CHAPTER TWO

REVIEW OF RELATED LITERATURE
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The study and review of the available literature on the area of study is a prerequisite for the research proper. It keeps the researcher aware of the extension of field, the studies already conducted within the field and the theoretical leads fathomed by the earlier studies. The literature studied by the researcher in the field of Medical Sociology in relation with the problem of study may be classified under following heads. Though such a classification is arbitrary to some extent, it gives a clear idea about theoretical issues.

1. General studies on Medical Sociology.

2. Studies on Public Health Policy and Health Care Delivery system in India.

3. Utilization of health services in India, and

4. Family planning and eye camp studies.

1. General Studies on Medical Sociology:

'Medical Sociology', 'Sociology of Health' and Sociology of Medicine are different terms employed to refer to the studies by individuals or groups in interaction with the environment, disease host and agent or carrier of disease, affecting their health through illness, suffering pain and discomfort and efforts made in restoring their health to a normal state through self or directed efforts of the practitioners of health. The concepts of health and disease have cultural relativism and their perception is influenced by the belief structure, value pattern and values prevailing in the society (Mehta S.R, 1982).
Robert Strauss (1957) made an attempt to classify Medical Sociology into two separate but closely interrelated areas; Sociology in Medicine and Sociology of Medicine. In the first category the sociologist as a member of the team, collaborates with the physician and other health personnel in studying social factors relevant to health disorders. In the second category the organization, role relationships, norms, values and beliefs of medical practice are a form of human behavior. This distinction made in Medical Sociological studies seems to be an arbitrary, categorization as is done in case of 'applied' and 'pure' research.

Cockerham, (1978) states that sociology is concerned with the function, structure and roles of social institutions and processes and with the social behavior of persons and groups, and likewise Medical Sociology deals with social facets of health and illness, the social functions of health institutions and organizations, the relationship of the system of health care delivery to the other social systems besides studying the social behavior of health personnel and those people who are consumers of health care. S.R Mehta (1982) says Medical Sociology is to be conceived as discipline dealing with an interface between the providers and consumers of health and medical care services. This has relevance in the Indian context in view of a large population seeking services from limited health resources.

The earliest theoretical contribution to Medical Sociology come from the American sociologist Talcott Parsons (1951) who formulated the concept of the sick role, and later Robert Merton (1957) and Howard Becker (1961) studied medical students with several of their colleagues was particularly influential in the theoretical development of the new branch. By early 1960 several well known American sociologists like Fred Davis, Howard Freeman, Eliot Freidson.
Sol Levine, David Mechanic, Anselm Strauss and Leo Reader were being identified as Medical Sociologists. The important text books in Medical sociology have been written by Mechanic (1968,78) Twaddle & Hessler (1977) Cockerham (1978) Coe (1978) Denton (1978) etc which have been important contributions in introducing the new branch to the readers.

William Cockerham (1983) in his overview of Medical Sociology mentions four categories of researches that dominated the American studies in Medical Sociology.

1. The Sickrole and the patient physician relationship.
2. Help-seeking behavior,
3. The socialization of medical and nursing students and
4. Death and dyeing.

Cockerham also mentioned about the current trends in American Medical Sociology as largely oriented towards changing patient physician relationship, health care delivery, and social policy, help-seeking behavior, stress and life events, aging and mental illness.

Kevin White's (1991) trend report on 'The Sociology of Health and Illness' has made a fine review of theoretical approaches of the discipline. The earliest theoretical contribution is of course from Talcott Parsons who viewed medicine as a special mechanism of social control. He viewed illness as a deviant social state brought about by disruption of normal behavior through disease. Parson's 'sick role' can be described as 1) The sick person is exempted from normal social role depending upon the nature 2) the sick person is not responsible for
his or her condition 3) the sick person should try to get well since being sick is undesirable and 4) the sick person should seek technically competent help and cooperate with the physician. Parson has addressed to two fundamental issues: First, are sickness and disease conditions imposed on us? Or do they involve motivational factors on the part of the individual?

Another important theoretical approach to Medical Sociology is that of Marxists who explain the health care and medical care in contemporary society as part of the capitalist mode of production. Each stage in the development of economy produces the conditions for the development of specific diseases and generates its own explanation of them as well as providing them a therapeutic framework. The medicine in capitalist society is capitalist medicine (White Kevin, 1991).

The Marxist's study of the necessary relationship between public health and state is particularly of more interest. Rosen (1963) associates the public health with the growth of mercantilist state in the 18th century with its equation of the health of the individual with the power of state. This state's development of concern for individual had three bases (Hannaway 1981). First, national consciousness and state formation led to a concern about infant and maternal mortality. Second, the growth of inter state rivalries led to a concern about the health of the army. Third, colonial expansion led to a concern for the health of the navy. According to Vagero (1983) the failure of 19th century revolution led to the individualistic slant to the medical knowledge as it is today. With that the clinical medicine under the control of medical profession and located in hospitals became the dominant form of medical practice. The destruction of agrarian village life led to the destruction of folk knowledge of healing. Thus Marxists...
view the current form of professional health care delivery and its historical
development as the product of the development of capitalism.

According to this approach the changes in the medical knowledge and
practice are shaped by political, ideological and economic factors. Though Marx
himself had little to say about health and disease Marxist scholars have developed
the insights of his general position and extended the works of Engels (1974)
Engels essentially created social medicine and laid the basis of a Sociology of
Health. He made three central points 1) what people suffer from is not the
product of their own individual make up 2) There should be social explanation
of individual circumstances, rejecting the explanation that pointed to devine
providence. 3) sickness and disease are the product of social condition and not
biological occurrences.

The Marxists have also explained both production of ill health and
consumption of health care commodities in contemporary western society in
terms of class relationship. The role of state in health care is discussed by the
Marxists. According to Navarro (1976, 1980, 1983) the state is the configuration
of public institutions and their interrelationships. It’s intervention in the health
sector is viewed by Marxists as in other sectors, as that of strengthening the
private sector through contracts and subsidies and by taking care of the
unwanted responsibilities of the private sector. For example setting up of NHS
programme in England was to rationalise the organization and delivery of health
care. On doing so the state defined health largely in terms of access to care and
by claiming to provide universal access to care it has contributed to the belief
that class inequalities in health and access to care have disappeared. Marxists
mainly view the state's intervention as an eye wash to weaken any resistance to
capitalism.

The feminist front provides a different theoretical approach to health and society. Though there are different theoretical bases for different strands of feminism, in general, feminists argue that the institution of medicine operates to maintain a subordinate position of women in patriarchal society. Medicine is a male dominated institution of social control. Feminist health sociologists argue that medicine controls women by enforcing of passivity, dependence and submission as appropriate feminine traits. Thus operationalisation of medical knowledge subjects women to socially determined and constructed roles (White Kevin, 1991).

With the theoretical approaches to Medical Sociology or 'Sociology of Health and Illness' as analysed in Kevin White's (1991) trend report, we shall move to the Indian situation and development of Medical Sociology in India.

