STUDY OF THE COMMUNITY AND COMMUNITY HEALTH WORK IN TWO PRIMARY HEALTH CENTRES IN CHAMOLI DISTRICT OF UTTAR PRADESH

Dissertation submitted to the Jawaharlal Nehru University
in partial fulfilment of the requirements for
the award of the degree of
MASTER OF PHILOSOPHY

DEVENDRA KUMAR BUDAKOTI

774

926

CSMCH

CENTRE OF SOCIAL MEDICINE AND COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI—110067. INDIA

JULY - 1988

जवाहरलाल नेहरु विश्वविद्यालय
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI-110067

19 JULY 1988

CERTIFICATE

Certified that the dissertation entitled "STUDY OF THE COMMUNITY AND COMMUNITY HEALTH WORK IN TWO PRIMARY HEALTH CENTRES IN CHAMOLI DISTRICT OF UTTAR PRADESH" submitted by Devendra Kumar Budakoti, is in partial fulfilment of six credits for the degree of Master of Philosophy of this University. This dissertation has not been submitted for any other degree of this University or any other University, and is his own work.

I recommend that this dissertation be placed before the examiners for evaluation.

D. Banerji
Chairman

D. Banerji
Supervisor

Centre of Social Medicine & Community Health
School of Social Sciences
Jawaharlal Nehru University
NEW DELHI - 110 067

Gram : JAYENU   Tel. : 667676, 667557   Telex : 031-4967 JNU IN

Dedicated to:

THE HILL WOMEN

WHO WORK HARD

AND

SUFFER MORE

ACKNOWLEDGEMENT

First and foremost, I owe my greatest indebtedness to my guide Prof. D. Banerji, who not only encouraged and helped me but also provided a constant source of enlightenment and learning all through the period of my research.

The faculty members of the Centre of Social Medicine and Community Health who gave their valuable suggestions.

In my field work in Chamoli district, many people were helpful and hospitable. Shri Chandi Prasad Bhatt, Sarvodaya and Chipko leader made my stay comfortable at Gopeshwar. Dr. D.S. Pal, Dr. Upreti, Dr. T.P. Dimri, were very cooperative and hospitable. Mr. D.D. Devrani, was particularly very helpful along with Mr. Negi at Gopeshwer. Mr. Bartwal, Mr. Kimothi, at P.H.C. Pokhari and Mr. S.N. Purohit, Computor at P.H.C. Tharali were very helpful.

The Administrative Staff of my Centre, particularly Mr. S.K. Sarkar, along with the documentation officer, Mrs. M.D. Rastogi and Dr. Lakhan Singh were helpful.

Mr. Gajanan Hegde has done a good job with the Computer-Word Processing and completed the work well in time, despite being overloaded with the seasonal typographic works.

K.V. Narayana was forced to come to my rescue and Sherap Shenga with whom I had fruitful discussions.

Wing Commander, Dr. M.M. Dhasmana, always inspired me to do field work in the hills.

My parents encouraged me throughout my studies and my brothers Sattoo and Suman have been very understanding and also constant critics.

And, Swagata Sinha Roy, gave hope for a better tomorrow, despite constraints.

19th July 1988

Devendra Budakoti

DEVENDRA K. BUDAKOTI

CONTENT

Acknowledgement

List of Tables

List of Maps

CHAPTER-I:	INTRODUCTION	1
CHAPTER-II:	METHODOLOGY	31
CHAPTER-III:	DISTRICT PROFILE: CHAMOLI	38
CHAPTER-IV:	RESULTS - PHC AND VILLAGE COMMUNITY POKHARI	85
CHAPTER-V:	RESULTS - PHC AND VILLAGE COMMUNITY THARALI	121
CHAPTER-VI:	DISCUSSION	150
CHAPTER-VII:	SUMMARY AND CONCLUSION	158
	APPENDIX-A:	165
	APPENDIX-B:	167
	BIBLIOGRAPHY	168

LIST OF TABLES

Sl.No.	Title of the Table	Page No.
1	Demographic Profile of District Chamoli	41
2	Educational Institutions in the District	43
3	Class wise number of students in educational Institutions:A	44
4	Class wise number of students in educational Institutions: B	45
5	Sex ratio in different age groups	51
6	Transportation and Communication in the District	52
7	Number of medical and health institutions in the District	66
8	Allopathic health services in the district	67
9	Position of available build and accommodation - for Health Department in the District	70
10	Staffing position - Health Department, 1987	72
11	Annual sterilization report	75
12	Geographical accessibility to allopathic Hospitals/Dispensaries/PHCs	76
13	Geographical accessibility to ayurvedic Hospital/Dispensaries	77
14	Geographical accessibility to Family Welfare, M.C.H., Sub-centre	78
15	Immunization - 1986-87, in the District	82
16	Maternal and Child Health in the District	83
17	Annual patients - PHC Pokhari	92
18	Yearwise Family Planning, MCH and Immunization Achievement in PHC Pokhari	96
19	Tuberculosis Report: 1986, Dist. Chamoli	102
20	Monthly Patients - PHC, Tharali-1986	128
21	Medical Care Achievement: PHC Tharali-1987	129
22	Yearwise Family Planning, MCH and Immunization achievement - PHC Tharali	132

LIST OF MAPS

3.1 District Map: Chamoli

4.1 Development Block, Pokhari: Health Institutions

5.1 Development Block, Tharali: Health Institutions.

CHAPTER I

INTRODUCTION

The dynamics of the present health status and the health services development in the country has to be seen in the light of various historical, political and socio-economic forces which have influenced and shaped the state and society in India.

"Both the health problems and the health practices of a community are deeply embedded within its ecological, social, economic and political systems. These have a profound influence on the size, extent, and nature of community health problems. They are also of critical importance in the formulation of politics, plans and programmes for dealing with them. Obviously health services are but one of the many factors that influence the health status of a population. Furthermore, as in the case of other factors which influence the health status of a community, its health services are a function of its political system. Political forces play a dominant role. Decisions concerning resource allocation, manpower policy, choice of technology and the degree to which health services are made available and accessible to different segments of the society are examples of the manner in which the

political system shapes community health services" (Banerji, 1985; 3).

The history of national movement shows that leaders in their attempt to get mass support and for mobilisation, promised to give freedom and justice to its toiling masses.

The leaders also had to respond to the aspirations and struggles of the people and hence we have the Constitution which is a product of national movement and the constitutional provision for providing health services for all as contained in the Directive Principles of the State Policy is one of the many promises that the national leaders had made.

The colonial health policy was basically meant to cater to the needs of the rulers for their survival in a 'hostile' environment and to some extent to the Indian upper class.

The emergence of civil lines, cantonments and the hill-stations in the country is a part of that policy (Banerji, 1985; Ramasubban, 1982; Mitchell, 1971).

Independent India's health policies, plans and programmes are traced from the national movement against colonial rule.

In 1938, the Indian National Congress set up a National Planning Commission (NPC), under the chairmanship of Jawarhal Nehru; a sub-committee on National Health (Sokhey Committee) was set up to look into the various aspects of Health and Health Services in the country and to make suitable recommendations for its improvement.

On 31st August 1940, the National Committee adopted the recommendations of the Sokhey Committee report which stated:

1. The State should be responsible for the preservation and maintenance of peoples' health.

2. The integration of curative and preventive services in a single health care organisation under the state control.

3. The training of Basic Health Workers in personal and community hygiene, first-aid and simple medical treatment to meet the immediate needs of the people.

The national movement and the Second World War had put enough pressure on the British government, as a result of which they had to make certain 'promises', which played an important role in shaping the destiny of India.

A Health Survey and Development (Bhore) Committee (Government of India, 1946) was appointed by the British government in 1943, to give a comprehensive health care to the people. The report which was submitted in 1946, was taken as the basis for the health policy of the Indian government.

The Bhore Committee report has such proposals and recommendations which continue to be pertinent and valid even today. The report continues to shape and guide the national health policies and plans.

The principles which guided the Bhore Committee were (Government of India, 1946; v-vi):

1. No individual should be denied adequate medical care because of his inability to pay for it.

2. The health services should provide, when fully developed, all the consultant, laboratory and institutional facilities necessary for proper diagnosis and treatment.

3. The health programme must, from the beginning, lay special emphasis on preventive work.

4. Medical relief and preventive health care must be urgently provided as soon as possible, to the vast rural population of the country.

5. The health services should be located as close to the people as possible to ensure maximum benefit.

6. The active cooperation of the people must be secured in the development of the health programme and the idea that ultimately the health of the individual is his own responsibility must be inculcated in him.

7. Health development must be entrusted to ministers of health who enjoy the confidence of the people and are able to secure their cooperation.

Social orientation of medical practice and high level of public participation were also emphasised by the Bhore Committee.

The Committee also said that the physician of tomorrow must be a scientist and a social worker, ready to cooperate in team work, and be in close touch with the people and serve them as a friend and as leader he should direct all his efforts towards the prevention of disease and becomes a therapist where prevention has broken down; acts as a social physician protecting the people and guiding them to a healthier and happier life (Banerji, 1985).

Factors Influencing Policies and Development

The policies of a nation and the path of its development has to be seen in a historical perspective and in the context of its political economy (Desai, 1984, 1976; Dutt, 1979; Navarro, 1976).

Health policies and their development are also to be seen in the overall development strategy of Indian economy (Battelheim, 1968).

"Health and health services development thus remains basically a socio-cultural process (Banerji, 1985b). For the deprived sections of populations, particularly in the third world, the struggle for health and health services is a part of the struggle to wrest their rights from their tormentors." (Banerji, 1986; 8).

"However, socio-cultural processes, by themselves, do not lead to health and health services development. They merely generate aspirations among the people who can activate the political system (Banerji, 1985b). It is the responsibility of the political leadership to articulate the people's aspirations in the form of political commitment (the so-called political will) and political action. Political actions include allocation of priorities for health and health services, mobilisation of resources and

policy formulations and initiation of the required administrative processes" (Banerji, 1986; 8).

The state intervention in the economy and hence also in the field of health sector has its origins in the western countries. The type of state interventions will depend upon the political economy of a particular nation. The intervention in a capitalist country will differ from that of a socialist country and countries with 'mixed economy' (Renaud, 1975; Berliner, 1975, Navarro, 1977).

In India the concept of mixed economy gained prominence as the state planned to play a dominant role in its development. The leading industrialists also wanted the state to play a major role in developing the economy, not because they preferred a 'socialistic pattern of society' in the country, but because of their weak capital base and the dependency syndrome created by the colonial rule. These industrialists had evolved a comprehensive plan (A Plan of Economic Development for India, 1944) popularly known as the Bombay plan, in which they put forth their ideas, as to how the economy should be developed and what role the state should play in economic development. The Bombay Plan, prepared under the leadership of the leading industrial houses, called for the state control of the economy and stated in unambiguous terms that state alone could mobilize

means of production on the scale necessary. It also conditionally accepted the state ownership of social overheads.

Health Planning

From 1951-52, the Five Year Plans gave policy direction and developmental strategy.

India being predominantly an agricultural country, the state intervention in the field of agricultural and rural development was given top priority.

The community development programme started in October 1952, was a strategy for rural development. Health services development became a part of the community development programme. The establishment of primary health units (later centres) in each development block was part of the rural health services development under the community development programme (Dutt, 1965).

The involvement of foreign agencies and international institutions has to be looked into with some seriousness. The role of World Health Organisation, UNICEF, World Bank, International Monetary Fund, Rockefeller and Ford Foundations in helping the various programmes and projects and in influencing them through the technical

collaboration and monetary assistance, must also be looked into (Banerji, 1986).

The International Committee on Planned Parenthood was invited to hold its third international conference in Bombay by the Family Planning Association in November 1952. The purpose of this invitation was to focus public attention in India on the question of population control at a time when important plans for the development of the country were being formulated.

We can see how right from this period, the myth of population problem was being projected as a hurdle to national development (Banerji, 1986; Demerath, 1970).

International Aid

In the post-Second World War period, the United States have given massive aid for the reconstruction of war-torn Europe and parts of Asia. Later the European Recovery Programme, also called the "Marshall Plan" came up for the development of European economy, which had been shattered due to the War. Similarly, there was "Colombo Plan" for the South Asian countries.

Aid was also received by other developing countries of Asia, Africa and Latin America.

In India, aid came first in the form of Food-Aid; later it took the shape of technical and monetary assistance. This was received through various development programmes and projects - till the end of PL-480, in the late sixties. Now also we receive monetary assistance from World Bank and IMF for various developmental programmes and projects in the country (Shenoy, BR, 1974).

The US aid is linked with its foreign policy objectives, of checking the spread and influence of communism and maintaining of political and economic *status quo* in the developing countries which had been newly freed from their European masters after the Second World War. Many scholars see the international aid as a part and form of imperialism (Demerath, 1976; Hayter, 1971; George, 1976; Frank, 1984).

It is important to quote Harry Cleaver (1977: 557-79) in this regard:

> In a conference in 1950 at Harvard School of Public Health, the Dean, James Simmons said, "Powerful Communist forces are at work in this country and throughout the world, taking advantage of sick and impoverished people, exploiting their discontent and hopelessness to undermine their political beliefs. Health is one of the safeguards against this

propaganda. Health is not a charity, it is not missionary work, it is a merely good business, it is sheer self-preservation for us and for the way of life which we regard as decent. Through health we can prove to ourselves and to the world the wholesomeness and rightness of democracy. Through health we can defeat the evil threat of Communism.

Halverston argued that American support for malaria control could be recieved throughout the world only as a Humanitarian action on the part of the people of the U.S., and their government towards their fellow beings. This would do much to counteract the anti-U.S. sentiments which have been aroused by subversive methods in these countries. If properly carried out programs like these will challenge the Russian approach.

Dr. Russell pointed out that although malaria is no longer a problem in the U.S., it is of tremendous importance to the American businessmen, as 60% of our imports come from and 40% of our exports go to countries in which it is a problem. While concluding, Dr. Russell pointed out that a Malaria Eradication Programme was a dramatic undertaking that would penetrate into the homes of people and would thereby

prove to the people of these under developed countries that we were really interested in their well being".

The present government of India, Thailand, the Philippines and Indonesia, among others have undertaken malaria programs as a major element of their efforts to build political strength and combat communist infiltration.

Health Sector Objectives in Five Year Plans:

The First Five Year Plan, for the health sector had a seven-point public health programme. Malaria control was given top priority as it was the most important public health problem in India.

The following are the priorities in health plan:

1] Provision of water supply and sanitation
2] Control of malaria
3] Preventive care of the rural population through health units and mobile units
4] Health services for mothers and children
5] Education and training in health care
6] Self-sufficiency in drugs and equipments
7] Family planning and population control.

The Second Plan: The general aim of health programmes during the Second Plan period was to extend the existing health services to bring them within the reach of all the people and promote a progressive improvement in the level of national health. In addition to malaria, all communicable diseases control programmes were to be started.

The specific objectives were:

1] Establishment of institutional facilities to serve as a basis from which services could be rendered to the people.

2] Training programmes for developing trained persons in the health field.

3] Communicable diseases programmes to be intensified

4] Campaign for environmental hygiene.

5] Family planning and other services to improve health status of the people.

During the previous plan, some advances were made in the attack on malaria, filariasis, T.B., Leprosy and V.D. The control measures will now be intensified and launched on na' 'on-wide basis.

1] Proposal for control of filariasis - during Second Plan.

2] A programme for Tuberculosis control.

The Third Plan was to continue the basic objectives of the previous plans. the plan was to expand and strengthen the health services in the rural areas. The integration of public health with maternal child health, nutrition was also planned.

Health Survey and Planning (Mudaliar) Committee (Government of India, 1962) recommended the consolidation of the advances made in the first two plans. The Family Planning programme got top priority in its implementation and revenue allocation. In the Third Plan there was a basic shift from the clinic approach to extension in the Family Planning programme.

The national programmes to control and eradicate major diseases like, Malaria, Tuberculosis, Leprosy, Filariasis and later Trachoma continued. These were vertical programmes, as they had a unified and single line of command from top-centre to the bottom-PHC level. These programmes were highly techno-centric, unipurpose with mass campaign and military operation stretegy. The International Organizations like W.H.O., UNICEF and other foreign

agencies, who were giving financial and technical support, advocated this approach. All these control programmes were not integrated with the community development

In this period, we had other Committees which looked into the various aspects of the Health Services and its implementation. These Committees also looked into Medical Education, Research and Manpower Planning.

<u>The Fourth Plan</u>: The Kartar Singh Committee (Government of India, 1973), came at the time of Fourth Plan, it was "The Committee on multipurpose workers under Health and Family Planning". In this period, we see an international campaign to eradicate small-pox, backed by WHO, and other financial institutions of the world (Basu, et al., 1979).

"Development is the Best Contraceptive", came up as a slogan in 1974, but we soon show the population policy and its implementation in emergency of 1975 (Karan Singh, 1974).

<u>The Fifth Plan</u>: This Plan came with the "minimum needs programme" (Government of India, 1974). Increasing of primary health centres and sub-centres, upgrading of PHCs and more allocation for drugs and accommodation facilities for the medical staff.

The "Community Health Worker Scheme (CHV)" in 1977 was a major development in the rural health services, which came with the slogan, "Health by the People". Prof. Banerji calls it a major watershed in the history of health services development in India. "Reorientation Of Medical Education (ROME)" was also initiated in 1977.

The Sixth Plan adopted the objective of "Health for all by 2000 AD", which was enunciated in ALMA-ATA declaration in 1977. The declaration came up with the concept of primary health care approach, which was based on self-reliance, and inter-sectoral development, bridging the cultural gap, making technology subservant to the people, people's participation in health services and a comprehensive health care package to the people, so that health for all by the year 2000 AD becomes a reality.

In 1981, the ICSSR-ICMR Report "Health for all: An Alternative Stregegy" (ICMR & ICSSR, 1981), came out with suggestions and recommendations, so as to provide health for all by 2000 AD. The report was basedafter studying and looking into the state of affairs of Health and Health Services in the country. Despite the criticism, the government has yet to come out with a cogent plan of action to rectify the situation.

The statement on "The National Health Policy-1982, (Government of India, 1982) reiterates India's commitment to the goal of "Health for all by the year 2000 AD" through the universal provision of comprehensive primary health care services. The national health policy has all the elements of primary health care. The policy also states the plan for self-reliance in drugs and other medical infrastructure and the removing of cultural gap between the health services and the people.

Priority was given to extension and expansion of the rural health infrastructure through a network of community health centres, primary health centres and sub-centres, on a liberalized population terms. High priority was given to the development of primary health care as close to the people as possible. These have been done under minimum needs programme.

A primary health centre for a population of 30,000 and a sub-centre for a population of 5000 was planned. A health guide and a trained dia for a population of 1000 was planned. For the Tribal and Hill areas, due to the problem of geographical accessibility, the Primary Health Centres was to be opened for a population of 20,000 population and a sub-centre for 3000 population areas.

<u>The Seventh Plan</u>: The Plan objectives for the Health Sector states (Government of India, 1985) that: The nation is committed to attain the goal of health for all by the year 2000 AD. For developing the country's vast human resources and for the acceleration and speeding up the total socio-economic development and attaining an improved qulity of life, "Primary Health Care" has been accepted as one of the main instruments of action. Primary health care would be further augmented in the Seventh Plan. In the overall health development programme, emphasis will be laid on preventive and promotive aspects and on organising effective and efficient health services which are comprehensive in nature, easily and widely <u>available</u>, freely <u>accessible</u> and generally <u>affordable</u> by the people.

The major thrust to achieve these objectives, about ten areas have been cited (Government of India, 1985: 272-287):

1. The minimum needs programme would continue to be the sheet-anchor for the promotion of the primary health measures with greater emphasis on improvement in the quality of services rendered and on their outreach. These will be backed up by adequate strengthened infrastructural facilities and establishment of additional units where they are not available.

2. Intersectoral coordination of health and health related services and activities with nutrition, safe drinking water supply and sanitation, housing, education, information and communication and social welfare will be made as part of the package for achieving the goal of health for all by 2000 AD.

3. Community participation and people's involvement in the programme involving active participation of voluntary organisations and massive health education movement.

4. Qualitative improvement in health and family planning services, supplies and logistics require greater attention, education and training programmes to be made more need-based. Adequate provision of essential drugs, vaccines and sera. Special attention for ensuring production, pricing and distribution and universal accessibility, availability and affordability.

5. Comprehensive coverage of urban, school, mental and dental health services.

6. Strengthening of control and eradication of communicable diseases programme at all levels.

7. Development of specialities and super-specialities with proper attention to regional distribution.

8. Training and education of doctors and para-medical personnel to be overhauled, so as to relate it to the health problems of the people. Medical training to be need-based, problem centred and Community oriented. Development of health manpower and management.

9. Medical Research for common health problems. Evaluation of intervention and technologies, management information system (MIS), for plannign, implementation and evaluation of health services.

10. Indian systems of medicines, to be developed in teaching, training and research for better standardization, integration and wider application.

Rural Health Programmes

For developing health care delivery system in rural areas, the 7th Plan proposes to use the approach and strategy initiated in the 6th Plan and will pursue vigorously with thrusts on the following areas.

1] Consolidation of the health infrastructure already developed by making up deficiencies in respect of trained personnel, equipment and other physical facilities.

2] The three tier system of sub-centres, primary health centres (PHCs) and Community Health Centres (CHC)

would be further strengthened by converting the existing maternal and child health (MCH) centres and rural dispensaries into PHC's and sub-district hospitals into CHC's and by setting up new functional units wherever necessary. Construction works would be taken up in areas where rented building are not easily available. Low cost models of housing for health centres would be adopted to the extent possible.

3. The multipurpose worker (MPW) scheme would be extended with emphasis on training for ensuring attitudinal changes and developing the required skills among them.

TH-2806

4. Complete integration of the organizational set up under health, family welfare and MCH programme. Financial integration towards the objective of funding all the services as a package programme under a common budget head will also be attempted.

5. Community participation, through village health committee block and district level panchayats and greater participation of voluntary organizations.

6. The state sector, minimum needs programme would be further strengthened by the following programmes - some on-going and some new under the central sector:

DISS
614(545)
B859
St

a) village health guide scheme

b) establishment of sub-centres

c) basic training of para-medical and para-professionals required for rural areas

d) augmentation of laboratory facilities, and

e) orientation, training, integrated health management, information, supply of manuals, kits and other education materials as a part of multipurpose worker's scheme.

