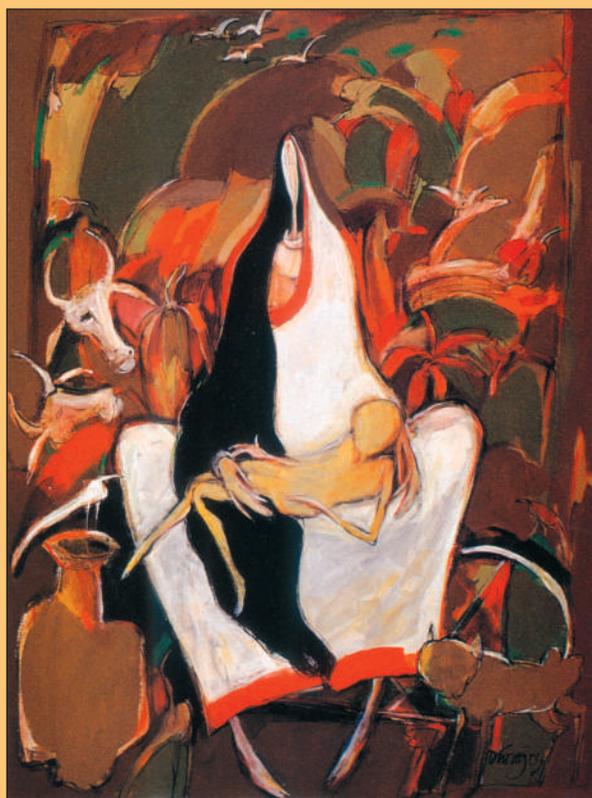


The Pratichi Health Report

With an introduction by Amartya Sen



NUMBER 1 ■ PRATICHI (INDIA) TRUST

- When citizens cannot even get free medical diagnoses or blood tests, or obtain basic medication for clearly identifiable substantial illnesses, there is something deeply wrong with the framework of state health services.
- A far-reaching reorganization of public health services seems to be needed.
- Many of the changes that are needed are matters of better organization, rather than of larger expenditure.
- It is particularly important to bring the issue of responsibility in medical services into the spotlight of public attention, along with the prevalence of ‘quacks’ and the explosion of expensive private practitioners to whom the patients tend to go because of the lack of elementary public health services.
- The remedy must also lie in more public discussion, in the media and elsewhere, about appalling exclusions in state health services, with disastrous impacts on the lives of the poor, along with non-performance by a substantial part of the public health care officials, including doctors.

Amartya Sen

t/m BOOKS

Rs 100; \$5

ISBN 81-88297-03-8

The
Pratichi
Health Report

NUMBER 1, 2005

PRATICHI (INDIA) TRUST



First published in 2005 by TLM BOOKS
in association with PRATICHI (INDIA) TRUST
A 708, Anand Lok, Mayur Vihar I,
Delhi 110091, India
Phone/Fax: (91 11) 2275 2375
Email: bookshop@littlemag.com
Website: www.littlemag.com/books.html

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EDITORS: SAMANTAK DAS AND AODIITI MEHTTA
DESIGN: ANTARA DEV SEN
COVER ART: DHIRAJ CHOUDHURY, 2003

ISBN 81-88297-03-8

Printed at Aditi PrintoFast, New Delhi
TLM BOOKS is an imprint of Indigo Publishing Pvt Ltd

The Delivery of Primary Health Services

A STUDY IN WEST BENGAL AND JHARKHAND

By the Pratichi Research Team:

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AMRITA SENGUPTA

With an introduction by

AMARTYA SEN

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANM	Auxiliary Nursing Midwife
APHC	Additional Primary Health Centre
ARI	Acute Respiratory Illness
BDO	Block Development Officer
BPHC	Block Primary Health Centre
BPHN	Nurse of Block Primary Health Centre
BPL	Below Poverty Line
CMIE	Centre for Monitoring Indian Economy Pvt. Ltd.
CMOH	Chief Medical Officer of Health
DOT	Direct Observation and Treatment
ENT	Eye, Nose and Throat
FPW	Family Planning Worker
GNM	General Nursing Midwife
HA(F)/	Health Assistant (Female)/
HA (M)	Health Assistant (Male)
HIV	Human Immune Deficiency Virus
HS(F)/	Health Supervisor (Female)/
HS (M)	Health Supervisor(Male)
ICDS	Integrated Child Development Service
ICMR	Indian Council for Medical Research
ICPD	International Conference on Population and Development
ICSSR	Indian Council for Social Science Research
IIPS	International Institute of Population Sciences
MH&FW	Ministry of Health and Family Welfare
NFHS	National Family Health Survey
NGO	Non-Government Organization
NSSO	National Sample Survey Organisation
ORS	Oral Rehydration Salt
PHC	Primary Health Centre
PHN	Nurse of Primary Health Centre
RCH	Reproductive and Child Health
RMP	Registered Medical Practitioner
SC	Scheduled Caste
ST	Scheduled Tribe
TB	Tuberculosis
UMP	Unqualified Medical Practitioner

Introduction

Amartya Sen

THE PRATICHI TRUST has been involved in trying to facilitate discussions on significant policy issues, including basic education and health care. This is in addition to our relief and reconstruction activities, which are also proceeding, particularly in the **Orissa Project**, which began with arranging relief from the effects of the supercyclone in 1999, but has been extended to long-term community development. The Pratichi School at Nagari village has made a good start, and the work is being extended to the building of a multiple-purpose community centre (including a cyclone shelter). Nevertheless, much of the focus of the Pratichi Trust is on investigation and analysis of public policy. This report — our first in the field of health care — is part of that commitment.

The earlier studies undertaken by the **Pratichi Research Team** were concerned with primary education, and the empirical investigations were focused on six districts in West Bengal (Birbhum, Medinipur, Puruliya, Bardhaman, Murshidabad and Darjeeling) and one in neighbouring Jharkhand (Dumka). We have been specifically concerned with needed reforms in the organization of primary schools to make them more functional and effective, and we have made a number of concrete proposals, with a particular focus on giving the parents (especially from the disadvantaged families) a bigger voice in the running of the respective schools. We have also focused on integrating the fight against child hunger with that against illiteracy, particularly through good arrangements for cooked mid-day meals that can be served in the schools.¹ We are encouraged by the positive response of the West Bengal government and the teachers organizations to the various proposals we have made, in addition to the positive feed backs we have consistently received from the regular parent-teacher meetings arranged by the Trust.

This particular report presents our basic findings in our first investigation of basic health services in two districts in eastern India — one in West Bengal (Birbhum) and another in Jharkhand (Dumka). Some of the main findings, which seem to have considerable policy relevance (despite the small size of the study), are briefly presented below. The intention is to facilitate — and in some cases initiate — public discussion on these vitally important issues.

SOME OF THE MAIN FINDINGS

The Trust team has been concerned with: (1) the respective situations in the two adjacent regions of West Bengal and Jharkhand; (2) the comparative picture between the two, and (3) the policy issues that are powerfully raised by the findings, which seem to have significant general relevance.

Birbhum in West Bengal and Dumka in Jharkhand are not only adjacent to each other, they also have many similarities in climatic, epidemiological and demographic conditions. But they also have sharp differences in economic and political background. We have investigated the health services received by people in 24 villages, based on random selection, from 6 blocks (3 blocks in each of the two districts). The data relate to 432 households selected on the basis of stratified random sampling from these 24 villages.²

1. NON-FUNCTIONING HEALTH CENTRES: An immediate problem we were distressed to observe concerned the non-functioning nature of parts of the public health service, particularly in Dumka. Even before the nature of the medical services offered could be observed, the absence of functioning indicated a serious health hazard, especially for Dumka. While all the 10 Primary Health Centres (PHC) we visited in Birbhum were functioning, of the 9 in Dumka, 2 were completely shut, and the other 7 seemed to open irregularly. While medical officers were actually available in all the 10 PHCs in Birbhum, only 1 out of the 9 PHCs in Dumka had any medical officer at all (though they are supposed to be present in all of them as a part of the health service).

The situation is much worse for the ‘sub-centres’, which are supposed to be run with the help of paramedical personnel to provide day-to-day health care. They are meant to have a basic role in local health care and in essential health education. Alas, only 11 of the 18 sub-centres in Birbhum were actually functioning, and the picture was much worse in Dumka, with only 5 of the 13 designated sub-centres working at all, and even those functioned with much irregularity.

Even as far as the larger Block PHCs are concerned (one in each block), in the case of one block in Dumka, we could not find any doctor whatsoever despite visiting it on four consecutive days. The Birbhum Block PHCs were, however, functioning reasonably well (though in one case we were surprised to find a Block PHC doctor practising in his private clinic). Indeed, in some cases — as in the Block PHC in Sainthia — the doctors evidently worked with exemplary zeal and dedication.

2. NON-AVAILABILITY OF BASIC SERVICES: The lack of basic facilities in the clinics that actually did function was the second problem that we encountered. Diagnostic services are meant to be offered at the more central level of Block PHCs, of which there is one in each of the three blocks we investigated in the two districts. Testing for malarial parasite (a common disease in both districts, but particularly in Dumka) was highly irregular and often non-available in the 3 Block PHCs in Dumka (but they are provided in the Birbhum Block PHCs). None of the Dumka Block PHCs actually provided standard blood tests and other simple diagnostic facilities (including testing of urine or stool), though they are meant to be provided in every Block PHC. The situation in Birbhum was, again, much better, with 2 of the 3 Block PHCs providing these services, but the missing one is unfortunate for the block involved.

Regarding treatment, the availability of medicine is extremely limited in both the districts, and none at all was available in the case of one PHC in Dumka. Some of the patients interviewed claimed, in both the districts, that the PHC and Block PHC staff charged them money for medicines which are meant to be provided free as a part of the public health service.

A difference in favour of Birbhum is the limited presence of hospital beds and also of child birth facilities in all the three Block PHCs in the West Bengal district, while none of the Block PHCs studied in the neighbouring Jharkhand district had either of these facilities at all.

3. PRIVATE HEALTH CARE, EXPLOITATION AND MEDICAL DECEIT: One result of the non-functioning of public health services and the limited range of services offered is the wide use of private practitioners, to whom the patients — even very indigent ones — are forced to go. Sometimes they are sent there by the public health servants themselves. In some cases the public servants themselves seem to prefer seeing patients for money in private, rather than for free as a part of public service.

There is also the further problem of exploitation based on the ignorance of the patients, which takes the form of the ease and immunity with which quacks operate in the private sector, fleecing the patients in exchange for providing nothing other than placebo satisfaction.³ Cases of evident exploitation were found in both the districts, though its frequency is much higher in Dumka. While 29 per cent of the surveyed population in Birbhum seem to have been served, and substantially “charged”, by straightforward quacks, that proportion is as high as 62 per cent in Dumka (with another 14 per cent going to *ojhas* and other ‘magic healers’ who are mercifully less expensive).

4. ECONOMIC DEPRIVATION AND INDUCED DESTITUTION: Not only do the prevalence of quacks and the diversion of patients from the state sector to expensive private care have negative health effects, they also seem, in many cases, to initiate economic ruination by forcing families of ill people to go into indebtedness and to sell assets (including land), with profound impacts on life and livelihood. This is particularly so because of the high “charges” the private practitioners, whether or not qualified, extract from poor people. We found many cases in which the patients were

economically strained — or even ruined — through high charges, sometimes for services falsely claimed to be curative (like giving saline injections to deal with malaria).

The connections between health neglect and economic exploitation and impoverishment have to be more fully understood, so that the economic and health aspects of the present system are discussed simultaneously in an integrated way.

5. POLICY ISSUES AND PUBLIC DISCUSSION: The policy requirements to deal with these failures include the need for greater regulation and monitoring, perhaps even something comparable to the ‘inspection system’ for schools (which too is non-functioning in most districts, but for which there is at least an institutional structure and provision). Another policy possibility is much greater control and supervision of the activities of state sector doctors.

Much, however, will depend on the ability and willingness of the state sector to provide the basic medical services, especially needed by the poor. It is in the limited coverage of public health services, combined with the non-functioning of designated centres, that the roots of the problem can be traced. When citizens cannot even get free medical diagnoses or blood tests, or obtain basic medication for clearly identifiable substantial illnesses, there is something deeply wrong with the framework of state health services.

The remedy must also lie in more public discussion, in the media and elsewhere, about appalling exclusions in state health services, with disastrous impacts on the lives of the poor, along with non-performance by a substantial part of the public health care officials, including doctors.

6. NEGLECT OF BASIC HEALTH KNOWLEDGE: The importance of public discussion also relates to the neglect of basic health knowledge: for example, that regarding ‘oral rehydration’ as a strategy for dealing with gastro-intestinal diseases that take the form of dehydration. The fact that some of the patients believe that faced with dehydration they should drink less rather than more water is an appalling example of this. To the general lack of health information from which the rural population in both districts suffer, we must also add the almost total neglect of awareness of AIDS as an epidemic, the grip of which over India is expected to rise sharply.

The problem of knowledge and understanding also has bearing on the prevalence of quacks and the economic exploitation that goes with it, on the basis of ignorance of the patients and their families. A public health care system has to be concerned both with delivery of medical services (diagnostic, preventative and curative), and with general enhancing of medical understanding and knowledge about health. The education linkage has to be brought out for more public criticism.

7. IMMUNIZATION AND OTHER SERVICES: One of the peculiar features of the health services in both states is the neglect of some particularly important services, such as immunization (which is left to other organizations) and arrangements for child birth. These services are natural complements of normal health care (and are

provided in this way in almost every country in the world).

The neglect does have real penalties. For example, the proportion of children with full immunization in Birbhum is only 45 per cent; that proportion is exactly zero in Dumka. Also, the proportion of deliveries that take place at health institutions is only 47 per cent in Birbhum and just 6 per cent in Dumka. When these gaps are added to the omission of basic health care (including facilities for diagnosis and for treatment), the picture of health services that emerges is seriously disturbing. The lacunae are substantial even in the district of West Bengal that we surveyed, and they are particularly outrageous in the district in Jharkhand that we examined.

A CONCLUDING REMARK

We hope that raising these questions may help to bring into focus some serious gaps that need to be considered as soon as possible. There is obviously a cost side of the story as well, but the costs of expanding health care have to be compared with many other fields in which public money is fairly extensively spent.

What is also important to recognize is that many of the changes that are needed are matters of better organization, rather than of larger expenditure. It is particularly important to bring the issue of responsibility in medical services into the spotlight of public attention, along with the prevalence of “quacks” and the explosion of expensive private practitioners (with or without any qualifications) to whom the patients tend to go because of the lack of elementary public health services.

A far-reaching reorganization of public health services seems to be needed, judging even from the limited picture we could construct on the basis of our investigations. The need is very much stronger in the district of Jharkhand that we studied than in the adjacent district in West Bengal, but there are many changes that are needed in West Bengal as well.

December 2004

NOTES

1. 1 See Pratichi Education Report I, Kumar Rana et al, with an Introduction by Amartya Sen (Delhi: TLM Books, and Pratichi (India) Trust, 2002); Pratichi Education Report II, Kumar Rana et al (forthcoming); the above reports are also available in Bengali translation: Pratichi Siksha Pratibedan, Kumar Rana et al, Deys, Kolkata; Jharkhandre Etohop' Secet'reak' Obosta, (in Santhali) (Delhi: Pratichi (India) Trust, 2003); Kumar Rana and Samantak Das with A. Sengupta and A. Rafique, “State of Primary Education in West Bengal,” Economic and Political Weekly, May 31, 2003; Kumar Rana and Samantak Das, “State of Primary Education in Jharkhand,” Economic and Political Weekly, March 13, 2004; Cooked Mid-day Meal Programme in West Bengal: Possibilities and Challenges, Kumar Rana et al (forthcoming).
2. The fieldwork was done during October 2002 to August 2003, and the data analysis was performed in our Santiniketan office. The investigation was conducted by Kumar Rana (Team leader), and Subhrangsu Santra, Arindam Mukherjee, Abdur Rafique and Amrita Sengupta (with assistance from Munni Hembrom, Agnesh Murmu, Agatha Baskey and Pushpa Murmu). Helpful advice from Samantak Das and Sibaditya Sen is also acknowledged.
3. “Quacks” are defined as persons offering alleged medical services without having any qualification in any recognised system of medicine — allopathic, homeopathic, or any other.

Preface

“Why do you waste time and money on research?” We were asked this question repeatedly by many people (including government officials and non-government functionaries) in both the states of West Bengal and Jharkhand. Senior government officers and NGO functionaries added, “Enough research has been done. Now it is time to do some substantial work.” We pondered over the question seriously and asked ourselves, “Can research play an effective role in making things better? Does it have a positive impact on peoples’ lives? To what extent can research influence the policies and programmes of the state to make them more effective?”

The role of research in the developmental field, especially in the formulation of policies, is undeniably important. Yet, the scepticism we encountered made us review the impact that Pratichi’s own research work has had. At the time of writing this report, the small Pratichi research team, which began work in May 2001 under the guidance of its Chair Professor Amartya Sen (with a modest one roomed rented office and an equally modest budget) had completed three studies on primary education in West Bengal and Jharkhand. Two of these have already been published and the third is forthcoming.¹ The release of the preliminary findings of the first study on the Delivery of Primary Education in West Bengal (on 10 November 2001) and the publication of the report (on 16 August 2002) have not only attracted wide media attention in the state in particular and in the country in general, but have also created an important public discourse on the state of primary education in West Bengal. Apart from media intervention, our trust has tried to make research findings and policy suggestions (formulated on the basis of the findings) available for parents and teachers of primary schools through Bangla, Hindi and Santali translations of the summary reports and through organising two workshops with parents and teachers².

These initiatives are in keeping with Pratiche's objective of intervention through peoples' action. That is to say, the reports are not meant as criticism of the government or other agencies but are aimed at the public domain, in order to create an environment for peoples' participation in developmental activities.

While the preliminary indications gathered so far, do not allow for complacency, they do give cause for belief in meaningful research. The parent-teachers' workshops and other feedback fora (we have received hundreds of very valuable responses from many villages and individuals) confirm that the reports have made a positive impact upon peoples' awareness. There is considerable evidence for this claim of which we will put forth only two. The research team has seen some primary schools where the teachers have become active, rising from their self-admitted "hibernation", in "removing the dust and stains from the system that have been gathering since long". Second, in a district of West Bengal, the Chairperson of the District Primary Education Council verbally acknowledged the veracity of our findings while taking new initiatives like the formation of mother-teacher committees. The experiments, he said, "are yielding excellent results"³.

In addition to this, many residents of the study villages insisted that Pratiche highlight the issues relating to the public health delivery system. The demand for a public discussion on basic health (and primary education and social security) that had been raised in academia (particularly by Amartya Sen) has now emerged from the grassroots (where most of the respondents are not familiar with the original works of Sen). Now the question is, "Why another study?" particularly when there is a plethora of research work available on health.

First of all, the very valuable studies that are available are either specific to certain issues (Reproductive and Child Health is probably the most researched area) or of a very general nature, which certainly give a wider picture but which do not always deal with the intricacies and interconnections between health and other developmental issues.

Health services, as Rabindranath Tagore pointed out in 1923, "must be seen as part of the overall framework of society and culture". Health as defined by the World Health Organisation is "optimal, physical, mental and social well being" and requires an analysis of the complexities of various related issues in the broader spectrum of development. An illuminating discussion by Drèze and Sen in *India: Development and Participation*⁴ underlines the importance of the interconnections between health, education and development.

The Pratiche (India) Trust considered it important to make an enquiry into the state of the health delivery system aimed at finding such interconnections. The investigation has deliberately been made in a relatively small geographical area to deepen the scope of the study. We hope this study will aid in the understanding of some of the problems concerning public health and health services through vigorous public discussion.

We are grateful to a number of individuals and organisations for extending many kinds of support. We apologise for not being able to mention everyone separately.

Professor Amartya Sen, Chair, Pratichi (India) Trust has been the main guiding force of the study and, despite his busy schedule, he consistently took note of the progress of the study and advised the research team. We owe a debt of gratitude to Professor Jean Drèze who read the earlier drafts and generously gave his suggestions from time to time. We are greatly indebted to Ms Antara Dev Sen, our Managing Trustee, without whose help this report would not have seen the light of day. We are particularly grateful to Dr. A.K. Roy of Economic Information Technology, Kolkata, Professor Dikshit Sinha of Visva-Bharati, Santiniketan, Dr. N.C. Gandhi, MS, Dr. Dipankar Chakraborty, MD, and Dr. Amalendu Bikash Toong, MBBS, for their valuable contributions during the course of the study and their comments on an earlier draft. Shivaditya Sen and Samantak Das, members of the Pratichi Co-Ordination Committee at Santiniketan, apart from academic suggestions during the course of the study and on the draft report have consistently provided moral strength and invaluable support to the team. It would have been extremely difficult for the research team to conduct the study in Dumka without a wide range of support extended by the members of the Ayo Aidari Trust, Dumka, a Santal women's NGO. Our sincere gratitude to all of them.

We are also grateful to Liby T. Johnson, Debu Dattagupta and Basudev Besra for their comments on an earlier draft. We are greatly indebted to Dr. P. Koshy, Coordinator, Pratichi (India) Trust and Saumik Mukherjee, Administrative Officer, Pratichi Research Office, Santiniketan, for their support all through the study. Thanks are due to Arabinda Nandy, Sumita Mukherjee and Ratan Ghosh for logistical and other support. The study team is also grateful to a great number of respondents at various levels.

NOTES

1. Rana et al (2002) *The Pratichi Education Report I*, with an introduction by Amartya Sen; and Rana et al (2003) *Jharkhandre Etobop Secetreak' Obosta* (Santali translation of 'The State of Primary Education in Jharkhand'). The English version of the report on Jharkhand will also be published very soon as a part of *The Pratichi Education Report II* (comprising a report based on a second study on primary education in West Bengal, a report on primary education in Jharkhand and a comparative analysis of the West Bengal and Jharkhand studies).
2. On 6 July 2002, at Bolpur, West Bengal and on 6 July 2003, at Dumka, Jharkhand.
3. Interview with Mr. Gautam Ghosh, Chairperson, Birbhum District Primary Education Council
4. Drèze and Sen ([1995] 2002)

Overview

In the *Mahabharata*, one of a series of riddling questions asked by the Yaksha was, “What is the greatest achievement of humanity?” King Yudhishthira, famed for his wisdom and righteousness, replied instantly, “Recovery from ill health.” The importance of health and health care found a significant place in the ancient scriptures and mythologies of India and the world. *Asvin*, the divine twin physicians¹ (who were deprived of sharing *Soma* with the other Gods of the *Indra* cult for they ‘have wandered and mixed with men, performing cures’) forced the Gods into allotting them a share of *Soma*. *Asvin* (the connection of whom is not peculiar to the Indian pantheon and is found elsewhere, e.g. Pindar’s *Pythian Ode*) won the fight with the Gods of the *Indra* cult with the help of the mortals.² Sickness was one of the worldly despairs that made Prince Siddhartha’s mind restless and forced him to leave his home and family to attain enlightenment (*Bodhi*). Indeed, the recognition of the importance of health care created the basis for the flourishing of medical sciences in India, more than two millennia ago.³

“If most of them [the population] are like the living dead, then it is not possible for the nation to shoulder their responsibilities.”⁴ The visionary Rabindranath, aside from establishing the strong linkage between ill health and the crippling of the mind in his literary works (e.g. in *Malancha* – a novel), took on the responsibility to establish cooperative health societies in 1923 when the colonial government was found wanting in catering to the basic health needs of the people⁵. He understood that the nation could not prosper if the people were not freed from illnesses that chained them to poverty, ignorance and perennial frustration.

Do the “living dead” alone suffer? Drèze and Sen argue, “Few subjects can be more important than health as a constitutive element of the well being and freedom of a nation.”⁶ Health ailments not only have an impact on individuals but also lead to class, gender and other social discriminations and act as an active agent of unfreedom. The ICSSR/ICMR report (1981) observed, “Health is a function not only of medical care but of the overall integrated development of society – cultural, economic, educational, political and social.” And the most direct relationship of health ailments is found with poverty. The same report observed from a cross tabulation of prevalence or incidence of diseases by economic class in a population group, that most infectious and nutritional deficiency diseases common in developing countries can really be considered to be “diseases of poverty”. Studies show that not just economic poverty but also limited access to health care is also caused by low social status, including gender

inequity.⁷ Sen has pointed out that in the “use of hospital and medical services women emerge as systematically underprivileged vis-a-vis men”.⁸ The relationship between particular classes and castes (*Hari, Dom* and other “low-borns”) and particular diseases (cholera and diarrhoea) is found in both literary works (for example in many novels by Sarat Chandra Chattopadhyay) and in academia.⁹ Although health is of primary concern to every individual, the meaning of health varies from person to person. The effects of ill health also have a changing nature. For an agricultural worker being confined to bed has far greater implications than for a salaried employee with greater social security. In a country like India where substantial variations based on region, class, social groupings, etc. are important constituents of society, the dynamics of health cannot be delinked from such diversities.

INDIA, WEST BENGAL AND JHARKHAND: HEALTH IN PERSPECTIVE

Although the importance of health was recognised as an important policy matter in the Indian National Congress’s agenda in 1938 (it had set up a sub-committee on health chaired by Col. Sokhey under the National Planning Committee) and the colonial government had also set up a Health Survey and Planning Committee (popularly known as the Bhore Committee) in 1943 and many subsequent committees had been set up by the government of independent India¹⁰ it is only in the recent past that health has increasingly been recognised as a measurable indicator of human wellbeing.¹¹

On the whole, India has achieved many successes between 1951 and 1997 in terms of:

- Higher life expectancy - from 32.1 years to 62.4 years
- Lower birth rate - from 39.9 per thousand to 27.2 per thousand
- Lower death rate - from 27.4 per thousand to 8.9 per thousand.¹²
- Lower infant mortality rate - from 146 per thousand to 68 per thousand.¹³

Smallpox has been wiped out. Great success has been achieved in the movement to eradicate polio. The rate of immunisation of mothers and children has increased considerably.¹⁴ Yet, far more needs to be done. In terms of health care, India is lagging far behind not only the developed countries but also developing countries like China, Cuba and neighbouring Sri Lanka.¹⁵ Again, there are inter-regional and inter-group variations in the achievements attained. For example, the life expectancy at birth (74 years) in Kerala is not only higher than the national average but is also higher than South Korea (73 years). Similarly impressive are the variations in the achievements of lowering the rate of infant mortality – Kerala has a figure (12 per thousand) very close to many developed countries. The national infant mortality rate is still alarmingly high and some of the Indian states have a rate considerably higher than the national average (Bihar, for example, has a rate of 78 infant deaths per 1000 live births). There are variations due to class, caste and gender as well.

A lot of work is required to combat the spread of communicable diseases, which, “are seen to be responsible for more than half of the ‘burden of disease’ in India”¹⁶. Tuberculosis claims one life every minute, accounting for an annual number of

5,00,000 deaths. Diarrhoea and other water-borne diseases are commonplace. Vector-borne diseases are another area of serious concern. Just the reported cases of malaria stand at 2-3 million¹⁷ (since the majority of the people in rural areas depend upon private or other non-governmental sources for treatment, data on malaria is presumably affected by gross underestimation). More alarming is the fact that 80 percent of the Indian population is prone to malaria.¹⁸ Morbidity is still very high particularly among the rural population¹⁹. Another alarming point is that, “the household expenditures on the treatment of sickness are large” and poorer people have to spend more, in percentage terms, than the richer, on the treatment of sickness²⁰, which often drives the poor to indebtedness and pauperisation.²¹

Coming to the states of West Bengal and Jharkhand, the general condition of health and health care is far from encouraging, even though West Bengal is better off than Jharkhand and its figures are better than the figures for India as a whole.

Table 1.1. Select health indicators

Indicators	India	West Bengal	Jharkhand
Infant mortality rate (per thousand)	68	49	54
Percentage of child births at medical institutions	33	40	14
Percentage of children who are fully immunised	42	44	9
Percentage of families visited by health workers	14	18	4
Percentage of population using govt. health system	29	24	19

Source IIPS, 2000

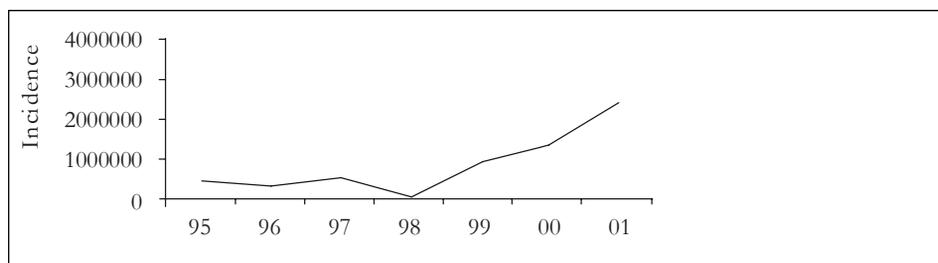
It is unfortunate that, despite the attention given to schemes for reproductive and child health over the years, the infant mortality rate is not only high compared to the developed countries but also to states like Kerala. West Bengal's achievement with regard to indices of infant mortality, childbirth at medical institutions, children's full immunisation and families visited by health workers looks much better in comparison to figures for India as a whole and Jharkhand (though nowhere near the optimum level). However, use of government health care systems both in West Bengal and in Jharkhand (the latter has an abysmal record in all these matters) indicates a large gap between the public health care system and its utilisation by the people. There is every possibility that this is related to the poor functioning of the system.

If this is the situation in the area of reproductive and child health, an area so prioritised and well-funded, the condition of the curative health services cannot be expected to be satisfactory.

The published figures of the government of West Bengal regarding the occurrences of communicable diseases and the deaths therefrom are alarming. There has been a sharp increase in the incidence of communicable diseases in West Bengal over a period of seven years, from 1995 to 2001.²² (*See chart 1.1*)

After many efforts to procure secondary information from the Health Department, Government of Jharkhand, we could collect some figures pertaining

Chart 1.1
Incidence of Communicable Diseases in West Bengal (1995-2001)



Source: *Health on the March (2001-2)* State Bureau of Health Intelligence, Directorate of Health Services

only to the occurrence of malaria. This casual record-keeping and reporting system has also affected the medical documentation of the Union Government.²³ However, the general morbidity and mortality patterns in Jharkhand, as reported in studies and the print media, are worse than that obtaining in the West Bengal and the all India patterns.²⁴ A survey of three vernacular dailies²⁵ over a period of three months (October – December 2002) showed that each of these dailies carried one news article on average every day pertaining to peoples' health. These included accounts of occurrences of diseases, deaths due to illness, poor health services (including the complete absence of some services in the rural areas) and so on. The news items also highlighted the gross irregularities and corruption in the functioning of the Primary Health Centres (PHCs), hospitals and other health departments and institutions. Some of the news items also came down severely on the running of certain health programmes, such as, for example, the malaria and TB eradication programmes.

Malaria data provided by the State Malaria Control Department, Jharkhand, tell only a very small part of the story, as use of government health services is very limited and people depend mainly upon Unqualified Medical Practitioners (UMPs), popularly known as “quack doctors”, or simply “quacks”, in the rural areas. The collection and testing of samples is also not free from faulty practices.²⁶ Despite this, even the inaccurately reported incidence of malaria in the state shows the widespread prevalence of the disease. In 2001, out of a total sample of 8,21,581 cases 1,25,229 cases (15.24 percent) were found to have tested positive for malaria. Another worrying fact is that in Jharkhand, “about 60 percent of the cases - in some areas 85 percent - are of *Plasmodium falciparum*, infamous for its killing potential”.²⁷

Before its inception as a separate state, Jharkhand was felt to have been neglected by its parent capital, Patna. A 1990 development ranking of the districts of Bihar showed that the districts included in the newly created state of Jharkhand scored the lowest in the human development indices. Although these districts contributed 70 percent of Bihar's revenues, the share of revenue expenditure that these districts got was only 20 percent.²⁸ Studies show that the health status of people and the functioning of the government health care system in Jharkhand have always been neglected.²⁹ Preliminary indications suggest that the newly-formed state still has a long way to go in order to cope with the needs of the people in fighting widespread illnesses

of various kinds. The major diseases (malaria, diarrhoea, tuberculosis and other communicable diseases) have increased in virulence because of widespread poverty and hunger. According to the Jharkhand Government's own reports, in 2001 the per capita food availability in Jharkhand was 52 percent less than the requirement³⁰. The per capita daily food availability in Jharkhand was 230 grams as compared to 523 grams in the rest of India. Hunger – mainly due to the lack of an inequitable distribution system³¹ - causes widespread malnutrition,³² which, in turn, makes health problems much more acute. The situation becomes graver still when the health infrastructure of the state does not provide adequate health services to the people.

Both West Bengal and Jharkhand suffer from poor health infrastructure. In 1998, when Kerala had 9.1 rural hospitals per 1,00,000 population, the comparable figures for West Bengal and Bihar (from which Jharkhand was subsequently carved out as an independent state) were only 0.2 and 0.1 respectively. At the same time, while the per capita health expenditure in Kerala was Rs 122.07, the figures for West Bengal and Bihar were Rs 71.90 and Rs 58.81 respectively. In a ranking of the states according to the number of Primary Health Centres per 1,00,000 population, West Bengal and Bihar were at the 18th and 19th positions respectively.³³

Health infrastructure has not improved significantly since the formation of Jharkhand. A comparison between the two states shows that although both states are deficient in terms of the required health infrastructure, West Bengal is somewhat better endowed.

Table 1.2 Health infrastructure in West Bengal and Jharkhand

	West Bengal	Jharkhand
Population	80,221,171	21,843,911
Area (sq. km)	88,752	79,714
Density	904	338
Sex Ratio	934	941
Literacy Rate	69.22 percent	54 percent
No. of PHCs and rural hospitals	1,368	498
Rural population served by each PHC and rural hospital	42,204	47,769
Area (sq. km) served by each PHC and rural hospital	64.87	160
No. of sub centres	8,126	3,697
Rural population served by each sub centre	7,104	5,659
Area (Sq. K.M.) served by each sub centre	10.9	19.9

Sources: West Bengal: State Bureau of Health Intelligence, Directorate of Health Services, *Health on the March: West Bengal, 2001-2*; Jharkhand: Department of Health and Family Welfare, 2001-2

The above table shows that, in terms of number of PHCs, both the states are far behind the norm of one PHC for every 30,000 people in general and one PHC for every 20,000 people in hilly and tribal areas. Jharkhand is worse off given the scattered settlement pattern which obtains in the state with most of the villages suffering from poor connectivity. One can well imagine the ground level situation as each of the PHCs, on average, caters to an area of 160 square km. Although the

number of sub-centres in Jharkhand is proportionately higher than in West Bengal, in practice it is hardly possible for a sub-centre, with only one or two health workers, to effectively serve an average area of 19.93 square km. In this respect, the condition of West Bengal is relatively better.

The above figures, however, do not tell the full story as to what the impacts of the functioning of the health delivery systems has had on peoples' lives in real terms and what the implications are when the systems fail to deliver. The present study aims to find out these interconnections.

SCOPE AND LIMITATIONS OF THE STUDY

The main issues that the study examined were related to:

1. The pattern/s and extent of illnesses in households;
2. The nature and source/s of treatment;
3. Cost of treatment and source/s of money for meeting such costs;
4. Abuse of patients' ignorance, if any, by medical practitioners and supplier — both government and non-government;
5. Reproductive and child health services;
6. Status of public delivery systems of health care;
7. Impact of health services available and implications of non-availability;
8. Peoples' perceptions regarding ways and means to improve health services.

