SUMMARY AND RECOMMENDATIONS

8.1 SUMMARY OF RESULTS

Socio-Economic Profile

1. The age-distribution of women covered under the study is concentrated around younger age-groups. But comparing the age-distribution of women for Jaipur and Barmer, we find that the proportion of women in older age-groups is higher for Barmer than Jaipur which shows comparatively younger respondents in the sample from Jaipur.

2. Out of total 300 women, around 28.0 percent women are literate. The female literacy is 38.0 percent for Jaipur and 18.0 percent for Barmer.

3. A total of 98.0 percent and 77.3 percent women from Jaipur and Barmer respectively are engaged in household activities with no direct income. There is significant difference in the working woken population of these districts. Interestingly, only 2 percent from Jaipur against 22.7 percent women from Barmer are engaged in income generating activities. This difference is attributed to the tradition of women as house-wives engaged in household activities in Jaipur and low economic condition of Barmer compelling women to come out of their houses and take part in income generation as weaving, stitching and working as labourers/daily wage earners.

4. As observed, very low proportion of women are engaged in employment activities and whatever women are engaged have very low income. Out of total 300 women, 87.7 percent of women have no income followed by 11.0 percent in the income group Rs.(1-1000), 0.7 percent in the group Rs (1000-2000) and 1.3 percent in the group Rs. (3000-4000)
5. Similar to the age-distribution of women, the age distribution of husband is also concentrated more in older age-groups for Barmer in Comparison to Jaipur.

6. As against the low female literacy rate in both the districts, the literacy rate is quite high for their male counterparts. The literacy rate for husband is 85.3 percent for Jaipur and 42.0 percent for Barmer.

7. The employment situation of husband shows that the highest proportion i.e. 42.7 percent are engaged in self employment (agriculture) followed by 19.3 percent as labourers, 17.7 percent in self employment (business) and 12.0 percent in Service (Private Service). The significant difference in two districts is the highest concentration of husbands in self employment (agriculture) in Barmer whether it is evenly distributed in all categories for Jaipur with highest proportion in self employment (business). This is attributed to more business opportunities in Jaipur and limited avenues other than agriculture in Barmer.

8. The income distribution of husband is concentrated in low income groups of Rs. (1-3000). The proportion of husband in low income groups is higher for Barmer in comparison to Jaipur which shows an overall low income in Barmer. The income distribution of the whole family of women including in laws etc. do also shows the same pattern.

9. The majority of couples covered under the sample from Jaipur as well as from Barmer have number of children ranging from 1 to 4. The distribution of family size shows that out of 300 survey couples, most of them have the family size of 5-10 members. The interesting fact is higher proportion of smaller family in Barmer in comparison to Jaipur which may be attributed to low economic condition in Barmer compelling the family separation for economic pursuits. The average family size is 6.79 and 5.03 for Jaipur and
Barmer respectively. The average children size is 2.53 and 2.59 for Jaipur and Barmer respectively which shows higher size for Barmer.

10. The average age at marriage and age at effective marriage for female is 12.74 years and 15.07 years respectively and for males, it is 17.04 years and 19.28 years respectively.

Utilisation of Maternal-Child Health and Family Planning Services

11. The knowledge about primary health care services is satisfactory in both the districts. Around 93.3 percent and 91.3 percent of women from Jaipur and Barmer have knowledge about primary health care services available in rural areas.

12. The physical parameters affecting the utilisation of primary health care services presents varied facts in rural areas of these two districts. Around half of the surveyed communities have the access of nearest primary health care centre within 1 Km distance. Obviously, the community has to cover more distances to reach to nearest health centre in Barmer comparing to Jaipur. The majority of couples go on foot to use the services at primary health centres. The proportion of the couples taking more time to reach health centre is higher for Barmer than Jaipur which shows tough accessibility conditions in Barmer.

13. Ante-Natal Check-ups play an important role in improving maternal health conditions. Only 12.0 percent and 3.3 percent of women from Jaipur and Barmer respectively were visited by health worker during pregnancy. It is really a poor performance of quality of care of our primary health care system in rural areas.

