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Regional Health Infrastructure in North Bengal at the Time of COVID19 Pandemic

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Abstract

The current outbreak of COVID 19 has a profound impact on the regional health infrastructure of West Bengal. The present study scrutinizes the level of health infrastructure across the different regions of West Bengal. The existing evidence on health infrastructure clearly shows the wide disparity within the regions of West Bengal. It is found from the study that the backward regions have limited availability of health manpower, equipment, masks, sanitizer, Personal Protection Equipment (PPE) kit and insufficient health infrastructure during the pandemic. The test per million populations was quite low in North Bengal Region. The growth of COVID-19 cases and development the regional health infrastructure in West Bengal with reference to North Bengal has been analysed. The testing facilities and their expansion during lockdowns have been critically looked and found that the private laboratories are confined to urban centres only. The existing health infrastructure at district level and its preparation to combat COVID-19 is also captured systematically. The government of West Bengal hires the services of private health care hospitals throughout the state acknowledges the fact of deficient health care in the state.

Key words: COVID-19, Health Infrastructure, Governance, North Bengal.

Introduction

The healthcare services and their delivery vary across the different districts of West Bengal. It is evident from the study of Purohit (2008) that the efficiency of public health delivery system of West Bengal remains low and substantial disparities exist across the different districts in terms of per capita availability of hospitals, beds and manpower resources. The other dimensions are such as inadequate and inefficient budget allocation for

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health, the rural-urban disparity in spending of medical healthcare services (Choudhury, 2006). Majority of the people in rural areas go the public hospitals in accessing health care services but government health infrastructure presents a sick image (Soman, 2002). The five districts of West Bengal such as, Uttar Dinajpur, Maldah, KochBihar, Murshidabad and South 24 Parganas are characterised as high priority districts with majority of tribal population whose composite health index is below 50 per cent (Government of India, 2015). These districts are considered as backward region due to the insufficient socio-economic outcomes and lack of infrastructure facility and its unique geography (De, 1990). The economically backwards region are mainly situated in six northern districts of Darjeeling, Jalpaiguri, Koch Behar, Malda, Utttar Dinajpur and Dakshin Dinajpur, three western districts of Purulia, Bankura, Birbhum and Sundarban areas of North and South Twenty-Four Pargana district (Government of West Bengal, 2004). The major constraints in the development of these districts are due to historical reason, distance and locational consideration and social composition. The key health statistic has significantly improved in West Bengal as well as in the districts of West Bengal but the disparity within the districts is not wipe out (Government of West Bengal, 2016).

In this context, Regional Development (RD) should be viewed as the articulation of qualitative changes in the geo-bio-techno-social complex of interdependent phenomena in such a manner that the quality of human life improves within the framework of the integrity of the ecosystem (Raza, 1988). The RD refers to change in regional productivity as measured by population, employment, income and laboring conditions. It also means social development which includes quality of public health and welfare, environmental quality and creativity. The RD does not mean the exploitation of virgin territory or the domination of one culture over other but, instead, improving the conditions of chronically underdeveloped regions or regions undergoing cyclical change (Nelson, cf. Bingham & Mier, 1993).

The inter-regional disparity in health outcomes, infrastructure is very prominent between the districts, regions and socio-economic groups of West Bengal. The health care system in North Bengal provides an interesting case study for conceptualising the development dynamics of the region and its various dimensions of health care services. The structural and economic issues of North Bengal are a little different from the rest of the Bengal, and it contains several characteristics of deprivation such as occupational differentiation, the urbanisation process, education, social services, health facilities, and the local labour market (Xaxa 1985). Health outcomes of North Bengal are far below the state average and national average, and in some cases, they are close to the national average (Government of West Bengal, 2016). In North Bengal, health care infrastructure has been

minimal, and a significant gap exists in the health care institutions (SCs, PHCs, and CHCs) as per the population norms. The population below the poverty line is more than 40 per cent in most of the districts in North Bengal (Government of India, 2008). The differences in health care availability are captured and explained by the level of development of North Bengal and other parts of Bengal.`

Under this circumstance, it is utmost important for the provincial and national governments to effectively utilize the existing resources of health infrastructure and plan strategies during global pandemic and lockdown. The Coronavirus pandemic begun its journey from Wuhan in China in December 2019 and travelling through Europe (Jan-Feb 2020) and West Asia (Mar 2020). Further, it has reached to the new world USA and India (Mar 2020). However, nationwide lockdown was obviously a bold step to prevent and safeguard the human health of its citizens. Moreover, India's health care systems are far behind from some of the developed countries like the United States of America, United Kingdom, Canada, Cuba, Germany and the Russian Federation, and developing country like Bangladesh and Sri Lanka (Hossain, 2018).

