CHAPTER 6
SUMMARY, CONCLUSION AND SUGGESTIONS
6. Summary, Conclusion and Suggestions

6.1 Summary of the findings

One of the key determinants of human development is the ability to live long and healthy life. It is the availability of Health Care Services at an accessible distance, with effective and complete utilization of the Health Care Services which plays a significant role as the prominent determinant in achieving the nation’s health. India lives in its almost 6.5 lakh villages. If basic health care does not reach the rural areas, no matter how much progress is achieved in the urban and semi-urban areas, the overall growth as a nation will be retarded. India has made significant progress in improving healthcare. But improving access to basic healthcare services to the rural population is perhaps one of the most pressing, from a straightforward human development perspective.

This study was undertaken in order to explore the primary health care in rural areas of Anand and Kheda districts of Gujarat, its infrastructure, manpower availability and the acceptance and utilization of such facilities and services by the rural community and efforts of government and the other non governmental agencies in promoting the health through health programmes. This study is a meaningful exercise in understanding the rural community’s requirement with respect to the primary health care need, especially maternal and child health care need. The findings of the study are summarized as listed under.

Major Findings

1. According to Health Care Facility survey, 100% of the villages have health care facilities of government and the NGO, Tribhuvandas Foundation. Private health care facilities are present in 98% of the villages. Also every village is having at least two ASHAs, one VHW residing in the village and service is available around the clock. Only 1% of the villages have Ayurvedic health care facility and no village has Homeopathic facilities in spite of one of the goals of the National Rural Health Mission (NRHM, 2005–12) is to streamline AYUSH (Ayurvedic, Yoga & Naturopathy, Unani, Siddha and Homeopathic systems) into main stream of Rural Health Care System.
2. According to the Indian Public Health standards norms there exists a considerable gap in terms of availability of health professionals and services in Sub Centers (SC) and Primary Health Centers (PHC). 96% of the SCs have Female Health Workers and 100% of the SCs do not have Male Health Workers, 96% of SCs have Nurses / ANMs and 96% of the PHCs have only one doctor and there are hardly any specialist doctors like Gynecologists or Pediatricians. 10% of the PHCs are having an issue with the continuous supply of essential medicines. Even though IPHS norms suggest that every PHC should have 1 Lab technician only 60% of the PHCs have one Lab Technician.

3. According to household survey, the awareness level of the households is excellent with respect to the availability of the different type of health facilities and the availability of the health professionals and services. According to households the doctors, nurses/Auxiliary Nurse Midwife (ANMs), drugs/medicines and lab facilities are available 81%, 90%, 83% and 76% respectively in Anand district and are available 75%, 92%, 82% and 71% respectively in Kheda district.

4. Irrespective of their demographic background like caste, income, education, 100% of the households are aware of the different types of medical facilities available in their villages. 75% of the households of Anand and 90% of the households of the Kheda district expressed that traditional healers (tantriks or “Bhuva” in Gujarati) are also present in their villages. It is also noticeable that even though 90% of the households of Kheda district are aware of the traditional healer’s presence, no one prefers to use their services.

5. Accessibility is the second key component in the rural health care services. household survey found that for 48% of the households of Anand and Kheda districts, health care facility is available within 1 Km distance, where as 6% of the households of Anand district, 13% of the households of Kheda district have to travel more than 7 Km distance to reach the nearest health care facility. More than 30% of the households have to travel more than 3kms to access the nearest health facility.

6. Accessible distance during emergency medical care in both the district is by the EMRI 108 services. Households are awareness level about the service is 96.7% and
the beneficiary rate of this service is 74.5% and the households are highly satisfied about the EMRI services.

7. Acceptance of the health care facility is very crucial in rural context. The three different prominent health care facilities in the villages are government health facility, private health facility and an NGO sponsored Tribhuvandas foundation. It is noticeable that households of Anand district utilize relatively more (about 70%) of TF services compared to government services, where as the households of the Kheda district use almost about 65% of government health facility. In both the districts, the households use the private health care facility only during emergencies.

8. It is found from the survey that the utilization of the health facility largely depends on the availability of health professionals and medical services. Utilization of the facility is significantly associated with the availability of the doctors and medicines. The utilization of the health facility is also significantly associated with the distance to the health facility. It is expressed by the households during the survey that they prefer to use Tribhuvan das Foundation facility as it lies almost in the heart of the village.

9. The households have given average rating of 2.93 to government health care facilities, 2.43 to private facilities and 2.29 to TF facilities.

10. The Family structure (Type of family) is a significant demographic factor influences the utilization of the health care facilities. Joint families use more government health facility and nuclear families prefer NGO sponsored TF facility. It is noticeable that the demographic factors like religion, caste and even the family income is not so significant in the utilization of the health facilities.

