre. There is no integration of the functions at all levels.

Salient Features of Interview Data Generated from the Services Personnel

CLASS IV CADRE :

The general response of this group to the questions were as follows :

1. None were aware of the PHC functions except that of the OPD and the so called emergency services (as they put it). None mentioned the aim of training of health personnel as an important function of the RHTC.

2. All of them supported the claim of the beneficiaries that medicines were not available.

3. All of them had grouses against the administrative staff and medical personnel and reported following as major problems faced by them and the RHTC/PHC in fulfilling its objectives :

a. Severe disciplinary action against them for petty reasons like refusal to serve at the residences of senior officers after office hours.

b. A sort of game played by the administration in transferring the class IV staff to PHC farthest away from their residences (out of the 3 PHC's of the field area).

c. Lack of benefits, even of simple treatment procedure or reimbursement of medical bills for the class IV.

d. Role ambiguity, as seen from the case of a sweeper had worked as a dresser and had not been paid for that job; medicine carrier a person carrying drugs etc. to subcentres was manning the reception at the OPD. The ward boys often took over as dresser.

According to this group problems at large were as follows :

e. Trend of private practice by the medical personnel of the RHTC.

f. Lack of sympathy for the beneficiaries from the doctors.

g. Administrative high handedness in dealing with employees.

All the above reflected in the dismal conditions of cleanliness in the PHC area, and services given to the indoor patients. Suggestions for improvement were not given by this group except by one who said that the medical personnel should change their attitudes.

NON OFFICER CADRE AND ANMS

In this group all the employees reported the aims of the RHTC as services and training of health personnel. None reported research. In descending order of quality, the following functions were being executed by this group :

› immunization procedures and recording.

› Out patient department dealings.

› Indoor patient services and emergency dealings.

The problems reported by this group regarding their functioning were :

- Distances from which they had to travel to the subcentres,
- PHC from their residences (especially so far the ANM).
- Quantity of medicines not, enough to serve all beneficiaries.
- Lack of basic ointments in the dressing room.
- Dismal conditions in the indoor patients department at the PHC leading to lesser number of people coming for this service and were usually referred to the city hospitals by the doctors.
- Lack of facilities for conducting tests apart from routine urine and Hb blood tests. All other tests were referred to the city hospitals.

Quite a few personnel of this cadre were employed in legal disputes to obtain permanency of their posts or pay scale revision, with the directorate and hence were absent from then work quite often.

This group was less critical of the officer cadre and administration because of personal reasons. However an undercurrent of discord was evident, as transfers and promotions depended on this crucial relation. The ANM´s especially faced the ire of officials as they could be transferred from the PHC´s at random wish of the administrative personnel. Strictness meant transfer to emergency duties, which was not very sought after by the female employees (ANM´s, Staff Nurses).

Perceptions towards training indicated resentment towards the trainees. Quite often there were reports of clash of opinions with ANM trainees. The rapport with interns was very limited for these employees.

Problems cited for general functioning of RHTC/PHC as perceived by this group were :

- Lack of community support and callousness on the part of medical officers to give out the services in a better manner.
- Larger population to be served by an ANM that is 8000 -9000 contrary to the norms of 5000 - 6000 (see Table 1d).
- Private practice by certain medical officers.
- Convenience of the people with money to go to the referral hospitals at Delhi.

All the above reflected in the following status of functioning :-

- Non-existent services by the ANM to large segments of populations.
- Only immunization and family planning services being made available through the PHC.
- Non-existent or negligible amount of recording of vital statistics except when surveys were conducted through the office of the C.M.O./Officer-in-charge at all levels i.e., subcentres, PHc.
- Suggestions for improvement was not very forthcoming from this group.

OFFICER AND MIDDLE CADRE (EXCEPT MEDICAL OFFICER IN-CHARGE)

1. All the functionaries employed at this level cited the three aims and felt that these aims were being fulfilled 100%.

2. The problems perceived by this group of functionaries for their own efficient performance were reported as three fold :

a. Lack of say in policy matters at the decision making level.

b. Lack of quick promotions and salary increases.

c. Stagnation in work due to no change or innovation over large periods of time.

