CHAPTER - X

FINDINGS, CONCLUSIONS AND SUGGESTIONS

10.1 IMPORTANT STUDIES IN THE FIELD OF RURAL HEALTH AND MEDICAL CARE

10.2 SUMMARY OF FINDINGS

10.3 CONCLUSIONS

10.4 SUGGESTIONS
FINDINGS, CONCLUSIONS AND SUGGESTIONS.

INTRODUCTION:

Health status is one of the important indicators of the human development. In most of the countries it is the health status of the people, which determines their well being and their socio-economic development. Speaking on health problems, Jawaharlal Nehru observed on health problems that the fund can be available for the big wars, but there is no reason why they should not be provided for to fight against ill health (Gopal S. 1984).

In the context of developing countries like India, the nature of health problems is different. In our rural areas where about 70 percent of our population resides both physical (geographical) and social environments are not congenial for the health of the people. The most striking problems in the rural areas of our country are lack of safe drinking water supply, insanitary living conditions and malnutrition. Hence, safe water supply and sanitation has received the world wide attention and the United Nations had declared 1981-91 as the "International Drinking Water Decade".

Fluoride contaminated water is a major problem which is associated with the dental fluorosis and with the skeletal damages in both children and adults and also with early aging. Hence, fluoride is one of the important contributing factor in spreading endemic diseases. Not withstanding the efforts by W.H.O., and by many national governments and voluntary institutions, the developing country like ours, is still severely threatened by endemic diseases. This situation is thwarting the physical, mental and social well-being of the people and thereby affecting the economic progress of the country and which not only creates the problems of health but also of social welfare and social justice. Thus, the failure in the area of modern medical and
health care to attain complete or optimum physical, mental economic and social well-being of people calls upon the planners, doctors, social workers, scientists to analyse the health system to find out the yawning gaps.

10.1. IMPORTANT STUDIES IN THE FIELD OF RURAL HEALTH AND MEDICAL CARE:

As is apparent from the detailed discussion on existing literature in the field of rural health and medical care in India, we arrive at a conclusion that health and disease are not merely biological phenomena. The Socio-Cultural, economic and education, nature of health services and their utilization also affect the health profile of a community. Thus, it is no denying a fact that the consideration of such factors is indispensable to planning, organizing, implementing and monitoring the medical and health care programmes in any community for the far reaching results. Therefore, the sociological dimensions related with rural health and medical care in the geographical and cultural prospective is the main focus of the present study. The present study is an attempt to explore the health needs and draw attention on the reality of health systems in rural setting.

10.1.2. ABOUT THE STUDY:- The main aims and objectives of the present study are as follows.

(i) To study the nature and extent of the problems of health confronted in the area under study, (ii) To understand the relationship between the quality of water consumed and incidence of diseases like fluorosis, (iii) To examine the impact of Tungabhadra river water supply on the health condition of the people in the area under study, (iv) To know the people's perception of health and disease and to understand the beliefs, habits and practices and their influences on the health behaviour of the people, (v) To study the role of social, cultural, economic
and educational factors in health and disease; (vi) To bring out the practices of rural people in relation to their health problems including dietary practices, maternal and child health; (vii) to find out the impact of health disorder on economic and social conditions of the family; (viii) To study the people’s awareness about health services and their utilization of available health services in the community; (ix) To bring out the basic needs of health of the rural community; (x) To understand the community responses to the present health problems; (xi) To suggest measures and areas of improvement in the health care delivery system for providing adequate health care services to meet the health needs of the community.

The needs for undertaking this study on rural health and medical care arise due to the following facts:

1. The researcher has not come across such study earlier and hence, this study may be used by those who are interested in the aspects of rural health and medical care.

2. The study highlights the existing social, cultural, economic and educational aspects of health problems and also explores the health needs of the people and will be helpful in discerning the gaps in the field of rural health and medical care and would indicate the area which still to be attempted by future studies.

10.1.2 THE FIELD SETTING:

Kalkeri village covered by the study belongs to Mundaragi taluka in Dharwad district in Karnataka. The reorganisation of districts in Karnataka during 1997 resulted into the new Gadag district and the study area is now included in the above said district. Kalkeri is a small village with 3,568 population (1991 census) located just 9 km away from the taluka headquarter Mundargi town on Mundargi Shirahatti road. The study village is situated in the most backward area of the district, and is under
the grip of its own health problems. It is my personal observation that the village is facing problems of low nutritional standard, low economic status, lack of sanitation, and poor hygiene, resulting in substandard health of the masses. My personal discussion with the Medical Officer of Mundargi Community Health Centre, has also revealed that the local fluoride contaminated ground water is also responsible factor for its bad effects on the health condition of the people in the region.

Under such circumstances, the present study tries to analyze sociological factors responsible for health hazards.

10.1.3. METHODOLOGY:

Due to the constraint of time and man power resources available, it was thought desirable to carry out a survey of about one-fourth of households in the Kalkerí village with the help of interview schedule. From the village referred above, 745 houses enumerated for this study of which 190 houses have been selected by random sampling technique which accounts for 26.2 percent of the households.

The pre-coded interview schedule have been used for the purpose of collection of respondents to various questions from the heads of households. These have suitably been modified in the light of observation made and finally administered to the respective category respondents during the period of four months. To supplement the data collected with the help of interview schedule, the official records have also been referred for relevant information for our study. The data have been analyzed in the form of cross tables, and percentage methods have also been used in the same tables. Chi-square method has also been followed to test the significant of the relationships or differences between the variables used in this study.