Objectives

The research paper tried to enquire the following objectives:

1. To explore and assess the impact of shortcoming of health infrastructure in North Bengal during Pandemic.
2. To examine and analyze the existing regional health infrastructure and its preparedness during Pandemic in North Bengal.

Data Base and Methods of Enquiry

All the five NSS regions of West Bengal are considered in the current study. The five regions are the Himalayan Region (Darjeeling, Jalpaiguri, and Cooch Behar), Eastern Plain Region (Uttar Dinajpur, Dakshin Dinajpur, Malda, Murshidabad, Birbhum, and Nadia), Southern Plains Region (North 24 Parganas, Kolkata, and South 24 Parganas), Central Plains Region (Bardhhaman, Hugli, Haora) and Western Plain Region (Bankura, Purulia, Paschim Medinipur, and Purba Medinipur). Each of the regions is taken as a unit of analysis. The present study for the analysis of inter-regional disparities of health infrastructure are based on primary as well as secondary data sources. The North Bengal region is selected for the primary survey as it constitutes a relatively backward region in terms of development initiatives, and the share of poor vulnerable SC, ST, and Muslim populations are quite high as compared to the rest of Bengal. Within North Bengal, the study emphases on one best performing and worst-performing district in terms of health outcomes i.e. Darjeeling and Uttar Dinajpur.

Secondary data for the availability of health infrastructure are collected from various sources such as Statistical Abstract of 2012 and 2015,

Government of West Bengal, West Bengal Human Development Report (HDR) 2004, Health on March 2012 and Health on March 2015-16 (Draft Copy) of Department of Health and Family Welfare (DOHFW), Government of West Bengal. The data regarding the availability of COVID19 health infrastructure and reported cases are collected from the Health Bulletin, DOHFW, Government of West Bengal. Moreover, the data vis-à-vis number of sample tested for COVID 19 and testing laboratories are computed from ICMR notification, Health Bulletin and population Census 2011

Results and Discussion

Regional Health Infrastructure in North Bengal

The regional health care is always a kind of neglected areas of Government of West Bengal since independence. It is evident from the study of Hati and Majumdar (2011) that the infrastructural facility of West Bengal is found to be insufficient to treat the majority of the patients due to high population pressure. This is also responsible for reducing healthcare efficiency and poor level of healthcare delivery to the population of West Bengal. The epicenter of regional health care in North Bengal and only referral hospital is the *North Bengal Medical College and Hospital* which was set up in 1968. Till recently, it is only Medical College catering health services in North Bengal and its catchment starting from Malda (300 kms) in the South, Cooch Behar (200 kms) in east of Assam, Darjeeling (80 kms) and Sikkim (120 kms) in North and adjoining Bihar and Nepal in West. However, four Medical Colleges have come up in recent past and these are situated at Malda (2011), Berhampore (2012), Raiganj (2018) and Cooch Behar (2018). It is well-known fact that all the northern districts of the State of West Bengal i.e. Cooch Behar, Jalpaiguri, Darjeeling, North and South Dinajpur, Malda, Murshidabad etc. is considered to be unskilled labour supply zone in most of the cities of India and the migrant labourers are engaged in various kinds of urban services typically known as *Unoranised Sector* in economic terms (Hannan, 2020: www.vikalp.ind.in).