Hyman (1968) classified the sociologists into two categories, one, those utilising the medical settings as convenient strategic place for the testing of general sociological theory and the other committed to apply sociological theory and research to the solution of medical problem. He considered the first category as with 'deduction' orientation and the second with 'inductive' orientation.

The beginning of Medical Sociology in India was more of inductive orientation type. During fifties the Sociologists and Social Anthropologists were involved in the Public Health Programmes by the Government of India. Their earliest involvement was as members of the multidisciplinary team consisting health administrators, medical practitioners health educators, sanitarians and social scientists in Govt. of India research- cum-action projects on environmental
sanitation in the mid fifties. The projects were held in Najafgarh (Delhi) and Sirgur (Calcutta). The contribution of Medical Sociologists in these projects was mainly related to evaluation research. This job was to provide feedback to social structural elements and cultural patterns influencing health behaviour of people towards sanitation and acceptance of Rural Latrine Programme.

After these projects were over the sociologists and social anthropologists involved there got placements in institutions like National Institute of Health Administration and Education (NIHAE) and the Central Health Education Bureau (CHEB) at the government of India level. With the setting up of these institutions the research and teaching components of behavioural aspects of health related to administration and education got strengthened. A number of studies were conducted on the national health programmes like malaria, smallpox, tuberculosis, leprosy, maternal and child health, family planning etc. with emphasis on factors retarding or accelerating the acceptance of these programmes (Mehta S.R., 1992). This is how Medical Sociology took birth in India and the involvement of sociologists and social anthropologists in health studies increased manifold with the introduction of family planning programmes and with the expansion of health education in the various states. The medical colleges developed departments of social and preventive medicine and in some of these centers studies on the health behavioural aspects were carried out and some of these studies were done in collaboration with the social scientists. The establishment of Indian Council of Social Research (ICSSR) in 1970 as the apex body at the national level for promoting social science research and teachings has also influenced the development of Medical Sociology in India.

In spite of these developments Medical Sociology could not make much
headway in the number of studies conducted. In universities during 1960s the progress of Medical Sociology was not very encouraging except a few field reports and dissertations. Some sporadic studies which were often by-products of the large village and community studies, touched upon the social and cultural aspects of health and medical care. These studies provided insights on both the folk and western medicines practised in certain rural and tribal areas, on belief structures, health notions and attitudes of people towards health practices etc.

The two very famous and important studies made by foreign anthropologists about medicine in rural India are the one by G.MorrisCarstairs (1955) and the other is by McKim Marriott (1955). Both the studies were made in the early years of 1950. Cartairs in his study of medicine and faith in rural Rajasthan has pointed out the differences between the points of view of physician and the village folk with regard to theories of etiology, techniques of curing and conceptions of roles of the physician. Cartairs himself practiced medicine in two villages in Rajasthan and experienced misunderstanding between himself and the clients because both the patients and the doctor viewed each other through different cultural glasses. According to Cartairs sickness is as much a moral as a physical crisis to the people of rural India. In the people's conception the roots of illness extend into the realm of human conduct and cosmic purpose. To set the patient right morally as well as medically, the healer must serve as a link between moral man and purposeful cosmos.

McKim Marriott's study on 'Western Medicine in Village of North India' highlighted the responsibility, charity, power, respect which are important in interpersonal relations in medical sphere. His study of medical practice and
practitioners in the Indian village of Kishangarhi attempted an analysis of the social and cultural problems involved in introducing more effective medical techniques to a conservative Indian village. The analysis reveals several contrasts and conflicts that have existed in the past between the roles assumed by indigenous and by western medical practitioners, conflicts that have acted as obstacles to the spread of western medicine. The author opines that the successful establishment of effective medicine here appears to depend largely on the degree to which scientific medical practice can divest itself of certain western cultural accretions and clothes itself in the social home spun of the Indian village.

Some other studies which give brief descriptions of traditional medicine practices include Gould (1957, 1965), Minturn & Hitchcock (1963) Khare (1963) Leslie (1967, 68) Oplar (1958, 1963) Lewis (1958) etc. Most of these studies mentioned above are done by foreign anthropologists based on their observation in the field and are primarily explorative and to some extent diagnostic in nature.

The development of Medical Sociology in Indian universities has not been very satisfactory though they have brought forth some dissertations and Ph D theses. The sociologists working in health organizations have also made certain studies which are problem oriented and field based researches and many times they have foregone theoretical sophistication and methodological regard in many of their studies because of pressure of time from the planners and administrators.

The Medical Sociological literature produced in India is sometimes voluminous in the form of Ph D theses and many times in the form of stray articles based on micro level studies. Many of these can be classified under
applied studies and very few have a broad theoretical base in sociology. Such contributions are not only made by sociologists but also from social worker and public health administrators. Some studies have been evaluative studies of health programmes and health care delivery system while some other on a variety of subjects like differential utilization of modern medicine, the role of doctor as a professional, the doctor-patient relationship, the hospital as a modern organisation, the health policy of India, the various health programmes in India and their utilization etc.

The researcher considers the study on Mass Health Camps as essentially an applied study. To make an applied study, a sound knowledge of theory is equally essential. A sound knowledge of the infrastructure of health care delivery system, the different categories of health personnel involved in health camps, the study of hospital organization, with a sociological perspective, the doctor-patient relationship, the help seeking behavior and the lay referral system in our society, all these have an important bearing on the problem of study. The researcher has made an attempt to include in her review of literature all possible and available writings on these topics.

Medical Profession, the Doctor-Patient Relationship, the Hospital Organization.

One of the earliest writings on medical sociology in India was that of A.L. Shrivastava (1970) whose article on 'Medical Sociology in Indian setting' divided the whole field into the following categories.

1. Medicine and culture, 2) Medicine and social system,
3) Internal organization of the hospital, and 4) Special problems concerning the health of Indian population and the problems concerning the extension of medical facilities in India.

This was an earliest delineation of scope of Sociology of Medicine in India which holds good even today. The author also said that the problems of health and medicine in India should include the problem of health education to masses, the rural health care and medical facilities, the study of patient in the socio-economic setting of the family, the local practice and taboos, prevention and control of disease by government and non government agencies and the problem of brain drain.

A study on 'Measuring Patient Satisfaction in a General Hospital' was made by A.Timmappayya, Uday Parekh and K.C. Agarwal (1971). The study of patient satisfaction was carried out in a large community general hospital in Delhi. Four wards, two medical wards (Male/Female) and two surgical wards (Male/Female) were taken for study. The patient satisfaction interview schedule (PSIS) was administered to 167 patients in the test phase and another 83 in retest phase. The results were interesting. Education appeared to be positively correlated with patient satisfaction. Longer stay at the hospital contributed to greater satisfaction. Patients mainly complained against food, nursing, orderlies, sweepers, discharging policy of the hospital, lack of communication from their doctors, favoritism, ward comforts etc. The doctors felt that for better patient satisfaction the politicians interference should be stopped, more public relations work should be done, and more beds and equipment were needed. The doctors felt that the behavior of the nurses and sweepers also contributed to the patient
dissatisfaction. The study was an earliest study of patients and doctors.