3. Problems perceived in general functioning of RHTC/PHC by this group were :

a. Lack of basic infrastructure for the functioning for example - only 5 out of 8 subcentres have a building.

b. Lack of interest on the part of the non-officer cadre to work and perform basic duties.

c. No lady doctor available to the large number of women beneficiaries for gynecological services.

4. Suggestions of improvement given by this group were :

a. Conversion of the PHC to a general hospital keeping in view the increase in population in the field area.

b. Training facilities to be improved by increase in staff so that better performing para medical staff could be generated.

B. VIEWS OF TRAINERS AND TRAINEES

Trainers Profile :

There were only 5 trainers of the following designations :

1. Public Health Nurse Supervisor (n = 1).
2. Public Health Senior (n = 2).
3. Tutor (n = 1).
4. Health Education Officer (n = 1).

The post of principal of the training school was absent. The average age of trainers ranged from 35-55 years. Majority of trainers[4] were females. The educational qualifications ranged from B.Sc. Nursing to Masters degrees in Social Sciences.

The supporting staff to the trainers were -

1. Senior and Junior Medical Officers in-charge of training.
2. Hostel Warden.
3. Nursing Supervisors from the various hospitals.

Salient Features of the Interview Data Generated from the Trainers

1. The trainers emphasized the role of training and research more than the services as they were involved in the above. They undermined the role of the PHC services and its link with the training format.

2. The trainers conducted classes, seminars, field demonstrations in the following areas -

ANM TRAINING	ORIENTATION TRAINING	
ANM TRAINEES (according to preference)	**NURSING STUDENTS**	**INTERNS**
1. Midwifery	Community Health	Training at the PHC and field visits on the course of preventive and social Medicine as Prescribed.
2. Nursing Fundamentals	Communicable diseases	
3. Micro Biology	Environmental Sanitation	
4. Anatomy and Physiology	Working of a PHC	
5. Psychology	Village life case study	
6. Child Care/Nutrition	Field Visits	
7. Community Health		
8. Working of PHC		
9. Environmental Sanitation		
10. Vital Statistics		
11. Field Visits		
Duration : 1 and 1/2 years	1 month for 1st yr. students 1 month for 3rd yr. students	1 to 3 months
Evaluation: Tests/Certificate Exam.	Report to Nursing Supervisor.	No Evaluation

Problems perceived by the trainers for their own functioning :

a. Interference by the MCD in selection procedure, leading to less qualified trainees being selected.

b. Less staff owing to less resources given to the training school in terms of money and man power.

c. Educational inputs need overhauling. Now a CBSE course is being formulated for rationalization of the courses for

ANM's however no course guidelines available for ANM course.

d. There is lack of rapport with the faculty of the Lady Harding Medical College and the trainers leading to a very superficial training for the medical interns.

e. The nursing and intern training is of very short duration.

f. Resources like transportation, audio-visual materials which were earlier gifted by WHO/UNICEF are now on the decline.

g. A total lack of awareness in the community about community health, sanitation and training facet of RHTC.

3. The trainers were not very forth coming in giving out the problems of the RHTC/PHC functioning and reported politicalization by medical officers to be the main factor of the sick state of the centre. They visualized that more resources and stricter selection and evaluation procedures could help them to give out better training.

Trainee Profile :

1. <u>ANM Trainees</u> (n = 20) (all females).

a. The average age of the trainees ranged from 18-21 years.

b. 5 of them were married.

c. They all possessed the basic certificate of higher secondary (10th class). Only 5 possessed the certificate of Senior Secondary (12th class).

d. The average income of the families which they came from was Rs. 1000 to 2500 per month. Fathers/husbands were government servants or in private business.

e. The trainees belonged to higher castes of (Jats & Brahmins) hindi speaking belt of Delhi areas and the Rohtak District of Haryana.

f. All of them had to stay in the hostel provided and were getting a stipend of Rs. 125 per month.