Having this background in mind, let us look at the rural health infrastructure in North Bengal in relation to the whole state of West Bengal. Table-1 shows that average population served per rural health care institution are very high in North Bengal as compare to rest of Bengal. Although, the population density is low in the districts of North Bengal with 804 persons per sq.km as compare to 1029 persons per sq. km in West Bengal (Census, 2011). This table also indicates that there are insufficiencies of rural health infrastructure in North Bengal to treat majority of the rural patients in normal times.

Table-1: District/Region-wise Health Infrastructure (Institutions) in West Bengal. (As on 31.12.2016**)**

Regions	Number of Healthcare Institutions				Average Rural Population served per Healthcare Institutions			
	SC	PHC	BPHC	Rural Hospital	SC	PHC	BPHC	Rural Hospital
Himalayan Region	1173	90	8	30	5508	71789	807626	215367
Eastern Plains	2888	246	21	75	6931	81369	789033	266892
Southern Plains	1810	111	13	39	5719	93260	796293	265431
Central Plains	1885	210	16	52	5202	46694	612862	188573
Western Plains	2613	257	18	77	5950	60497	863757	201917
North Bengal	2276	161	12	59	6148	86914	1166090	237171
West Bengal	10369	914	76	273	5997	68034	818199	227777
Mean	576.1	50.8	4.2	15.2	5987	73083	1070618	234524
SD	252.9	25	3.6	6.2	1664.3	30038.6	849650.3	93945.4
CV	43.9	49.3	86.1	40.7	27.8	41.1	79.4	40.1

Note: a) As per IPHS, one Sub-Centre established for every 5000 population in plain areas and for every 3000 population in hilly/tribal/desert areas whereas a Primary Health Centre (PHC) covers a population of 20,000 in hilly, tribal or difficult areas and 30,000 populations in plain areas and each CHC thus catering to approximately 80,000 populations in tribal/hilly areas and 1, 20,000 populations in plain areas.

Source: *Computed from Census of India (2011), Health on March 2015-16 (Draft Copy), Directorate of Health Services, Government of West Bengal*

Table-2 shows the availability of beds in Primary Health Centre (PHC), Block Primary Health Centre (BPHC) and Rural Hospital. Average population served per PHC, BPHC and rural hospital beds are quite high in North Bengal as compared to the state average and rest of the Bengal. As per the Bhore Committee (1946) recommendation, there should be at least one bed per thousand populations (Government of India, 1946). However, India still struggles to achieve this target for the rural areas. Average population served per BHC beds in North Bengal is about 87457 persons in comparison to 51604 persons in West Bengal. The corresponding figure for PHC and rural hospital beds in North Bengal are 11267 and 7307 persons in contrast to 8919 and 6643 persons in West Bengal. This reflects the unequal regional health infrastructure at the aggregate level. But if we compare and contrast across districts and regions picture gives an impression that Kolkata surrounding areas are better served than their distant areas.

Table-2: District/Region-wise Health Infrastructure (Institutional Beds) in West Bengal. (As on 31.12.2016)

Districts/ Regions	Number of Beds in Healthcare Institutions				Average Rural Population served per Healthcare Institutional beds (Calculated as per 2011, Census)			
	PHC	BPHC	Rural Hospital	Total Rural	PHC Beds	BPHC Beds	Rural Hospital Beds	Total Rural Beds
Himalayan Region	660	110	1010	1790	9789	58736	6397	3610
Eastern Plains	1988	360	2440	4788	10069	46027	8204	4181
Southern Plains	860	185	1310	2355	12037	55956	7902	4396
Central Plains	1571	270	1926	3767	6242	36318	5091	2603
Western Plains	1893	280	2665	4838	8213	55527	5834	3214
North Bengal	1242	160	1915	3327	11267	87457	7307	4206
West Bengal	6972	1205	9361	17538	8919	51604	6643	3546
Mean	387.3	66.9	519.5	974.3	9526.8	86854.1	7109.8	3740.1
CV	46.7	94.8	44.6	45.0	43.5	102.9	45.0	41.5

Source: *Computed from Census of India (2011), Health on March 2015-16 (Draft Copy), Directorate of Health Services, Government of West Bengal*