Primary Health Centre (PHC) is the most important executive centre of health services at the grass roots level. It has its own importance in providing health services to the rural Indians. The earliest study of PHC was made by the Narangwal Group at Ludhiana under the auspices of the John Hopkin's University school of Hygiene and Public Health (1970). The multi-disciplinary study team had the involvement of social scientists. The study made an attempt to relate health services to the community health needs. H.S.Takulia (1967) the chief social scientist with others produced a book on 'Primary Health Centre Doctors in India'.

A number of studies on doctor patient relationships' have been made. Mohan Advani (1975) made a study of 'Doctor-Patients Relationship in Indian Hospital' for his doctoral work. In this study he identified the discussions of existing hospital social systems, behavioral components of doctor-patient relationships, perceptions of doctors and patients and their interaction patterns. The social status and the professional values of the doctor influenced their practice. He found that the doctor's preferred role relations with patients subscribe to Parsons' affective-neutrality in order to avoid emotional involvement with the patients. The patients are greatly affected by the duration of contact, previous experiences and the size and image of hospital. The socio-economic status determined their choice of the hospital, mode of treatment and level of satisfaction.

Though T.N.Madan's earliest study was about 'Who Chooses Modern
Medicine', he has also conducted two studies on doctors as professionals (1972, 1980). The former is a study of private practitioners and the latter is of doctors who are practicing at the institute i.e. All India Institute of Medical Sciences, New Delhi (AIIMS). In both the studies an attempt was made to know who are the doctors interns of their social background and how they have been trained.

Madan points out in his study that the medical profession is divorced from prevailing socio-cultural condition and also encourages the acquisition of all the qualifications for their own sake. This leads more and more doctors to get for one of the two equally counter productive courses of action either they choose to emigrate to western countries or they cater to the needs of well to do and wealthy.

Madan says medical education seems to have failed to impart a student a sense of social awareness and responsibility. This affects his role performance in the real work setting in the hospital. A doctor considers his success to depend upon his professional competence determined by his intellectual capabilities combined with technical skills and not merely based on good will. Professional recognition of colleagues is highly valued by the doctors in the work setting. Madan's sociological analysis of doctors brings forth different facets of a doctors' personality as a professional.

Venkatratnam (1979) has made a role analysis of doctors and nurses. He has analysed the role performance of doctors and nurses applying the concept of 'status' and 'role' within the structural functional perspective. The author has analysed different role expectation models of doctors and nurses about their own as well as each others roles in the hospital organizational setting.
Both in terms of expectations and performance, nurses accept their subordinate position to the doctors.

Oomman's (1976) study on 'Doctors and Nurses' attempts to analyses the occupational role structure of professional allopathic doctors and nurses working in public hospitals in Delhi. Oomman focusses on the consequences of the transformation of the occupational roles of doctors and nurses from that of private practitioners to as public servants and the effect on their working in the organizational set up i.e. public hospitals.

Ambika Chandani (1980) in her exploratory study - The Medical Profession: A sociological exploration, attempts to examine the subtle aspects of profession. She interviewed 152 doctors from institutions as well as from private in the city of Jodhpur. She finds that the profession of medicine is largely opted for by the family. Altruism and not individual aggrandizement is considered the motivating factor in joining this profession. Dedication, humanism, expertise and courtesy are the social qualities that a doctor should possess, but the present day doctors do not possess these.

Ramanamma and Bambawale (1978) have studied the 'Occupational Attitude of Physicians'. They tried to explore the following aspects of medical profession 1) Whether the amount of time spent per patient by doctors is in relation to a) patient's illness and b) doctors rewards, 2) The degree of interaction between the physician and the patient in order to perform the role obligation of a physician and 3) whether the physicians are able to attain affective neutrality in their interaction with their patients.

The results of their study are as follow:
1. The general practitioners combine physical cure along with the psychological and emotional cure of the patients.

2. The paid physicians even though they have less monetary gains are compensated by curing patients who have abnormal complications.

3. Usually the consultants get patients with a case history from general practitioners or government hospitals. They can not give much emotional and psychological satisfaction along with the physical cure as the time they can utilize for examining the patients is too little.

The authors have also examined the time spent per patient by doctors in relation to the patient's illness and the doctors' rewards. They have observed a negative relationship between the two. These two factors seem to make or mar the careers of professionals but yet the doctors have not felt the need to change their style of work. The authors have found maximum degree of interaction between the general practitioner and his patient. The interaction between the paid physician and his patients and consultant and his clients is comparatively less. All these categories of professionals can perform their role without any emotional involvement. The authors have concluded that each type of practice has its own silver timing and the rewards are generally much more than in any illness.

Madhu Nagla (1980) carried out a study on Sociology of Medical Profession: A study at Medical College Hospital, Rohtak (MCHR) in the state of Haryana. She has analysed the medical profession, the professionals and the professionalization to identify the basic attributes of profession and how profession differs from an occupation. She also describes the social importance
of medical practice that illustrates the wide variety of problems presented to doctors. She says medical profession is predominantly a male profession and the data reflects a larger representation from higher castes and classes. Almost all doctors studied were satisfied with their profession though they had some problems like the unfair terms of service, the hard and tedious work, the unsatisfactory financial reward, the loss of freedom to move etc. Because of these problems some doctors are dissatisfied and frustrated with their work.

A study by Vandana Sharma (1987) on student physicians in a medical college at Simla, revealed that their professional socialization involves reorientation of their ideas and values as they pass through various steps of their training. The professional socialization starts much earlier in life when as a child, the person sees the role of a doctor in various situations like attending to relatives in the house or simple socialization of the family member with a doctor. This helps the individual to form ideas about the role of a doctor. Further, it is observed that students initially are idealistic in their approach towards the profession but gradually this idealism gives way to a more practical approach to the profession. The professional aspect of the occupation, the assurance of a job after completion of training, stable income and to be considered as a member of a professional group with high status and prestige are some of the major factors motivating a student to join medical profession rather than their ideal of serving the human sufferers.

The above study was conducted a decade after the study made by Chandani (1977). We find a slight difference in the motivational factors to opt for medical profession. The present study shows that it is not so much the idealism to serve and the altruistic attitude which motivate students to choose medical
profession. There are other factors which are more important in choosing this profession. Thus there is some degree of decadance of idealism attached to medical profession. But this study also confirms the fact previously studied by Chandani that the family experience is closely associated with the decision to join the profession.

The above mentioned are some of the important medical sociological studies conducted in India focussing on medical profession, the role of doctor as a professional and his interactions with the patients. There are some studies made on hospital organization and the patients interactions in the hospital organization.

Indu Mathur's (1975) doctoral dissertation makes an analysis of interpersonal relation in a hospital between the various categories of medical staff and patients themselves. The findings reveal that the behavior of conformity and nonconformity in a subsystem is influenced both by the internal organization and organization of the larger system of which the hospital is a subsystem. The socio-cultural values in the main system are reflected in the functioning of the hospital. The physical and social environment provided to the patient has a therapeutic significance and can accelerate or retard his recovery.