<u>Family Welfare and Maternal and Child Health</u>:

Family planning and MCH is to be integrated for betterment of the services and improvement of health status of mothers and children.

The programme in "Family Welfare" includes:

1] Special drives and camps for sterilization by laparascopic technique.

2] Mobilization for implementation of the programme related to IUDs, oral pills and conventional contraceptive use.

3] Education and enlightenment of people on the benefit of late marriage.

4] Inter-sectoral coordination and cooperation and involvement of voluntary agencies (NGO's).

5] Involvement of women and youth groups in social and economic activities, and also of village health committee and mahila mandals.

Maternal and Child Health

1] Training of medical and para-medical in MCH.

2] Associated areas of child immunization, nutrition and control of communicable diseases in infants will be given attention.

3] Development of peripheral infrastructure.

4] Training for health guides, MPW and birth attendents.

5] Filling of vacancies, facilities such as accommodation and transport to workers.

6] Opening of more post-partum centres.

7] Universal immunization.

8] Community participation - Mahila mandals, youth clubs, etc.

Primary Health Care

The primary health care concept came up at the Alma-Ata Declaration in 1978. We have also noticed that some of the basic elements and thoughts of the primary health care approach present can be seen right from the

Bhore Committee report to the present National Health Policy of 1982.

Inspite of all this, when it comes to the implementation of policy, plans and programmes, we notice that there are elements which are, above-down, curative, technocentric and elitist in orientation and approach (Banerji, 1986).

The Alma-Ata Declaration (WHO-UNICEF, 1978) advocated a 'Below-up' approach through the primary health care strategy with the aim of giving health for all by 2000 AD.

Not going into the criticisms of the declaration, what we see is that there are western scholars and health specialists, who advocate 'selective primary health care', which negates the PHC approach (Navarro, 1984; Banerji, 1984).

In actual implementation, we see how UNICEF, being partner and co-sponsorer of the Alma-Ata declaration have deviated from the basic principle of primary health care by their programme - GOBI - Growth Chart, Oral rehydration, Breast feeding and Immunizaion (Grant, 1983).

Taking up the issues concerning the people and health services, WHO expert committee on New Approaches to

Health Education for Primary Health Care (WHO, 1983) has strongly endorsed the views of scholars like Brown and Margo (1978), Nyswander (1967) and Moarefi (WHO, 1978b), describing the conventional approach as paternalistic and commendment like, patronising and victim blaming.

The alternative objectives suggested by it is, to foster activities that encourage people to WANT to be healthy, to KNOW how to stay healthy, to DO what they can individually and collectively to maintain health and to seek help when needed (Banerji, 1986: 51).

Many social scientists have worked in health and related field and have produced volume of literature. They have covered fields like, health education and behaviour, health services in rural and urban areas and family planning, MCH, communicable diseases, sanitation, medical education, health economics and management and political economy of health.

Many of these studies have been unidisciplinary, using 'western frame of reference'. They have not paid often adequate attention to issues such as the poverty, class, exploitation and conflict in society. Even western scholars, like John McKinly, admits that research suffers from at least the following limitations: "much of it is: A

theoretical, frequently ahistorical, usually apolitical, defensive of the *status quo* and dominated by managerialism" (McKinly, 1984).

It is unfortunate that most social scientists who have studied the health culture of rural populations in India have over-stressed the prevalence of superstitutious health beliefs and practices. They have not paid adequate attention to the powerful social, economic and political forces instrumental in causing the decay and degeneration of health culture of the masses. Worse still, even in their descriptions of the existing situation, they have betrayed a pronounced ethnocentric bias (Banerji, 1984: Mimeo, p.10).

"Of late, there has been much more detailed analysis of the relationship between health and health services development and socio-cultural and economic conditions (see for example, Banerji, 1985a; Banerji, 1984d; Illich, 1977; McKeown, 1976; McDermott, 1969; Indian Council of Social Science Research and Indian Council of Medical Research, 1981). These have opened additional dimensions for social science study"[6] (Banerji, 1986: 6).

In India many studies have been undertaken by various scholars like Banerji, Qadeer, Panikar, Djurfeldt and Lindberg, Zurbrigg, Bose and Desai and many others, who

have looked into the social aspects of health services and its development.

Various schemes and programmes and accessibility to the health services have also been studied. The government institutions like National Institute of Health, Administration and Education (now National Institute of Health and Family Welfare) have conducted studies in various field of health and health services. The studies like the integration of health services at various levels of organization and degree of acceptance of the concept of integration by the people (NIHAE, 1971b). There is the study by Timmappya on district health organization. Again in 1978 a number of extensive studies on the community health volunteers scheme have been carried out at NIHFW.

Nineteen villages (eleven of them PHC villages) drawn from eight states of the country were included to study the health behaviour of the population with particular reference to the services that were being provided by the PHCs. The picture that emerged from this study was particularly uncharitable. On the whole, the PHC dispensary projected poor image, discrimination against the poor and the oppressed, poor quality of medicine (only red water), lack of medicines, nepotism, bribary and often rude behaviour of the staff were some of the charges levelled

against most of the dispensaries. Because of this poor image, the dispensary was unable to satisfy a very limited portion of the demand of the villages for medical care services. The enormous unmet felt need was the main motive forces for the rise of a very large number of so-called Registered Medical Practioners (RMPs) or quacks. The family planning programme also present an image which was just the opposite of what was intended. The image in rural areas was that of an organization which used coercion and other kinds of pressure tactics and ofter bribes to entice people to accept vasectomy or tubectomy.

There wa also considerable unmet 'felt need' for the services of the auxiliary nurses, midwife at the time of child birth. Many villages were keen to have an ANMs services because they consider her to be more skilled than the traditional Dai. Whenever the ANMs have provided services the Dai's role have become less significant.

Against the findings from the study of '19 villages' (Banerji, 1982) and against the many important changes that have taken place while implementing the primary Health care in India, it was felt worthwhile to undertake a study of the community and Community health work in Two Primary Health Centres in Chamoli District of Uttar Pradesh.

The object is to assess the present situation with a view to assessing the possibilities of attaining the goal of health for all by 2000 AD. Chamoli district of Uttar Pradesh was selected to get an idea of the problems that are specific to a hill district of the country.

However, because of constraints of time and resources, the study had to be limited, both in terms of the study population as well as the functions of the primary health centres.

The functions of the primary health centres that are proposed to be studied, particularly are:

1) Family planning programme

2) Maternal and child health

3) The immunization programme.

By looking into these specific programmes and its implementation, we may, to some extent, assess as to how much committed and prepared the government is, in their objective of giving health for all by the year 2000 AD.

Objectives : Against the background of the plans and programmes, the present study in a small way proposes to study the community health work in two primary health centres of district Chamoli, in the context of coverage and accessibility of:

1) Family planning programme
2) Maternal and child health
3) The immunization programme.

In this way, we will try to attempt how far the district medical and health department is geared to the objective of health for all by the year 2000 AD, through the primary health care approach.

Health studies in remote regions which have rugged hilly terrain, poor acccssibility, predominance of subsistence agriculture, virtually no industries, low levels of productivity and income and whose economy is dependent upon outside income, has not been undertaken. The present study is a small attempt to do so.

CHAPTER - II

METHODOLOGY

1 The Study Population: An attempt has been made to assess the functioning of selected PHC's in the district. To study the PHC-complex, two PHC's (A) POKHARI and (B) THARALI were chosen. The main criteria was that the PHC should not be enroute to the pilgrim routes to Badrinath and Kedarnath, as the PHCs in these routes are well connected with road transportation and in the 'Yatra" season, these PHCs are well equipped with medicines and staff to cater to the pilgrims. Due to the risk of accidents in the routes, especially in the tourist seasons, the health department is very cautious in the 'Yatra season' of Badrinath and Kedarnath. It was thought that the PHCs in these routes may give a different picture of a PHC's activities and operations, and hence were not taken for study.

The socio-economic conditions of the study population is undertaken to delineate the patterns of interactions between the village communities and the primary health centres.

Two villages were taken in each PHC, one of which is the PHC village and the second village which is in the remoter area of the PHC.

2 <u>Data Required</u>: In order to study the community and community health work in the two primary health centres of district Chamoli of Uttar Pradesh, some general and specific information was required. The socio-economic conditions of the villages, general occupations and sources of livelihood, housing, water supply, medical and educational facilities and communications and more important, the responses of the people to the services offered by the PHC, particularly maternal and child health, the anti-natal and post-natal care by the ANMs, the family planning programmes - giving of oral pills, IUDs and other contraceptives and the immunization of infants and childrens.

At the PHC level, the coverage of family planning programme, the maternal child health and the immunization programmes were taken. The responses and perceptions of the PHC doctor and the para-medical staff about the health status of the people and the quality of health services available to the people. The staff was asked about the attitude and behaviour of the people to the health innovations that are introduced by the primary health centres.

Along with this, the staffing position, the logistic support like equipment, medicines, building, accommodations and the official records on the coverage of

the Maternal and Child Health, Family Planning and immunization will be noted. Tuberculosis and Leprosy programmes also to be seen at PHC and district level.

Secondary data were collected at the district level to get an understanding of the functioning of the district health administration. The staffing position in the district, the health facilities and accessibility, the building and accomodation at the district and block level.

Data were also collected to get an overview of the socio-economic situations in the district as a whole. The survey of socio-economic profile of the district is done for a better understanding of the functioning of the health care services in its socio-economic milieu.

3 Tools Used: Field work was conducted to collect basic information about the health services in the district. Participation and non-participation observations were done and recorded, so as to see the community health work in two primary health centres in district Chamoli.

A general schedule for the PHC was used to get information about the manpower and logistic support at the PHC and through the records of the PHC, information on coverage of Maternal and Child Health, Family Planning and

immunization was seen. Tuberculosis and Leprosy programmes were also looked into.

Interviews were conducted with the doctor and the para-medical about the health services in general and about people's behaviour to health innovations.

Similarly, in the village, a general schedule was used to get some basic information about the village, viz., on occupations, housing, sanitation, water supply etc. The people were interviewed in groups and individually, depending upon their availability to get information on their understanding of health problems, the functioning and services provided by the PHCs. Questions were also asked about their socio-economic conditions and political awareness. Data collected were qualitative in nature.

The secondary data about the district in general was collected from the Census report of 1981, and the district statistical handbook of 1986 (Handbook-Chamoli, 1986).

The information on staffing position, availability of health services, accomodation and building was done through the records at the chief-medical officer's office, at the district headquarters.

Certain basic informations about the villages was also seen from the unpublished records available at the district statistical office.

4 <u>The Process of Data Collection</u>: Field work for data collection started in two phases. The first was the visit to the district headquarters at Gopeshwar in the month of October 1987, to get some basic information about the district in general and health services in particular. This was done with the visit to the CMO's office and the district statistical office. The investigator had also gone to Garhwal University to get information pertaining to research work done in the field of health services in the region.

A general discussion with few of the local college teachers, journalists and Chipko leader and activists was done. The investigator also went to Joshimath block and to village RENE, known for its Chipko movement. Later went to DEVAL and THARALI block. From the first visit a general idea of the district was known through the information gathered from the CMO's office and the statistical handbook.

The second phase started only after getting the basic information of the district, the locations of the PHCs etc. The basic planning for the second phase was done at the Centre of Social Medicine and Community Health, JNU,

Delhi. The second phase started in mid-November and continued till mid-December.

The second phase also started with the visit to the district headquarters at Gopeshwar, so as to plan the field visit to the selected PHCs of the district. The first field visit was to PHC-POKHARI. After general introduction and settling down at this block beadquarter, data collection, along with interviews started in the subsequent days.

The village Nakholiyana was studied which is a part of Pokhari gram sabhas. The second village selected was Nali. It is one of the remotest villages of the PHC. A Mahila Mandal meeting was called here and women were interviewed in general. A Family Planning Camp was also visited in this area.

In the PHC, a monthly meeting of the PHC staff was observed along with interviews of ANMs and male workers. All the three medical practitioners in this block headquarter area were also interviewed.

Similarly, the second PHC-THARALI was studied. The PHC-village Tharali and one of the remotest village Dungeri, were studied to know the people, their response to the health services provided by the primary health centre. Data were collected at the PHC and village through general

observation of activities and through the interviews of people in groups and individually. The data were qualitative.

The field work involved a lot of walking as the district lacks road communication and transport facilities, more so in the interior and remoter regions of the district.

The advantage of belonging to the region, knowing of local language and my family background of Army, helped the investigator to have an instant rapport with the PHC staff and the people in the villages. The frankness and openness of the people both at the PHC and in the villages was very advantageous in knowing the situation of health services in the district.

2.5 Limitations of the Study: The study is limited to only the three major aspects of the health services, viz. maternal and child health, family planning and immunization programme.

The study may not have all the details of the PHCs, the village communities and the health culture of the people.

The limitations have come up due to the paucity of time, finance, difficult terrain and very limited facilities of transport and communication and availability of information in the region.

CHAPTER - III

DISTRICT PROFILE : CHAMOLI

An Overview of District CHAMOLI

The hill district of Chamoli was formed in the year 1960. It is one of the eight hill districts of Uttar Pradesh state. The hills of U.P., called Uttarakhand, are situated in the North-Western part of the state.

The district which is situated in the Central Himalayan region, has an area of 9,125 sq.km. It is 129 km. from south to north and 117 km. in its breadth from east to west. In its north lies Tibet and to the north-east the district of Uttarkashi, on the east is Pittoragarh and on the south-east, is district Almora. On the south-west is the Pauri-Garhwal district and on the west is the Tehri-Garhwal district.

G.D. Berreman (1983: 253), who has extensively worked and studied the people and society of Uttarakhand, writes, "Himalayan people live a hard, self-sufficient life of subsistence farming, animal husbandry and craftsmanship. There are few of the landless and bonded labourers, and few of the wealthy and absentee landowners which abound on the plains. Their caste system, although firm, is simpler than

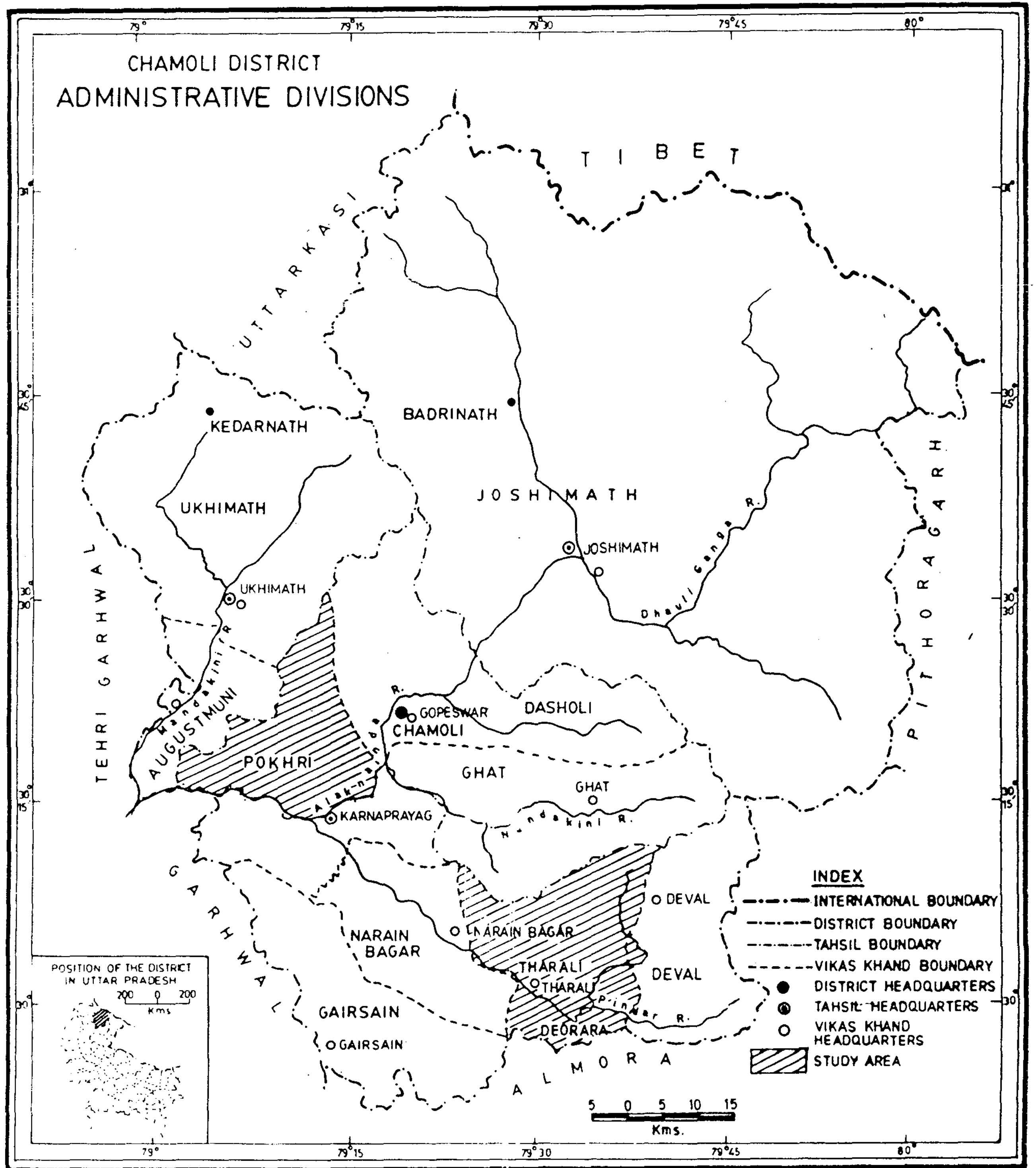


Fig. 3.1

that of the plains. Its occupational rigidities, hierarchical social segregation, economic disparities, consequent human miseries and resentments seem less than those of the plains. They are vitally aware of the vulnerability of their soil, forests, and water, and of their utter dependence upon them. As a result, they nurture their difficult and fragile mountain environment for more carefully and intelligently, with more foresight, than the exploiters, entrepreneurs, and politicians of the plains are wont to do - perhaps more than plainsmen nurture their own plains environment".

The District has four sub-divisions - Joshimath, Ukhimath, Chamoli and Karnaprayag with district Headquarters at Gopeshwar.

The district is divided into eleven development blocks, viz. Joshimath, Karnaprayag, Gairsain, Narayan-bazar, Tharali, Deval, Dasholi, Ghat, Pokhari, Ukhinath, and Augustmuni.

About 58% of the area is under forests with steep and rocky structures where only terraced cultivation is possible. Though the actual area of forests will be reduced if the area under perpetual snow and rocks is ignored.

Climate and Rainfall

The district climate varies according to the altitude of the place, as the elevation of the district ranges from 1,200 m to 8,000 m. The winter season, as in most parts of Northern India, is from about mid-November to March. Similarly, rainfall being heaviest in the monsoon from June to September, with 70-80 per cent. of the annual precipitation is accounted for in the southern half of the district and 55 to 65 per cent in the Northern half.

Demographic Profile

The population of the district, according to the 1981 census was, 3,64,346, of which, the population in rural area was 3,35,174 (91.99%) and 29,174 (8.01%) in the urban area (see table 1).

The district has a density of 40 persons per sq.km. as against the state average of 377. There has been 24.53% increase in population, in the last decade.

The urbanization process has been low. In 1971 the urban population accounted for 4 per cent and rural population, the remaining 96 per cent. In 1981, there was a marginal increase in the urban population which accounted for 8.01 per cent. while the remaining 91.00 per

Table 1:

DEMOGRAPHIC PROFILE OF DISTRICT CHAMOLI

Name of Development Blocks	Area Sq.Km.	% of area of district	Population	% of population of district	Density	Total No. of Males	Total No. of Females	Sex Ratio	SC/ST population	% of SC/ST population	Sex ratio of SC/ST	% of LITERACY			% of Main workers	% of cultivators	% of Agri. Labourers	% of Household workers	% of Marginal workers	% of other workers
												Male	Female	Total						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
JOSHIMATH	3635.0	39.83	18638	5.11	5	9471	9161	967	7493	40.20	1077	53.69	17.20	35.74	53.68	32.82	0.05	6.00	5.34	9.45
KARNAPRAYAG	299.3	3.28	26065	17.15	87	12225	13840	1132	3961	15.19	959	63.61	25.17	43.20	49.68	34.54	0.07	0.40	8.68	5.79
GAIRSAIN	406.8	4.45	4926	11.23	100	19408	21518	1108	5914	14.45	1046	51.79	11.55	30.63	51.85	42.75	0.04	0.37	4.87	3.80
NARAYAN BAZAR	274.0	3.00	36958	10.14	134	16813	20145	1198	6452	17.45	1052	57.67	17.14	37.58	51.72	42.36	0.02	0.19	4.83	4.31
THARALI	272.4	2.98	23588	6.47	86	11170	12418	1111	4477	18.97	1031	53.00	13.33	32.11	47.22	36.39	0.13	0.55	4.12	6.01
DEVAL	511.0	5.60	15774	4.32	31	7623	8151	1069	3017	19.12	929	53.75	10.87	31.59	55.92	42.96	0.20	0.31	8.79	3.63
DASHOLI	794.0	8.70	26779	7.34	34	13204	13575	1028	7219	26.95	942	54.54	18.41	36.22	45.26	32.34	0.27	1.07	6.12	5.44
GHAT	283.0	3.10	22480	6.16	79	10850	11630	1071	4419	19.65	988	44.84	7.89	25.36	52.89	41.05	0.07	0.07	8.29	3.39
N.POKHARI	547.8	5.99	40248	11.04	73	18529	21719	1172	7007	17.40	1010	56.68	20.47	37.14	47.36	38.93	0.50	0.50	3.70	4.10
UKHIMATH	1026.0	11.24	30472	8.36	30	15106	15366	1017	4405	14.45	984	60.71	15.93	38.13	51.83	42.40	0.44	0.44	2.50	6.41
AUGUSTMUNI	516.0	5.65	51213	14.04	99	24316	26897	1106	9807	19.14	993	57.27	19.32	37.34	50.88	37.49	0.31	0.61	6.73	5.70
DISTRICT																				
RURAL	9050.0	99.17	335172	91.99	37	160364	174808	1090	64606	19.27	1002	55.40	16.59	35.16	50.62	38.66	0.146	0.77	5.57	5.48
URBAN	75.0	0.82	29174	8.00	389	17979	11195	622	7444	25.51	780	75.24	45.61	63.87	43.73	7.94	1.8	1.94	2.55	30.86
TOTAL	9125.0	-	364346	-	40	178343	186003	1042	72050	19.77	977	57.40	18.34	37.46	50.67	36.20	0.14	0.87	5.32	7.51

Source: Compiled from Statistical hand-book - Dist. Chamoli, 1986.

cent constituted the rural population. The literacy rate for the district was 37.46 in 1981, which is well above the state average of 27.2%. There is slight variation in the various blocks of the district (see table). It has second position in the rural male literacy rate in the state, which is 55.40%. The women's literacy rate in the rural area is quite low - 16.59 per cent. The literacy rate is quite high in Uttarkhand (39.3%), compared to state average of 27.2% per cent.