Lastly, the observation method has also been used in recording the community environmental conditions of the study.
village. The experiences of doctors and members of the health team of Mundargi CHC have also been used where there was a need of explanation and analytic understanding of the phenomenon affecting the general health of the people of the community.

10.2. SUMMARY OF FINDINGS,

1) BACKGROUND CHARACTERISTICS:

Here the data analysed so far has been summarized about the background characteristics of the respondents in fourth chapter. Out of 190, respondents interviewed a majority of respondents 105 (55.3 %) in all the four social classes were male members, and their proportion increased with the rise of class position. Whereas, 85 (44.7 %) of the respondents were female and their proportion increased with the fall of class position. Most of the respondents of all the four classes belonged to the Middle age group (31 years to 50 years) and 71(37.4 %) were married. There were 1408 household members in the 190 sampled households. All the four classes had good number of female members in the sample population. On the whole, the sample population of all the four classes were found to be young (21 to 30 years) and 69 (36.3 %) were unmarried. There was no significant different in the household size of the different class households.

The study has been covered almost all the caste groups on the basis of their proportion in the total population of the sample village. In the sample, a majority of the respondents 147 (77.4 %) were Hindus and a few 43 (22.6 %) were Muslims. The educational status, occupational status, and economic status of the respondents increased with the rise of class position. The educational level of the household respondents increased with rise of class position. Higher the class position, higher was the occupational position of the household members. The relationship
between occupation and household health was also studied with a view of understanding the disease pattern of the different occupational structure.

The basis of the village economy was predominantly agriculture. Of all the 22 endogamous groups in the sample were dependent upon the agriculture either wholly or in a part. The number of farmers 36 (18.4 %) increased with the rise of class position. The number of unemployed persons were less among the very low and high class households respectively.

Most of the High class households lived in pucca and semi-pucca houses. Whereas, a majority of the middle, low and very low class households lived in kucha houses. A majority of all the four classes lived in independent houses. Whereas, the remaining sample households shared their dwelling with other households. On the whole, 115 (60.5 %) joint families and 75 (39.5 %) nuclear families were found in the sample households. The number of rooms of each households increased with the rise of class position. Except a few under the study, a majority of the household respondents did not took the advantage of air and sunlight. Out of 190, households, 110 (57.9 %) households had one or more cattle and other animals. The High and Middle class households had separate bathroom, latrine and water supply, but most of the Low and very Low class households lacked these facilities.

Only a few households had a drainage system in their area but level of satisfaction with its functioning decreases with the fall of class position. On the whole, the level of satisfaction regarding scavenging services also decreased with the fall of class position.

2). DISEASE PATTERN (HEALTH PROBLEMS):

The diseases suffered by the respondents were divided into (I) Chronic diseases and (II) body system-wise illnesses.
(I) Chronic diseases: Heart related diseases, cancer, paralysis, asthma, diabetes, tuberculosis, polio and fits, and

(II) Body-system-wise illnesses includes the problems pertaining to all parts of the body system.

As it was expected, the chronic diseases were mostly the diseases of the rich and the old, the number of chronic disease patients increased with the fall of their class position. Since, the rich and the very old respondent parents were found in the High and Middle Class households they were more prone to Chronic diseases. On the whole, the victims of Chronic diseases were a few in the sample when compared to the body system wise illness, and their proportion increased with the fall of class position. It was an expected trend attributed to their poor working conditions and living conditions of the Low and the Very Low classes would create a situation for chronic diseases.

Other illnesses deal with assortment of ailments in the body system. All the four classes had a maximum number of symptomatics who were above 24 percent of the total household members in the sample. The number of symptomatics belonging to different classes increased with the rise of class position. A very high rate of skeletal damages, dental caries, and gastrointestinal diseases could be attributed to the consumption of fluoride contaminated ground water as well as unhygienic river water supply of the locality, poor income, poor living conditions, and their ignorance of disease and health services due to their low educational status.

3) PERSONAL HYGIENE AND HABITS IN CULTURAL PERSPECTIVE:

It has been observed that customs, and practices with regard to personal cleanliness are governed by rites and rituals, which effect people's behaviour in regard to their personal hygiene in the community. The data regarding cleaning of hands
revealed that respondents having rural background and illiterate use mud, which is culturally determined. While only a few respondents who belonging to the High class households wash their hands in soap. We observed that most of the respondents simply throwing of a little water on their hands before meals. This habit again is responsible for ill-health of the people.

The data regarding the ablution practices, it has been found that even if there is a provision of public latrines in the village, the people use to sit at road side indiscriminately for easing themselves. Hence, this hygienic conditions, both personal and environmental, are also found to be poor in the community under study.

The general observation regarding the habitual drinkers in the community under study reveal that there is more number of drinkers. But in our household survey, only a few 19(18.26 %) of the respondents are found to be habitual drinkers and a majority of them (59 %) are found among illiterates. This situation gives rise to behaviour induced diseases. The morbidity survey shows a prevalence of the diseases of eyes and teeth respiratory and gastric disorders. We feel that until the socio-economic and educational status of these people is improved, the overall picture of personal hygiene and health cannot be improved and this improvement can be seen only when there is change in the attitude and behaviour of the people through the massive drive of health education.