Shrivastava's (1979) study on 'Human Relation in Social Organizations' explores the nature of interaction in a hospital situation which exists among the three interacting units of the hospital organization i.e the doctors, the patients and the paramedical staff. The major findings of the study are as follows:

1. The hypothesis that the patients approach the problem of health and
disease according to the cultural norms they adhere to is partially proved.

2. The doctor's behavior towards patients is not much influenced by the socio-economic status of the patients.

3. The expected behavior of the doctor is not translated into reality.

4. Illiteracy and language problems are major barriers to the closer interaction among doctors, patients, and paramedical staff.

5. The dissatisfaction among the paramedical staff indirectly affects the doctor-patient interaction.

6. It is partially proved by the data that the bureaucratic structure and process in the hospital is often affected by the socio-cultural demands on hospital personnel and

7. One of the major causes of conflict in the hospital is excessive bureaucratic control and non-recognition of the professional competence of its personnel.

The doctors are experts and have specific relations with their patients, whereas patients insist upon a diffused and intimate relationship with a doctor. This constitutes the dilemma of human relationship which is further complicated by organizational limits and demands upon both.

Anita Minocha's (1996) sociological study of a women's hospital is a significant contribution to qualitative literature in Medical Sociology. Her book 'Perceptions and Interactions in a medical setting: A Sociological study of a Women's Hospital', is based on her study conducted in the 1970's at a women's general hospital in New Delhi, when Sociology of Medicine was striking roots in
Indian soil. The author says that the study demonstrates essentially the dovetailing of medicine into different aspects of social life. It shows how attitudes and behavior related to caste are crystallized in the social interaction in the hospital ward, how the web of social obligations that bind members of the Indian family operate during illness, how people perceive and respond to newer technologies and to higher education and how professionals perceive, and perform their roles. Thus it deals with women in medical spaces, women as patients, as medical professionals, semi-professionals and lower level workers, and as administrators running a complex organization resembling a 'total institution'.

Many interesting observations are made by Minocha like how the patients in the wards react to the medical procedures and instruments. The syringe, the thermometer, stethoscope, x-ray and other apparatus comprise important charismatic elements of modern medicine demonstrating to the patients the power and efficacy and the patients pin their hopes and faiths to the presence of such components in their treatment.

The author also mentions about the dehumanization felt by the patients in the modern hospital. In the Indian setting the dehumanization is not similar to that in the west where highly sophisticated, complex and incomprehensible procedures and instruments are used. The patients in Indian hospitals encounter relatively simpler technology. Here the dehumanizing factors in the hospitals may be found in complex rules for admission, overcrowding, long queues, lack of basic amenities, attitude of the non-medical staff, scarcity of drugs etc. The author also mentions about the advantages of large wards which can accommodate a number of patients. The patients will be sharing their
experiences with others and try to alleviate each others anxiety. By doing so the patients try to come to turns with their illness and reduce stresses and worries occasioned by the gravity of the disease.

The patients in the study by and large belonged to the lower class and showed reticence in approaching the doctors and sought alternative avenues to satisfy their curiosity. Anitha Minocha says that the family plays a very significant role during the patient’s stay in the hospital. Hospitalization causes considerable dislocation not only within the patients’ family but in some instances a series of families. The family makes efforts to create home like condition within the ward. Large groups of visitors around each patient are a common sight in the ward during visiting hours.

Minocha’s book has been an important contribution in the study of patients and hospitalization in the Indian setting.

2. Studies on Public Health Policy and Health Care Delivery System in India:

There have been a number of writings on health policy and health care delivery system in India. Some are informative giving details about development of health policy and health care delivery system in India while some other studies have made a sociological analysis. Subject experts like D.B. Banerji (1981) and Imrana Qadeer (1991) have made critical reflections on the above subjects.

social scientists have contributed their ideas and insights in the field of health planning and administration.

D.Banerji (1981) traces the historical and socio-cultural foundations of health services systems. He writes that India has a long history of health services systems. After independence, the new leadership though committed to provide health services to one and all, did not consider it necessary to bring out any basic changes in the existing systems. The medical colleges and the number of doctors have grown rapidly but they are alienated by rural masses. The leaders being persuaded by foreign consultants set aside large amounts for running of mass campaign against specific diseases like malaria, small pox, leprosy, trachoma, filariasis etc. But Banerji opines that these campaigns have hindered the development of a permanent health service system in the rural areas and at the same time many of these programmes have failed to achieve the set goals. Banerji, based on carefully conducted empirical study of health behavior of rural population, states that there is no significant cultural resistance to the acceptance of modern medicine as long as they are efficacious, available and accessible to the people. But the existing health services are working at a grossly low level of efficiency which has led to considerable under utilization.

A very important publication with regard to framing of a suitable health policy and the improvements in the existing health service system is 'Health for All: An alternative strategy', - A joint Committee report from ICSSR and ICMR (1980). Eminent people from the medical sciences and social sciences have prepared this report. The report points out that though we have succeeded in reducing the mortality rate and increased the longevity of life, the infant mortality, maternal mortality and communicable diseases are still high in the country.
Certain sections of people like women, children scheduled caste and scheduled tribe and lower classes have not improved their health status to the expected level.

The committee criticizes the present health system as 'top heavy, over centralized heavily curative in to its approach, urban elite oriented, costly and dependency creating'. It proposes an alternative strategy which would be 'community based, people oriented, economic, decentralized, democratic and participatory'. The committee proposes an alternative health service model where preventive, promotive and curative services are integrated at five levels.

At the village level there will be a health care centre for every 1000 population run by community Health volunteer (CHU) selected by the local community itself. The next level shall be a sub centre with 5 beds for every 5000 population and run by a Multi Purpose Health Worker (MPHW). There will be a community health centre (CHC) for every 20 sub centre for a population of 1 lakh. It will have 30 beds and other facilities like laboratory, x-ray unit and operation theatre. It serves as a referral centre for lower level health care activities and also coordinates the health care activities at the Panchayat Samiti or Block level. These three levels of health services will be in charge of Panchayat Raj.

For every 10 CHCS or a population of one million there will be a District Health Centre (DHC), with a 200 bed hospital with many specialities. Above DHC there is specialist centre for every five million and this centre will have 20 independent special units each having 20 to 30 beds.

The Committee also suggested community to share portion of the recurring
expenditure. But this suggestion for financial participation is not realistic.

This report is criticized on several issues. Yesudian in his review says that it is neither radical nor revolutionary and the ability of the Panchayat Raj to manage the health services as suggested by the committee is questionable. The committee should have concentrated in the aspect of implementation of the model and evaluation of the already existing model, then it would have helped the health planners to a great extent.