But all these facilities remain Kolkata-centric and this facility would have no meaning for rural mass and labour supply zones of the State if facilities are not decentralized and percolate down further. The MP of Darjeeling district pointed out in a local daily that there is a huge deficiency of manpower resources in North Bengal (Anonymous, 2021). This region required 574 surgeons, 7062 community medicine doctors, 1326 health workers in PHCs and 9171 health worker in SC. However, the state government unable to fill the vacancy of 503 surgeons, 1251 community medicine doctors, 576 health worker in PHCs and 7139 health worker in SCs of North Bengal (ibid.). Moreover, it is reported that 50 doctors of Raiganj Medical College and Hospital, Uttar Dinajpur were on leave and stayed in Kolkata till 24.03.2020. They were brought back from Kolkata with the intervention Mr. Arvind Mina, DM Uttar Dinajpur and to work in the Medical College (Uttar Banga Sambad: 25.03.2020). The same situation is found in North Bengal Medical College and Hospital, Darjeeling and reported that most of senior resident doctors, Assistant Professors and Associate Professors were on leave and stuck at Kolkata due to sudden lockdown (Uttar Banga Sambad: 25.03.2020). It is also evident that all the newly established regional medical colleges in the State, senior experienced doctors work only for three days and rest of the days in a week, they remain in Kolkata. This not only hamper regular treatment but lack of advisory and consulting facilities for the upgradation of regional health care and

peripheral regions in the State suffer from proper guidance and planning. The North Bengal region is one of such example.

COVID-19 Pandemic and Preparedness of Health Infrastructure

The COVID-19 has spread in all the districts of West Bengal and daily more than 1000 new cases reported in the state. The rate of increase of COVID-19 creates an alarming situation in the urban part compared to the rural part. The West Bengal has the seventh most number of reporting cases (30013 cases) and the fifth number of reporting deaths (932 deaths) among the other Indian states (as on 12/07/2020). In May, the death reported in West Bengal as per the death audit committee had triggered a great deal of political controversy in suppressing the number of deaths. While the state health department had claimed that the death reported in COVID-19 cases follows the protocol set by the Indian Council of Medical Research (ICMR).If we tracking the testing pattern of West Bengal then the number of samples tested are only 519 at the end of March to 16525 till 30th April. In the month of May to June, West Bengal ramp up the testing to around 9, 000-10,000 testing per day after the interference of the High Court. The Hon'ble High Court of Calcutta had admitted bunch of writ petitions questioning the state's handling of the pandemic on April 17, 2020 and asked the state government to report its "adherence to effective screening on war-footing" and "acceleration of the rate of sample collection and testing" (Bose, 2020). The factual data of COVID-19 testing was available at aggregate level and the regional and district-level picture was not available in public domain. In response to a clutch PILs on issues of more testing, protection to the medical professionals and audit committee reports on COVID deaths, High court of Kolkata tells the state to look into the requirement of more testing on war footing by following the guidelines of WHO and ICMR (Singh, 2020).

