CHAPTER - ONE

INTRODUCTION

Health is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity” (WHO, 1983). This positive concept of health is now being accepted by all, including the medical fraternity, because it recognises the importance of the society and the social aspect of the individual in developing perfect health. Medicine - a science which deals with the health care cannot claim to be purely and dichotomically biological because it is also a social science. Though many physicians still doubt the contribution of sociologists as being relevant to medicine, there are several other factors that have brought the two disciplines together.

In the words of Rodney Coe (1978) they are:

1. “The increased interest in the control of chronic diseases paved the way for the increased emphasis on the concept of multiple causation of the diseases that is, factors other than biological are also regarded as important in determining the diseases;

2. The increased emphasis on the long-range participation of every citizen in prevention of diseases and hence on health education;

3. A growing world-wide recognition to provide adequate medical care to all communities and all people and hence need to measure needs of medical care available at present and ways to meet the gaps;

4. The importance of rehabilitating the patients who have suffered disability through illness and accidents in their own social milieu;
5. The emergence of occupational health as an important science to help cope with the problems caused by industrialisation;

6. The broadening of epidemiology to include the study of ecology and the interest in the causes of disease expanded to include differential effects on different population in different environment (Dak T. M., 1991, p6).

Thus the above factors relate to the diseases affecting human groups and the ways in which various groups react to the diseases. All these provide a substantial ground for the application of sociological knowledge and research techniques in the field of medicine.

Rodney Coe has identified at least four dimensions from this standpoint:

1. The differential distribution of illness in terms of social structure and the differing life style impose on people, provide clues about the nature and causes of diseases.

2. People view the diseases from perspectives of their culture and based on their perspectives, they tend to respond to the disease in predictable way.

3. People develop an array of institutions to treat the diseases that appear in their group.

4. The treatment of disease involves more than the mere application of medical knowledge through medical institutions. It involves physicians, hospitals, pharmaceutical firms and other supporting institutions in the modern complex society and religions, rituals, neighbors and kinsman.
supporting medical efforts of the healers in the traditional simple society (Dak T. M., 1991, p7).

The distribution of disease in the society, the cultural perspectives on disease, the role, attitude and values of health providing institutions, the relationship of treatment and support of facilities all these form the subject matter of a special branch of sociology identifiable as Sociology of Medicine or Medical Sociology or Sociology of Health.

David Mechanic (1968) has mentioned as many as 15 most important and common areas of study in the field of medical sociology. They are:


This above list gives us an idea about the wide extent that Medical Sociology encompasses.

The health administrators have been seeking the help of sociologists to evaluate health programmes to study different dimensions of pathological conditions and also to identify ways and means to promote community participation in health programmes (Boek and Hilleboe, 1956). The sociologist’s understanding of the people’s needs and diseases and community’s leadership patterns and power structure can be of great help in enlisting public support, particularly in health programmes, affecting
sensitive areas of social and individual behavior. Thus in the present times the new discipline Medical Sociology is brought very close to Public Health and Social medicine (Rosen, 1977).

India, since 1947 as an independent country has made efforts to evolve an effective health-care delivery system which would function efficiently to achieve its health programmes. The huge populations mainly concentrated in villages, many, being very inaccessible - the mass of the uneducated and traditional minded populace have not fully accepted the health programmes as conceived by the planners. The health planning also has the follies of 'overly centralised' and 'top heavy' approach with an improper infrastructure all of which have thwarted the success of health programmes.

India as an independent welfare state has taken the responsibility of health of its citizens. In 1947 when India became free, Ministries of Health were established both at the centre and at the state. Subsequently the Constituent Assembly adopted the Constitution of India on 26th Nov., 1949. In article 246 of constitution of India covers all the health subjects and further they have been enumerated in 7th schedule under three distinct lists, Union list, Concurrent list and State list. Article 47 of the Constitution and the Directive Principles of the State Policy States - “That the state shall regard the raising of the land of nutrition and the standard of living of its people and the improvement of Public Health as among its primary duties” (Park and Park 1989).

Thus it is clear that health care is a public right and it is the responsibility of the government to provide this care to all and in equal measure. Hence, the Indian government abides by this principle. As a
consequence the health of the citizens has become the responsibility of both
the state and central governments.

The process of the health planning in India began with the work
initiated by the well known Bhore committee in 1946. In the years that
followed several other committees were set up by the central government to
review the implementation of the various aspects of health policy and
updating its planning in the country. The committees that deserve mention
are: Mudaliar Committee (1961), Chadah Committee (1963) Mukherjee
Committee (1965), Jangalwala Committee (1967), Jain Committee (1968),
Kartar Singh Committee (1973) and Shrivastava Committee (1975) (Shah
Geeta, 1985). Besides these some other studies on health policy and their
concerted planning were conducted by autonomous institutions like the
ICSSR and ICMR. Finally the important recommendation from these studies
could be thematically grouped under the following headings: a) to improve the
existing structure of health care delivery system, b) to improve the
supporting services for a proper and quick delivery of medical facility and
c) to improve the quality of delivery system thereby improving the health
standards of the mass (Nagla and Nagla, 1991).