The study has been conducted to gather in-depth information at the household level. We depended heavily upon the perceptions of the villagers — both male and female — in order to get an objective assessment of their health status and the health delivery systems in place. We have at the same time tried to gain a broader picture of the health delivery system through interviewing district and block level officials and other persons concerned with health delivery. The study thus analyses health problems and their implications in considerable depth, attempting to draw out interconnections between health and other socio-economic factors, like poverty, lack of credit, illiteracy, and so forth.

While peoples' views are the primary strength of the study, the same vantage point has some limitations. As regards actual health problems, since no medical practitioner was directly involved in collecting household level data, the real picture of the prevalence of ailments is bound to be a fragmented one. People often have no clear idea as to what a particular disease is called. There were other problems too. Objectivity varies from person to person. When a relatively affluent person could afford to take rest for a few days after falling ill, an agricultural labourer could not afford to do so. In many cases, while men were found to have taken medical advice and treatment, women remained untreated for similar kinds of ailments and continued performing their daily duties.

Besides the problem of objectivity, the study has limitations in terms of the area surveyed and the sample size. The study was conducted in two districts (Birbhum in West Bengal and Dumka in Jharkhand) with a relatively small sample size (431 house-

holds). However, despite its limited size, the depth of the study and other corroborative evidence (such as interviews at state and district levels, media reports, published and unpublished materials, etc.) highlight some important aspects of the health delivery systems in the two states with general implications for the country as a whole.

THE REPORT

The report is divided into three parts. The first part (comprising Sections 1 to 3) begins with a general overview in Section 1. Section 2 discusses study areas - districts, blocks and villages and the methodology used in the study. The study highlights are dealt with in Section 3.

The second part (Sections 4 - 8) contains the main study report. As mentioned above, we examined a sample of 431 households, consisting of different social groups – in terms of class, caste, gender, etc. Section 4 of the report provides details about the households. In a country with a diverse health delivery system like ours it is obvious that people of different social backgrounds use (or are forced to use) many different health delivery services. Section 5 analyses the prevalence of different health care responses to different ailments and deals with the different practices (and mal-practices) of medical services (public and private, with different categories of practitioners – qualified, UMPs, traditional practitioners, and so on). This section also discusses the various impacts of ailments and the diverse modes of treatment, with particular emphasis on the social dimensions, such as education, of such treatment.

Reproductive and child health care services are a major area that has attracted wide policy attention – both from government and non-governmental agencies. Despite many different interventions, this aspect of health still has enormous scope for improvement as important studies like the NFHS II suggest. Section 6 deals with the ground realities concerning the reproductive and child health services available in the rural areas of West Bengal and Jharkhand.

The inequitable health delivery system, the emergence of unqualified quacks as “indispensable” alternatives, particularly in Dumka, and the tremendously exploitative nature of private health services increases prevailing class distinctions. Also, the huge expenditures that people are often forced to incur for “reasons of health” can have negative impacts on some positive developments like land reform, enhancement in wage income, etc. Section 7 deals with the cost of health care and its complex economic and social implications.

Public health services are of two kinds – preventive and curative. While official curtailment of curative health services is noticeable all over the country, there are variations in the degree of withdrawal from place to place. The functioning of the preventive health services also varies. There is a clear distinction between the delivery of health services in the two study districts. The contrast between Birbhum and Dumka suggests that, despite the poor functioning of public health institutions, the poorer sections of the people in Birbhum do benefit, to a certain extent, from the public health services. The near-absence of these services in Dumka has forced people into

the private health system in its entirety. The last section (Section 8) examines the different public services made available to the respondent households and tries to analyse the impacts of the implementation of particular services.

The third part of the report contains the appendix tables and list of respondents (other than selected households).

Our report is suggestive rather than definitive in nature. Yet, many of its findings, as media reports and general discourse suggests, are applicable to other areas of West Bengal and Jharkhand and for the country in general. We hope the report will generate public discussion and debate on various issues concerning health and lead to public action on such issues.

NOTES

1. Chattopadhaya (1977:239-40), Bhattacharya (2000:238-239)
2. See Bhattacharya (2000: 238- 239)
3. Chattopaddhaya (1977)
4. Quoted in Sinha (2003)
5. See Choudhury (2001); Sinha (2003)
6. Drèze and Sen ([1995] 2002:201)
7. See Dasgupta and Chen (1998) and the literature cited there
8. Sen (1998)
9. Hunter ([1868] 1996)
10. See Anita et al (2000:8-9)
11. Shariff and Sudarshan (1996)
12. Parikh (2002) quoting Economic Survey (1999-2000), Government of India
13. IIPS (2000)
14. IIPS (2000)
15. See Drèze and Sen (2002: 128-9, 201-207)
16. Murray and Lopez (1996), cited in Drèze and Sen (2002)
17. Through the effective implementation of programmes taken up immediately after independence, malaria was nearly eradicated from the country. The incidence of malaria came down to 1,00,000 in 1965-6 from 75 million in 1951-2. But the figure rose again to 6.4 million in 1976. The decline rate of malaria cases is still very low. (Annual Report: 2001-02; Ministry of Health and Family Welfare, Government of India)
18. See Annual Report: 2001-02; Ministry of Health and Family Welfare, Government of India.
19. See Shariff and Sudarshan (1996: 66) NSSO (1998).
20. See Shariff and Sudarshan(1996: 70)
21. See Rana and Johnson (2003).
22. State Bureau of Health Intelligence, Directorate of Health Services, Govt. of WB (2002)
23. For example, in the Evaluation Coverage document (File No. N 23011/102/2001-Ply, Ministry of Health and Family Welfare, Government of New Delhi) one finds the data for all the states and union territories except Jharkhand. There is no reason why Jharkhand could not supply the data when Chhatisgarh and Uttranchal, states formed at the same time as Jharkhand, could do so.
24. Rana and Johnson (2003), Rao (2002)
25. Hindustan, Dainik Jagran and Prabhat Khabar (all published in Hindi from Ranchi)
26. Sainath (1996), Rana and Johnson (2003).
27. Interview with Dr. A.T.S. Sinha, State Entomologist, Jharkhand on 24 April 2003 at his office. Also see Ministry of Health and Family Welfare, Government of Jharkhand (2002).
28. See, for details, Singh (2003: 277-8) and the literature cited therein.
29. *ibid.*
30. Vision 2010, Government of Jharkhand (undated)
31. See Rana et al (forthcoming)
32. See Rao (2003) and the literature cited there.
33. www.mediindia.net

Study Areas and Methodology

As mentioned earlier, two districts, Birbhum in West Bengal and Dumka in Jharkhand, were selected for the present study. In this section we will briefly describe the districts with reference to their health delivery systems. We shall also try to present an overview of the study blocks and villages for the benefit of readers.

BIRBHUM

General: Birbhum lies in the central-west part of West Bengal. Part of the district falls in the Ganga basin and part of it is an extension of the tracts of the Santal Parganas. The districts of Pakur (Jharkhand) and Murshidabad (West Bengal) bind it to the north. On the east Birbhum has boundaries with Murshidabad and Bardhaman districts of West Bengal, on the south with Bardhaman again - the Ajoy River forming the boundary for the entire distance. On the west Birbhum is bound by Dumka district of Jharkhand. The district has a total geographical area of 4,545 sq. kilometers, forming 3.75 percent of the total geographical area of West Bengal and contributing 4.3 percent of the population of the state. According to the 2001 Census, Birbhum has a total population of 30,12,546 and a population density of 663 with SCs and STs forming 31 percent and 10 percent of the total population respectively. Among all 19 districts of West Bengal, Birbhum stands 14th in the rank of literacy – with a literacy rate of 62.16 percent, which is lower than the state average of 69.22 percent.¹

Health: Birbhum district first drew attention for major health interventions after an epidemic of malarial fever broke out in 1871 taking a large toll of lives. An account

of deaths caused by various illnesses shows that 86.4 percent of a total of 14,941 deaths were due to malarial fever that entered the district from Bardhaman and Hooghly. Cholera accounted for 4.9 percent of total deaths.² Endemic diseases continued to add to the suffering of people in the next century as well. Realising the extent and implications of the health problems of this pre-dominantly agricultural district and the absence of an effective public health delivery system Rabindranath initiated the setting up of health cooperative societies in 1923.³

The inadequate and poor functioning of the public health delivery system continued even after independence. A socio-economic study of a village Sahajapur, close to Bolpur town, found in 1958⁴, “It is obvious that the facilities offered by these [government health systems] have not yet reached the people of a village as close to Bolpur as Sahajapur. The reason given by villagers for inadequate use of these free facilities are delay, inadequacy of staff at the dispensary and the consequent lack of adequate care and attendance.” (p. 32) The report also noted that, “the benefits have not been shared equally by the different classes of people. The upper socio-economic groups have benefitted more.” (p. 142)

The Left Front government, after assuming power in 1977, has taken many different initiatives to upgrade the quality of life of the people, including several health programmes. Yet, the present health infrastructure of the district has a long way to go to meet the demands of the present situation. At present, the health delivery system, despite many positive changes, exhibits inadequacy in terms of numbers of Primary Health Centres and sub centres, shortages in staff strength, etc. As of 31st March 2002, there were 77 Primary Health Centres, (PHC), each of which served a population of 39,124 on an average. The number of PHCs included 19 Block Primary Health Centres (BPHC). Each of the PHCs served an average area of 59 square km. The number of sub-centres was 419, serving a population of 7,190 each, on average, and the average area covered by each sub-centre was 10.8 square km. While the average population served by each of the PHCs was nearly double the general norm (each PHC is supposed to serve a population of 20,000), the figure for the average number of people served by a sub-centre was relatively better, though the number was still higher than that prescribed (each sub centre to serve a population of 5,000).

Table 2.1 Public health facilities in Birbhum

	Number of health centres	Persons served per centre	Norm as per GOI	Average area covered under each centre
Primary Health Centres (PHC)	77 (including 19 BPHC)	39,124	20,000	59 sq. km
Sub-centres	419	7,190	5,000	10.8 sq. km

Source: Health on the March: West Bengal 2001-2, State Bureau of Health Intelligence, Directorate of Health Service
BPHC: Block Primary Health Centre

Apart from the existing PHCs and sub-centres, there is one District Hospital at Suri, two sub-divisional hospitals and four rural hospitals, most of which were

reportedly ill equipped. Since most of the PHCs have no in-patient departments (only two PHCs have indoor facilities, and while the BPHCs have indoor facilities, the service delivery was reportedly of low quality), the hospitals have to shoulder the responsibility of patients needing admission. Indoor facilities in many of the PHCs have been withdrawn in recent decades. Shortages of funds and staff have had their effects on the infrastructure and level of services provided. For example, a BPHC has been recently elevated to the status of a Rural Hospital, but due to the non-receipt of financial sanctions the PHC staff had to manage the whole operation. This has created enormous pressure upon the staff and, as a doctor mentioned, “Any day the system may collapse. How long can people work under such circumstances?” According to him, the hospital staff “have to work more than 16 hours a day”. The staff was managing the hospital with considerable dedication with an average of 800 out-patients and 30 in-patients per day. We had to wait for about six hours on 26 November 2002 for an interview with a doctor who was struggling to manage the large number of patients. In spite of employing all the available doctors (including one homeopath and one Ayurvedic physician for allopathic treatment – there was apparently no other way to run things – “if you call this medical abuse, then so it is”, said a doctor in a somewhat harried manner) it was visibly very difficult to deal with the situation.

Table 2.2 Staff strength in the Birbhum District Health Department

Sanctioned posts	No of persons	Posted	Shortage
Medical officer	210	210*	Nil
Nurse (ANM+GNM)	582	426	156 (26.8)
Pharmacist	103	90	13 (12.6)
Gr. D staff	447	374	73 (16.3)
Sweeper	150	109	41 (27.3)
HA (F)	425	382	43 (10.1)
HA (M)	425	207	218 (51.3)
HS (F)	71	63	8 (11.3)
HS (M)	71	14	57 (80.3)
BPHN	19	18	1 (5.3)
PHN	22	18	4 (18.2)
Computer	20	14	6 (30)
Ophthalmic Asst.	22	22	Nil
X-ray technician	15	15	Nil
ECG technician	5	5	Nil
Physiotherapist	3	3	Nil
Ward master	17	17	Nil
Store keeper	26	25	1 (3.8)

Source: CMOH office Birbhum, visited on September 11, 2003

*Including 24 Doctors on contract

Figures in parentheses indicate percentage

As with the shortage of funds and staff, the motivation of the doctors and health workers (barring a few exceptions like the example cited above) was also wanting. In one of the surveyed BPHCs we saw a doctor engaging in private practice during duty hours. He was not the least embarrassed about displaying the timings of his private practice quite prominently - 8 am to 1 pm – the very time he was supposed to be present on duty at the outdoor clinic of the BPHC! Such practices are not uncommon⁵, not just in West Bengal or Jharkhand, but all over the country. More upsetting is the inability of the concerned governments to take any firm action against such malpractices.

The general media discourse vindicates both the facts – governments' failure in providing adequate health care facilities (funds, infrastructure, medicines, doctors, health workers, etc.), which gets further aggravated in part due to dereliction of their duties by the medical community.⁶

The incidence of communicable diseases in the districts was found to be relatively high and was being handled with the limited staff strength of the district health services.

Table 2.3 Some of the major communicable diseases
Birbhum 2000-2001

Name of the disease	Treatment	Deaths
Acute Diarrhoeal Diseases	37,516	66
Pneumonia	1,630	86
Enteric Fever	2,973	7
Viral Hepatitis	205	14
Malaria	344	23
Tuberculosis	2,392	37
ARI* (excluding pneumonia)	38,710	37

Source: *Health on the March: West Bengal 2001-2*, State Bureau of Health Intelligence, Directorate of Health Services

*ARI = Acute Respiratory Illnesses

The above figures, obviously, do not tell the whole story since many of the patients depend heavily upon private practitioners and the incidents of increased illness remain officially unreported and hence unrecorded. In May 2003, in the district town of Suri, there were 40 qualified private allopathic medical practitioners, no less than 15 homeopaths, and some other practitioners (*chandsi, unani, vaidya* and unqualified allopaths) and the number of patients treated by them far outnumbered the patients treated at the District Hospital. There were no less than eight nursing homes with an average in-patient capacity of 15.

Similarly, in one of the block headquarters on a particular day, the number of patients who visited the private sources was much greater than the number of patients treated at the PHC. Such practices were not only confined to the towns, even in the remotest corners of the district, private medical services are the main source

of health care. Of these sources, many of the practitioners are unqualified practitioners, who are growing in number day by day.

Of the qualified allopathic private practitioners in Suri town about 50 percent were government doctors. Some of them were seen advertising their private practices on the local cable TV network. One of the hospital doctors allegedly passed on his visiting card (made with a rubber stamp, mentioning the address of his private clinic) to the patients in government facilities with a verbal suggestion to visit him privately for better treatment. As reported by some doctors, chemists and residents of Suri, barring only two or three, all the doctors of Suri District Hospital, were engaged in private practice. This is not unique to Birbhum. Lucrative private practice by some doctors with less attention being paid to the patients of state institutions characterise the disorder and ineffectiveness of the health delivery system in West Bengal.⁷ The inadequacy of the health infrastructure and staff strength coupled to the inefficient (and somewhat unethical) functioning of the public health system has implanted the belief in people's minds that "doctors at hospitals don't even find time to listen to the patients, but in their private clinics they do a thorough check up – *jama kapor khule dakhe* (literally, a detailed check up after unclothing the patient)".

DUMKA

General: Dumka was formerly a subdivision of the Santal Pargana district⁸ until it was given the status of a separate district in the early seventies of the last century. The district was divided into two in April 2001 (the new district created, Jamtara, comprises 4 of the 14 blocks of old Dumka district).

Dumka has an area of 4369.2 sq. km. The major part of the district is located in hilly or undulating areas. It is bordered by Godda and Pakur districts (Jharkhand) in the north, Deoghar (Jharkhand) in the west, and Dhanbad (Jharkhand) and Birbhum (West Bengal) in the east.

According to the 2001 Census, Dumka has a total population of 11,02,217 with a sex ratio of 961. Tribals form 47 percent of the total population. The major tribe is the Santal that forms about 90 percent of the total tribal population of the district. The other tribes found are Mal Pahariya, Mahli and Kol. The literacy rate in the district, according to the 2001 Census, is 48.31 percent, much below the national average and lower than the state average. There is also a large gap between the literacy rates for males and females. The literacy rate among males is 63.28 percent and 32.68 percent among females.

The availability of land for cultivation is low and massive land alienation, mainly during the period of British rule, had left the tribals and other poorer communities with the limited option of seasonal and long term migration for manual work, local wage work and gathering forest produce. The majority of the rural folk (and also many urban people) suffer from acute hunger, ill health and indebtedness.⁹

Health: The relationship between hunger, illness and death in the district dates back to the early records of the health department of the erstwhile Santal Pargana district. Records show that deaths caused by diseases like cholera, smallpox and malaria occurred more in the years of famine and bad harvest. In the years 1897, 1906, 1908 and 1919 deaths caused by diseases were high. The same years were marked by famines and bad harvests.¹⁰ Although the British rulers introduced allopathic medical facilities in the districts, their inadequate spread, on the one hand, and the acuteness of hunger, poverty and ignorance, on the other, have made people victims of several diseases. The 1921 census noted a huge fall of 83,744 in the population, mainly because of the endemic attack of cholera.¹¹

Before the introduction of allopathic medicines, people of the area generally practised two kinds of medicines – *ayurvedic* (by the *kabirajs / vaidis*) and *unani* (by the *bakims*). Another kind of medicine was also introduced to the district with the growth of Santal settlements in the late 18th and early 19th century. This medicine was called *rebet ran* in Santali (literally “root medicine”, meaning herbal medicine). Rev. P.O. Boddington, in his book, *Santal Medicine and Connected Folklores* ([1925] 1986) had recorded more than 300 prescriptions. At the same time the Santals, who formed a large part of the population by the middle of the 19th century, carried on their beliefs on evil spirits (*bonga*), sorcery and witchcraft as both preventive and curative treatments.¹²

However, despite their traditional beliefs and cultural practices the Santals were found to be quite receptive to allopathic medicines. Although, O’Malley, Roychoudhury and others have accused the Santals and other *adivasis* of being, “allergic to vaccination” and “abhorring allopathic medicines”, records (noted by none other than Roychoudhury) show that a programme of mass vaccination against smallpox produced excellent results.¹³ And as present-day observations show, almost all the *adivasis* have widely accepted allopathic medicine as their main source of treatment of illnesses. In our study, we found few patients using traditional and other sources of treatment (that are not allopathic), even though allopathic treatment was not only more expensive but suffered from gross corruption and abuse (mainly because of its wide practice by people with little or no competence). In rural areas of Dumka district people mainly depended upon unqualified allopathic medical practitioners. If such is the case, the question arises - why do they not visit the modern (allopathic) public health services?

Let us look at the present day health facilities provided by the government.

Compared to other parts of Jharkhand, Dumka district is better placed in terms of health facilities.¹⁴ Fourteen PHCs (located at the block headquarters), fifty-one Additional PHCs (henceforth APHC – located in different villages of the blocks) and 386 sub-centres form the framework of the government rural public health service. Each of the PHCs, as on 31 March 2002, served a population of 26,993, which was much more than the prescribed norm. Each of the PHCs on that date catered to an average area of 95 square km. In a district with hills, forests and difficult terrain and with very poor connectivity, it becomes extremely difficult for the people to access health facilities. Sub-centres were also found to be insufficient vis-a-vis the

prescribed norm. Each sub centre, on average, served a population of 4,545, while the prescribed norm for the hilly and tribal areas is one sub centre per 3,000 population. Each sub centre catered to an area of 16 square km.

Table 2.4 Public health facilities in Dumka

		Persons served percentre	Norm as per GOI	Average area covered under each centre
Total Number of Primary Health Centres (PHC)	65 (including 14 PHCs located at block headquarters)	26,993	20,000	95 sq. km
Total Number of sub-centres	386	4,545	5,000	16 sq. km

Source: Prasad Dr. Hari Sharan, Dr. Dharmendra Kumar, and Abinash Kumar, *National Anti-Malarial Programme (2003), District Implementation Plan – 2003, District Dumka, Jharkhand*

While accessibility to public health services was difficult, the actual services provided, as reported by many respondents (and as observed by this team), were almost non-existent. For example, in Dumka Sadar Hospital, diagnostic services like x-ray, pathological tests, malaria parasite tests, etc. were not available. Besides the cost of the tests (which were also, as a doctor remarked, not quite reliable), patients also had to bear nearly the entire costs of the prescribed medicines as they were “in short supply”.

As regards the staff strength, as on November 2002, there was a large gap between the posts sanctioned and the staff in actual position.

Table 2.5 Strength of health staff in Dumka district

Posts	Sanctioned	Actually posted	Vacant	Percent shortage
Medical Officers	191	110	81	42
Nurses	29	28	1	3
Compounders	56	3	53	95
Laboratory Technicians	65	21	44	68
X-ray technician	1	1	0	0
Drivers	35	33	2	6
Supervisors	80	60	20	25
Multipurpose Health workers (Male)	261	139	122	47
Multipurpose Health workers (Female)	470	435	35	7

Source: Civil Surgeon, Dumka, in an interview on 31 October 2002.

Includes Jamtara. See also, 'District Implementation Plan, National Anti Malaria Programme, 2002'.

Mahasweta Devi, one of the finest writers and activists of our time, once suggested that the hospitals of West Bengal be renamed after the different hells (*kumbhipak*, *krimimukh*, *rourab*, etc.) that are mentioned in Hindu mythology.¹⁵ One wonders

as to just how the PHCs and other hospitals of Dumka are to be described! Some of the PHCs visited were shared with various animals – goats, cows and dogs. Parts of some PHC buildings had nearly collapsed. Many doctors we came across during the study in Dumka did not seem to find it necessary to use the stethoscope at the hospital, let alone using “the scalpel as the sword”. We heard a doctor murmuring, “*aa jata hai sala sab matha chatne!* (The damned lot turns up to chew our heads!)”

Many of the government doctors in Dumka, as in Suri, were engaged in private practice. However, compared to Suri the number of private clinics and nursing homes was found to be much less in Dumka. There were about 20 such clinics and five nursing homes in all — the reason being attributed to the economic and social backwardness of the district.

Some government doctors, as we were informed by people in Dumka town and in the villages, insisted that the patients see them at their private chambers. We personally knew of a woman who was advised by a doctor in the Sadar Hospital to get admitted to his own nursing home for better treatment. A doctor once told one of our researchers, “*private mein jaane ke liye nahin kahenge to kya marne ke liye haspatal me rakh denge?* (What should I do, ask [patients] to visit private doctors, or let them stay in the [government] hospital and die?)”

Both in Birbhum and Dumka, it seems, private practice is rampant and is fast replacing the public health delivery system. The difference is merely one of degree. While in Birbhum public services are available to a certain extent and the poorer people can get some relief and benefits by using these services, in Dumka the public medical system is virtually non-existent. There is another difference as well. In Birbhum the quacks – despite growing in number – are yet to monopolise the market and private medical practice is carried on primarily by qualified allopathic doctors. In Dumka, poverty, ignorance and inaccessibility to government health services (in terms of connectivity, etc.) work together to create a happy hunting ground for quacks. (*For more on quacks, see section 5.*)

SELECTION OF BLOCKS

Three blocks from each of the districts were selected for the purpose of the study. In **Birbhum** the selected blocks were Nanoor, Sainthia and Rajnagar. The selected blocks are spread across the district and are representative of the geographical, topographical and demographic features of the district.

Nanoor is located on the alluvial plain, bordering Bardhaman and its lands are considered to be very fertile. The population comprises Muslims and different caste Hindus. As regards the health delivery system, Nanoor has one Block PHC, three PHCs and 30 sub-centres. The health staff of the Block health centres, as reported by the doctor in charge of the BPHC, were insufficient in number to cater to needs. For example, of a required (and sanctioned) 60 field workers, there were only 43 at the time of our interview (5 May 2003).

Sainthia is located in the central part of the district. Apart from agriculture, people of this block have a range of different occupations – trading, salaried employment, etc. The population mainly consists of different caste Hindu and scheduled caste communities. The Block PHC of Sainthia has recently been elevated to a rural hospital. Besides, there are five PHCs and 28 sub-centres. It was mentioned by the officer in charge of the Sainthia Rural Hospital cum Block PHC, that there was a severe staff shortage both at the hospital and at the block level. For example, there were seven doctors posted at the time of interview (26 November 2002) though the minimum requirement was 14 doctors.

Rajnagar mainly comprises undulating areas bordering Jharkhand. Lands are mainly unirrigated and return a lower yield compared to the other blocks. The population consists of a large number of adivasis, the Santal and Kora being the major tribes. There is one block PHC, two PHCs and 15 sub-centres in the block. A mobile medical unit also reportedly exists, but was not in service. (See Appendix for detailed staff position in the PHCs of the three studied blocks.)

In **Dumka** our selected blocks were Jarmundi, Shikaripara and Gopikandar.

Jarmundi is located at the northern side of the district bordering Deoghar, another district of Jharkhand. Agriculture and wage earnings are the two main occupations. Lands are undulating and cultivation is completely rain-fed. The population of the block comprises mainly other caste Hindus and tribals form about 19 percent of the population. The health infrastructure included one PHC, four APHCs, one referral hospital and 31 sub-centres at the time of survey. There were just three doctors (for one PHC, four APHCs and one referral hospital) posted during the period of our fieldwork (August 2003).

Shikaripara block is located in the south-eastern part of the district, bordering Birbhum district of West Bengal. Some parts of the area are low lying lands where rice is grown. Some of the lands are high and undulating in nature. However, cultivation is completely rain-fed and the majority of the population, particularly tribals, who form about 50 percent of the total, depends upon wage earnings. For wage earning, people rely mainly upon seasonal migration. The block had one PHC, three APHCs, one mini PHC and 30 sub-centres. Of a total of 11 doctors' posts sanctioned, only three were actually filled during the survey. There were two nursing staff and 29 ANMs in position during the survey.

Gopikandar is situated in the south-western part of the district. Once very thickly wooded, this block still bears the sign of its past with considerable forest coverage. Besides cultivation and wage earning, people of the block – about 70 percent adivasis – depend upon the forest for their livelihood. While giving good livelihood support, the forest is also responsible for the wide prevalence of malaria in this block. The malaria parasite found in this block is mainly of *Plasmodium falciparum* – considered to be a killer. Records at the malaria department of the PHC show that in the year 2001 out of a total of 4,430 samples collected, 389 cases were found positive for malaria. Nearly 99 percent of the positive cases were of *Plasmodium falciparum*. Despite paying five visits to the PHC we could not meet any medical officer and on the fifth visit we

were able to finally procure the health system's data on the block from a staff member of the PHC. Besides the PHC there was one APHC and 12 sub-centres at the time of our visit (September 2003). The inadequate number of health centres, with even poorer service delivery makes the situation explosive for this disease-prone tribal block.

All the three blocks, as found during the PHC visits (November 2002 and August 2003), suffer from tremendous shortages of staff. Shortages in terms of doctors and other health workers is not only a matter of discontent for the public and the health officers but is also a fact that has been acknowledged in the proposed health policy of the Government of Jharkhand.¹⁶

VILLAGES

The study was carried out in 24 villages equally distributed in six blocks over two districts. The randomness of selection offered some commonalities as well as diversities among the villages. However, the differences are more striking than the similarities when compared to the villages of the two districts as a whole.

The estimated population in the villages of Birbhum varied between 700 and 3,000 (barring three villages where the population was, respectively, 130, 150 and 370). Among the villages in Birbhum district, eight were inhabited predominantly by Scheduled Castes. Two villages were entirely inhabited by tribals, mainly Santals. In one of these two villages some households belonged to the Kora tribe as well. The proportion of manual wage earnings from agriculture is higher than any other occupation. However, unlike in Dumka (where wage labouring and cultivation were seemingly the chief occupations for almost all the households), some of the households in Birbhum were found to be pursuing other occupations, with trade, service, non-agricultural wage earning, being the main ones.

In Dumka the villages are much smaller than the villages in Birbhum. The estimated population in the Dumka villages ranged between 259 and 623. As far as the social composition of villages is concerned, tribals, almost all of whom are Santals, are predominant in most of the villages in Dumka. Of the 12 villages we surveyed, five were inhabited solely by tribals, mainly Santals. Only one village had a negligible proportion of people from the Mal-Paharia tribe. In another five villages Santals are numerically stronger than the others. In one of the remaining two villages there were only SC inhabitants. The other village was predominantly inhabited by other caste Hindus. In almost all the villages people were found to depend on agricultural wage work and cultivation for their livelihood.

A striking difference, pertaining to the prevalence of diseases, was observed between the villages of the two districts. Malaria was reportedly the most common, as well as most menacing, of all diseases in the majority of the villages in Dumka. Next came diarrhoea, kala-azar, TB, etc, while in Birbhum, stomach ailments, colds and cough and diarrhoea, were reportedly the more common diseases.

In terms of the available health facilities, the Dumka villages were found to be

extremely underprivileged. While in Birbhum 10 out of 12 villages were served with an Anganwadi centre (under the Integrated Child Development Scheme – ICDS) in Dumka such centres were found only in seven of the 12 villages.

The distance to the nearest primary health centre or hospital from the villages in Dumka was substantially larger than in Birbhum. While the distance to the PHCs from the villages in Birbhum ranged between 0 to 9 kilometres, in Dumka this was between one and 19 kilometres. Even if the physical distance between the villages and PHCs in Dumka is ignored there are other factors which makes accessibility more difficult in Dumka than in Birbhum. Hilly tracks and the inadequacy of transport facilities are of great importance. There are social factors as well. The experiences of patients and their relatives in the PHCs and hospitals in Dumka were not encouraging, sometimes even verging on the disgusting. In Birbhum too, people had had similar experiences, but to a lesser degree, as responses indicate, than in Dumka.

Accessibility (in terms of distance) to a hospital was more difficult in Dumka than in Birbhum. The largest distance between the studied villages and the nearest hospital was 27 kilometres in Birbhum while it was 62 kilometres in Dumka. The shortest distance was 8 kilometres in Birbhum and 17 kilometres in Dumka. Seven villages in Birbhum were located within 20 kilometres from the nearest hospital whereas in Dumka we found only one such village.

In terms of private clinics and qualified doctors, in Birbhum all the villages were located within eight kilometres from such services, while in Dumka this distance ranged from 25 to 30 kilometres. The same is the case with unqualified medical practitioners. While in Birbhum, such UMPs or quacks were found in almost all the villages, in Dumka only three villages had such UMPs.

Another notable difference between the villages of Birbhum and Dumka was with regard to the local political and economic structure. The absence of local self-government (like Panchayats) was quite visible in Dumka. A case study of two Santal villages, one each in Dumka and Birbhum (with similar demographic and geographical features), showed that the residents of the West Bengal village, despite smaller land ownership status, were doing relatively better in terms of wage rates, income opportunities, land tenancy¹⁷, rates of literacy and awareness, higher access to public facilities, and so on. The difference in literacy status between the two districts (Dumka has a much lower literacy rate than Birbhum) also plays a major role with regard to people's health and the public delivery of health services.

Some intra-district differences among the villages were also noticed (like the geographical, demographic and other differences between the villages of Rajnagar and Nanoor – of Birbhum – or between the villages of Jarmundi and Gopikandar of Dumka district). Such differences are also important determinants in the health sector.

METHODOLOGY

SELECTION OF DISTRICTS, BLOCKS, VILLAGES AND HOUSEHOLDS

Selection of districts: The two districts, Birbhum in West Bengal and Dumka in Jharkhand were purposively selected for the study. The main reason for this was that in the Pratichi (India) Trust's study on the Delivery of Primary Education, Birbhum was one of the six selected districts in West Bengal and Dumka was the selected district in Jharkhand. Keeping in view a comparative study, we kept the area of our study confined to these two districts, which have many common features like geo-climatic conditions, demography, etc., although the differences are also marked, particularly in terms of political organisation, land ownership, literacy and other development indices.

Selection of blocks: In both Dumka and Birbhum we studied the health status of the same blocks that had been selected randomly for the purpose of our previous study on primary education.

Selection of villages: In Birbhum we retained the same six villages that were selected for the Pratichi study on primary education and added six new villages using random sampling methods. In Dumka all the twelve villages were randomly selected for studying both primary education and health.

Selection of households: The study was done in two phases. In the first phase a quick listing of the village households was carried out. The listing sheet was designed to collect basic information about the names of the heads of households, levels of literacy, enrolment in primary school, general morbidity, etc. In case of villages with 200 or less households the listing was done in full. In case of villages with more than 200 households, a large proportion was listed (i.e. one half for villages with households between 201 and 400, one third in case of villages with households between 401-600, and so on). Households were stratified first according to social identity – Scheduled Caste, Scheduled Tribes and Others. A further stratification was done according to the occupation of the households: cultivators, agricultural and other labourers, service holders, traders, artisans and others. From the stratified tables, different households were randomly selected so as to get a proportionate representation of the different castes and occupations. Some women headed households were deliberately selected.

In general the reference period considered was the year preceding the study visits. However, for issues like immunisation, infant and child mortality, stillbirths, abortions, etc. different reference periods have been considered and are duly mentioned in the respective sections.

MAIN STUDY

The study was done under the guidance of Professor Amartya Sen, Chair, Pratichi (India) Trust. After an in-house workshop, conducted in September 2002, a household questionnaire was finalised in three parts in order to (1) list all the members of the households, the status of literacy, schooling, highest educational qualification,

occupation, morbidity and mortality, (2) assess the prevalence and extent of different ailments, (3) find the various sources of health care, (4) assess the cost of treatment involved for various ailments, (5) assess the delivery of the public health services both at home and outside – visits made by the health workers, services availed at different points of the public health delivery system, such as immunisation and other services, which included reproductive and child health services, (6) assess the income and expenditure pattern of the households, etc. The first part of the questionnaire was used for general information, the second for the ailments and various medical services and the third for ascertaining the income and expenditure pattern.

Two medical practitioners, Dr. N.C. Gandhi, MS, and Dr. Amalendu Bikash Toong, MBBS, kindly volunteered to make an assessment of the medical knowledge of UMPs (quacks) in the study areas. Based on ten interviews with the quacks the two doctors tried to gauge the real understanding of the quacks regarding different diseases, their treatment and the actual practices they have been engaged in. The research team has also taken medical opinion/information/advice from the above-mentioned doctors and from Dr. Dipankar Chakraborty, MD, at various points.

The research team also received help from Dr. A.K. Roy, Chief Executive of Economic Information Technology and Professor Dikshit Sinha of Visva-Bharati who gave much valuable advice during the finalisation of the questionnaire and the writing of the report.

Another in-house workshop was conducted at Santiniketan to discuss fieldwork. Since Santali is the lingua franca of rural Dumka, and only one of the research team spoke the language, we took assistance from Santali speakers Ms. Murni Hembrom, Ms. Agatha Baskey, Ms. Agnesh Murmu and Ms. Pushpa Murmu all of whom are experienced field workers. In addition, all of the above have substantial knowledge about the life and society of these areas. This team of research assistants also participated in the workshop.

The main fieldwork was carried out during October – December 2002.

Besides filling up of the questionnaires the research team members kept meticulous field notes recording several other interviews and observations (between October 2002 and September 2003). Persons the research team talked to included doctors – both public and private, qualified and unqualified, traditional practitioners, witch doctors, chemists, medical representatives, government officials at various levels (state, district and block), NGO functionaries, people from donor agencies, money lenders, villagers other than selected from households, and so on. We have also collected many different materials, like prescriptions, medicine foils, receipts etc. apart from published and unpublished documents regarding health and health services and tried to examine and analyse all of them.

