Chapter I

INTRODUCTION

1.1 STATEMENT OF THE PROBLEM

Ever since independence, the principal national aim has been to secure improvement in the quality of life for Indian people. Adequate health and family welfare services is one of the most important component of improved quality of life. Majority of the Indian population still lives in rural areas, the future of healthy India therefore, could be built only on all-round development of Indian villages. It was to this effect that the integrated and comprehensive approach to our health and family welfare programme was made by establishing primary health centre and sub-centre infrastructure all over the country. Government of India has been making all out efforts and has committed to provide "Health for All by 2000 AD" by signing the WHO-sponsored Alma-Ata declaration of 1978.

The Government has put a major thrust on developing health infrastructure based on the population size and has made continuous efforts to establish sub-centres at village level, primary health centres at block level, community health centres at sub-district and district hospital at the district level. Rajasthan has been a step ahead in establishing sector PHCs at sub-block level and Block PHCs at block level with the aim to have more accessible and approachable health facilities to rural community. Apart from these conventional health institutions, the state has further extended its efforts in establishing Mother and Child Welfare Centres (MCWCs), Post Partum Centres (PPCs) and First Referral units (FRUs) to provide specific and specialized health and family welfare services.

The private health service system has experienced parallel growth with Government health infrastructure. The epicentre of private hospitals and nursing homes is universally in urban areas. Nearly three-fourths of the medical facilities including specialized care are concentrated in urban where only one-fourth of the
Indian population lives. At the same time, the three-fourths of the rural population is left with the remaining one-fourth of the medical care (K. Srinivasan, 1987). Though a vast network of government health service infrastructure has been built, it is felt that its utilisation has not been adequate, rather it is under-utilised. People still use their home remedies or go to the private practitioners some of whom are not even adequately trained like Registered Medical Practitioners and local Baidyas. This reflects less faith in available services provided through primary health care.

It is particularly so in rural areas where large fraction of sub-centres and primary health centres are ignored by the clients who crowd the district, state or national health service units which should really be serving as referral units (Talwar P. P. and S. C. Bhandari, 1989). This pattern of utilisation has affected quality of services at all levels. The low patronage of services in rural areas (sub-centres and primary health centres) has disheartened the staff and they have lost interest. And the overcrowding in hospitals has affected degree of attention which is necessary for quality services.

It is a general concern of the people as well as the health planners and health providers that the present services are not adequate to fulfill the requirements of the community (P. H. Reddy, P. J. Bhattacharyajee, K. N. M. Raju and R. Sivaram Raju, 1983). But what about the services available at the vast network of government run institutions in rural areas currently operating? Is the available services optimally utilised? Rural People still visualize the services at sub centres and primary health centres as curative centres and not as preventive and promotive care centres. The prima facie estimates shows that people are not conscience towards preventive and promotive health care and even for curative health services they prefer to traditional healers or rush to private hospitals in hope of better attention and quality care.

It is therefore necessary to understand reasons for under utilisation of the health services in rural areas, so that efforts can be made to remove the bottlenecks and
improve the utilisation of available maternal-child health and family planning services provided through primary health centres, thereby affecting overall health status of the community and the quality of health care services. A review of studies showing under-utilisation of services is given in Section 4.5 of Chapter IV.

1.2 SCOPE OF THE STUDY

Despite large health infrastructure all over the country, it is a fact that services are inadequate to cater the needs of the people. But why people do not utilise optimally the available services at the primary health centres and sub-centres? We can not achieve the goal of health for all only by furthering and upgrading the facilities. We have to avail and use the available facilities upto maximum extent.

The low utilisation of available facilities is attributed to the factors associated with service providers as well as from the client’s side. The community prefers to go to local RMPs and tradition healers rather going to nearest sub centre at their doorstep. This repulsion of the people may be due to dissatisfaction and discontentment from the services and attention provided through primary health centres. The lack of awareness and conscienteness towards better health practices in the community could be other reason of not utilising services already available at local health institutions run by government. Thus to bridge this gap between the service providers and the community becomes the first priority to improve the utilisation of health and family welfare services.

Maternal and child health is the most important aspect of our health services. The primary health system undertakes several interventions for promotive and preventive care of mother and child along with curative and referral services. The high infant and child mortality in Rajasthan is definitely caused by low utilisation of services. (R. N. Gupta, 1988). As per the data from National Family Health Survey-2 (1998-99), the states with low level of complete immunisation like Rajasthan (16.0 percent), Bihar (10.6 percent) and Madhya Pradesh (22.4 percent) have very high infant and child mortality where as the same is very low in states like Keral...
and Tamil Nadu with high immunisation level. Some studies have been done on the utilisation of MCH and family Planning services but while examining the utilisation, the regional variations and inter correlation between social, economic and cultural factors and moreover incorporating the both side i.e. community and management factors responsible for low utilisation has not been examined at micro level so far. Thus this study has the scope to usher in unexplored areas of non-utilisation and focus on the dimensions to bridge the major gaps such as easy accessibility to services, availability of doctor/staff and medicines at primary health centres, quality of services as well as lack of awareness and demand generation etc which have also emerged prominently under the review of literature (Section 4.5 of Chapter IV). The present study is an endeavour to examine the availability, utilisation level and the factors responsible for low utilisation of MCH and family Planning services based on data collected from 8 villages in rural areas of Rajasthan.

1.3 CHOICE OF THE STUDY AREA

The health situation in Rajasthan is far from encouraging despite an extensive physical infrastructure and a large health manpower engaged in the delivery of health services. The situation can be judged from the fact that out of the 90 problem districts identified in India, based on birth rate, infant mortality rate and institutional delivery, 27 district belonged to Rajasthan (MOHFW, GOI, Annual Report, 1993-94). The maternal mortality rate (MMR) of 677 per lac live births (SRS, 1997) in comparison to national average of 408 and infant mortality rate (IMR) of 81 per 1000 live births (SRS, 1999) against the national average of 71, are much higher than the national average and also to major states in the country. The health status of people in rural areas of Rajasthan is pathetic. Encountered with high illiteracy, low income, old taboos and customs and scattered villages, the access to the health services are very poor and thus severely restricting the utilisation of the services.
The tough geographical and climatic conditions do also precipitates the accessibility and availability of MCH and Family Planning Services. As per the policy of the government, primary health care institutions are established based on the norm of population size. As per the present norm, one sub centre is created at a population of 5000 for plane areas and 3000 for hilly/tribal areas. Similarly, one primary health centres is created at a population of 30000 for plane areas and 20000 for hilly/tribal areas. This is not favourable to the desert characteristics of Rajasthan, where the same size of population is scattered over a vast area in comparison to plane areas.

Barmer and Jaipur Districts of Rajasthan are selected for the present study. Barmer is one of the most backward districts of Rajasthan. It represents the typical desert characteristics of the state. The villages are scattered and scanty with poor transportation facilities. High illiteracy and ignorance compounded with poor accessibility work as a major deterrent in utilisation of services. Jaipur is comparatively developed district of the state with better social, economic and accessibility conditions. Keeping these points in mind, rural area of Barmer and Jaipur districts of Rajasthan are selected for the present study. One backward and one developed district are taken to present comparative picture and to reach findings more prominently and specifically. Two sub centre areas are taken from each of two PHCs viz.; Kelnor from Barmer and Kotkhawada from Jaipur to study the utilisation of MCH and Family Planning Services through primary health centre.