4) COMMUNITY ENVIRONMENT AND HEALTH:

It is observed that the major part of the community under study contains deteriorated and unplanned housing, congested zig-zag streets, dirty and almost blocked drains making the total environment unhealthy. The living conditions of a large part of the population are not conducive to health. The water supply is unpotable and insufficient to meet the needs of the people. The
presence of domestic and stray animals render the home and its surroundings highly polluted. Thus, the socio-economic and biological environment of the locality is not conducive to health.

The community has got the services of the Primary Health Center yet, the health awareness and action consciousness is at the lowest ebb. The reasons to be attributed are poverty, ignorance and lack of people’s faith in public health centre. On the community level it is observed that efforts for community organisation for better health sadly look in the community under study.

5). BELIEF SYSTEM AND RELATED HEALTH PRACTICES:

‘Health’ as defined by the villagers is essentially a result of absence of illness/disease/injury in the body and normal functioning of the body. It means only when a person he or she remains free from all types of illness is considered as healthy. While, “illness” or “disease” has been considered as a malfunctioning of the human body. It means when a person completely stops his day-to-day work and confines to bed, he become sick. It has been found that 31 percent of the respondents in the village considered poverty, germs and confined to bed as the general cause of disease and considered as sick or ill person. 26 percent wrong combination of food; 20 percent excessive heat or cold, and bad and irregular habits, 15 percent malfunctioning of the human body; only 8 percent of the respondents believed that inability to perform his or her daily expected role, are considered as a general causes of the diseases.

Similarly, it has been found that 41.6 percent absences of disease/illness/injury in the body and normal functioning of the body; 27.4 percent ability to perform daily routine physical work without any difficulty, eats more, hard work and long lives; 16.8
percent good muscular body, freedom from worries and sorrows and well adjustment with others; only 14.2 percent right condition of the body is God's gift and good deeds of the past lives. Thus, the respondents of the study village are considered the concept of "health".

It has been observed that the respondents are diagnosing the external symptoms of certain disease like jaundice, fever, and cholera. 42 percent of the respondents are considered diarrhea, vomiting, excess heat in the body, thirst, dry skin and sunken eyes as external symptoms of cholera; 39 percent looks sad, yellowish eyes, urine, nails and loss of appetite are considered as external symptoms of jaundice; only 16 percent of the respondents considered looks pale black body, high body temperature, head ache, and body ache are the external symptoms of a person suffering from fever; only 3 percent of these respondents do not know about causes of disease.

It has been observed during the study that deistic, demonistic, supernatural, rational etc are considered as causes of various diseases by the respondents. Committing sins or misdeeds of the past lives have been considered as the cause of diseases like asthma, tuberculosis, paralysis, and whiteness (Bilupu/Thonnu) by the respondents of the study village. Similarly, intrusion of ghosts, demons and witch comes in the demonistic belief. Smallpox and measles are believed to be caused by deistic factors as stated by most of the respondents. Thus, for the treatment of small pox/measles both the government and private doctors are not consulted at all, but certain traditional notions are being followed to avoid any ill effects on the patient and worshiping goddess Durgadevi is performed. A good number of respondents believed mosquitoes bite as the cause of malaria.

Similarly, it has been observed that the villagers also believe in the prevention of diseases. They believe in the efficacy of modern medicine than any other system of medicines, particularly in diseases like tuberculosis and madness. However,
many other practices are also prevalent in the study community, for example, home medicine followed by treatment, traditional healers are not much popular in the study village. In Kalkeri there are only one or two traditional healers from Muslim community of the village are providing magico-religions and herbal therapy to the patients. Snake/scorpion bites are also treated by magico-religion therapy. Besides this, private medical practitioners are also consulted by the villagers. Role of private registered medical practitioners have been found crucial in the village health system. But the government practitioners whether medical or ayurvidic are visited very rarely. The villagers rather than getting admitted in hospital have preferred treatment at home.

It has been found during the study that there are 57 percent non-vegetarians, 43 percent are found to be vegetarians. The nutritious diet as described by the respondents include milk, butter, ghee, fruits, green vegetables, pules end cereals and improvement of health could be ensured by taking such nutritious diet. The idea of hot and cold food is also found to be present in the village.

It has also been found that greater care and more concern are shown in the households, particularly when head of the family or earning member falls sick. The villagers also believe in providing help and co-operation to their close relatives or neighbours during their illness. Similarly, they expect the same response from their relatives or neighbours in the time of need and emergency.

The data regarding health practice during illness reveal that 78(41.7%) of the respondents tend to prefer to go to consult local private practitioners; 49 (25.7%) of the respondents consult the private doctors in the nearby town; most surprising thing is that 31 (16.3) of the respondents do not bother for their illness and take old medicine prescribed by a doctor many years ago. Till now, 16(8.6%) seems to be believing in witchcraft treatment; only 8(4.3%) tend to prefer to go to a specialist in town; a few 6(3.1%)
of the respondents tend to prefer to go to the nearest hospital; whereas, use of home medicine and consulting the midwife or trained dia in the village are almost negligible (1.0%) use of home medicine seen to be practicing only in case of dog bite as first aid treatment by the villagers.