NOTES

1. See Annual Report 2000-2001, Department of School Education, Government of West Bengal
2. See Hunter ([1877] 2001).
3. See Choudhury (2001); Sinha (2003).
4. Bhattacharya et al (1958)
5. See Soman (2002), for a case study on rural health care in Birbhum district.
6. A survey of three newspapers over six months (The Times of India, Anandabazar Patrika and Ganashakti, the latter well-known as the ruling CPI(M)'s mouth-piece) found more than one news items every day on average related to public health issues. Most of them highlighted the ill-equipped government machinery to combat various diseases and deaths caused from them. The grumbling level rose very high in June 2003 following several children's deaths in Murshidabad district.
7. See Duttagupta (2000)
8. Santal Pargana district was created in 1855 from parts of Bhagalpur and Birbhum districts. The formation of the district followed the Santal insurrection of 1855 and was designed to pacify the Santal unrest.
9. Rana (2001a, 2002); Rana and Johnson (2003)
10. See Roychoudhury (1965:616)
11. Roychoudhury : (1965:616, 623).
12. The Santal way of life is quite dialectical in nature. They reason several diseases as physical disorders (mainly of the vein and nerve and blood). Again their belief in spirits, witchcraft and their magical treatment by *ojhas* were also found to be widely prevalent. See for details, Bodding ([1925] 1986)
13. Roychoudhury (1965: 617)
14. The figures are for old Dumka district, i.e. before it was bifurcated in 2001 as the disaggregated figures concerning health facilities were not available at the time of survey.
15. See Devi (1999:112)
16. Department of Health and Family Welfare, Government of Jharkhand (2002)
17. While in Dumka, Santal cultivators get 1/3rd of the harvest and the landowner gets the rest, this is just the opposite in Birbhum.

Report Highlights

BACKGROUND

West Bengal has done comparatively better in terms of infant mortality, deliveries at medical institutions, children's full immunization, etc., yet, the increase in the incidence of communicable diseases in West Bengal is a major cause of worry. According to official data, the incidence of communicable diseases in the state has sharply *increased* between 1995-6 and 2000-1.

For all the major health indicators except infant mortality, the record of Jharkhand has been abysmally poor. Despite the non-availability of secondary data on communicable diseases in Jharkhand (only the data for malaria is available), media reports and other sources indicate a high rate of occurrence of communicable diseases. Malaria is a menace for Jharkhand – in 2001 from a sample of a little above 8,00,000 slides, examination results found more than 15 percent positive cases of malaria of which 60-85 percent were cases of *plasmodium falciparum* – a fatal disease.

Both the states suffer from absolute levels of inadequacy in terms of public health services. In West Bengal each Primary Health Centre serves a population of 42,204, on average. In Jharkhand this figure is 47,769. (The government norm is to set up one PHC per 30,000 persons in general and per 20,000 persons in Hilly and Tribal areas).

The same is the case for the Health Sub-Centres. Each Sub-Centre in West Bengal serves, on average, a population of 7,104. For Jharkhand the figure is 5,659. (The government norm is to set up one sub-centre per 5,000 persons for the general population and one per 3,000 persons in Hilly and Tribal areas).

Jharkhand's case is particularly disadvantaged for a large part of the state is covered with hills and it has a much higher tribal population (27 percent) than West Bengal (7 percent).

SOME MAJOR FINDINGS

Health Ailments and Medical Treatment: One major cause for concern is the reliance on unqualified medical practitioners (UMPs) – popularly known as quacks – for medical treatment. These quacks include unusual degree holders (Registered Medical Practitioners, whose degrees are allegedly bought from various institutions); homeopathic degree holders (who practice allopathic medicine); non-matriculantes who cannot even read the names of medicines (since they are written in English) and depend upon the medicine dealers’ guidelines (who label the medicines, for the benefit of the “doctors”, with the names or symptoms of the diseases a particular medicine is used for) and also some medicine shop owners. We have even come across a man who possesses a certificate from a veterinary training programme, but provides medical treatment to humans.

In Dumka the extent of such dependence is much higher – 62 percent. In Birbhum 29 percent reportedly sought medical treatment from quacks. While in Dumka 12 percent and 11 percent relied upon the public health services and private qualified doctors respectively, in Birbhum the respective figures are 33 percent and 29 percent.

The main reasons for dependence upon quacks (despite many being aware of their incompetence – in Dumka they are derogatorily called *jboldanga*, *jbolabala*, and so on) by the poor are (1) poor functioning of the public health services and (2) inability to bear the cost of medical treatment at a private qualified doctor’s clinic/nursing-home/hospital.

The cost factor is very important. While the private doctors are understandably the most expensive sources of medical treatment, the unfortunate reality is that the cost of medical treatment at the public health institutions is higher than that of the private unqualified (quack) sources. Public health services have almost ceased to be free – only four percent of the patients who visited the public health services in Birbhum and 0.23 percent in Dumka got completely free treatment. In terms of getting all the prescribed medicines from PHC/Hospital only 14 percent in Birbhum and 13 percent in Dumka have been benefited.

In sharp contrast to the popular belief (mainly of doctors and a part of academia) that rural people in general and tribals in particular depend mainly upon witch doctors, magic healers or herbal practitioners, we found very few who have depended wholly upon such sources. Even those who resorted to such services did so due to reasons of financial stringency or problems of accessibility to the public health services.

Medical treatment not only involves high costs but also high risks because of many different forms of gross medical abuse (perpetrated not only by quacks but also by qualified doctors). For example, in Dumka, the indiscriminate use of saline drips (for almost every sort of ailment) is a common phenomenon and in Birbhum the most visible form of abuse is over-medication (use of multiple antibiotics and other drugs, use of the same combination of drugs prepared by different companies, use of unnecessary and harmful medicines, etc.).

There are also other kinds of abuse, like not exercising due care and vigilance (particularly in cases of childbirth and surgery - both in private and public institutions). One patient had to have his leg amputated due to the carelessness of the doctors and the subsequent wrong treatment meted out to him.

Gender discrimination can be seen very clearly from the fact that 62 percent of the patients in Birbhum who remained medically untreated were women. In Dumka this figure is 75 percent. Gender discrimination is also evident from the fact that more men than women were treated in public health centres and by private qualified sources, while the majority of the patients treated by quacks comprised women.

The Delivery of Public Health Services: While in Dumka all the PHCs visited were ill-equipped and functioning poorly (part of the premises of some PHCs have even become permanent shelters for different domestic animals and for the homeless, vagrants and beggars), in Birbhum no such uniformity was found. Some of the PHCs we visited have been working very well and some were not. The functioning of the PHCs, it seems, depends upon the motivation of the doctors and other health staff. While in one PHC we had to wait for five hours for an interview with the Block Medical Officer of Health since he was completely engaged with patients (on that particular day there were more than 500 out-patients!), in another PHC we found the Block Medical Officer practicing in his private chambers during working hours. There was a board displaying the timings of his private practice (8 am to 1 am), which matched exactly with the working hours of the out-patients' department, in clear violation of medical ethics and service rules.

Private practice by government doctors is a major phenomenon in both the districts, though less at the PHC level at Dumka (probably for the wrong reasons – many people complained that the PHC doctors spent most of their time in their native places, far away from their postings). In both the districts however, a large majority of the government doctors posted in the hospitals engaged in private practice. Often many of them were found at their private clinics during duty hours.

The case of services delivered at the sub-centre level by health workers is simpler. While in Birbhum 37 percent of the respondents acknowledged that a health worker had visited their homes during the year preceding the survey, in Dumka the figure was 26 percent. The reported visits were often made after very long intervals – sometimes just once a year.

In Birbhum only 46 percent of the pregnant women received iron folic tablets and 70 percent received tetanus injections. In Dumka the respective figures were 27 percent and 26 percent. Only 19 percent of the respondents in Birbhum and 10 percent in Dumka said that a family planning worker had visited their homes during the year preceding the survey.

Nearly 50 percent of the respondents in both the districts who have ever visited public health institutions (PHC/hospital, etc.) expressed dissatisfaction over the services delivered. Many complained that the doctors and health staff did not even speak with them.

Despite many problems, the condition of the public health institutions was found to be relatively better in Birbhum. While almost all the TB patients in Birbhum received treatment from public institutions, this was not the case in Dumka, where almost all the TB patients sought treatment from private qualified sources. This has its financial implications as well – in Birbhum the average cost of treatment for TB was Rs. 1,270, in Dumka it was Rs.2,003.

In both the districts the implementation of programmes related to the prevention of communicable diseases (malaria, diarrhoea, etc.) has not been confirmed by our respondents.

Implications of health ailments: The major implication of health ailments is in terms of financial loss or liability. While the poorest section of people (below Rs. 16,000 annual income) in Birbhum had to spend 18 percent of their annual income on health care, in Dumka it was 12 percent. Twenty-one percent of the respondents in Birbhum and 37 percent in Dumka said that they had to borrow money at interest rates of 50 to 120 percent per annum for medical treatment. Many were forced to sell their properties – both movable and immovable – to pay for treatment or in order to repay loans incurred for medical expenses.

The high cost of medical treatment has, in some cases, reversed positive changes. Such changes include mortgaging or selling of land that had been allotted under the land reforms programme, working for lower wage rates against contractual loans taken for medical treatment, etc. in Birbhum and the renunciation of the achievements made through political movements in terms of lowering the rate of interest and reducing exploitation by moneylenders in Dumka. The vicious cycle of health ailments, loans taken, loss of wages, loss of property and poverty and hunger is a very common reality for many families.

Besides the financial implication, one major negative impact of health ailments is on education. Many children simply cannot attend school because of illness. It is also a major cause for dropping out (both because of ill health and also because of other consequences, like engagement in income generating work to repay loans taken for health care, engaging in farm work to compensate for parents' or elderly relatives' illnesses, etc.).

TABLE 3: HEALTH SERVICE AT A GLANCE

		Birbhum	Dumka
Sources of treatment	Public Sources	29 percent	12 percent
	Private Qualified	33 percent	11 percent
	UMP (Quack)	29 percent	62 percent
	Homoeopathy	7 percent	0
	Kabiraj and others	2 percent	15 percent
Reason for choosing different sources		<ul style="list-style-type: none"> • Private qualified for better service • Public services chosen mainly by the poor • Dissatisfaction over public service delivery and expensive private health care force some to resort to the quacks 	<ul style="list-style-type: none"> • Nearly defunct public health services and financial incapability to pay for the private qualified doctors force the majority of the patients to seek services from quacks
Treatment completely free of cost		4 percent	0.23 percent
Average cost of treatment at different sources	Public	Rs 959	Rs. 1,115
	Private qualified	Rs. 3,155	Rs. 1,490
	Quacks	Rs. 480	Rs. 858
Satisfaction with the public health system		50 percent	50 percent
Private practice by government doctors		High at all levels	High at Hospital level but low at PHC level
Attitude of public health servants		Varies from person to person and area to area. While some were found very dedicated, negligence towards public duties is, it seems, very common. Negligence includes remaining absent from duties, not attending to patients, impolite behaviour towards patients, etc.	Negligence follows almost a uniform line. Negligence includes long absence from the work place, not caring for patients, unsympathetic and rude behaviour toward patients, etc. Also many of them were found explicitly contemptuous of the patients' cultural and economic background.
Extent of full immunisation		45 percent	None
Home visits by health workers		37 percent	26 percent
Institutional deliveries		47 percent	6 percent
Childbirth assisted by <i>dais</i>		53 percent	93 percent
Pregnant women who received iron and folic acid tablets		46 percent	27 percent
Pregnant women who received tetanus injections		70 percent	26 percent
Family planning counselling received		16 percent	9 percent
Incidence of Infant mortality		68 per thousand	79 per thousand
Incidence of Child mortality		70 per thousand	74 per thousand

Background check

Households, Morbidity and Awareness

For an in-depth inquiry our study covered a total of 431 households: 215 in Birbhum and 216 in Dumka. The social composition of the rural areas of Birbhum and Dumka is reflected in the sample households. Of the total sample in Birbhum, we have 39 percent Scheduled Caste, 20 percent Scheduled Tribes and 41 percent other caste households (including Muslims). Compared to Birbhum we have less SC representation (10 percent) in Dumka, but the number of ST samples is, in keeping with the demography of the rural areas of the district, much higher (79 percent). Similarly, we have less other caste samples in Dumka district (11 percent). The following table gives the detail of the social composition of the households.

Table 4.1 **Distribution of households by social group**

	SC	ST	Others	Total
Birbhum	85 (39)	43(20)	87(41)	215(100)
Dumka	22(10)	170(79)	24(11)	216(100)
Total	107(25)	213(49)	111(26)	431(100)

Figures in parentheses indicate percentage

ECONOMIC AND OCCUPATIONAL PROFILE OF THE SAMPLED HOUSEHOLDS

Landholding size: As far as landholding is concerned in both the districts majority of the sampled households belong to the category of landless¹ and marginal farmers (below 2.5 acres). As a whole 21 percent of the households was reported to be landless. The extent of landlessness was significantly higher (34 percent) in Birbhum than in Dumka (8 percent).

The high level of landlessness in Birbhum is mainly due its historical landholding pattern (the SC and ST groups form the majority of the landless agricultural workers). Although the implementation of land reforms launched by the Left Front Government has brought about an improvement in the situation, yet the relationship of social structure and land holding pattern can still be seen. Another reason for the high level of landlessness among our sampled households in Birbhum district is probably because of the fact that some of our ST and Muslim households have immigrated to the district from outside. For example, in one study village almost all the households have in-migrated from Dumka district some fifty years back. Their economic condition never allowed them to buy land and they earn their livelihood mainly from agricultural wage work. In another village, Muslims from Bihar have settled down some thirty years back. Their primary occupation is rag picking, petty trade, and wage work.

In Dumka, the situation is different. The Scheduled Castes form the majority of the landless. Santals who form the majority of the ST population in-migrated to the district in the late 18th and early 19th century and settled to make the lands cultivable. Although they have lost large areas of the best cultivable lands to the *dikus*,² they have not become completely landless as the British Government enacted laws immediately after the great Santal *Hul* (rebellion) of 1855 to protect tribal lands (a step that was taken to mollify the Santals' unrest).³

Apart from the landless households, as mentioned above, a large section of the sample households belong to the marginal farmers' category. The respective figures for Birbhum and Dumka are 53 percent and 75 percent.

While ownership of land between 2.5 and 5 acres was almost similar in both districts (11 percent and 10 percent households respectively for Birbhum and Dumka), the case for landholding of 5 acres and more was different in the two districts.

Table 4.2 Distribution of sampled households by land holding size

	Birbhum	Dumka	Total
Landless	73 (34)	17 (8)	90 (21)
<2.5 acres	113 (53)	162 (75)	275 (64)
2.5 – <5.0 acres	24 (11)	22 (10)	46 (11)
5.0 acres and above	5 (2)	15 (7)	20 (4)
Total	215 (100)	216 (100)	431 (100)

Figures in parentheses indicate percentage

Birbhum has a very small figure (2 percent) of households having more than 5 acres of land, but in Dumka the figure was higher than that of Birbhum (7 percent).

However, bigger land holding size does not necessarily indicate higher economic status. This depends upon different factors, viz. fertility and productivity of land, assured irrigation, etc. These made for wide regional variation in productivity of land across the districts. Dumka district has great variation in land quality and the STs have limited control over fertile *baihar*⁴ lands. Almost the entire district is mono-cropped, since there is no assured irrigation (barring a little area of Raniswar block bordering Birbhum, which gets some irrigation from the Massanjore dam on the Mayurakshi river). Birbhum is in a relatively favourable situation (again the same Massanjore dam provides substantial irrigation facility to this district) except for some of the blocks.

In both the districts rice is the main crop and staple food. Saving some intra-district variations, productivity in Dumka district in general is miserably low. This makes the annual income considerably lower than that of Birbhum. Whereas rice production in Dumka is less than 10 quintals an acre on average it is more than 16 quintals/acre in Birbhum. However, part of Birbhum district is mono-cropped and the productivity, in accordance with the land quality, is similar to that of Dumka. Rajnagar is one such block among our samples (it also has demographic and climatic similarities with Dumka).

Income class of the sampled households: Though Dumka's position in terms of land ownership is slightly better than that of Birbhum, the position is reverse as regards the level of income of the households. While 60 percent of the combined sampled households reported an average income below Rs 16,000 per annum, disaggregated figures for Birbhum and Dumka show great variation. While in Birbhum 39 percent of the total households fall under this income category, in Dumka the figure stands at 68 percent. Again, in Dumka, the number of households having an income of more than Rs 60,000 p.a. was just two percent; it was considerably high in Birbhum - eight percent.

The level of income varies widely across social groups. In Birbhum 32 percent of the SCs, 56 percent of the STs and 37 percent of the other castes belonged to the category of below Rs 16,000 p.a. income. For Dumka the figures were 55 percent, 73 percent, and 46 percent respectively. Hence, extent of poverty was found much higher among the ST communities in comparison with the others in both districts. However, the condition of STs in Birbhum was comparatively better than the position of their Dumka counterparts.

There was a great difference in the average annual income of the households found in the two districts as well. This was Rs 26,268 and Rs 16,378 in Birbhum and Dumka respectively.

Source of income is much more limited in Dumka vis-a-vis Birbhum. Though cultivation and labour hiring are the major income earning activities in both the districts average annual income widely differs between the households in the two districts.

Briefly, Dumka has very limited options for income generation – both from agricultural and non-agricultural sources. Inability of the lands to produce, unfriendly tenancies, absence of irrigation facilities, etc. work together to reduce productivity. This also results in creating a productive labour market in the area.⁵ On the other hand, land reform and canal and other irrigation facilities have not only resulted in higher agricultural output in Birbhum than in Dumka, these have also created better employment opportunities, with higher wage rates, in the agricultural labour market. Apart from agricultural activities, Birbhum offers some other options like other non-agricultural wage work, trading, etc.

Occupational profile of the sampled households: The majority of the sampled households reported a combination of different livelihood sources. However, in our study we have considered one of these as the main occupation. The main occupation has been recorded according to the responses of the households – the occupation that the concerned respondent thought contributed most to the household's sustenance.

The occupation of the sampled households was concentrated in agriculture and allied activities. As far as the main occupations were concerned, 42 percent reported manual wage work, 38 percent reported cultivation, and seven percent reported government or other jobs. The rest had a combination of other main occupations.

The extent of both cultivation and hiring out labour in Dumka district was reported to be higher (42 and 44 percent respectively) than in Birbhum (35 and 40 percent respectively). While trading in Birbhum was the primary occupation for 11 percent sampled households, in Dumka it was negligibly one percent. Again, trading was highly concentrated among the 'other' caste households and the SC and ST households formed the majority of the labourers in both districts.

GENDER OF THE RESPONDENTS

Though the selection of chief respondents (from the selected households) was made on the spot, primarily according to availability, males and females have almost equal representation. Out of 431 respondents 49 percent was female. The proportion of male respondents was a bit higher in Dumka (55 percent) than in Birbhum (47 percent).

In case of the questions related to reproductive and child health, naturally, 100 percent of the respondents were females.

LITERACY STATUS OF THE RESPONDENTS

As a whole, 44 percent of the total number of respondents was literate. Overall female literacy was very poor (25 percent) compared to overall male literacy (62 percent). Literacy status of the respondents varies widely across the districts. In

Birbhum 33 percent of the females and 67 percent of the males were found to be literate. The total rate of literacy in Birbhum was found to be 49 percent. In Dumka, the respective figures were miserably low – 15 percent, 58 percent and 39 percent.

The above figures, it perhaps worth mentioning, were lower than the literacy rates found in the 2001 Census at both state and district levels.⁶

FAMILY SIZE AND SEX RATIO

Average family size of the sampled households in Birbhum was 4.92 and in Dumka it was a little larger (5.16). Average children⁷ per family in Dumka was also higher (1.90) than in Birbhum (1.54).

According to the 2001 Census, the sex ratios in Birbhum and Dumka are 949 and 961. In our study the figures are 936 and 973 respectively. As far as children are concerned a great difference in the sex ratio was noticed from the overall figures for both the districts. It was 860 females for 1000 males in Birbhum and 1091 females for 1000 males in Dumka.

CHILDREN'S PROFILE

There are close linkages between ailments and quality of education (attendance, quality of learning achievement etc.). While poor rate of attendance in school was one of the major causes of poor quality of education, sickness was one of the major causes for poor rate of attendance. Of the total number of children suffering from ailments, 73 percent in Birbhum and 78 percent in Dumka did not attend school during the period of ailment. Diseases that stopped them from attending school were fever, cold and stomach ailments, etc. in Birbhum and malaria, fever and cold, and stomach ailments in Dumka.

LEVEL OF HEALTH AWARENESS OF RESPONDENTS

The level of health awareness was found to differ across families according to their social, economic and educational status. For example, initially many people reported only major ailments (that involved substantial amounts of money and time) and reports of their minor illnesses came only after repeated questioning.

When asked whether any member of the household had suffered from any sort of illness during the reference period, often the short duration ailments – like fever, mild diarrhoea, rheumatic pain, etc. – remained unstated. However, the occurrences of such ailments were found in high numbers after thorough questioning. Such under-reporting was more common among the SC and ST communities, and more particularly among the women. The perception about ailments, it seems, has a strong

relationship with the ability to take rest during the period of suffering. Many of our respondents were found working – at home and outside – with high temperature or complaints regarding bowel or chest, and so on. A female respondent in Dumka district was suffering from malaria during the fieldwork of the study. She was found working in the field – cutting upland paddy. We asked her questions when she came back from the field. She started shivering (from malarial fever) during the later part of the interview. “You are ill, yet you went to the field?” we said. “It’s nothing. Such fevers are normal. Who else will do my work?” she replied. Also she said that she used to go to bed only when the temperature rose very high. Otherwise she performed her daily chores. The family depends upon wage earning and small cultivation for livelihood. And a day’s rest means losses in terms of work and earning. To prevent the immediate loss, people of such income groups often try to ignore their illnesses. However, such forced self-deceptive notions make them pay dearly – many a time with their lives.

However, we found exaggerated reports of illnesses from a tiny section of the respondents (from relatively well to do families).

Taking care of ailments differs across classes. While the rich visit the health care provider immediately after detecting the symptoms of illness – however mild they might be – the poor wait for some time hoping for natural healing of the ailments and visit a medical practitioner only after the illness becomes acute. We have seen people suffering from tuberculosis who hire out their labour. “*Bose thakbo to sansar chalbe ki kore?* – How will the family survive if I sit idle [and don’t earn]?” Such people become the worst sufferers. First, the desperation in terms of earning forces them to continue manual labour even when unwell. Second, the fear of the anticipated cost of treatment prevents them from visiting a healthcare provider. And third, when they finally visit a doctor (or equivalent healthcare provider), either it becomes too late to recover or extracts a heavy price - both in terms of money and health (long suffering, propensity to turn into a more serious illness, and so on.). The condition of the women in this regard, as mentioned earlier, is much worse than that of the men. Besides earning outside the family (which is a common feature of the SC, ST and other poor households, in sharp contrast to the people of upper economic strata), the women have to take charge of the kitchen and do other household chores. Since women, particularly in the *adivasi* households, shoulder the main responsibility of running the households, they often keep quiet about their illnesses. As a female respondent realized, “*vet’ adoin’ laiak’. Laikhan ma kborca.* (I don’t think it proper to complain about illnesses. A complaint means [increased] expenses.)” It is only when they can no longer bear to stand the pain that they tell other members of the family or go to a healthcare provider. In many cases male members were found to be silent about the females’ health ailments.

The selection of provider/s for health care also becomes immensely important. Many a times, poor economic condition, ignorance (mainly because of illiteracy), and absence of proper public health delivery work in tandem to force the patients to take resort to perverse and corrupt healthcare providers. Such cases were very common

in Dumka district in particular, but Birbhum was not an exception altogether. For example, in the rural areas in Dumka the practice of administering intravenous saline water, popularly known as ‘saline’, is commonly used by the quacks for almost every sort of ailment, which is not only usually unnecessary and expensive, but also counter-productive in many cases. Similarly, in many areas of Birbhum, rampant use of antibiotics was found to be a very common practice not only among quacks but also among many qualified medical practitioners. Poor and ignorant patients’ vulnerability is often used by incompetent and dishonest practitioners for making money. (We have discussed this in more detail in section 5.)

Awareness about the health problems in Dumka was found to be poorer than in Birbhum. The study collected information on awareness about AIDS. Only 24 percent of the respondents in Birbhum and 20 percent of the respondents in Dumka had heard about AIDS. However most of them in both the districts admitted that they did not know anything about it.

To have an understanding of the awareness of the mothers regarding some important aspects of health we incorporated some questions on this. One such question was whether they had ever seen or heard the name of ORS (Oral Rehydration Solution). While 70 percent of the respondents in Birbhum replied in the affirmative, in Dumka it was only 31 percent.

Nine percent of the respondents in Birbhum believed that smaller amounts of water should be given to the children during diarrhoea. The figure was as high as 43 percent in Dumka. Some of the respondents in Dumka even believed that children suffering from diarrhoea should not be given any water *at all* because, “it would cause more motions”.

While 64 percent of the mothers in Birbhum believed that patients suffering from diarrhoea should be given more water than normal, only 25 percent in Dumka thought so. It appears that the differences between the two districts in terms of literacy, political assertion, relatively better economic condition and the delivery of public health services have led to the differences in awareness among them.

GENERAL MORBIDITY AND MORTALITY

Concerning morbidity, the survey collected information at two levels – first during the listing of households and second during the canvassing of the main questionnaires. Both the sources reveal that almost all the houses suffered from one or other kinds of ailments.

At the time of enlisting the households 87 percent of a total of 1,337 households in Birbhum and 79 percent of a total of 944 households reported to have suffered from one or another kind of ailment. The main questionnaire canvassing, which enabled us to see the households more closely, shows that 95 percent in Birbhum and 99 percent in Dumka suffered from one or more diseases. (See more on this in section 5.)

Great variation was found in terms of occurrence of diseases across the districts. Malaria, tuberculosis and diarrhoea occurred more commonly in Dumka than in Birbhum. In Birbhum majority of the ailments reported were fever, diarrhoea, other stomach ailments, etc. One major difference found between the two districts was occurrences of epidemics. While at least one of the surveyed villages in Dumka has witnessed 35 epidemic deaths in the year preceding the study, no such incidence was reported in the villages of Birbhum.

Differences in terms of mortality were also quite visible. While the incidence of mortality was 30.6 per 1,000 in Dumka (in the sampled households) in the year preceding the survey, in Birbhum it was much lower (7.5 per 1,000). While deaths caused by disease were very few (only one of eight) in Birbhum, it was quite high in Dumka (27 of 39).

Our enquiry on various health-related issues in the districts of Birbhum and Dumka must be seen against the above background.

NOTES

1. The word landless refers to those who do not own any cultivable land.
2. Diku, a term of Mundari origin, is used all over Jharkhand to denote non-tribals in general. The term also indicates the considerable dislike of tribals towards non-tribals, which is mainly due to the experiences of land alienation and other sorts of economic and extra-economic exploitation of the former by the latter.
3. See, Bradley Birt (1908), Datta (1937), Roy Choudhury (1965), etc. Also Santal Pargana Tenancy Act 1949.
4. Lands in Dumka district are mainly of four types. *Baihar* is the low and fertile rice growing land. *Baid* is semi-upland that grows rice subject to good and regular precipitation. *Bargi* is a piece of land generally attached to the houses that grow vegetables, maize, lentils, mesta, etc. *Tandi* is upland, almost barren. Productivity is very low and crop production completely depends upon rain. Generally coarse cereals and pulses are grown in such lands.
5. Seasonal outmigration for agricultural wage work is a common feature of this area.
6. Rana et al (forthcoming)
7. Children refers to those aged 14 years or under.

THE SICK INDUSTRY

Ailments, health care and some related issues

As the popular saying goes, demand breeds supply, and the health sector all over the country has seen the emergence of a range of service providers. The inadequacy in terms of public provision for health has created a large market for various private health services.¹ In this section we would like to discuss how people suffer from various ailments and how different people use different sources of health care in our study areas. We shall also try to examine social impacts and implications on grounds of class, caste and gender in the context of paid and unpaid health services.

PREVALENCE OF AILMENTS

As mentioned earlier, the study involved two phases of fieldwork – first the listing of the households of the villages; and second, in-depth inquiry in the selected households. We have thus two sets of data for the general trend of morbidity from the listing sheets. Data from the sampled households provide a basis for detailed analysis of the various ailments.

From a total listing of 1,337 and 944 households in Birbhum and Dumka respectively, occurrences of any ailment (in the last one year prior to our visit) was found in 87 percent households in Birbhum and 79 percent households in Dumka. The high rate of morbidity has further been confirmed from our sampled households. Of a total of 215 households in Birbhum and 216 in Dumka the incidence of any ailment (at household level) in the year preceding our visits was reported in 95 percent and 99 percent households respectively. The variation between the findings of the initial listing and the in-depth inquiry was mainly due to the nature of the survey – listing was done more rapidly, which did not leave much scope for thorough

probing into the facts. The in-depth study allowed us to examine the facts carefully – in general we noticed a tendency to under-report ailments (including some major ones), particularly among the poor people. This was particularly so in the cases which remained untreated or when people continued working under compulsion in spite of being ill. Repeated requests to report every ailment concerning each of the members of the households during the reference period led to more accurate estimates of morbidity and this can account for the differences between the two sets of data.

Table 5.1 Prevalence of ailments

	From listing sheet		Sampled households	
	Total households	HHs suffered	Total households	HHs suffered
Birbhum	1337	1165 (87.1)	215	204 (94.9)
Dumka	944	750 (79.4)	216	213 (98.6)

Figures in parentheses indicate percentage

As regards the percentage of population who suffered from ailments, we found a further worrying picture. In Birbhum more than 42 percent of the total population suffered from ailments in the year prior to our visit. Exactly same was the case in neighbouring Dumka district. (See Appendix Table B.4 for details.)

Figures for family members who suffered from ailments in the sampled households were identical in both the districts – 2.19 persons on average per household suffered from ailments during the reference period. However, the caste-wise break up of the ailing persons gives a different picture. While considerable variation among different caste groups was found in the figures for average family members who suffered in Birbhum district, in case of Dumka the figures were relatively more uniform. The following table reveals the situation.

Table 5.2 Health problems in last one year

	Birbhum			Dumka		
	Total number of patients	Total number HH suffered	Average number of patient/HH	Total number of patients	Total number of HH suffered	Average number of patient/HH
Scheduled caste	184	83	2.22	49	22	2.23
Scheduled tribe	69	37	1.86	369	167	2.21
Other caste	194	84	2.31	50	24	2.08
Total	447	204	2.19	468	213	2.19

The table shows that in the SC households of both the districts almost similar number of average family members suffered from ailments during the reference period. However, figures for ST and other caste households varied between the two districts. While the figure was low in case of the ST households in Birbhum, it was higher in Dumka. Again, in case of the other caste households it was just the opposite – high rate of reporting of ailing family members in Birbhum and a comparatively lower

figure for Dumka. One probable reason for lower numbers in the ST households in Birbhum could be the underreporting (despite subsequent probing) of the respondents about ailments. The research team, in Birbhum, suffered from the problem of communicating with the tribal households, many of whom did not speak Bangla – the lingua franca in the district. In Dumka we could overcome this problem with the help of local research assistants who spoke the local language (Santali).

Extent of illness: The accounts of illnesses given are based on people's own perception. In general poor people tended to underreport their ailments while complaints of ill health was higher among the comparatively affluent sections of the society. In spite of consistent probing, chances of such underreporting and the contra cannot be ruled out.

The major ailments found in Birbhum were stomach ailments, fever, cold and cough, skin diseases, bone related ailments, and so on. While there were some similarities in terms of prevalence of diseases in the two districts some major variations were also found. In Dumka, for example, the major illness that people suffered from was malaria, which was negligible in Birbhum. Similar was the case of *kala-azar* (*Visceral leishmaniasis*), which was not found in Birbhum.

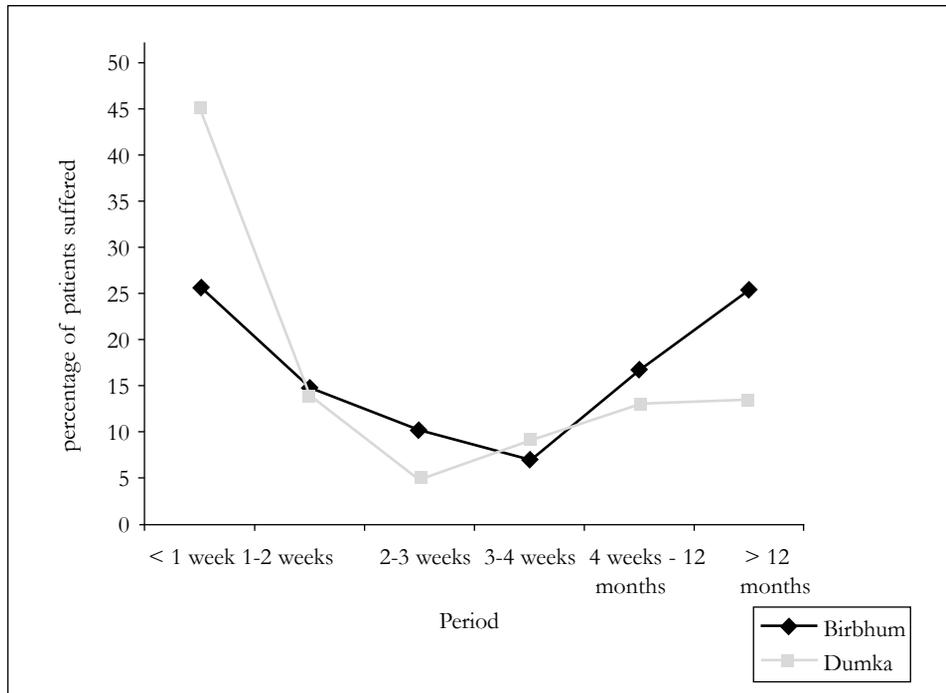
Again, there were some variations between males and females in the pattern of ailments. For example, while females in Dumka suffered from malaria in greater numbers than males it was opposite in the case of TB. In Birbhum, more males than females suffered from cold and cough but in case of eye problems it was otherwise. Overall, as can be seen in the following table, the proportion of females who suffered from ailments was greater than that of their male counterparts.

Table 5.3 Prevalence of ailments (with gender break up)

Ailments	Birbhum		Dumka	
	Male (as percent of total male population)	Female (as percent of total female population)	Male (as percent of total male population)	Female (as percent of total female population)
Malaria	0	0.4	7.6	12.4
Diarrhoea	0.9	1.0	3.1	3.4
Kala-azar	0	0	0.7	0.2
TB	1.3	0.2	3.3	0.9
Jaundice	0.9	0.8	0.9	0.7
Other Stomach ailments	7.5	7.0	4.0	3.9
Fever, cold etc	15.7	12.7	7.6	10.1
Bone related diseases	3.5	2.1	2.9	2.3
Skin diseases	3.3	2.9	3.1	1.1
Chest problems	1.3	2.0	2.0	1.9
Eye problems	0.4	2.3	0.2	0
Gynaecological problems	NA	4.7	NA	1.4
Others	6.4	7.2	5.1	5.2
Total	41.1	43.4	40.5	43.5

Period of suffering: It worth a mention that in many cases the long period of suffering in particular ailments not only prolongs the pain but also creates a range of various problems – financial, social and others.