It has been observed that the low access to basic health care facilities is
a common phenomenon in most of the developing countries. In order to
provide the minimum basic health facilities it was decided by the Health
Assembly of the WHO to launch a global movement known as “Health for All
by 2000 A. D.” In the year 1978 the same became known as ‘Alma Ata
Declaration’ and India as a member is a signatory to it. To achieve ‘Health for
All’ the Indian government has been striving rigorously to extend basic health
facilities particularly to the vulnerable sections of the society. In this process
'Health for All' has been defined as 'a level of health that will enable every individual to lead a socially and economically productive life (Govt. India, 1981). It must be noted here that the existing health care delivery system all these years had been an adoption of the Western model which is top-heavy, over centralised, elite oriented, urban based punctuated with bureaucratic hurdles which over emphasized only the curative aspect, large urban hospitals, doctors and drugs. This approach requires to be replaced by an alternative model strongly rooted in community providing adequate efficient and equitable referral services, integrative of both preventive and curative aspects and combining all the valuable elements in our culture and tradition with the best elements of Western health delivery system. (ICSSR - ICMR, 1981).

For the first time after independence our central government could work up a National Health Policy (NHP) in as late as 1983. The NHP declared clearly its missions, objectives, programmes, targets approaches and strategies. The policy document recognised the health programmes and priorities of the rural masses and as such upheld in the back ground the philosophy of Alma Ata Declaration. Though the targets drawn on the paper by NHP seem feasible, the real implementation at the micro-level needs to be related to socio-cultural milieu.

The present study of Mass Health Camps is made with a sociological analysis of health programmes following a particular approach called 'Camp approach'. Two major themes have emerged in recent years in the delivery of health services. They are a) The services should be organised to meet the needs of the entire population and not merely the selected groups. The health services should cover the preventive curative and rehabilitative services and
b) It is now fully realised that the best way to provide health care to the vast majority of rural people and urban poor is to develop an effective primary health care services supported by an appropriate referral system. (Park and Park, 1989). The study of Mass Health Camps comes under the first theme.

**Statement of the Problem and Conceptual Frame Work:**

In the expression Mass Health Camp the term 'Mass' intends to provide health services to a large number of people. Further such health services so provided should meet general health needs of the people only then it could be defined as serving the mass. For example, the services as immunization, family planning or eye care and cataract operation can be provided to a large number of people mainly through camp approach.

In the present study the researcher, intends to make a thorough study of 'Mass Health Camps' by exploring all its complex aspects. The researcher visualises the Mass Health Camps as having three vital components: 1) The organizers that is those who arrange the camp, 2) The professionals those who provide the actual health services to the people, and 3) The beneficiaries those who make use of the health services at the camp.

The researcher intends to make an explorative study of the Mass Health Camps from a sociological perspective. Thus the study deals with the organisation of the camps, the beneficiaries, their socio-economic status and their interactions with the camp situations and the role performance of the professionals in the camp.
What is Mass Health Camp?

The term camp has been defined in Webster’s New Twentieth Century Dictionary (1977 p. 261) as “group of tents, huts etc. used for temporary lodging”.

The term ‘camp’ as it is used as an approach in health services also connotes the same verbatim meaning that it is a temporary structure. The health camp no doubt does provide a certain health service but only temporarily. It is a temporary arrangement to do so which is not regularly available to the people and which is not easily accessible to the people in that particular area.

A Mass Health Camp connotes three things: one, that it is organised to provide to a large number of people than the ordinary number of beneficiaries forming a ‘Mass’, it deals with some aspect of ‘Health’ and it is temporary in nature, as such designated as a ‘Camp’. A few more connotations may be added to the phrase Mass Health Camp-i.e., it usually provides a health service which is not easily available or accessible to the people and it is provided free of cost. Such Health Camps provide medical services nearer to the doors of the people. The camps are arranged keeping in view those people who because of their socio-economic conditions and inhibitions and the non-availability of the required services in their own places, and therefore are deprived of the medical facilities. The Mass Health Camps also intend to increase the awareness of the people about the health programmes and popularise them.

A close observation of the health camps reveals that they can be classified on the basis of their purported objectives. For instance, some
camps, conducted as health checkups are undertaken and cases with serious illness are referred to hospitals for further treatment. To this category belong a school health check up camp, a diabetes check up camp, a dental check up camp, health check up of women and children, skin check up and even heart disease check up camp. For simple ailments free drug is distributed and prescriptions are also given in such camps. In dental check up camps short procedures like temporary filling and simple extractions are made.