14. The proportion of pregnant women, who visited to any health facility including private, is 70.6 percent and 3.3 percent for Jaipur and Barmer
respectively. It shows satisfactory picture in Jaipur but pathetic position of Barmer. Majority of these women visited for 1-3 ANC check-ups. We find that 50.0 percent and 80.0 percent of women (out of women who visited to some health facility for ANC check up) from Jaipur and Barmer respectively utilised services available at primary health care centres. The major reasons of not utilising primary health care services are lack of facilities, low presence of doctor/staff and poor quality services. The high proportion of women (though very low in absolute term) utilising services from primary health centres in Barmer is due to lack of private services in desert areas.

15. The regular monitoring of weight of pregnant women is a part of ANC services. But only 15.3 percent of women from Jaipur and 2.7 percent of women from Barmer could avail this facility. The iron folic tablet, which are very important for pregnant women in general and compulsory for anemic cases, was taken only by 63.3 percent and 14.7 percent of pregnant women from Jaipur and Barmer respectively. Again Barmer is far behind in utilising ANC services which are adequately available at primary health centres which shows lack of awareness in the community as well as poor delivery services of the health system. Around 58.9 percent and 90.9 percent (out of total women who received iron folic tablets during pregnancy) from Jaipur and Barmer respectively received iron folic tablets from primary health centres and the rest from private sources. Which again shows the major shift of the women towards utilising private services in Jaipur and dependence of women on primary health centres in absence of private sources in Barmer.

16. TT immunisation during pregnancy is vital for protecting mother and child from tetanus. Around 69.3 percent and only 8.0 percent women out of total surveyed women from Jaipur and Barmer received TT immunisation during pregnancy. On average, the total proportion of women who received TT immunisation is 38.7 percent. Out of total immunised women, 65.4 percent and 83.3 percent of women from Jaipur and Barmer respectively received
the same at primary health centres and the rest from private sources. The trend is again same for these two districts as for other ANC services. There is provision of two doses of TT immunisation for pregnant women but only 76.0 percent and 33.3 percent of women (who received TT immunisation) from Jaipur and Barmer respectively received two doses of TT immunisation which again shows the poor follow up of health care services.

17. The institutional delivery is very low in Rajasthan (around 11 percent - NFHS 1992-93). The increase in institutional delivery can be of great help in reducing maternal and infant mortality in the state. The place of last birth reported by women covered under the study shows that the highest proportion of 77.3 percent deliveries were conducted at home followed by 14.7 percent deliveries at primary health care centres and 8.0 percent at private nursing homes. In Barmer, the home deliveries amount to 94.6 percent in comparison to 60.0 percent of Jaipur. Still around 64.3 percent deliveries is being attended by traditional birth attendants with district wise proportion of 38.0 percent for Jaipur and 90.7 percent for Barmer. The major reasons of not going to primary health centres are lack of facilities and poor quality services as expressed by women.

18. The primary health system is well equipped for child vaccination. Around 55.3 percent and 19.3 percent children from Jaipur and Barmer respectively received vaccinations BCG, DPT (3 doses), polio (3 doses), polio booster, DPT Booster and measles. Overall, 37.3 percent of children received complete vaccinations. Out of vaccinated children, 66.3 percent from Jaipur and 100.0 percent from Barmer utilised the vaccination facilities from primary health care centres and rest from private sources.

19. From the analysis of utilisation of different maternal-child health and family planning services, the fact emerges that the utilisation of preventive services available at primary health centres is higher than the curative services. Like in the case of child illness from fever/cough, around 40.7
percent from Jaipur and 56.2 percent from Barmer utilised the treatment services of primary health centres and rest of private services. The major reasons of low utilisation are lack of facilities, absence of doctor/staff and poor quality services.

20. Similarly 50 percent and 57.4 percent children out of children who took treatment for diarrhoea from Jaipur and Barmer got the services from primary health centres and the rest preferred the treatment from private sources. Again reasons of going to private services are: lack of medicines and other facilities, doctor/staff not regularly present in the health centre and poor quality in terms of less attention and poor follow up services. The couple's complaint at large was that doctor if at all available simply writes the prescriptions and asks to purchase the medicines from outside medical stores. The community feels that if there is no medicines, there is no use of visiting primary health centres.