2. <u>Nursing Students</u> (n = 30) (all females).

a. The average age of the students ranged from 18-21 years.

b. They were all single doing the B.Sc. nursing at the LHMC.

c. The average income of their families ranged from Rs. 2000 - 4000 per month.

d. The trainees belonged to all states of India, mostly from the southern states of Kerala and stayed in the hostel premises in LHMC.

3. <u>Internship Students</u> (n = 6) (all females).

a. The average of this set of trainees ranged from 23-24 yrs.

b. They were all single.

c. The average income of their families ranged from Rs. 4000 - 6000 per month.

d. All lived in Delhi city and commuted everyday to and fro to RHTC.

<u>Evaluation of the Training Courses by the Trainees :</u>

1. All the trainees in the ANM training course felt that the duration of the course was very short. They were very critical of the selection procedure which they believed was tedious and tough (as forms were not readily available).

They felt that only a few portions of the course, like the midwifery, really helped them in practical situations. They were critical of the existing PHC services and field conditions and complained of the high-handedness of the PHC service non-official cadre personnel. They also complained about their uniforms which were similar to that of the class IV employees and felt that the stipend being paid to them was extremely meagre. None talked about their role as ANM's in the villages and relevance of the course. They all had ambitions to take up government jobs after the completion of the course.

2. Incomplete contrast to the above set of Trainees were the Nursing students who perceived themselves to be relegated to secondary status at the PHC. They felt that they could have been trained of the PHC working at Delhi itself rather than come to Najafgarh. They pointed out the fact that this training would not help them as the problems faced by them in their own states were entirely different. However none of them had any inclination towards working in a PHC, and all hoped to be placed abroad in foreign countries as staff nurses. Their awareness was more as they talked about the RCA project and commented that the villages still did not have sanitary latrines.

3. The internship students commenting upon the orientation training were tight lipped and felt being over worked. The one's who had come to gain practical experience, came,

worked and went away. There was no long term contact with the PHC and training block. Long term contact of interns with the community was ruled out due to the short duration of the course.

It was a helpless situation as the interns helped the patients only in being referred to Sucheta Kriplani Hospital, where these trainees came from.

According to interns, their condition was worse as they had to visit the Palam PHC also to provide services and traveling time was very high.

The whole situation becomes ironical as the beneficiaries do not trust their acumen as against those of the medical officers. This causes frustration and ego clashes from time to time.

4. Suggestions of improvement were not given as it was felt by majority that the orientation training was a mere formality.

The following profile of the RHTC Najafgarh is projected through the preceding analysis.

<u>BENEFICIARIES LEVEL</u> :

1. There is emphasis on immunization and family welfare programme at the RHTC.
2. There is inadequate provision of drugs for the beneficiaries
3. No adequate ANM services are provided to the community at large.
4. Referrals to the city hospitals is very common.

PHC SERVICE PERSONNEL LEVEL :

1. The PHC service personnel are dissatisfied with the status of the RHTC/PHC primarily due to :

a. Stagnation in work roles.

b. Friction between man professional and para professional and professional cadres of employees.

2. Absence of a lady doctor for gynecological services is felt.

3. No ambulance available.

4. The load on PHC Najafgarh is more due to non-functioning of Ujwa and Palam PHC (refer to figure - 2).

TRAINERS AND TRAINEES

1. The training aim is bogged done because of

a. Lack of resources like transport.

b. Lack of interest at decision making levels towards training.

c. Lack of strict selection and evaluation procedure regarding trainees.

d. Lack of relevance of context of training for the trainees.

The rationalizations put forward by the administrative personnel, officer-in-charge and the medical officer-in-charge, of the profile generated above are as follows :

Beneficiaries Issues :

1. The top officials were highly satisfied with the services provided to the beneficiaries. They felt immunization goals had been achieved 100% in line with the health for all call of the decade.