Similarly, the number of given symptoms and disease recognised as significant to seek treatment increased with the rise of class position. A majority of the Middle and Low class households did not seek treatment for some of these symptoms and diseases because they considered them as minor ailments. On the other hand, financial problem blocked a majority of the very low class households to take treatment for these symptoms and diseases. While most of the High Class households sought treatment immediately.

Only 173 households sought advice from laymen during their illness. Of them, a majority of the High Class households consulted their relatives, other three classes mainly consults their neighbours. Quite surprisingly, a few of the respondents consulted their local teachers before going to a doctor. The common advises given by the laymen are (1) advise to go to a doctor (2) prescribing medicine and (3) advise to take rest. While a majority of the High and Middle classes considered laymen's advice completely; while, a majority of the Low and the Very Low Classes partially considered laymen's advice; and some of Very Low Class households do not considered the advice of laymen.

The date regarding the help received from others during sickness and this increased with the fall of class position. The prominent kinds of help received by others are (1) financial help, (2) suggestions, (3) medicines, (4) need of company in the hospital and (5) food items.

Out of 173, only 33 households do not have medical expenditure and most of them belong to the Very Low Class. The medical expenditure increased with the rise of class position. The priority given to medical expenditure along with the other
household expenditure items was comparatively low in all the four classes. It is observed during the investigation that majority of the respondents do not make use of the available free health services provided by the local Primary Health Centre (PHC). Whereas only a few of the respondents utilize the free health services.

The villagers also believed in providing greater care and more concern in the households only when the head of the family or any earning member falls sick. Similarly, it has been observed that the villagers also believed in mutual help and co-operation to their relatives during their illness, and at same time they expect the same responses from their relatives during their need and emergency.

It has also been observed in the study village that the sick role was assumed by taking rest and treatment as prescribed by the concerned doctor/traditional healer/their nearest and dearest laymen.

Despite a vast network of health services and facilities in state of Karnataka and in Dharwad and Gadag districts including Mundargi Development Block in which the studied village come, health problems particularly, water born diseases and skin diseases were high. Similarly, both personal and environmental hygienic conditions were also found poor in the village under study.

Community agencies have an important role in the promotion of better health conditions particularly in our rural areas. It has also been observed in the field during my study that a few voluntary agencies viz, Rotary Club of Mundargi and Local Self Government i.e., Grampanchayat were serving the people of Kalkeri village in this direction.

(6). MATERNAL AND CHILD HEALTH:
The data analysed so far has been summarized in such a way to test the hypotheses formulated in the study. This section deals with the hypotheses and the data regarding the differential knowledge and perception of need for maternal health services and data regarding the utilization pattern of all the four social classes in the sample.

In accordance with the hypothesis, the perception of need for pre-natal care was high in all the four classes. However, this perception level increased with the rise of class position. A good number of those who perceived the need utilized the pre-natal care. The High and the Middle class mothers got better pre-natal care than the low and the very Low class mothers. Most of the high and the middle class mothers went to the private health centres for pre-natal care; Whereas, a majority of the Low and very Low class mothers went to the public health centres for pre-natal care. A majority of the mothers had child delivery at home in all the four classes in the sample. Some of the High and Middle Class mothers had child delivery in the private nursing home. Whereas only a few of the Low and Very Low Class mothers went to the public health centres for child delivery. The High and Middle Classes selected the private health centres because of the availability of good medical care and services, and availability of qualified doctors, but the availability of free and less expensive medical care was the major criterion for the selection of the public health centres by the Low and Very Low Classes. Since the low and very Low class mothers went for free medical care, they did not have any medical expenditure for the child delivery. The High and Middle Classes had the highest medical expenditure.

The perception of the need for post-natal care was comparatively high for High, Middle and Very Low classes, the number of persons utilized the post-natal care increased with the decrease of class position. The High and the Middle class mothers went to the private health centres for post-natal care, and the low and very low class mothers used the public health
centres. The type of health centres utilized by different classes for maternal health services was an expected pattern of utilization.

The analysis of the child health care services has been divided into (a) feeding of the infant and (b) nutrition programme. A majority of the respondents from all the four classes perceived the need for feeding the infants. It has been observed that usually infants were suckled by the mothers till the next pregnancy was ascertained or breast feeding lasts up to the age of two to three years and in some exceptional cases up to five years. Most of the infants in the sample households started eating solid and semi solid foods at the age of 10 months or at the most a year. However, what was being fed to the babies in our rural area was extremely shocking. A most of the High class mothers had given commercially prepared cereals and baby foods which were harmful to a baby as they lack mineral. While, a majority of the Middle, Low and very Low classes gave only a breast Milk to their infants.

The knowledge of nutrition programme was found to be maximum in all the four classes. On the whole, most of the High, Middle class respondents, did not perceived the need for nutrition supplements, because the programme was meant for the poor. This programme was well utilized by those low and very Low class respondents who perceived the need for nutrition supplements. Most of the beneficiary children were receiving 2 kg raw-rice per month-through the co-operative society in the name of midday meal. In the school, and a few pre-school children were getting solid foods and other nutrients on all the working days except Sunday. A few of the respondents were satisfied with the programme. Whereas, a majority of the respondents were not satisfied with this programme. A major complaint against the nutrition programme was that poor quality of food, children did not like the food, and the food was served very late.
(7) HEALTH SERVICES AND THEIR UTILIZATION:

The present study has analysed the data regarding the knowledge and utilization of health services in different social classes. So far the findings of the study did not deviate widely from the general hypotheses formulated in the present study.