21. The knowledge of women about different family planning methods is highest for sterilisations in both the districts followed by the knowledge of pills, condoms and Cu-T. The difference in the knowledge level of women from Jaipur and Barmer is very high and significant. It reflects the poor IEC activities in desert district of Barmer.

22. Limiting method specially tubectomy is more popular among couples in comparison to different spacing methods. Under spacing methods, condom is more popular than oral pill and Cu-T. The use of FP methods is very low in Barmer in comparison to Jaipur. The use of any FP method was found to be around 45.4 percent for Jaipur and only 6.7 percent for Barmer. On average, proportion of couples using any FP method was 26.0 percent for both districts together which is very low.

23. Observing the utilisation of contraceptive facilities available at primary health centres, we find that on average 45.5 percent couples got pills from
primary health centres and rest from private sources. Similarly for Cu-T, 42.9 utilised health centre facilities and rest from private sources. And for condom, 45.0 percent utilised the services from primary health centres and rest from private. But the only satisfaction is the hundred percent female sterilisations at primary health centres. Thus we observe that despite all investment, infrastructure and interest, the facilities for spacing methods are still not reaching to the needy couples or the couples themselves are not willing to use due to poor quality and follow up services.

24. The follow up by health worker necessary for couples using different spacing and limiting methods is very poor which is a major reason of low utilisation of services available at primary health centres. Like in the case of Cu-T insertion, if the women is not visited after insertion for the after use effects and she is not properly convinced and treated, she would go for withdrawal of Cu-T. And the effect will not remain with her only rather she will de-motivate other women towards non-use of the method as it creates many health problems.

25. Even in the case of female sterilisations, the satisfaction level towards the quality care is not very encouraging. And the comparison of quality care during sterilisation and after sterilisation shows that the satisfaction level of sterilised women is lower for after sterilisation in comparison to during operation.

View of Health Personnel about Low Utilisation of Services

In the second part of the survey, the health personnel including ANM, Medical officer, health education officer, male health workers etc. were interviewed to know their opinion and perception about low utilisation of maternal-child health and family planning services. Major factors responsible for low utilisation as expressed by health personnel are as follows:
* The community have more trust on local non qualified doctors and faith healers and go the health centre only when the matter turns serious.
* Lack of commitment in the staff towards work.
* Lack of basic facilities at primary health centres.
* More interest of doctors and para-medical staff towards private practice and less attention to primary health centres.
* Stay by doctor/staff to nearest city and not staying in the institution
* Poor IEC activities due to lack of IEC material
* Inadequate budget for primary health centres.
* There is lack of supportive supervision to the subordinate staff
* Lack of political commitment towards family welfare.
* Lack of public health approach.

Regression Analysis

Utilisation of maternal-child health and family planning services by social and economic characteristics has been tried in very beginning to have a primary idea about the association of utilisation variables with different independent variables. Based on primary trend of cross tabulation analysis, logistic regression analysis showing the effects of different physical, social, economic and interaction variables on a set of utilisation variables has been tried to be more specific and present micro analysis of relationship among dependent and independent variables.

Knowledge about primary health care services, women education, husband education, visit of health worker to couples have over all positive and significant effect on utilisation of different maternal and child health services. This shows the necessity of improving the awareness through effective IEC activities and enhancing the home visits by health workers. On the other hand, physical parameters like distance of health centre, time taken to reach health centre, transportation cost have negative and significant effect on utilisation of services. Keeping in view the desert conditions of Rajasthan, where villages are scattered
and far-flung situated, there is urgent need of starting mobile health services as well as involvement of NGOs which can improve the coverage and quality of services. The health workers should also be provided with some transportation facility.

The effect of husband income is negative and significant on the utilisation of different MCH and family planning services. This shows very interesting phenomena and is attributed to the fact that as the husband income increases, the couple's affordability to private services increases and due to lack of facilities and poor quality services they go to the private services. The family size has also negative and significant effect on utilisation which shows that higher is the family size, lower would be the importance for health care service utilisation due to increased liabilities in large families. The interaction effect of women education by husband education is positively significant. On the other hand the interaction effect of women education by husband income is negative and significant for majority of the utilisation variables.