The status of women, can be seen from the low literacy rate, compared to the male. Even the attendance of girls is low in primary schools and much lower in middle schools. The approximate percentage of girls in primary school comes to 40 per cent and their percentage further falls down to 20% approximately at the middle school level (see table 3 and 4).

The sex-ratio is 1043 females per thousand males. This sex-ratio is present in all the rural areas of the hill districts of U.P. In Chamoli, the rural sex-ratio is 1093, with U.P. average of 893. Sex ratio is one of the most important features of the population composition of the U.P. Himalaya.

Table 2:

EDUCATIONAL INSTITUTIONS IN THE DISTRICT - BLOCKWISE

Year/District/ Block	Junior Basic School	Senior Basic School		High School/ Intermediate		Post-Graduate College	Uni-ver-sity
		Total	Girls	Total	Girls		
1	2	3	4	5	6	7	8
1983-84	706	134	5	70	5	3	-
1984-85	731	142	6	70	5	3	
1985-86	786	150	8	90	5	3	-
BLOCKWISE [1985-86]							
JOSHIMATH	64	14	1	4	-	-	-
KARNAPRAYAG	69	13	1	7	-	-	-
GAIRSAIN	76	12	-	12	-	-	-
NARAYAN BAZAR	80	19	2	11	-	-	-
THARALI	51	11	1	5	-	-	-
DEVAL	44	10	-	3	-	-	-
DASHOLI	56	13	-	4	-	-	-
GHAT	49	10	1	3	-	-	-
N.POKHARI	94	14	-	8	-	-	-
UKHIMATH	69	9	-	10	-	-	-
ANGOSTMUNI	94	21	2	13	1	1	-
DISTRICT							
RURAL	746	146	8	80	1	1	-
URBAN	40	4	-	10	4	2	-
TOTAL	786	150	8	90	5	3	-

Source: Statistical hand-book - Dist. Chamoli, 1986.

Table 3:

CLASSWISE NUMBER OF STUDENTS IN EDUCATIONAL INSTITUTIONS—A

Year/District/ Block	Class 1 to 5				Class 6 - 8			
	Boys		Girls		Boys		Girls	
	Total	SC/ST	Total	SC/ST	Total	SC/ST	Total	SC/ST
1	2	3	4	5	6	7	8	9
1983-84	30993	5963	22668	2983	13283	1952	4009	383
1984-85	32138	8816	23181	4706	14003	2409	4062	1207
1985-86	32164	6005	22952	3502	14707	2107	4010	907
BLOCKWISE [1985-86]								
JOSHIMATH	1161	608	867	705	355	301	164	56
KARNAPRAYAG	2712	297	1919	123	794	130	130	35
GAIRSAIN	3940	495	1834	161	1316	112	430	52
NARAYAN BAZAR	3478	477	2353	162	1594	191	285	92
THARALI	1964	411	1143	171	948	134	223	30
DEVAL	1278	269	621	95	753	126	103	20
DASHOLI	2459	737	1717	473	1341	140	501	34
GHAT	1962	391	871	162	560	85	54	25
N.POKHARI	3243	553	2946	271	1619	132	380	74
UKHIMATH	3465	381	2177	147	1581	127	405	37
AUGUSTMUNI	4416	874	5323	319	2126	227	722	58
DISTRICT								
RURAL	30578	5493	21771	2789	12987	1719	3411	513
URBAN	1586	512	1181	713	1720	388	599	394
TOTAL	32164	6005	22952	3502	14707	2107	4010	907

Source: Statistical hand-book - Dist. Chamoli, 1986.

Table 4:

CLASSWISE NUMBER OF STUDENTS IN EDUCATIONAL INSTITUTIONS - B

Year/District/ Block	Class 9 to 12				Degree Classes			
	Boys		Girls		Boys		Girls	
	Total	SC/ST	Total	SC/ST	Total	SC/ST	Total	SC/ST
1	2	3	4	5	6	7	8	9
1983-84	9605	1281	1455	91	1157	95	72	12
1984-85	10312	1459	1657	258	1219	107	82	12
1985-86	10985	1944	4778	400	1423	239	218	41
BLOCKWISE [1985-86]								
JOSHIMATH	281	131	67	28	-	-	-	-
KARNAPRAYAG	996	171	210	1	-	-	-	-
GAIRSAIN	945	78	152	12	-	-	-	-
NARAYAN BAZAR	770	85	93	2	-	-	-	-
THARALI	675	65	121	8	-	-	-	-
DEVAL	299	20	281	2	-	-	-	-
DASHOLI	997	361	133	111	-	-	-	-
GHAT	268	47	228	7	-	-	-	-
N.POKHARI	984	101	895	12	-	-	-	-
UKHIMATH	1007	97	143	11	-	-	-	-
AUGUSTMUNI	1770	112	1667	9	265	42	29	1
DISTRICT								
RURAL	8992	1268	3990	203	265	42	29	1
URBAN	1993	676	788	197	1158	197	189	40
TOTAL	10985	1944	4778	400	1423	239	218	41

Source: Statistical hand-book - Dist. Chamoli, 1986.

Religions and Caste Composition

The district has predominantly Hindu population (99.41%) and then Mulsims with 0.43 and Sikh with 0.08 per cent. The Scheduled Caste being about 17.26 per cent and Scheduled Tribe 2.52 per cent. Whereas the Scheduled Caste population is present all over the district, the tribal population is more concentrated in the interior sub-division of Joshimath.

The significant castes in the district are the Brahmins, Rajputs and the Harijans, represented by Doms, Kols, Lohars and Bajgirs.

The tribal are generally called BHOTIAS, the Bhotiyas are mainly subdivided into the TOLCHA and MARCHHA. The tribal population is getting stratified on the basis of caste categories. The tribal population is distributed in the upper valleys of the Himadri rivers comprising of the north-eastern part of the Uttarkhand Region, near the international borders with Tibet and Nepal. The Bhotiyas can be seen right from the Mana-niti-pass region upto the Kali valley.

The Economy

The economy of the hills is now generally called the 'money-order economy', which means, the dependence of

the people on remittances of income earned in non-agricultural pursuits in various parts of the country.

For generations the people living in the hill areas had a life style based on the subsistence economy comprising mainly of animal husbandry and agriculture. The support base of these came from the natural ecosystem which provided them with food and fodder. There was enough water sources and fertile top soil, which managed its subsistence agriculture.

In post-independent India, the region has seen increasing felling of trees, construction of roads and dams, which has led to ecological degradation. Due to indiscriminate exploitation of the natural resources, the young and fragile Himalayan ecosystem has been disturbed.

Hill Development: In the name of rural development, people are temporary employed in some scheme to repair roads, canals or fencing of some forest land, for which they are paid in cash and kind.

The scheme of loan giving, for various purposes like buying of cattle, goats, mules etc. have not served its purpose. This system of giving loans has now corrupted the simple hill folks, as at every stage of getting the

loan, there are commission and 'kick-backs' and there is no secret about it. This is how we are planning and running our rural development programmes!

With nothing much done to develop the rural areas of the hills and the increasing pressure of population on small percentage of land available for cultivation, poor yield and very low income through agriculture, the people, especially the males, are forced to leave the place for their livelihood.

Inspite of a growing concern in the country about such problems as soil erosion, floods, landslides, siltation of dams, degradation of flora and fauna in the Himalayan regions, there has not been any concrete policy, plan and programme to preserve and maintain the devastating consequences of the ecological and environmental degradation. A stage has now come where the population is threatened of being deprived of its basic life support system.

The district of Chamoli, as other hill districts of U.P., has a very under-developed agriculture. With an area of 42.6 thousand hectares available for cultivation, which is only 4.7 per cent of total area of the district, one can see how limited is the land available for

cultivation. This implies that the per-cultivator holding size is very small.

However, while population density is low as 40 per sq. km, the district population has risen by 24.5 per cent in the last decade. The district population per hectare of sown area works out to be 8.5, as compared to 6.0 for the whole state. One can see the pressure of population on the available land, with the above facts and with 36% of total population reported to be engaged in agriculture.

The causes of agricultural backwardness can be easily seen from the fact that about 42.6 thousand hectares is available for cultivation, which is only 4.7 per cent of total area, out of which only 2.8 thousand hectares is irrigated, which comes to about 6.46% of net irrigated area from total sown areas. The fertilizer use per hectare is only 5.1 kg with no use of modern implements and tools. With a rugged terrain, the yield in agriculture is not able to provide food for subsistence of the population. The region remains to be net importer of food grains from the plains.

Due to poor agriculture, the related secondary and tertiary sectors of economy have also not developed. The agricultural labour in is only 0.17 per cent.

In the year 1984-85, the total cereals productions was only 63.3 thousand metric tons and potatoes production was 26.2 thousand metric tons. There are about 1138 small industrial units, which employ about 3486 persons.

In a situation, where agriculture is backward, with virtually no indsustries in the district, the youths prefer to migrate to plains for gainful employment. Traditionally the youth of the region joined the army, para-miliatary, police and other low class jobs in government departments.

With increasing literacy rate, the rate of migration and unemployment rate has increased, as there is no scope or incentive for educated youth to do some self-employment. Only a small portion of men of working age finds local employment on road construction works or on the local staff of government office. High literacy has given rise to considerable net out migration.

Migration and the coming of 'money-order economy' has direct relationship. These two phenomenon are common to all the eight hill districts of U.P. (Dobhal, 1983).

The migration is only in the working age group and majority of the masses go to the plains or join service, as agriculture hardly provides employment or subsistence.

Sex-ratio in different age group gives us the migratory group and the health status of women can be seen, from the sex ratio, in the age group 60 and above, which is 931.

Table 5: Sex Ratio in Different Age Groups

	Age group	Male Number (%)	Female Number (%)	Total (%)	Sex Ratio
1.	0 - 14	58424 (50.03)	58331 (49.96)	116755 (39.40)	998
2.	15 - 59	70906 (46.83)	80517 (53.17)	151423 (51.75)	1135
3.	60 & above	12632 (51.78)	11761 (48.21)	24393 (8.33)	931

[Based on 1971 Census]

Transportation and communication is generally poor in the district. Road communications in the district received a big boost, after the Chinese war in 1962 and also due to the pilgrims centres of Badrinath, Kedarnath and other religious and tourist centres. The district has 314 post-offices, 60 telegraph offices, 376 telephones, 60 PCOs, and 109 bus station/stops. The Railway head is at Rishikesh, which is approximately 215 km from the district HQ (See table 6).

Table 6

TRANSPORTATION AND COMMUNICATION IN THE DISTRICT

Year/District/ Block	Post Office	Tele-graphic Office	Tele-phone	Public Call Office	Railway Station	Bus Station/ Bus stop
1	2	3	4	5	6	7
1983-84	304	57	372	57	-	107
1984-85	304	57	372	57	-	109
1985-86	314	60	376	60	-	109
BLOCKWISE [1985-86]						
JOSHIMATH	36	6	7	6	-	11
KARNAPRAYAG	34	8	10	8	-	17
GAIRSAIN	24	3	3	3	-	9
NARAYAN BAZAR	35	5	7	5	-	10
THARALI	20	5	11	5	-	5
DEVAL	19	1	1	1	-	1
DASHOLI	24	5	19	5	-	10
GHAT	27	1	6	1	-	2
N.POKHARI	19	1	1	1	-	6
UKHIMATH	23	9	21	9	-	16
AUGUSTMUNI	37	6	26	6	-	14
DISTRICT						
RURAL	298	50	112	50	-	101
URBAN	16	10	264	10	-	8
TOTAL	314	60	376	60	-	109

Source: Statistical hand-book - Dist. Chamoli, 1986.

From Pilgrimage to Tourism

The Himalaya have been sacred to Hindus. The region of Uttarkhand has a prehistory as well as historic background and legend. The Himalayan region has important centres of pilgrimage since long. District Chamoli has major religious shrines like the temple of Badrinath and Kedarnath. It is the DEV-BHOOMI (The land of Gods) for all the God-fearing Hindus. The pilgrimage centres have sown the seeds of tourism in the region. Since time immemorial tourism in the form of pilgrimage has been a regular feature. It provides a lot of attractions for the adventure seekers, mountain lovers, through its beautiful landscape, natural scenery and wide range of flora and fauna. After the main Hindu centres of pilgrimage - Hemkund Saheb is a great place of pilgrimage for the Sikhs, which is also located in this district. The Valley of Flowers, has since long attracted the adventurous people and nature scientists. The mountains and peaks in the district have attracted people. There has been a regular mountaineering expeditions in the famous peaks of the district viz. Kamet, Nandadevi and Trishul.

Inspite of the lack of infrastructure for tourism, in the recent years, there has been an increasing number of tourists for trecking, mountaineering, water sports and the

winter sports, along with the regular stream of pilgrims to the temples of Badrinath and Kedarnath.

Social and Political Movements

The impact of socio-economic and political change in the country has also influenced the culture of the hills.

Due to lack of any concrete hill development policy and programme, the region has faced underdevelopment in all the sectors of the economy. The disenchantment of the people has been seen in various movements in the region.

Chipko is one of the well known movements which shows people's solidarity to fight for its rights and to prevent its natural resources. Much has been written and reported on Chipko by various people and institutions (Shiva, 1988; Das and Negi, 1976).

The Chipko movement had its impact at the National and International levels, on the various ecological movements in the country and in the world.

The Tehri dam project and the agitation against the project has come from the Chipko movement. The Tehri dam still remains a controversial issue to ecologists, geologists, civil engineers and planners.

The movement is said to have been started in the tribal village of Reni, in Joshimath sub-division of district Chamoli. Women have been active participants in this movement. Gaura Devi's name always comes in readily when one talks of village Reni and the Chipko women. Gaura Devi has no formal education, but through practical experience, knows the importance of trees and forests for the well-beings of the people. The Chipko movement later swept the whole of Uttarkhand region and later we see its impact in various parts of the country and abroad.

Demand for separate hill state of Uttarakhand has been there right from 1951, but there was never a mass mobilisation for this demand. The formation of 'Uttarakhand Kranti Dal' in the early seventies raised its voice primarily for a separate hill state. It is now gathering momentum in the hill areas and the support base is also coming from the hill peoples who have settled or migrated for jobs in the various parts of the country.

G.D. Berreman (1983: 253) writes, " 'Uttarakhand ' and 'Chipko' are examples of words of hope which have become rallying cries for mobilisation of action of Himalayan peoples of Uttar Pradesh.

"The regional press, regional political leaders and parties, regional associations, regional universities -- all

are products and instrumentalities of this trend, both are advocates of, and arenas for, its formulations and dissemination.

"The indigenous, conservationist Chipko movement (of Berreman, 1979: 27.32, 36.37; Das and Negi, 1976); Dogra, 1980) is but a vivid expression of their understandiang of, and concern for, the environment as the basis for their well-being. This movement brought together men and women, high caste and low caste, Bhotiyas and Hindus, to protect their forests in direct confrontation with rapacious entrepreneurs but on quick profits from forests contracts thoughtlessly or callously awarded by uninformed or disinterested officials, who, in so doing, put the very livelihood of local inhabitants and vital resources of the nation at risk.

"The Uttarakhand movement in U.P., for example, has asserted regional pride and solidarity, working towards various kinds of regional institutions, regional representation and self-administration and protective legislation.

"This social and political movement has attracted the attention of officials, politicians, scientists and public throughout India and beyond for the same reason that it offers hope to the Himalayan people and the thread of

optimism to me because it has been a grassroot movement among a wide variety of people in U.P. Himalayas organized to prevent the wanton destruction by outside entrepreneurs under government license of Himalayan forests and thereby to conserve the water and soil which they protect as well as the fodder, firewood and lumbar they produce.

"All are necessary to the survival of the mountain people and, if only they knew it, of the plains people as well. This movement has demonstrated, in the context of social and political action, the ability of mountain peoples to define a problem and its solution and then work together despite differences of culture, caste, community, sex, economic conditions, education, and political sophistication, to solve that problem even in the face of official indifference or opposition. It is these qualities which their leaders and their government must tap if these people and their environment are to be preserved and to prosper, thereby contributing to the welfare and prosperity of the nation.

"Unhappily, the Chipko movement has remained limited in extent, scope and effectiveness, and seems now to be becoming mired down and subverted by political manoeuvering quite unrelated to its original purposes. A much broader, more concerted, better financial, and more

widely supported effort to prevent Himalayan ecological devastation is required. This kind of effort is possible only through uncompromising and enlightened government programmes designed and implemented in the public interest, free of exploitative entrepreneurial influence and with full participation and endorsement at every level (formulation, implementation, evaluation, and administration) by representative members of the entire range and diversity of Himalayan peoples" (Berreman, 1983: 261-262).

In district Chamoli, the Chipko movement has special significance, as it started in the interior subdivision of Joshimath, but the demand for separate state of Uttarakhand has not yet taken grassroots in the district. There are students, youth and teachers and people in urban areas, who have taken active part and interest in their bid for a separate state of Uttarakhand. But a grassroot movement for this demand is yet to be seen. The demand of Uttarakhand still remains to be a urban and middle class phenomenon in all the eight hill districts of U.P.

Health Services in the District:

Historical Development

The 'Health Culture' of India, can be traced back to the Vedic period, where perception, meaning and the response to the various health problems of the individuals and of society were based on their understanding of man, nature and God. Thus the health behaviour of the people was centering around the religious institutions.

The Ayurvedic system of medicine which was practised from earlier times all over the country was also in vogue in this district for the treatment of different physical ailments, though the various kinds of herbs and minerals, till the British introduced the allopathic system of medicine.

Through the government patronage, the allopathic medicine got established, and the Ayurvedic system got relegated to the background, though it still met the needs of the majority of the people, as the allopathic medicines were not accessible to the vast majority of the people who lived in the rural areas.

The plants and herbs greatly valued in Ayurveda are found in this district. Minerals such as sulphur, borax, gypsum and silajit (impure sulphate of alumina) are

also considered to have great therapeutic value in Ayurveda, as is Musk, which is obtained from the musk deer which is found in this district. The district also has a number of thermal and medicinal springs which are known for their healing properties. Some of these are the Gaurikund on the way to Kedarnath and another one near Trijugi Narayan.

In the past, as in the rest of the country, the diseases were generally attributed to sins, crimes and disobedience of religious and natural laws and accordingly those who treated such troubles claimed to possesss healing powers through magic, incantatious, exorcism and propoitiation of malevolent spirits and stars.

"The shrines of Kedarnath and Badrinath have been attracting pilgrims since the earliest times from all parts of the country. Indigent pilgrims and sadhus who have to face hazards of the country, endure sharp changes of climate and suffer from inadequacy of provisions on their way, at times fell sick and were stranded.

"A SADABRAT endowment was created early in the nineteenth cenury, mainly for the purpose of providing free food to such persons.

Later the surplus funds came to be devoted to works of general utility. By about 1910, the entire

proceeds of the Trust were devoted to the maintenance of the dispensaries at Ukhimath, Badrinath, Chamoli, Joshimath and Karnaprayag, which were placed in the charge of the civil surgeon who had his headquarters at Pauri in Garhwal. The district boards, Pauri-Garhwal, also contributed to the charges of the maintenance of these dispensaries" (District Gazetter - Chamoli, 1979: 142-150).

After Independence, the Medical and the Public Health Departments in the state were amalgamated in 1948 and a Directorate of Medical and Health Services was created which controlled the allopathic, the Ayurvedic and Unani Institutions and services. A separate directorate was created in July 1960 to have an effective supervision and encouragement of the Ayurvedic and Unani Institutions. The state Ayurvedic dispensaries in the district are controlled by the directorate and their expenditure borne by it. The Chief Medical Officer has the local administrative control and power.

Organizational Set Up

The district health services are headed by the Chief Medical Officer (CMO) who is assisted by three Deputy CMOs in the district.

The CMO has his administrative staff which includes Administrative Officer, the Head Clerk, Stenographers and a number of clerks and assistants to do day-to-day administrative work.

There is a Health Education and Information Officer with a projectionist for screening the films on health and education and family planning.

There is a district hospital at Gopeshwar which is headed by a Senior Medical Superintendent. The CMO is overall administrative incharge of the district hospital, but the Senior Medical Superintendent has equal status with the CMO.

The district has a T.B. hospital, with a district T.B. officer at the hospital and another doctor at the district T.B. Centre. Both the doctors stay at the same location. There is also a police hospital with a medical officer incharge.

There are 16 primary health centres, 11 in each block and five of them are additional PHCs. Except one none of the additional PHCs has a doctor. These additional PHCs have been converted from the state allopathic dispensaries.

The PHC buildings are undergoing further construction for upgradation. The district has 42 state

allopathic dispensaries (SAD), only ten of which have a doctor present; in the rest of 32 SAD, only 25 have now appointed Ayurvedic doctors who are working on daily wages of Rs.50 per day.

Female hospitals are attached to the PHC without any additional doctor or building. The district has a post-partum centre, which is part of the district hospital.

There are doctors at the PHCs and the sub-centres have the ANMs and the male workers at the periphery, to carry the task of family planning, maternal and child health and the immunization programme.

The District Hospital

The present district hospital was first located at Chamoli, before it was shifted to Gopeshwar. The roots of this district hospitals can be traced to a dispensary founded in 1894 at Chamoli, which functioned till 1960, when it was converted to a district hospital, when district Chamoli was carved out of district Pauri-Garhwal. The district headquarters and the hospital were shifted to the present site at Gopeshwar in early '70s, due to massive floods in Alakhanda river at that time which washed away the small town of Chamoli causing heavy damage to life and property.