Anita Minocha (1986) in her article 'Social Science Perspective in Health Care Delivery System' says that the subject of health care delivery is as much a sociological challenge as a medical one. She objects to the conceptualization of village as a harmonious, homogenous, united and self conscious entity with its members participating in joint action for the welfare of all. Thus one has to identify the real social units or communities within the village for involvement in health related activities. Minocha points out that it is the politico-economic dimensions of the village life that have considerable significance in providing health services equitably to all sections of the village. Minocha also writes about the perceived health needs of the community which are exaggerated in the deliberations on health policy and planning. The actual medical and health care of the people may not coincide with what they perceive as their health needs. Thus it is necessary to estimate the real health need of the community.

In her another article on 'Socio-Economic Equity and Health', Minocha (1991) says that to appreciate fully the play of socio-economic factors in defining the disease spectrum of a population, we should separate socio-cultural factors from the economic ones. Because there are diseases influenced more by socio-
cultural than economic. The author points out that the socio-cultural factors tend to moderate the influence of purely economic factors and that health equity may or may not stem from only economic inequities. Thus it is necessary to identify all possible sources of health disparities other than economic inequities.

Imrana Qadeer (1991) in her article 'Beyond Medicine' makes analysis of the health status of Indian people. She says in a stratified hierarchical society where the resources are limited, those at the bottom of society have the least access to resources and the poor are not only deprived of wealth but also of health as they are more exposed to disease in their unhealthy environment. The personnel of the PHC are closer to the elite at the village level. In the urban areas the health care facilities are largely in the hands of private practitioners and their proportion is nearly 65%.

Debabar Banerji (1991) has made a critical review of the 'Health policies and programmes in India in Eighties'. The positive achievements in the field of health is developing a wide network of health services in the country. But there have been many weaknesses in the health programmes. The state level leadership is crucial because it is the state governments which are responsible for the actual implementation of the various health policies and programmes. Because of the corresponding increase in health services the qualitative and quantitative demands on the health administrators at the state level have increased and unfortunately many Directors of Health Services (DHS), the chiefs at the state level have failed to live up to their responsibility. A DHS is required to provide leadership to the entire health service system including implementation of the various health programmes, education and training of various types of health workers and providing research support to different
programmes. A generalist administrator cannot cope with such responsibilities which require a very high level of technological and epidemiological inputs. Thus he should be avoided.

Banerji points out that district health organization forms a critical point in the network of the health services in the country. Thus the competence of the chief medical officer and his team of district level officials is central to the successes of the work in community health centres, primary health centres, sub centres, taluka hospital and dispensaries. Personnel working at this level do not receive adequate support in the form of supplies of drugs and equipment from general administrative and financial backup. As a result a number of studies conducted at district and village level paint a very dismal picture. Thus Banerji says it is the cumulative result of inability of the administrators at district, state and union levels to offer the right kind of leadership to the health services of the country.

In his article Banerji also discusses individually the failures of different national health programmes. His suggestions for strengthening health programmes are 1) strengthening of top leaderships at union state and district level. 2) Development of more optimal system for programme implementation. 3) Drastic restructuring of the family welfare programme. 4) Curbing interference of generalist administrators in technical aspects of health service development in the country.

Banerji also points out that preoccupation with extension of coverage of rural population has led to the neglect of the situation in the urban areas. The urban health service should become a major area for action in the coming five
year plan.

Geeta Shah (1980), R.K. Sapru (1986) B.K. Nagla and Madhu Nagla (1991) have made sociological analyses of the health programmes and health policy. The different committees right from the Bhore Committee (1946) to the Shrivastava Committee (1975) give an idea about how the health planning, health care infrastructure and manpower have developed to reach the present status. The national health policy was finally framed in 1983 and it has stressed on the provision of preventive, promotive and rehabilitative health services to the people representing a shift from medical care to health care.

Apart from the study and review of national health policy the utilization of health services at different levels like at PHC and at general hospital have been an interesting area of study for social scientists.

3. Utilization of Health Services in India:

One of the pioneering studies made in the utilization of health services is T.N. Madan’s (1969) ‘Who chooses modern medicine and why’? The author made a study in Gaziabad in 1968 by survey of 500 households. The responses for the interview schedule were tested for significance of association with the socio-economic characteristics of the household head or household like age, education, occupation place of birth and upbringing, monthly household income and religion. It was hypothesized that younger better educated white collar workers are more likely to prefer allopathy and urban background and relative economic well being were also considered factors conducive to the choice of allopathy.
The findings revealed that majority of the respondents have a first preference for allopathy. Two-third of the household heads also said that they make use of more than one system of medicine. The common reason for this is to make the treatment more effective. The rural urban differences did not affect the choice of medical system. The age of the decision maker also does not seem to be an important determinant. The assumption about the association between Hinduism and ayurveda is confirmed by the data. But Hindus also display a high preference for allopathy. Thus in Madan's study religion has emerged as a significant factor in the choice of treatment but not an obstacle in the growth of modern medicine.

Occupation and income are significant determinants in the choice of treatment. Higher income seems to go both with a greater concern for effectiveness as well as with a greater reliance on a single system of medicine.

The author agrees that his conclusions are based upon a data drawn from a single north Indian city. So no claim for general applicability of their conclusions are made.

A sociological study by Dhillon and Shrivastava (1972) attempted to explore 'How people perceive illness and what they do when they fall sick'. According to this study people consider illness as an episode only if it is accompanied either with fever or pain or a person is incapacitated from taking care of himself. The study also showed that there is greater concern for health of the earning members and the family heads than for other members in the family. The curative behavior is greatly influenced by the way people perceive illness. Except for serious and abrupt illness there is invariably a time lag between perceived onset of illness and seeking medical care.
S.M. Bhardwaj (1975) analyzed the type of medical practitioner and the system of medicine. One hundred and four rural heads of households from selected villages of Roopar district of Punjab were surveyed. The findings indicated, contrary to the views of many social scientists that the English medicine and allopathic physicians were preferred over the indigenous medicine and its practitioners. All the caste groups including the untouchables scheduled caste and the jats showed a substantial preference for the allopathy. Less than four percent of the sample of household heads showed a pure preference for 'desi' medicine. About one third of the sample said that their preference for allopathy and indigenous medicine would depend upon the particular malady. Thus the expectancy of cure is more consequential than a traditional commitment to a system of medicine.

The studies on the social aspect of the utilization of health services go back to seventies when John B. McKinlay (1973) made a study of social networks, lay consultation and help seeking behavior. His study considered the question of what is the apparent role of the family, its kin and friendship networks in the use of health and welfare services? Eighty seven working class families consisting of two sub samples of carefully defined 'utilizing' and 'under utilizing' respondents were studied in Aberdeen, Scotland over a period of nearly one and half years. After controlling the samples for socioeconomic status, parity, education level, proximity to services and length of residence in the city, noteworthy differences were found between 'utilizers' and 'under utilizers' on various aspects of their social networks. The under utilizers relied on an undifferential group of readily available relatives and friends as lay consultants before using the service, while the 'utilizers' appeared to differentiate between friends and relatives, and be
independent of both these sources of social control. An attempt is made here to trace some of the implications of their differences for the understanding of help seeking behavior.