Chart 5.1 Period of Suffering



It can be seen from the above chart that while about 26 percent of the total patients in Birbhum suffered for less than a week, in Dumka it was much higher. Forty five percent of the total number of patients suffered for a week or less. Reporting about the suffering period also has its social roots. Most of the wage earners and other poor families had no option but to work even when ill, thus ignoring, and exacerbating, their illnesses. Hence, the period of suffering (which was often reported keeping in mind absence from work), is likely to have been understated in such cases. Also the varied perception about ailments might have influenced the reporting. While 25 percent of the total patients in Birbhum reported to have been suffering for more than one year, the figure for Dumka was found much lower – a little above 13 percent.

The longer the period of suffering, the more exacting it becomes – in terms of health, cost of treatment, loss in terms of work, loss of moral confidence, affecting the household, etc. For example, many of the TB patients and their families in Dumka district, as we found during our study, had become ruined after exhausting all their assets and belongings. The two-way effect of tubercular diseases – sucking money in the form of cost of prolonged treatment and remaining unproductive for an even longer time (*durup jom* – sitting idle and eating without contributing) – left

sufferers with no other option but to borrow money at high rates of interest. (We shall discuss this at greater length in section 7.)

THOSE WHO REMAINED UNCARED FOR

Although the prevalence of ailments was pervasive and people were found to resort to various health care services, in some of the cases patients remained untreated. While a large majority of the suffering people availed of one or other kind of health services in both the districts, yet 12 percent in Birbhum and eight percent in Dumka reported not to have taken any kind of medical treatment. (See appendix table B.6 for details.) Here, we shall briefly discuss the main reasons for not taking medical treatment.

Reasons for not taking treatment: Most of the respondents of both districts expressed their helplessness in terms of financial affordability of the cost of treatment. Thirty seven percent of such patients in Birbhum said that financial handicap was the main reason for not taking treatment. The figure was much higher in Dumka (64 percent). Accessibility to health services, it seems, was a big problem in Dumka. Nineteen percent of such patients said that the reason for not taking treatment was the difficulty in accessing health services. It was negligibly two percent in Birbhum. Fifty six percent of such respondents (those who did not take medical treatment) felt that it was not necessary to take medical treatment since the ailments were perceived to be milder in kind, which could be cured naturally. In contrast, such responses (treatment not felt necessary) were 14 percent in Dumka.² (See Appendix table B.7)

“Paisa nei dekhabo ki kore? – We have no money, how can we avail of health services?” was a general complaint of the poor villagers of Birbhum. Dumka was also no exception. For these people, as their experience went, the public health delivery system has ceased to be free, and the fear of monetary involvement in many cases left the patients out of the realm of health services.

The ordinary villagers of both the districts, saving a few exceptions, were visibly upset with the public health delivery systems. Most of them complained *“haspatale gele daftar pua jai na, osudh to baire theke kinte hoi tahale ki labh okhane giye? (Doctors are not available in hospitals, we have to buy medicines from private sales counters, what is the point of going to hospital?)”* In Dumka the complaints were more serious in nature – many of the respondents complained that doctors and health workers did not speak to them (*ro^o ge ban ro? ak’*) even after the suffering people queued up for a long time to meet them. To our utter astonishment, we were told by some respondents that some doctors and health workers in Dumka charged money at the PHCs! Poor functionality of the public health delivery system has created a sort of skepticism about the PHCs and hospitals. This could well be a reason for many people for not taking treatment for some ailments, which were perceived to be less serious in nature. However we have seen in many cases that such negligence, even in very minor ailments, could take a fatal turn. One of the villagers in Dumka district neglected a chronic headache. It was thought that the simple headache would be cured in due

course and it was not worth spending money on. Later on, the patient had to pay a heavy price – he simply collapsed and died after he was taken to hospital following a deterioration in his condition. Doctors at Mohulpahari Mission hospital told the relatives that it was some kind of infection in the brain.

Doctors on the other hand, particularly in Dumka, criticised the adivasis for not visiting the health centres. They held the adivasis’ “superstitious belief” in evil spirits (*bongas*) and their dependence on witch doctors (*ojhas, jangurus*, etc.) responsible for their not using the public health services. Not only the doctors but also many other people including some academics subscribe to this belief in the adivasis’ “superstitious beliefs”.³ However, our study found that very few of our respondents resorted to *ojhas* or the likes. It is probably the inadequacy and ineffectiveness of the public health delivery system that serves to develop an inhibition towards the government doctors and makes people depend upon private providers. In some cases, they are forced to live with their illnesses untreated. There were however, some remarkable exceptions. Some of the government doctors were very dedicated and in such places people were seen to rely heavily upon them. Interestingly in such places, incidence of “no treatment received” was nearly zero.

Incidence of “no treatment received” has another dimension as well. Of the total number of patients who did not receive any treatment at all, 62 percent in Birbhum and 75 percent in Dumka consisted of females. Again nine percent of the male patients in Birbhum and four percent in Dumka remained untreated, but among female patients the percentage of those who remained uncared for was much higher – 14 percent in Birbhum and 11 percent in Dumka.

Table 5.4 No treatment and gender inequality

	Total number of patients not taking treatment	Proportion of male patients not taking treatment	Proportion of female patients not taking treatment	Percent of patients not taking treatment (to the total number of patients)	
				Male	Female
Birbhum	52	20 (38.5)	32 (61.5)	8.9	14
Dumka	36	9 (25)	27 (75)	4.0	11

Figures in parentheses indicate percentage

Underreporting illnesses and the neglect of ailing females by their male counterparts are the two phenomena that we observed throughout our study (more on this presently). Underreporting of illnesses by women is probably caused by a combination of factors. Women are chiefly responsible for running the household, hence the fear of expenses for treatment and subsequent silence. Moreover, the inherited knowledge about males’ neglectful response towards the suffering of women might have caused the underreporting. Accessibility was another big problem, particularly in Dumka. In some villages people have to walk for four-five hours to catch a bus. In such cases visiting a health service centre not only involves a strenuous journey but also creates various domestic problems concerning childcare, cattle care, and

others. While for male patients, “treatment not received” occurred only in cases of perceived mild ailments, women were neglected even in cases of serious illness. For example, in Dumka five female patients suffering from malaria remained unattended by any health service provider, while no man was thus neglected. (For details see appendix table B.6b).

DIFFERENT MEDICAL SERVICE PROVIDERS

We found two main kinds of health services in our study: (1) Public Health Services, including government doctors and health workers at different levels – from hospital to the sub-centres, and (2) Private Health Services. Private health services can further be divided into: (a) Private Qualified Allopathic Practitioners – private clinics, nursing homes, etc. (b) Private Unqualified Allopathic Medical Practitioners (UMP) – popularly known as “quacks”; (c) Homeopathic Practitioners; (d) Herbal Medical Practitioners and others including witch doctors. (The herbal medical practitioners, in the study area are generally called *kabiraj*, and the witch or magic doctors are identified by many different names, viz. *ojha*, *janguru* and *deasi*).

Quacks: Private unqualified medical practitioners or quacks (technically UMPs) perhaps need some clarification. In our study we have considered those UMPs or quacks who are (i) practising medicine without having registered with any of the recognised medical councils in India (Allopathic, Homoeopathic, Ayurvedic, Unani, etc.), or (ii) practising a certain kind of medicine but being registered with a different kind of medical association (for example practising allopathic medicine with a homoeopathic diploma or degree).

The term ‘quack’ has come from a 16th century Dutch word ‘quacksalver’ that combined two words ‘quack’ and ‘salve’, implying one who quacks or boasts about his salves.⁴

Quacks, however, are not unique to any particular area. In fact, as a TV programme on the style of functioning of the quacks (most of whom had no basic knowledge either of the diseases or of their treatments) showed, quacks are fast emerging to run a parallel system of health care.⁵ Concerned at their uncontrolled (mal)practices and plundering, the Government of Delhi tabled an “Anti Quackery Bill” in the state Assembly in 1997, but for reasons best known to the law makers, the bill’s fate was consigned to oblivion.

The widespread prevalence of quacks in Dumka district has also been acknowledged in public and other documents⁶ and their prevalence and alleged incompetence were frequently mentioned by the public health officers in Birbhum district.

As mentioned in the methodology part of this report, the study team with the expert help of two qualified allopathic doctors made an assessment of UMPs with a sample of 10 quacks in the study areas. The initiation of the assessment was felt to be important because of the widespread prevalence of UMPs who, in many areas, are the only source of medical treatment.

The assessing doctors used some simple criteria for measuring the knowledge

of diseases and their treatment the quacks possessed. The UMPs were questioned on the symptoms and causes of some common diseases like malaria, diarrhoea, jaundice, etc. and their medical treatments. The doctors also tried to collect information concerning the background and qualifications of the quacks.

The main findings of the assessing team are given below:

1. Out of the ten quacks, five said that they possessed a degree called RMP, two said that they possessed a degree called Electro Homoeopath and one said that he possessed a Homoeopathic Diploma and the remaining two had no degree at all.

2. All of them said that they had been practising allopathic medicine only.

3. Diseases they claimed to have been treating were malaria, diarrhoea, cough and cold, fever, jaundice, joint and other pains, etc. However, some of them seemingly had more expertise – one even said that he performed eye operations! And one said that he treated cancer patients successfully!

4. Knowledge about the symptoms and causes of diseases varied from quack to quack. For example one said that a symptom of jaundice was black stool and he applied antibiotics for treatment. Another said that malaria was a water-borne disease and the treatment of malaria was a combination of saline, antibiotics and chloroquine! All the ten quacks had different ideas about the doses of chloroquine.

Use of saline was widespread in Dumka. For every sort of ailment, the interviewed “practitioners” strongly maintained that no treatment could be done without saline, since “saline increases blood in the body, gives nutrition (*pushiti*) and faster relief.”

In Birbhum, antibiotics, painkillers and cough syrups were reported to be the most commonly used medicines. One UMP said that he used sleeping pills for any sort of pains and aches.

Some of the “doctors” did not even know the brand names, let alone the generic names, of the medicines they use. One “doctor”, while asked which antibiotic he would use in jaundice, said that he did not know the name of the medicine, but could recognise it by seeing the packaging foil!

5. Of the ten interviewed quacks six had reportedly worked with a qualified doctor for some time – ranging from one to three years. One said that he had worked with a “senior” quack for two years.

6. However, all of them seemed to know how to give intravenous injections. Also they knew which drug to use for some of the simple symptoms, like fever, loose motion, inflammation and pain, etc. (at least they could identify the drugs by seeing the foils). At least for some cases this knowledge proved to be sufficient.

7. Despite their very low level of knowledge about diseases and their treatment, the interviewed quacks have been doing good business. The main reasons they mentioned for their widespread “field” were, difficulty in accessing the public health system by the suffering folk, poor functioning and consequent unreliability of the public health system and high cost of treatment at the private qualified doctors’ clinics on the one hand and easy access to the quacks and their comparatively lower cost of treatment (often with credit facility, bartering of service for poultry, grains, vegetables, trees, fruits, cattle, etc.) on the other.

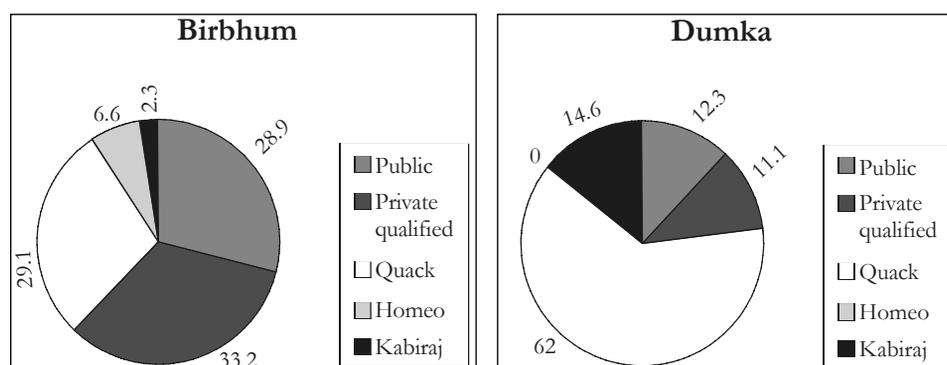
However, as the assessing doctors felt, apart from the poor functionality of the public health services and the extortionate practices (and many a times malpractice) of the private qualified doctors, the low level of health awareness was another main reason for the growth in the number of quacks. While in many cases of diarrhoea simple ORS was enough, the quacks use saline – only to make money. Similar is the case of malaria – where simple chloroquine can cure a patient quacks use many different medicines, which are not only unnecessary but also counterproductive in many cases.

Proper delivery of health services along with special and consistent programmes on health awareness can not only prevent malpractice but can also prevent many diseases, the assessing doctors concluded.

Different sources of medical treatment: The 395 cases of ailments in Birbhum for which medical treatment was sought (from any source) can be classified on the basis of different sources as mentioned above. Of them only 29 percent reported to have availed of the public health services, 33 percent saw private qualified doctors and 29 percent took the services of the quacks. Homeopaths contributed in giving medical treatment to seven percent of the cases, and around two percent of the sufferers resorted to other sources – *kabirajs* and *ojhas*. Hence the dependence on private health services was as high as 71 percent.⁷

While in Birbhum we have seen a considerable section of people relying upon the public health services, in Dumka the situation was awfully poor. Only 12 percent of a total of 432 cases (for which medical treatment was sought) used the public health facilities. In sharp contrast with Birbhum only in a few cases (11 percent) treatment was done at private qualified sources, while quacks had the largest share – 62 percent. No patient was found to have visited a homeopath in Dumka. However, compared to Birbhum more cases (15 percent) were found to rely upon *kabirajs* and *ojhas*.⁸

Chart 5.2 Different sources of medical treatment



Different sources of treatment for different ailments: A varied picture of the different sources of treatment used for different ailments was found in our study. All the patients who suffered from malaria in Birbhum (although the number was negligible)

HERE A QUACK, THERE A QUACK

In popular expression Janeswar (name changed) is no more than a *jboltanga* (man with a rag bag), yet, for many people he is the only one to rescue them from ill health. A medical practitioner with no medical qualification, he treats about 5-6 patients a day on average. But during the rains the number of patients increases to 20-25 a day. “*Kabhi kabhi to nahane kbane ka samay nabin milta* (Sometimes I don’t find the time for bathing or eating),” he proudly mentioned about his roaring practice. He earns the most during the *bimari* (illness) season that, according to his claim, supports him for the rest of the year. However, besides medical practice, he has several “side businesses” as well.

Born in a *Sundi* family with the traditional occupation of making and trading country liquor and also with some agricultural production (his father owned three acres of land that has been divided among three brothers), Janeswar, the youngest of the siblings, stopped studying after completing his matriculation in 1988. He did not enter into either of the traditional occupations, as they were “no longer profitable”. He managed to find a job (using a political connection) with a nursing home at a district town in then Bihar (now Jharkhand) and worked there for five years where he learnt “medicines” that included administering injections, reading temperature and blood pressure, dressing of wounds, administering saline water, etc.

After realising that a paid job was “actually nothing but working like a bonded labourer,” he choose to work independently and started practicing medicine, first in a neighbouring Santal village. Slowly, “*naam hota gaya* – my fame started spreading” and new villages were added to his list. He has recently (November 2002) bought a new motorcycle to cope with the pressure of work. The bicycle he had so far used, could not help him adequately. “*Babot daurna parta hai* (I have to travel a lot)”. He never ignores a call from a patient as that may cost him his reputation of ready availability. Twenty years ago, he says, there were very few medical practitioners in the locality. “*Ab to bhar gaya hai* (Now the area is full [of quacks]).” People are taking up medical practice as a lucrative business. This change, he argues, has come about in a very natural way. In the past, people depended upon traditional medicines for (1) they had no money to spend, and (2) traditional medical practitioners were available in almost all the villages. People generally abhorred allopathic medicines for their high cost. Also the availability of traditional medicines like herbs and their practitioners, on the one hand, and difficulty in accessing hospitals or practicing doctors on the other, had helped to develop this abhorrence. Although many people still suffer from hunger, hard cash is not a distant dream, unlike it was in the past. Income from wage work, particularly from migration, has brought a change in the economic condition. “*Usiko chusne ke liye ab sab koi daktar ban jata hai, daktori karna aye chabe nabin ayae* (To suck that money, now everyone has turned doctor, no matter whether they are capable or not).” He, however, has a very high self-appreciation as a good practitioner who has worked hard to learn the trade – “*babaot papar belna para*”. The secret of his success, he evaluates, is his capability to feel the pulse of the patient. “You were asking about use of saline water. It’s because of the demands of the patients. If you don’t administer saline, people won’t trust you as a good doctor. “*Bimari tan me nabin, man me rabta hai* (Illness is not in the body but in the mind. One cannot repair the body without satisfying the patient mentally... *Aisa babot sa baat hai* (There are so many other tricks...))”

According to him, he earns Rs 150 on average a day. However some other people mentioned that it was much more than that. He did not hide the fact that he charges much for the medicines he supplies, since he has to do almost all the treatments on credit. “People repay the cost according to their convenience. So, why should not I charge the interest for my investment?” However, he fixes the cost according to the paying capacity of the patients.

As for his “side businesses”, he lends money on interest, buys paddy during harvest to sell later at a higher price and also does some trading in timber and bamboo. Some villagers said that the “side businesses” did not need any extra effort. His main occupation of a medical practitioner enables him to come closer to the people and he can carry on his trading simultaneously.

With the self-styled honorific “Dr.” prefixed to his name that makes him *daktorsabeb* among the villagers he is not unique of his kind. In both the study areas such *daktorsabeb*s or *daktarbabus* were found in large numbers.

saw private qualified practitioners, but in case of Dumka 76 percent of the malaria cases were treated by UMPs. Perhaps people considered it worthless to visit the public health services about which they only had bitter experiences. Moreover, where malaria is so common a disease, pervading almost all the households, reliance upon a locally available source has probably been caused due to easy access and the availability of credit facility for medical treatment. (See more on this in section 7.)

In case of tuberculosis the situation is completely reversed. While in Birbhum the majority of the patients who suffered from tubercular diseases were found to utilise the public health services, in Dumka such patients were overwhelmingly reported to have visited the private qualified doctors. One main reason for such a situation could be the relatively effective running of the DOT (Direct Observation and Treatment) programme in Birbhum where poor patients get free treatment (a general observation was that almost all the TB patients belong to low income groups). In Dumka the absence of a functional public health delivery system and the proven ineffectiveness of quacks in treating such patients were the main reasons for relying upon private qualified doctors. It is a common feature that poor patients of Dumka, being deprived of the free services had to sell almost all their assets and belongings to pay for treatment.

In case of diarrhoea, patients in Birbhum were found to visit the public, private qualified and unqualified medical practitioners equally. However, in Dumka, reliance on quacks was found in more than 90 percent of cases.

For ailments like jaundice in Birbhum qualified private doctors were visited most. In Dumka people were found to have consulted the *kabirajs* most. Cases of other stomach ailments in both the districts were treated mostly by private qualified doctors and quacks. In case of minor fever and cold, quacks were found to be the chief source of treatment in both the districts. Another interesting fact is that the female patients with gynaecological problems in Birbhum mostly visited private qualified doctors while in Dumka quacks and traditional treatment played a major role. The table below provides the details.

Table 5.5 Distribution of different sources of medical treatment

	Birbhum					Dumka			
	Govt.	Pvt. qualified	Quack	Homeo	Kabirajs & others	Govt.	Pvt. qualified	Quack	Kabirajs & others
Malaria	0	100	0	0	0	14.9	4.7	75.7	4.7
Diarrhoea	30.0	30.0	30.0	10.0	0	5.6	0	91.7	2.8
TB	71.4	28.6	0	0	0	17.4	52.2	26.1	4.3
Jaundice	0	66.7	22.2	0	11.1	11.1	11.1	22.2	55.5
Stomach ailments	28.9	34.8	27.3	9.1	0	12.5	30.0	45.0	12.5
Fever, cold etc	28.4	21.6	43.3	6.7	0	5.9	5.9	76.5	11.8
Gynaecological	25.0	40.0	10.0	15.0	10.0	0	0	50.0	50.0

In percentage

In many cases people reported to have sought many different services for a particular disease. For example some of the TB patients in Dumka went to the private qualified doctors after failing to recover from the illness following treatment at the public hospital or with the quacks. Similarly in Birbhum many patients told us that they had visited the private qualified doctors since the treatment at the hospitals did not help them at all. Again some of the patients in Birbhum reported to have switched to homeopaths, as the cost of treatment for some chronic ailments at the private qualified sources was felt to be too much to bear.

Health ailments and gender: Another important aspect is the gender division and discrimination in terms of availing various sources of treatment. Male patients in Birbhum visited the government health services and private qualified doctors more than females; it was just the opposite in the case of quacks and homeopaths. In Dumka, medical treatment of the females at private qualified doctors' clinics was found to be in much less in number. Again, females being treated by quacks surpassed the number of males. The following table gives the details.

Table 5.6 Gender distribution and source of treatment

	Birbhum		Dumka	
	Male	Female	Male	Female
Public health facilities	58.8	41.2	47.2	52.8
Private qualified	53.4	46.6	66.7	33.3
Quack	47.8	52.2	47.0	53.0
Homeopath	34.6	65.4	0	0
Kabirajs & others	44.4	55.5	49.2	50.8

As percentage of total patients visiting each source

The ailments-wise break-up shows that of a total of 31 female patients in Birbhum who suffered from stomach ailments and received any medical treatment, only 19 percent were treated by private qualified doctors, whereas in case of male patients this figure was 42 percent (out of a total of 41). As we know, getting treated by private qualified doctors is a distant dream for most of the respondents in Dumka; female patients with ailments like malaria, diarrhoea and stomach problems were treated by the comparatively easily accessible quacks.

As regards the different service delivery systems, in both the districts, the importance of any particular service depended upon several factors. For Birbhum private qualified doctors were the major source of treatment for (1) their easy accessibility – road connections in the district are much better than in Dumka; (2) relatively higher and assured income of the people and (3) wider class division – while in Dumka the level of inequality among the respondents was found to be much lower, in Birbhum it was comparatively higher. The relatively affluent people of the society shunning the lower quality of services delivered in the public

health sources found it more convenient to “buy” their health. The following graphics based upon their responses illustrates the class dimension of health care.

In case of Dumka the alarmingly high reliance on quacks has mainly been caused by (1) poverty – generally people were not in a position to spend cash which was necessary for both private and public health services (in terms of buying medicines, and getting the diagnostic tests done); (2) inaccessibility – both in terms of physical (for many villagers it involves a good three hours’ walk to catch a bus) and social distances (many villagers simply cannot communicate with the Hindi-speaking doctors who also suffer from a general abhorrence towards the adivasis and other low-borns) and (3) much lower level of literacy that gave very little confidence to the poor villagers to visit a doctor either in hospital or in a private clinic. We witnessed many people seeking help of the “*alo parhao bo*” – educated people” for taking a serious patient to a “*latu daktar* – literally “big doctor” or to the hospital.

In short, the root cause of the emergence of a disordered and unequal parallel in the name of private health care, which is fast replacing the public health services, lies in the poor functionality and effectiveness of the sub centres, PHCs and hospitals. The system that could prevent inequality and class division and could save the

Chart 5.3 Class and sources of treatment I

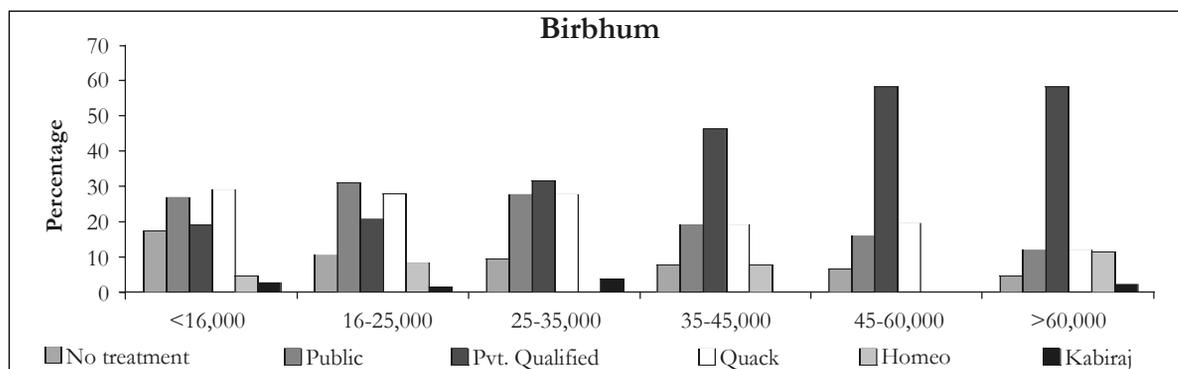
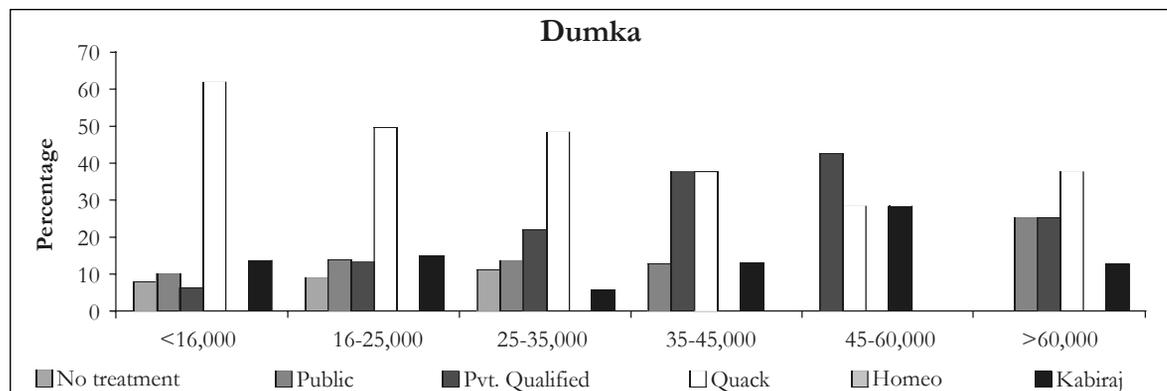


Chart 5.4 Class and sources of treatment II



lives of hundreds and thousands of suffering people is itself pushing the poor masses towards complete destitution both directly (through not providing health care) and indirectly (by encouraging an exploitative paid health care system).

INCOME CLASS, LITERACY AND MEDICAL TREATMENT

Income class and literacy are almost inseparably intertwined. As we have found in our study, the poorer the households the less progress they have made in terms of literacy and educational status. The table presented below shows this strong inter-connection between income class and level of education achieved.

Our findings further suggest a strong correlation between educational level and choosing of the sources of medical treatment. Households having no adult literate member were found to depend more on quacks, traditional practitioners and on the public health delivery system – all of which are relatively more accessible and affordable. Also, such households had more number of cases of “no treatment”. On the

Table 5.7 Income class and educational level

	≤ Rs.16000		Rs.16001-25000		Rs.25001-35000		Rs.35001-45000		Rs.45001-60000		Above Rs.60000	
	Birbhum	Dumka	Birbhum	Dumka	Birbhum	Dumka	Birbhum	Dumka	Birbhum	Dumka	Birbhum	Dumka
Illiterate	40	51	43.5	20.9	9.1	0	10	0	9.1	0	0	0
Upto class 4	22.4	15.6	21.7	20.9	36.4	23.1	30	20	9.1	0	5.5	0
Class 5-8	20	23.1	17.4	27.9	31.8	15.4	20	40	18.2	0	0	25
Class 9-10	7	8.2	7.2	18.6	0	23.1	10	0	9.1	0	5.5	0
Madhyamik and above	10.6	2	10.2	11.6	22.7	38.5	30	40	54.5	100	89	75
Total	100	100	100	100	100	100	100	100	100	100	100	100

Both Tables 5.7 and 5.8 are according to the highest educational level achieved by any adult member of household
Figures are in percentages

Table 5.8 Educational level and source of treatment

	Illiterate		Up to class IV		Class V to VIII		Class IX to X		Madhyamik and above	
	Birbhum	Dumka	Birbhum	Dumka	Birbhum	Dumka	Birbhum	Dumka	Birbhum	Dumka
No treatment	12.4	10.2	8	11	18	4.3	10	6.8	9.8	0
Public health services	34.9	12.1	24.8	9.8	20.5	3.5	30	15.1	16.3	0
Private qualified	18.6	3.6	40.7	7.3	24	8.7	23.3	15.1	37	46.9
Quack	27.9	60.2	19.5	64.6	27.4	53.9	30	52.1	27.2	46.9
Kabiraj	2.3	13.9	2.7	7.3	2.4	20.9	3.3	10.9	0	6.2
Homeopath	3.9	0	4.4	0	7.2	0	3.3	0	9.8	0
Total cases	129	166	113	82	83	115	30	73	92	32
Total households	68	84	47	36	40	51	14	23	46	22

other hand households with higher educational levels were found to have depended more on qualified private practitioners.

It is possible that because of the relatively higher educational status people could identify the differences between the services provided in the public health system and at the private clinics.

Perhaps the level of education (along with relatively higher income – often higher income and higher educational status are intertwined) plays a big role in not relying upon quacks and traditional medical practitioners.

SANTAL TRADITIONAL MEDICINE AND SORCERY

“Formerly when religion was strong and science was weak men mistook magic for medicine, now, when science is strong and religion weak, men mistake medicine for magic.”

— Thomas Szasz.

We found only 15 percent of the people in Dumka resorting to other sources of health care including *kabirajs* and *ojbas*. Further break up shows that, contrasting sharply to the popular notion of the urban middle class that “adivasi superstition makes them more keen to seek help from witch doctors or magic men”, very few of the Santals and other people sought spiritual services from the *ojbas* or *jangurus* during their illnesses. Most of them sought medical help from the traditional herbal practitioners – 50 of the total 63 patients who used “other” sources of treatment were treated by the traditional herbal practitioners and only 13 sought the services of the *ojbas*.

However, as we have seen, practices of traditional herbal treatments are also rapidly being replaced by allopathic practices – mainly by the quack practitioners. Many people attribute the reason for this shrinkage to the extinction of herbs with increased deforestation. The logic, however, does not seem to stand the scrutiny of reason – many of the herbs and other ingredients mentioned by Bodding ([1925] 1986: 161-403) are still not very difficult to find. Perhaps there is a much deeper social cause behind the diminishing practice of Santal traditional medicine. One probable reason could be that the Santal ideology of life did not allow medical practice to be an occupation. Taking money for curing diseases was considered to be wrong – although accepting gifts against healing ailments was a common practice. The remnants of such practices are still to be found. The tremendous pressure of the market on the one hand and not developing medical practice (by the Santals) as a source of income perhaps combined to lessen the traditional practice of medicine to a large extent. Also it is quite possible that traditional medicines could not cure all the diseases and their action could be slower than that of allopathic medicine. The popular middle class belief that adivasis depend on *ojbas*, *jangurus*, sorcery and witchcraft, and are quite reluctant to accept modern treatment is a century-old illusion, which the adivasis themselves want to reject in many areas. While asked about the ‘golden days’ of traditional medicine (before allopathic medicine was introduced) an

old Santal quite clearly mentioned that he did not think of any such golden days. “*Unjokebe hon horku goc’koa, pase netar thora kom goco’ke’ kana-* people used to die [of diseases] in the older times too, perhaps the number [of deaths caused by diseases] is less now.” It is the absence of the public health and other services that, on many occasions, force people to take shelter in ignorant beliefs. (This has been discussed in section 2 as well.)

HOSPITALISATION

In both the districts we found some cases of hospitalisation, which reflects the class dimension of health care. In Birbhum, we found a total of 17 hospitalisations – 11 males and six females. This was only four percent of the total patients (447) of Birbhum. While 16 of them were admitted to public hospitals, only one was admitted to a private hospital. Patients were hospitalised for ailments like stomach problems, malaria, jaundice, diarrhoea, fever, gynaecological problems and a few other ailments. Interestingly all those admitted to the public hospitals belonged to the poor income category (an yearly income of less than Rs 25,000) and the lone patient admitted to a private nursing home belonged to the highest income category (an annual income of over Rs 60,000). Although almost all the respondents grumbled against the condition of the government hospitals (“*goal gharer thekeo kharap*” or “*narak be narak*” ie “worse than a cowshed” or “pure hell” were among many different negative comments made by the villagers) their dependence on them was reasoned by the cost factor. Public hospitals were found to be cheaper than the nursing homes and many people simply could not imagine paying the costs of a nursing home. Though cheaper, in all the cases of hospitalisation people had to spend large sums of money that they had to arrange with a lot of difficulty (sometime by selling assets, etc). (See more on this in section 7.)

Table 5.9 Extent of hospitalisation

	Birbhum			Dumka		
	M	F	Total	M	F	Total
Government hospitals	10	6	16(94.1)	1	4	5(71.4)
Private hospitals	1	0	1(5.9)	0	2	2(28.6)
Total	11	6	17(100)	1	6	7(100)

Figures in parentheses indicate percentage

Seven cases of hospitalisation (two percent of the total cases of ailments found in the district in our study), including one male and six female, were found in Dumka. Five among them were admitted to public hospitals and two of them to private hospital and nursing home. Ailments included stomach problems, malaria, TB, jaundice, diarrhoea and fever. Here too, the respondents expressed utter unhappiness as regards the conditions of the public hospitals, financial involvement and behavioural attitude

of the doctors and other health staff, while they found the use of the government hospitals helplessly unavoidable for the same reason mentioned in the case of Birbhum, i.e. public hospitals are comparatively less expensive than private ones.

As the majority of our respondents were poor villagers, in most cases they found themselves unable to afford the high cost involved in hospitalisation (and also, in some cases, felt helpless because of the long distance to the nearest hospital), despite having the urgent need to admit a patient to hospital. Also in some cases, as respondents in both the districts reported, authorities of the public hospitals refused to admit the suffering patients with the excuse of non-availability of beds (or space – in the public hospitals anyone can see patients lying on the floor). A patient from a village in Dumka district was taken to the Sadar Hospital with a lot of difficulty. The patient was suffering from cerebral malaria and he had to be carried on a *duli* (a cot) to the bus stand, seven kilometres from the village. The hospital authority refused admission. What the patient received as “care” was a prescription for medicines to be bought from the market. His relatives brought him back with two days’ medicines, as they did not have any money to get him admitted to a private nursing home. The patient died within a day.

MEDICAL ABUSES: FATAL DISORDERS

If the non-availability of medical treatment from the public health delivery system imposes a heavy economic burden on the suffering people and their families (as they have to depend upon the market to buy medical assistance), unethical and corrupt medical practices by different medical practitioners make things worse.

As we have seen earlier in this section, the unqualified medical practitioners (quacks) who form the backbone of the health services, particularly in Dumka, operate without sufficient medical education. In almost all the study villages (and also in some other villages) the quacks were seen to carry saline water bottles with them, which are used as the most common medicine for any sort of disease. The first thing they were seen to do was to administer saline water even before doing a physical check-up, let alone trying other modes of treatment. According to a Block PHC in-charge in Dumka, “These illiterates without knowing the consequences of administering saline kill many patients. There is very little scope for using saline water in cases of malaria; rather, it generally proves counterproductive if administered during fever. The only motive behind such ill-practices is to squeeze as much money as possible from the poor ignorant patients.”