The head of the district hospital is the Senior Medical Superintendent. The hospital has one surgeon, one orthopedician, one each ENT, cardiologist and dental surgeon. The hospital has vacancies one each for eye surgeon, physician, pathologist, anaesthetist and pediatrician.

The hospital has one lady doctor at the post-partem centre, which looks after the family planning cases, the delivery cases and the maternal child health. She also goes to the family planning camps which are held in various parts of the district.

The post-partum centre which is supposed to give free medical services is reported to taking money for its services. In the month of December 1987, the lady doctor of the hospital was charged with corruption and for negligence, while performing a delivery operation. A court case was filed at the local district court by affected party against the doctor.

The medical facilities available in the hospital include cardic investigation centre, an orthopedic unit, emergency service, anaesthetic unit, ENT unit, dental medical and surgical unit, X-Ray, eye unit and ambulence service.

Health Services and Institutions

There are a number of medical and health institutions, services and facilities available in the district (see table 7 and 8), as the official records shows.

Starting from the bottom, it has 124 sub-centres and 361 health guides. The number of beds (allopathic) available in the whole district is 430. The district has one general nursing training centre, one female health workers training centre, one tehsil level post-partum centre at Joshimath, and one town PPC at Gopeshwar.

There are 11 PHCs with 5 additional PHCs, five female hospitals which are attached to the PHC, without any separate building or doctor. There are 42 state allopathic dispensaries, 58 Ayurvedic dispensaries, 6 Homoepathic dispensaries. There is a T.B. hospital with leprosy unit and venereal disease clinic. And finally there is the district hospital to which the serious and complicated cases are referred to from the peripherial areas. The T.B. hospital is about 5 km away from the main town.

The Health education is almost a neglected field. The vehicle allocated for the purpose to the health education and information officer is hardly at his disposal.

Table 7

NUMBER OF MEDICAL AND HEALTH INSTITUTIONS - BLOCKWISE

SL. NO.	Name of the Block	Name of Primary Health Centre	No. of Allopathic Dispensary (SAD)	No. of Ayurvedic Dispensary (Hospital)	No. of Homeopathic Dispensary	No. of Female Hospital	No. of Subcentre
1.	2	3	4	5	6	7	8
1.	JOSHIMATH	JOSHIMATH	7	5	1	1 (PHC Joshimath)	12
2.	DASHOLI (CHAMOLI)	DASHOLI (CHAMOLI)	2	6	2	-	12
3.	GHAT	GHAT	3	6	-	-	6
4.	KARNAPRAYAG	KARNAPRAYAG	5	5	-	-	11
5.	N.POKHARI	1. POKHARI	2	5	-	1 (PHC) Pokhari)	14
		2. Add.PHC-Chopda	-	-	-	-	
6.	NARAYAN BAZAR	1. NARAYAN BAZAR	1	9	-	-	14
		2. Add.PHC-Chopta	-	-	-	-	
7.	THARALI	THARALI	4	1	1	1 (PHC Tharali)	9
8.	DEVAL	DEVAL	2	5	-	-	6
9.	AUGUSTMUNI	1. AUGUSTMUNI	7	4	1	-	16
		2. Add.PHC-Chimtoli	-	-	-	-	
10.	GAIRSAIN	1. GAIRSAIN	2	7	-	1	13
		2. Miathan	-	-	-	(Garsain)	
11.	UKHIMATH	1. UKHIMATH	7	5	1	1	11
		2. Add.PHC-Phata	-	-	-	(Ukhimath)	
	TOTAL	16	42	58	6	5	124

SOURCE : C.MO's office : Gopeshwar

Table 8

ALLOPATHIC HEALTH SERVICES IN THE DISTRICT - BLOCKWISE

Year/District/ Block	Hospital and Dispensary	Primary Health Centres	Total No. of Services available	Total Workers	
				Doctors	Para-Medical
1	2	3	4	5	6
1983-84	53	14	424	36	191
1984-85	54	14	428	68	438
1985-86	53	15	428	72	423
BLOCKWISE [1985-86]					
JOSHIMATH	6	-	24	2	30
KARNAPRAYAG	4	-	16	3	26
GAIRSAIN	3	2	22	5	37
NARAYAN BAZAR	1	2	16	4	32
THARALI	5	1	26	5	31
DEVAL	2	-	12	2	16
DASHOLI	2	-	8	1	25
GHAT	3	1	18	4	22
N.POKHARI	3	2	20	4	36
UKHIMATH	8	1	38	7	30
AUGUSTMUNI	7	2	40	6	48
DISTRICT					
RURAL	44	12	240	43	333
URBAN	9	3	188	29	90
TOTAL	53	15	428	72	423

Source: Statistical hand-book - Dist. Chamoli, 1986.

It is generally used for family planning purposes or for VIP visits during the Yatra seasons. Due to the problem of accessibility, the film shows and other exhibitions are only shown up to the road head villages.

Only Joshimath female hospital has a lady doctor; none of the rural female hospitals has got a lady doctor. These so-called female hospitals are attached to the PHC building. One or two rooms are given and it is called a female hospital. There is no separate logistic or infrastructural facility for these female hospitals, except that an additional pharmacist and 2-3 ANMs are posted in the PHC. One of these ANM is only for family planning duties.

Building and Accommodation

The primary health centres have government building only for 12 out of the 16 PHCs. The rest of the 4 PHCs are in the building taken on hire. Most of these 4 PHCs are additional ones which were converted from the state allopathic dispensary (SAD).

Out of the 42 SAD, only 5 have government buildings and 37 are located in hired buildings. All the five homoepathic dispansaries are on hired buildings. Out of the five female hospitals, 4 are attached to the PHC building and one of them has a rented building. The sub-

centres which total about 124, has only 4 in government building and 120 in hired accommodation.

Accommodation for the doctors and medical staff is very limited. Construction work is undergoing at the district HQ and at the various PHC sites for the doctors and few for the para-medical staff.

In the district, only 3 type-4, 6 type-3 and 15 and 10 houses for type 2 and 1 respectively are available (see table 9).

The T.B. hospital and clinic staff and doctors are better housed as a new complex has come up there.

PHcs have accommodation for the doctor and pharmacist and many ANMs live in the same room of the sub-centre building in the village.

Staffing Position

There are vacant posts at various levels in the district, particularly those of doctors and the technical staff.

The medical officer (senior pay scale), out of the 6 sanctioned posts only 3 are present. The doctors at the general grade level, who are specialists in their respective fields are not available at the district level

Table 9.

POSITION OF AVAILABLE BUILDING AND ACCOMODATION: DISTRICT CHAMOLI

SL. NO.	Institutions	Total No. Operational	In Government Building	Building on Hire
1.	Primary Health Centre	16	12	4
2.	State Allopathic Dispensary	42	5	37
3.	Rural Homeopathic Dispensary	5	-	5
4.	Rural Female Hospital	5	4 (3 attached to Hospital)	1
5.	Sub-Centres	124	4	120

Residential

Sl No	Accomodations	Type-4		Type-3		Type-2		Type-1	
		Built	Under constru-ction	Built	Under constru-ction	Built	Under constru-ction	Built	Under constru-ction
1.	District Hospital/ Chief Medical Officer Office - Gopeshwar	3	-	6	8	15	4	10	8
2.	T.B. Clinic/Hospital	-	-	3	-	20	-	32	-
3.	Primary Health Centre (PHC)	8	12	6	-	24	8	32	6
4.	State Allopathic Dispensary (SAD)	5	7	1	-	7	5	7	10

hospaital, and some of these posts are also sanctioned for some PHCs. Thus out of the general grade medical officer, there are 70% vacancies existing (see table 10).

The other medical officers and doctors at various PHCs, SAD and other at the T.B. hospital and district hospital at general duties are also vacant. Out of 9 female doctors, only 2 are available in the district. Thus out of 113 sanctioned posts of medical officer (ordinary grade) only 41 are presently working which shows that about 64% of posts of medical officer at the general duties level are vacant.

25 Ayurvedic doctors have recently been appointed on daily wages basis in the state allopathic dispensaries.

None of the PHCs has a laboratory technician, generally a basic health worker is seen doing the job of laboratory technician. There are no dental hygienists.

As regards staff nurses, out of 28, about 11 posts are vacant. Similarly Refractionist and B.C.G. technician are not there, as per the sanctioned posts. Laboratory technician for malaria work, out of the 9 sanctioned posts, only 3 are presently filled.

About food and sanitary inspector, only three PHCs have got this post; in the rest of the PHCs these posts are

Table 10:

STAFFING POSITION

DISTRICT CHAMOLI: 1987

SL	Name of the Post	Sanctioned	Working	Vacant
1.	Medical Officer (Sp. grade)	2	2	-
2.	Medical Officer (Sr.pay scale)	6	3	3
3.	Medical Officer (general grade)	27	8	19
4.	Medical Officer (ordinary grade)	113	41	72
5.	Ayurvedic/Unani doctor	10	9	1
6.	Homeopathic doctor	6	3	3
7.	Administrative Staff	37	30	7
8.	Medical Staff	144	109	35
9.	T.B. Control Programme Staff	9	4	5
10.	Leprosy Control Programme Staff	25	20	5
11.	Nursing Training Centre	3	3	-
12.	Malaria Control Programme	105	91	14
13.	Sanitation, Food Adultration	19	6	13
14.	Immunization (EPI)	32	21	11
15.	Health Staff - others	4	3	1
16.	Family Planning & Maternal Child Health	95	62	33
17.	ANM	159	159	-
18.	Dais (MCH)	36	31	5

Source: Compiled from CMO's Office Records; Gopeshwar-Chamoli.

lying vacant. Similarly out of 4 posts of Food and Sanitary Inspector sanctioned for Yatra Route only 2 are presently working.

Posts are also vacant in respect of para-medical assistant, vaccinators, compoundor and Health Inspectors.

Only the posts of ANMs are completely filled up at the PHC, sub-centre, urban F.P. centre, Tehsil-PPC, additional PHC, Rural female hospital and state allopathic dispensary. This has been possible because of training centre at the district level. The post of basic health workers are almost all filled. This has also been possible because of basic health worker training centre at the district level.

The other staff includes the driver and the technical workers. Posts of one Junior Engineering (Civil), one engine technician and 19 drivers, 2 being vacant. Out of these 10 are under the CMO, one for District hospital, 6 for PHCs and 2 for Yatra-Route.

The other class 4 employees like ward-boy, ward Aya, orderly, cook, sweeper-cum-chowkidar and other class IV employees are generally present according to the sanctioned strength.

Vehicles: There are 24 vehicles, out of which only 20 are on road. Out of 4 off the road, one was involved in an accident, one is condemned, two are under repair and one vehicle is to be auctioned which is on the road.

The total number of Refrigerators is 21. Of these, only 14 are in working condition.

There are 5 Laproscepic units available and these are in a working condition.

The Performance

If we go by the targets achievement in official records, we may get the idea that everything is going well in all fronts of Health Centres. But the fact is that the immunization and MCH programme is neglected due to the pressure of achieving family planning target, as government priority is to make the family planning programme a success (see table 11).

Moreover because of the geographical accessibility (see tables 12, 13, 14) which is very poor in this hill district, the peripheral workers have difficulty in completing the task of MCH and immunization. There is no incentive and facilities for these workers to work and live in remote rural areas.

Table 11:

PROGRESS REPORT

ANNUAL STERILIZATION REPORT

DISTRICT CHAMOLI

SL.	Year (A)	Target (B)	Achievement (C)	
1	1965-66	-	546	
2	1966-67	-	1131	
3	1967-68	-	1643	
4	1968-69	-	1662	
5	1969-70	-	661	
6	1970-71	-	747	
7	1971-72	-	294	
8	1972-73	-	655	
9	1973-74	-	92	
10	1974-75	639	323	
11	1975-76	985	1193	
12	1976-77	7815	7153	
13	1977-78	-	12	
14	1978-79	2277	190	
15	1979-80	1525	162	
16	1980-81	1369	214	
17	1981-82	752	388	
18	1982-83	2045	1805	
19	1983-84	2760	2000	
20	1984-85	2410	3115	(I position)
21	1985-86	2210	3058	(III ")
22	1986-87	2640	3509	(IV "

1986-87		Target	Achievement
	(1) IUD	488	4155
	(2) CC uses	488	3374
	(3) Oral pills	58	727
	(4) M.T.P.	12	241

1987-April to September:

Sterilization	IUD	C.C Uses	Pills	MTP
598	2486	1796	338	64

Source: CMO's Office.

Table 12

Number of villages and their distribution in the various blocks of the district, according to their distance from various Health Services Institutions

[Geographical Accessibility]

Blocks	Allopathic Hospitals/Dispensaries/ Primary Health Centres					
	In village	Less than 1 km	1-3 km	3-5 km	5 km or more	Total villages
1	2	3	4	5	6	7
JOSHIMATH	4	2	1	5	73	85
KARNAPRAYAG	4	4	10	26	103	147
GAIRSAIN	5	-	20	35	155	215
NARAYAN BAZAR	3	2	15	22	177	219
THARALI	6	3	14	27	39	89
DEVAL	3	-	12	5	43	63
DASHOLI	4	1	26	21	55	107
GHAT	4	7	6	6	61	84
N.POKHARI	5	1	26	21	131	184
UKHIMATH	9	58	7	18	43	135
AUGUSTMUNI	9	5	17	29	115	175
TOTAL DISTRICT	56	83	154	215	995	1503

Source: Statistical hand-book - Dist. Chamoli, 1986.

Table 13:

Number of villages and their distribution in the various blocks of the district, according to their distance from various Health Services Institutions

[Geographical Accessibility]

	Ayurvedic Hospitals and Dispensaries					
Blocks	In village	Less than 1 km	1-3 km	3-5 km	5 km or more	Total villages
1	2	3	4	5	6	7
JOSHIMATH	3	2	3	8	69	85
KARNAPRAYAG	5	5	23	35	79	47
GAIRSAIN	7	3	25	20	160	215
NARAYAN BAZAR	8	2	40	38	131	219
THARALI	1	-	3	2	83	89
DEVAL	5	2	6	17	33	63
DASHOLI	5	6	17	20	59	107
GHAT	5	6	11	13	49	84
N.POKHARI	5	8	13	24	134	184
UKHIMATH	5	11	24	25	50	135
AUGUSTMUNI	4	4	18	25	124	175
TOTAL DISTRICT	53	49	183	227	971	1053

Source: Statistical hand-book - Dist. Chamoli, 1986.

Table 14
Number of villages and their distribution in the various blocks of the district, according to their distance from various Health Services Institutions

[Geographical Accessibility]

Blocks	Family Welfare and Maternal and Child Health Centres/Subcentres					
	In village	Less than 1 km	1-3 km	3-5 km	5 km or more	Total villages
1	2	3	4	5	6	7
JOSHIMATH	12	3	1	4	60	85
KARNAPRAYAG	10	6	23	39	69	147
GAIRSAIN	10	2	36	39	123	215
NARAYAN BAZAR	16	10	59	74	60	219
THARALI	11	4	7	19	48	89
DEVAL	6	1	5	19	32	63
DASHOLI	11	1	10	23	63	107
GHAT	8	-	4	9	63	84
N.POKHARI	16	5	25	22	63	84
UKHIMATH	13	26	47	28	116	184
AUGUSTMUNI	18	40	43	35	21	135
TOTAL DISTRICT	136	98	260	316	693	1503

Source: Statistical hand-book - Dist. Chamoli, 1986.

In the family planning programme, the whole district administration is involved. There are targets for every department and for every individual. This has led to bad-blood and fight among various departments for cases at the village level and near the camp site.

Field workers agree that other programmes and services are badly effected because of family planning programmes. Their job is wholly dependent upon the achievment of F.P. target. Letters threatening the field workers come from CMO and the M.O incharge, in case the filed worker has not shown any improvement in his performance in getting his required number of cases. The threat which is implied in the letter ranges from leave cancellation to stopping of increments, promotions, postings and finally termination.

At the PHC meeting the major issue is that of F.P. programme cases. Similarly at the CMO meeting, the doctors' major point of discussion is on family planning, and about the camp dates, the camp sites, etc.

Petty politics starts at village level, as there is scramble for cases among the various department officials.

The poor villager has problems and dilemmas, as ten persons come to please and promise him something in return. But how can the poor villager oblige every one, he has to be nice to the Gram Pradhan, for one or other reason, he may be wanting loan from the Gram Vikas Adhikari and give the case to BDO's office. The School teacher also comes for a cse, and lastly he has to oblige the health department, as they finally take care of the 'victim'. In fact the health department officials capitalize on this factor.

The family planning programme is now going to the door step of people, and thus today we see F.P. camps being held in such remote area which has no road communications and electricity.

The health guides are now virtually the paid department agents to get family planning cases. They have no medicines, no incentive to work for any other health services in the rural areas. The government wants people's participation only for family planning programmes.

At the policy level the government has accepted that MCH and family planning will ago hand in hand. But the ANM's major concern is to get cases for family planning. People in the village are not aware of anti-natal and post-

natal care which the health centres are supposed to be provide.

The monthly budget realised by the treasury office has separate allaocation for family planning programme. In the month of November 1987, the budget for medical services was approximately Rs.17,91,000 and for family planning it was Rs.3,77,000 approximately.

Immunization is completed in time and very comfortably like the IUD, oral pills and condoms target, inspite of F.P. programme pressure. Field workers are supposed to have thermos flask, but they carry the vaccines in their Jholas, as there is no ice anyway! The PHC staff agrees that the MCH and immunization achievement target (see table 15, 16) and their data are forged as the terrain is difficult, accessibility is poor, settlements and the location of villages in remote areas makes difficult for them to complete their target in time. The investigator was told that that the problem of cold-chain maintenance starts right from the state capital at Lucknow. Invariably some vaccines are not accommodated in the cold-box, right at Lucknow. Similarly at the CMO's office, only one 165 litre refrigerator cannot accommodate all the vaccines in the freezer.

Table 15:

Immunization - 1986-87 (monthwise)

Dist. Chamoli

Sl.	Month	DPT	Polio	BCG	TT (Pregnent women)	TT (10 years)	TT (16 years)	D.T.	Typhoid (TAB)	Measles
1.	April 86	536	501	1323	284	508	368	430	218	184
2.	May	525	685	-	496	565	465	1142	160	1056
3.	June	933	549	885	414	525	379	818	378	489
4.	July	508	429	588	309	160	189	902	538	174
5.	Aug.	939	655	528	546	168	377	1330	340	121
6.	Sept.	819	905	423	416	445	152	1093	942	109
7.	Oct.	732	631	1064	430	608	406	1017	1439	62
8.	Nov.*	400	100	535	200	100	200	20	50	00
9.	Dec.	935	355	579	359	372	181	885	740	74
10.	Jan.87	715	378	489	346	203	267	830	459	48
11.	Feb.87	1021	832	360	408	375	404	965	647	210
12.	Mar.87	1355	1329	709	511	837	469	626	997	620

*Strike by U.P. Govt. Employees.
Source: CMO's Office, Gopeshwar.

Table No.16:

MCH
Dist. Chamoli

Sl.	Month	Anomic cases Iron (all mothers)	3 months - 90 tabs Iron (children)	Vitamin A solution	
1.	April to Aug. 1986	1192	571	756	
2.	Aug.	140	154	226	
3.	Sept.	146	117	770	
4.	Oct.	138	209	657	
5.	Nov.	24	280	200	
6.	Dec.	258	632	407	80
7.	Jan. 87	177	279	989	
8.	Feb. 87	167	306	1335	
9.	March 87	425	686	1009	114

Source: CMO's Office, Gopeshwar.

What to talk of potency! There is hardly any ice to carry the vaccines to the PHCs. There is also the perpetual problem of erratic and low voltage supply of electricity.

We also know that out of total 21 refrigerators, only 14 are in working condition.

We can guess the potency of the vaccines before it finally reaches its victim! Moreover, it is humanly and socially not possible for the field worker to cover her territory in a specific time period.

CHAPTER IV

RESULTS: PHC AND THE VILLAGE COMMUNITY

Development Block - Pokhari

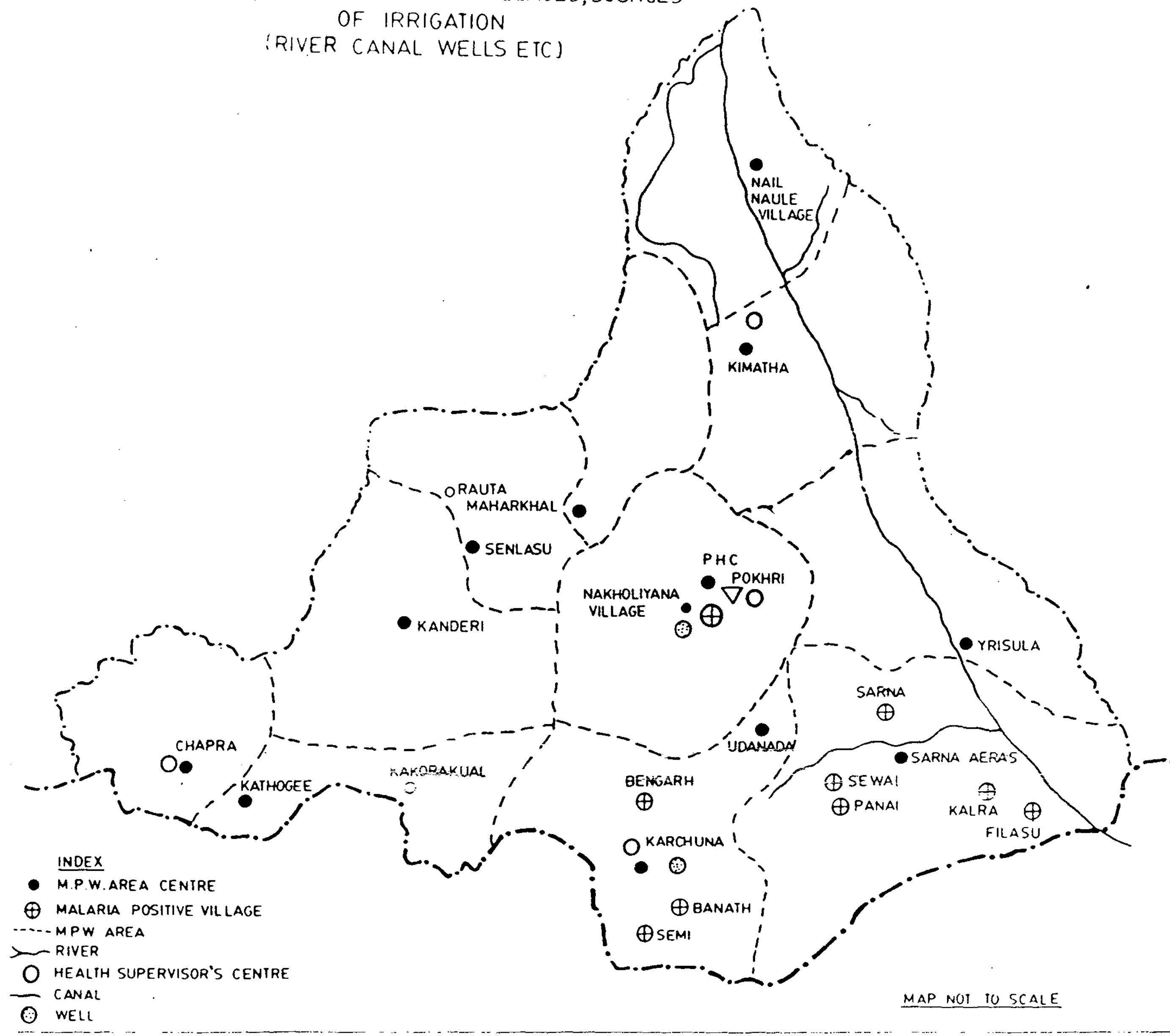
The block headquarter of Pokhari is situated at a height of 1850 m, and about 65 km away from the District HQ - Gopeshwar. The block has an area of 547.8 sq.km, which is 5.99% of the district area. The block has 86 gram sabhas with 184 villages. The block of Pokhari falls under the sub-division of Chamoli.