Such exclusive studies focussing on help seeking behavior of people in India are almost nil. This is an area which is fertile for social investigations in the medical world.

Bhatnagar (1978) in his study of some Punjab villages found that his respondents were taking allopathy treatment but a large proportion of respondents from the less progressive villages depended on indigenous treatment. The people from less progressive villages did not utilise medical facilities provided by the government health agencies. Improper care and non-availability of medicines were the important reasons for non-utilization.

Yesudian and Ashok Kumar (1979) in their study on differential utilization of health services in a metropolitan city found that various health services were utilized more by the rich than by the poor. The selection of health centre by the well-to-do persons was on the basis of their personal knowledge of the doctor in the centre and at the same time they utilized private health services too. The poor on the other hand depended entirely on public health services for all their health needs. Lack of resources and ignorance were the causes for the poor being unable to utilize properly the health services.

Trakroo's (1980) study on 'Social Patterns of Seeking Medical Care' was confined to understanding analyzing and comparing two rural settings regarding their curative behavior, namely, primary health centre and non-primary health centre villages in Haryana state. The main objective of the study was to find out
the rural people's perception of health followed by their responses to sickness and thereby to identify pattern and predominant preferences for seeking medical care. The finding of this study concluded that rural people of Haryana within the frame of reference of good and normal health, essentially underlined the importance of well developed physique, capable of withstanding physical strains.

Kakkar and others (1981) conducted a study in rural Rajasthan on 'Differential Utilization of Health care services'. It is apparent from the findings of the study that social inequalities played an important role in the utilization of health services. The members of lower classes and scheduled castes remained deficient not only in terms of possessing adequate knowledge about disease etiology but also about seeking medical care in time while their counterparts belonging to higher classes or non scheduled castes seemed to have drawn greater benefit from the government health services. They found dualism in health care services i.e. on one hand there were hospital oriented services run by specialists and super specialists who followed sophisticated western technology, on the other hand the primary health centre net work primarily looked after by ill trained and ill equipped paramedical workers who lacked supportive supervision. The consequence of this situation is that the poor whose medical needs were the greatest were put to maximum deprivation in terms of provision of health services as well as their utilization.

C.A.K. Yesudian (1988) has made a study of 'Utilization of Health Services in Urban India' which is an excellent example for a systematic study with clear theoretical guidance. His study was conducted with an intention to analyze the inequalities existing between different social classes in the utilization of health services in an urban community and also to identify some of the factors
responsible for such in qualities. The basic assumption of the study is that higher the social class better would be the utilization of health services.

The study was made in Madras city choosing an area in the city having all classes of people i.e. high, middle, low and very low. A disproportionate stratified random sampling of 400 households was used. The findings of the study indicate that the preventive health services were not fully utilized by the sample and the use increased with the rise in the social class. The communicable diseases were more prevalent among the young and poor and chronic diseases were found to be the ailments of the old and the rich. A majority of low and very low class patients who suffered by chronic disease and physical disability either did not go for treatment or stopped the treatment. As expected most of the high and middle class patients used private health centres where as low and very low went to public health centres. However good proportion of the middle class patients utilized government hospitals for chronic diseases and physical disability. On the whole the government hospitals were well utilized for inpatient services by a majority of the patients including many middle class and few upper class patients.

Regarding the utilization of maternal and child health services the need for prenatal care was perceived by all. But the utilization of prenatal care was low for the very low class. The upper class and middle class mothers went to the private health centres while the low and very low class mothers approached the public health services.

Regarding the utilization of government health services, half the sample utilized both government and private health services. But none of the high and
middle class households depended on the government health services alone. Bribery and favoritism were the two major complaints put forth against the government hospitals. Lack of cleanliness was the complaint of a good number of the high and middle class patients. Private health service was preferred because of its availability and its proximity. The major complaint against private health care was that it was very expensive and none of the low and very low class patients had gone to the private health centres alone.

Nichter (1981) in his study of rural health care delivery system in India suggests that the practice of medicine is culturally responsive and that the physician should be trained to communicate with their patients within their conceptual frame work. Cooperation between modern and indigenous medical practitioners should be encouraged. In this regard it is emphasized that cooperation will depend upon a sharing of basic medical resources and knowledge and an understanding of basic cultural concepts of health and healing and mutual respect is a prerequisite to the establishing of a workable rural referral network. Nichter agrees with Banerji's criticism of foreign and Indian social scientists for exaggerating the cultural resistance to allopathy in India. Nichter opines that India should develop adequate health care delivery systems and also should educate the doctors to be more sensitive to villager's ideas and needs and pass on valuable health ideas in the manner the villager can understand and adopt.

Joanna Kirkpatrick (1981) in her study of the delivery of hospital services in north India presented data and analysis from a case study of the gynaecology ward of an Indian mission hospital in Punjab conducted in 1965-66. Micro situations involving patients and hospital staff and their social interactions in
terms of role expectations and unofficial behavior are analyzed from the perspective of symbolic interactionism and the definition of the situation. The microsituations include reference to illness definitions, concepts of the hospital, diet and its complications, ritual and secular status in the ward, pollution, blood as limited resource, escorts in the ward, the patient or sick role and instrumental v/s impressive aspects of the nursing role in relation to the social structure of the clientele. The author concludes that a model is delineated which represents and predicts client institution interaction in societies where the social structure of secondary institution varies from that of primary groups and institution. Kirkpatrick accepted the fact that the shortage of trained nurses in the developing countries make it imperative that kinsmen be accepted as part of the health care team.

Van Deer Veen (1981) in his study of socio-cultural aspects of medical care in Valsad district of Gujarat state, showed that there is a vast discrepancy between the medical facilities of private practitioners in the urban centres and the state paid rural primary health centres. Though the majority of rural population and the tribal communities are dependent on the services of the PHCs, the state health centres are still underutilized. The efforts to introduce modern medicine have too often neglected the fact that the average Indian villager interprets the relationship with a doctor in terms of the diffused many stranded and mutually obligatory relationship. It has been illustrated in the study that socio-cultural aspects influence the effectivity of medical care.

Indu Mathur (1982) in her study of 'Rural Medical Health Care in a changed setting', has made a study of mobile surgical camps in Rajasthan. She has
made a close observation of certain specified features of social structure and organization of the camps which are not present in the treatment situations of that level.

-S.Shrinivasan (1984) made an attempt to study the perception of rural population in utilization of health care services in selected primary health centres in Tamil Nadu. Two primary health centres were selected for this purpose. Observation and interview technique were employed for collection of data from 125 respondents selected at random from five sample villages and were interviewed through an interview schedule. This study revealed that 65% of the respondents had utilized the health care services of the selected health centres. It is significant to find that the people still preferred the traditional practice of conducting delivery at home.