However other facets of the primary health care (see perspective for full description) were not mentioned at all. The charts on the walls of the RHTC/PHC showed target results of immunization and family welfare actions in the field areas.

But were even these services adequate?

"A woman beneficiary complained that she had been given a copper-T insertion at the centre which had got severely infected due to unhygienic procedures. She had to go to the referral hospital to get treatment for the same and had to spend about Rs. 500 on drugs and transport."

2. On drugs non-availability, it was rationalized that certain drugs like cough syrups and ointments for wounds were not essential.

   The administrative view point was that funds granted by the D.G.H.S. towards drugs was static since many years, whereas the population around the PHC had increased manifolds leading to a resource crunch.

   However a record in the administrative office of the D.G.H.S. expenditure reports (1981-1990) indicated that expenditure on drugs and salaries took away a sizable portions of resources in terms of money.

3. There was utter confusion as far as the ANM services were concerned. Going through the annual reports of the RHTC (1990-91) (an unbound paper), one found that there was

confusion as to whether the ANM was designated MPW (f) or not. Whether the ANM school was a training school for MPW (f) training or not.

One official was frank enough to admit non-performance of ANM's due to :

a. Lack of good training.

b. Politicalization of selection of the ANM's.

c. Inadequate facilities at subcentres (only five out of eight subcentres have permanent buildings).

d. Commutation problems of non-resident ANM.

The solution he thought was the selection of VHG (volunteer within communities) as ANM's.

What was not indicated was the unnatural work load on the ANM serving a population of 7000-8000 sometimes 10,000 population.

The other rationalization given for non performance of ANM's in the areas of health education and family welfare was that RHTC field area has high communication inputs and people actively seek out health services themselves.

4. On the issue of referral to city hospitals the standard view was that RHTC was based only on PHC services and people could travel to city hospitals for major ailments, emergencies, complicated cases of pregnancies and vasectomy procedures.

No real rationalization could be found for this issue because by the officials as doctors had referred normal cases of deliveries to the city hospitals (for those who could afford fees etc.) even before they reached the PHC. For those who could not afford to go were stuck with dismal conditions and poor services at the PHC´s.

A case cited by one of the class IV employees was that of a woman who had been checked in for normal delivery at the PHC and had been referred to the hospital by the doctors upon complications. However due to lack of ambulance services, she had delivered while being transported to the city in a private taxi.

Service Personnel Issues :

1. The officials felt that due to MCD and DGHS control of selection procedures, the choice of service personnel was limited. This effected their interest and efficiency as they considered themselves permanent employees.
   Strictness led to friction and politics amongst various cadres personnel.
   There was hence no staff rationalizations, promotions and job improvement procedures existing.

2.a. Administrative data indicated that there was no provision for a lady doctor´s post from the D.G.H.S. However, going through the annual reports (1966,1971) of the RHTC one finds that there was [illegible] a post of lady doctor due to heavy MCH emphasis.

b. Ambulance services were not provided due to the severe resource crunch.

3.a. PHC Ujwa was almost non-functional due to the reason that there is a dispensary near by at Jaffarpur (refer to figure - 2).

b. PHC Palam was being shunned by the community because of non-availability of expert personnel there.

Trainer and Trainee Issues :

1. The training block was funded by the funding agencies earlier now there is no aid even to maintain this block.
   The ANM training course is on the verge of closure as the MCD has issued a notice of saturation of ANM posts in the field areas of Delhi. The whole training course loses its relevance if the trainees cannot get inducted in the field areas familiar to them.

2. This factor had not been mentioned to the ANM trainees who were all desirous to work in Delhi or Haryana only. The course curriculum being taught was based on Nursing course and WHO guidelines, which do not properly fit in with the service demands.

3. One official was of the opinion that as their were no functions like communicable diseases control malaria work, recording of vital statistics being done, hence the ANM's and orientation trainees could not visualize the actual

picture of the working of a PHC. Some of these functions have been taken over by the MCD on a permanent basis.