Some camps are preventive in nature like the immunization camps where immunization is provided against certain diseases. ‘Pulse Polio’ is one such camp where polio drops are administered to children below five years of age on a fixed day in fixed centres all over the country.

Some other camps are curative in nature like eye camps where the cataract lens of the eye is operatively removed so that the patients sight is restored with the help of spectacles. The curative camps are of longer duration and the patients have to stay for nearly one week or sometimes more.

Another type of camps may be categorised as health promotive camps like family planning camps. Family planning is a public health issue and it is intended to promote health status of both the mother and the child. In addition to this there are also rehabilitative camps like the one attended by this researcher where artificial legs were made to order and provided as required to the physically handicapped persons-medically termed prosthetic camp.

The diagnostic and preventive camps are conducted lasting over a short time, the duration being one single day or even a few hours. But the curative,
promotive and rehabilitative camps which involve medical interventions run for a longer period of time usually for a week or ten days. These attract people from the surrounding areas and sometimes even from far off places too. It all depends on what kind of service that is being given. For example, providing artificial legs is a very rare service and this researcher observed that patients had come from long distances to avail themselves of this rare facility.

Indu Mathur (1981) has made a study of mobile surgical camps conducted in rural Rajasthan. She has noted certain specific features of the social structure and organisation of the camps which are not present in other treatment situations of that level. They are as follow:

1. The situation is temporary, scarcity of time accelerates action at both ends,

2. The treatment process does not involve any financial consideration,

3. All the staff work as a team. There is no compartmentalization, distance or competition in the actual working of various departments. Relation among the staff is more on equality basis and interactions are informal and free. Credit or discredit is shared by all and the individual merges with the team,

4. Surgical team is dependent on patients for its success,

5. Humanistic value is central, around which all activities are organised,
6. Communication is free, uninhibited, frequent and unobstructed among all the categories of staff as well as between staff, patients and organizers,

7. There is an atmosphere of mutual trust and confidence,

8. The staff stays all the time with the patients and their activity is closely watched by colleagues people and the organizers,

9. The third party of philanthropists or local leaders who take initiative in the organization of the camps mediate between the camp staff and the people, and

10. The camp with all its inpatients, relatives and visitors looks more like a mela (a village fair).

Along with these factors enumerated by Indu Mathur (1981) the researcher on the basis of her study wants to add the following observations to the conceptual frame work of the 'Mass Health Camp'.

a) A well planned and extensive publicity usually precedes a Mass Health Camp,

b) A Mass Health Camp has three important components i.e. the organizers, the professionals and the beneficiaries and the absence of any one of them makes it impossible to arrange a health camp,

c) A proper coordination of all the three components is very important for the smooth conduct of the camps,
d) The Mass Health Camp is based on altruistic ground of different levels of people that is the organizers, the professionals and the paramedical staff,

e) Mass Health Camp is more suitable and practicable particularly when a health service that is generally needed by a larger proportion of the population is to be provided. But the health services towards individual ailments do not come under camps as each of such ailments need special and personal attention,

f) Mass Heath Camps are much more suitable for a third world country like India where it is urgent to provide certain basic health services to a large number of people as they stay far away from cities where specialized health facilities are usually concentrated.

Scope of Study:

The researcher for the present study has selected only such of those Mass Health Camps which have a duration of at least 5-7 days so that she could have an adequate opportunity to study the organization of the camp, the beneficiaries and the professionals that is all those who participate in such camps.

Further the researcher has chosen for her study the Family Planning Camps and the Eye Camps which have at least a week's duration. Initially the researcher had also chosen immunization camps for her study. She was also present to observe the 'Pulse Polio' programme and collected the required data. But since it was conducted for a short time that is only for one day, and the study of the beneficiaries differed from the study of beneficiaries from eye
camp as well as from family planning camp, the researcher decided to exclude the data relating to the immunization camp in the final analysis of the present study.

Originally the field scope of this study was planned to cover Eye Camps and Family Planning camps conducted only in and around Belgaum city. But later the geographical area was extended to the whole of Belgaum taluka. However, a close study of the beneficiaries revealed that they were not confined to the limits of Belgaum Taluka but gathered from different parts of Belgaum district.