In fact, one of our research team members witnessed a malaria patient dying in such a condition. His field note reads:

Duna Soren. Caught a fever 2 days back. First he did not take it seriously – he thought it was a common fever and will come down shortly. That was not to be. On the second night he started shivering heavily. His mother put a lot of rags and clothes on him. Yet the shivering continued. In the morning his mother had to call “X” Mondal, a quack living in a nearby village. (It was a two-member

household. His father died of TB two years back. His sister died of diarrhoea last year). Mondal was remarkably quick to come. As a mere coincidence, we encountered Mondal near Duna's house. Some other people were also there and we went to his house. He was still shivering. Mondal quickly took out a bottle of saline water and arranged to administer it. He did not note the temperature. Nor did he do any check up. Shivering grew, and the boy frequently sprang up and down. Within half an hour he died. "*Bhagwan ne bula liya Aadmi kya kar sakta hai?* (God has summoned him, what can we mortals do?)" Mondal said philosophically. When asked about the reason for not giving any medicine to lower the temperature first he angrily said, "*Aap daktar hain ki hum hain?* (Who is the doctor – you or me?)" He also said that at this stage only saline could save life. "Saline," he emphasised, "is the most important 'medicine' for treating all kinds of ailments!"

What can be more pathetic than the fact that the most unscientific mode of medical treatment still exists in a country where medical scientists in 6th century B.C stood "in defence of the intrinsic efficacy of medical science" and courageously ignored *adrsta* and *karma*?⁹

We came across some quacks who cannot even read the names of medicines on the foils. One was seen to have bought medicines from a pharmacist's shop at Dumka where the shopkeeper marked the bunch of foils or bottles of liquid medicine by labelling them with their particular usage, viz. 'for diarrhoea', 'for malaria', 'for fever' and so on. We saw a quack in Birbhum use a single syringe for administering injections to many patients without sterilising it.

Some of the quacks were also reported to have sexually abused female patients. In a Dumka village we were told: "With one unmarried woman, the quack said he had forgotten to bring his stethoscope and fondled the breasts of the patient pretending to do a check-up. However, not all villagers were as ignorant as this particular illiterate patient and some of the young men of the village beat him black and blue as punishment..."

Not only the quacks, there is evidence of severe medical abuse even by qualified private practitioners. Suna Hembram was suffering from general weakness. He visited a highly qualified medical practitioner at Dumka town who aside from government service and private medical practice owns a medicine shop, a pathological laboratory and a nursing home. After checking up the patient he prescribed three medicines (all in tablet and capsule form) and advised a Malaria Parasite test. His assistant (called a compounder) took him to the nursing home, administered a saline and then took him to the laboratory for a Malaria Parasite test and also for an X-ray! No paper or bill or receipt was given. When Hembram asked for the accounts, he was given a piece of scrap packaging paper from a medicine bottle charging Rs 900. Hembram had only Rs 500 with him. His wife borrowed the rest from a relative living at Karharbil on the outskirts of Dumka town and got her husband released. Hembram, however, did not come round. After 15 days he saw a physician at Deoghar, who is known to be sympathetic towards poor patients, who diagnosed

that Hembram had low blood pressure! This time he had to spend only Rs 75, which included his bus fare.

While private practitioners are accused of medical abuse which they indulge in only to earn money, in the most unethical ways, government doctors were also frequently held responsible for negligence in treatment. A patient with a fractured leg was treated at the Dumka Sadar Hospital. He had to spend Rs. 800 for the treatment. But after the plaster was removed, his leg was found to have become deformed. The fractured bone had not joined properly. The government doctor told him that it was irreparable. Later, the patient visited a private doctor in Patna. He had to go through a surgical operation to repair the damaged leg, which claimed a sum of Rs. 15,000.

Cases of medical abuse in Birbhum too ranged from quacks to qualified medical practitioners, though to a lesser extent compared to Dumka.

Many of the quacks of Birbhum were seen to remove the foils of the medicines before giving them to the patients. Some people in the study area and some qualified doctors maintained that such practices (by the quacks) was to safeguard themselves from future legal complications (death caused by wrong medication etc.). Some of the quacks were also reported to have been using “magic treatment” or religious rituals (*puja, manot*, etc). One such quack told us that no foreign practices could be successful in India unless it was backed by Indian religious faith. “*Viswase milay vastu, tarke babudur* – it is faith that yields fruit, not reasoning”. One quack started his allopathic practice when he was only a student of Class 8. He has a reported area of 10-12 villages where he travels regularly. According to him his popularity had increased because of the “unique” practice of mixing allopathic medicine with religious rituals. Another quack said that he uses a long range of antibiotics, “*kono ekta to lagbei!* (One of these will surely work!)” This he did, as he had to save the patient’s life.

Many of the people who seek services from the public or private qualified practitioners also reportedly fall prey to medical abuses. After consulting with a government doctor in his private chamber a pregnant woman was admitted to a sub-divisional hospital of Birbhum for childbirth. At the time of delivery neither a doctor nor a nurse assisted her. She was released after three days (and during her stay in the hospital she remained almost unattended). In the evening of the day of release from the hospital she started shivering and was taken back to the private clinic of the said doctor, where she was told that there were traces of placenta in the uterus. She was prescribed medicines worth Rs. 800. When the problem persisted, despite taking the prescribed medicines (that her husband had to arrange for by borrowing money), she visited the doctor again and again, but there was no positive result. Only the list of medicines was made longer and consequently the burden of loan. Finally, when she was advised by the doctor to get admitted to a nursing home, her frustrated husband took her to another doctor who, thankfully, could cure her at a comparatively cheaper cost.

Collection of prescriptions (in most cases written on plain or scrap paper), medicine packages and diagnostic reports by the research team and subsequent examination by some expert doctors indicate several cases of medical abuse by the public and private qualified doctors. They include use of wrong and excessive medicines (a

patient suffering from simple cough was given medicines for TB), lack of care in diagnosing the diseases correctly and prescribing blindly (advising multiple antibiotics for the same illness, use of banned combination of multiple drugs, e.g. cough syrup, non-enteric-coated digestive enzyme preparations), doing surgical operations carelessly, and so on and so forth. Reference to a particular diagnostic laboratory or medicine shop or doctor was also found in many cases.

As we were told by some doctors, believed to be very ethical in their practices, many of the doctors prescribe a range of unnecessary medicines simply to earn commission from medicine companies. One of the doctors in Jharkhand was seen to prescribe one particular tonic in every prescription. The medical representative of that particular company told one of the researchers that the doctor was paid a certain percentage as commission on the wholesale price of the medicine! One of the doctors was even seen to preserve the prescriptions in duplicate as a record, since he would get his share from a particular pharmaceutical company!

Medical abuse through excessive and unnecessary prescribing of medicines is not new in our country. The Hathi Committee (1975) found that thousands of different brands of different combinations of medicines were available in the Indian market, which were not necessary. Instead of such a long list of medicines, the committee suggested that the production of medicines be limited to 117 generic products, which were sufficient to treat every kind of disease in the country¹⁰. The World Health Organisation recommended 258 drugs, while the pharmaceutical industry in India (largely controlled by the multinational companies) is permitted to produce and market more than 60,000 drugs and formulations. There are about 50,000 brand products of irrational combinations and yet the standard textbooks recommend only 30 fixed-dose drug combinations.¹¹

The drug production in the country was worth Rs.10 crores in 1948; in 1999 it was worth Rs 29,000 crores.¹² When the PHCs and other public health service units suffer from acute shortages of drugs this gigantic private drug market - often using and promoting unethical practices by doctors - siphons out this amount from the common people mainly because of the absence of a regulatory mechanism.

Lack of effective regulatory and controlling measures for drug use (and abuse) can be seen clearly in the rural areas. Buying medicines over the counter without prescription is a general practice in India. We have observed medical abuses of more serious nature. In both the study districts we were told by some respondents that they had bought medicines from grocers in the local *haats* (periodic - generally weekly - markets). We have seen a quack selling expired medicines labelled "physician's sample". The list of such practices can go on endlessly.

SOCIAL IMPLICATIONS OF HEALTH AILMENTS

The presence of various ailments in peoples' lives has some obvious implications that create direct negative effects in their social and economic life. We have found diverse problems arising from the health ailments of the respondents which

we shall briefly discuss here with particular emphasis on the social aspects. The economic relations of health (a cycle of poverty, illness and further impoverishment) are discussed in section 7.

Abstaining from work and other related problems: The long period of suffering of the patients due to an ailment was reported to be a major difficulty. The longer the time of suffering stretches, the more the patient and her family members lose in terms of working days. As the respondents said, the ailments bring forth many problems. Illness of a particular person not only affects her life but also involves the whole family. While she herself loses the working days, other family members also lose the time needed to (1) take care of the ailing person, and (2) work overtime to compensate for the work assigned to or performed by the ailing one, or to suffer the loss of production.

Our data suggest that the actual loss of work by the adult patients (more than 14 years of age) was high. About 55 percent of all adult patients (180 out of 329) in Birbhum had to abstain from any sort of work for a certain period due to illness and in Dumka, where the majority of our respondents were daily labourers, the problem was more acute. It was distressing to find that more than 69 percent of the total adult patients (221 out of 318) in Dumka had to sit idle for a certain period due to their illness. (See appendix table B.14 for details). In terms of days the picture becomes more dismal. In Birbhum among the total of 180 patients, more than 56 percent failed to do any sort of productive work for at least a week and another 23 percent had to abstain from work for a period of between one and three weeks. The figures for Dumka were further depressing – they were 55 percent (one week) and 26 percent (between one and three weeks). There were also patients who abstained for longer periods in both the districts. The following table gives the details.

Table 5.10 Loss of work owing to illness in terms of days

	Birbhum	Dumka
	Percent of total patients	Percent of total patients
Up to one week	56.0	54.8
Two weeks	20.6	15.4
Three weeks	2.8	10.4
Four weeks	8.9	8.1
One to six months	8.9	9.5
More than six months	2.8	1.8

In the year preceding the study

The average number of person-days lost due to illness in the year preceding the fieldwork of the study were 19 and 20 days respectively in Birbhum and Dumka. As we have already mentioned, the majority of our respondents were daily wage earners, so the loss of working days meant losing the wage income (not only for the particular

patient but also for her family members). It also included loss of crop for some of the cultivators who could not take care of the farming owing to illness. The high extent of losing working time and money on numerous occasions caused other serious damages.

In some cases, like tubercular diseases, people had to abstain from work for more than a year. In such cases, as we were told, many families had been ruined for they had to suffer a double blow – losses in earning and expenditure on medical treatment.

Negative effect on children’s education: One major loss reported by the respondents was missing of school by the children following illness.¹³ Of the patients in Birbhum (447) 17 percent were enrolled in primary schools. In response to the question whether there was any effect in attending school for illness, 73 percent of the students admitted that they had to stop going to school for a certain period owing to various illnesses. Only 27 percent of them could attend school despite being ill. In Dumka, where primary school children formed 11 percent of all patients (468) the situation was even worse. Of them 78 percent remained absent from school during their illness. The table below provides the details.

Table 5.11 Effect of illness on children’s attendance in the schools

Absenteeism	Birbhum	Dumka
Yes	55 (73.3)	38 (77.6)
No	20 (26.7)	11 (22.4)
Total no. of students	75 (100)	49 (100)

Figures in parentheses indicate percentage

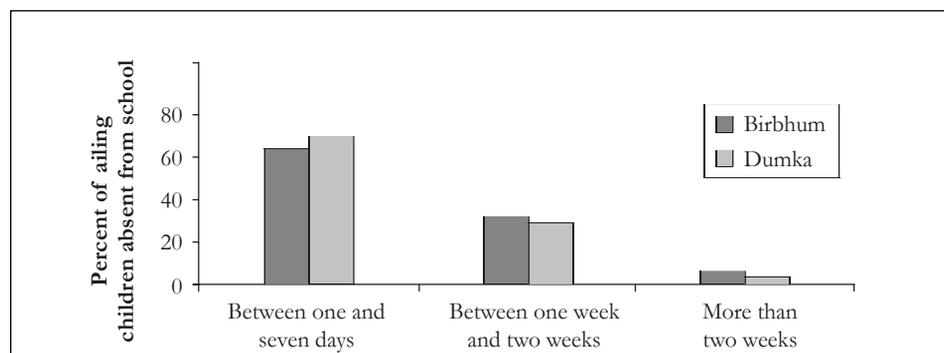
For 64 percent of such primary school children in Birbhum, the extent of absenteeism in school due to illness was between one to seven days in the month prior to our visit. For 31 percent of such students it was between one week and two weeks. The rest remained absent for even longer periods. The situation was more or less similar in Dumka. Sixty eight percent remained absent between one and seven days. For twenty nine percent it was between one and two weeks and for the rest it was more than two weeks. Chart 5.5 explains the situation.

Some of the parents reported that many students dropped out of school because of long periods of suffering, either of the children themselves or of their family members. A student of Class 4 of a village in Dumka had to start ploughing as his father suffered a long period of illness. There was no other capable member in the family to do the work and they had no money to hire a labourer. “*Ado okoi si ak’?* – who would plough the lands?” and “*ban’ casa lenkhan cet’ jomak’.* *O’are ma cet’ hon banuk’ ak’?* – what shall we eat if we don’t cultivate? We have nothing left at home to eat.”

Loss of family income and cost involved: Expenses incurred on health care and loss of income owing to illnesses, as we have pointed out earlier, have a dual effect upon the economic foundations of the households. Many a time people have to sell

their assets and have to take loans for both health care and survival (in absence of regular earnings). (We have discussed this in section 7 in more detail.)

Chart 5.5 Period of absence in the primary schools due to illnesses



Increased vulnerability to other diseases: Many of the complex ailments, as some medical practitioners told us, increase vulnerability to other diseases as well. Weakness caused from a particular disease like malaria might make the ground friendly for other diseases. In many cases, particularly among the wage earning families, people have to start working even without getting fully cured, which often makes them suffer from other illnesses later. Wrong and incomplete treatment also causes other ailments. For example, many of our respondents who suffered from malaria had been suffering chronically as the quacks and other practitioners did not give them the full course of medicines.

Also, because of lack of awareness and sometimes out of compulsion, people, particularly children, become sick after coming in close contact with a family member or others suffering from communicable diseases.

The various social implications of health ailments strongly suggest the urgent need for the effective functioning of a public health delivery system, comprising both preventive and curative aspects, as a safeguard for peoples' health, education and livelihood.

NOTES

- 1 Dreze and Sen (2002:200); Bourdier (2003: 205-6)
- 2 The NSS Fifty-second round in 1995-96 shows that in rural areas of India, lack of money was a reason for not taking treatment in 24 percent cases. See NSSO (1998: 21)
- 3 Paul Singh (2002:47), Also see Chaudhury and Choudhury(1985:39)
- 4 The word was commonly used as 'quacksalver' in English upto the 17th century, in later times abbreviated to 'quack'. References to quacks or quacksalvers are widespread in the literature of the age (e.g. Ben Jonson [1605], "They are quacksalvers/ Fellows that live by venting oils and drugs". *Volpone* II ii.)
- 5 "*Desh bhar me panaphte jholachhap doktor*" Zee News, August 24, 2003, 21.30 PM.
- 6 See Prasad, Kumar and Kumar (2003), SHAPE (2003)
- 7 NFHS-II has similar observations in West Bengal; 60 percent of the households used the private medical sector, 24 percent used the public health services. See IIPS (2001)
- 8 NFHS-II has similar observations in Jharkhand; 70 percent of the households used the private medical sector, 19 percent used the public health services. See IIPS (2002)
- 9 Chattopadhaya (1977:188-9)
- 10 See Bhattacharya (1987:6)
- 11 For details see Anita et al (2000) and literatures cited there.
- 12 Phadke (1998) and CMIE (1999) cited in Anita et al (2000: 23)
- 13 Also see Rana et al (2002) and Rana et al (forthcoming)

MOTHER AND CHILD

REPRODUCTIVE AND CHILD HEALTH SERVICES

The Ministry of Health and Family Welfare introduced the Reproductive and Child Health programme (RCH) in 1995 as part of the paradigm shift¹ in its ongoing family welfare programme. The major impetus for this shift can be traced to the changes in the international discourse around population policy that followed the International Conference on Population and Development (ICPD) in Cairo in 1994. India was one of the 179 countries that ratified the resolution of the ICPD.

In 1996, safe motherhood and child health services were incorporated into the reproductive and child health programme. This new programme sought to integrate maternal health, child health and fertility regulation interventions with reproductive health programmes for both women and men. With regard to maternal and reproductive health the important areas of the programme include:²

- Provision of antenatal care, including at least three antenatal care visits, iron prophylaxis for pregnant and lactating women, two doses of tetanus toxoid vaccine, detection and treatment of anemia in mothers and management and referral of high-risk pregnancies.
- Encouragement of institutional deliveries or home deliveries assisted by trained health personnel.
- Provision of postnatal care, including at least three postnatal visits.
- Identification and management of reproductive tract and sexually transmitted infections.

In rural areas, the government is supposed to provide reproductive and other health services through its network of Primary Health Centres (PHC), sub-centres and other health facilities. In addition, pregnant women and children can obtain services from private agencies on a payment basis.

In rural areas, a female paramedical worker, (Auxiliary Nurse Midwife - ANM or Female Health Assistant) is supposed to be posted at each sub-centre to provide basic maternal health, child health and family welfare services to women either in their homes or in the health clinic.

In spite of numerous attempts by the Government of India and other agencies to improve maternal and child health, the overall achievements are still far from encouraging. Many different variations – regional and socio-economic – are found in the achievement of goals. Kerala, contrasting sharply with Bihar and Uttar Pradesh, has shown remarkable achievements in the field of reproductive and child health – comparable to the developed countries.³ Again, people belonging to the upper socio-economic strata were found to exist in a much better condition (not only in terms of maternal and child health but also in terms of general health status) than the rest of the population.⁴

Our study chiefly aims to examine the delivery of basic health services – both general and reproductive – in order to find the linkages between service delivery and its impact. In this section we shall discuss the reproductive and child health services made available to people in the study areas.

Studies like the NSS and NFHS II, whilst finding some improvements, have detected many weaknesses and suggested larger areas for further improvement to achieve the optimum level of reproductive and child health. In agreement with the broader studies, our inquiry points out some micro level details of the problems concerning the services of reproductive and child health.

Our study shows that despite many different claims regarding the achievements in reproductive and child health, there is a long way to go to make these services available for all, particularly in the rural areas. The study did not have much scope for examining the different aspects of reproductive and child health. We emphasised the delivery of health services and shall accordingly discuss some of the issues pertaining to reproductive and child health.

CHILDBIRTH

An important component of the reproductive and child health programme is to encourage safe delivery under trained supervision, and under hygienic conditions. Our findings in this regard are worrying.

Fifty-three percent of the deliveries of the youngest living children of mothers in Birbhum took place at home; in the case of Dumka this was 94 percent. In both the districts a large number of respondents (70 percent in the case of Birbhum and 53 percent in the case of Dumka) felt that it was not necessary to take pregnant women to hospitals, as, traditionally, childbirth takes place at home. As we shall see in section 8, the poor functioning of the sub centres, PHCs and hospitals, the low levels of awareness and poor service delivery of other programmes like antenatal care and immunization, are rampant.

In addition, the poor infrastructural facilities available in the public health centres, their distance to the villages and the costs involved in child deliveries outside the home confined people to their traditional sphere. For example, in Dumka the facilities for childbirth were available only in hospitals. The PHCs did not have this facility. Thus we

found only five mothers who gave birth in hospitals, of whom four gave birth in private hospitals and only one in a public hospital. Many of the respondents of Dumka said that giving birth in a hospital was very expensive and thus not widespread.

The distance from place of residence to the hospital played a major role in determining the place of birth. Only 21 of the PHCs⁵ of Birbhum (out of 77 – including BPHCs) have childbirth facilities. Of a total of 27 mothers who gave birth to children in hospitals in Birbhum, 52 percent went to public hospitals, 37 percent to nursing homes and only 11 percent delivered their children in the PHCs. Such a situation has created the demand among a majority of respondents in both the districts for childbirth facilities at the PHC level in order to facilitate the ability of mothers to avail of services at an accessible location.

However, we find a sharp contrast between Birbhum and Dumka with regard to institutional deliveries. Despite many difficulties, the relatively superior operational status of the public health system in Birbhum could attract a larger number of mothers to institutions for their deliveries.

The lack of transport facilities was reported to be a major problem hindering childbirth at hospitals. This was particularly serious in the villages of Dumka, though many residents of Birbhum villages were also found to suffer from this problem.

Family members of a pregnant woman of Boro Sangra village were initially reluctant to take her to the hospital, given the problem of transportation. Finally she was taken to Purnadarpur hospital by trolley (a three wheeled manual-powered carriage, the only means of transportation in many villages) following persistent labour pain for many hours. The child was born on the trolley, but the mother's condition worsened. After admission to the hospital, it took her about two weeks to recover. In the meanwhile her family had to spend a huge sum of money for related expenses – Rs. 5,000 – which they borrowed.

Assistance in child birth: A woman reported in a frustrated voice “*amader Dai bhalo, garib manusber haspatale bharti ho maron, Bed, osud sab kena, tar upar dakatar-nurseder kato katha* - We poor people are better off with the village *Dai*. Going to hospital is very expensive and cumbersome, we have to pay for the bed and medicines. In addition, the doctors and nurses treat [us] in a harsh manner”.

Ninety-four percent of the deliveries in Dumka reportedly took place at home. A large proportion of the mothers were assisted by village *dais* during childbirth. Only in one percent of the cases was childbirth assisted by a government doctor. (*See Appendix table C.4 for details.*) While 53 percent of the births in Birbhum were assisted by *dais*, 28 percent of cases were found to have been assisted by trained health staff (ANM, nurses, etc.). The figure for doctors assisting mothers in childbirth was poor (*only 14 percent*), but better than that of Dumka.

Complications in delivery: Reports of complications during childbirth were 23 percent and 28 percent in Birbhum and Dumka respectively. However, since most rural women interviewed took the complications for granted we anticipate a gross

understatement in the reportage of complications during childbirth. In fact cases of septicaemia, incessant bleeding, etc. were considered quite normal. The types of complications that (mainly literate) mothers reported were:

- Prolonged labour
- Delayed expulsion of placenta
- Excessive bleeding
- Infections
- Weakness

Complaints were made in some cases that the hospital staff did not pay adequate attention to their complications. A heart-rending story was narrated by a grief-stricken mother of Birbhum who lost her son of 18 days due to the negligence of the hospital staff. It was a complicated case. The mother was unconscious after the delivery at the hospital. The nurse did not tie the umbilical cord properly and the subsequent incessant bleeding combined with the carelessness of the hospital staff took the life of the child. The mother believed that because of their poor economic background, the hospital staff did not bother to look after the child. They did not even feel sorry for the tragedy.

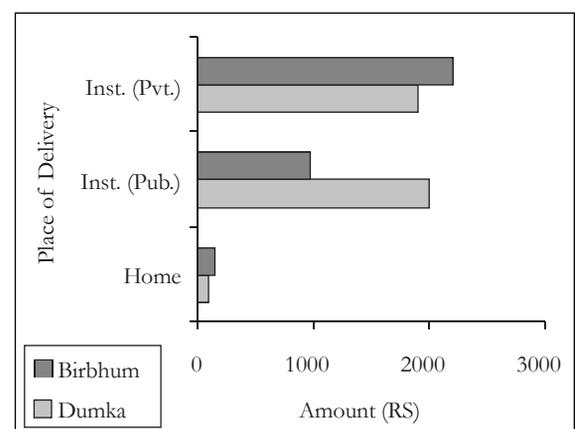
Cost involvement in childbirth: A majority of our respondents (especially elderly people at Birbhum) remembered that earlier the PHCs had been equipped with some indoor facilities and the rural poor used to get treatment free of cost. Mothers admitted to the PHCs or hospitals for childbirth, they remembered, used to get nutritious food. But nowadays, many respondents said, childbirth has become an expensive affair.

The anticipation of high expenditures to be incurred at hospitals was an obvious reason for not using hospital services for childbirth. While the average cost per childbirth was found to be Rs. 372 in Birbhum and Rs 250 in Dumka, the cost involved in conducting home deliveries was much lower. In Birbhum expenses on home deliveries was found to be Rs 150 and in Dumka it averaged Rs 99 per case.

In the case of deliveries conducted at public and private hospitals, the differentials in the expenditures incurred were much higher. In Birbhum, the average expenditure on childbirth in public hospitals was Rs 969 and in Dumka it was much higher – Rs 1,900. In the case of private hospitals or nursing homes the figures for Birbhum and Dumka were Rs 2,200 and Rs 1,875 respectively.

The cost differentials during childbirth point to the existing social differences in terms of affordability, awareness and functioning of the public health system. While the other caste or higher caste people of Birbhum incurred more expenditure on childbirth (Rs 694 an average) people of the SC and ST communities spent much less (Rs 255 and Rs 233 respectively) on childbirth-related expenses. Similarly, while expenditure incurred on childbirth by other castes in Dumka was Rs 638, the figures for the SCs and STs were Rs. 259 and Rs 191, respectively. Also noteworthy is that a

Chart 6.1 Expenditure on Childbirth



large part of the expenditure on childbirth was incurred on payments made to birth assistants. Actual expenditure on nutrition, medicine, etc. was found to be negligible.

Many families, in both districts, who earn their livelihood from daily wage labour, complained that they had become indebted to meet expenditures on childbirth, particularly in cases where pregnant women had to be shifted to hospitals. The patients felt themselves to be completely at the mercy of doctors and even in the case of normal deliveries, doctors were seen to prescribe a long list of medicines, many of which medical experts themselves termed classic examples of drug abuse. Attendants and other staff reportedly extorted money from the relatives of women admitted to hospital.

Chandana, a woman from Birbhum district, was taken to hospital for childbirth. The family had neither enough money with them nor the time required to get the BPL (Below Poverty Line)⁶ certificate from the Panchayat to avail of free healthcare. The attending doctor gave a long list of medicines to the family members to procure immediately from the market. Since they did not have any savings they mortgaged some utensils and ornaments and borrowed money at a high rate of interest – ten percent per month or 120 per cent per annum!

PREGNANCY RELATED CARE

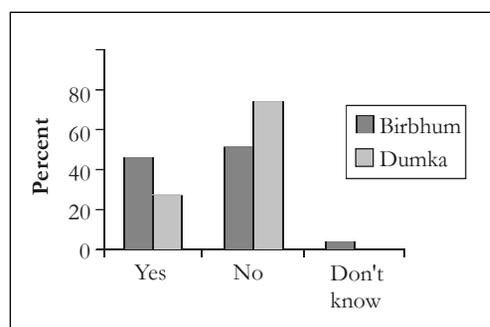
Institutional deliveries are directly linked to regular antenatal care as health workers in rural areas are supposed to motivate women to undertake institutional deliveries.

Antenatal care refers to pregnancy related health care provided by a doctor or a health worker in a medical institution or at home. The reproductive and child health programme prescribes that women must receive two doses of tetanus toxoid vaccine, adequate amounts of iron and folic acid tablets and at least three antenatal check ups that include blood pressure checks and other procedures to detect pregnancy-related complications.⁷

The reference period for this data was the two years preceding our study visits. As regards preventive services, pregnant women in Birbhum have reportedly received more benefits than have their Dumka counterparts. While in Birbhum 46 percent of the women (26 out of 57) reportedly received iron and folic acid tablets, the figure for Dumka was only 27 percent (22 out of 82).

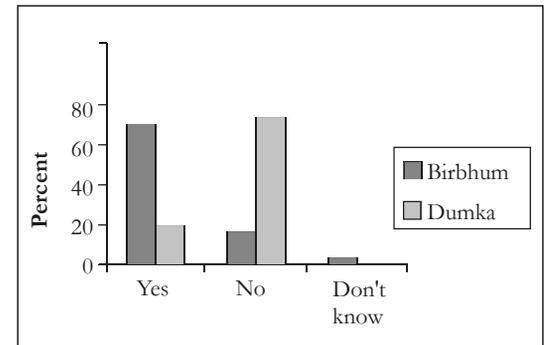
In response to a question as to whether pregnant women received adequate quantities of iron and folic acid tablets, 77 percent (of those who received these tablets) in Birbhum replied in the affirmative while the figure for Dumka was much lower – only 36 percent. Some respondents in Dumka reported having purchased iron and folic acid tablets from the market. Interestingly, a doctor in a PHC said that they possessed adequate stocks of such medicines but these could not be made available to the women due to shortage of staff! He also bemoaned that rural women were reluctant to consume iron and folic acid tablets.

Chart 6.2
How many got iron & folic acid tablets



Almost 70 percent (40 out of 57) of the eligible women in Birbhum said that they had received at least one tetanus toxoid injection during pregnancy but in the case of Dumka the figure was extremely low – only 26 percent (21 out of 82). Some of the mothers in Dumka told us that they had had to pay a sum of Rs 30 to be administered tetanus toxoid injections from private clinics. As regards the number of tetanus toxoid injections, only 45 percent of the total number of respondents (40) in Birbhum who had received a dose of the TT injection during pregnancy reported having received all the required doses. In Dumka the figure was even less – only 33 percent of a total of 21 mothers.

We came across a number of cases of young mothers in Dumka who had never visited a doctor during the entire period of their pregnancy. Antenatal pregnancy check ups had a correlation with the literacy level among women, while a related consideration was the reported high financial outlay required for doctor visits. Many female respondents earned their living and simultaneously managed their household chores. Going to see a doctor meant losing a day's work, which seemed almost unaffordable. However in Birbhum most women, particularly from the other castes, reportedly visited doctors – mainly private ones – at least once during pregnancy. An elderly woman in Birbhum commented deprecatingly, “*Ekhon du masher poati baleo daktarer kachhe chhutchhe, amader samoi osab chilo na.* (Nowadays even two months' pregnant women are rushing to doctors but in our time we never did such things.)” However, the cases of the tribal women and many women of the scheduled castes in Birbhum were not found to be very different from the situation obtaining in Dumka.

Chart 6.3**How many got tetanus injections**

POST-NATAL CARE

The health of a mother and her newborn child depends not only on the health care she receives during pregnancy and childbirth but also on the health care she and her baby receive during the first few weeks after delivery. Postpartum check ups within two months after delivery are particularly important for non-institutional births.

Recognising the importance of postpartum check ups the Reproductive and Child Health Programme strongly recommends three postpartum visits.⁸

The Rapid Household Survey, for both West Bengal and Jharkhand, found that very few women actually receive postnatal check-ups (32 percent for West Bengal and 14 percent for Jharkhand).⁹ Our findings also do not show a better picture.

Assistance by health professionals is an inseparable part of the postnatal check up. This requires thorough and regular contact between the women and the health workers.

Although the postpartum check-up is a priority item in the job list of ANMs in both districts, in reality a negligible number of women reported having been visited by the ANMs after childbirth, let alone getting any assistance. A few of the committed

ANMs in Birbhum district reportedly conducted the postpartum check-ups, essentially at the time of infant vaccinations but these came across as stray incidents. It was reported that child vaccinations (only in Birbhum, not in Dumka) received some importance, but postnatal check ups and assistance remained neglected. Three ANMs in different villages of Birbhum complained that too much work pressure hardly allowed them to visit their entire area regularly.

STILL BIRTH AND ABORTION

The numbers of stillbirths (based on lifetime data) was found to be low (of the total of 231 mothers in Birbhum, only five percent and only six percent of 183 mothers in Dumka reported to have had stillbirths in their lifetime). Ten mothers in Birbhum reported 11 stillbirths. The figure for Dumka was exactly the same. (See Appendix table C.9 for details).

The cases of abortions were found to be relatively higher in Dumka, where 42 cases of abortion were reported by 27 mothers. A total of 21 abortion cases were found among 18 mothers in Birbhum.

Of the total cases of abortion in Birbhum 19 (90 percent) were reportedly spontaneous and two (10 percent) were induced. In Dumka the number of abortion cases was quite high (42). Thirty one (74 percent) of them were spontaneous and 11 (26 percent) were induced.

All the induced abortions were reportedly done in private institutions (in both the districts). Both the cases of induced abortions in Birbhum were reportedly done at the private clinic of qualified doctors. On the other hand, only two out of the 11 women in Dumka reported to have undergone abortions at private doctors' clinics. While none of them visited government institutions, nine of them had help from

CHURKI'S STORY

Churki, a Santal woman in Dumka went to the government hospital for an abortion during her third pregnancy. The gynaecologist at the hospital, who has a nursing home of her own, advised her to see her at her private clinic-cum-nursing home without doing even a routine check-up.

Following the advice of the doctor, she was admitted to the nursing home and the abortion was subsequently done there. The doctor charged Churki Rs 1,500 and collected the money in advance. After the termination of pregnancy, Churki's condition deteriorated. The doctor asked for more money for medicines and said that one more small operation had to be performed. Another Rs 1,500 was paid to her. Churki's husband had to sell his pair of bullocks to meet the expenditure.

The condition of the patient deteriorated further. Finally after four days had elapsed, the doctor asked that the patient be shifted to the Sadar Hospital – where she collapsed and died.

Churki's unfortunate husband could not even ask the doctor as to why the patient had not been treated at the Sadar hospital where she had been brought in the first place and why she was shifted to the hospital from the nursing home just on the verge of death. Was it not to extort money in the first instance and to avoid responsibility for death in the second?

local *dais* or other village women for the abortion. Unscientific methods of abortion are likely to lead to complications, yet women preferred these methods since they are easy to access and also less expensive. In addition, their experience of government hospitals has created a sense of abhorrence in them. Experiences at private doctors' clinics did not seem much better.

Table 6.1 Cases of Abortion

	Number of Respondents having abortion	Number of abortions	Spontaneous	Induced
Birbhum	18	21	19	2
Dumka	27	42	31	11

INFANT AND CHILD MORTALITY

Infant and child mortality rates are important indices for measuring the quality of life and for monitoring population and health programmes.¹⁰

In spite of a series of initiatives,¹¹ the infant and child mortality rates of West Bengal are still very high - 49 and 68 (per thousand) respectively. In Jharkhand the respective figures were 54 and 78 (per thousand) respectively.

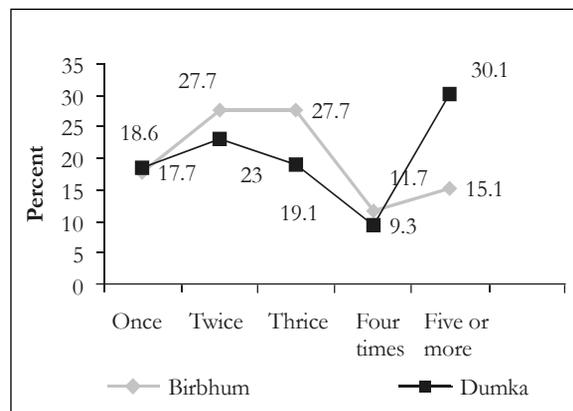
In our study as well, the reported rates of both infant and child mortality were found to be high. In Birbhum the infant mortality rate (0-12 months) was 68 per thousand (43 of 635) and the child mortality rate (1-5 years) was found to be 70 per thousand (45 of 635).

These figures were much higher in Dumka – infant mortality rate was 79 per thousand (43 of 535) and the child mortality rate was 74 per thousand (40 of 535).¹² Despite some anticipated inaccuracies in data (both because of sampling and non-sampling errors) the high figures for child and infant mortality are definitely worrying.

There are multiple reasons for the high rates of infant and child mortality, foremost among which are:

- (1) Absence of basic health services, like antenatal and post-natal care;
- (2) Poverty and hunger and subsequent malnutrition;
- (3) Pervasive illiteracy, particularly among mothers and subsequent inability to gather knowledge of proper health care;
- (4) Social practices (such as marrying at very young age) which are also connected with illiteracy, poverty and other socio-economic power relations.

The probability of dying in early childhood was higher in some population groups than in others. Our study revealed that infant and child mortality was more prevalent among young mothers (in many cases mothers were as young as 15 or 16 years of age), particularly those from a lower economic background, who are trapped in the nexus of lack of food, education, awareness and health care.