The block has a population of 40,248 according to 1981 Census, which comes to 11.04% of the district population. It has a density of 73 persons per sq.km of area, compared to 40 of the district. The sex ratio of the block comes to 1172 females per thousand male population. The Scheduled Caste and Tribes constitute about 17.40% of the total block population. It has 4 inter-colleges, 4 high schools and 85 primary schools. The literacy rate of the block is 37.14%, with male literacy rate of 56.68% and female of 20.47%.

The percentage of total workers is 47.36. Agriculturists constitute about 38.93% of the total population. There are 3.70% of marginal workers and other workers are about 4.10%.

DEVELOPMENT BLOCK POKHRI

MAP OF PHC POKHRI SHOWING AREA, MALARIA POSITIVE VILLAGES, SOURCES OF IRRIGATION (RIVER CANAL WELLS ETC)



Map. 4.1

21% of the area is covered with forests, out of the total available area of 272.4 sq.km. Only 9.25% of land is available for cultivation, of which only 8.64% of land is irrigated. There are 8 persons per hectare of sown area, which shows the pressure on the land.

The Block has been connected by roads to Gopeshwar, Karnaprayag and Augustmuni block. Still the transportation and communications in the interior region is very poor. The total length of pucca road is only 120 km. According to the statistical hand-book of 1986, there were 19 post offices, one telegraph office, one telephone and public call office, and 6 bus-stations/bus stops.

A small township is emerging near the Bus-Station. The PHC and the BOD's office is located nearby. Many shops have come up. There is branch of the State Bank of India and a PWD guest house, PWD office is also located in this area. There are about 10 small market places in the block, but the Pokhari market area is emerging as a town and within 5-10 years, it may become a small town.

The people are engaged in agriculture, but many people have joined army and police services to supplement their income. Most people have to buy their provisions from the 56 fair price shops present in the block's villages.

Officially 55% of the villages are electrified. Many villages have power lines coming to the villages, but never have power in them. In the Pokhari gram sabha area, out of 9 villages, only one has power supply, few of the other villages have poles with power lines. The place of tourist importance in the block are its three temples, Nagnath being the most famous.

The Health Services in the Block

The block has one PHC, with an additional PHC at Chopda. It has two state Allopathic dispensaries (SAD); five Ayurvedic Dispensaries and 14 sub-centres. It has a female hospital which is attached to the PHC.

The block has 40 Health guides and 8 private practitioners, two of which are BAMS and are employed on the daily wages scheme, in the SAD.

It has 4 Fever Treatment Depot (FTD), which are run basically by 4 persons in different parts of the block, who make slides and give medicines. Similarly there are 20 persons for drug distribution, so it is termed as Drug Distribution Centres (DDC) Centres. With such shortage of drugs at the PHC itself, we can guess the situation of FTD and the DDC's.

The block has an additional PHC at Chopda, which was converted from an Allopathic Dispensary. It has a hired building. The only staff it has is a pharmacist, a ward-boy, a cook and a sweeper-cum-chowkidar. An additional PHC has been opened since the block population has crossed 40 thousand people.

Primary Health Centre - Pokhari

The PHC-Pokhari was opened on 1st April 1960. The PHC is situated 100 m below the market bus-stop. The PHC has a government building and has accomodation for the M.O.I/C; pharmacist and a ward boy. The PHC has a Jeep which is used primarily for family planning programmes. It has four beds, for the indoor patients. The female hospital is also attached to the PHC. The PHC has a microscope and a small laboratory, which is handled by Basic Health workers. The PHC has two refrigerators, both of which are out of order for more than a year.

The Staffing Position

The PHC has one doctor, who is the medical officer incharge, who is M.B.B.S. and belongs to the Provincial Medical and Health Services (PMHS). The doctor of this PHC is from the Bhutia Tribe. He joined the service late, as he was in private practice.

The posts of M.O.-II and M.O.-III are vacant. The post of lady doctor for the female hospital is also vacant. In the absence of M.O.I/c, the pharmacist of the PHC handles the cases.

The post of laboratory technician and compounder is vacant. The laboratory technician's job is done by basic health worker and the records are maintained by the block extention educator, with the help of other supervisory staff.

There are two pharmacists, one for the PHC and the other for the Female hospital, but both of them distribute the medicines from the same counter and store.

There are 18 female workers: 2 Lady Health Visitors and 16 ANMs. One LHV and 3 ANM are in the PHC, while the rest are in the sub-centres. Two of the ANM are from Kerala and one LHV, who is from Kerala, has married a local person, who does some radio-repairing job near the market place.

There are 12 male workers under the PHC, 4 of them are male Health Supervisors. Two of them are at the PHC; these are the Health Inspector and a Health Assistant-Senior grade, who does the job of B.E.E. The rest of the male workers (multipurpose workers) are at the sub-centres.

Then we have the account-cum-clerk for administrative duties. The jeep driver and the cook, ward boy and a ward aya for the female hospital. There is also the non-medical assistant for the leprosy programme, called the leprosy worker.

The PHC has 40 health guides and 8 private practitioners. Two of the BAMs are practising near the market place. Both of them are economically well off, have built good houses. They are also employed on the daily wages basis to run the state allopathic dispensary.

The PHC cook and the ward boy, who have no clear cut defined jobs, do the odd jobs of the PHC, including the job of giving medicines and injections, doing dressing work, as well as helping the doctor at his personal work.

Health Services and Coverage

The conditions of the PHC services can be seen from the fact that, almost every prescription has some medicines or the other, which has to be bought from the market or rather from the private practitioners' shop.

It is interesting to note that all the staff of the PHC are experienced in giving injections and medicines and doing the dressing job. In fact, the sweeper of this PHC

is considered to be the best in giving injections and in dressing the wounds. I also happened to see him doing the dressing job. Even the driver, when asked, said he is experienced in giving injections and medicines.

The total number of patients in the year 1986, was 21,136, out of which 11,451 were new, 9,685 were old and 69 were indoor patients. There were 468 minor operations. There is some fluctuation in the number of patients coming to the PHC in summer and winter seasons. It was noticed that there were more patients in summer. The number of patients per month ranges between 1800-2000, with daily average of 40-60 patients (see table 17).

The doctor and the pharmacist write the prescription and generally the pharmacist is assisting the doctor. The other pharmacist is generally found giving the medicines and is invariably assisted by the class IV employees. The senior pharmacist is also an expert at tooth extraction, which comes under minor operation.

The female hospital staff has a female supervisor and three ANM's, one of which is only for family planning duties. There are hardly any MCH activities done at the PHC. With no manpower and infrastructural support, it is a big farce to call it a hospital.

Table 17:

ANNUAL PATIENTS: PRIMARY HEALTH CENTRE: POKHARI

Year	Total	New Patients	Old Patients	Indoor Patients	Minor Operations
1981	21,835	11,335	10,500	68	742
1982	29,459	13,541	15,918	70	818
1983	23,425	11,615	12,810	37	622
1984	17,773	8,658	9,125	88	518
1985	21,923	11,108	10,815	73	575
1986	21,136	11,451	9,685	69	468

The other staff has nothing to do with the services at the PHC level, except to organise family planning and in writing the reports on various programmes and doing the computer's duties.

Lack of medicines at the PHC forces the people to go to the practitioners for medicines. In fact, they are told to buy medicines which are not available in the PHC. The medicines which were meant for the health guides, have been used by the PHC, as the PHC fell short of medical supply.

The type of patients coming to the PHC shows that people are suffering from respiratory diseases like T.B. and asthma. The children and infants suffer from enteric fevers and worm infection.

The women are generally anemic and a large number of them have leucorrhoea.

PHC Meeting

The investigator had the chance of attending a PHC meeting at this PHC. While attending the monthly meeting of the PHC, one can see the major emphasis is put on family planning. The meeting is well attended by all the ANM's and male health workers, including the supervisory staff at the PHC. The meeting is officiated by the M.O.I/c. The Block

Extension Educator (BEE) read the letter of Dy.C.M.O., which only talked of Family Planning targets and their achievement. The district was to organise special Family Planning Camps, and the Dy.CMO's letter gave the reference of District Magistrate's letter to the Health department. The letter of the D.M. in turn gave the reference of Chief Secretary's letter in this regard. Various prizes were announced in the letter. One can also see camp dates and prizes being announced from Radios and in the local press.

The whole district administration is involved in the family planning programme. A separate budget is allocated for Family Planning programme. The ANM and the male workers were pulled up for being slow with their F.P. work. Individual ANM's and male workers' performances were seen from the number of cases they have produced before and the number of cases they still have to bring. The field workers were asked as to why they had not completed their F.P. targets. Most of the ANMs quietly heard what the doctor and the BEE had to say, only few of the field workers opened their mouth to explain their problems or give reasons for the delay in getting cases.

The Family Planning Programme

In this programme, major emphasis is put on sterilization. The main targets of this programme are the

women. In fact, now the word Family Planning means sterilization of women.

In case of IUD, pills and condoms, the targets are completed in time, the records show that these targets are completed much before time (see Table 18).

When the field workers are asked about the success rate of contraceptives, they say it is hardly 20%, some have even put it below this rate. When a male worker was pressed to reveal the truth of work conducted in the field, other than F.P. cases, he said, "please don't dig the graves"!

It was seen in the meeting that most ANM's were not trained to put IUDs. In the case of pills, the ANM's just distributed them; most women are reported to be taking the iron pills and throwing the rest of the contraceptive pills. Most women have complained of reaction and there is no feed back on this problem. Similarly, there is no follow up of IUD cases; most women remove it themselves, but the targets are completed.

The condoms are of very bad quality and even when they are distributed free of cost, they are not used, but thrown by the people themselves.

Table 18:

YEARWISE FAMILY PLANNING, MCH AND IMMUNIZATION ACHIEVEMENTS

PRIMARY HEALTH CENTRE - POKHARI

Sl	Items	1986-87 Target	1986-87 Achievement	1987-88 Target	1987-88 Achievement
1.	Sterilization	280	331	280	276 (upto 22 Feb.88)
2.	IUD	230	392	346	417 (upto 31 Jan.88)
3.	C.C. Users	292	350	348	350 "
4.	Oral pills - Cycles	28	55	20	60 "
5.	DPT	1050	767	990	1079 (upto 31 Jan.88)
6.	DT	900	433	705	827 "
7.	TT (pregnant mothers)	680	786	682	463 "
8.	TT (10 years)	480	500	484	666 "
9.	TT (16 years)	200	210	215	540 "
10.	TAB	700	725	705	640 "
11.	Polio	1050	350	990	458 "
12.	Measles	-	-	207	10 "
13.	BGC	-	-	990	1105 "
14.	Iron Folic Acid (large)	1350	1350	1353	997 "
15.	Folic Acid (Small)	1000	997	1018	741 "
16.	Vit.A soln.	1200	1000	1232	400 "
17.	Ante-Natal Care	-	1886	1771	2000 "
18.	Post-Natal Care	-	-	1771	- "
19.	Total deliveries	-	800	1771	706 "
20.	Dais Trained	-	-	2	2 "

Source: Records of PHC - Pokhari.

Neither is the PHC, nor is the health department, interested knowing about the success or failure of IUD, pills and condoms, they just want the targets of these contraceptives completed. In such a situation, there is an easy way out - by making 'FERZI' entry in the record book.

One field worker said that the oral pills have about 10% success rate, and 10-12% for IUD. Most women complained of reaction to the oral pills, but there is no drug to control these reaction. Though there are lots of preconditions for using the contraceptive pills, mentioned on the cover of the packet, yet the conditions of women's health is not looked into while giving the contraceptive pills.

Immunization

As per 1986-87 records, the PHC had not completed its major immunization targets. DPT was given only to 767, against a target of 1050; similarly D.T. was given to 433 instead of 950 and polio vaccine was given to 350 against the target of 1050.

Figures of achievements are very interesting to note (see Table 18). This PHC has two refrigerators, both of them have been out of order for more than a year. When

the investigator checked at the CMO's office later, he was told that all the refrigerators of the PHC's had been repaired.

We all know that vaccines lose their potency in the absence of low temperature. So, with the refrigerators out of order, we can well imagine the effectiveness left in the vaccines - if any is left at all! - by the time they come to the PHC, then go to the sub-centres and are finally given to the people.

The cold-chain is not maintained right from the PHC. All the field workers have been officially provided with thermos flasks but most workers do not have it, even when they have it, there is no ice available at the PHC. The field workers carry the vaccines in their bags. With the difficult terrain and geographical conditions, it is practically impossible to complete the immunization in a short period of time.

The supervisor said, "Even if the first dose is given, the second is either not given or is delayed." In the montly progress report, one can see some vaccines being given.

In this region, there is no one to keep a check on the implementation of the programme. Senior officials don't

go to places, which have no road connections. Even if a Dy.CMO makes an effort to go to an inaccessible area, he does it only at the time of some family planning camp which may be organized in the region or which is a short distance from the road head. The immunization programme lacks a logistic support to it, and the problem of the field workers is understandable. It is in fact, not possible to cover the region due to the difficult terrain and inaccessibility of the interior villages. Moreover, the non-availability of people in the day time is also a factor.

Maternal and Child Health

The MCH activities are looked after by the female hospital staff, consisting of one female supervisor and three ANM's, one of which is for family planning programme.

MCH is the most neglected service of the PHC. The Lady Health Supervisor, Mrs. Ammu, who hails from Kerala, has throughout been in this district. She said, "most women are anemic and on the clinic day we don't have any nutrition to give to the children and mothers. We only give them Iron pills and vitamin A solution. According to her the MCH coverage is about thirty per cent. The ANMs at the female hospital, which is attahed to the PHC, have targets for anti-natal and post-natal care (see table 18).

As one supervisor said, "ANMs are completing the target only in their registers. Most deliveries are conducted at home by the untrained dais, but the recorded deliveries in the registers are 90% 'FERZI'".

Once the BEE noticed in a register that the folic acid tablets supplied were for only 400 individuals, whereas in the ANM's register, it had shown 413 individuals, who had been given folic acid. The supply was for 400 and the distribution showed was for 413. One can see the value of records and can draw conclusions from such an incident.

The ANM's complained that women don't come forward for anti-natal treatment, because of lack of education and old traditions which are still deep rooted in the villages.

Due to transportation and communication problems, the ANM's do find difficulty in covering their respective areas. Women do a lot of work in the villages and their nutrition is always less for the hard labour they put in. The ANM's say that mothers are not in a position to give better attention to their young child, as the work load, keeps her busy throughout the day.

As the ANM's are themselves busy with the family planning target, they cannot pay much attention to the ante-natal and post-natal care. There is hardly any incentives or facilities for the field workers.

The National Tuberculosis Programme

A large section of population suffers from tuberculosis It includes persons of all age groups and sex.

The tuberculosis cases registered in the year 1986, at PHC Pokhari were 98 patients. Out of which 45 males and 53 females. 25% of the patients were below the age of 12. Out of the 98 patients of tuberculosis, 73% lost treatment and only 26% continued their treatment for the PHC. In the year 1987, till November, there were 63 cases with 31 males and 32 females. Children below the age of 12 were about 23%.

The Health department blames the people for not coming in time for check up and treatment and for not taking the treatment regularly.

The tuberculosis cases are referred to district T.B. centre for proper diagnosis, later they are given medicines from the PHC. It is difficult to talk of the precision of the diagnosis but cases are generally put under the category of pulmonary and extra-pulmonary tuberculosis (Table 19).

Due to geographical and financial reasons, patients are not in a position to come regularly to the health institutions for taking injections or medicines.

Table 19

TUBERCULOSIS: Report Dist. Chamoli
Report: Jan to Dec. 1986

(A)

	New Out-patients	Examinations				New Tuberculosis Patients Detected			
		X-ray Total	X-ray New	Sputum Total	Sputum New	Sputum Positive	Sputum Negative	Extra Pulmonary	Total
1	2	3	4	5	6	7	8	9	10
DTC	2766	1011	670	891	839	50	351	67	468
PHLs	85570	33	33	2458	2390	97	483	185	765
Total	88336	1044	703	3349	3229	147	834	252	1233

(B)

	New TB Patients put on treatment	Tuberculosis Patients Under Treatment at the beginning of the period	Transferred from other facility/	Transferred to other facility	Lost from treatment	Reported dead	Completed treatment	Table No. of T.B. patient under treatment at the End of Period
1	2	3	4	5	6	7	8	9
DTC	468	459	91	11	483	6	80	438
PHLs	765	404	13	1	164	16	5	996
Total	1233	863	104	12	647	22	85	1434

(C)

Name of PHI	PHI Months included	New Out-patients	Sputum Examinations Total	Sputum Examinations New	Tuberculosis Patients Detected Total	Tuberculosis Patients Detected Sputum Pos.	On treatment at the end of the period End of Period
1	2	3	4	5	6	7	8
Pokhari	13	10802	335	329	108	1	132
Tharali	11	2114	111	111	37	5	45

Source: District Tuberculosis Centre - Gopeshwar: Chamoli.

The National Leprosy Control Programme

Inspite of a leprosy worker whose only task is to look for leprosy patients, through the survey in the villages under his project, and give them medicines at their door step, this is the most neglected programme. In the annual report of this PHC (April '86 to March '87), the number of patients in the register is 41; 9 left the treatment or may have gone out for treatment, three of them died (not necessarily of leprosy). Now the Register has 26 patients.

The leprosy worker said, "people hide when they come to know, we are from leprosy programme. They don't give us 'lift'. So we don't tell them, why we have come. People don't want to be checked. We never find people in the village telling about leprosy. They generally come to the PHC or the doctor sometimes sees it by chance". Of the 26 cases, only four come to the PHC regularly to collect their monthly medicine quota.

The leprosy worker goes home to deliver medicines to about 8 cases, . When asked, what he does of the remaining tablets, which were supposed to be given for the rest of the 14 patients, he quietly said that he throws the tablets and the rest is target completion. He hardly finds cases through survey, as it is difficult task.

The leprosy worker says that the programme is neglected and the people too don't come forward, as the society debars them. In one such case, a patient who refused to leave the village after being repeatedly told by the villagers, had to finally leave after the house in which he stayed was burnt down by the villagers.

The worker said that even at the main leprosy hospital at Dehradun, the conditions of the patients was bad. They are not looked after properly. While talking about the attention paid to this programme, he cited a case of village Salna, where 6 leprosy patients were living. The villagers wrote to the district magistrate, to remove the leprosy patients from the village and to make alternative arrangements for their stay, treatment and rehabilitation. The district magistrate is said to have replied back that they don't have any facilities for this and that the gram sabha should look into the matter and make necessary arrangements.

Sub-Centres

The politics of opening new sub-centres can be seen from the fact that some sub-centres are opened in a population of about 300-500 and the distance between the two sub-centres will be around 2 to 2.5 kms. In some cases,

even 1 km. In an extreme case, there is a sub-centre catering to 5000 population. There is a district advisory committee on Health, which also looks into the matter of opening of new sub-centres. they are opened in a particular location on political connections.

The supervisor says, "We have repeatedly recommended for the opening of a sub-centre in a particular location, for the larger interest of the people, but it is of no use". All the sub-cenbtres have a single room, which is hired from the villagers. The ANM also generally stays in the same room.

Pokhari Gram Sabha

This gram sabha has a population of 805, according to 1981 Census, with three hundred and forty four families. These families are spread in nine villages in various sizes of area and population. This gram sabha has all the three major caste category, viz. Brahmin, Rajput and Harijans. There were 267 Harijans in this gram sabha and only four migrant tribals, engaged in trade activities.

According to the 1981 Census, only 40% males and 11% females were literate. Out of the 51% total main workers, the male workers were 58% and female were 42%. But almost cent per cent females workers were engaged in agriculture, whereas only about 30 to 35% males workers were actually engaged in agriculture. Males are seen working in the market areas, in construction and labour jobs, few of them are small shop owners. Females do not work beyond their field and home.

Devi Ram Pant is the gram Pradhan of this village sabha. He is a member of the Congress Party. I was told that Mr. Pant had a small vegetable shop in 1972. In later years, he added a tea stall, and today, he has a grain shop, a book and stationery shop, has two buildings, his brother has a general store. Now he also owns a truck. This has happened in just ten years.

Mr. Pant was elected in 1981 panchayat election. Traditionally the Pradhan used to be a rajput - choudhary, but in 1981, a brahmin won the election. The election politics and caste combination is very interesting. The rajputs supported the brahmin - Pant, inspite of the low percentage of brahmin population, as there was a strong harijan candidate. The rajputs sensing the mood of the other caste people, thought it better to support the brahmin, than to have a harijan as their Pradhan. Mr. Pant being a Congress worker, also got some support from the few harijan families, hence he could win the election by a very narrow margin.