11. In rural areas, pregnancy care and delivery of the child is practiced in a very primitive way taking the help of elder ladies of the house / community and dai of the village. Given this background, the expectant mother visiting the health facility for antenatal checkups and successively delivering the child in the institution is influenced by many demographic characteristics. The significant demographic factors that influence the expected mother to have antenatal check-up and delivery in the institution are the husband’s education, and Expected mothers education.

12. House hold survey reveals that 83% of the antenatal mothers have at least one time Antenatal Checkup (ANC), of which 59% of the mothers have more than 4 times
ANC. It is also statistically true that there is an association between the number of ANC and taking Iron Folic Acid (IFA) tablets and getting vaccinated (TT).

13. It is found that institutional deliveries in Anand District are 87%, of which 88% of the deliveries are in government hospitals and 12% in private hospitals. Deliveries at home are 13%, of which 26% of the deliveries are by the untrained dais or without the assistance of any type of medical assistants. Correspondingly, institutional deliveries in Kheda district stand at 79% of which 71% are in the government hospitals and 29% in private hospitals. Deliveries at home in the Kheda district is 21%, a little higher compared to Anand district, of which 26% of the deliveries are without the help of any type of trained medical assistance.

14. Satisfaction level of the expectant mother is significantly influenced by the expectant mother’s age and expectant mothers education. Satisfaction level is low when mother’s age below 25 years and also the education is inversely proportional to the satisfaction level. Also the other factors which have influence on the satisfaction level is the type of the family and place of delivery. Satisfaction level is high if the expectant mother is from the joint family and if it is in government health facility or private health facility.

15. 80% of the newborns or infants (less than 1 month) get the colostrums feeding within 6 hours of birth and 88% of the infants get their normal breast feeding. It is statistically found out that there is an association between colostrums feeding and the infection in newborns. It is also found that there is an association between breast feeding and occurrence of diarrhoea among the newborns.

16. Common ailments among children under 5 years of age are diarrhea, on an average, 26% followed by respiratory infection in 8% and ear infection in 6% of the children. Further the Kathlala taluka of Kheda district shows as high as 60% for diarrhea and Tarapur taluka of Anand district is also significantly high with 40%. It is found from the study that Khambat taluka has as high as 13.3% of the under 5 children with respiratory diseases and ear infection is noticeably higher in Sojitra taluk of Anand district with 40%.

17. In Anand district, the immunization coverage for children is relatively better than the head district. The percentages of children that are fully immunized are just above 50%. Full
immunization is affected because of the drop out ratios from DPT1 to DPT2 and further reduction to DPT3. The percentage of Polio drops being given to children is relatively appreciable. This is exclusively because of the highly focused programme for Polio eradication from the country by 2010. Immunization coverage of children under 5 years was not appreciable. The achievement of full immunization is affected as the DPT drop ratio has drop down from 91% to 69% from the first dose to third dose.

18. The prominent maternal and child health programmes in rural areas are Mamta Divas, Chiranjeevi Yojna, Janani Suraksha Yojna, Awareness of the households on different health care programmes addressing maternal and child health, immunization, health education about hygiene and sanitation is very good ranging from 61% to 98%, in which awareness of the households of Anand are relatively higher compared to the households of Kheda district. It is also found that the proportion of people getting benefits from these programmes is relatively less which ranges from 34% to 90% compared to the awareness.

19. Achieving the Millennium Development Goals 4 and 5 calls for many practices in maternal health care. The two key practices for the better maternal and child health are regular Antenatal check-up and delivery at the Institution. The different health initiatives like ASHA’s household visit, VHW’s household visit, Mamta divas and MCH programmes are significantly associated with number of the antenatal checkups and the delivery at institutions. Institutional deliveries are also significantly associated with the Chiranjeevi Yojna and EMRI services. Similarly there is a significant association between Mamata Divas and immunization coverage.

20. It is found from the household survey that majority of the households prefer government facilities for their health care needs. Also households have the opinion that the government facilities are mainly for the antenatal check up, delivery and immunization for the children. The programme like “Information, Education and Communication” conducted by an NGO, TF is more popular and has many beneficiaries. Also its found during the survey that the mothers take the post natal counseling from the Village Health Worker of TF than the ASHAs of government facilities. Also NGO in the village effectively educating the rural community with respect to health and hygienic practices.
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### 6.2 Suggestions to improve the rural health care services

Health policies, several Committees and Commission recommendations have spelt out several measures to improve the quality and quantity of rural primary healthcare system and its services. Their strategy is to generate demand for public Health Facilities, provide options to population and increase participation by NGOs and private sector in the healthcare provision. Simultaneously, it rightly does not treat the problem as exclusive to the public health department. An integrated approach involving different departments like sanitation, construction, water supply, education, power, roads, etc. is well recognized. NRHM is a comprehensive effort in this direction. Appointment of ASHA and AYUSH practitioners and full involvement of Panchayati Raj Institutions (PRIs) in monitoring and delivering healthcare services to local population are important ingredients of the strategy.