On the whole curative health services were concerned, the public health services were not fully utilized by the sample households. Though only a few households utilized the health check-up, test medicine services, the number of them who utilized these services increased with the fall of class position. Whereas, a majority of the respondents were not utilized the government health centres as the timing of the hospital was not suitable also increased with for fall of class position.

In regard to the utilization of the private health services, most of the households from all the four classes utilized private clinics and hospitals for their health problems. Availability of the good treatment and personal knowledge of the doctor were the dominant factors for all the four classes to their utilization of private health centres.

The data regarding the utilization of the services of the traditional healers has clearly showed that a good proportion of the sample households from all the four social classes utilized the services of a traditional healer. Faith in traditional healer and disease has a religious causes were said to be for dominant factors for the middle, low and very low class households to go to a traditional healer for speedy recovery of their sickness. The need for traditional healer in these sample groups increases with the fall of class position. But a majority of the households were not utilised the services of the traditional healer for their illness because of their scientific belief in the efficacy of modern drugs and medicine.

The data regarding the preventive health services clearly showed that the knowledge of immunization methods was found
to be high among all the four social classes and these immunization methods were also fully utilized by all the social classes. But with few exceptions, the two major reasons for not vaccinating their children were that the respondents either found their children too young for all vaccinations or that they expected that health personnel would advise or come for giving vaccinations, negligence and ignorance were the causes predominately found among the very low classes.

Lastly, regarding the promoting health services, the data analysed clearly showed that the High and Middle class households had better knowledge of family planning when compared to the low and very low class households. A majority of the respondents were in agreement with the statement that one should not have many children. Whereas, only a few of them were disagreed with this statement would reflect their fatalistic attitude, religious belief and insecurity of life in the old age. A majority of the respondents mentioned that one should have 1 to 2 children to make an ideal family and to lead healthy life. Whereas, some of them were mentioned 3 or more children attribute its reasons to their support in old age and the nature of their family occupations i.e. agriculture. But it was apparent from the analysis that by and large, the choice was between 2-3 children for making an ideal family and to lead healthy life.

It was also found that the High and Middle Classes had better knowledge about the minimum gap between two children for the health of both the mother and the children when compared to the low and very low classes. Similarly, the High and Middle Classes had better knowledge about the methods of birth control when compared to the low and very low classes. The common methods used for birth control were contraceptive oral pills taken by women and condoms by men.

Further, it was clear that more number of males than females were knowing the family planning methods. But more number of females were adapted these methods. More number of
respondents in the joint family (large family) were practicing family planning methods than those in the nuclear family (small family). However, there was no relation between the practicing behaviour of the respondents and their type of the family in order to improve the family planning services. It has been suggested by the respondents that their should be some control on the schedule of services. Besides, this contraceptive oral pills should be distributed to the eligible couples for one month and the health workers should develop more courteous attitude towards the current eligible couples with a view to motivate them. Above all, health education should provide to the people through the experts and educationalists in order to achieve the desired goal of the governmental policies in regard to the effective implementation of the family planning programme at the national level.

10.3 CONCLUSIONS:

The present study gains significance due to its pioneering efforts to explore an otherwise neglected, nevertheless important field of rural health and medical care. Though there is abundant literature on rural health and medical care, still there has been an unfilled gap in the literature on Medical/Health sociology. Due to the absence of much needed empirical research in the field of rural health and medical care, has indeed made scholars myopic to the realities of the situation.

Especially in India, health/medical studies represent a wide gap in the literature on rural health and medical care. Most of the works on health and medical care in India have concentrated on various socio-cultural aspects of health and diseases, medical and health administration, medical profession and medical organization, the patterns of seeking medical care, acceptance of indigenous, western and modern medicine, social satisfaction and concept of health, social structure and economy, the water, nutrition, environmental hygiene and so forth. Notwithstanding the
fact that we have a number of studies on rural India, the need for more studies on rural community in relation to health and medical care can not be denied. Still this study has some unique features and differs from other studies conducted in this area. Therefore, the sociological dimensions related with rural health and medical care in the geographical and cultural perspective is the main focus of the present empirical study. The present study is an attempt to explore the health needs and to draw attention on the reality of health system in rural setting. Thus, the present study gains significance in the light of foregoing discussion. And as such, the findings of the present study may be considered as important contribution to the empirical understanding of rural health and medical care.

Within the coverage of this study, having discussed the various aspects of rural health and medical care, a few inferences can be made. In the discussion of major findings of the present study we may begin with the confirmed basic assumptions that the persons, who are living in a particular geographical area, are subjected to face their own specific health problems, and there is a relationship between the qualities of the water consumed and incidence of disease like fluorosis.

The findings pertaining to the disease pattern in the studied village reveal that about 12.78% of total population from the sampled households suffered from skeletal damages, dental fluorosis, G.I.D, and skin diseases are attributed to the fluoride contaminated ground water as well as the unhygienic Tungabhadra river water supplied for the human consumption. About 3.7% of the total population in the sample household members are suffering from chronic diseases like heart disease, cancer, asthma, paralysis, tuberculosis, leprosy, fits, piles, diabetes and polio. The worth mentioning is that 5 leprosy cases and 5 polio cases are released from the treatment. Therefore, they are considered here as old patients. But remaining 1022 household members are found to be healthy.
and the very low class households are in need of more maternal and child health services than the high and middle class households. Nutrition programme is well perceived by the low and very low class households because the programme is exclusively meant for them only.