Other Issues :

No action has ever been taken on the complaints, mostly anonymous, of the PHC doctors indulging in private practice.

The general picture that emerges after the perusal of the views and opinions of different cadres of people working for PHC/RHTC Najafgarh and beneficiaries. That the situation at PHC/RHTC is grim and worth giving a serious thought.

The grimness of the situation at PHC/RHTC is further proved by different groups of people interviewed having a consensus on this view.

DISCUSSION

The Perspective Revisited :

The preceding section dealt with the presentation of the facts emerging from the interviews with a cross section of individuals at the RHTC Najafgarh. Almost a global view has been established on the functioning of the RHTC. Upon an analysis of the facts and their linkages with the perspective described in chapter - II, the following issues emerge -

A. Community Felt Needs :

The beneficiaries of the PHC, (OPD/MCH clinics) at RHTC Najafgarh are inadequately provided for. Their felt needs have not been understood at all. There is hence a glaring discrepancy between what is needed, what is given and what ought to be given as primary health care.

The above point is best seen through the following factors :

1. A shortage of drugs, essentially to be given at a PHC.
2. The status of sanitary facilities in the field area is still low inspite of the fact that this area was under the RCA project. Though this function has been taken over by the MCD, the RHTC could still play a role in providing the same to the people, as now there is a felt need for proper sanitation.

It is important to note that the population characteristics have changed in this area since the establishment of the RHTC.

The changes are :

1. There is more floating population of working class in the area.
2. There is a steady urbanisation process going on in this area. As is seen through the annual reports of the RHTC (1966, 1971, 1991), the population consists of more service class people now though self employment through agriculture is still the major occupation.

These two changes can said to have created a changed character of felt needs for the PHC services. The lower/middle economic class of the community still prefers the free services of RHTC/PHC. However the richer classes do not use the services as they can afford to go to the city for medical services.

However the quality of services given to the lower/middle classes matches their low health status. They are given non epidemiological based immunization and family planning services. The PHC hence becomes a referral joint, a tool to propagate selective health services and restrictive development.

B. Economic Control of Health Services by Medical Professionals

In the health services system, a medical professional is the leader. Even the Bhore committee envisaged the role of a physician to be sensitive to the social factors underlying medicine. However due to the type of education system and the politico-economic situation prevailing in the medical field, the professionals have failed to carry forward health services on a

foundation of social justice.

The RHTC/PHC Najafgarh is no exception to the above trend. Just outside the RHTC premises stands a private physician's shop and a drug store, doing brisk business of giving inadequate symptomatic treatment for gastrointestinal disorders.

This not only undermines but speaks about the facility of the massive paraphernalia called the PHC/RHTC Najafgarh. In the RHTC block complete ignorance of the public regarding the private practice by RHTC doctors is an alarming trend because privatisation can not be said to an answer to the health problems of the people.

Education and Training of Health Manpower :

This issue is the most paradoxical as well as most ironical, as the education and training of health manpower is caught in social trap.

The services prevailing are inadequate and the personnel trained on such service fields have wrong and superficial conceptualisations of community health.

The case of the trainees in Najafgarh reflects this scenario. They are being trained without an understanding of the community needs and problems in long term objectives of the training of health manpower.

The higher economic status of the trainers and trainees makes their training and the services they might provide,

irrelevant to the masses which belongs to lower socio-economic strata of the community, as they propagate certain class relevant ideas which might not be rationalised by the masses at large.

The Top-Down Policy Approach :

This characteristic is a reflection of the inequalities prevailing in the world/society due to a power game based on politico-economic factors.

The practices of comprehensive primary health care and integrated health function have not come across to the RHTC Najafgarh from the D.G.H.S. and Ministry of Health. These policies, as a functionary pointed out are very difficult to implement.