**The Objectives:**

So far there have not been any studies particularly from the sociological point of view except the one made by Indu Mathur (1981) and it pertains to the study of mobile surgical camps in Rajasthan. This study comes very close to the study of Mass Health Camps but not Mass Health Camps proper. It is a short study focusing more on the professionals and their behavioral changes as a result of changed situation. But a study of the community involved therein has not been touched upon whereas in the present study the researcher intends to make an explorative study of all aspects of the Mass Health Camps. The indication is definitely and consciously towards the community as such and the study is especially made more from the point of view of beneficiaries. At the same time the organization of the camps and the professionals involved in the camps are also studied side by side.

The objectives of the study may be stated as finding answers to the following questions:
1. What constitute the factors involved in the organization of the Mass Health Camps and what are the problems faced by the organizers?

2. Who are the people who benefit from these camps? Is there any particular class sex and age difference noticed among them?

3. Are the camps successful in bringing under their cover all the people they intended to?

4. What are the factors that motivate the beneficiaries to attend the camps? What kind of lay referral system exists behind this?

5. How do people respond to the camp conditions?

6. What differences does a sociologist find between a Health Camp and a Hospital?

7. What kind of relationship exists between the doctor and patients in such Mass Health Camps.

8. Do the beneficiaries really benefit from such camps?

9. How do professionals involved in these camps react to the camp condition and what impressions have they formed regarding such camps?

10. What improvements are possible in the present setup?
Methods and Tools:

Since the area of the present study is virgin pure and as yet not widely explored. However, a general review of literature on Medical Sociology and many applied and related studies conducted on different aspects of health services in India is a paramount prerequisite to the study of Mass Health Camps. Apart from this theoretical background, the researcher had to depend entirely on the information generated during her field studies and their analysis. To achieve this, the researcher had to follow a suitable research methodology and tools.

To begin with, in order to acquire thorough knowledge of the public health services, the researcher descended on the methods of 'experience survey' and 'non participant observation'. The available literature on public health and health care delivery system in India was studied thoroughly. Frequent visits to District Health Office were made by the researcher to acquaint herself with the actual health services provided to the people at the district level, the block or taluka level and then at the village level. Subsequently inquiries about the health services provided through camp approach were made at the District Health Office. The meetings and discussions with the staff of District Health Office about the actual conduct of the Health Camps furnished a broad idea about the actual working of the Health Camps.

Through all the above procedures the researcher learnt that every month laparoscopic sterilization camps are conducted in fixed Primary Health Centres (PHCs) and in this connection a time table about the camps is released in the beginning of every month. Eye camps are also held in different
parts of the district throughout the year. Every health camp, whether organised by government agencies or NGOs should take prior permission from the District Health Officer, giving the details about their plan of organization. This was the basic information on which the researcher undertook a baseline study. The researcher wrote to about 70 Primary Health Centres along with a charted table to fill information about the various Health camps conducted under them during the past three years. They were also requested to mention the type of camp, when it was conducted and how many attended it. Only 1/3 of the total PHCs thus contacted furnished their information. The information revealed that the tubectomies were conducted in all PHCs and some general health check up camps were also held at the PHCs. It is clear from the information furnished that the family planning and immunization services are a regular service in the PHCs. Thus they are not conducted in the form of Health Camp. Laparoscopic camps are conducted only in certain PHCs where the facilities to conduct operations are available, and for these the experts from the District Centre come and undertake the surgeries. But the laparoscopic sterilization camps are conducted for only one day and it is felt that, that is a too short a period for the researcher to make any thorough study of the beneficiaries. Thus the researcher had to exclude the laparoscopic sterilization camps from her study of Health Camps. Many medical officers at the PHCs explained that of late the tubectomies since they are held regularly in PHCs have lost their 'Mass Camp Approach'. So there were no Mass Family Planning tubectomy camps held in the district over the past 4-5 years.

Apart from this basic information about Health Camps in the district got through the District Health Office and PHCs, the researcher also
contacted the organizers and conducted 'experience survey'. The organizers belonged to both government and non-government agencies like the PHC medical officers, the branch manager of Family Planning Association of India in Belgaum, their population Education Officer, the field workers as well as the supervisors, the government health workers like nurses, male and female health workers, ANMs, wardboys, O.T assistants, the Block Extension Educators, the ophthalmic assistants, the anganwadi teachers and also the attending doctors all these supplemented required information to the researcher.

Different sets of people furnished information about various aspects of the Mass Health Camps. The researcher in her discussions with FPAI staff came to know about the month long tubectomy camps conducted by Belgaum FPAI branch once or twice in a year to boost their sterilization targets. The researcher further sought permission from the FPAI branch manager to study the month long sterilization camps. However, for the study of eye camps conducted in the district, the researcher obtained permission from the District Health Officer. These official routine had to be followed by the researcher before the field work was taken up.

