CHAPTER EIGHT

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The present study is more of a microlevel analysis which restrains the researcher from making broad generalisations. Even though the study has not been very expansive enough it has exposed the present trends in Health Camps, the direction of the activities and the patterns of utilization of the available health measures by the beneficiaries. The study of camp organisation and management both at the field level and at the base hospital level has made certain facts clear that are essential for an efficient organization and execution of such Health Camps. The possible bottlenecks and the inherent lacunae that are likely to arise at the organizational level, can also be predicted on the basis of the present study. Though there have been no indepth studies on Mass Health Camps from sociological perspectives, the researcher has made certain hypotheses in the beginning of the study on the basis of the literature available on utilization of free health facilities. At the end, the researcher attempts to sum up the study on the basis of the experience survey, field observation and analysis of the collected field data keeping the earlier hypotheses in mind.

The present study of the beneficiaries of the Health Camps brought out the following facts with regard to their background characteristics which are essential in the understanding of the nature and functioning of the Mass Health Camps in the Indian context.

The age structure of the present sample of eye camp beneficiaries very much conforms to the general expectation, cataract is an age related problem and 92% of the sampled eye camp beneficiaries are above 50 years of age with
an average age of 61.4 years. This should forewarn the providers of health services, especially of Third World country like India to make a collective and concerted effort to fight out cataract blindness which is on the increase as a result of an increase in proportion of the 'greying population' of the country.

The age of the beneficiaries is an equally important factor in sterilization camps where it is considered ideal to undergo operation between the ages of 20 to 30 years. The present sample of sterilization camp beneficiaries has an average age of 25.7 years which is definitely an ideal period for such operation.

Earlier studies have indicated a slight preponderance of women among the eye camp beneficiaries. The present sample also conforms to this general expectation with more than half of the sample (53%) constituting women. The marital status of the eye camp beneficiaries also indicates that nearly 60% of the women beneficiaries happen to be widows while among men only one (3%) is a widower. This fact makes it imperative for the organisers to focus their facilities more on old women and widows who generally receive less attention and neglect in our society.

The study of rural urban status of the beneficiaries of both eye camps and sterilization camps indicate differing trends. It is generally expected about eye camps that more number of rural people take part since, such health facilities are inaccessible to them in their own places and as such prevalence of blindness is higher in rural areas than in urban areas. (Directorate General of Health Services, 1993). But the present eye camp sample displays a slight urban bias with 53.5% urban beneficiaries. Since four of the five eye camps
studied by the researcher were arranged in Belgaum city itself that perhaps explains the urban bias of the beneficiaries.

The same trend does not hold good with regard to the sampled beneficiaries of sterilisation camps as they show a strong rural bias (68%). FPAI Belgaum branch has its field area mainly covering 34 villages in Belgaum Taluka. Thus the rural bias of the sterilization camps held at FPAI hospital is self explanatory.

In both types of camps maximum number of beneficiaries have come from Belgaum Taluka inclusive of Belgaum city where as only 7% of eye camp beneficiaries and 13% of sterilization camp beneficiaries have come from places out side Belgaum taluka. The study regarding the distance covered by the beneficiaries also indicates the same trend i.e. the eye camp beneficiaries have come from an average distance of 15 kms and the sterilization camp beneficiaries have come from an average distance of 10.3kms. Thus in general it can be said that all these camps have attracted a majority of the beneficiaries coming within a radius of about 15kms from the camps site.

In both types of camps Hindus dominate; their representation is as high as above 80% while Muslims are around 10%. Jain's representation ranges from 5% to 7%. The Hindu Muslim ratio in the sample is very near the ratio of both of the religious groups, in the total population. The Jain representation is a little more since Belgaum district has relatively high Jain population. The Christians are totally absent in the samples of both types of camps.
Among Hindus it is the 'medium castes' which dominates the samples. Though Lingayats are the 'dominant castes' of Belgaum district followed by Marathas and Kurubas, it is the Marathas who have more representation in sterilization camps. This again is due to the villages covered by FPAI which are mainly dominated by Maratha populations. Both the 'high castes' and 'low castes' have very less participation in these free camps for availing themselves the benefits. This indicates that the camp organisers have to shift their focus more on the low castes, who are deprived of these free health facilities, either due to lack of awareness or due to their social disability.

The educational levels of the samples of both types of camps are not similar. The eye camp sample displays a very poor educational status, i.e. 60% of the respondents being illiterate. The literacy rate of the female beneficiaries of the eye camps is still worse, with 90% of them being illiterate. But the situation is much better and brighter with the sterilization camp beneficiaries where 66% of the sample happen to be literate and among them 80% have education up to the high school. This difference in educational levels is due to generation gap between the two female samples of two different types of camps.

The data also confirms the expectation that women with better educational level accept sterilization in more numbers than the illiterate ones.