Chart 6.4**Frequencies of pregnancies***(of ever married women in 14-49 age group)*

Family planning has got the largest attention among all the different health services and programmes. The preoccupation with family planning arises partly from the widespread recognition of a real need for reproductive health services and partly due to an obsessive fear of the ‘population bomb’ among political leaders, policy makers and health administrators.¹³ A lot of time, money and energy have been spent on family planning at the cost of many other vital health care programmes, particularly curative ones.

The promotion of female literacy has a direct effect on reducing fertility as well as family size, as is evident from data collected in both Birbhum and Dumka. The level of literacy among the women (in our surveyed households) of Birbhum was relatively higher (33 percent) than in Dumka (15 percent). In Birbhum the average family size was 4.92, whereas in Dumka it was higher at 5.16.¹⁴ As regards the numbers of pregnancies and childbirths, the trend of having fewer children in Birbhum vis-a-vis Dumka can clearly be seen from the above graphic (Chart 6.4). While in Birbhum only 15 percent of the ever-married women (14-49 years of age) had more than five pregnancies, in Dumka the figure was just double (i.e. 30 percent).

These findings are in complete consonance with the general response of people in the rural areas of Birbhum and Dumka. In Birbhum most of the mothers, particularly the younger ones from higher economic strata, said that they did not want more than two children. However, for the poor (and in most cases illiterate) households, family planning did not seem to have much meaning. Rather, some of the mothers reported that more children were advantageous for them as a larger number of children meant more earning hands. A Santal man said that he was afraid for children’s survival (as his lived experience was of high mortality rates) and so he did not use any family planning measures. His 32 year-old wife had become pregnant six times and had delivered five live children (one had been a spontaneous abortion).

The role of literacy in reducing family size is also indicated by the fact that many literate mothers in Birbhum district said that they read posters, wall paintings, etc. that helped them to learn about the importance of family planning. For the higher income group, radio, television, newspapers and other printed materials play a major role in disseminating information.

Above all, the delivery of basic health services plays a decisive role in this regard. As we shall see in section 8, household visits by health workers and service delivery (preventive, curative and educative) were abysmally poor in both districts. The situation becomes much more miserable in the case of socially and economically underprivileged households (this was more the case in Dumka). In general, health workers were found to visit the relatively rich upper caste households more than the poorer lower caste ones. Many of the SC, ST and Muslim households complained that the health workers never visited their households: “*amader barir chhaya o maraina* (They do

not even step on the shadows cast by our homes).”

The lack of antenatal and postnatal care and its subsequent negative implications (high infant and child mortality, in particular) plays a definitive negative role in the slow spread of family planning programmes.

One of the main jobs of the ANM is paying door-to-door visits in order to create awareness among couples, to distribute contraceptive pills and to counsel different family planning measures. But in both of our study areas it was reported that ANM visits were largely restricted to those houses that had pregnant women, children eligible for vaccination and ligation cases.

Only 26 percent of respondents in Birbhum reported that family planning workers had visited their houses in the 12 months preceding the survey. In the case of Dumka the figure was a low ten percent. The respondents who said that ANMs had visited them added that their visits were irregular (more on this in section 8). Only 16 percent reported counselling on family planning in Birbhum while in Dumka it was lower still – only nine percent.

The ANMs also had their own story to tell. According to them, the Government had stopped supplying contraceptive pills. Only 19 percent of married women (14-49 years) in Birbhum reportedly received pills and the figure was much poorer in the case of Dumka – only four percent.

Some of the ANMs in Birbhum said that they used to organise ligation camps, but for the last one year the Government had stopped sanctioning incentive monies (Rs 240 per woman) for ligation cases. As a result of this a misunderstanding has developed between the women and the ANMs. The women thought that the ANMs were misappropriating the money while the fact was otherwise.

Women in some villages of Birbhum complained strongly that they had not been supplied with any materials while undergoing the ligation. Reportedly, they had had to even buy the threads and blades used for the operation. In addition, the doctors insisted that they undergo a blood test, which cost them Rs 120.

Chart 6.5

Distribution of women by the number of childbirth
(of ever married women in 14-49 age group)

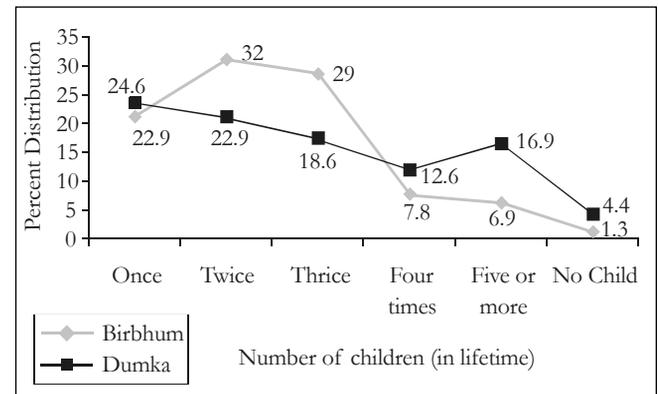


Table 6.2. Family planning services delivered

Services availed	Birbhum		Dumka	
	Number	Percent	Number	Percent
Households visited by family planning worker	60 (235)	25.5	19 (183)	10.4
Counselling on family planning	13 (80)	16.3	5 (56)	8.9
Distribution of contraceptive pills (Mala D)	15 (80)	18.8	2 (56)	3.6

Figures in parentheses indicate total number of respondents

Family planning programmes, it is argued, have become fully women-centric. This places the responsibility and risk of contraception solely upon women.¹⁵ In our study too we found that the programmes carried out by ANMs were either to promote ligation or women's contraception. Cases of distribution of condoms, performing male sterilisations and promotion of other methods of male contraception were reported to be nearly absent.

PROBLEMS OF WOMEN'S HEALTH

In accordance with the principles of the International Conference on Population and Development (ICPD) the Indian Government accepted (in the late 1990s) the need to focus on improving the quality of women's lives by promoting gender equality and reproductive choice. The Reproductive and Child Health programme included elements of maternal health, treatment of reproductive tract infections and the prevention of HIV and AIDS.

A large number of poor women in rural areas suffer from gynaecological disorders, especially reproductive tract infections. In West Bengal, according to the NFHS II, 42 percent of the women surveyed suffered either from vaginal discharges or from problems related to the urinary tract. The figure for Jharkhand was 45 percent.¹⁶

Respondents (females of 14-49 years) in both districts reported gynaecological problems like vaginal discharge, vaginal pain, etc. A total of 24 (21 percent) women in Birbhum reportedly suffered from gynaecological problems. (As mentioned earlier, underreporting cannot be ruled out). Of these 20 (83 percent) were said to have seen doctors and four (17 percent) did not receive any advice or medical treatment. Among the 20 patients visiting any doctor, only five (25 percent) admitted to having visited the public health institutions and the rest were treated at different private sources, mainly by UMPs.

URMILA'S STORY

Urmila Mete (name changed), a widowed woman of a Birbhum village is the head of her household. She earns her living from daily wage work. Afflicted with a severe gynaecological problem, Urmila did not receive any treatment despite paying repeated visits to a BPHC. She had to undergo a surgical operation, which cost her Rs 8,000. To finance this she had to take a loan at an interest rate of 10 percent per month. She sold all her livestock (a major source of income) and she also had to liquidate a part of the money she got under the Indira Awas Yojna for constructing a house. The house remained incomplete. To add insult to her injuries, she received a notice from the BDO's office to complete the construction immediately to avoid legal complications!

Only eight (eight percent) of the women in Dumka reported having suffered from gynaecological problems and all of them took advice from UMPs. Although our research team was assisted by some Santal women research assistants, the problem of underreporting persisted, particularly with regard to gynaecological ailments. This was largely because gynaecological problems were perceived as "natural and congenital" and not as ailments.¹⁷

There was also the problem of shyness and inhibition. Many women, particularly in Birbhum but also in Dumka, whispered about different family health prob-

lems, but while replying to particular questions they kept silent. Open discussions about female health problems are a social taboo.

The gynaecological problems of women in Birbhum remained unattended to by health workers mainly because of financial constraints and the natural reluctance of traditional women to visit male doctors at the hospital or in their private chambers.

Most of the women respondents in Birbhum said that none of the female health workers ever talked about gynaecological problems. The health workers reportedly concentrated only on pregnant mothers and never paid any attention to other problems. It was surprising that a health worker herself in Dumka district said that gynaecological problems “are part of a women’s life” which have been “given by God” (“*Bhagwanka den hai*”). A complex mixture of social taboos and inhibitions concerning women’s health problems and the poor functioning of the educative and curative health services has made this problem especially acute.

The dominance of male doctors in the Primary Health Centres, as mentioned above, was another constraint to greater reproductive health for women. Social norms hinder women’s ability to talk to or be examined by male doctors. At the same time female health workers were not found to be trained to deal with the broader range of reproductive health disorders.

A story was recounted by a research assistant of Dumka district. She had a gynaecological problem and visited the Sadar hospital at Dumka. She had to visit the hospital for three consecutive days, as the “lady doctor” was not available – for unknown reasons. On the third day she became agitated and voiced her complaint. A male physician finally examined her, recommended a number of diagnostic tests and prescribed a long list of medicines to be bought from the market. After estimating the costs of the diagnostic tests and medicines (approximately Rs 1,200), she gave up since she did not have that much money. One of her colleagues knew a private gynaecologist in a district town of Jharkhand who had the reputation of being patient-friendly (unlike many other private doctors) and took her to the gynaecologist. The total cost of check up and medical treatment the patient had to incur was Rs 250, and the advice she got from the doctor has reportedly enriched her to a great extent.

Cost involvement on women’s diseases: The variation in the cost of gynaecological treatment in the two districts points to the varied perceptions concerning diseases and also towards the variations in the delivery of health services.

The average expenditure on the treatment of women’s diseases in Birbhum was Rs 1,072, whereas it was only Rs 274 in Dumka. While the cost of treatment of gynaecological diseases in Birbhum was roughly 38 percent of the average cost of treatment of all ailments (Rs 2,764), in Dumka it constituted only 15 percent of the average cost of treatment of all ailments.

Our findings indicate the following:

- The level of awareness (among women and men) concerning women’s diseases was lower in Dumka than in Birbhum
- This is reflected not only in the poor reporting of ailments but also in the

types of medical treatment accessed. Most of the women in Dumka were treated by relatively cheap sources (UMPs or kabirajs), while in Birbhum the general tendency was to see the more expensive private doctors.

■ The above also reflects the poor delivery of public health services in both the districts, but more acutely so in Dumka.

The poor delivery of health services is also evident from the data collected on awareness of HIV and AIDS. Few of our respondents had ever heard of AIDS – only 24 percent in Birbhum and 20 percent in Dumka had done so. These respondents were confined to the groups of relatively better-educated women and men who reportedly learnt about HIV and AIDS from sources other than health workers.

Instead of a holistic view of women's health status before a woman becomes pregnant, maternal health services in effect covered only pregnant women. Educational programmes to help women in deciding their reproductive role in a safe and meaningful manner were nearly absent in our study areas.

The interaction of class and gender inequality makes a young girl, particularly one from a poor and rural background, more likely to suffer from ill health, anaemia, malnutrition and illiteracy than a young boy. According to NFHS II, 61 percent and 73 percent of the women of West Bengal and Jharkhand respectively suffered from anaemia, which is the result of malnutrition¹⁸. Sex bias plays a negative role in this regard.¹⁹

AN ADIVASI FOOD CALENDAR

Months

Menu

November - February

Rice twice a day (not necessarily in adequate quantities - many commented that they had to ration the food in accordance with the family income) with a little *dal*, which is skipped when vegetables are cooked. Meat or fish is taken very occasionally (once or twice a month).

March - June

As above. Vegetables are a rarity. Some fruits collected from the forests or from homestead gardens are eaten.

July - October

Rice once a day (many families get rice only once in two or three days) with one vegetable. Buying dal becomes almost impossible as this is the hungriest of all seasons. Both money and food become distant memories. Wild roots and, very occasionally, boiled beans are used as the staple food. Going hungry for several days on end is quite common.

In standard health manuals the prescription of a balanced diet for women includes cereals, vegetables, animal proteins, nuts and so on. The majority of the women in our study area, particularly those belonging to some Adivasi communities, do not even get enough grain to keep the pot boiling, let alone the requirement of nutritious and protein-enriched food. This food calendar (*see left*), prepared from the responses of more than 100 women in Dumka and part of Birbhum district illustrates the extent of hunger. Such a situation demands not only the effective delivery of health services but also the equitable distribution of food.²⁰

CHILDREN'S HEALTH SERVICES

Role of the ICDS: Nutritional status is a major determinant of the health and well-being of children. Inadequate and imbalanced diets coupled with chronic illnesses are associated with the poor nutritional level of children. The NFHS II describes the state of children's health in West Bengal and Jharkhand, some figures from which are tabulated below.

Table 6.3 Nutrition of children under three years of age

	West Bengal (percent)	Jharkhand (percent)
Underweight (Weight to age)	54	59
Stunted (Height to age)	49	42
Wasted (Weight to height)	25	14

Source: NFHS II

To protect the health and nutrition of pregnant and lactating mothers and children between the age of 0-6 years, the Government of India implements nutritional supplementation through the Integrated Child Development Scheme.

The main objective of this programme is to promote the physical and mental development of the child. Major activities taken up include (1) health check up of pregnant mothers and children between the ages of 0-6 years; (2) provision of supplementary food, primarily to compensate for the lack of nutrition; (3) referral services; and (4) pre-primary education. This is done through a Centre known as the Anganwadi Kendra and managed by a worker and helper who are both female. The main activities of the Anganwadi centres in both the districts observed were the supply of a gruel or *'khiachr'*. None of the workers, as reported by many respondents, performed any health check-ups or carried out any programme of pre-primary education. Some of the Anganwadi workers maintained a register of pregnant mothers and newborn children. The same register was also reportedly used by the ANMs. A number of Anganwadi workers complained that they seldom found time to do health check-ups or other work related to children's health because of their workload, which included cooking and serving supplementary nutrition inputs, maintaining registers and helping in many different programmes like the immunisation programme.

Out of 12 villages in Birbhum, 11 had Anganwadi centres. None of them was functioning better than that described above.

Some respondents from Birbhum were not at all aware of the existence of the Anganwadi programme. Though some of the respondents were aware of the existence of such centres they did not think it worth their while to send their children to the centres. "*Eto tuku ata gola dai ote chheleder ki hobe?* [The centre] provides a small ball of dough to the children, what is that worth?"

The scenario in Dumka was even worse. Seven villages out of twelve had no Anganwadi centre. People were unaware of the functioning of the Anganwadis.

Here too, the workers complained about poor infrastructure, lack of equipment like weighing machines, the shortage of blackboards for teaching, the irregularity of food supplies and the heavy workload.

Most of the Anganwadi centres in both the districts were a part of the Reproductive and Child Health Programme only on paper. Very few of them had any significant role in this programme. Despite this, and, particularly in the tribal villages, the small quantity of gruel (*kbichri*) was also considered a very important addendum to the diet of the children and their parents. The food, however small in quantity, is very valuable since “it can stop children from wailing (out of hunger) for some time”.

An important input for children’s health could be the effective running of the mid-day-meal scheme in primary schools. The programme has the potential not only to improve children’s health, but also to ensure children’s enrolment and school attendance. As reported in Pratichi’s education reports,²¹ many children did not attend school simply because they had to forage and provide for their own food. In many cases, especially in Dumka district (and also in parts of Birbhum) acute hunger forced children to roam the fields and forests in search of roots or animals. As found in a study by Sen and Sengupta (1983) in two villages of Birbhum district, special programmes of supplementary food can have a positive impact on children’s health.²²

Immunisation: The Government has been implementing the universal immunisation programme for children against vaccine-preventable diseases; yet, it is far from reaching its goal. We have discussed this in detail in section 8. However, it worth mentioning here that a large section of children, particularly in Dumka, remained outside the realm of immunisation. Although immunisation coverage was much higher in Birbhum than in Dumka, only 45 percent of the children were found to be fully immunised. Not a single child was found fully immunised in Dumka.

Both mothers’ and children’s health, particularly in the rural areas, are very far from reaching the goals set nationally and internationally and the poor public provisioning of health delivery is an important reason for this state of affairs.

NOTES

1 Pachauri (1996) cited in Kumar Rachel (2002) notes that what is required in the National Family Welfare Programme is an ideological shift, which “in turn would necessitate a change in the existing culture”.

2 IIPS (2001:175)

3 Drèze and Sen (2002)

4 NSSO (1998), IIPS (2000)

5 Reported by CMOH-I Birbhum, (interviewed on 29 January 2003).

6 The BPL families are supposed to get free healthcare along with many other benefits. However, the selection of the BPL families, both in West Bengal and Jharkhand, has created a lot of resentment among ordinary villagers. Many villagers complained that their names were not included in the list of BPL families, whereas many undeserving families got the privilege. We have come across some very poor families whose yearly income, as reported by their fellow villagers, did not exceed Rs.10,000 but who were excluded from the BPL list. On the other hand we have found some families enlisted as BPL, even though they had more than 2-3 acres of double-cropped lands.

7 IIPS (2001:176)

8 MH&FW in IIPS (2001:192)

9 IIPS (1999)

10 MH&FW (1992) cited in IIPS (2001)

11 IIPS (2000, 2001, 2002)

12 However, we must mention here that aside from the general problems of reporting of age, etc. (that specific family health studies like NFHS II reported having faced), our study did not incorporate the age and period specific complex calculations. Calculation of infant and child mortality has been made on the basis of lifetime data of total number of pregnancies, abortions, still births and live birth. Nevertheless, care and precaution were taken while collecting data to maintain the accuracy of data pertaining to reproduction. Cross-checking was done at different points.

13 Drèze and Sen (2002:209)

14 Fertility rates of West Bengal and Jharkhand as found in NFHS II were 2.3 and 2.8 respectively. We, however, did not calculate the age specific fertility rates.

15 Kabeer (1995: 211)

16 IIPS (2001:196) and IIPS (2002:Fact Sheet)

17 Even in more specialised studies like the NFHS II and Rapid Household Survey, figures for prevalence of gynaecological problems for Jharkhand were lower than that for West Bengal. This has direct linkages with literacy and subsequent awareness and also the effective functioning of the public health delivery system, which, as we found, was relatively better in West Bengal than Jharkhand.

18 IIPS (2001:156) and IIPS (2002:Fact Sheet)

19 For an illuminating discussion on sex bias concerning children found in two villages in Birbhum see the study conducted by Sen and Sengupta (1983).

20 For this see Sen (2001).

21 Rana et al (2002), Rana et al (forthcoming)

22 Sen and Sengupta (1983)

Wealth as health

COST OF MEDICAL TREATMENT AND ITS IMPLICATIONS

The economic condition of the households surveyed in both the districts was poor and as we see in this section, the costs of treatment for various ailments makes the poverty even more acute and unbearable. The high cost of treatment in both districts has a far-reaching impact on the poorer households, as they are more susceptible to various ailments. In this section we shall discuss the impact of cost on health care and its implications for different households. We shall briefly review the general economic condition of the households in Part I before going into the details of the relationship between health care expenditure and household economics in Part II.

PART I

OCCUPATION-WISE DISTRIBUTION OF SAMPLE HOUSEHOLDS

The main occupation of the majority of sample households in both the districts was wage earning (both agricultural and non-agricultural) followed by cultivation. Out of a total number of 215 households in Birbhum, 40 percent were engaged as wage labourers and 35 percent as cultivators. The rest were engaged in a range of occupations like petty trading, service, business, artisanship, etc. In the case of Dumka, wage earners and cultivators formed 44 percent and 42 percent respectively of a total of 216 sampled households and the rest depended upon different livelihood options.

LAND-HOLDING PATTERN OF THE SAMPLED HOUSEHOLDS

The land holding pattern also indicates the poor economic base of the households. While 66 percent of the total households in Birbhum owned some cultivable land a considerably high 34 percent were landless. In the case of the Dumka the extent of landlessness was found to be lower than that of Birbhum – only eight percent of the sampled households were without any cultivable land. However, the high-

er extent of household land ownership, as discussed in detail in section 4, does not assure higher economic status, since agricultural production is sparse in Dumka – where the soil is generally unproductive and irrigation facilities are almost absent, outputs are irregular or inadequate vis-a-vis requirements. In addition, the land distribution pattern in Dumka is such that the majority of the land owning households (75 percent) belonged to the marginal farmer category. In Birbhum the picture was different – 52 percent of the farmers belonged to the category of marginal farmers. Again, the double cropping facility in parts of Birbhum and the better scope for other income opportunities placed Birbhum in a better position than Dumka as regards the economic status of households.

ANNUAL INCOME DISTRIBUTION OF THE SAMPLED HOUSEHOLDS

The average annual income in the sampled households in Birbhum was Rs. 26,268 while the figure for Dumka was a meagre Rs. 16,379. The income group wise clubbing of the sampled households shows further differentials between the two districts. While households below the Rs.16, 000 annual income group formed 39 percent of the total in Birbhum, it was as high as 68 percent in Dumka. (Households have been classified into six annual income categories. See Appendix table D.1 for details.) While eight percent of the households in Birbhum belonged to the above Rs. 60,000 annual income category, such households formed only two percent of the total households in Dumka.

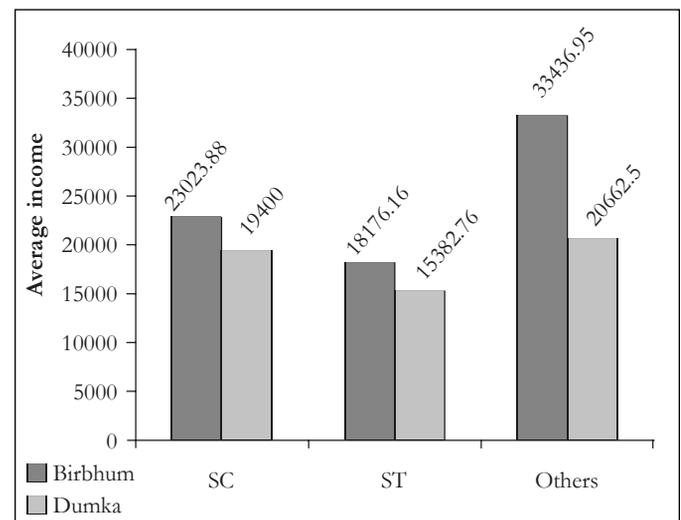
INCOME CLASS OF SOCIAL GROUPS

The annual income of the different caste groups also shows a great variation. While the Scheduled Tribes in both the districts were found at the bottom of the income levels the Other Castes category was at the top, leaving the Scheduled Castes in between the STs and others.

Of the total SC households of Birbhum, 32 percent belonged to the below Rs. 16,000 annual income category. For the STs and others, the respective figures were 56 percent and 37 percent. Only three percent of the SC households, two percent of the ST households and 16 percent of the other households belonged to the above Rs 60,000 annual income category.

For the SC, ST and other households, the figures for the lowest annual income group category (below Rs 16,000) in Dumka were 55 percent, 73 percent and 46 percent respectively. For the highest annual income group category (above Rs. 60, 000) only 5 percent of the SC households, one percent of the ST households and four percent of the other households in Dumka belonged to this group.

Chart 7.1 Average annual income of the household



The average annual income of the households of different social groups, as can be seen from the above graphic (for more details see Appendix table D.1), shows the relationship between economic class and social stratification, which have their reflections in the health sector.

EXPENDITURE PATTERN OF THE SAMPLED HOUSEHOLDS

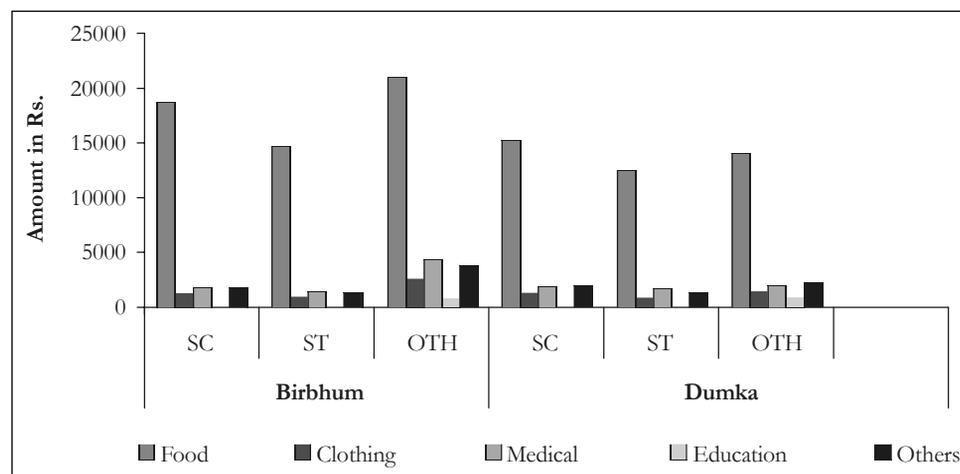
The differences in terms of annual income of the different social groups are also reflected in the annual expenditure patterns of the households. While the average annual expenditure pattern of the SC and ST households in both the districts shows a large share of spending on food (more than 80 percent of the total expenditure, with a slight variation in Dumka) the case of the other communities was found to be different. The other caste households not only had the opportunity to spend more on education, health and other expenditure heads but could also make some savings. As regards health expenditure as a percentage of total annual expenditure, figures for both the districts were a little above ten percent. The following table gives the details.

Table 7.1 Expenditure Pattern of the Sampled Households

	Birbhum				Dumka			
	SC	ST	Others	Total	SC	ST	Others	Total
Food	80.94	80.7	62.8	71.6	78.15	81.2	67.4	78.9
Clothing	5.64	5.21	7.52	6.55	6.91	5.53	6.8	5.9
Medical	7.45	8.19	13.2	10.5	10.05	10.79	9.66	10.54
Education	0.88	0.61	2.29	1.57	0.76	0.97	3.84	1.35
Others	7.69	7.4	11.4	9.57	9.89	8.28	10.45	8.78
Balance	(-) 2.6	(-) 2.11	(+) 2.79	(+) 0.2	(-) 5.76	(-) 6.77	(+) 1.79	(-) 5.4

As percentage of total income

Chart 7.2 Item-wise expenditure pattern of the households



The SC and ST households in both the districts, as can be seen from the above table, had a negative income-expenditure balance. Again, in the overall picture of Birbhum we have found a slight edge of income over expenditure, which was completely different in the case of Dumka. Since expenditure on food was reported on a daily consumption basis (and the fieldwork was done during the harvest season) some inaccuracy in the data used to arrive at an annual projection cannot be ruled out. However, other expenditure figures (clothing, medical, education) seem more accurate as such expenditures, generally incurred in cash, were in larger volumes and in most cases people could remember the figures. The negative balance of income and expenditure was adjusted for by the households in two ways: (1) Taking loans to meet expenditures and (2) Consuming less during the hungry seasons (July – October). Whatever be the case, daily life in the rural areas in both districts was harsh.

Chart 7.2 shows the average annual expenditure for different items by different income groups.

PART II

EXPENDITURE ON HEALTH CARE

There is a popular belief among the Santals, that people become impoverished after falling ill,¹ and the relationship between poverty and health ailments is well articulated in their folk-literature. We have seen in the earlier section that a large number of people in the rural areas suffered from many different ailments and the majority of them sought medical treatment from various sources. This involved a certain amount of monetary hardship besides losses in terms of time, productivity, etc. In this section we will focus on the economic aspects of ailments and their treatments.

The average cost of medical treatment per household in Birbhum was Rs. 2,764, which was more than ten percent of the average annual income of the sampled households. The average cost of medical treatment was found to be very high among the households of other caste communities, at Rs. 4,417 (13 percent of the average annual income). In case of households of the SC and ST communities of Birbhum, the average cost of medical treatment was Rs. 1,716 and Rs. 1,490 respectively, which was seven and eight percent of the average annual income of the respective caste groups.

The average cost of medical treatment per household in Dumka was Rs. 1,727 (more than ten percent of the average annual income). In this district, the average cost of medical treatment was higher among the other caste households, at Rs. 1,996 (around 10 percent of average annual income). However, the income figure for the SC households (Rs. 1,950 or 10 percent of average annual income) in this district was almost similar to that of the other caste households. The figure for the ST communities in this district was much lower – only Rs 1,660, but as a percentage of the average annual expenditure it was higher (11 percent) than the SC and other caste households. (See Appendix table D.3 for details.)

Income group-wise cost of medical treatment of the households: The cost of medical treatment by income group in the sampled households in the districts also shows variation. The poor of Birbhum district (incomes below Rs. 16,000 annually) spent much more on medical treatment than their Dumka counterparts.

The lowest income group households in Birbhum incurred an annual expenditure of Rs. 2,052 on medical treatment alone, which constituted 17.9 percent of their average annual income. The same figure was Rs. 1,356 in Dumka, which constituted 12.4 percent of the average annual income of these households. While the average expenditure on medical treatment was higher for the upper income groups (Rs. 5,561 in the case of Birbhum and Rs. 3,786 for Dumka), the percentage of such expenditure to total annual expenditure was found to be sharply different.

While the cost of medical treatment for the lowest income group in Birbhum formed a large share of their total annual income (17.9 percent), the figure was much lower – only 6.3 percent, for the uppermost income group. In the case of Dumka, the average cost of medical treatment for the uppermost income group was nearly 5 percent of annual income, which was much lower than the figure for the lowest income group (12.4 percent). It can be seen from the graph that the lowest income groups – the poorest of all – suffer the most from health ailments, being more susceptible to various diseases. The cost of treatment consumes a large share of their meagre annual income.

Cost of hospitalisation: Of the 447 persons in the sampled households in Birbhum and 468 persons in Dumka (who suffered from any ailment in the year preceding the canvassing of questionnaires) 88 percent in Birbhum and 92 percent in Dumka were found to have undergone medical treatment. Only a small number of hospitalisations were reported. Again, we found some variation amongst the two districts concerning hospitalisation of patients. While 3.8 percent (17 in number) of all

Chart 7.3 Annual health expenditure: by caste

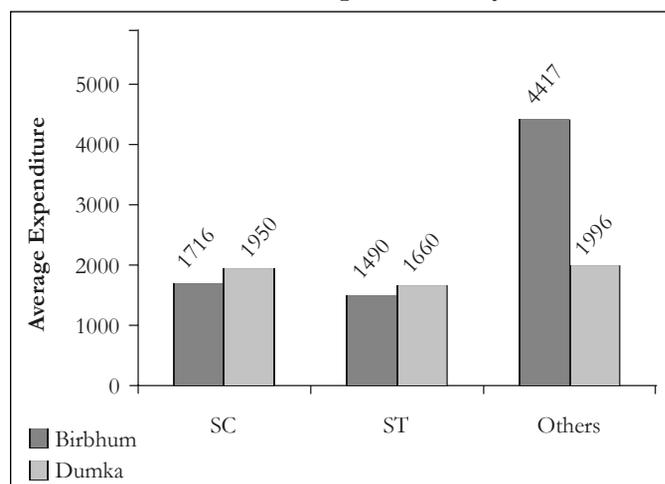
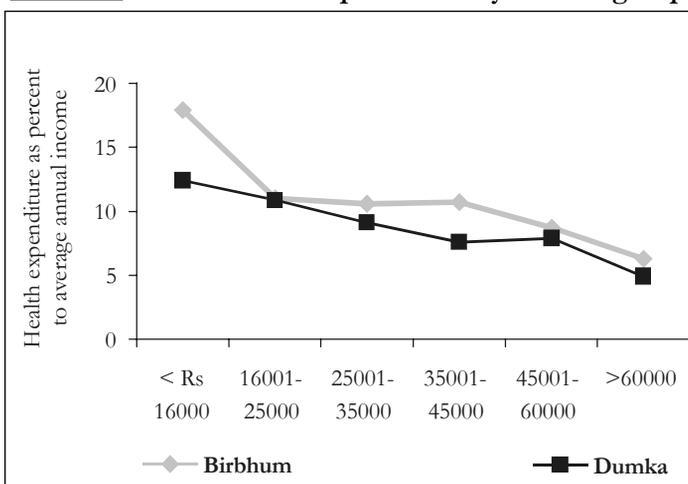


Chart 7.4 Annual health expenditure: by income group



patients in Birbhum were reportedly hospitalised, the figure for Dumka was only 1.5 percent (seven in number). In some of the cases, respondents mentioned that despite needing hospitalisation many could not avail of the same because of the anticipated costs involved, and the difficulties in accessing hospitals.

The average cost per hospitalisation in Birbhum district was Rs. 9,171, while it was Rs. 2,258 in Dumka. The cost of hospitalisation included rent for beds, travel expenses, medicines, charges for diagnostic tests and other medical expenses.

Of the total 17 hospitalisation cases in Birbhum, only one was admitted to a private nursing home, the cost of which was similar to that obtaining in the public hospitals. However, the patient was suffering from Hepatitis and needed only three days' hospitalisation. Of the 16 patients admitted to the public hospitals only two received free bed and medicines. The others had to pay for these.

Of the total seven cases of hospitalisation in Dumka five were reportedly admitted to a public hospital and the rest resorted to private treatment. While the average cost of hospitalisation in the public hospitals was Rs. 2,302 – ranging between Rs. 600 and Rs. 5,500, the average cost in private hospitals was Rs. 2,150 – in the range Rs. 2,000 - Rs. 2,300. As reported, none of the patients admitted to the public hospitals was given free beds or medicines. (*See Appendix tables D 10 and D 10.a for details.*)

Service-wise cost of treatment: Qualified private doctors were found to be the most expensive source of medical treatment in both the districts. Obviously, the socio-economic differences between the two districts have influenced the expenditure pattern on medical treatment. While the average cost of medical treatment by private qualified doctors per patient in Birbhum was Rs. 3,155, it was Rs. 1,490 in Dumka.

Public health facilities came as the second most expensive source of medical treatment in both districts. The average cost of treatment per patient (at public health facilities) in Birbhum was Rs 959, while the figure for Dumka was higher (Rs. 1,115). The high cost of public health care in both the districts indicates the gradual ebbing

BARIK AND AJIJUL

Barik Sheikh, 70, is a large farmer of a Birbhum village. He cultivates more than ten acres of double-cropped land, having assured irrigation from two submersible tube-wells. He uses these not only to irrigate his own land but also for hiring out and this assures him a substantial income, and relatively large savings. The finance accumulated came to his assistance when he suffered a heart attack. He spent Rs. 71,000 on treatment, yet he did not have to borrow or seek assistance from others. His land, submersible pump and other assets remained intact.

The case of Ajjul Sheikh of the same village is in diametrical contrast to the above. He is a 26-year-old construction worker and is the only earning member of his family. One of his legs was badly injured following an accident. Ajjul went to the subdivisional hospital at Sian, Bolpur, and despite spending a substantial amount of time and money at the government facility found no improvement in his condition. He was subsequently admitted to a private nursing home where his leg was amputated. He had to spend about Rs. 90,000 on his treatment. Since he had no savings or other assets he had to sell his house. Handicapped in both ways – physically and financially – he now lives a poor man's life at his in-laws' residence.

of a free public health delivery system. Of course there is much greater difference between the two districts in the degree of utilisation of public health services and their cost. The difference in cost between the public sources of treatment in the two districts, perhaps ‘justifies’ the high degree of reliance on private services in Dumka, as the costs of the public health sources was found to be much higher in Dumka. Conversely, the relatively large gap between public and private (qualified) sources of treatment ensured that public sources were the first choice for a relatively higher numbers of patients (29 percent) in Birbhum than in Dumka (12 percent).