The consumption of health services is also controlled by the process of social stratification because of unequal economic status of different social classes. Notwithstanding the health services are available freely to the poor in the government health centre, low income is a barrier for them to consume health services. The findings of the present study reveal that the low and very low class households do not use health checkup because of low income and consumption of curative health services is also blocked due to low income of the poor classes. Due to financial difficulties the poor had child delivery at home than that of the high and middle class households.

Further, the process of social stratification has perpetuated inequality in the utilization of health services. The better educational and economic status of the high and middle class households has produced a situation where the high and middle class households have less health needs but high knowledge of health services, and high perception of the need for services and high capacity to consume health services. On the other hand, the "low" educational and economic status of the low and very low class household have large amount of health needs but poor knowledge of available health services, low perception of the need for health services and low capacity to consume health services. Thus, the process of social stratification has formed the differential utilization patterns of health services.

The findings pertaining to the maternal health service clearly reveal that the material health service needs of the low and very low class household are high but they do not perceive its importance and their financial difficulty prevents them from going to hospital for child delivery. On the other hand, the high
and middle classes do not have these barriers and they start pre-natal care early, pay more pre-natal visits, and get more medical assistance. They also perceive better post-natal care.

The findings pertaining to the child health care clearly show that the mothers of the study village are not aware of the breast feeding which is good practice from the point of view of health of the infant. However, what is being fed to babies in the village under study is extremely shocking. On our probing we learnt that what's expensive is best, but it is not so. With few exceptions, a majority of the mothers interviewed belonging to all the four social classes do not perceive the importance of breast feeding to the infants during their weaning period.

The findings clearly show that preventive health services needs of the low and very low class households are "high" when compared to their perception of the need for these health services. So naturally the utilization of the preventive health services is "low" in the low and very low class households. But none of these factors come in the way of the high and middle classes. Their need for preventive health service is "low" but their perception of the need for the preventive health services is well. Thus, a dichotomous utilization pattern of preventive health services is clearly visible in the village.

Similarly, the findings pertaining to the curative health services clearly show that the curative health needs of the low and very low class households are also "high". They are in greater need of health services for their chronic diseases. But their knowledge of disease is "low" and they do not perceive the importance of many symptoms and diseases to seek health services. Further, they are not aware of even the freely available health services in the public health centre and even transportation expenditure is an economic burden for them to utilize health services. On the other hand, the high and middle class households do not have these barriers and their major health need is health service for chronic diseases. Their better
economic status gives them the advantage to consume health services from the private health centres. Thus, the limited curative health service need of the high and the middle classes are well met. Whereas, the health need of the low and very low classes is not properly met.

The findings pertaining to the promotive health services clearly reveal that the High and Middle class households have better knowledge of family planning programme than that of the low and very low class households. Similarly, the high and middle class households have better knowledge about the minimum gap between two children for the better health of both the mother and the child, and better knowledge about the methods of birth control when compared to the low and the very low class households. The common methods used for birth control are contraceptive oral pills taken by women and condoms by men. Further, it is clear that more number of males than females knows the family planning methods. But more number of females has adapted these methods. Similarly, more number of persons in the joint family is practicing family planning methods than those in the small family. However, there is no relation between the practicing behavior of the respondents and the family type.

Thus, the present study clearly proves that the fact that the low and very low class households do not consume enough health services to meet their various health needs. Apart from their inability to consume private health services, they fail to utilize the freely available public health services. The main reasons for such a condition are that they are not aware of all the available free health services; they fail to perceive the need to seek health services for many health problems; and their poor economic background to consume health services. So any health service plan should be formulated in such a way that it should bring about equality in the utilization pattern of health services.

Although the study results are by no means conclusions, but they indicate that more and better data based on a random
household sample of the study village survey which could produce a more reliable picture of rural health culture and of differential utilization patterns of health services.

10.4. SUGGESTIONS:

The results of the foregoing study present an empirical picture about the rural health care. The findings are the pointers to the existing health problems of Kalkerí village of Gadag district in Karnataka. Lack of safe and sufficient wholesome drinking water, poverty, poor food habits, and high incidence of water born diseases particularly skeletal flourosis, dental caries, and early aging and other skin diseases due to the effect of consumption and utilization of local ground water and alternative water supply of defective Tungabhadra river water, are all multiple problems which tend to aggravate the situation in rural areas of newly established Gadag district. Here attempts have been made to give suggestions for solving community health problems. They are as follows:

1) SAFE-WATER SUPPLY:

Next to air, water is the prime necessity of health and availability of safe drinking water supply can prevent and control many diseases. Therefore, strengthen and protect community water supplies through improvement of existing sources, construction of new sources, disinfection of water and other methods and techniques to prevent contamination of water, so as to prevent major water-born diseases and deaths of children and poor people. Health policy and administration should therefore give top most priority for providing safe water supply so that it will help to promote better health of the citizens.