The occupational studies of the beneficiaries of both types of camps indicate that, in both the camps nearly 70% of the beneficiaries are farmers and artisans. Only a little more than 10% have salaried jobs while others do petty businesses and work as casual labourers.
A study of the income of the beneficiaries of both types of camps gives us an idea regarding their economic level. It is evident that in both types of samples, the maximum beneficiaries belong to the lower economic class. But a slight variation is noticed in the economic structure of both the samples. In the eye camps sample the beneficiaries belonging to ‘very poor’ and ‘lower economic class’ dominate, where as the sterilization camp sample is dominated by ‘lower economic’ and ‘lower middle class’. This difference may be due to the fact that family planning camps are held in FPAI hospital which provides the camp a stable appearance of a hospital. The lower middle class who prefer to come to hospital, perceive it more as a hospital than as a camp. But the eye camps have no such base hospital structure with permanent staff, and though many eye camps are conducted in hospitals with proper OTs, they, have still a temporary existence. Thus they are classified as ‘field camps’ which have not been able to attract many people from lower middle class.

A study of the breadwinners of the beneficiaries families reveals that more than half of the sterilization camp beneficiaries have their husbands as the breadwinners while in the eye camps, nearly 45% of the beneficiaries have their son/sons as the breadwinners of their respective families; and further one fourth of these beneficiaries themselves are the breadwinners. This difference is mainly due to the difference of age groups to which the two samples belong.

Both joint family and single family structures are found in almost equal measures in both the samples of camp beneficiaries. The single family status of the sample has slightly more representation in eye camps. Regarding the size of the family of the sterilization camp beneficiaries, the sample comes
mainly from slightly bigger families (average number of members being 9.3) than the eye camp beneficiaries. The beneficiaries of sterilization camp belong to a younger age group when they are still attached to the stem family, which is usually big in size. The eye camp beneficiaries belong to older age group, i.e. a stage when there is more disintegration of a joint family with parents living on their own or children going out of the stem family to set up their nuclear families. To some extent this may explain the variation in family sizes of the two samples.

The educational level of family members of the beneficiaries of both camps is studied to find out whether the beneficiaries come from an educated background or not as it has its relevance. The children of eye camp beneficiaries for example are definitely better educated than their parents. Nearly 90% of the eye camp beneficiaries have educated at least one of their children at least up to high school. While about 75% of the sterilization camp beneficiaries have one or even more brothers and sisters educated up to high school level. Thus it can be surmised that better educational level of the family members definitely brings about more awareness about health facilities thus available to the beneficiaries.

A study of sex distribution of children of sterilization camp beneficiaries is made in order to know the parents’ sex preference of children. This study of course indicates a strong preference for son or sons. Only those couples who are satisfied with the sex distribution of their children come forward for sterilization operation.

More than half of FP camp beneficiaries have come forward for operation when their last child is not even one month old. Hardly 7% of
beneficiaries have their last child above the age of three years. Thus most of the beneficiaries do not wish to follow some temporary methods of family planning; and wait till their last child attains the age of 3 years, and only then go in for sterilization. However, this is not a healthy trend in following family planning. On the other hand they should be educated about temporary FP methods and they must be persuaded to adhere to them for sometime. By providing constant supervision and follow up, the service providers should earn the trust of the beneficiaries about the temporary methods; (which they don’t have at present) so that they can postpone their sterilization till the last child grows up to three years of age.

How early or late the patients with eye complaint seek camp facilities is studied and it is found that nearly 56% of the patients with cataract blindness have sought camp facilities within one year of cataract blindness. About 15% of the camp beneficiaries have delayed it for as many as more than 5 years.

About one third of sterilization camp beneficiaries have not delayed at all in seeking the camp facilities after achieving the ideal family size of two children. But the remaining beneficiaries have come for sterilization after only begetting more than two children. The reason for this delay is of course accounted for as the wish to have one or more sons in the family.

Among eye camp beneficiaries nearly 56% of them consulted doctors, both government and private, before coming to the camp; but among sterilization camp beneficiaries, only one third of them consulted doctors before coming to the FP camps. While the others straightaway came to FPAI hospital without consulting any doctor.
In the present study we have attempted to know how the beneficiaries get information about the organization of such camps; and who are the main sources of information to them. It is found that nearly 80% of the eye camp beneficiaries have not learnt about these camps through any hand bills or news about eye camps published in newspapers. These beneficiaries also have no acquaintances who have already made use of such eye camps. The main sources of information about these eye camps have been through grass roots level workers such as Health Workers, Anganawadi teachers and relatives and friends who themselves have heard or read about such eye camps. About 85% of sterilization camp beneficiaries have their relatives or friends or acquaintances who have already undergone operation at the FPAI hospital. So, through them that they have come to know about the hospital and its services. But, the study reveals that only 40% of them know about the camp at FPAI hospital through the field workers. The remaining 60% have come to the hospital without any idea what so ever of the camp that is being conducted. The researcher finds that the formal agencies of publicity, like publishing the news about the camps in the newspapers or printing and distributing handbills hardly reach the people who need information. Thus the printed media is not at all effective in spreading the news about the camps. This also proves that lay referral system alone is much more influential in such cases in directing the health seeking behaviour of the majority of the common men and women than the formal agencies of information in print.