P.H.Rao (1985) has made a study of utilization in a PHC in Bihar. On the basis of the data collected about the utilization of health services at PHC level, the author gives the following suggestions:-

1 The working hours may be adjusted to the convenience of the people.

2 Improvement in supervision required for effective functioning at the sub centre level,

3 The medical officers, instead of permitting them for private practice should be given non practicing allowance so that they can spend more time in supervision of activities of field staff.

4 Regular units from the district hospitals offering specialist services
should be made,

5 Proper accommodation should be provided to all PHC staff.

6 The medical officer has to be imparted the skills of planning organizing and evaluating the activities, and

7 The number of registers maintained by the field staff may be reduced and collecting and compiling processes may be streamlined.

Indira Murali and J.R.Bhatia (1984) have given an evaluative report on the mobile medical team (MMT) scheme initiated by Tamil Nadu state government in 1977 to provide comprehensive health care to the rural population. The scheme of MMT was a new approach to provide health services to rural areas. The main aim of this new strategy was to make health services available and accessible to the hitherto uncovered or inadequately covered population in interior villages. The study findings clearly indicated effectiveness of the scheme whereby there was manifold increase in the number of patients seen and treated in farthest villages.

The findings of this evaluation study by and large indicated that the new strategy of delivery of health care to the rural mass through MMTs was effective in improving the coverage of population for different components of health care particularly curative medical care, maternal and child health care, and some community based preventive services. However, there was no obvious improvement in national health programme of malaria and tuberculosis. The services were found to be acceptable to the village population. This evaluation study indicates that MMTs can be effective in providing health care in accessible
rural areas.

Malini Karkal (1991) in her article on 'Health and Health care service in India', lays bare the cold statistics to show how and why errors in conception formulation of policy lead to poor health status. In spite of many achievements Karkal concludes, that the health situation is far from satisfactory.

Banerji (1991) in his writing on trends in health services development in India, sees, access to health services as a part of wider struggle to get access to fruits to socio-economic development in the society. Banerji also takes a critical look at the dependency created on medical technology which he calls as 'technocentric' programme. He says such programmes have no relationships to the perception of the people about their health needs. Banerji says family planning programme has become a 'menace' to the people, and population growth is due to poverty and an unjust social order rather than vice versa. On the whole Banerji says the health services in India have moved away from the people for whom it was and is being planned.

Recently some more studies have been conducted on patients in Indian general hospitals. Madhu Nagla (1991), Manju Agrawal and Ajit Dalal (1994), R.D.Sharma and Hardeep Chahal (1995) are some of the scholars who have contributed to the study of patients in the hospitals with sociological perspectives.

In a study conducted by Agrawal and Dalal (1994) the patient's affective reaction to stressful hospital environment were studied. The six reaction categories taken in this study were anger, anxiety, depression, helplessness, disengagement, and rationalization. Data were collected from 122 hospitalized
patients. It was found that the characteristic responses of both male and female patients were depression rationalization and sense of helplessness. Gender differences in affective reactions were observed. Male patients showed less anger and anxiety than females, but they were higher on disengagement and rationalization.

R.D. Sharma and Hardeep Chahal (1995) study on patient's satisfaction in public health system reveal some more interesting facts about patient satisfaction. Patients in this study exhibited low level of satisfaction. The low degree of patient satisfaction was significantly related to all factors hypothesized to be important by the authors i.e. doctors, nurses, medical assistants, management, sanitation cleanliness and other medical facilities. About 72% of the respondents in general were dissatisfied with the out patient services of the public hospital. Rude behavior, partial treatment, insincerity towards their jobs and negligence were the main problems, experienced by the indoor and out door patients against doctors. Business class respondents belonging to below average education, displayed average satisfaction with regard to overall out patient services. The highly educated were least satisfied with out patient and in patient services. A number of patients remarked that nurses were always busy in their own work rather than attend to the patients and they favor only those patients who offer them money. The out door patients remarked that compared to doctors the medical assistants were more cooperative and helpful. Female out patients were more satisfied than the male out patient. Sanitation and cleanliness of out door and indoor wards was the common problem faced by the patients.

The author concludes that the present scenario of the public health system
is a product of ill equipped health units, uncontrolled mercenary medical professionals, carelessness and negligence of medial staff, absence of accountability and defunct regulatory bodies.

Purohit and Siddique (1994) in their study of utilization of health services in India have found some new developments in the pattern of utilization. There is a growing popularity of indigenous and non-allopathic systems. Another finding is that the involvement of private sector in expansive tertiary care has grown considerably in the form of corporate hospitals. As against the National Health Policy guidelines the regional disparities in health services utilization among different expenditure groups of states as well as rural urban disparities tend to continue. Inspite of this inadequacy of health services and prevalence of inequality in utilization, no serious governmental initiative to encourage appropriate utilization by means of devising health insurance and other cost recovery mechanisms have been made.

The article by Sunil Nandaraj (1994) "Beyond the Law and the Lords" bares many ugly pictures of private health care. The medical practice in private sector has increased tremendously and the hospital care in private hospital has also increased. But the quality of private health care is questionable. There is what is called as 'cut practice' between the general practitioner and specialist consultant (The G.P gets commission for referring the case to the consultant). This cut practice also exists in all types of radiological and pathological diagnostic centres. The private practitioners get in to many unethical practices which have degraded the sanctity of the profession. The private prescriptions contain unnecessary use of injections irrational drug combinations, hazardous drugs and unnecessary drugs are prescribed. The doctor's charges are also exorbitant,
irrational and arbitrary. There are no restrictions or guidelines for the fees charged by the practitioners or consultants in the country and 75% of the practitioners do not give any receipts.

The private nursing homes lack floor space, do not have trained personnel, disgusting sanitary conditions, no proper water supply and narrow passages etc. Majority of private hospitals generally refer patients who develop complications to public hospitals so that they are not liable for cause of death.

The book by Rama Baru (1998) on 'Private Health Care in India', has analyzed and criticized the process of privatization of medical care in India and its implications for health services. In India as in other third world countries the pressure for delimiting the state and privatizing welfare services has evidently more to do with finding newer markets than with the welfare of the poor. Baru's book which is based on an empirical study of private hospitals in Hyderabad, is one of the first and delineates the emerging patterns of medical care in private sector within a historical and global perspective. The author has made a study of the social background of the entrepreneurs which suggests the movement of capital from agriculture and business into medical care in Andhra Pradesh. The study shows how the growth of the private sector has a negative impact on the public sector and in the process raises questions regarding quality of care, efficiency of services and the social responsibility of medical professions.

4. Studies on Family Planning Programme and Eye Camps:

The family planning was accepted officially as a national programme by the Indian Government in sixties and from then onwards it has been a major programme among all the health programmes. Good amount of money is spent
on the implementation of the programme by the government. Though the programme was launched almost four decades ago the results have not been satisfactory and uncontrolled growth of population is still a major problem for the health planners.

Family planning is one area where a number of social scientific studies are conducted. The researcher is discussing only a few studies on family planning which are relevant to her study.