While taking of general development in the region, Mr. Pant said that people are being given loans, but 90% of which is being misused. People don't get the full amount of the loans as the government agents take part of it as their commission. Lot of money has been given through loan scheme to buy cattles like buffaloes, but if you see around, you will hardly find milch cattles. If loans are given for, say 300 cows or buffaloes, one will hardly find 30 of them around. Similar is the case of sheep and goats. This corruption in loan distribution is all over the district. Roads have come up only in the last 20 years, but there have been no employment opportunities for the people. There has been an increase in political awareness of the people. The

harijans have traditionally supported the Congress Party. Mr. Pant supports the formation of Uttarakhand state.

Village Nakholiyana:

Nakholiyana village comes under the Pokhari gram sabha. It is situated about a kilometer below the Pokhari market place. The village has a harijan majority. Presently it has about 130 households. About 40 persons are serving in military. There are about three teachers who are working in the plains.

The village has four water points. It has no electricity, inspite of it being close to the B.O.D.'s office. Electric poles with wire connection has come to this village a year ago, but there is no power supply. Even if the power supply comes, the majority of the people may not be in a position to get the electricity connection, as the cost of getting the connection plus the other fitments may be beyond their means.

Sanitation is poor, with the cattles kept at the basement, the sanitary and hygiene conditions are not maintained.

The Village Economy

Agriculture in the village is of subsistence level, and in the year of drought the situation had become worst.

There are traditional artisans, like blacksmith, carpenters and masons in the village. Many of them are now engaged in construction works on contract basis. Some people have opened tea and cigarette stalls near the market place. Some village youths can be seen in construction site, generally employed on daily wages. It is difficult to see able bodied males and females in the village in the afternoons. Men are doing some work outside the agriculture sector, women are busy with their cattle, or are out to collect firewood and fodder.

Few families whose men are in military service send money-order regularly; few of the men are pensioners from army and police service. Few make money by selling illicit liquor.

Talking to a group of women in this village, they said that there has not been any change in their life. The young girls do not go to school, they still get married at a very young age. Most of them complained of some problem or the other, related to their health.

Consumption of Liquor

About 10-15 families in this village brew the local liquor. There is a high rate of consumption, especially because of the district being a 'dry district'.

After the formation of Mahila dal, with the active guidance and support of other active persons in the neighbouring villages, a small movement started to stop this business at the village level, which happened to be the major supplier of liquor in the area. The movement effected the business of the people who made it on a commercial scale. Inspite of the law and clear evidence, nothing happened to these people, instead the village women were abused by the concerned households. Nevertheless, liquor is still made, but their business had slightly declined as the pressure comes from officials and the people. Another party which operates from a different area also makes illicit liquor but as it has patronage with the local patwari and the officials, his business has not been effected, in fact the movement in the village has increased his business. This party which has its liquor trade centre at a different location is also a shop owner and a small time contractor. When the others were harassed by the officials, this powerful group was not touched. It is a open secret, as to where the liquor is made and sold.

The army personnel on leave are believed to be selling their rum for almost 200% profit.

School Education

The schools have no proper infrastructure, the buildings are in a bad shape, students do not have even mattress to sit upon. There are no facilities for games and other recreations. As a school teacher says, there are no black boards and chalk in the school. These government schools are for name-sake only and the officials never go to see the conditions of the school especially in the interiors, which are in the worse state. Students are not well clothed and people of poor background only send their children to such village schools. There are hardly 30% girls in the schools. The Navodaya School which is a part of the New Education Policy, is proposed to be opened in such locations, where only the children of officials and rich people can go and study. They do not open such schools in villages or in the interior of the district, says the school teacher.

Talking of change in last 20 years, the teacher said that except the coming of roads, nothing concrete has happened. These roads have only come after the Chinese attack in 1962, otherwise no one knew of Chamoli district,

but then what to say and whom to say, "A government employee is a bonded labour".

Community Health Guides

The CHGs are now government agents to get family planning cases. The government in its health policy-1982 (Government of India, 1982), paid lip service to the Alma-Ata Declaration and primary health care. The government has, through its order, No.7850/16-11-85-6(51)/86, dated 3 December 1986, has given the final blow to the scheme of 'peoples participation' in health services. After the order of removing the CHG was quashed by the Allahabad High Court, the government took them back on the condition that they will get a minimum of three cases per year, so as to get their stipend of Rs. 50/- per month.

Health Services

Inspite of being a part of the PHC village, the people do not get benefit out of it, as they still have to depend upon the private practitioners.

Shortage of medicines at the PHC is a known fact and hence people sometimes directly go to the private practitioners, who do not take any fees and only charge for their medicines. These doctors are like shopkeepers who

give medicine as per the patients demand and PHC's prescription. As their practice-cum-selling is like business, they give what their 'clients' want or prefer. Their income is only from the commission on medicines sold. The doctors, staff understand the general socio-economic conditions of the people, which has led to cases of malnutrition, anemic women and underweight babies and infants.

Inspite of being close to PHC, deliveries are generally conducted at home by dais and there is hardly any MCH services at their doorstep. People do talk of vaccines (Tika) given to the children, but the women are hardly aware of its type or relevance. Women are generally not aware about anti-natal and post-natal care. The ANM may frequent the area and their houses, if there is a possibility or pressure of family planning cases.

Village Naili:

Naili is one of the interior villages of the Pokhari block. The nearest road head is 7 km below the village. The village has an area of 144.48 sq.m. According to 1981 census, it had a total population of 378, with 184 males and 194 females. It had 69 families. There are 98 males and 32 females who are literate. There were 98 male

workers out of which 89 were in agriculture and 9 in other works. All the 123 females workers were engaged in agriculture.

This gram sabha has three villages, Naili, Nauli and Shidoli. Presently Naili has 55 families, and has Rajput population. The gram Pradhan, Bikendra Singh Ramola, was elected in 1981 panchayat election. There was less political calculations and manipulations in his election. He is 5th standard pass and supports the Congress Party. He has no idea of Jan-Morcha, he has a radio and listens to news and film and folk songs.

The village has a tap-water point, but there is hardly any water coming in it. Villagers generally depend upon the natural source to get their water. The electric poles were put in 1985, but till date, there is no electricity in the village. One retired army subedar has already put electric fitments in his house in the hope that they will soon get power supply.

The Village Economy

Agriculture is supplemented with service outside for livilihood. The villagers buy most of their food items from the fair-price shop which is in the neighbouring

village. There are about 12 persons in the army, one in police and three in civil department. There are about 13 pensioners, out of which, 11 are from army, 2 are Ex.INA soldiers, and one from civil department. To a large extent the village economy runs on money-orders and pensions.

Agriculture being backward, and life in the fields very tough, people have to depend on outside source for extra income to survive. All the families have land and cattle, but not enough milk to drink or sell.

Liquor is made in this village, but not much on commercial scale. The pradhan denied, about the brewing of liquor, after the formation of Mahila dal in the village.

In winters, a few families stay with their cattle in the same Kaccha house for keeping them and the cattle warm. There is also the fear of panther-tiger, taking away their cattles.

The Mahila Dal was formed a year ago and in a meeting with the them, where about 21 women could attend the meeting, most were illiterate and only three of them had seen the plains. Most of them were married at an early age and the women who had undergone family planning operation complained of pain. These women are generally busy throughout the day.

Rural Poverty: There are few families in this village who face hardship in the months of winter. One such person is Kundan Singh, who has a wife and five young children. He complained that he does not have enough to eat. Agriculture yield is not enough to subsist and the village poors have to do labour work in road or other construction sites for employment.

In the name of rural development, only loans are given to the people, which has now corrupted the village folks also, as commissions are demanded at every stage.

Three major programmes have been launched in the drought areas of the district. They are: (1) Forestation; (2) Pasture land; (3) construction of play fields. People employed in these schemes are paid in cash and kind.

As agriculture remains poor and backward, it has not generated employment for people, like it is difficult to find agricultural labour in the village.

Poor agriculture has not generated any input demands from other sectors of the economy. Nothing concrete has come out of rural development schemes in the district.

School Education

The conditions of schools is same everywhere, no proper building, no mattress for students to sit upon, in cold climate; there is no chalk supply and no facilities for sports and games.

An ex-subedar, Sur Singh, said that the condition of our village school is same since my childhood, there has been no change in teaching methods or teaching materials for the school children.

Even the teachers from the hills want a posting to a better place, which has better facilities for their accomodation and transport and later for their families and children's education.

Health Services

The accessibility to the health services is poor as road head is about 7 km below the village. There are lot of cases of injuries and accidents, mainly by fall from a rock or tree. Most of the victims are women, as they do the major work in the field or in the jungle.

In one case of accident, which came to the PHC at Pokhari, a woman was hit by a falling stone in the jungle, which could have been fatal. The woman who was hit by 9 AM

in the jungle, could be brought to the village by 12 noon. The village party reached the roadhead with the victim by 1 PM, where she was given some first aid by a multipurpose worker, which gave her some relief and stopped the bleeding. The party had to wait till 3 PM for the bus, so as to reach the primary health centre.

Many women have died by fall from the rock and tree in the region. Accessibility to medical help is delayed due to lack of transportation in the area. People talked of the lack of transportation as their major problem.

Deliveries are generally conducted at home by untrained dias. In a delivery case, a lady of this village had to be carried to Gopeshwar by 8-10 people who started at 4 AM, through the jungle and hilly route to reach the district hospital, by 12 noon.

People do not know of MCH activities of the primary health centres. At the village level birth and death are not reported in time. Infants death occurring within few days of birth are generally not reported.

The health officials, especially the field workers, go to the villages to look for cases for family planning. Villagers only know of F.P. programme, as the field worker always talks of cases, his ultimate interest is to get few cases to complete his target.

The Community Health Guide of this village has hardly anything to give first aid, and has no medicines since January 1987. The CHG of this village, Mr. Gopal Singh, is an ex-havildar from Garhwal Rifles, who was trained at the PHC for three months and was given a first aid kit. Initially he got some medicines, but now there is nothing. People prefer to take the patient to the district hospital at Gopeshwar than to their PHC. He said, "the PHC has hardly any medicines and hence people have to buy from the shops". The CHG hardly comes to the PHC for meetings, as they do not get any medicines or help and they are only told to get cases for family planning. He said, Rs. 50/- is not the main issue, it is hardly any amount for me, but I can hardly give any first-aid to the people, who come to me at the time of some injury or fall.

Family Planning Camps

The Family Planning Camps are now organized in the interior regions of the district to help people to adopt family planning methods.

The health services come to the people's door step for family planning, but not for providing other services like MCH and immunization. At the camp site, one can see the officials of other departments, like pathwaris, B.D.Os.

The camps are generally held in the local school buildings. The F.P. camp held near Nali village, was in a high school building. One of the class-rooms is converted into an operation theatre, within an hour. The adjacent room is ready for post-operative rest and recovery. A person who is used to seeing sophisticated operation theatre for any kind of operation work may be shocked to see this camp O.T. and its activities.

Before the camp date, the field workers go to the neighbouring villages and look for the possibility of getting cases. One can see the level and nature of interaction of the health workers with the village community. They visit families where possibility of finding a case is there. Petty politics starts at the village level. In village Naili, the gram panchayat adhikari, had come before the health department workers could land, to woo the gram pradhan and the mahila dal.

There were at least 6-8 potential cases of family planning in this village, but on the day of F.P. Camp, not a single case from this village came up due to the manipulation of gram pradhan and the B.D.O.'s official. One could see the gram pradhan and the Naya panchayat adhikari in the Camp's vicinity, only to be cursed by the PHC staff. Had there been cooperation by all the district officials, the number of cases would have certainly increased.

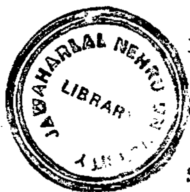
CHAPTER - V

RESULTS : PHC AND THE VILLAGE COMMUNITY

DEVELOPMENT BLOCK - THARALI

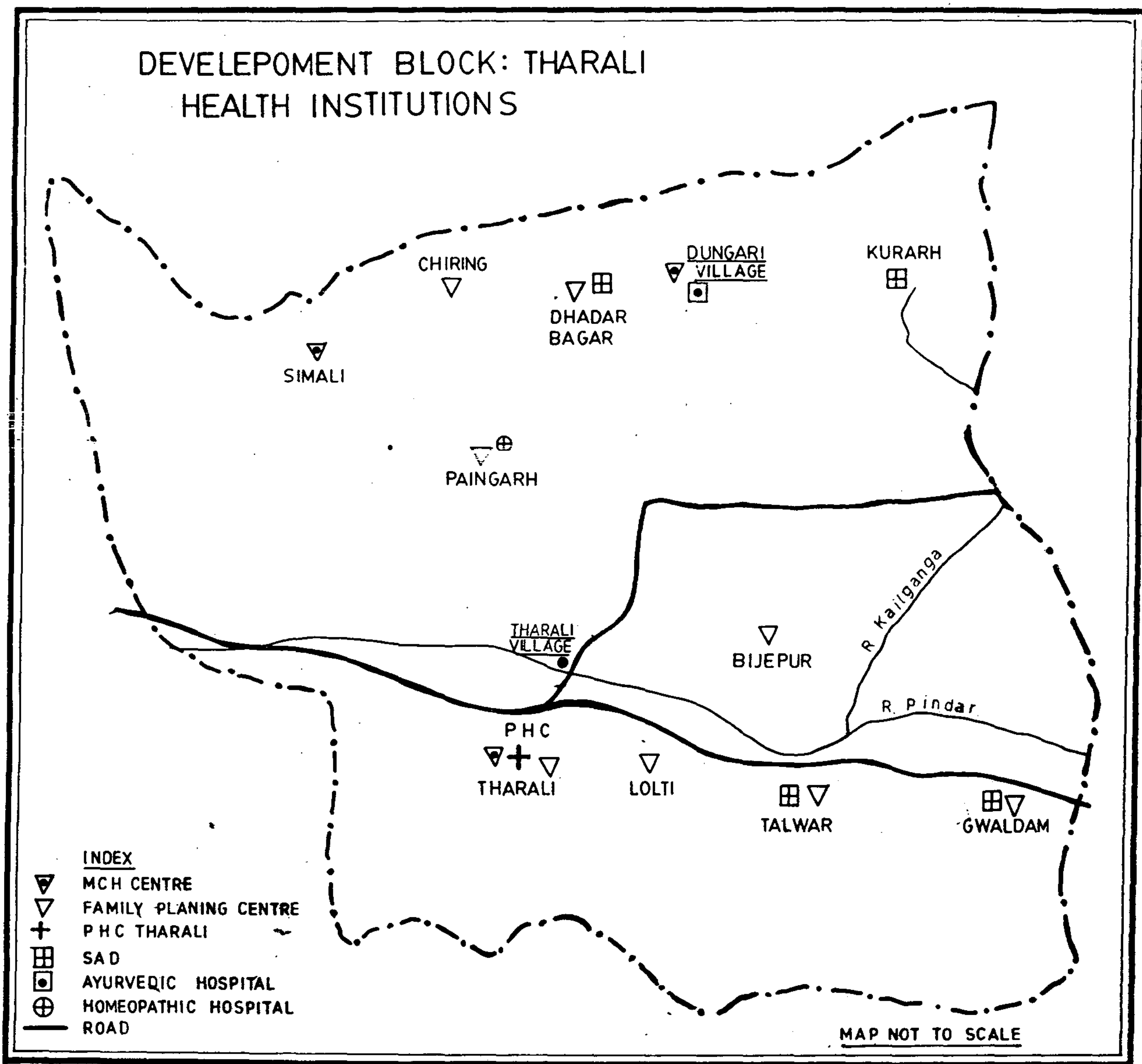
The block town of Tharali is about 95 km away from the district headquarters. The block has an area of 272.4 sq.km, which is only 2.99% of the district area. The block has 45 gram sabhas with 89 villages. Tharali block comes under the Karnaprayag sub-division.

The block has a population of 23,588 which is only 6.47% of the district population. The block population has increased by 29.65% in the last decade. It has a density of 86 persons per sq.km, compared to 40 of the district. The sex-ratio of the block is 1111 females per thousand males.



The Scheduled Castes and Tribes together constitute about 18.97% of the block population. The block has 50 primary schools, 9 middle schools, one middle school for girls at Tharali, four high schools and three intermediate colleges. The literacy rate of the block is 32.11% with male literacy to 53% and female with 13.33 per cent.

The percentage of main workers is 47.22, with 36.39% of cultivators, 4.12% of marginal workers and 6% of other workers.



Map. 5.1

With an area of 272.4 sq.km, the forests occupy 24% of the area, only 12% of land is available for cultivation, out of which only 7.76% is irrigated. The pressure in the land can be seen from the fact that there are about 7 persons per hectare of sown area.

The transportation and communication in the block, especially in the interior region is very poor. It has only five bus-stations/stops and the total length of the main road in the block is 54 kms. It has 20 post-office, 5 telegram offices, 11 telephones, five PCO's in the block. The small town of Tharali has come up because of the main road linking to Kumoan division and is also a junction to Deval and Gairsain blocks. The State Bank of India branch and various block offices are also in the vicinity of this emerging township. The standard of the small town can be known from the fact that, of the few available hotels, none have a bathroom or toilet facilities.

The township is emerging on the banks of river Pindar, which is connected by a iron bridge. The main road is old historic road connecting Almorha district to Chamoli and from Tharali it is along the bank of Pinder river. Officially, 36% of villages are electrified, but the village Tharali, from whose name the block is named, has only electric poles and no power supply.

Due to poor agricultural conditions and yield, the people generally have to buy food items from the fair price shops. There are about 51 fair price shops in the block, as part of the public distribution system.

The Health Services in the Block

The block has one primary health centre, four state allopathic dispensary (SAD), one ayurvedic hospital, one homeopathic dispensary, one rural female hospital and ten sub-centres. It has 21 fever treatment depot (F.T.D) and 44 drug distribution centres (D.D.C), these are basically for malaria treatment.

The four allopathic dispensaries (SAD) in the block are manned by three Ayurvedic doctors on daily wages and only one SAD has a permanent doctor from allopathic medicine. All the above institutions come under the CMO directly.

Primary Health Centre: Tharali

The PHC-Tharali is located about 100 m above the main road. The PHC building is quite old and as the land sliding, there is a regular danger to the building. There is a long proposal to change the site of the PHC, but till date even the new site is not chosen.

The old M.O.I/c house adjacent to the PHC building has almost collapsed because of land-slide and the M.O.I/c of the PHC stays in a hired accomodation. The female hospital is also in this PHC building. The only available accomodation is for the pharmacist. It is difficult to see any logic as to why so called female hospital at the first place is called a hospital. It has no infrastructure of its own and the manpower of a pharmacist and few ANMs those are working as a part of the PHC and carrying out the MCH and family planning programme.

The PHC has no vehicle. It has two refrigerators, both of which are said to be in working condition. The PHC has a microscope and the laboratory technician's job is being done by a basic health worker.

Changing the present site of the PHC is long over due, but the delay in the choice of the new site for the PHC, seems to be because of the vested interest of the few private practitioners, who are about 5-6 in number and generally hold an Ayurvedic degree.

The present site is also unsuitable and uncomfortable for the patients, as they have to walk and climb about 200 metres from the bus-stop. With the lack of medicines, at the PHC, people prefer the practitioners than to climb the distance in vain.

The PHC pharmacists can be seen doing the doctor's duty when the doctor is on leave or has gone to some meeting or camp. The pharmacist can be called *de facto* M.O.II! and this is also true of other PHCs.

The Staffing Position

The PHC is headed by medical officer incharge, who is an M.B.B.S. and is from the Provincial Medical and Health Services (PMHS). The post of medical officer II is vacant. The M.O.-III, an Ayurvedic doctor is present in this PHC. There is a post of pediatician, which is vacant in the PHC.

The M.O.I/c is a young bachelor, who has been recently transferred from a nearby SAD. He lives in a hired accomodation about 50 metres below the PHC building. The doctor believes in family planning programme, as a solution to many problems faced by the people.

Among the supervisory staff, there is a food inspector, a health inspector and a block extension educator.

The rural female hospital which is attached to the PHC, has a post of lady doctor, which is vacant at present.

There are two pharmacists in the PHC, one of whom is for the female hospital. There are eleven ANM's under

the PHC, two of whom are for PHC and one for female hospital, and the rest eight are in the various sub-centres. There is one vaccinator and five basic health workers, one of whom does the laboratory technician's job at the PHC, while the rest are in the sub-centres. There is one senior clerk to help in administrative and accounts works and a computer who does the compilation of the medical and health data. The only "computer" present in the district works in this PHC.

There are three dais, one at PHC, two at the sub-centres. Two ward boys one for the PHC and one for the female hospital. Two cooks, one each for PHC and female hospital, similarly, two sweepers and one peon. There is one leprosy worker.

The PHC has 20 health guides and 10 private practitioners in the blocks, most of these practice around the PHC town of Tharali. There is also a dentist, a young boy, trained by his ex-serviceman father, who was dental assistant in the army. The dentist only extracts the tooth and give some medicines for pain etc.

Out of the five posts of doctors santioned for the PHC, only two are present, the rest vacant. The job of Lab technician is done by a Basic Health worker.

The cooks of the PHC and female hospital only do some odd jobs of the PHC, and also help in giving medicines, injections and dressing jobs. The PHC has 4 beds for indoor patients. The patients are not provided with foods, and hence the cooks do odd jobs such as other personnel jobs of the PHC doctors and staff.

Health Services and Coverage

The services rendered to the people can be seen, from the fact that every second prescription has some medicines which have to be bought from the market. The staff admits that the medical and drug supply is generally poor. On an average, 10-15 patients come to the PHC (see table 20), which may slightly more in summers, as compared to almost double the patients coming to the popular private practitioners of this block. The patients prefer to visit the private practitioners, than to climb 100 m uphill and again coming to the market to buy medicines from the private practitioners.

The private practitioners only take money for their medicines and their practice is more on the business lines. Patients are like clients, who direct them to give injection, or prefer a particular medicine for their illness.