In the case of unqualified medical practitioners (UMPs or quacks), there was a much larger difference between the two districts. While in Birbhum the average cost of medical treatment taken from an UMP was Rs. 480 per case, in Dumka it was Rs. 858. Perhaps the relatively better accessibility of the public health services in Birbhum was responsible for a lower percentage of patients visiting quacks (29 percent) than in Dumka (62 percent). Despite the high cost of medical treatment by UMPs, people continued to seek their services, as the poor condition of public health facilities and the poor socio-economic condition of the households combine to create dependence on the services of quacks. The poor service delivery of the public health centres made the UMPs a better choice than expensive private doctors. The modes of operation of these quacks (such as giving treatment on credit, ready availability and willingness to render service) were reportedly what attracted villagers in Dumka district to them.

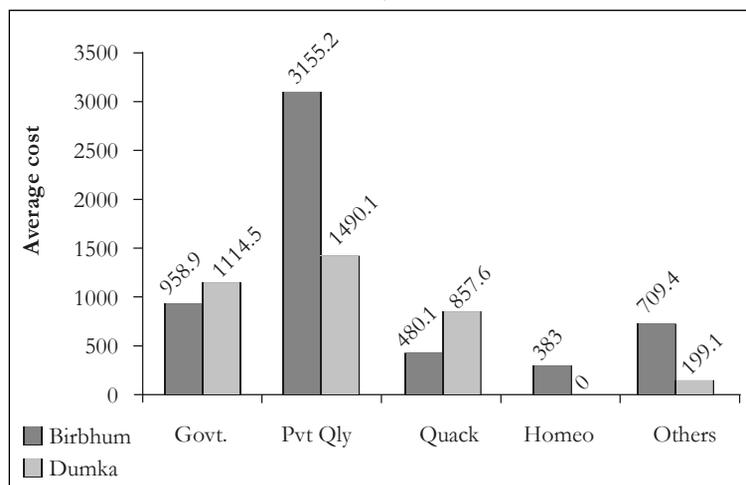
While we found about seven percent of the patients visiting homeopaths in Birbhum, in Dumka there was no case at all of patients visiting homeopaths for treatment. The average cost per case for homeopathic treatment was Rs. 383.

As for the other sources of treatment – mainly herbal medical practitioners (*kabirajs or vaid*s) and witch doctors (*ojhas, deyasis, jangurus*) the average cost involvement per case in Birbhum and Dumka was Rs. 709 and Rs. 199 respectively. However, very few people in Birbhum were observed seeing such practitioners. On the other hand, in

Dumka such practitioners were relied upon by 14 percent of the patients, which was higher than the number visiting public services. As we have discussed in section 5, such dependence was not a reflection of “superstitious belief”, or “abhorrence towards modern medicine”, but the compelling factor of inaccessibility and consequent inability of people to avail of modern health care.

Cost involvement, as the responses indicate, is a major factor in choosing particular health services – although not the only one. Many of the respondents in Birbhum attributed their choice of going to UMPs to their experience of the UMPs being less expensive than the PHCs or hospitals. Such experiences were much more

Chart 7.5 Cost of treatment: by service



common in Dumka. However, the cheaper or more readily available private sources were not considered sufficient for all the different ailments suffered by people who had to choose expensive sources for critical cases. In the following section we shall discuss the cost involvement of different ailments in a disaggregated form.

Ailment-wise cost of treatment: As mentioned in the previous section, the pattern of ailments in the two districts was different, yet there were some common diseases that people from the sampled households of both districts suffered. These were largely stomach ailments, diarrhoea, the cold-cough-fever syndrome, bone related diseases, gynaecological problems, skin diseases, TB, etc.

While for some of the ailments the average cost of medical treatment in both the districts was found to be similar, in other cases the degree of difference was quite notable. For example, in the case of cold-cough-fever, the average cost of treatment per patient in Birbhum and Dumka was Rs. 208 and Rs. 177 respectively, but the respective costs for the treatment of diarrhoea were Rs. 614 and Rs. 981. The main reasons for such similarities and differences are complex and sociologically embedded – the delivery of public health services, perceptions of people about different ailments and sources of treatments, the accessibility to various services, the socio-economic status of the households, etc.

Let us take the case of the average cost of treatment for cold-cough-fever. In both the districts, people considered the ailment to be of a non-serious nature and took the help of locally available UMPs. Interestingly, in case of this particular ailment the difference in the pattern of medical treatment between various sources (i.e. government public health centre, qualified private doctors and UMPs) was less significant. A similar use of medicines was found on examination of the prescriptions (and medicine foils and cartons used) by all three service providers. Perhaps, the common degree of effectiveness of all the three major sources of medical attention made people depend more on the relatively cheaper and more easily available source of medical treatment – the UMPs. Use of UMP services for this particular ailment was further justified by the saving of time that would accrue through patronage of the UMPs as against visits to public and private sources. Hence, the cost of medical treatment in real terms made quacks more economically acceptable for this particular ailment.

In the case of tuberculosis the average cost for medical treatment in Birbhum was much lower (Rs. 1,270) than in Dumka (Rs. 2,003). The main reason behind this was that the majority of the patients (71 percent) availed of the public health services in Birbhum, while private qualified doctors were the chief source of such treatment (52 percent) in Dumka. The relatively high success rate of the public health delivery system has perhaps attracted the majority of the patients in Birbhum, while the public sector in Dumka has apparently failed to do so.

This process has a class dimension as well. A large majority of the TB patients in both the districts belonged to the poorer economic classes, for whom the public health delivery system was a preferred source given the financial implications of medical treatment. It was the utterly deficient and near-defunct public health system

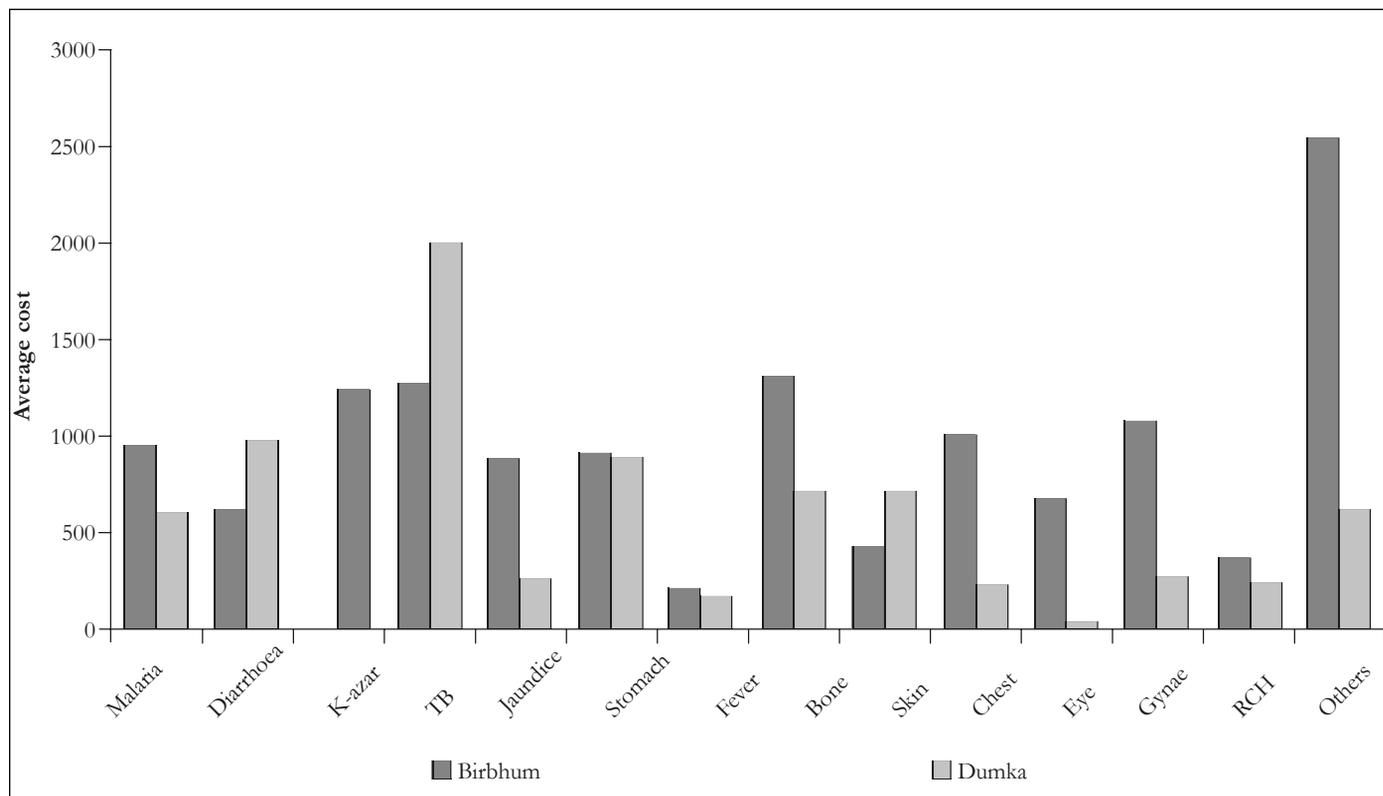
in Dumka that compelled the poorer patients to seek private health services. A relatively better functioning public health system in Birbhum was able to make a huge difference in health seeking behaviour. This finding has special relevance for district health administration in particular and for the health sector of the country as a whole. When a modicum of public attention can make a significant difference in health seeking behaviour, there no real reason why the district health administration in Dumka cannot make the services effective and why the Birbhum administration cannot make such services universal. An equitable public health delivery system would be of immense help, particularly for the poorer sections of society.

It is also worth noting here that, in both districts, peoples’ own perceptions regarding the seriousness of the diseases kept them away from the UMPs.

The cost of treatment of other diseases was found to be much higher in Birbhum than in Dumka, specifically heart diseases, ENT problems, epilepsy, accident injuries, etc. A high degree of difference in the perception of the seriousness of such diseases was found amongst the people of the two districts. While most patients in such cases in Dumka were treated by local UMPs (and in some cases by *kabirajs*), nearly all in Birbhum sought advice and treatment from qualified private doctors.

The poor delivery of public health services becomes more visible in the case of

Chart 7.6 Cost of treatment: by ailment



malaria. There is very little scope for making a comparison between the two districts with regard to the cost of medical treatment for malaria, since Birbhum had only two patients. In Dumka, malaria was a menace that many a time ruined households due to the high cost of medical treatment. The average cost of treatment for malaria in Dumka was Rs. 611 per case (the lower and upper limits being Rs. 100 and Rs. 4,500). The wide extent of malaria prevalence (where all members of many households reportedly suffered from malaria) exacerbates the situation by forcing the households to spend a significant portion of their annual household income on malaria treatment.

The chief source of treatment for malaria in Dumka, as seen in the previous section, was the UMPs. The frequency of malarial attacks made the quacks indispensable, for at both public health points and in the clinics of private qualified doctors people need hard cash for medical treatment, while the UMPs treated them on credit. The same was the case with kala-azar, diarrhoea and other stomach ailments. This indispensability has given rise to rampant drug abuse and corrupt practices in pervasive and exploitative “health bazaars”.

We shall briefly examine the complexities of this market in the following part of our discussion.

MEETING THE COST OF MEDICAL TREATMENT

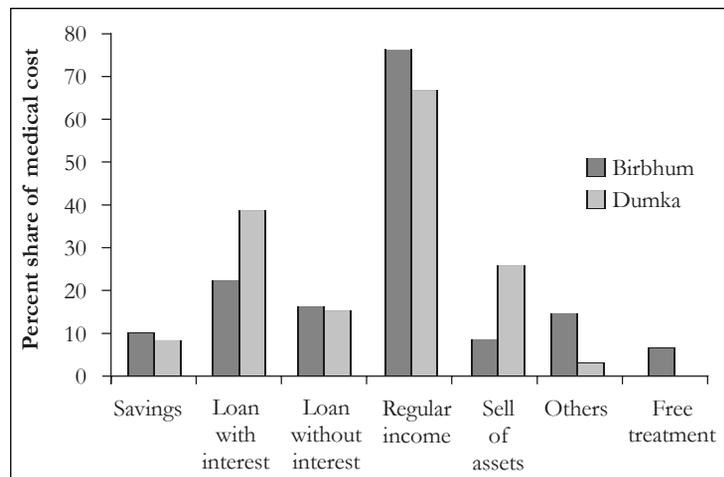
“Rog ki sahaj jinis he, hoy hate mare, noi bhate mare?”

(“Illness is not an easy thing – it kills either by hand [i.e. directly] or by [depriving one of] rice [the main staple food]!”).

As shown in table 7.1 many households suffer from an adverse pattern of low income and high expenditure. At the same time, poverty, hunger and ignorance have created an environment that results in malnutrition and various ailments.² The absence of an effective public health delivery system has made things worse. We have earlier discussed the abusive and corrupt practices of private doctors (quacks as well as qualified private practitioners). The financial cost of health care, both at the private and public facilities made people, particularly those from the poorer classes, more vulnerable.

Respondents recounted many different stories about their sufferings particularly those concerning the arrangement of money for meeting the costs of medical treatment. The money reported to have been spent in the year preceding the study was arranged, in most cases, from many different sources including regular income sources, savings, loans (with or without interest), proceedings from selling assets and properties, mortgaging of assets and properties, etc. Assets included livestock, trees, ornaments, utensils, bicycles, wristwatches, etc. while property included land and buildings.

In several cases, the cost of medical treatment in both the districts was met from the regular income of respondents either in full or in part. In a significant number

Chart 7.7 Cost Management of Medical Treatment

In Dumka the picture was much more dismal – only 0.23 percent of the total number of patients reportedly received treatment free of cost.

of cases (in Birbhum 21 percent and in Dumka 37 percent), medical treatment was paid for by borrowing money at interest. While a small fraction in Birbhum (1.5 per cent) mortgaged land and other assets to borrow money, in Dumka this was as high as 8.6 percent. In nearly 100 percent of the cases, loans were taken from local *mahajans* (moneylenders) the rate of interest for which reportedly varied between 50 percent to 120 percent per annum.

In Birbhum 14 percent took interest-free loans from relatives and friends. This was a little above 13 percent in Dumka.

Only four percent of all patients in Birbhum got free treatment, the majority for cold and cough.

ECONOMICS OF TREATMENT: CYCLE OF POVERTY, ILL-HEALTH AND FURTHER IMPOVERISHMENT

The cost of medical treatment has different meanings for different households. While the share of expenditure on medical treatment as compared to total expenditure for upper income group households was relatively much smaller, in case of the poor it was just the opposite. Thus while a relatively rich respondent thought his household expenditure on medical treatment was regular or normal, a poor respondent felt it was appallingly high. It not only cost her assets and properties (and imposed a restriction on the consumption of food, money for education and other requirements of wellbeing) but also forced her to take a loan – at a high rate of interest.³

While many of the households lost their movable and immovable properties, a large number of respondents thought that the cost of medical treatment was an insurmountable hindrance to their well being. Rani Bagdi, who had to sell a pair of calves for medical treatment worth Rs. 1,000, said that only after a full year would she have enough of an income to enable her to buy a small piece of land. For Bijon Das, an agricultural labourer, the expenditure on medical treatment meant forgoing an education for his children who were forced to drop out of school owing to lack of money.

The high cost of medical treatment, to a large extent, becomes responsible for impoverishment (and, in many cases, pauperization) of most of the poorer households. As a respondent of Dumka expressed helplessly, “*ghadla kbon thora gan babok’ rakap’ak’ ar thain mente mit mugra paraoak’, ado cikaik’ ak’, arbon gabirre n’urbak’ me* - as we try to raise our heads a little above the hole [which we have been thrown into] a huge club smashes us deeper inside the hole”.

HEALTH CARE AND INEQUALITY

Apart from aggravating the poverty status of households and making them more susceptible to further illnesses (because of malnutrition, etc.) the high cost of medical treatment also exacerbates inequalities in society. The poor become impoverished while a small section of society – medical practitioners, moneylenders, traders and some relatively rich farmers at local levels – accumulates huge wealth. Such accumulation is much higher at the national level – plundering by the pharmaceutical industry and the private health market is a well-known fact.⁶

A major constituent of the rise in inequality at the local level (not only in economic terms but also in social terms, like access to education and other opportunities) can be attributed to the financial implications of health care. The cost of medical treatment for poorer households plays a very important role in reversing and/or negating some social advancements. We shall try to illustrate this with two examples – one from West Bengal and another from Jharkhand.

As part of the land reform programme of the government of West Bengal Madan Badyakar was given a piece of land (0.16 acre approximately). Many of his fellow agricultural labourers also benefitted from the land distribution programme. Helped further by the enhancement in agricultural wages, the land reform programme, as Badyakar mentioned, brought about a sea change in their life, with food security, increase in the standard of living and increased educational opportunities, particularly for children. It also gave the socially backward community a voice with which to raise protests against age-old social discriminations. However, the recurring health expenditure every year hindered him from making any savings. Rather, every year he had to take different measures such as selling animals, trees, and borrowing money for meeting health-related expenditures. At a certain point in time the income expenditure pattern became sharply mismatched. Three years ago he had to spend a huge sum of money for the medical treatment of diarrhoea (from which the entire

THE DEBT TRAP

Dhuma Soren, a respondent of Dumka, and his entire family suffered from diarrhoea, malaria and rheumatic pain. The total cost of medical treatment for the reference year (October 2002 – September 2003) was Rs. 3,400. He had to sell a goat, three hens and a bullock to meet the cost. He had a single bullock and he used to plough his lands by pairing it with his brother's.⁴ As a kind of distress sale, he had to lose some money in the above transaction. In addition, he had to take a loan of Rs. 500 from a *mahajan* at an interest rate of 50 percent per annum. He has four bighas of land (1.33 acre), which he had to lease out on *miyad* (also called *bhorna*)⁵ basis for two reasons – (1) to arrange for the money for medical treatment and (2) due to helplessness in terms of ploughing land arising out of the sale of his bullock. In most cases, the cost of ploughing the land is beyond the capacity of the poor cultivator. He had no idea at all as to when he could resume his cultivation. He anticipated that the lease would continue for a few years longer (due to non-repayment of loan and inability to cultivate due to lack of input).

Hence for the poor farmer, the cost of medical treatment – Rs 3,400 – became monstrous in reality. He had to lose his herd of livestock and also the crop, which as he feared, would entangle him in a long-term debt trap – if not a death trap. Dhuma was not an isolated example; he represented a large number of respondents, both in Dumka and in Birbhum.

family suffered). With no source of money left he had to lease out the land that he was allotted under the land distribution programme. Till the date of interview (in December 2002) he had not succeeded in getting back his land from the leaseholders.

We heard many stories of reverse tenancies of a particular form (the ownership exists on paper but in effect the land is being cultivated by someone else). Cases where there has been a reversal of wage enhancement were also noticed. Many wage-earning respondents reported that they had to work for lower wage rates in order to make up for advances taken (mainly for health care) from employers. Also, such advances effectively bound them to particular employers, since they could not work for others until their debts were repaid.

Dumka district in Jharkhand witnessed a widespread movement in the 1970s against moneylenders (who were simultaneously traders and landowners). Money lending formed the basis for land tenancies and other economic relations where tribals became the victims of exploitation by other castes. The movement launched by Shibu Soren (a legendary figure in Jharkhand) had a very positive impact and for some time money lending was either stopped or the rate of interest came down radically (to 25 percent from 50 percent per annum). But the fruits of the movement did not last long. As a respondent, Fatu Soren, noted: “For some years the *mahajans* remained very timid. The rate of interest came down and some of them stopped lending money. Many of them were forced to write off the loans and vacated the lands they had grabbed. But the tribals could not sustain life without taking loans. Hunger, particularly during September and October, and pervasive health ailments forced people to revert to the *mahajans*. Now, *mahajani* is back, albeit with some changes.”⁷

Fatu and many others held high medical expenditures largely responsible for the

SAH THE MONEYLENDER

Two Sanskrit terms, *mahat* (great) and *jana* (person) are combined to form the term *mahajan* – the popular name for moneylenders. A. K. Sah (name changed), from a semi-urban locality in Dumka district inherited moneylending as a profession. His ancestors came from the Bhojpur area of Bihar to the district sometime in the 19th century following the political turmoil created during the great Indian mutiny of 1857. “We are traders and do not like a situation of socio-political unrest, so our ancestors left Bhojpur to find a peaceful area for trading and living,” said he.

Mr. Sah has two younger brothers. He runs a provision shop and one of his brothers runs a medicine shop. The third trades in various things including forest produce, rice, coal, bricks, and earthen tiles and, of course, engages in money lending.

Money lending, he admitted, forms a large share of their investment and income. “*Yaban bina mahjanaike byapar nahin chal sakta hai* (Here trading cannot take place without *mahajani*),” he says, as it is a kind of insurance for other trades. Other businesses can make a loss, but not *mahajani*. “*Dubne ke liye paisato dubta hai par kitna dubayaega? Aakhir hamre paas nahin aa karke santal ko chara bhi kya hai?* (Sometime we have to write off some amount, but not much. What else can the Santal do but come to us for loans?)” he said confidently. He, however, thinks that money lending is more a social service than a business. “People would starve without loans from the moneylender,” he claimed. And the interest he charges (theoretically 50 percent per annum, but in practice it is 50 percent per six months or even less, as the loan has to be returned in Magh [January-February], although in most of the cases the loan is taken between June and October), he terms “a little service charge” to sustain him! Sustenance, obviously, has a different meaning for him – a truck, a pucca house, shops and so on, which are built upon the poor peoples’ vulnerability to hunger and illness.

reversal. The moneylenders interviewed also subscribed to the above view. Some of the moneylenders interviewed admitted that no less than 50 percent of the total borrowings of the poor was done to meet the costs of medical treatment.

There are other forms of moneylending too. As discussed earlier, the UMPs often charge high prices for medicines since they deliver their services on credit.

The high cost of medical treatment has also been responsible for undoing some other positive developments. For example, increased job opportunities in the Bardhaman rice fields since the 1980s helped the tribals of Dumka to get a secure income from migration. In sharp contrast to the limited job availability in the district and the much lower wage rates prevailing in the locality, not only has the scope of employment widened through migration, but earnings have also increased manifold because of higher wage rates. This has had some impact on the tenancy relations as well. Before the 1980s, tribals used to lease out their land, but the present trend is different – non-tribals are leasing out lands to the tribals. Yet, neither the increased income nor the changes in tenancy have apparently had a positive impact on economic relations. The changed tenancies are very owner-friendly. The increase in income and the political movement taken together could have brought about a major change in exploitative forms of tenancies as well as in the lending pattern. For this to happen people need a safeguard for health care – which would enable them to save their hard earned money of which about a quarter is spent on medical treatment⁸.

Social security in terms of health care could play a decisive role in the well being of people and in reducing the prevailing social inequalities in the poorly served areas.

NOTES

1. Mentioned in *Horkoren Mare Hapram Koreak' Katha*, which is considered to be an authentic account of Santal society and culture. It was recorded from the oral descriptions of Kolian Murmu by a Norwegian missionary L.O. Skrefsrud and translated into English by P.O. Bodding. First published in Santali in the early 1870s. Latest English translation published in 1999 by Bahumukhi Prakashan, New Delhi.
2. For example, the inequitable distribution of food in our country leaves many people hungry while millions of tones of food are stocked in public godowns. See Sen (2001) for details. Starvation death and suffering from malnutrition in present day India is a hard reality. Our study area, particularly Dumka, is one of the worst sufferers of hunger and malnutrition. The direct relationship of hunger, malnutrition and occurrences of diseases is a well established fact here.
3. Similar observations were made by Rana and Johnson (2003).
4. This is a common practice in Dumka district. Many people cannot buy or keep a pair of bullocks because of poverty. The single one is used to make a pair with a similar animal. The system is based upon mutual cooperation.
5. *Miyad* is a fixed rate tenancy. There are four main tenancies found in Dumka district. *Kirshani*, *Bhaga*, *Kut* and *Miyad*. *Kirshani* and *Bhaga* are based on crop sharing. When in *Kirshani* a non-tribal leases out land to a tribal – the sharing is generally 2:1 by the owner and cultivator respectively. *Bhaga* is done between two tribals on the basis of 1: 1 crop sharing. *Kut* is a tenancy between a non-tribal landowner (who charges Rs 800 or 8 kat of paddy – about 320 kg per year) and a tribal cultivator. In case of *miyad* it is done between two tribals (against Rs 500 or 5 kat of paddy – 200 kg). For details, see Kumar Rana, in Rogaly et al (2001a).
6. See Anita et al (2000)
7. For details see Rana (2002), Rao (2002)
8. Rana (2001a)

Delivery of Public Health Services

The medical expertise of the British surgeon Dr. William Hamilton may well have been responsible for earning the British the *farman* for business operations from the Mughal emperor Farrukh-siyar, whom, as legend goes, Dr. Hamilton cured from a chronic and severe illness. It was an important milestone in the British East India Company's quest for legitimacy to support its actions and plans. Nevertheless, after establishing themselves as the rulers of India the British largely undermined the extension of health services to its subjects. It was the government of independent India that took up the policy of extending health care services to the masses at large – particularly those who lived in the rural areas. Thus came up the Primary Health Centres (PHC) and Health Sub Centres to deliver health services to the suffering people who otherwise had very little access to the paid urban health services and thus depended largely upon different traditional sources. The establishing of the PHCs and sub centres thus brought modern health services to the doorsteps of the people.

First of all, despite the shortfall in the number of PHCs and sub centres from the declared norm (one PHC to serve 30,000 persons and one sub centre to serve 5,000 persons)¹ many PHC and sub centres were set up in the rural areas. These centres became the channels for protecting peoples' health not only in terms of providing curative services but also in terms of providing preventive services. In addition, these centres were given the responsibility to educate people concerning their health – by generating awareness about illnesses, their causes, prevention, etc. While the PHCs took up the major challenges of curative services, preventive services were shared by the PHCs and the sub centres, with the latter taking on the main responsibility of making people - particularly mothers - aware about health and health care. One Health Assistant (Male) and one Health Assistant (Female) – the latter being in-

charge of the centre, with a long list of duties (including immunisation, health campaigns, counselling, child health care, family planning and so on)², at least one-trained Dai (midwife – for assisting in childbirth) in each village and a community health guide (mainly for counselling and taking an active role during epidemics, and so on) for every 1,000 persons were also added to the team of health workers³.

At the block level, one Block PHC with some other PHCs was set up. The PHCs with two doctors and some other staff were to operate as intermediaries between the sub centres and BPHC with the outpatients' department (check up, giving medicines, referring to the BPHC for major illnesses, immunisation, etc). The BPHCs with both outpatients' and inpatients' departments (both for general health care and child birth), and various pathological and other diagnostic tests were to act as the main health guard of the rural people. In this section we shall discuss to what extent people in rural West Bengal and Jharkhand have been able to access and benefit from these services.

As regards the perception of people concerning different health services, very few of the respondents interviewed had a clear idea about the particular services delivered at different levels. Many of them had no idea about the existence of the sub centres at all and the majority of our respondents had little faith in the public health delivery system. In most cases, people were found to depend more on services other than the public delivery system (discussed in detail in section 5). The main reason behind this, as we were frequently told, was the poor quality of services delivered at the public health centres. However, the major complaints raised were mainly against the curative services. Although far from satisfactory, as we shall see, achievements in the field of preventive services were found to be higher than in the curative ones. In this section we shall discuss preventive and curative services, and the delivery of public health services in three separate sub sections.

Part I

EXTENT OF REALIZATION OF PREVENTIVE SERVICES

As health services at different levels have many different preventive programmes (in fact preventive programmes are becoming much more emphasized than curative ones) we asked our respondents about the implementation of the preventive programmes that include disinfecting water, sterilizing, repelling and killing vectors on the one hand and immunizing people, particularly mothers and children, against various diseases on the other.

IMMUNISATION

Among other activities, the national population policy⁴ has declared its aim to ensure universal immunisation. Accordingly, the respective state governments have been carrying on the programme of vaccination of children against six preventable

but serious diseases – tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis, and measles⁵. Children who have received one dose each of the BCG and measles vaccination and three doses each of the DPT and polio vaccines are considered to be fully immunised.

Although state governments have been running universal immunisation programmes for children the achievement level is still poor, as found by NFHS II, in both the states in general and in Jharkhand in particular.⁶ The following table highlights our findings.

Table 8.1. Extent of vaccination

	Birbhum	Dumka
Received any vaccination	93	97
BCG	93	21
DPT	88	14
Polio	93	95
Measles	48	2

As percentage of total children of 12-23 months

As shown in the above table, the programme of immunising children against various diseases in general has been able to bring a high number of children under the fold; the picture is morbid in Dumka, when it comes to particular vaccinations. While the percentage of children who received any vaccine is higher in Dumka (97) than in Birbhum (93), vaccination against BCG, DPT and measles is found to be deplorable. It is only in the case of polio vaccination that Dumka has a better performance than Birbhum.⁷ The high rate of polio vaccination is seemingly because of the Pulse Polio Programme, which is one of the most focussed activities run by the government.⁸

While immunisation against polio has achieved large coverage the same is not apparently true for the other vaccinations, particularly in Dumka. Whereas 88 percent of the children in Birbhum received DPT, for Dumka the figure was abysmally low - only 14 percent. Similarly, while 93 percent of the surveyed children in Birbhum received the BCG vaccine, in Dumka this figure stood at a meagre 21 percent. As far as the vaccine against measles is concerned the extent is well below other vaccinations – 48 percent in Birbhum and a microscopic two percent in Dumka.

Doses of Polio and DPT vaccines received: Our study collected information on doses of DPT and Polio vaccination for children aged between 12 to 23 months. In Birbhum only 34 percent of the children were found to have received all the three required doses of DPT, for polio it was slightly higher (38 percent). For Dumka the figures were 0 percent and 26 percent respectively.

Regarding the question as to whether the first dose of polio vaccine was received immediately after the birth of the children the affirmative responses for Birbhum and Dumka were 38 percent and 9 percent respectively.

Extent of full immunisation: Although 93 percent of children (in Birbhum) were reported to have been covered under vaccination, only 45 percent were reported to be fully vaccinated. None in Dumka was found with full vaccination.⁹

Place of vaccination: One main reason for the successes and failures in terms of immunisation is probably the accessibility and affordability of the services. While in Birbhum all the vaccinations were reportedly received from public sources, in Dumka the case was different. In cases of polio, BCG and DPT, two percent, 17 percent and 13 percent of the children (who received any dose of the respective vaccines) were immunised from paid private sources. Parents of many villages of Dumka said that immunisation from private sources was expensive in two ways – the cost of vaccination and the cost involved in travelling to the urban centres.

Table 8.2. Sources of vaccinations

	Birbhum (percent)		Dumka (percent)	
	Public	Private	Public	Private
BCG	100	0	83	17
DPT	100	0	88	12
Polio	100	0	98	2
Measles	100	0	100	0

Many of the mothers in Dumka area (and some in Birbhum) were simply unaware about different vaccines and their doses. In such cases it becomes even more important for the public delivery system to act effectively. In both the districts we saw that most of the children were vaccinated in or around the villages and in Dumka the majority of the parents of the children who had not been covered by the immunisation programmes said that there was no such service available in the locality. PHCs were far away and most of the sub centres functioned poorly. The main reasons we found for the low rates of vaccination in Dumka (and also in parts of Birbhum) were:

- (1) Low levels of awareness among the parents about vaccination (even when they knew about *tika* they had no idea as to where the *tika* could be administered);
- (2) Problem of accessibility (it was not very easy to take the children to the distant centres – generally PHC or private providers at the urban centres); and
- (3) The cost involved in vaccination. Although the actual cost could be very little, the long distances that needed to be travelled and the loss in terms of time and income (generally the whole day), particularly for wage earners (whose number was very high in Dumka) proved to be of great consequence.

The success of pulse polio immunisation and the relatively higher success of Birbhum district concerning other immunisations suggest that there is enough scope for improvement of the immunisation services through the public delivery system. The functioning of the grass-root level preventive services has to be made effective and meaningful.

 PRE-NATAL PREVENTIVE CARE

Pre natal care of the pregnant mothers is one of the important programmes carried out among the preventive services. This includes vaccination of pregnant women against tetanus and supplying them with iron folic tablets.

However, like other preventive programmes, this programme too, we found, suffered from incompleteness, particularly in Dumka. While 70 percent of the women in Birbhum reportedly received tetanus injections during pregnancy the figure for Dumka was only 26 percent.

Concerning the receiving of iron folic tablets the picture was more upsetting. Only 46 percent of the pregnant women in Birbhum reportedly received the iron folic tablets. For Dumka the figure was only 27 percent. A PHC in-charge in Dumka said that there was no dearth of iron folic tablets - *bhare pare buye hain*. Yet, he admitted, most of the pregnant women were not covered because (1) it was difficult to make these tablets available to all pregnant mothers as the number of health workers was much less than required; and (2) even when tablets were supplied to the beneficiaries they did not bother to consume them out of simple negligence.

However, a female health worker presented it differently. First of all she contradicted the doctor's view about the availability of sufficient stocks of the required medicines. "*PHC me reh sakta hai, magar centre me nabin aata* – they may be available at the PHC level, but not at the sub-centres". Secondly, she said that the negligence of pregnant mothers as regards consuming iron folic tablets stems from ignorance. "*unke kya pata ki iska mahatva kya hai* – they are unaware of the importance of the iron folic tablets". And the enormous job profile of the grass-root level health workers did not allow them to do the consistent counselling required.

Availability of vaccines at the sub-centre level, both in Birbhum and Dumka, was a great problem. The sub centres in the rural areas suffer from the problem of storage, as most of them are ill equipped (some of them were running in dilapidated buildings without doors and windows). Even the PHCs, particularly in Dumka, suffered from storage problems. In a Block level PHC of Dumka, the in-charge showed us a refrigerator, which according to him, "could best be used as an *almirah*", as the supply of electricity was extremely erratic (power cuts for 14 to 15 hours a day was normal and sometimes there would be no power for three to four consecutive days).

Hence, the non-availability of the required vaccines at the right times and places creates a vacuum that is further increased by the ignorance of parents caused by high levels of female illiteracy (in both the districts but particularly in Dumka) and by the absence of a coherent awareness-generating programme.

 GENERATING AWARENESS

Creating awareness among people, particularly among mothers, is an essential part of the duties assigned to health workers. In a country with widespread illiteracy, particularly among women, awareness-generating campaigns using wall writing, poster-
 ing,

leaflet distribution, etc. have their own limitations and the most effective way of creating awareness about health and health services is direct contact with the villagers.

One male Health Assistant and one female Health Assistant at every sub-centre are supposed to spearhead the public health programmes in the rural areas. They are supposed to visit each family within his/her 'geographical area of operation duly fixed once in a month in a 16 days' cycle i.e. 4 days in a week'¹⁰.

A Health Assistant (Male) is supposed to perform different activities associated with malaria and other communicable diseases, immunisation, family welfare, nutrition, environmental sanitation, recording of vital events, first-aid and treatment of common ailments. The duties of a Health Assistant (Female) are associated with pre-natal and post-natal care of the women at home, care in the clinic (at the sub centre) care in the community (visiting the households in the villages), etc.

However, a mere list of the many different tasks assigned to health workers does not guarantee the effective delivery of health services. In a situation where some of the health workers themselves (in both districts) were found to be unaware of their assigned duties, the knowledge of the villagers concerning the services available from the public health delivery system can well be imagined. The lack of access to information further exacerbates the lack of the availability of proper health services.