**Pilot Studies:**

Prior to the actual field work, the researcher conducted some pilot studies both on eye camps and family planning camps. The Pilot study helps developing an acquaintance with the field of study and thus facilitates in preparing tools for data collection. For instance to know the family planning sterilization the researcher attended laparoscopic sterilization and tubectomy operations conducted at certain PHCs. Since the tubectomies are conducted
on a particular day of a week usually on Friday, the service has become a routine and as such the beneficiaries are only a few in number. Thus it has lost the usual camp milieu. In contrast the laparoscopic sterilizations are conducted at camps because larger number of beneficiaries are brought to the spot from the surrounding areas to the PHCs. But as these are conducted only for one day and the patients are discharged the same evening or latest by the next morning, the researcher could not choose them for her study. But the Pilot study of these camps did provide a good field knowledge to the research worker and brought about an understanding of the role of grass roots level health worker.

For the Pilot study of an eye camp the researcher attended an eye camp conducted at a PHC in a village near to Belgaum city. This camp lasted for seven days and the researcher attended all the seven days of the camp including the previous screening examinations held at three different villages. All the steps involved in the organization of the camp were noted and studied. The camp was organised by an NGO i.e. Lion Ladies Auxiliary and the Lady organizers were informally interviewed by the researcher. The other people involved in the eye camp like the medical officer and his staff, the health workers the ANM, the nurses, the Block Extension Educator, the visiting team of ophthalmologists all were informally interviewed to have an in-depth knowledge of all aspects of the eye camp. The researcher also observed the beneficiaries and held informal conversations with them and their attenders.

The Pilot studies of both the eye camps and family planning camps furnished understanding of the camps from the proper perspective and on the basis of the experience gained in the field, the researcher prepared an
interview schedule to be used in the interview with the beneficiaries of the camps in the field work proper.

The Schedule:

An interview schedule is prepared with open end questions to be used at the time of interviewing the beneficiaries. It is a common schedule used for the beneficiaries of both the family planning and the eye camps. The difference was only in the set of questions regarding their 'health problem'.

The schedule has the following subject headings and the questions are so framed as to elicit information on the matters related to these subject headings.

1. **Demographic data**: The name, sex, age residential address, religion, caste, the marital status, age at the time of marriage, the spouses being alive or dead etc. are covered.

2. **The family**: Information about the members of the family, the type of the family, the main occupation of the family, the income of the family etc. are included.

3. **Education**: Questions pertaining to the educational level of the beneficiary his/her spouse and also the other family members are asked to get a picture of the educational status of the beneficiaries and their family.

4. **Place**: The place of their residence from which they have come to the campsite, the distance covered, the mode of travel, the money spent as transport and information about those who accompanied the beneficiaries to the campsite constitute some of the items included.
5. **Health Problem:** The questions about when the health problem started, what did they at the beginning do about it, whom did they meet and consult what advice did they get and whether they had any earlier surgical experience, these form the questions of the eye camp beneficiaries.

The family planning beneficiaries are asked about their parity, what family planning methods did they follow, where was their last delivery conducted, what is the sex and age of the last child, whom did they consult about sterilization etc.

6. **About the camp:** What did the beneficiaries already know about the camps, from who did they learn of the camps, whose advice did they seek, whether they had any previous experience of camp - such questions are put in order to learn from the beneficiaries what knowledge already did they have about camp.

7. **Decision to undergo operation in the camp:** Who was responsible in taking the decision to undergo operation in the camp? Whether all at home agreed or not, was there any delay in making a decision, if so why? More details are elicited from the family planning beneficiaries.

8. **Faith:** Questions about the faith and the confidence of the beneficiaries in the treatment available in the camp are included in this section.

9. **Arrangements in the camp:** How are the arrangements in the camps? Are the beneficiaries happy with them? The social experience in the camp, their visitors and attenders and others are asked about.
10. The follow-up questions: This part of the schedule includes those questions which are asked a couple of months after the operation is conducted. Questions about the after effects of the operation and the physical and psychological well being of the beneficiaries and changes noticed if any etc., are enquired about. The researcher would meet personally the patients at the time of their follow up visit for others the same schedule of questions are mailed who are missed by the researcher at the time of follow up visit.

The Questionnaire: A mailed questionnaire containing about 14-15 questions is prepared for the professional mainly to elicit their point of view regarding the camps.

The interview schedule is prepared in English language with all the open end sub questions. At the time of administering the schedule the researcher translated them into either Kannada or Marathi or Hindi as the linguistic situation of the beneficiary required and of course recorded their answer in English.

The interviews are conducted for a minimum of 40 minutes to one hour. Some informal conversation with the beneficiaries has to be followed in order to develop rapport with them before beginning the interview. In case of very old beneficiaries who come for treatment in the eye camp it is their attenders who help in providing personal information.