Both eye camps and sterilization camps involved surgical procedures and majority of the beneficiaries had no prior surgical experience. Nearly 90% of the Family Planning Camp beneficiaries and 65% of eye camp beneficiaries
had no previous surgical experience. Inspite of this there was high level of self motivation among eye camp beneficiaries to undergo operation in the camp itself as it is clear that 85% of them decided on their own to undergo cataract surgery in the camp. Among FP camp beneficiaries 45% of them decided to undergo sterilization without consulting anybody at all and only one fourth of the women beneficiaries have consulted their husbands. Family planning is a delicate issue which needs consent from the husband and as well as elders at home in our society. Inspite of it, many women are assertive enough to decide on their own.

Majority of beneficiaries of both these samples repose full faith in the treatment that is available in the camps. Very few are either apprehensive of the treatment or have no confidence in it.

The camp organizers have issued instructions to the beneficiaries to bring attenders to attend on them during the camp. More than 60% of the camp beneficiaries are attended by first relative in both of these camps. But it is dismaying to note that nearly 15% of the eye camp beneficiaries have no attenders at all; this state of affairs probably indicates the neglect of old by the members of their family.

Free treatment in the camp is generally considered as the main attraction that draws beneficiaries to the camps. In both the camps though nearly 85% of the beneficiaries knew about free treatment in the camps only 20% stated openly and frankly that they have come to the camp mainly for the sake of treatment that is free of any charge while the others said that they have come to the camp with an expectation of receiving good treatment. It is
surprising that 10% of the beneficiaries did not know about the treatment being totally free in the camp.

In a way such camps encourage community living. Naturally because the beneficiaries are accommodated in one or two big halls and they have to stay together though for a short period. The beneficiaries welcome this arrangement and did not show any discomfort or shyness for having to stay together with other strangers. Instead, they experience a sort of 'we feeling' because, all of them have undergone the same operation. The camp beneficiaries are visited frequently by their family members and friends in the camps. It is observed that in the sterilization camp beneficiaries have more number of visitors than the eye camp beneficiaries.

Both eye camps and sterilization camps have served as a very good base for a study in the field of Medical Sociology. The organizational aspect of these camps reveals the need for co-ordination of several people and the researcher feels that camps organized at the base hospital have ready infrastructure for such camps.

The researcher while interacting with the beneficiaries tried to probe into the social differentiations that exist in the campsetting. The samples appear homogenous as far as their economic background is considered. But there are obvious religious and caste differences among them. And on no occasion did these beneficiaries tend to express caste differences openly. For instance, it is found that most of the beneficiaries are least bothered about who cooks their food and who serves it to them. It is the opinion of many that such differences should not be maintained in a public place such as the
health camps. A curious observation is that the beneficiaries tend to group together mainly on the basis of common language and common native village.

The researcher observed that doctor-patient relationship is definitely not satisfactory in the camps especially in field camps, perhaps because doctors come from a distance, conduct operations and go back to their respective places. Many times the patient does not know who operated on him. A large number of patients, the lack of time of doctors who are usually busy in their routine work, and such other factors hamper the doctor patient relationship. Where as in base hospital camp the resident doctor is constantly there and is therefore responsible for his/her patients; this breeds a lot of scope for normal doctor patient relationships. The researcher observed that the patients in the field camps accepted this abnormal relationship without any grumbling and instead tried to associate more intimately with the paramedical staff in place of the doctor.

The depersonalization and dehumanization of the patients are the inevitable out come of our modern hospital organization. A mass health camp cannot escape from these maladies. The researcher observed that the organization of large number of surgeries to be accomplished efficiently with the least waste of time out of necessity leads to depersonalization and dehumanization of patients in the camps. Since the camp conditions are more flexible than those available in hospital the inmates of the camps soon overcome these feelings and do not get depressed about it because it is inevitable. Patient attenders are allowed to stay and visitors are also allowed to visit these patients unhindered and the patients are permitted to move about in the camp premises. This liberty mitigates and compensates for the feelings of depersonalisation. Further the patients in the camp also get the opportunity
of mixing with others; and additionally food and medicines are properly supplied to them which fact makes their stay in the camp quite comfortable.