2) PROMOTION OF NUTRITION:
Like water, food is also being considered as prime necessity of health. Availability of safe and nutritious food can prevent and control many diseases. The present nutritional status of the under privileged sections of the people in the study community in particular and rural India in general is far below. Therefore, it is necessary to increase it above the present level so that poor people can be saved from the consequences of malnutrition. The personal discussion with the senior lady health volunteer of Mundargi Community Health Centre reveal that the nutritional anaemia in the study village is very high. So, it is necessary to control the food adulteration, and making safe food supply within the reach of all. At the same time it is quite important and necessary to make people aware of the nutritious foods and encourage to cultivate of the same.

Health education has to move into the rural areas as a part of Health policy and effective administrative strategies so that the majority of the poor and under nourished will be benefited.

3. PROMOTION OF SANITATION AND PERSONAL HYGIENIC HABITS:

With regard to the family latrines, although there is a provision of latrine which provided by the state government in the houses of poor classes, most of them not being accustomed to the use of latrines, use these for washing clothes, taking bath and other purposes. It is true that latrine is a difficult problem in the study village during the monsoon. Like the people of other rural areas, the inhabitants of Kalkeri village are in the habit of going out to the fields for defecation is another responsible factor for hookworm infection. The eggs of hookworms may develop into larva by suitable environment. These larva usually find their way back into the human body through the skin of barefoot. People have their idea that the latrine is a dirty place where nightsoil is found in heaps, which produce bad smell. The use of latrine is
considered as a symbol and character of urban people. It has no place in village life. The idea of ritual pollution is associated with the use of latrine in most of the village people appear to be a fiction rather than a fact.

Similarly, absence of any drainage system in the major parts of village lanes helps the germs of different bacterial diseases e.g., diarrhea, dysentery, typhoid, and fevers. Flies which also breed in the accumulated dirty water in the street lanes may carry the polio virus and this may be aggravated by the habit of defecation in the open field. Since the people do not have a clear idea that flies and insects are responsible for transmitting diseases, they do not take measures to check their breeding. Thus, indiscriminate defecation should therefore, be avoided and one should consider the following carefully:

1. Every home should have a latrine.
2. Excreta should not contaminate ground water, surface water, and the surrounding land.
3. There should be no odour molestations.
4. Excreta should not be accessible to flies or animals.
5. The latrine should be safe but inexpensive to construction, operate and maintain.
6. Above all, there is need for well planned and result oriented health education programmes to disseminate correct knowledge about sanitation to the people. This can be achieved through school education, adult education mass medias like radio, television, newspapers, and films, which can influence the community and change their outlook towards the sanitation process.

With regard to the personal hygienic habits, although the villagers lack in the theoretical knowledge of hygiene, they are nevertheless clean people. The High and Middle class households take bath at least once a day and wash hands before meals when compared to the Low and Very Low class households. However, they seem to be unhygienic in some other matters because they
rear animals inside their residential portion, which probably act as carriers of disease.

The villagers will be able to do a lot in preventing common diseases in a family and surroundings by practicing healthy and hygienic habits. Some of these habits and activities identified as follows.
1. To keep the house and surroundings clean and neat.
2. Take special care in using water. As far as possible, use only boiled water.
3. Washing hands thoroughly and periodically before and after use of food.
4. Personal cleanliness and hygienic including proper nails cutting and wearing clean dress.
5. Avoid touching food with unclean hands.
6. Proper disposal of household wastes.
7. Prevent a number of diseases by timely consultation and immunization.
8. Teaching children about cleanliness and oral health in day to day life.

Similarly, regarding habits, it is well known fact that health problems in a family in particular and community in general is contributed mainly by regular habits of alcohol consumption, smoking and chewing tobacco etc. It is observed that many youngsters apart from the grown up people are increasingly becoming victims of these habits which erodes the health of the people. But they can be controlled to a great extent by the disciplined way in which they mould the children in early stages. Therefore, there is need for full community support to fight against these habits, which erodes the health of the people and create a grave social problems. In view of the magnitude of the problem, the health policy should therefore, frame special programmes and check out effective methods to control and eliminate these habits among the people of our country in general. In fact, health education to the people through non-
formal techniques should be given on personal and community oriented basis specially in the context of sanitation, personal hygiene in habits.

4. MATERNAL AND CHILD HEALTH CARE:

With regard to the maternal and child health care service, the health centre plays an important role in providing these services. This service can be integrated with Primary Health Centres. So that the majority of the rural people will be able to avail the facilities at lesser cost/no cost and without much difficulty. All the pregnant women in the rural areas should be brought under the scheme and similarly all children should be immunized and saved from the major communicable diseases like measles, diphtheria, polio and tuberculosis. The lady doctor, nurse, midwife and the female basic health workers should take active part in providing these health services. The basic health worker and mid-wife would identify the pregnant women in the village locality and bring them to the health centre and advise the mother on hygienic living, family welfare and child rearing and also prepare her for the child delivery. If there is any per-natal complications, the mother would be referred to the nearest government maternity hospital. Normal child delivery would be attended at the health centre by the lady doctor with the help of nurse and mid-wife. After child birth the mother and the child would undergo regular health checkup for sometime. The child will be immunized against communicable diseases in due course.

Nutritive programme for the poor children is an important aspect of child health care. A protein-enriched food should be given to the village children. Mere supply of food supplements to the village children through the schools and pre-school centre is not important, but this programme should be effectively implemented. For this purpose, the administrative strategies adopted should be powerful enough to influence the people and
take them into confidence, so that successful results can be obtained.