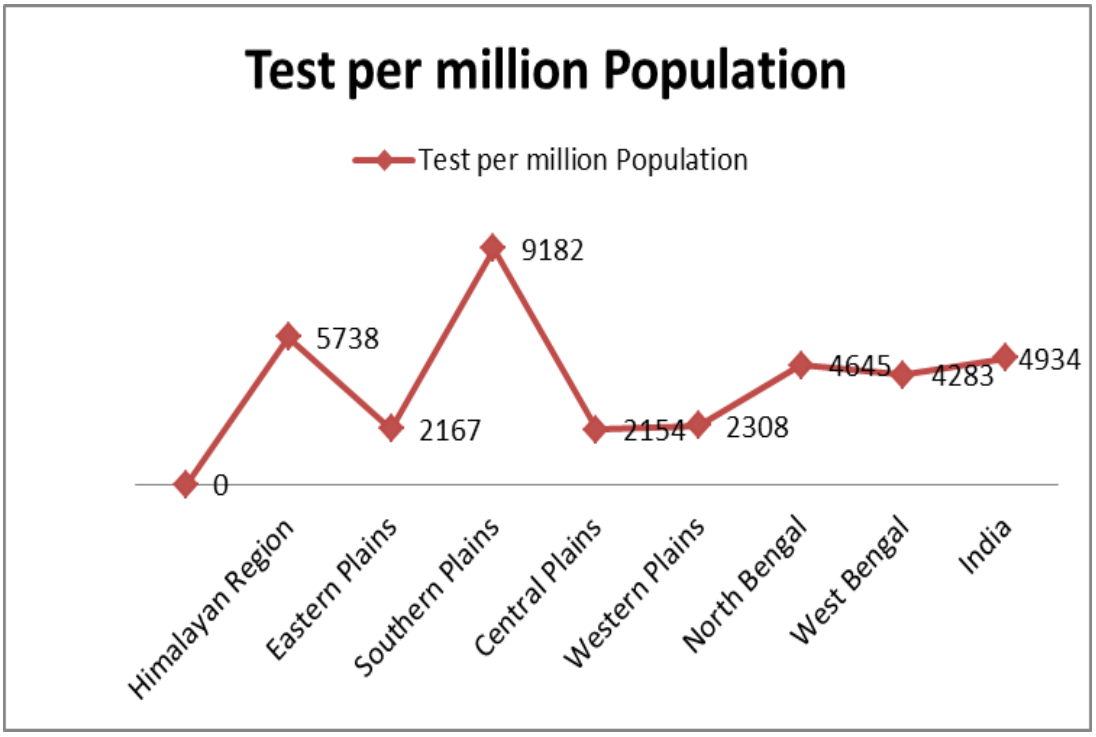
Table 3: Region-specific COVID-19 Testing Laboratories and Sample Tested

	ICMR lab as on 20/06/20				**Sample tested as on 20/06/20**	**Test per million Population**
Regions	**Govt**	**Private**	**Total**	**Lab Per Million population**		
Himalayan Region	5	1	6	0.7	48999	5738
Eastern Plains	9	0	9	0.4	52976	2167
Southern Plains	13	13	26	1.1	208152	9182
Central Plains	3	1	4	0.2	38950	2154
Western Plains	5	0	5	0.3	40470	2308
North Bengal	7	0	7	0.4	79953	4645
West Bengal	35	15	50	0.5	390942	4283
India	722	259	981	0.8	6807226	4934

Source: *Computed from ICMR notification dated 20/06/20, Health Bulletin20/06/20 and population Census 2011*

Among the other region of West Bengal, the test per million populations is highest with 9182 in Southern Plain Region and mainly concentrated on Kolkata only (see Table 3). The test per million populations was quite low in Eastern Plain and Central Plain Region (see Figure 1). ICMR lab for both government and private is mainly located in Kolkata. All the 12 private labs are located in Kolkata and one each in Siliguri, Durgapur and Diamond Harbour. The Anandaloke Sonoscan Centre in Siliguri not functional till date (June, 2020). In September, North Bengal experiences an increase of about 100-150 positive cases per day and it was a major setback in the delivery of health care services in North Bengal. In nutshell, the testing infrastructure is not satisfactory in North Bengal and periphery remains neglected by the state. This testing infrastructure also gives an impression of low priority of peripheral districts in governing health in West Bengal.

Figure 1: Region-wise Test per Million Populations in West Bengal



Source: *Computed from Table 3*

Table 4: Region-specific COVID-19 Health Infrastructure and Reported Cases

Regions	COVID-19 infrastructure As on 20/06/20						COVID-19 Cases (as on 20/06/20)		
	Public (Government designated COVID hospital)			**Private Hospital**					
	Hospital	Beds	Beds vacant	Hospital	Beds	Beds vacant	Cases	Recovery	Mortality
Himalayan Region	10	1095	794 (72.5)	0	0	0	1040	611	6

Eastern Plains	18	1601	1435 (89.6)	0	0	0	1430	994	10
Southern Plains	20	3815	2595 (68.0)	25	812	264 (32.5)	7045	3494	424
Central Plains	18	2725	2359 (86.6)	0	0	0	3077	2088	91
Western Plains	11	1104	1002 (90.8)	0	0	0	873	633	6
North Bengal	16	1376	1030 (74.9)	0	0	0	1744	1104	6
Rest of Bengal	61	8964	7155 (79.8)	25	812	264 (32.5)	11721	6716	531
West Bengal	77	10340	8185 (79.2)	25	812	264 (32.5)	13531	7865	540