The RHTC/PHC Najafgarh hence is a far cry from being a model unit as it´s functions have stagnated over time due to unrealistic policies which cannot be implemented. The reason being lack of understanding of what the community needs. This is further seen from the objectives of the research projects conducted and funded by RHTC which tend to propagate family planning and study of epidemiological problems faced by the higher classes of the society, (e.g., smoking & heart problem link) rather than understanding the community characteristics of this area.
(Reference : Annual Reports - 1971 1990 on studies conducted).

In conclusion it can be said that the historical beginning

of the RHTC of propagation of western medicine and evolution on social engineering of the masses is still being carried forward is the phase of it´s growth or rather it´s stagnation.

The relevance of the centre now lies in understanding community at large, so that it can provide adequate services.

SUMMARY

The basic aim of the present study was to analyse the functioning of the RHTC Najafgarh.

For this purpose data was collected from the following sources :

1. Documents.
2. Interview with Dr. P. R. Dutt (ex-officer-in-charge RHTC Najafgarh).
3. Beneficiaries and Functionaries of the RHTC Najafgarh.

The picture which emerged through the above data was that there were several lacuna in the functioning of the RHTC.

Some of the drawbacks in the functioning were :

1. Poor Community services.
2. Unhealthy interpersonal relations.
3. Socially and/or field irrelevant Training Programmes.
4. Research conducted by RHTC not based on epidemiological lines.

Various issues have been tackled in the analysis of the above problems. They are :

1. Community felt needs.
2. Control by medical personnel.
3. Education and training of health manpower.
4. Top-down policy approach.

In conclusion the study justifies the need to go back to the people/community to understand and provide relevant services to them, to prove relevence of massive infrastructures and funds that are spent in the name of improving community health.

APPENDIX

INTERVIEW SCHEDULES USED

FOR BENEFICIARIES

1. Since how long have you been getting services at RHTC?
2. What services are available at RHTC?
3. Are you happy with the services?
4. If not then what are the reasons in your opinion?
5. Give suggestions to improve the RHTC services.

FOR PHC SERVICE PERSONNEL

1. What are the objectives of RHTC?
2. What are the objectives of the PHC?
   a. Goals
   b. Services provided.
3. To what extent are the objectives being fulfilled of the PHC/RHTC ?
4. List major problems faced by RHTC/PHC in fulfilling its objectives.
5. How can these problems be solved?
6. Suggestions to improve functioning of RHTC/Unit.

FOR TRAINEES

1. What type of training are you getting here?
   Content
   Type
   Duration
   Facilities

2. Is it relevant on the field for you?

3. What problems do you face while training?

4. How can these problems be solved?

5. Suggestions to improve the training schedule?

FOR TRAINING STAFF

1. What are the objective of RHTC?

2. What are objectives of your training school?

   Content of Training

   Type of Training

   Duration of Training

   Facilities for above

   To what kind of trainees (selection of same)

3. To what extent are the objectives of RHTC/School being fulfilled?

4. Please list major problems faced by the RHTC/School in fulfilling it's objective?

5. How can these problems be solved?

6. Suggestions to improve functioning of RHTC/School.

FOR OFFICER-IN-CHARGE, MEDICAL OFFICER-INCHARGE, ADMINISTRATIVE OFFICER

1. What are the objectives, organization structure and functions of Najafgarh RHTC?

2. To what extent are these objectives achieved?

3. Najafgarh was supposed to be the model RHTC of GOI and the first PHC. How much do you think that role has been fulfilled and reasons for non-achievement if any?

4. Please evaluate the services rendered by the RHTC.

5. Please evaluate the present research projects.

6. What is the hierarchy at this moment for policy formulation of the centre?

7. What role does the funding agency play at the RHTC?

8. How much of the community involved with the institute at this time? What are the feelings and attitudes of people towards RHTC?

9. What are the training activities performed at RHTC?

10. How would rate the performance of Institute today? What changes would you envisage/introduce if you are still involved with it.

11. What role in the present perspective, should RHTC play in the Health Services System?

The above questions were put to Dr. P.R. Dutt in context of the phase 2 in the historical note.

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