In our study only 37 percent of the sampled households in Birbhum and 26 percent of the households in Dumka were reportedly visited by any health worker during the year preceding the survey. Again, the majority of the visits were made by Health Assistants (both male and female) and ICDS workers and not by doctors or senior health workers.

In the households reportedly visited by health workers, a large number of respondents said that the visits were made only once in a year or so.

Table 8.3. Periodicity of visits by health workers

Visits made by health workers to the households	Birbhum	Dumka
Between one and two months	14	9
Two – three months	8	4
Three months – 12 months	15	13
No visit at all	63	74

As percentage of total households which reportedly received any visit

Village wise data sheets and observations further indicate that the delivery of health services is not only different in the respective districts but there are also considerable intra district variations. We found a sharp dividing line between the villages with positive and negative responses. While the positive responses were found only in a few villages, the negative responses were distributed over a large number of villages. Our observations also support the above findings. The relatively better functioning of some sub centres was due primarily to the dedication of their workers, not because of any policy or structure. In most of the cases the sub centres were left to

the mercy of the individual health workers, some of whom – out of humanitarian commitment – tried to keep the system running in spite of many difficulties.

QUALITY OF SERVICES AT HOME

Similarly, when asked about the quality of services extended by the health workers during their visits, most of the respondents expressed satisfaction. This again shows that a small section of health workers who visited the villages had tried to do justice to their jobs.

Eighty six percent of the respondents of Birbhum (visited by health workers) said that the health workers talked nicely with them. In Dumka, the figure was lower – 45 percent. Seventy eight percent of such respondents in Birbhum responded that health workers spent sufficient time with them. The Dumka figure was much lower – 55 percent.

As to what type of services were delivered at home, vaccination ranked first. (The list included supply of pills, condoms, follow-up after sterilization, counselling for family planning and other related services, awareness-generation on prevention of diseases, treatment of general ailments, etc.). The other services provided were negligible (see Appendix table E 7.b for details). A female health worker in Dumka said that she felt helpless for she was seldom provided with the required pills and other medicines. Besides, she complained, she found very little time to visit the households as the area assigned to her was large and there was no communication available. Another female

A HEALTH ASSISTANT'S DILEMMA

Kalyani (name changed), a Health Assistant (Female) has been serving one of our study villages in Birbhum for the last 15 years. The population she serves was estimated to be 4,000. She has to discharge her duties under a great range of difficulties – some of which are related to serious policy matters. For example, along with discharging other duties she is supposed to provide contraceptive pills, which were out of supply, and organise ligation camps – which put her in utter difficulty as her honesty was questioned. Women who undergo ligation are supposed to get some money (as an incentive to promote family planning) from the government. Sanction and disbursement of such incentive amounts have not taken place for a long time. The women in the village (and their relatives) hold Kalyani responsible for this, as she is the only contact between them and the ligation camps. Sometimes she became upset for she failed to make people understand the matter and despite many requests no one from the higher levels of the health services came to help her.

The bureaucratic and ill managed functioning of the system often becomes responsible for its poor delivery. Kalyani, as part of her long list of jobs, has to be present for three days at the sub centres to attend to the TB patients under the DOT (Direct Observation and Treatment with short course chemotherapy). There was no TB patient to attend the clinic, yet she had to sit idle at the sub centre waiting for the TB patients as, “*Hakim nare to bokum narena* – the rules are so rigid that one cannot modify them”. Her major complaint was that because of such an illogical work schedule, she could not visit the households in the way she intended to. She raised many other practical issues, such as poor infrastructure of the sub centre, non-availability of medical equipment and essential drugs, shortage of staff, etc. “*Jato kaj thake, maa durgar mato dasta bat gajaleo sesh kara jabena* – the long list of tasks we [health workers] are assigned cannot be performed even if we grow ten hands like Goddess Durga!” she exclaimed in frustration.

health worker reported that her area was under thick forest cover and villages were scattered. To add to her problems, the area is prone to elephant attacks.¹¹

While there were practical difficulties faced by some health workers, some of them, as we have seen, neglected their duties simply because of the perceived difficulties. Many of them were found to live in urban or semi-urban areas, from where it was very difficult for them to commute to their areas of operation. In addition, their difference from the villagers they are supposed to serve – both in terms of status and mentality – perhaps leads to the development of inhibitions towards villagers and rural life. Some of the health workers in both the districts, echoing the doctors, officials, and other middle class persons, held the villagers responsible for their ailments. “Villagers are filthy”, “they are illiterate”, “they don’t care for their health,” “they don’t want to use modern medicines”, were a few of the comments made by health workers.

OTHER PREVENTIVE MEASURES

Measures to prevent Diarrhoea: In both the districts, diarrhoeal diseases were reported to be among the most common. Difficulty in accessing potable water is one of the major causes behind the increase in diarrhoeal diseases. In almost all the villages studied in Dumka there is scarcity of drinking water, which becomes acute particularly during the summer. In addition, despite the installation of many hand-pumps in the villages most of them were out of order during the survey. Villagers reported having lodged many complaints but to no avail. Some villagers alleged that the block office asked for money to repair the hand-pumps, which villagers could not afford. Thus, many of the villages, particularly those located in the hilly areas, depend upon streams or open dug wells for drinking water. In none of the study villages was the distribution of purifying agents (bleaching powder, etc.) recollected by the respondents. In some of the villages, the quality of water was found to be extremely dirty and unhygienic – particles of different kinds of organic and inorganic matter were quite visible, in the water.

The situation in Birbhum was relatively better, but the district is not completely free from problems regarding potable water. At least in two of the 12 villages surveyed, the situation was very similar to that of Dumka. The other villages were also not completely free of drinking water pollution. As reported by some of the PHC authorities in Birbhum, programmes related to water purification were carried out only in specific areas where diarrhoea took an epidemic turn.

It worth a mention here that the Panchayat and Rural Development department of the Government of West Bengal has launched a programme of sanitation, “Gramin Swastha Vidhan” in 1991, which has been very successful in some districts (for example, Medinipur East and Hoogly). The programme became operational in 1993-4. The number of low cost toilets built in the state has increased more than a hundred-fold (from 19,565 in 1993-94 to 2,079,493 in 2002-3).¹² In an interview, an official of the department said that Nandigram II of East Medinipur district has become the first fully sanitized Community Development Block in the country and

they were expecting one or two districts to be fully sanitized very soon. The achievement of the sanitation programme, as mentioned by the official, has had a direct impact in reducing the occurrences of water borne diseases, particularly diarrhoea. However, the programme has yet to achieve significant success in Birbhum district.

Though the importance of sanitation has been acknowledged in public policy¹³ in Dumka district no trace of such a programme was found. Nearly 100 percent of the people were reportedly using open grounds as toilets, which increases the possibility of the occurrence of diarrhoea.

Measures to prevent malaria: Although we found very few malaria cases in our study areas in Birbhum, it has remained a menacing killer disease in the district, as we have mentioned earlier. In 2001-2, the reported cases of malaria in Birbhum¹⁴ were 412 of which 35 percent were of *Plasmodium falciparum*.

Dumka is known to be a malaria-prone district. In our study area malaria patients formed 24 percent of the population that suffered from any ailment during the year preceding the study. As mentioned earlier, malaria is an acute problem for many parts of the country, and takes a heavy annual toll. The Central Government has launched the National Anti-Malaria Programme, which comprises preventive, curative and other measures to eradicate the disease. Spraying of pesticides is one of the important preventive measures. However, none of our respondents in Dumka (including the residents of the malaria-prone villages of Gopikandar block) confirmed any such spraying.

The National Anti-Malaria Programme 2002 in the district claimed to have distributed mosquito nets. It also claimed that distribution of mosquito nets was done among 100 percent of the households in Gopikandar block, 40 percent of the households in Jarmundi block and 20 percent of the households in Sikaripara block. Gopikandar is a highly malaria-prone block - the incidence of malaria was so enormous that it took 35 lives from a single village in our study area in the year prior to our visit. However, contrary to the claim of the health officials, *none of the respondents was found to have received any mosquito nets in the block.*

As part of the preventive programmes, mass communication (mainly wall writing) has been carried out both in Birbhum and Dumka. But the effectiveness of such programmes cannot extend beyond the boundaries of the literate population. The most essential mode of generating awareness, direct contact, was found to be largely absent.

Part II

CURATIVE SERVICES

When the much-focussed and heralded public health services for prevention of diseases suffer from such gross deformities, the state of the curative services can well be imagined. We have seen in section 5 that only a small fraction of the patients visited the public health centres for healthcare. An absolute majority of the suffering

people depended upon private providers in general and quacks (UMPs) in particular.

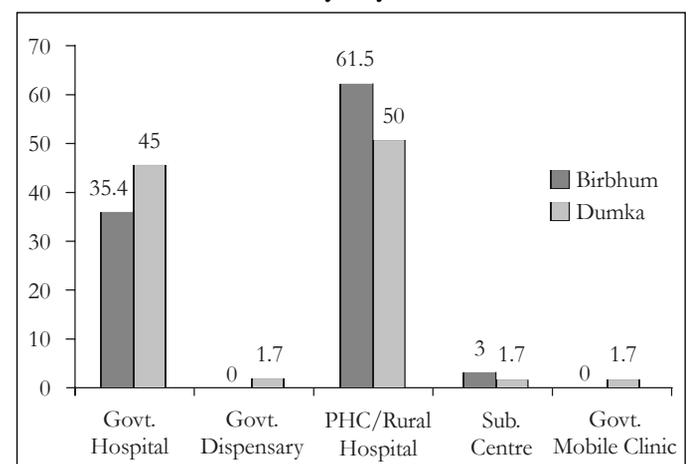
While asked whether any member of the sampled households visited the public health centres during the year preceding the survey only 30 percent in Birbhum and 28 percent in Dumka responded in the affirmative. Of the total number of visitors, more than 90 percent visited either the hospitals or the primary health centres.

From the graphic below, it can be seen that a considerable section of rural households visited the hospitals. Most of the respondents put this down to the fact of (1) accessibility to the hospitals and (2) almost zero service delivery at the grass root level and poor service delivery at the PHCs. In many cases, PHCs routinely refer patients to hospitals because of the non-availability of healthcare facilities in the PHCs. Many of the respondents said that they preferred to visit the hospitals directly to avoid wasting time at the PHCs. “The PHC doctor will send the patient to hospital anyway, so why not go to it straight away?” In most cases the PHCs were ill-equipped, particularly regarding diagnostic services and supply of medicines. The problem is further aggravated by the reported carelessness of the PHC staff. As we saw at a block PHC in Birbhum, one of the two doctors engaged in private practice during his duty hours. He did not bother to hide his practice and displayed a board highlighting the time of private practice (between 8 AM to 1 PM) for the benefit of patients! The sole doctor left at the PHC, who was perhaps considered by his colleague to be a fool, was completely unable to manage the crowd of patients. “Sometimes I feel frustrated since I cannot do justice to the patients,” he said. In such a situation, patients often found it more useful to visit private practitioners.

In Dumka many of the respondents complained that not only did the PHCs refuse to give them any medicine, but some of them also charged money for treatment. And in many cases doctors or other health staff did not even bother to listen to the patient, - “*anjom hon ba anjomak*.”

In addition to such attitude and functioning, the negligence that people experienced made them skeptical about the PHCs. In a village of Dumka district a sudden outbreak of diarrhoea claimed 11 lives in a span of 3 days. (This happened during the period of our study.) People reported matters to the PHC immediately but to no avail. The outbreak spread like prairie fire. After three consecutive messages were sent to the PHC, six bottles of saline were given to the villagers to administer to patients “with the help of local quacks”. Another incidence of such an outbreak was reported to the Sadar hospital, which, according to some respondents in Dumka town, acted only after the district administration took a serious view of the matter. In this case some of the villagers could approach the district administration through a person known to them who lived in the town, and who had strong political and bureaucratic clout. A third incident: In Gariapani, one of our surveyed villages, during the year preceding our survey 35 people

Chart 8.1
Use of Different Public Health Services
by any member of Household



died of malaria (*Plasmodium falciparum*), locally called “brain malaria”. As reported by the villagers, when the patients were dying the local PHC was sent repeated requests for help. No action was taken. In the end villagers lodged a complaint to the concerned BDO. Still no action. Mention may be made that the village is inhabited by poor and mainly illiterate people who have no political or bureaucratic connections.

These incidents say a lot about the relationship of class and utilization of public facilities. The complaints of the poor (and illiterate and socially backward) remain unheeded while the powerful can make the services functional to a large extent.

The condition of the hospitals was not found to be very different, though for some cases, particularly for the complicated ones, they were reported to be unavoidable. Both in Birbhum and Dumka respondents reported that most of the hospital doctors had their private practices and they took much more care at their respective private chambers than in the hospital. Yet, for many of the poor patients even the partial and crippled services become important.

We can see from the following table the services sought by patients. While for 100 percent the purpose of visits to the public health system was treatment of ailments in both the districts a considerable number of households in Birbhum visited the public health units for child delivery. Since a large majority of our respondents belonged to low income groups, it was nearly impossible for them to afford the cost of nursing homes for childbirth. Although most of the households made many complaints against the conditions in the hospitals (including poor maintenance, unsympathetic behaviour, not giving medicines, etc.), the service was still utilised for it was far less expensive than that of a private clinic or nursing home.

In Dumka, however, approaching the public services for child delivery was not found to any significant degree. This was mainly because of the inaccessibility of

THE DOCTOR'S HONOUR

When patients who come to health centres are treated with such indifference, the situation of field visits and medical treatment at patients' homes can well be imagined. A combination of sheer unconcern towards their services and utter skepticism about the health delivery system itself (perhaps the skepticism is to defend their indifference) has created a situation of total standstill. While asked about the field services delivered by doctors and health workers, a doctor in a block level PHC of Dumka sarcastically said, “*Ab to doktor logon ko haatiya me baniyagiri karna parega* (Now the doctors have to work the way the petty traders do in the weekly markets).” The reason for this sudden outburst was a circular issued by the health department of the Government of Jharkhand that directed PHC doctors to distribute anti-malarial drugs in the weekly markets (*haatia*). Such a move, he thought, was insulting towards the ‘noble profession’ of doctors. All the PHC doctors we visited severely criticized the government for letting the doctors down before the public eye. “*Hamara izzat mittipalit ho gaya* – our honour has been stained.”

However, some of the qualified doctors in Dumka town (mainly Santals) said that such a move could yield excellent results had the government taken the issue seriously. Since *haatias*, particularly in tribal areas, play a major role in public life (even allopathic medicines were being sold in the *haatias*) and generally their distances are not too far from the villages, it could bring a sea change in the malarial situation had the doctors run mobile clinics in the *haatias*.

That was not to be. *Izzat* remained unhurt. The programme failed.

hospitals (the PHCs of Dumka were not equipped with adequate child birth facilities and the family planning and reproductive health programmes to generate awareness were comparatively much less successful).

Table 8.4. Services sought from public health system

	Birbhum	Percent	Dumka	Percent
Medical Treatment	65	100.00	60	100.00
Immunization	5	7.70	5	8.30
Antenatal care	2	3.10	3	5.00
Child birth	26	40.00	1	1.70
Total number of Households	65	-	60	-

(Responses not mutually exclusive)

Let us examine some other aspects. Of the total number of households who visited the public health delivery system:

- Only 14 percent in Birbhum and 13 percent in Dumka reported to have got the prescribed medicines from the health centres / hospitals.
- As much as 49 percent in Birbhum and 53 percent in Dumka complained that the public health servants did not spend enough time with the patients.
- Only 43 percent and 42 percent in Birbhum and Dumka respectively explicitly said that the public health servants behaved nicely with them.
- In 23 percent cases in Birbhum and 27 percent cases in Dumka, health workers other than doctors or nurses examined the patients at the public health centres.

The above findings clearly indicate that people have many different reasons for complaining about the public health delivery system, particularly in Dumka but also in Birbhum in general. The frustration that has grown from the poor performance of the system have pushed them to the private sector, which promotes unequal delivery and is often an unethical, incompetent and corrupt system based only on money.

The rush to seek services from private doctors – mainly quacks – is not only associated with the poor quality of services provided in the concerned public institutions but also, as mentioned by many doctors of the PHCs and hospitals, due to their limitations owing to poor infrastructure and equipment, poor staff strength and short supply of medicines. Most of the patients, as reported, had to buy the medicines and to get their diagnostic tests done from outside the public health system. In addition, the increasing trend of introducing user charges, for the hospitals, as a doctor mentioned, was gradually building up repulsion (towards the public hospitals).¹⁵

The opinions of doctors in both the districts concerning the functioning of the public health delivery systems include the following:

- (1) Poor accessibility to the PHCs and hospitals, which are the main points for curative services. In most of the cases connectivity (in terms of road links, telephone, etc.) was found to be abysmally poor. Ambulance facility was not available in any of the three PHCs visited in Dumka. In Birbhum, though this facility was avail-

able in all the three BPHCs visited, it was reported to be far from adequate. Particularly in Dumka, where for many villagers travelling to the PHC required one whole day, people find it convenient to avail of the services of quacks.

(2) The non-availability or inadequacy of equipment, inpatient facilities (in PHCs), diagnostic facilities, medicines, poor staff strength, etc. made the health staff helpless. Doctors also admitted that since in many cases people have to bear a large share of the cost of treatment at the PHC or hospital they opt for private providers.

(3) Some of the doctors complained that the procurement of medicines and equipment was also not free from corrupt practices. Often the PHCs and hospitals are supplied substandard medicines and equipment. In Dumka, for example, a doctor said that a CBI enquiry has been launched against a particular branch of the health department in the district for alleged involvement in corrupt practices. One doctor in Birbhum mentioned that the list of drugs supplied to the PHCs was prepared many years ago and has not been updated for the last one and half decades.

(4) According to some health personnel, many of the staff (including the doctors) were also responsible for the poor delivery of services. As one said, “Many of the doctors forget that the profession [of medical service] is a noble one and demands complete dedication, in accordance with the [Hippocratic] oath taken [by doctors].”

(5) In Dumka, almost all the doctors mentioned that they faced a lot of difficulties in communicating with patients since most of the villagers speak Santali. Similarly, “Patients also fail to understand the doctor’s advice correctly.”

Part III

FUNCTIONING OF THE PUBLIC HEALTH SERVICES

From the above discussion, one thing becomes very clear – that the poor running of the public health services, particularly in Dumka district, is a reality that has spread its roots into the depths of peoples’ minds. The unreliability of the public health services is increasingly pushing the people towards private practitioners.

The study team visited all the BPHCs and PHCs of the study blocks (13 in Birbhum and 12 in Dumka) and some sub centres under those PHCs (18 in Birbhum and 13 in Dumka). The visits (that included interviews with several local residents) suggest a fair degree of difference in the functioning of the health delivery system of the two study districts.

While in Dumka district almost all the additional PHCs and sub centres were non-functional and the functionality of the PHCs (at the block headquarters) was very poor, in Birbhum things were considerably different. While in Dumka district some of the sub centres and even PHCs only exist on paper (some sub centres were found to be used as public lavatories by local people!) in Birbhum all the PHCs and sub centres have physical and operational existence.

However, we found inter-block variations in terms of infrastructure, staff pat-

tern and the delivery of health care at the PHCs and sub centres of Birbhum district. While some of the sub centres in a particular block were found to have been occupied by vagabonds or destitutes and the local residents reportedly had no idea about the running of the sub centres, in one block the sub centres acted as one of the main pillars of the health system (interestingly in that particular block, the BPHC did not have the reputation of good service delivery).

Table 8.5 Functional Status of the public health delivery system

	Birbhum			Dumka		
	BPHC	PHC	Sub-centre	PHC	APHC	Sub-centre
Existing and functioning regularly	3 (100)	7 (70)	10 (56)	3 (100)	-	2 (15)
Existing and functioning partially	-	3 (30)	6 (33)	-	7 (78)	5 (38)
Existing but defunct	-	-	1 (6)	-	2 (22)	3 (23)
No physical existence	-	-	1 (6)	-	-	3 (23)
Total visited	3 (100)	10 (100)	18 (100)	3(100)	9 (100)	13 (100)

Figures in parentheses indicate percentage

Table 8.6 Service availability in the public health system

Services	Status	Birbhum			Dumka		
		BPHC located at Block headquarters	PHC operated under the BPHC	Sub centre	PHC located at Block headquarters	Additional operated under the PHC	Sub centre
Medical officer's availability	Available	3*	8	NA	3**	1	NA
	Not available	-	2	NA	-	8	NA
Availability of medicines	All prescribed medicines	-	-	-	-	-	-
	Partial	3	8	11	3	8#	4
	No medicine	-	-	-	-	1	-
Diagnostics facilities	Blood	3	-	NA	3	-	NA
	Pathological	3	-	NA	-	-	NA
	X-ray	1	-	NA	-	-	NA
	No test	-	8	NA	-	9	NA
Bed facilities	Available	3	2	NA	-	-	NA
	Not available	-	6	NA	-	9	NA
Child birth facilities	Available	3	2	NA	-	-	NA
	Not available	-	6	NA	-	9	NA
Total number of centres visited		3	10***	18***	3	9	13***

* However, at least in one case we have found a doctor practicing at his private clinic during working hours. Also in some cases absenteeism among some of the doctors was found to a large extent.

** Irregularity in attendance by the doctors was reportedly a common phenomenon. In fact, in one of the PHCs we could not find any doctor in spite of four consecutive visits.

*** Data for two PHCs in Birbhum was not available. Seven sub centres of Birbhum and nine sub centres of Dumka were found closed on the days of visit, although visits were planned according to the operational calendar of the sub centres (In Birbhum sub centres were supposed to open on Monday, Wednesday and Friday between 8 AM – 12 PM. In Dumka sub centres were supposed to open every weekday between 8 AM – 12 PM except Tuesday.)

In fact, very little medicine was reportedly provided to the patients. Also in some cases, as some of the respondents alleged, both PHC and APHC staff charged money for the medicines given to them.

As mentioned above, the APHCs in Dumka district were found to be almost defunct. Although the situation was comparatively better in Birbhum, all the BPHCs and PHCs suffer from infrastructure, staff, fund and other problems. Above all, the problem of motivation among the health personnel seems to have made the problem worse.

CONCLUSION

The poor functioning of the public health delivery system, particularly in Dumka district, has left beneficiaries, especially the poor, at the mercy of the private health care (non-)system. In Birbhum the situation is comparatively better, yet it still demands a lot of attention. Such dependence on private practitioners not only has economic implications but also much deeper social implications. Private practitioners, who have almost zero accountability to the public, are divided into two broad classes – qualified and unqualified. In most of the cases, the poor have no option but to depend upon unqualified quacks and only the comparatively wealthy can afford the services of qualified medical practitioners. Even when the poor avail of the services of qualified doctors (often by selling and/or mortgaging their assets, sometimes becoming completely pauperised in the process) they are not assured of the care that a rich patient gets. In this manner, the absence or inadequacy of the public health services – which are supposed to safeguard the interests of the poor – and the gradual withdrawal of the state from the health sector (either completely or in the form of introducing user charges), coupled to the dependence upon private services, intensifies class and social barriers with adverse impacts on health, economy, literacy and other social factors.¹⁶

Finally, there is a rich heritage of public health care in India. History not only provides examples of the flourishing of scientific medical practices in India more than two thousand years ago, but also suggests a public health delivery system since ancient times. The remnants of a public hospital of the Magadhan period at Kumrhar, Patna, the capital city of present day Bihar, still amazes visitors. Public health delivery systems were also available during the later period of Mughal and Sultanate rule in India. After gaining freedom from two hundred years of colonial rule, India now has a functional democracy. The gains of such a democracy can very easily be undone in the absence of an effective public health delivery system.

NOTES

1. For the hilly and tribal areas the respective norms for PHC and sub centres were 20, 000 and 3,000. See State Bureau of Health Intelligence, Directorate of Health Services, Govt. of WB (2002:73), Department of Health and Family Welfare, Government of West Bengal (1985:2-3), Dutta (1962:58)
2. Department of Health and Family Welfare, Government of West Bengal, (1985 : 2-3)
3. State Bureau of Health Intelligence, Directorate of Health Services, Govt. of WB (2002:73).
4. MH&FW, Government of India (2002)
5. Source IIPS (2001)
6. Also see IIPS (2002)
7. As the media reports suggest, West Bengal has still a considerable number of polio cases and the immunization programme has not yet been able to cover all the children.
8. During the pulse polio campaign, many of the doctors and health workers reported, all other normal programmes come to a near halt. The whole health infrastructure is employed to make the programme a success. This overemphasis, as some doctors and health workers opined, has converted the programme into a kind of ritual that has resulted in a slackening of effort, at least by a part of the campaigners.
9. NFHS-II has found that 43.8 percent in WB and 8.8 percent in Jharkhand had been fully immunised.
10. Department of Health and Family Welfare, Government of West Bengal (1985:27).
11. In Gopikandar and Kathikund blocks of Dumka district, as media and other reports go, many of the houses in several villages were destroyed by elephants. We also visited several such houses.
12. Department of Panchayat and Rural Development, Government of West Bengal (2003)
13. Department of Health and Family Welfare, Government of Jharkhand (2002)
14. State Bureau of Health Intelligence, Directorate of Health Services, Govt. of WB (2002).
15. Introduction of user charges in some African countries like Zimbabwe has had an adverse impact on the attendance at outpatients' departments of the public health centres. In post-reform China, introduction of user charges adversely affected the TB control programme. See Andrews and Mohan (2002) for details. However, in some parts of India, e.g. Madhya Pradesh, introduction of user charges has reportedly had a positive impact on the health delivery system under some innovative programmes. The nature of user fees collected in such programmes, nevertheless, excludes the poor patients on the basis of self-certification. Also such programmes are yet to prove their applicability to the whole country as the reported examples were largely based on individual or group philanthropy. See Kumar (2003) for details.
16. The experience of pre and post reform China is of particular importance in this context. In pre-reform China public delivery of health services had had a considerable positive impact on the overall development of Chinese society. (Dreze and Sen: 2002: 128 -29). But in post reform China the withdrawal of the public health delivery system and introduction of a market-based system has had a serious adverse impact on Chinese society (Hinton: 1996)

Bibliography

- Agnihotri, Satish B. (2002), Quality of Health services :Developing evidence based perceptions, mimeographed.
- Andrews, S and S Mohan (2002), “User Charges in Health Care: Some Issues”, Economic and Political Weekly, September 14
- Anita, N.H, G.P. Dutta, A.B. Kasbekar (2000), Health and Medical Care: A People’s Movement, Foundation for Research in Community Health, Pune/Mumbai.
- Bhattacharya, J.P and associates (1958), Sahajapur, West Bengal:Socio Economic Study of a Village, Agro Economic Research Centre for East India, VisvaBharati, Santiniketan.
- Bhattacharya, Sukhamoy (1987), Prasanga Osudh (Bangla), Norman Bethun Janasasthya Andolon, Kolkata
- Bhattacharya, Sukumari ([1970] 2000), The Indian Theogony : Brahma, Vishnu & Siva, Penguin Books, New Delhi
- Bodding, P.O, L.O. Skrefsrud, S. Kono ([1887, 1942] 1999), Traditionas and Institutions of the Santals (English translation of *Horkoren Mare Hapramkoreak’ katha*), Bahumukhi Prakashan, Delhi
- Chattopadhaya, Debiprasad (1977), Science and Society in Ancient India, Research India Publications, Calcutta
- Chaudhury,B and S.Choudhury)(1986), “Tribal Health, Disease and Treatment : A Review Study” in Choudhury, B(ed) Tribal Health: Socio Cultural Dimensions, Inter- India Publications, New Delhi.
- Choudhury Aparna (2001), Sriniketaner Gramonnayane Nanibala Roy, Sreyashi, Alapani Mahila Samiti, Santiniketan (December; 7 Pous 1408 Bangla year)
- Dasgupta Monica, and Lincoln Chen (1998), “Introduction” to Dasgupta, Monica,

- Lincoln Chen and T.N.Krishnan (ed) Health, Poverty & Development in India,, Oxford University Press, New Delhi.
- Dattagupta Debu (2000), Niramoy Aaschhe, Naya Udyog, Kolkata
- Department of Health and Family Welfare, Government of West Bengal (1985), Multipurpose Health Programme, Department of Health and Family Welfare, Government of West Bengal, Kolkata
- Department of Health and Family Welfare, Government of Jharkhand (2002), Health Policy of Jharkhand (proposed), Ranchi
- Department of Panchayat and Rural Development, Government of West Bengal (2003), Physical performance of Rural Sanitation Programme since inception (mimeo)
- Dreze J and Amartya Sen (2002), India : Development and Participation, OUP, New Delhi
- Dutt P.R. (1962), Rural Health Services in India: Primary Health centre, Central Health Education Bureau, Directorate General of Health services, Ministry of Health, Govt. of India.
- Frederic Boudier (2003), "Health Care in Rural Tamilnadu: Perspectives from Medical Pluralism to Social Development", in GAO Ersheng (ed) Reproductive Health, Gender and Development :An International Perspective – A festschrift for Prof. Kuttan Mahadevan , B.R. Publishing Corporation , New Delhi
- Government of Jharkhand, Vision 2010
- Hinton William (1996), Birat Biparit Yatra (Bangla translation of The Great Reversal by Santosh Rana) Rainbow, New Delhi
- Hunter W.W (2001), Statistical Account of Birbhum, Government of West Bengal , Kolkata
- Hunter W.W (1996), The Annals of Rural Bengal, Government of West Bengal, Kolkata
- IIPS (International Institute for Population Sciences) (2001), National Family Health Survey (NFHS) II, West Bengal, IIPS Mumbai
- IIPS (2002), National Family Health Survey (NFHS) II, Jharkhand, IIPS, Mumbai
- IIPS (2000) Key Findings 1998-99, National Family Health Survey (NFHS) II, India, IIPS, Mumbai
- IIPS (2000a) Reproductive and Child Health Project, Rapid Household Survey-Phase I and II, 1998-99, IIPS, Mumbai
- Kabeer, Naila (1995), Reversed Realities: Gender Hierarchies in Development Thought, Kali for Women, New Delhi
- Kumar Girish (2003), "Promoting Public – Private Partnership in Health Services", Economic and Political weekly, July 19-25,
- Kumar Rachel (2002), "Gender in reproductive and Child Health Policy" in Economic and Political Weekly August10-16
- MH&FW (Ministry of Health and Family Welfare) (2002), Annual Report 2001-2Ministry of Health and Family Welfare, Government of India, New Delhi
- NSSO (National Sample Survey Organisation) (1998), Maternal and Child Health

- Care in India, NSS Fifty-second round (July 1995-June1996), NSSO, Department of Statistics, Government of India, New Delhi.
- NSSO (1998) Morbidity and Treatment of Ailments, NSS Fifty-second round (July 1995-June1996), NSSO, Department of Statistics, Government of India, New Delhi.
- O, Malley LSS (1910), Bengal District Gazetteers : Santal Pargana, Bengal Secretariat Press, Calcutta
- Parikh Kirit S (2002), "Social Infrastructure As Important As Physical Infrastructure", in
- Parikh Kirit S and R. Radhakrishna (eds) (2002), India Development Report 2002, OUP, New Delhi
- Paul Singh K C(2002), "The Aspects of a Changing Context in Jharkhand", Jharkhand Journal of Development and Management Studies; Volume 1; Xavier institute of Social Services; Ranchi,
- Prasad Dr. Hari Sharan, Dr. Dharmendra Kumar, and Abinash Kumar, National Anti Malarial Programme (2003), District Implementation Plan – 2003, District Dumka , Jharkhand
- Rana K. (2001), "Parijayi Majur o Kicchu Sanslishta Bhabna", in Notun Ganatantrer Janya, May - June issue, Kolkata
- Rana K. (2001a) "Kangal kate bangal lan' calak'ak – Impoverishment and Seasonal Migration: Case of a Santal village", in Rogaly et al (2001), Seasonal Migration for Rural manual Work in Eastern India, Annexes to the Final Report, School of Development Studies, University of East Anglia, Norwich, UK.
- Rana K. (2002), Saontal Parganar Baromasya , CAMP, Kolkata
- Rana K. and Liby Johnson (2003), "The Hot Tempered Cold Fever : Illness and impoverishment among the adivasis of Jharkhand" Economic and Political weekly, April 12
- Rana K, A. Rafique and A. Sengupta(2002),The Pratichi Education Report-I, with an introduction by Amartya Sen TLM Books in association with Pratichi(India)Trust, Delhi.
- Rana K. S. Das, A.Sengupta, A. Rafique, S.Santra and A.Mukherjee (Forthcoming) The Pratichi Education Report II, TLM Books in association with Pratichi (India) Trust, Delhi.
- Rao Nitya (2002) Standing One's Ground: Gender, Land And Livelihoods In The Santal Parganas, Jharkhand, India, a Ph.D. Thesis submitted to the School of Development Studies, University of East Anglia,UK
- Rao Nitya (2003) "Jharkhand: Vision 2010, Chasing Mirages" in Economic and Political weekly, May 3
- Rao Nitya, L. Rurup and R. Sudarshan (1996), Sites of Change, FES, New Delhi
- Roy Chaudhury P.C (1965) Bihar District gazetteers: Santal Parganas, Secretariat Press, Patna.
- Sainath P (1996), "Malaria for All by 2000?" in Everyone Loves a Good Drought, Penguin Books

- Sen Amartya (1982), *How Is India Doing*, New York Review of Books, 29
- Sen Amartya (1999), *Development as Freedom*, Oxford University Press, Oxford
- Sen Amartya (2001), *Class in India*, Nehru Memorial Lecture, New Delhi (14th November). Published in *Bangla in Desh* (Kolkata) on January 18, 2003
- Sen Amartya and Sunil Sengupta (1983), *Malnutrition of rural children and the sex bias*, *Economic and Political Weekly*, 29, Annual Number
- Shariff, Abusaleh (1999), *India Human Development Report*, Oxford University Press, New Delhi
- Shariff, Abusaleh and Ratna M. Sudarshan (1996), "Elementary Education and Health in Rural India : Some indicators", in Rao, N, L.Rurup and R.Sudarshan (eds), *Sites of Change : the structural context for empowering women in India*, Friedrich Ebert Stiftung and UNDP, New Delhi
- Singh A.K (2003) "Jharkhand Katha: Swadeshi Colonisation", in Munda R.D and S. Bosu Mullick (2003), *The Jharkhand Movement: Indigenous Peoples' Struggle for Autonomy in India*, International Work Group for Indigenous Affairs, Copenhagen and Bindra Institute for Research Study and Action, Chaibasa
- Sinha Dikshit (2003), *Tagore's Experiment in Health Care: Health Medicine as an Aid to Rural Reconstruction* (Mimiographed)
- Society for Holistic Approach to Planned Environment (SHAPE), Kolkata, (2003), *Holistic Development Plan, Jarmundi Block, Dumka District, Vol I* , Statements, - conducted for UNDP, Government of India and SRI (Society for Rural Industrialisation,
- Soman Krishna (2002), "Rural Health Care in West Bengal", *Economic and Political weekly*, June 29
- Williams J P, M Chitre and M Sharland, (2002), "Increasing Plasmodium falciparum malaria in southwest London: a 25 year observational study", *Archives of Diseases in Childhood (Indian Edition)* Vol. 1, Number 4, October –December
- West Bengal Health System Development Project (2002) *Health on the March – West Bengal 2001-2002*, State Bureau of Health Intelligence, Directorate of Health Services, Government of West Bengal, Kolkata
- Williams J P, M Chitre and M Sharland, (2002), "Increasing Plasmodium falciparum malaria in southwest London: a 25 year observational study", *Archives of Diseases in Childhood (Indian Edition)* Vol. 1, Number 4, October –December

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