As far as possible the interviews are conducted in some sort of privacy though complete seclusion is not possible in camp situations. The secrecy of their responses is assured to the beneficiaries and they are all encouraged to give their frank answers and opinions.
Both the family planning and eye camp beneficiaries co-operated enthusiastically with the researcher and there was no problem whatsoever of communication. In order to interview the Marathi speaking beneficiaries the researcher took the help of a translator. And no difficulty was faced by the researcher during these interviews.

**The Sample:**

Totally five eye camps held between February 1996 to September 1997, and two one month long family planning camps held at FPAI Belgaum branch; one in August 1996 and another in September 1997 were attended for a thorough study by the researcher.

As earlier pointed out a health camp is a temporary phenomena and its transitory status creates problems in choosing a proper sample for any such study. Statistical rules of sampling can not be applied strictly in the study of this kind of temporary phenomena. For instance a time table is not (cannot also) strictly followed in the organization of the camps since it needs the co-ordination of so many things and so many people. Thus the researcher had to attend the eye camps only as and when they were arranged. The family planning camp held at FPAI Belgaum branch were studied in two consecutive years that is in August 1996 and September 1997.

It must be recorded here that the researcher was put under certain limitations of time in the study of camp beneficiaries. For usually the interviews of the camp beneficiaries had to be conducted only two days after the operation that is the third day of the camp. The researcher followed a random sampling method for choosing the beneficiaries for interviews. But even there the researcher had to choose only those who had fully recovered.
from the operation and who were physically fit to sit up and talk. The beneficiaries are not just ordinary respondents. For them attending a health camp and undergoing an operation is a real traumatic experience indeed. Thus the researcher had to wait for a sufficient time for them to rest and recover. Usually by the third day of the operation, the beneficiaries with normal health would be fully recovered and therefore fit enough for an interview.

By using random sampling method, the researcher interviewed 72 beneficiaries from five eye camps. One of these sampled beneficiaries after answering the initial questions, refused to co-operate and continue with the interview. Thus the total number of completed interviews in eye camps was 71. In the two, one month long family planning camps, the researcher could interview a total of 85 beneficiaries.

A follow up study of these camp beneficiaries was also conducted. For this, two methods were followed to collect information. One, was to meet the beneficiaries personally and enquire about their health after the operation in the camp. Another was to seek the same information by mail. A total of 71 beneficiaries of the eye camps responded to the follow up study. This was achieved either by personal interview or by mailed questionnaire. Among the family planning beneficiaries as many as 56 beneficiaries answered the mailed follow up questions.

Professionals constitute another important segment of health camps. The researcher often met them earlier, during and after the operation in the camps. Many informal chats and personal discussion were held with them to know of related things from their point of view. At the end of the study, a
mailed questionnaire was sent to 26 doctors who participated in health
camps conducted in the district; among them were both gynecologists and
ophthalmologists. But even after repeated reminders only, 17 doctors answered
the questionnaire accounting for nearly 65% of response rate.

Unstructured interviews of the organizers were held during on going of
these camps. A non-participant observation was made by the researcher
about different aspects of the organization of the camps. And a diary was
maintained throughout the field-work which mainly contained the
information obtained in informal chats, discussions and interviews. The
observations and insights of the researcher were also recorded in the diary.

Hypotheses:

The study of Mass Health Camps is explorative in nature and thus it is
not reasonable to start with any hypotheses at the beginning of the study.
Though there have not been any authentic sociological studies on Mass
Health Camps; yet a thorough study of literature available on health care
delivery system and the utilisation pattern of people in India, prompted the
researcher to make the following hypotheses about the forthcoming study:

1. The beneficiaries of the Health Camps and their family
members have a higher educational level than the commoners since
education brings awareness about camps.

2. The beneficiaries are usually from the lower economic class
and are mostly from rural areas since they cannot afford either of
such health services or it could be that such health services are not
accessible to them.
3. The beneficiaries usually come from the nearby surrounding areas of the campsite.

4. The beneficiaries could be apprehensive of the quality and care regarding the treatment in the camps because normally serving large numbers, free of cost usually deteriorates the quality of the service.

5. The professionals participating in camps may find the operative conditions unsatisfactory when they compare the facilities with those of the hospital conditions.

6. The doctor patient relationship may be adversely affected due to lack of time.

7. Utilisation of the camps by the socially disabled groups like scheduled caste and scheduled tribe may be very much less when compared to the others.

**Data Processing and Frame Work of Analysis:**

The data collected in interview schedules as well as those collected from the mailed questionnaire is transferred to long sheets manually. The questions have open end answers and the researcher preferred to transfer the answers in to the data sheets instead of coding them and feeding them into computers. The data thus collected is both qualitative and quantitative as such the researcher preferred to do it manually. Though this takes a lot of time for processing, the researcher gained a full first hand knowledge of the data. Then the statistical tables are drawn from the data sheets, for further discussion and analysis.
The data analyzed into different frames. The socio demographic features of the beneficiaries are analyzed giving at first a broad picture regarding those who are camp beneficiaries.