Note: COVID-19 beds including the isolation beds, in bracket showing the percentage of beds vacant,

Source: *Computed from Health Bulletin on 20/06/20, MOHFW, GoWB*

The current outbreak of COVID 19 has a profound impact on the existing health infrastructure of West Bengal. If we analyse spatially, the COVID-19 infrastructure in West Bengal then the Southern Plain Region has the highest number of both public and private hospitals with the maximum number of beds (see Table 4). Among the all-region of West Bengal, Himalayan Region and Western Plain Region has the lowest number of Government designated COVID-19 hospitals. All the private COVID-19 hospital is situated in Kolkata and North 24 Paragana district. Table-3 clearly shows that about 74.9 per cent of beds are vacant in North Bengal as compared to the state average of 79.3 per cent. In the Southern Plain Region, 32.5 per cent of beds are vacant in private hospital. But recently, peoples in Southern *Plain Region* suffer a lot to get a bed in private hospital. However, it is found from the telephonic survey that some of the people are getting beds by paying the amount of 1.5 to 2 lakhs through the backdoor route.

Governing Health and Outcomes in North Bengal

The state of West Bengal is unique in the country where left government ruled for more than a quarter of a century. The two major public initiatives had implemented by West Bengal Government in 1977 was land reforms and decentralisation which impacted positively in reducing poverty, and in the process of growth and development of the State. However, it is evident from various literature (Raychoudhuri and Haldar 2009 and Purohit 2008) and government reports (Government of West Bengal, 2004; Government of India, 2002) that the inter-district and intra-regional differences in the state are widening. The six northern districts are considered as backward region due to the insufficient socio-economic outcomes and lack of infrastructure facility.

To improve the health of the population, state government has introduced "Swasthya Sathi" scheme in the year 2016. The main feature of the Swasthya Sathi scheme is to cover basic health cover for secondary and tertiary care up to Rs. 5 lack per annum per family. Swastha Sathi covers up to 1.5 lakh through insurance mode and beyond 1.5 lakh to 5 lakh through assurance mode. All the pre-existing disease is covered in this scheme with irrespective of family size. All the district of West Bengal covers about 64 lakh families for secondary and tertiary care up to Rs.1.5 per annum per family. Critical illness like Cancer, Neuro surgeries, cardiothoracic surgeries, liver diseases, blood disorders etc., will be covered up to Rs 5 Lakh per annum per family, and the cost thereof will be borne by the State Government. About 7 crores 50 lakhs family included in the Swastha Sathi scheme till 30 April 2020 with 1570 empanelled hospitals and 1092825 persons befitted from the scheme (Government of West Bengal, 2020). The beneficiaries of this scheme avail the services from paperless, cashless smartcard valid for a lifetime with auto-renewed in each year (ibid). The token of the Swasthya Sathi card is distributed through the self-help groups. It is reported in Uttarbanga Sambad (2019) that the distribution of the Swasthya Sathi token depends upon the political affiliation of the member of self-help groups. This politicisation in the distribution of the token of the Swasthya Sathi card was leading to the deprivation of other villagers in getting the token. But during the fieldwork in North Bengal, it is revealed by the beneficiaries that private hospitals refused to treat patients with this card. Till now, this card is not utilised extensively by the empanelled hospital, which includes private hospital also. Recently West Bengal government has also passed an order with regard to the refusal of treatment by the empanelled hospitals (Order dated 08.01.2020, Memo No. HF/O/SS/EC_MEETING/2016/Part 2A/1997).

Other than this the process of decentralisation is also very poor in the districts of North Bengal. The evolution report of the Department for International Development (DFID) of Strengthening Rural Decentralisation (SRD) programme identified that these priority districts requiring more focus intervention and need planning on poverty. It is also found that the Fiduciary Risk Assessment (FRA) was also high in these districts. As per the Annual Administrative Report (2008-09), Panchayat and Rural Development Department, Government of West Bengal, most of the districts in North Bengal are the worst-performing districts in terms of service delivery by the panchayats of the respective districts. The literature on decentralisation of service delivery suggests that local-level democracy may not function well due to unequal distribution of assets, literacy, social status and political participation. The poverty alleviation effort of the West Bengal panchayats was not achieved successfully due to the phenomenon of limited accountability of gram panchayats in the presence of high inequality in socioeconomic status and political power (Bardhan and Mookerjee, 2003).