Given this context, the two districts Anand and Kheda are fairly doing better in terms of quantity of infrastructure and availability of emergency services. Although there is clear shortage of the qualified health professionals, their absenteeism at village level is considerably less. Districts also have excellent emergency services (EMRI 108) around the clock to access to the health facilities and to increase the institutional deliveries. Now it is the time to focus on the quality of the health care services to ensure the better health care services for the weaker section of the community.

1. Introduce the accreditation system for Health Facilities for their infrastructure, human resources, drugs and medical supplies based on the annual visits and can be graded based on the compliances of the norms.

2. Introduce the system of awards for the best performing health facilities in various categories. Similarly identify the best performer in each health facility under different categories based on the performance and commitment. The selection of such performers can be based on the feedback and ranking of the beneficiaries. The categories can be the sections which bring in quality in the work and work place like campus cleanliness, patient satisfaction, attending the patient early, less waiting time for patients, patient engagement during waiting, health education to patients.
3. Creating the better and hygienic living condition for the BPL families with basic necessities like toilets, bathing, drainage and good drinking water. Such living condition in the villages reduces the burden of morbidity.

4. Create special incentive schemes for the rural doctors and nurses to attract them for the service for stabilized stay of the health professionals in the villages.

5. Reduce the administrative burden of the health professionals especially nurses, doctors so as to enhance their focus on the health care quality. To build the good database and MIS, provision should be made to appoint one computer system generalist, who looks into data entry, software and hardware.

6. Now every citizen of the nation is having an identity of existence through the mega project of Unique Identification Scheme, which largely provides a base for the reach of the intended benefit to the beneficiary with the perfect identification. With UID as the base, Identify the BPL families and entitle the family with some specified amount per annum for hospitalization, treatment, medicine etc. Any other persons/ families using the facility need to pay a small amount for the service. The revenue so generated can be used for the improvising the facility in terms of quality.

7. Currently ASHA under NRHM are a volunteer health activist, who receives honorarium for her services. In the long run this system may collapse as this honorarium is too little to retain their interest in doing the job effectively. After 2 years of service, an effective ASHA can be put under intense training and can be appointed as Health educator at PHCs. (IPHS norms prescribe 1 health educator per PHC and currently there are no Heath Educators in any PHCs). If ASHA does not wish to move out of the village, appropriate training can be given and can be taken as an additional ANM on contract basis with regular salary and incentive for the performance.

8. The delivery of the health care in rural India is almost entirely curative in nature. But good health is possible only when there is a transformation with respect to the hygienic practices and utilization of the health services at the right time. Government should have Public Private Partnership in designing the effective social marketing of programmes at the health facilities in bringing the required behavioral change in maintaining the good health.
9. It is widely observed that the public health facility and private health facilities are working as two isolated units in the same industry. The policies and programmes should be made such that services, information and expertise can be combined and put to service for the benefit of the community’s health.

6.3 Conclusion

Rural Health Care Delivery system based on the Primary Health Care Approach was started way back in 1977 in India. Alma Ata declaration of “Health For All” in 1978 was a big challenge to achieve till India launched its ambitious programme of National Rural Health Mission, (NRHM 2005 – 12) to improve the health status of its rural community, especially the women and children of the weaker section of the society. NRHM focused on building up the infrastructure, improving the manpower at all levels of health care delivery centers like Primary Health Centres, Sub Centers as its core strategy. It emphasized the need of a Health Activist for each of the villages, thus introducing Accredited Social Health Activist (ASHA) in every village for every 1000 population. Also, it emphasized the need for community participation and partnership with the private health care providers and NGOs in creating awareness about the health care issues especially maternal and child health care through health education and different health care programmes.

This study of 49 villages of Anand and Kheda districts reveals that the availability and accessibility of health care is considerably improved. But when it comes to availability of trained manpower, there is shortage of doctors and para medical staff in different health care facilities. The awareness level of the community is very good with respect to the available health care services. But, further efforts are needed to bring in behavioural changes in utilizing the available health care facilities and reap the benefits. Health care programmes are to be made more effective to increase the ratio of the beneficiaries.
6.4 Further research in the area

Strengthening the health facilities only in terms of physical infrastructure and placing the required manpower on the job does not assure a good health to the community. It requires treatment in compliance with the set standards for both tangible and in tangible deliverables. The social marketing is a strong tool that can bring in behavioral transformation, which is key in public health promotion. Even though it is need of the times the research in this area is very limited. The research in measuring the impact and effectiveness is a prominent dimension to that can add to knowledge of the understanding social marketing further better. Keeping this in view, the following are the suggested research, which contributes to the existing knowledge in achieving the desired health in the community, nation at large.

1. Concept of “Quality” in health care and the various dimensions of quality health care.
   The governance, monitoring and controlling systems to ensure quality health care.
2. Effective social marketing of health programmes to bring in the behavioral changes to promote health.