Further the family background is analyzed in detail to understand the importance of family and to understand the importance of family and kinship relation while seeking treatment in a health camp.

The information and knowledge about the camp that the beneficiaries have gathered and how and why they have responded to the camp conditions is analyzed under ‘Camp and Beneficiaries’.

The social aspect of the health camp is analyzed taking into consideration the social differentiation, the depersonalization of the beneficiaries, the doctor patient relationship in the camp; community living and the visitors etc.

Analysis of the follow up study is made discussing the common complaints of the beneficiaries of the operation.

The researcher has analyzed the data collected in two types of camps: family planning camp and eye camp separately. The researcher felt that the two groups of beneficiaries belonged to two different age groups and their motives behind attending these camps are different. So the researcher preferred to discuss them separately though it made the discussion a little more bulky.

A study of camp attending professionals is made which highlights their perception of Mass Health Camps and intends to throw light on the problems and constraints that they experience as professionals in the camps.
Finally, conclusions are drawn on the basis of the analysis of the whole data.

Public Health, Health System and Health care Infrastructure in India:

A brief knowledge of ‘Public Health’ the ‘Health System’ and the present Health care infrastructure in India is essential since the present study on ‘Mass Health camps’ is made on this backdrop. We shall begin with the definition of public health.

The term public health came into general use around 1840. It arose from the need to protect the public from the spread of communicable diseases. The first public Health act appeared in 1848 in England to crystalline the efforts organised by society to protect promote and restore the peoples health. In 1970, C.E.A. Winslow, a former professor of public health at Yale university gave the oft-quoted definition of public health. The WHO Expert Committee on Public Health Administration, adopting Winslow’s earlier definition had defined it as: “The science and art of presenting disease, prolonging life and promoting health and efficiency through organized community efforts for the sanitation of environment, the control of communicable infections the education of the individual in personal hygiene the organization of medical and nursing services for early diagnosis and preventive treatment of disease and the development of social machinery to ensure for every individual a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realise his birth right of health and longevity”(WHO, 1952).

In developing countries such as India, public health has not made much headway beyond sanitary reform and control of communicable diseases. It has made tremendous strides in the industrialized western countries resulting in longer expectation of life and significant decline in death rates. In past 50 or 60 years, public health in developed countries has moved from sanitation and control of communicable diseases to preventive, therapeutic and rehabilitative aspects of chronic diseases and behavioral disorders (Park K., 1997).

Public health in its present form is combination of scientific disciplines (e.g. epidemiology, biostatistics, laboratory sciences, social sciences, demography) and skill and strategies (e.g. epidemiological investigation, planning and management interventions, surveillance evaluation) that are directed to the maintenance and improvement of the health of the people (Detels and Breslow, 1984).

With the adaptation of the goal 'Health for All' a new public health is now evident worldwide which may be defined as; “The organized application of local, state, national, and international resources to achieve 'Health For All' i.e attainment by all people of the world by the year 2000 A.D. of a level of health that will permit them to lead a socially economically productive life".
With an understanding of how public health is presently perceived by the health planners and providers we shall make a brief discussion on health system in India.

India is a union of 26 states and 6 union territories. Under the Constitution of India, the states are largely independent in matters relating to the delivery of health care of people. The central responsibility consists mainly of policy making planning guiding assisting evaluating co-ordinating the work of the state Health Ministries, so that the health services cover every part of the country and no state lags behind for want of these services.

The health system at the national level consists of 1) The Ministry of Health and family welfare, 2) The Directorate General of Health services, and 3) The central council of Health and Family welfare. At the state level, each state has its own health administration but the management sector mainly comprises of the state Ministry of Health and the Directorate of Health.

The Bhore committee (1946) recommended integrated preventive and curative services at all levels and the setting up of a unified health authority in each district. Subsequent committees have also recommended the same. Since 'health' is a state subject there is no uniform 'model' of a district health organization in India, each state developed its own pattern to suit its policy and convenience.

District is perceived as the most important unit for the development of health care infrastructure and its supervision. As early as 1946 the Bhore committee had given the concept of primary health centre (PHC) as a basic unit to provide close to the people as possible, an integrated creative and preventive health care to the rural population with emphasis on preventive
promotive aspects of health care. The programme of establishing Primary Health Centre in each community development Block having a population of 60,000 to 80,000 was launched as an integral part of the community development programme on October 2, 1952. Subsequently over the past forty five years the health service organization and infrastructure have undergone extensive changes and extension in stages following review by a number of Expert Committees. Progressive changes have been introduced into the programmes over the sixth and seventh Five Year Plan Period when the national norms for population coverage were adopted.