Based on the detail analysis of logit regression, multiple regression analysis was tried with composite index of utilisation as dependent and different social and economic characteristics as independent variables. The composite index was separately worked out for maternal health care, child health care, family planning and combination of all care services. The analysis shows that women education, husband education, home visits by health workers have positive and significant effect on composite index of utilisation. On the other hand; husband income, family size, distance have negative and significant effect on utilisation index of different areas.
8.2 POLICY RECOMMENDATIONS

The study based on the primary data collected from rural areas of Jaipur and Barmer districts of Rajasthan and on in depth analysis of utilisation of maternal-child health and family planning services proposes following recommendations to remove the bottlenecks prevailing in the system and suggests policy interventions for optimal utilisation of services available at primary health care centres.

1. Though the community at large is aware of the availability of services at primary health care centres but the motivation for utilisation is very poor. It needs effective and continuous IEC strategy to develop the demand and motivation towards maternal-child health and family planning services. The IEC activities undertaken currently are not effective enough to generate the desired impact. The local community participation in IEC activities can play an important role in effective dissemination of IEC messages. The voluntary organisations should also be involved to under take inter-personal communication activities in remote areas.

2. The utilisation of preventive care services has lots of scope to improve if health worker starts regular home visits. But, unfortunately the visit by health worker is very low. There is need to fix the weekly number of visits of health worker and the Sarpanch of the Panchayat Samiti should be given the responsibility to regularly monitor the visits.

3. The couples at large complained that they do not get any medicine from primary health centres. The regular supply of medicines at all the primary health centres should be ensured. Moreover the distribution and use of these medicines should be regularly monitored and strict action needs to be taken against the person responsible for irregularities. If there is lack of resources for medicine, the community can be nominally charged for medicines.
4. Lack of curative services adversely affects the utilisation of preventive and promotive care. Therefore, there is urgent need to improve the availability and quality of curative care to attract people towards preventive and promotive health care. The Panchayati Raj Representatives should be given proper orientation and training to monitor the functioning of primary health centres in light of recent initiative taken by Government of Rajasthan to transfer these institutions under Panchayati Raj.

5. The absence of doctor/staff from primary health centres and irregular appearance for some time or other creates disillusionment among community and they lose faith in primary health care system and prefers private services where they get better attention and regular services. The absence of doctor/staff from health centre during working hours is mainly caused due to their stay in nearby city areas and coming to health centre after long time commuting. Thus, the stay of doctor/staff at primary health centres should be made compulsory. But before this the department of health and family welfare has to ensure the basic staying facilities at primary health centres.

6. The quality has also emerged as the great concern compelling couples to go to private services due to poor quality services at primary health centres. Timely and proper attention by doctor/staff, good follow up service, proper working conditions of equipments, proper and timely doses of immunisation and curative services are some of the quality parameters. Thus adequate infrastructural and financial support to primary health centres should be provided to improve the quality of care. It also needs the commitment of doctor/staff towards their duty to serve the community.

7. The emergency obstetric cases can not be treated at PHC and sub centre level as the specialisation is not available at these places. When such cases come to primary health centres, they are discarded and are not given primary attention and referral services. There is need to further strengthen
the referral services which will attract the community in case of emergency as well. A total of 138 such FRUs are already opened by Rajasthan Government and the need is to strengthen the linkages between these FRUs and primary health centres through ensuring the availability of vehicles for this purpose.

8. The proportion of deliveries conducted at home is very high in Rajasthan as stated in the findings of the present study as well as NFHS 2, 1998-99. Though, efforts should be made to promote institutional delivery, but more importance needs to be given to regular orientation and training of local Dais to ensure safe deliveries through trained hands.

9. The monitoring and supervision of maternal-child health and family planning services is very poor in Rajasthan. The main reason for this is the lack of orientation and accountability in supervisory officers at district level. The poor reporting is another area which needs attention. The reporting system has lots of duplicity and repetition. This should be streamlined by reducing the quantity and enhancing the quality of reports. The monitoring at PHC and sub centre level should be strengthened by increasing the involvement of district level authorities. The monitoring responsibility of PHCs and sub centres to Panchayats can also play a significant role in improving the coverage and quality of services and thus the utilisation. The process of concurrent evaluation should be strengthened to monitor the performance of primary health centres.