Table 20:
MONTHLY PATIENTS: PRIMARY HEALTH CENTRE - THARALI

S. No.	Month	Male	Female	Male child	Female child	Total
1.	Jan.	302	108	61	36	507
2.	Feb.	315	111	56	32	514
3.	March	266	206	87	53	612
4.	April	133	118	29	24	304
5.	May	273	156	74	46	549
6.	June	294	163	79	47	583
7.	July	260	125	67	34	486
8.	Aug	230	99	52	29	410
9.	Sept.	256	109	67	37	469
10.	Oct.	183	80	63	22	348
11.	Nov.	116	57	27	13	213
12.	Dec.	219	96	59	31	405

Source: PHC Tharali records.

Table 21

MEDICAL CARE ACHIEVEMENT - YEAR 1987

PHC - THARALI

S. No.	Month	NEW CASES Male	Female	Male child	Female child	Total	Old Cases	Total	Medico-legal Cases	Accident	Emergency	Minor operation	Indoor Cases M.	F.	Mc.	Fc.	Total
1.	Jan.	235	114	49	22	420	160	580	2	1	1	1	1	7	-	-	8
2.	Feb.	202	73	42	15	332	165	495	7	1	5	2	-	7	-	-	7
3.	March	208	68	51	9	336	149	485	11	1	5	3	-	7	-	-	7
4.	April	202	67	71	27	367	183	550	2	4	8	5	1	-	-	-	1
5.	May	240	142	77	31	490	144	634	3	6	1	8	x	1	-	-	1
6.	June	218	143	80	57	498	161	659	3	2	3	10	1	1	-	-	2
7.	July	321	179	78	51	629	206	835	3	x	1	5	x	x	x	x	x
8.	Aug	243	148	69	34	494	163	657	x	x	1	3	x	x	x	x	x
9.	Sept.	251	76	35	33	395	134	529	x	x	1	x	2	x	x	x	2
10.	Oct.	187	52	44	22	305	91	396	x	-	-	-	-	-	-	-	-
11.	Nov.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
12.	Dec.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Source: PHC Tharali records.

The total number of deliveries conducted in the year 1986-87 was 296. Almost all deliveries are conducted at home.

While sitting with the staff at the PHC, one hardly sees any rush of patients coming to this PHC. While the staff understands the problem of location, they also admit the shortage of drug and medicines at the PHC. When the doctor is away on leave or goes for a meeting, the pharmacist is the next 'doctor' who looks after the patients. The pharmacist of the female hospital has a private practice at his residence, in the main town area.

The Family Planning Programme:

This programme is the main concern of the PHC; their jobs depends on this programme. The whole block machinary is involved in this programme. The pressure of the target is so high that the staff is busy with getting cases than look at other programmes. The supervisory staff understands that due to this programme, the other services are affected and neglected.

A supervisor says, "Slogans are different from reality", he was commenting on the target of "Health for all by 2000 AD". He continued to say, "if this pressure on us goes on, we can never achieve the target of health for all

by 2000 AD. He, infact, recommends that family planning should be given to some private or voluntary agencies.

The doctor of the PHC advocates family planning as people donot have resource and it a way to increase their status and education. The doctor favours the target system as he says "if there are no targets, then growth rate will increase". He says that the health services are not affected by the targets as the other services are still being done by the PHC. He says that inspite of targets, the general health services are satisfactory.

The impact of family planning programme on the population growth rate is said to be negligible, but the programme is given top priority. Most of those who went for family planning have more than four children. Females have been the target of this programme and 70-75% of the F.P. operations are done on women.

While every PHC staff is running and worried to complete the target for operations, the other methods of contraceptive are neglected. But the target of these are not at all a problem. The IUD, pills and condons also have targets, and it is interesting to see that the targets of these are completed much before the sterilization target are over. Care is not taken of as to how many take the oral

Table 22

YEARWISE FAMILY PLANNING, MCH AND IMMUNIZATION ACHIEVEMENTS

PRIMARY HEALTH CENTRE - THARALI

Sl	Items	1986-87		1987-88	
		Target	Achievement	Target	Achievement
1.	Sterilization	181	-	172	53 (upto Nov.87)
2.	IUD	166	223	213	224 (upto 31 Jan.88)
3.	C.C. Users	210	333	215	23465 pieces
4.	Oral pills - Cycles	28	45.5	60	1068 pkts.
5.	DPT	645	828	609	764 (upto Nov. (3 dose from June
6.	DT	555	777	437	601 (2 dose)
7.	TT (pregnant mothers)	335	275	420	200 "
8.	TT (10 years)	145	585	298	322 "
9.	TT (16 years)	230	361	132	185 "
10.	TAB	555	587	437	718 "
11.	Polio	645	734	609	344 (3 dose (June-Aug)
12.	Measles	110	20	127	37
13.	BGC	645	342	609	605
14.	Iron Folic Acid (large)	285	290	833	473
15.	Folic Acid (Small)	285	154	626	382
16.	Vit.A soln.	590	740	758	669
17.	Ante-Natal Care	-	321	1090	267
18.	Post-Natal Care	-	292	-	225
19.	Total deliveries	-	296	396	287
20.	Dais Trained	-	2	2	2

Source: Records of PHC - Tharali.

pills regularly, how many removed the IUD's and how many use the condons. Pills and condons are just distributed to the people, without any check on its proper use. The doctor admits that there is no follow-up of IUD's and pills.

The pressure of sterilization cases is so high that they cannot look into these matters. There has been no study on the effect and use of IUD, pills and condons by the department on any other agency. The PHC ANM said that the oral pills have disturbed the periods, IUDs have caused pain and bleeding. Womens on their own have removed the IUDs or have told the ANMs to do so. Women have complained of backache after operations. The health status of the women is very poor, this has been repeatedly told by the doctor, staff, ANMs and the private practitioners. They say most of them are anemic and have leucorrhoea. Under such poor health conditions, IUD and pills are still disturbed to complete the target (see Table 22).

Immunization:

With cold chain not maintained, even before the vaccines come to the PHC, one can imagine the type of immunization and the potency of the vaccines. This problem of cold chain maintenance is accepted by the PHC doctor. There are no thermos flasks. Even if a few ANMs have them,

the flask is broken. Even if everything is alright, there is hardly any ice. With poor communication and transportation in the interior region and villages, it is difficult, we may say not possible, for a health worker to use her vaccines on the same day. The villages are scattered in the rugged mountain terrain. Most villages have small size and population, with almost 50% of villages having less than 200 population and about 38% of villages between 200-499 population, under such a condition and situation, the peripheral workers just can not complete their task.

With cold-chain not maintained, the whole exercise becomes futile. The vaccines, by the time they reach the patients, are bound to loose their potency. Coupled with this is the low voltage and erratic power supply at the PHC and the block. The required doses and at the right time and interval have not been given due to irregular supply of vaccines. The effectivity of immunisation is further reduced as required doses are not given.

Targets of BCG was only about 50% completion and in case of Polio only 20 were immunized against a target of 110 (see table 22).

Maternal and Child Health

Administratively, the MCH and F.P. programmes must go hand in hand, but the situation in the field is

different. With a clear priority and emphasis on family planning, the MCH activities are neglected.

Rarely has the three doses of DPT given to children (infants). Similarly, the TT to pregnant mothers is not given, even if given not the complete dosage. This fact is accepted and told by the staff.

There were 321 ante-natal care (ANC) and 282 post-natal care (PNC) cases (see Table 22). The ANMs are busy with their family planning cases and giving contraceptives to the people, have hardly any time to meet the demand of the MCH.

ANMs also complain that people do not come forward for ante-natal care. They do not realize the importance of immunization. The PHC staff go to the villages and interact with them only when they are in search of cases for family planning. In the process of wooing the prospective cases they may render some services to the individual or the group.

<u>The National T.B. Programme</u>:

Tuberculosis is a major disease in the block. Doctors, staff and practitioners accept this fact, but also blame the people for coming late for check up and treatment. A private practitioner said there are 25-30% open cases of tuberculosis.

A supervisor said that the programme is not being fully used as it is not on priority with health department. There are many cases of respiratory diseases in the block.

Out of 37 tuberculosis cases, which were registered in the PHC, in the year 1986, 19 were males and 18 females. There were 7 children below the age of 12 years. Out of the 37 tuberculosis patients, only 9 (24%) continued their treatment and 28% (75%) are said to have 'lost treatment'.

The Leprosy Programme

This programme is hardly heard of in the PHC. There is a non-medicdal assistant, the leprosy worker, who looks after this programme. There were 35 cases in his register, out of which 4 have been reportedly cured in the year 1987. Now 31 patients are there.

There are only 18 patients undergoing treatment under him. 8 patients come to the PHC to collect their medicines and the rest of the patients are given the medicines at their door step by the leprosy worker. The leprosy worker is called the leprosy doctor by the people.

The leprosy worker says he has the survey problem, as the area is larger and the terrain is difficult

and in the village he has accommodation and food problems. People also do not come out openly and that creates problem to detect the leprosy cases in the area.

Not much attention is paid to this programme and people in later stage of leprosy have to go out to the plains for treatment and rehabilitation.

Community Health Guides

These guides who are officially about 20 in number are hardly seen around. Now that there job and pay depends upon getting cases for family planning, they are hardly part of health services. The health guides who were supposed to be a link between the community and the health services by the PHC, have now been reduced as paid agents of the government for getting family planning cases.

They do not have medicines and have no use for the welfare of the community. They do not like to take trouble for a small sum of Rs. 50 per month.

Now we see that the PHC interacts with the village community to get family planning cases and in the process, may render some services to the people, if they have the medicines etc. Field workers have been quite open and frank in this matter, but the doctor is quite tight lipped about

these issues. Health department has become a family planning department whose major task is family planning and the other programmes and services are minor and subordinate to all this.

PHC-VILLAGE THARALI

The block and the PHC get its name from the village Tharali which is about 2 km away from the PHC building. A small township has come up mid-way in last 6-10 years. Many people working in this town belong to the villages which are in the pheriphery. About 15 families have T.V. in the town area, but none in the village proper. The T.V. owners use disc-antenna to catch signals direct through satellite communication.

Tharali village has an area of 174.43 sq.m. According to 1981 census, the total population of the village was 872 and the number of families were 195. The village had 47 Scheduled Castes and 4 Scheduled Tribes. The village has brahmins as well as Rajput population. The 1981 census shows 38% male and 11% female literacy.

There are more male workers, but in cultivation we see more female than male workers. Five males are having household work and ten are marginal workers. Due to the proximity to the small town, few people work in the town.

According to the hill standard, people have pucca houses. The village has only one point for water supply. There is no electricity in this village, only poles with power lines has been installed a year back. The village which gives its name to the block has no electricity so far.

The Economy:

The general occupation of the people is agriculture, but many are serving in the military. Few people are serving in the plains. As agricujlture is not well developed and hence the land yield from agriculture, men have to take up other jobs for subsistance. People have land and cattle, but both have not been economically viable.

An Ayurvedic doctor of this village, who practices in the town area, says that there has not been any worth-while development. There is hardly any milk or ghee for the people. Agriculture is dependent on rainfall and they have vegetables coming from the plains. women do a lot of work and they have poor diet which has led to anemic condition and large number of them having Leucorrhoea.

There are more men in the total workforce, but there are more women engaged in agriculture. Able-bodied people are not seen in the afternoon, as most leave home for some work or the other, the economy of the village is not

based on agriculture, it is supplemented by occupation outside the agricultural sector. It is generally the men who work outside the village and women stick to their field or home. Generally it has been seen that there are more men than women in the villages which are close to some town, this is not so in the interior villages.

With low agriculture yield of cereals and vegetables, people have to buy these from the open market or the fair price shops. Money-order by people working outside and the pension money is to a large extent helping the people for their annual subsistence.

The Ayurvedic doctor feels that everything is going bad here and leaders come at the time of election with only promises and after that nothing happens. Educated youths do not get any job here and these youths are not interested to work in the fields and the only often is to go to the plains.

Krishan Ram, a blacksmith has a small patch of land, but it is of no economic use, he lives by making and selling various implements and tools. He has a cow, whose milk is just enough for tea, not for his young children. All his children were born at home, without any assistance from the PHC ANMs.

School Education:

The local primary school has no table or chair for its students and it is the central primary school of this block. It does not even have proper durrie for the students. The school building is also in a bad shape.

The local intermediate college has many posts of teachers vacant, especially in the science stream. About six teachers are appointed on the daily wages in the school.

One school teacher said that there has been only 10% development in the last 20 years. In matter of education, there has been an increase in the quantity not quality. Women education is still low. The percentage of girls in the inter-college is only about 20%. The pass-rate in high school level at the district level is only about 30%.

While talking of political awareness of the people the teacher said "people have now become more aware, but the element of caste in politics has come up, especially after the bye-election of H.N. Bahuguna in 1980". He blames the Congress party for this. He says that the element of caste has filtered down to the gram pradhan's elections.

Health Services

Inspite of being a PHC village, the people do not get any special benefit out of it. Talking to people about family planning, MCH and immunization, and the services provided by the PHC, people generally have nothing new to say, they have the same thing to say, that the PHC staff comes primarily to get cases for the F.P. programme, they do sometimes come for immunization. There is hardly any MCH activity and deliveries are conducted at home and mostly by the village dias.

People generally prefer going to the private practitioner, than to the PHC. Moreover, they have to walk almost two k.m. to reach the PHC building and later still have to buy some medicines for the shop.

One of the PHC pharmacist is also in private practice in the town and is quite popular. Patients prefer to go to him directly in morning or evening time, when he is free from PHC duties. People do understand the problem of health and hygiene and the importance of good food and nutrition for a better and healthy life, but at the same time they are also fatalist and god fearing.

Village Dungeri:

The interior village of Dungeri is 10 km away from Tharali town. There are no roads to reach this road, it has a uphill walking route. Mules are the main source of transporting store and other provisions.

The village has an area of 150-12 sq.m. and according to 1981 census, it had a population of 801, with 147 families. The village has Brahmins, Rajputs and Harijans with Scheduled Castes population coming to almost 40%. The percentage of total workers is 52%, out of which 91% are cultivators. There are more females in the village and so they are the main working force in agriculture. There is 21% male and 5% female literacy in the village.

Socio-economic condition:

In the year 1987, the number of families as per records of the gram pradhan is 267. The general occupation of the people is recorded as agriculture. As agriculture is of subsistence level, people have to seek employment outside to supplement their income. About 50-60 families depend upon the army service of the male member, and about 30-40% familes are dependent upon other government services.

Generally people have pucca houses, but in winter few families stay with their cattles, to keep themselves and

their cattles warm from severe winter, by having some arrangement for fire in the middle. There is also the fear of wild animals. There is a case of young boy who was lifted by a panther, whose body was never traced. The father tried all means to trace the body and also took the help of forest department, but was all in vain. Later he sent applications to various officers to get some compensation but he never got any help.

Except one harijan family, all families have land, few of the families have land and house at higher altitude, where they move in the summer season. The produce from land is not enough for subsistence, but the potato yield is quite high and few families are able to sell their surplus production of potatoes.

As transportation is a major problem in the interior villages, the middle men have made it big through the potato trade alone. Some families have mules, which are major source of earning for them.

As the village is spread in a large area, it has about 15 water points. The village has Ayurvedic hospital and a sub-centre. The Ayurvedic hospital has a part-time doctor, along with a compounder, a nursing orderly and a sweeper-cum-chowkidar. It has a post office, fair price

shop and a sahakari samiti office. The gram vikas adhikari also stays in this village.

The village is quite well demarcated on the basis of caste. The harijans stay in a different location, but the Brahmins and Rajputs stay quite close by.

Ramlal is the village pradhan, who won the election in 1982. He is the first Harijan Pradhan of this village, who has attended school till fourth standard. He has no knowledge of Jan-Morcha or V.P. Singh.

Social Change in the Village:

The socio-economic conditions of the harijans have improved in the last 10-15 years. More forest land has been brought under cultivation and the surplus potatoes production has improved their economic status. Some rural development schemes have helped them to buy buffaloes, sheep and mules. Some of the men now have jobs in the military and other government services.

The Pradhan said that people have now changed their tastes and habits; some have made gold ornaments. Now people have better houses and most of them have cattles. In the last 20 years there has been an addition of a high school and an Ayurvedic hospital. Doctors hardly stick to

this hospital, not only because of long distance but also because of lack of road communication, tough terrain and steep climb to reach the village. The hospital lacks medicine supply and people still go to Tharali to get medicines from the shop.

The Harijans now sit together in meetings and have tea together. Now they do not clean the glass, after having tea with other caste people. But at the time of marriage feast, the harijans are given a separate place to sit. The Pradhan said "the other caste people do not invite us on marriage occasions, but now being a Pradhan, some families do invite me, but I generally avoid, as I am made to sit separately while eating".

Untouchability can be noticed only at the time of inter-caste dining. Traditions are still maintained at homes and harijans are not allowed to or encouraged to enter the houses of other caste people.

Girls still get married before the age of 18, the harijans marry their daughters by the age of 16-17. In the village above Demjeri, child marriages are very common.

Village Politics:

Increasing economic status has made the harijan to assert their right at the political level. The block has 45

gram sabhas of which 4 gram sabhas have harijan Pradhans. Traditionally, the rajputs have been the village Pradhans, but for the first time, harijan was elected. The election of 1982 was quite tense for Ram Lal.

There were three rajput candidates and he was the sole harijan candidate. The Brahmins and the rajputs never got along well and the brahmins did not field a candidate, instead they supported the harijan. The Rajputs said that they will prefer a poor man, than a harijan pradhan. The present pradhan sensing some trouble on the day of polling, summoned the police protection. Thus on the polling day, there was one inspector, four armed policemen, alongwith a clerk and the polling officer.

The situation was quite tense, but after the election, everything was quite peaceful. the Rajput votes had split among three candidates, the harijan got complete support from his caste and also from the Brahmins. the election time showed the antagonism and under-currents among the caste groups in the village.

Alcohol Consumption:

The harijan of this village make illicit liquor on commercial scale. Dungeri is said to be supplying liquor to the neighbouring villages. In fact, at the time of

marriages, there is a demand placed in advance with the families whose major occupation and source of income comes from this trade. The Pradhan is well aware of this fact, but he is in no position to do anything about it. His own brother-in-law, who was given shelter in this village, supports his two wives and children by making and selling liquor.

The consumption of alcohol is quite high and it is said that there are large number of alcoholics in the area. It was reported that a school teacher had recently died by falling in a drunken state.

School Education:

Inspite of having a high school in the village, the percentage of girls in the high school is only about 10 per cent. There are no scheduled caste girls from class sixth to ninth standard, except one in 10th class, whose father happens to be a subedar in the para military force. In the last high school board exams only three students passed out of twenty one.

Community Health:

With an Ayurvedic hospital and a sub-centre in the village, deliveries are still conducted by untrained dias at

home. The Ayurvedic hospital has become ideal place for family planning operations in this interior region. The hospital lacks MCH services and people have not derived much benefit out of it.

Field studies show that people who live close to health institutions still have poor health services, which means geographical acessibility to health institutions is no guarantee of better health services.

CHAPTER - VI

DISCUSSION

Obviously, it was possible to get some very broad information concerning an overview of the socio-economic conditions and the health service system of Chamoli district from the study of two primary health centres, two PHC villages, two villages further away from the two PHCs and a family planning camp. It will, therefore, be emphasised once again that the current study suffers from unavoidable but severe limitations. However, even with this very limited study, it is possible to identify some major issues in health service development in the district.

One striking feature is that Chamoli district has a very wide network of services for social and economic development and for providing health services to the people. However, one immediately comes across two glaring short-comings. One is that many of the posts are lying vacant. The second problem, which is even more disconcerting, is that those who are in position, work at a very low level of efficiency. The result is that the people get very little benefit from them. One outcome of this state of affairs is the widespread phenomenon of corruption and dishonesty in government work. Over and above, there is the most

disturbing feature of being refractory to some of the basic needs of the people which the organisations are supposed to serve.

This region also has very peculiar socio-economic, demographic and ecological conditions. On one side there are the pilgrim centres of Badrinath and Kedarnath, along with the efforts to build up centres for tourist attraction in this area. On the other side, there is the extremely unhospitable land conditions which make it virtually impossible for the people to eke out even the most elementary subsistance needs. One consequence of this very difficult living conditions has been the tendency for the people to seek out employment in the army, para-military forces and government agencies. The pensions earned by the retired people and sending of money from those who are in employment elsewhere in the country becomes an important element in the economic life of the people of this district. Because of this reasons, the term 'money order economy' has come into existence. Incidentially, the records show that just in one month (November, 1987) more than one crore rupees were disbursed to the population of the district in the form of pensions.

The problems concerning the health service system became obvious even from a general overview of the health

service system from the district headquarters. There was little to show a live relationship between the Chief Medical Office and the various health institutions that are distributed in different parts of the district. The district organizations seem to be almost apathetic towards some of the basic needs of the institutions at the PHC level and below. The supply of drugs is one such critical area.

Carrying the trends of apathy, neglect and corruption from the district level to the interior regions, it was not surprising that there were open cases of corruption in the offering of loans. The open cases of illicit distillation of alcohol was yet another dramatic manifestation of the level of integrity and the capacity of the administration to enforce law and order.

However, in this overall situation of gloom and frustration it was most encouraging to observe some major movements. One was the world known Chipko Movement. While leaders like Chandi Prasad Bhatt deserve credit, the credit for this movement should also go to the women of this region. Along with this the untapped potential is manifested in the form of formation of Mahila Dal's fight against the racketeers indulging in illicit distillation.

Both the primary health centres, not surprisingly, present a very bleak picture. Only one out of the three

doctors is in position. There is acute shortage of doctors. More important is a conspicuous lack of motivation in the doctors and paramedical staff to implement the programmes that have been assigned to them. The situation at the sub-centres is obviously even more diplorable.