During the Eighth Plan the emphasis is mainly on consolidation of the existing health infrastructure rather than expansion. The thrust is given to qualitative improvements in the health services. Through strengthening of physical facilities like provision of essential equipment, supplying of essential drugs and consumables, construction of buildings and staff quarters, filling up of vacant posts of medical and para medical staff and in service training of staff.

We shall now examine the present health care network as it is established within the district. Primary health care infrastructure has been developed as a three tier system and is based on the following population norms.
### Centre Population Norms

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<th>Centre</th>
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<td>Plain Area</td>
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<td>Sub centre</td>
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<td>PHC</td>
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<td>CHC</td>
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**Sub Centre:**

It is the most peripheral contact point between the Primary Health Care System and the community. It is manned by one Multi Purpose Worker (Male) and one Multi Purpose Worker (Female)/ANM. At present the functions of the subcentre are limited to mother and child health care, family planning and immunization. As on 30-06-1996 there are 1,32,730 subcentres in the country.

**Primary Health Centres (PHCs):**

PHC is the first control point between village community and the Medical Officer. These are established and maintained by the state governments under the Minimum Needs Programme (MNP). A PHC is manned by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 subcentres. It has 4-6 beds for patients. The activities of PHC involves curative preventive and promotive and Family Welfare services. As on 30-06-1996, 21854 PHCs are functioning in the country. (Directorate general of Health Services, 1996).
Community Health Centre (CHCs):

CHCs are being established and maintained by the State Government under MNP. It is manned by 4 medical specialists i.e. surgeon, physician, gynaecologist and pediatrician supported by 21 paramedical and other staff. It has 30 indoor beds with one OT, X-ray, Labour Room and Laboratory facilities. It serves as a referral centre for 4 PHCs. As on 30th June 1996, 2424 community health centres are established by upgrading primary health centres.

Apart from these three levels of health services organizations the present organization of health services of the Government Sector consists of rural hospitals, subdivisional/tehsil taluka hospitals, district hospitals, specialist hospitals and teaching institutions.

Levels of Health Care:

It is customary to describe health care service at 3 levels that is primary, secondary and tertiary care level. These levels represent different types of care involving varying degrees of complexity.

1. Primary Care Level:

It is the first level of contact of individuals, the family and community with the national health system, where primary health care is provided. In the Indian context primary health care is provided by the complex of primary health centres and their subcentres through the agency of multipurpose health workers, village health guides and trained dais. Besides providing primary health care this bridges the cultural and communication gap between the rural people and the organised health sector.
2. Secondary Care Level:

At this level more complex problems are dealt with. In India, this kind of care is generally provided in district hospitals and community health centres which also serve as the first referral level.

3. Tertiary Care Level:

The tertiary level is more specialized level than secondary care level and requires specific facilities and attention of highly specialized health workers. This care is provided by regional or central level institutions. E.g. Medical College Hospitals, All India Institutions, Regional Hospitals, Specialized Hospitals and other Apex Institutions.

With this basic information about health system and health service organization in India, we shall make a brief study of the place of the present study that is ‘Belgaum District’.

Belgaum District:

Among the 20 districts of Karnataka states Belgaum district is situated in the north western part. It lies between 15° 23’ to 16° 58’ north latitude and 74°5’ to 75° 28’ east longitude. The district is surrounded by Maharashtra State in the north, Bijapur district in the east, Dharwad and Uttarkannada in the South, Goa and Maharashtra in the West (Government of Karnataka, 1987) The area of the district is 13, 415 sq kms the population 3583606, and the sex ratio is 954. The density of population is 267/sq kms. The urban population is 23.49% of the total population (Directorate of Health and Family Welfare Services, 1996).
According to 1991 census Belgaum district has 53% of literacy. It is 66.56% among men and 38.69% among women. (Directorate of Economics and Statistics, 1996-97).

The district at present has 122 PHCs, with 880 beds, 13 PHUs with 36 beds and 9 hospitals with 1060 beds. The district has 598 subcentres. The district hospital is the earliest and biggest hospital in the district. The present bed strength of the hospital is 720. This hospital has all specialized services in medicine, surgery paediatrics maternity gynaecology ENT, Skin Ophthalmology, psychiatry and dentistry. The district has two mobile eye units. Belgaum has vaccine institute which is one of the four institutions in India. (For more information about government health institutions in district see Appendix - I).

The district is considered backward from the overall point of view, but it is progressive in agriculture. It is rich with cultural heritage and has been an example of influences of different cultures. With this general information of the district we shall begin the study of health camps arranged in the district.