The follow up study helps us in assessment of the success of the surgery and also provides an idea about how the beneficiaries have been faring after the operation. All the camps studied by the researcher conducted follow up camps after 5-6 weeks of operation. Apart from attending these follow up camps the researcher also conducted her own follow up of the beneficiaries after a couple of months. The researcher wished to study the aftermath of operation as perceived by the beneficiaries.

The eye camp follow up studies reveal that about 70% of the beneficiaries are satisfied and are very happy about their eyesight after operation. They have no complaints at all. But 15% of the beneficiaries do complain of either pain or itching and watering in the eye. The remaining have found the spectacle unsuitable or suffer some hazy vision. Only one beneficiary has complained of total loss of vision which is in fact within the permissive range of failure rate of cataract operation which is between 2% to 3%.

The followup study of the sterilization operation indicates the same trend; i.e. about 75% of them are fully alright and have no physical or even psychological problem. The others do have some minor physical ailments like low back ache, general weakness, pain in legs and hands, mensus not started of irregular mensus white discharge pain in stomach, etc.

The researcher met both the resident doctor of FPAI hospital and the camp attending ophthalmologist to discuss some post operative complaints expressed by the patients. Regarding pricking pain and watering in eye the
ophthalmologist explained that many times it is due to the stitches which are not removed from the eye in the camps for fear of infection. If such complaints continue the patients should consult the eye surgeon and get the stitches removed. For many the pain gradually subsides all by itself. And if the pair of the spectacle is not suitable then it should be changed which would improve the vision.

The number of complaints after sterilisation operation are more due to poor general health condition of most of the women who lack nutritious diet. Many of the complaints expressed by women are not directly related with the operation at all. The researcher is lead to conclude that the operations conducted at both the camps have been generally successful and the complications if any are within the acceptable limit.

**Suggestions:**

The researcher proposes to make a few suggestions regarding the organization and management of Mass Health Camps. The camp attending surgeons are not very happy with the operating conditions of the camp OTs. So more attention should be given to improve the camp O.T. conditions by improving the supply of instruments, and ensure their proper sterilization and the maintenance of sterile atmosphere in the O.T which would definitely improve the quality of surgery.

Since the camp attending doctors are over burdened with both camp duty over and above their regular duty, a separate unit of camp attending doctors, should be formed whose main duty would be to attend the camps. The doctors who attend camps coming from medical colleges should also be relieved of their regular duties during the camp days so that they can devote
more time in the care of camp patients that would certainly improve doctor patient relationship in the camp.

The sterilisation camps, when began in 1960's were more of field camp type; but now they have over grown their 'mass camp' approach because sterilisation has became a regular facility in all PHCs. But the eye camps are still in their initial stage of field camp type, and hence forth they have to grow into base hospital camps. Once the field camps popularise the cause they should shift to the base hospital with all the proper and permanent infrastructure.

The community Health centres (CHCs) which at present cater to the health needs of one lakh of people should be provided with proper facilities for cataract surgeries; along with the appointment of ophthalmologists. The number of ophthalmic assistants should be increased and every two PHC should have at least one ophthalmic assistant. Belgaum district has 6 ophthalmic assistants working at PHC level while the district has 121 PHCs. These people work with grassroots level health workers and screen the cataract patients to be sent to CHCs for operation. The eye camps should be conducted at CHCs at regular intervals and the cataract patients from the nearby subcentres and PHCs should be sent to the camps conducted at CMC level. A better viable and proper information system should be developed to keep the people informed of the eye camps arranged at base hospitals. The block and taluka level general hospitals may also be expanded with facilities for eye surgeries. To conduct eye camps help from NGOs should be drafted for the supply of food and spectacles to the beneficiaries. Private practitioners should also be encouraged to take part in eye camps. The government ophthalmologists and the medical college doctors should be given extra
weightage during their promotions for serving in these eye camps. Thus conducting of eye camps in base hospitals is definitely a welcome improvement over the present prevailing conditions and the followup will also be more effective. The ophthalmic surgeons and the paramedical staff will work under less stressful conditions.

The researcher has been able to surmise from her study that the health camps have definitely reached the needy and the poor even in inaccessible areas. Yet there is a need still to bring more number of socially disabled people who because of their ignorance and backwardness have not been able to avail themselves of such health facilities. Some of the urban areas also suffer from inadequate public health facilities and field staff to cover the huge populations effectively. The urban slum dwellers are also deprived of health facilities in the same way as the rural poor. The researcher strongly feels therefore that the staff at the grassroots travel should be strengthened both at rural and urban areas.

Of course the improvements in the health parameters of the nation is certainly a significant achievement in Independent India. Towards this achievement, the health camps have been playing a vital role by offering substantial contribution. However, accurate quantification of this contribution is difficult. Yet the present study has made an effort to analyse and evaluate various sociological aspects of these health camps, and also to propose practical suggestions to improve and optimise the contribution of the health camps towards achieving the set goal of 'Health For All'.