The rampages of the family planning programme are particularly devastating under such conditions. It appears that the entire organization is existing merely to get some sterilization cass for family planning. Apart from almost total mobilization of the health organization the other revenue staff is also drawn in to get people for sterilization. There are three basic consequences of such rabid pre-occupation with the family planning programme. First, even the cases that are finally caught within family planning dragnet are of demographically marginal consequences. Most of them have already a large number of children. This is like closing the stable after the horse has bolted. Secondly, there is, over and above, considerable dishonesty in the reporting. The data from the field gives a vivid account of how casual have been the health workers in attaining the so-called targets concerning contraceptive pills, condoms and IUD insertions. Thirdly, and perhaps most importantly, this pre-occupation with attaining of the given family planning targets has had

devastating effect on the other health activities. Once a health worker is able to deliver, partly or completely, her quota of cases, she can forget about her other responsibilities and she will not suffer from any retribution. This came off vividly in the cases of tuberculosis and leprosy. There was little concern within the health organization about the need for the proper implementation of the programme. This meant proper diagnosis of the cases of tuberculosis and leprosy at the PHC level, and if necessary, referral at the district level. Then there is the vital question of having adequate treatment organizations. The staff was found to be blissfully unaware of their own responsibilities towards the patients. Under such conditions, it was not surprising that there have been so many children who have been branded as cases of tuberculosis; there were also so many non-pulmonary tuberculosis cases; even the cases of pulmonary tuberculosis were seldom confirmed with sputum examination and thus the basis of their diagnosis remain highly questionable. A very sad outcome of this gross neglect of the duties of the personnel concerned was the tendency to blame the victims for their predicaments. They were branded as defaulters while nobody branded the PHC as the defaulters even though the supply of drugs was erratic and it did not have proper diagnostic and treatment facilities. The fact that the

villagers ganged together to hound out a leprosy patient provides dramatic instance of the failure of the leprosy worker in particular and of the PHC and the CMO in general to take this malignant stigma out of the disease.

The sad story of the immunization programme starts right at the state headquarters where crates containing highly heat-labile vaccines were left carelessly in the corridors of offices under high temperature of the summer months. A similar situation was directly observed at the district health offices. There was also the case of refrigerators lying unrepaired for yeas together at the Pokhri PHC. Then there was the case of lack of ice in the thermoflask. There was also the case of non-use of any thermoflask. There was the false reporting of the cases. There were worse absentisms in the repeat visits. Taking all these together, one can reasonably come to the conclusion that the enormous expenses involved in the implementation of the immunization programme in Chamoli district (as indeed in the other 56 districts of UP), have literally gone down the drain with virtually no benefit to the masses.

The situation is even worse in the case of maternal and child health services. In both the primary health centres, there are so-called female hopitals without

any semblance of an organization. It was also evident that there was virtually no work carried out by the ANM in the sub-centres and in the villages. women were literally left to fend for themselves in coping with their child-births and with any problems that arise out of these. Geographical accessibility to health institutions has not made any difference in terms of quality and quantity of these services to the people.

The implementation of the health guide scheme follows the same sad trend. There is, in the first place, little relationship between the CHGs and the communities they are supposed to serve, even though the CHGs were supposed to be the representatives of the people who are trained to help the people to cope with their own health problems. Then there is the famous letter from the Government of Uttar Pradesh dismantling the entire system, followed by the stay order from the High Court. The crowning action from the State Government was to link the whole CHGs scheme with the catching of cases for sterilization. So, in fact, those who are supposed to be people's representatives to ensure that people get the sevices they need to cope with their health problems, virtually became the paid agents of the government for getting cases of family planning. This could perhaps sum up

the entire situation concerning the state of health services in Chamoli district.

It will require major efforts to improve the situation prevailing in Chamoli district. However this need not be brought about all of a sudden. Some steps can be taken immediately. For instance, the district level health adminstrators can provide supportive supervision to strengthen the hands of the PHC doctor and his team. He can also ensure that they do perform the duties for which they have been employed. Such actions will ensure that some of the urgent 'felt needs' for medical care services of the community are met at the PHC level itself. This can also ensure that chronic patients such as those suffering from tuberculosis and leprosy are given effective treatment facilities and they are motivated to continue the treatment prescribed to them. One outcome of these efforts will be to at least relax the pressure for achieving targets for family planning and immunization. Indeed, the problems for effectively carrying the immunization are so enormous that for the time being one can even think of limiting the programme only to the vaccines which do not need refrigeration and vaccinations which can be conveniently given by the multipurpose workers as the part of their normal community health work, and not as a massive programme with the objective of covering the entire population by 1990.

CHAPTER - VII

SUMMARY AND CONCLUSION

The present study has looked into the community and community health work in two Primary Health Centres in Chamoli District of Uttar Pradesh, mainly in the areas of Family Planning, Maternal and Child Health and Immunization, with a view to assess how far the health care system is equipped and geared to implement its policies, plans and programmes, as given in the seventh plan objectives for health sector and in the national health policy which is committed to achieve health for all by the year 2000 AD.

For the above broad objectives, the Primary Health Centres of Pokhari and Tharali in District Chamoli were selected. Apart from the two PHC villages, two other villages which are located away from the PHC were also selected. The villages in Pokhari block were (a) Nakholiyana and (b) Naili. Similarly in Tharali block, the villages were (a) Tharali and (b) Dungeri.

At the PHCs, a general schedule for the PHC was used to get information about the manpower and logistic support and information on coverage of Family Planning MCH, and Immunization were recorded. Tuberculosis and leprosy

programmes were also looked into. Interviews were conducted with the PHC doctor and few para-medical staff.

Similarly, in the villages, a general schedule was used to get basic information and interviews with the people in groups and individually, alongwith participation and non-participation observations. The data collected were qualitative in nature. At the chief medical officer's office, a general information about the health department and the services in the district was collected from the office records and through interviews.

To place the functioning of the health care system in its socio-economic context, we undertook the district profile, covering the general trends in population, its economy, agriculture, tourism and ecological movements.

The population trends show sex-ratio with more female population, predominantly rural population, with female literacy rate much lower than males and the migration of rural youth to the plains for employment.

The economy of the region is based on the 'money-order' and the pension, as agriculture is very backward, no industries, except few small-scale industrial units and no other source of employment for the educated rural youth, who seek work in plains and many of them are employed in the

military services and hence we have the 'money-order' economy in the region. In agriculture the total cultivable land is very limited. Poor and negligible irrigational facilities, lack of modern agricultural inputs and hence, low yield of food production, which is not enough for annual subsistance. Women are the main working force in agriculture, even in places where male population is higher.

Tourism has not helped the local people and their economy, as only few transporters and hotel owners have been benefitted. With the coming of road communication right up to the religious centres, people now go to these places directly, unlike before when they had to walk miles through small towns and villages and had to eat and rest at these places, thus giving employment during the tourist season.

Deforestation and ecological degradation has given rise to ecological movements like Chipko. This has shown people's awareness and concern for their environment, which is vital for their own survival and well-being.

The profile of health services in the district show top priority to family planning programme, but there is lack of logistic support to immunization programme. The infra-structure for maintaining cold-chain is also linked with the erratic and low voltage power supply in the

district. There are a number of vaccant posts of doctors and technical staff, both at the district hospital and at the primary health centres. At the PHC and at the village level the interaction is limited to the family planning programme and even when the health services are provided at the doorsteps the objectives is to woo the people to give or get family planning cases. Even in the case of IUD's and oral pills, there is no follow-up action. Neither is the department interested, nor has it the time and resources to do so. All these factors have led to cooking up of achievement targets. The maternal and child health and the immunization programmes are neglected, not only due to major emphasis on the family plannig, but also due to poor transportation and communication system in the district. This has led the field workers to manipulate the achievement targets. The supervisors and the officials are quite well aware of this phenomena.

The poor health services and lack of medicines at the PHCs have forced the people to seek relief from the RMPs and the serious and complicated cases generally go to Rishikesh or Dehradun in the plains.

The monthly progress reports are regularly sent to the CMO's office, which has only become a ritual to be completed at the end of the month.

The district profile shows the underdevelopment of the health care services is closely associated with the general socio-economic backwardness of the district. It only emphasises the need for intersectoral linkages in the process of development. We cannot develop a modern health care system in isolation; it requires profound changes in the economy and society.

Due to the general backwardness of the district, doctors are not taking up appointments in the hill areas and even those forced to do so, are busy seeking transfer from the areas. The problem for the doctors and other officials is not limited to accomodation, but also the need for better educational and recreational facilities for their children and families. As the 'middle class' families now are 'child-centred', the parents look for a better life and job prospects for their wards through better educational facilities and social milieu, which lacks in a backward region and hence the perpetual problem of vacant posts and transfer seekers in all the departments. This problem is even with the people who originally hail from the hilly areas.

All the doctors who are employed on the daily wages are graduates in Ayurvedic medicines, which only indicates the lack of market for them in urban and developed

areas, thus forcing them to take up jobs in the backward hill areas.

There is no effort to develop community participation, even through the health guides, as they are kept busy with family planning programmes by linking their job and stipend to the number of family planning cases procured. Moreover they have no medicines, and are of no use to the community in anyway.

Thus, we see that the government's commitment to primary health care and health for all is only on paper and it is not at all seen in its actions. The government will have to make a concerted effort to develop different sectors like agriculture, transportation and communications, education etc. simultaneously because without a coordinated effort in all the sectors, we cannot achieve the health for all target by placing the exclusive emphasis on the health services sector, and that also only on the family planning programme.

After recognizing the need to follow an integrated strategy of development, we make the following specific suggestions for the health care sector : the excessive emphasis on the family planning and its targets should be removed and the pressure for achieving targets for immunization programme should be relaxed.

Male sterilization should be encouraged as they are more simpler, surer and safer. At present women are the target of family planners. Equal emphasis should be given to contraceptives like IUDs, pills and condoms and there should be a follow-up of these. Incentive could be given to the IUD cases and only health department should be involved in family planning programmes to avoid petty politics and scramble among various department officials.

The final issue: We can not run the steam engine without the railways; can we implement the 'modern' health srvices without the basic developmental inputs? The answer from the field study is : NO!

SCHEDULE FOR PRIMARY HEALTH CENTRE

DATE:

NAME OF THE PHC VILLAGE:

RESPONDENT:

AREA COVERED: (POPULATION, BLOCK, VILLAGES)

OTHER HEALTH INSTITUION UNDER THE PHC
(SUB-CENTRE, DISPENSARY):

REFERRAL SERVICES:

MANPOWER

NUMBER OF DOCTORS:

NO. OF NURSES (LHV, ANM):

SUPERVISORY STAFF (FOOD INSP., H.I., BEE ETC.):

LAB. TECHNICIAN, PHARMACIST:

ADMINISTRATIVE STAFF
(ASSISTANTS, STATISTICIAN, OTHERS):

DAIS:

LOGISTICS

BUILDINGS:

VEHICLES:

EQUIPMENT (O.T., X-RAY, ETC.)

BUDGET-MEDICINE, STORES, OTHERS:

ACCOMODATION:

OTHERS:

STATISTICS ON COVERAGE

NUMBER OF BEDS:

PATIENT-ANNUAL-INDOOR/OUTDOOR:

DELIVERIES -ANNUAL-INDOOR/OUTDOOR:

FAMILY PLANNING CASES:

CONTRACEPTIVE (PILL, IUD, ETC.):

MCH (ANTE- AND POST-NATAL, IRON TAB, NUT.SUP. ETC.):

IMMUNIZATION (DPT, POLIO, BCG, MEASLES, ETC.):

CASES OF MALARIA, T.B., LEPROSY, OTHERS:

SCHOOL EDUCATION/HEALTH:

HEALTH EDUCATION-MOTIVATION, PUBLICITY ETC:

SCHEDULE FOR THE VILLAGE

GENERAL DESCRIPTION OF THE VILLAGE

NAME:

NUMBER OF HOUSEHOLDS:

POPULATION:

CASTE:

GENERAL OCCUPATION:

PEOPLE MIGRATED:

PEOPLE WORKING IN THE PLAINS:

HOUSING:

WATER SUPPLY:

SANITATION:

ELECTRICITY:

RADIO/T.V.:

CATTLES:

LANDHOLDING:

SCHOOL/COLLEGE:

HOSPITAL[PHC[DISPENSARY:

TRANSPORT AND COMMUNICATION:

RMP, VAIDS, ETC.:

TRAINED/UNTRAINED DAIS:

INJURIES, ACCIDENTS, SUICIDES:

BIBLIOGRAPHY

***BOOKS*:**

Agarwal, Anil: *State of India's Environment*: Citizen's Report, New Delhi, Centre for Science and Environment, 1982.

Banerji, D.: *Family Planning in India*: A critique and a perspective, New Delhi, PPH, 1971.

___________: *Poverty, Class and Health Culture in India*, New Delhi, Prachi Prakashan, 1982.

___________: Health Services Development in India, 1984, mimeo.

___________: *Health and Family Planning In India*, New Delhi, Lok Paksh, 1985.

___________: *Social Sciences and Health Sciences Development in India*, Lok Paksh, 1986.

Basu, R.N. et al.: *The Eradication of Smallpox from India*, New Delhi, WHO SEARO, 1979.

Battelhim, C.: *India Independent*, New York, Monthly Review Press, 1968.

Bondestan, L. and S. Bergstrom: *Poverty and Population Control*, London, Academic Press, 1980.

Borkar, G.: *Health in Independent India*, New Delhi, Ministry of Health, 1961.

Bose, A. and P.B. Desai: *Studies in Social dynamics of Primary Health Care*, Delhi Hindustan Publishing House, 1983.

Dabral, S.P.: *Uttarakhand-Ka-Itihas*, Dogadda-Garhwal, V.S.2022.

Dandekar, V.M. and N. Rath: *Poverty in India*, Poona, Indian Institute of Political Economy, 1971

Demerath, N.J.: *Birth Control and Foreign Policy*: The Alternative to Family Planning, New York, Harper and Row, 1976.

Desai, A.R.: *Social Background to Indian Nationalism*, Bombay, Popular, 1976.

___________ : *India's path of Development*, Bombay, Popular, 1979.

___________ : *Urban Family and Family Planning in India*, Bombay, Popular, 1979.

Djurfeldt, G. and S. Lindberg: *Pills against Poverty*, New Delhi, Oxford and IBH Publishers, 1975.

Dobhal, G.C.: *Pauri-Garhwal: A Regional Study*, Ph.D. Thesis unpublished, CSRD/SSS, JNU, 1983.

Doyal, L.: *The Political Economy of Health*, Pluto Press, 1979.

Dubois, R.: *Men, Medicine and Environment*, London, Penguin, 1968.

Dutt, P.R.: *Rural Health Services in India: Primary Health Centres*, New Delhi, Central Health Education Bureau, 1965.

Dutt, R.P.: *India Today*, Calcutta, Manisha, 1979.

Foucault, M.: *The Birth of a Clinic*, New York, Pantheon, 1973.

Frank, A.G.: *Critique and Anti-Critique: Essays on dependence and Reformism*, London, MacMillan, 1984.

George, Susan: *How the Other Half Dies*, England, Penguin, 1976.

Goinzalez, C.L.: *Mass Campaign and General Health Services*, Geneva, WHO, 1965.

Hayter, T.: *Aid as Imperialism*, Penguin, 1971.

ICMR & ICSSR: *Health for all: An alternative Strategy*, Pune, Indian Institute of Education, 1981.

Illich, I.: *Limits to Medicine*, Bombay, Rupa & Co., 1977.

Kilbourne, E.D. and W.G. Smillie (ed.): *Human Ecology and Public Health*, London, MacMillan, 1989.

Mamdani, M.: *Myth of Population Control*, Family Castes and Class in Indian village, New York, Monthly Review Press, 1972.

McKeown, T.: Role of Medicine: *Dream, Mirage or Nemesis*, London, Nuffield Provincial Hospita, 1976.

McKinlay, J.B. (ed.): *Issues in the Political Economy of Health Care*, London, Tavistock, 1984.

Mitchell, N.: *Indian Hill Station: Kodaikanal*, Chicago, University of Chicago, 1972.

Navano, V. (ed): *Imperialism, Health and Medicine*, New York, Baywood Publishing Co., 1979.

______________ : *Medicine Under Capitalism*, New York, Prodist, 1976.

Sahu, S.K.: *Health Culture of Oraons of Rourakela and Its Hinterlands*, Unpublished Ph.D. Thesis, CSMCH/SSS, JNU, 198

Singh, O.P. (ed): *The Himalaya: Nature, Men and Culture*, New Delhi, Rajesh Publishers, 1983.

Shah, K.T.: *National Planning Committee, Sub-Committee on National Health* (Sokhey Committee Report), Bombay, Vora, 1948.

Shenoy, B.R.: *PL-480 Aid and India's Food Problem*, New Delhi, Concept, 1974.

World Health Organization and UNICEF: *Primary Health Care: Report of the International Conference on Primary Health Care*, Alma-Ata, USSR, Geneva, WHO, 1978.

Wyon, J.B. and Gordon, E.: *The Khanna Study: Population Problems in Rural Punjab*, Cambridge, Harvard University Press, 1971.

Zurbrigg, S.: *Rakku's Story*: Structures of Ill-Health and Source of Change, New Delhi, Voluntary Health Association of India, 1984.

ARTICLES:

Bahuguna, S., "What Price the Hill Development", *Yojana*, May 1-15, 1984, p.4-7.

Banerji, D., "Tuberculosis as a Problem of Social Planning in India", *NIHAE Bulletin*, Vol. 4, No. 1, p.4-35.

____________ "Impact of Rural Health Services on the Health Behaviour of Rural Population: A Preliminary Communication", *Economic and Political Weekly*, Vol. 8, Dec.22, 1973.

____________ "Social and Cultural foundations of Health Services System in India", *Inquiry*, Supplement to Vol.XII, June 1975.

____________ "Facade of the Rural Health Care Scheme in India as an Opportunity", *Yojana*, Vol.22, No.14-15, 1978.

____________ "Technocentric Approach to Health: Western Response to Alma-Ata", *Economic and Political Weekly*, Vol.21, No.28, July 12, 1986.

____________ "Comment on New Patterns in Health Sector Aid to India", *International Journal of Health Services*, Vol.16(1), 1986.

Berliner, S.H., "A Larger Perspective on the Flexner Report", *International Journal of Health Services*, Vol. 5(4), 1975.

Berliner, S. and J.W. Salmon, "The Holistic Alternative to Scientific Medicine: History and Analysis", *International Journal of Health Services*, Vol.10(1), 1980.

Berreman, G.D., "The U.P. Himalaya: Culture, Cultures and Regionalism", in O.P. Singh (ed.) *The Himalaya: Nature, Man and Culture*, New Delhi, Rajesh Publishers, 1983, p.253.

Brown, E.R., "Public Health in Imperialism: Early Rockfellor Programme at Home and Abroad", *American Journal of Public Health*, Vol.66, 1976.

Cleaver, Harry, "Political Economy of Malaria Decontrol", *Economic and Political Weekly*, Vol.11, no.36, 1976.

______________ "Malaria and the Political Economy of Public Health", *International Journal of Health Services*, Vol.7(4), 1977, p.557-579.

Cramford, R., "The Ideology of Victim Blaming", *International Journal of Health Services*, Vol.7, 1977.

Dass and Negi, "The Chipko Movement", A paper sponsored by the *Anthropological Survey of India*, Calcutta, Sept. 1976.

Desai, A.R., "An Alternative Approach to Development" in Bose, A. et al. (ed.) : *Population in India's Development 1947-2000*, Delhi, Vikas, p.,89-100.

Grant, J.P. "A Child Survival and Development Revolution" *Assignment Children*, Vol.61-62, No.1, 1983, p.21-31.

Jeffery, Roger, "New Patterns in Health Sector Aid to India", *International Journal of Health Services*, Vol.16, No.1, 1986, p.121-140.

Karan Singh, World Population Conference, Bucharest (Romania), 1974.

Navarro, V., "Social Class, Political Power and the State and their Implications in Medicine", *International Journal of Health Services*, Vol.7, 1977.

______________ "A Critique of the Ideological and Political Position of the Brandt Report and the Alma-Ata Declaration", *International Journal of Health Services*, Vol.14(2), 1984, p.159-172.

Panikar, P.G.K., "Health Care Delivery System in India", *Economic and Political Weekly*, 1976.

Qadeer, I., "Health Services System: An Expression of Socio-Economic Inequalities", *Social Action*, Vol.35, July-Sept. 1985.

_____________ "Social Dynamics of Health Care: A Case of CHW Scheme in Shahdol District, *Socialist Health Review*, II, N.2, 1985.

Ramasubban, R., "Public Health and Medical Research in India: Their Origins Under the Impact of British Colonial Policy", Sweden *SAREC* (SAREC Report, R.4: 1982), 1982.

Renaud, Mar C., "On the Structural Constraints to State Intervention in Health, *International Journal of Health Services*, Vol.5(4), 1975.

Shiva, Vandana, "Ecological Movements in India", *Alternatives*, 11(2), April 1986, p.255-73.

Walsh, J.A. and K.S. Warren, "Selective Primary Health Care: An Interium Strategy for Disease Control in Developing Countries", *New England Journal of Medicine*, Vol.301, p.967-974.

GOVERNMENT DOCUMENT:

Government of India, Health Survey and Development Committee (Bhore Committee): *Report*, Delhi, Manager of Publications, 1946.

Government of India, The First Five Year Plan - *A Draft Outline*, New Delhi, Planning Commission, 1951.

Government of India, The Second Five Year Plan - *A Summary*, New Delhi, Planning Commission, 1956.

Government of India, *Report of the Conference on Social and Cultural Factors in Environmental Sanitation in Rural India*, New Delhi, Publication Division, 1957.

Government of India, The Third Five Year Plan - *A Draft Outline*, New Delhi, Planning Commission, 1960.

Government of India, Health Survey and Planning Committee (Mudaliar Committee): *Report*, New Delhi, Ministry of Health, 1962.

Government of India, Fourth Five Year Plan - *A Draft Outline*, New Delhi, Planning Commission, 19

Government of India, Fifth Five Year Plan, 1974.

Government of India, Group on Medical Education and Support Manpower (Srivastav Committee): *Health Services and Medical Education: A Programme for Immediate Action, Report*, New Delhi, Ministry of Health and Family Planning, 1975.

Government of India, *Committee on Multipurpose Workers Under Health and Family Planning Programme* (Kartar Singh Committee Report), New Delhi, Ministry of Health, 1973.

Government of India, *National Population Policy*, New Delhi, Ministry of Health and Family Planning, 1976.

Government of India, *Statement on National Health Policy*, New Delhi, Ministry of Health, 1982.

District Statistical Office: *District Statistics Handbook*, Chamoli, Gopeshwar, 1986.

Rizvi, S.A.A.: Uttar Pradesh *District Gazettes* - Chamoli, Lucknow, 1974, p.142-150.

Government of India; *The sixth five year plan* 1980-85, New Delhi, Planning Commission; 1980.

Government of India; *The seventh five year plan*; 1985-91, volume-II, New Delhi, Planning Commission; 1985.