As per the NHM manual, there should be certain committees like Rogi Kalyan Samity (RKS) at the district and block level and people's organization such as Village Health Sanitation and Nutrition Committee (VHSNC) at gram panchayat level. These committees are needed for decentralized outcome-based planning and implementation. But these types of committees are not functioning properly as per the NHM guidelines. The Rogi Kalyan Samity or patient welfare committee is an effective management structure for proper functioning and management of the hospital. The main objective of the RKS is to ensure proper accountability of public health providers to the society, proper availability of essential drugs, proper scientific disposal of hospital waste, provide drinking water subsidized food, medicine and cleanliness, introduce transparency in the management of funds, supervise the implementation of National Health Programmes, display of citizen charter, upgrade and modernize health service facility and undertake construction and expansion of building as per the hospital need (Government of West Bengal, 2010).

It is evident from the field work in North Bengal that RKS is ineffective to address the various objectives at the block level. The Rogi Kalyan Samity is functioning at the district level only. It is found from the fieldwork in the districts of Darjeeling and Uttar Dinajpur that the meetings were not conducted regularly at the block level. There are absences of activities between the Village Health Sanitation and Nutrition Committee (VHSNC) and the Sub-Centre in the North Bengal region. There was no such local-level community action under VHSNC on the issues related to health and its social determinants at the village level. Community-level services in the process of decentralized planning are not initiated by the VHSNC in the villages of Chakulia block in the district of Uttar Dinajpur. During the field visit, it was found that all the interacted ANM and ASHA workers were not aware of the constitution of Village Health Sanitation & Nutrition Committee and it's functioning. ASHA workers were unaware about their membership in the VHSNCs. The ANM and ASHA workers are not aware of the role of VHSNC and refer it as a function of Panchayat Samiti (Block Political Unit). However, the importance of VHSNC has been realized during COVID 19 Pandemic for controlling the spread of coronavirus in the villages.

Concluding Remarks

During pandemic, the improvement of health infrastructure and COVID-19 hospitals were developed in urban areas and metro cities of labour supplying states of Bihar, West Bengal, Odisha, UP etc. But now all these states should take sincere efforts and stimulate the chain of Rural Health Care Network of Sub-Centres, Primary Health Centres, Block Primary Health Centres and Rural Hospitals. The rural health care network is weak in labour supplying states and COVID-19 testing laboratories are situated in urban centres in these states. In West Bengal too, it is mostly Kolkata-centric.

During pandemic the alliance with private health facilities in West Bengal is attempted and this itself proves about weak health care system in the State.

However, the available evidences on decentralised institutions perceptibly show the poor performance of Panchyat Raj Institutions (PRI) in the backward regions of West Bengal. Within this backdrop, it is very important to promote the institutionalization of panchayat raj with functions like health, finance and functionaries. The Committees like Rogi Kalyan Samity (RKS) and Village Health Sanitation and Nutrition Committee (VHSNC) is the important instrument towards facilitation of inter-sectoral coordination, local community participation in decision making and improving facility-based health care services (Narwal 2015). But during pandemic, State government announces withdrawing of power from the *Rogi Kalyan Samities* and makes it more centralised to overcome the present crisis (ABP Ananda 2020). The centralized system of health administration is creating more problems to deal with the COVID-19 crisis in the rural populace of North Bengal. This pandemic requires more engagement of panchayats with the collaborative effort of self-help groups to set up quarantine facilities within the village premises and provide masks, sanitizer, food and safe drinking water to the vulnerable populace and migrant labourers. During this health crisis, Government should promote *Mobile Health Services* in the inaccessible terrain of North Bengal as well as on other backward regions which include the facility of doctor, lifesaving medicines and diagnostic testing kits.

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