5. UTILIZATION OF HEALTH SERVICES:

With regard to the utilization of health services, the main problems of the Low and Very Low Classes to utilize health services are, they do not perceive the need for health services and they are not fully aware of the available health services in the community. So any health service plan for rural areas should aim at tackling these problems. So that the Low and Very Low classes would consume properly the available health services.

To provide equal health services to all, the government has to nationalise the private health services but this can not be carried out successfully in a democratic setup. Further, the state do not have enough resources to provide health services to all. So, it is better to make use of the already available government and other private resources to the maximum extent to meet the health needs of the poor.

Especially, our cities have good health resources available for the poor. But our rural areas where the present study has conducted have name sake Primary Health Centre which lack proper equipments and health personnel. The health services provided by this is poor in quality and quantity. Many government dispensaries already existed in the study area, do not have permanent doctors and they lack proper equipments and required health personnel. --Doctors visited these dispensaries once or twice in a week that too for one or two hours in the morning and otherwise they are run by the nurses. They do not have proper laboratory facilities and they do not have equipment to attend to child deliveries. The data of the present study clearly reflect this situation. Only a small percentage of the sample households utilize the government dispensaries. Though a good number of
the Low and Very Low Classes suffer from Chronic diseases, only a few use the government health centre for their minor ailments.

Due to lack of integration of services and poor condition of Government Health Centers, a comprehensive health services of curative preventive and promotive health service is not possible in the study village.

Looking into all these existing problems of resources and administration, it would be better to plan out an comprehensive health service programme for the poor to meet their health needs effectively. For this purpose, the health service programme should be organised from the lower lever. A village may be taken as a basic unit of Taluka level health system and the health services which is already existed in the study village locality should be recognized fully to provide all the basic health services for the poor living in that village. It must have one male doctor and one female doctor and they will be assisted by a compounder, nurse, technician, health extension educator and basic health workers. The health centre staff would work as a team to provide promotive, preventive, curative and rehabilitative health services. They work in close collaboration with the voluntary agencies so that health service programmes can be carried out effectively.

These village level health centres would look after the basic health needs of the poor in the village. But making available the health services alone is not enough to achieve better utilization of health services. The available health services should equally utilized by the people. The basic health workers should work towards this objective. It is better to select these health workers from the local community because they are well aware of the health problems of the community, and they know the existing barriers in the community to consume health services.

Further, the basic health worker should use health education as a major weapon to elicit community participation in the health service programme. Another function of the basic
health worker is to collect the data regarding birth rate, death rate and morbidity rate. Therefore, for this purpose the basic health worker should be trained in collecting data he concerned.

With the leadership of the health extensive educator, these worker would make use of various methods including audio-visual methods to make people aware of their own health so that they may perceive the need of health services. These workers can teach the community about hygienic living, maternal and child care and also inform about the available health services in the community. Further, these workers should pay visit to each home in the village and identified their health needs so that the health centres may organise its health programmes to suit the community needs.

As part of providing promotive health services, the health centre would closely coordinate with the sanitation department and water supply department of the local self-government. Proper disposal of drainage and garbage and pure and safe water supply of the village would be supervised by the health centre and they would inform the respective departments whenever there is a lag in carrying out these functions. Environmental condition is also one aspect where community co-operation is very much needed to keep the surrounding clean. In this regard, the basic health workers organize the local community and explain the need for keeping the environmental hygiene.

In providing preventive health services, the health inspector, mid-wife, and the basic health workers pay visit to each and every home in the village every month and immunize those who have not immunized themselves against the major communicable diseases. Particularly, during the epidemics, special immunization programmes would be carried out. At these emergency period co-operation from the voluntary agencies and government hospitals may be sought.

Health checkup is another aspect of preventive health care. Children studying in school and pre-school and school drop-out
from the lower income groups would be covered by the health centre for health checkup once a year.

Similarly, in providing curative health services, these village level health centres should closely co-ordinate with the general and other special government hospitals. Usually, these health centres would treat only minor ailments. If any one had major health problems, he would be referred to the government general hospital or special hospital depending upon the kind of health problem.

So on the whole, the health centre works with the active participation of the community and the close coordination of the village general and special hospitals run by government. If these health centres achieve their goal of providing the basic health services to the poor, the over crowded condition existing in the health centres would reduce. Creating a good referral system is necessary to develop an integrated health service system and active participation of the community is important for providing comprehensive health services.

This how, the proposed health services scheme bridges the gap in the utilization of health services between the higher and lower strata to a great extent. Though equal utilization of health services may not be achieved with this limited sources, but the maximum utilization of available health services can be achieved. This medical care system provide the basic health services which they lack due to lack of integration between public health centres. Thus, this scheme would demonstrate the health services of the government general hospitals towards the periphery of the community by creating effective health care at the village level.

FUTURE STRATEGIES:

Health care is an aspect of culture and as such the health understandings and practices of the people also are integrated aspects of culture. The importance of research carried out by
sociologists on health culture lies in the future programme of health education which can provide the basic information about health care to health providers and health educators who can play a vital role in health care delivery.

The following are some health care strategies needed for further research in the field of Medical/Health Sociology.

1. Understanding socio-cultural barriers of health care and health education programme.
2. An investigation of the problems of accepting modern health care services.
3. Strengthening of rural research institutes which may serve as basic laboratories for further research works.
4. Development of effective communication strategies on health care in rural areas.
5. Development of effective plans based on the needs of specific rural community.