Malini Karkal and others (1978) have made a study of attitudes of women attending immunization clinic towards fertility regulations and fertility regulating methods. About 200 women attending immunization clinic at Wadia children's hospital in Bombay were interviewed. The findings showed that though women were aware of fertility regulating methods, their knowledge was not adequate to create confidence for acceptance and use. Quite often their information was negative. There women impressed that small family norm is acceptable to them but family planning meant limiting rather than spacing and so they said that after the desired family size they will resort to sterilization. Thus the authors conclude that the motivation for fertility regulation is there, but the knowledge regarding contraceptive method is limited for which proper health education imparted with a careful study of individual problems and guidance is needed.

Usha Anand (1984) has studied the factors affecting the decision to undergo tubectomy. Her study of 173 tubectomy clients drawn from the FPAI New Delhi branch revealed the following factors. The proposal for adopting tubectomy to a great extent originated by the wife who is also the final decision maker. But sometimes a joint decision of both the spouses, or the husband alone were also
made. Sterilization is a very personal and complex issue and couples take a long time to decide ranging from a few months to a couple of years. The woman plays an important role in decision making contrary to the popular belief. The majority of women took the decision to undergo sterilization rather than suggest it to their husbands, which was largely due to a consideration of the husbands' health and nature of his work. Thus women prefer to choose tubectomy to vasectomy.

V.N.Rajeshwari and P.B.Jorapur (1983) have made a study of changing pattern of family planning acceptors. The analysis as made of the data collected at District Medical office and the PHC register. It showed that family planning is reaching younger men and women with less number of living children over time. The average age for vasectomy was 26.9 years and tubectomy was 25.9 yrs. The Hindus registered more favorable response toward family planning as compared to other religions groups and they also seem to prefer tubectomy to vasectomy.

Indira Kapoor (1989) discusses the factors responsible for low utilization of health and family welfare services in India. She mentions that factors like policies and programme management, personnel management at various levels, implementation of services, role of the community and status and role of women are responsible for low utilization.

The resource allocation made for health and family welfare activities has not increased over the years. Personnel is the contact point between the services and people. The total commitment of the worker is needed whether he is the team leader or the periphery level worker. The multipurpose health worker
and the supervisor have a heavy work load which is not feasible. The provision of medicines, stationary and other materials and the follow up services are also important in proper implementation of the service.

M.Muni Krishna Reddy (1984) has made a study of status of women and family planning behavior among non adopters. The study clearly brings forward the real picture of rural women in India. Majority of them are illiterate and involved in traditional household occupation,. It is found that literacy of women is positively associated with the favourable attitude of family planning. The study further explains that socio-economic variations of the forward and backward communities should be minimized in order to develop the programme. 

With regard to the decision making process of family planning, joint decision of both husband and wife is the prevailing norm in the society.

P.J.Bhattacharjee's (1984) study of 'Family Planning Programme, Education and Development of Karnataka State' presents some conflicting results. The data compiled showed that 24% of the couples in the state had been effectively protected up to 1981. The reduction in fertility rate is many times linked with progress in development, literacy, female age at marriage etc. The author says that though these factors exert positive influence on the reduction of fertility, the mechanism which linked these factors may not be easily understood. The data collected at district level showed that literacy was negatively associated with child women ration (CWR). The author concludes that family planning achievement is not necessarily linked with development and a reasonable levels of performance can be achieved without any change in socio-economic conditions.
S.Siva Raju (1987) has made a study of socio-economic factors in family planning adoption. The influence of some of the vital socio-economic variables like caste, education and occupation of husband, parity, knowledge about the F.P.methods and attitude towards family planning programme are studied over a period of time among the adopters of two extreme cultural groups, caste Hindus and Scheduled castes in Andhra Pradesh. It is found that the association between the selected socio-economic variables and adoption of contraception is highly significant among those who have adopted in less than 5 years as compared to those adopted before 5 years or more. Further the association is more pronounced among caste Hindus as against the scheduled castes.

A micro level evaluation study about access to health and family planning services in rural 'Uttar Pradesh' is made by M.E.Khan and others (1989). It investigated the accessibility of health care services of people living in a typical north Indian village using in depth information collected by social scientists following anthropological techniques. The study indicates that though over time the health and family planning infrastructure has increased significantly, its accessibility to and utilisation by the rural masses have remained limited. The PHCs sub-centres and dispensaries were found to be ill-equipped, supplies of medicine were far less than required and to make the situation even worse the staff of the clinics did not function properly. Poor transport facilities further reduced the accessibility. The public health services to be effective should have an improved management and increased supply of medicines and a good transport system. The people are educated about necessities of immunization and other MCH care and family planning and are ready to adopt them if they are available.
A mention about the study of the mass sterilization camps conducted in Ernakulam district needs a reference here. S.Krishna Kumar (1974) who was the district collector of Ernakulam and was the principal organizer of the campaign analyses the ever biggest third vasectomy camp held in his district for 24 days from 27th July 1972 to 17th August 1972. The purpose of this campaign was to cover the maximum number of target couples. This campaign consisted of 15 decentralized camps held in seven talukas of the district. Vasectomies were performed at the camps and IUD insertions and tubectomies were done at taluka hospital.

The Ernakulam camps have set a world record in vasectomies performed for a given population group in a given length of time. They have shown that large masses of people can be motivated to accept family planning in a short span of time through a massive community effort. The author opines that effective planning and management will lead to improved programme performance.

Shereen Jejeebhoy (1997) writing about the 'Women's Reproductive Health Needs' argues strongly for a fresh look at India's population programme. The family welfare programme has not lived up to its title. The thrust of the programme has been disproportionately focussed on achieving demographic targets by increasing contraceptive prevalence and notably female sterilization. There is an urgent need to reorient the programme priorities to focus on reproductive health needs and on women based health needs. The reproductive morbidity is high and unsafe motherhood is still a reality in much of India and particularly in its rural areas. Despite the fact that abortion has been legal for
over 20 years, limited availability and poor quality have kept safe abortion beyond the reach of most poor women.

The risk elements affecting reproductive health are malnutrition, neglect of adolescent girls, contraceptive pattern, quality of reproductive health services, women's health seeking behavior, health information needs, sex education etc. The contraceptive pattern shows that there is an emphasis on terminal methods and female methods. The awareness of women non-terminal methods is generally poor. The author concludes that strategies to broaden the narrow focus of services and to put women's reproductive health service and information needs in the forefront are urgently required.

There have been some studies by Malini Karkal (1995), Leela Visaria (1994) and C.Satyamala and others (1992) which have pointed out that there is an increase in the morbidity of female reproductive health due to family planning methods, especially the intrauterine devices (IUDs) used for contraceptive purposes. Open up the natural protection and create a passageway for the infection to travel inside. Quite often the women who use IUD suffer more from Pelvic Inflammatory Diseases (PIDs). These diseases cause pains and aches as well as create blocks in the fallopian tubes. It is also pointed out that many times the women coming from the lower economic class become the targets for the government family planning programmes and they are pressurized to undertake family planning methods or to undergo family planning operation.

A study from the point of view of users about the quality of family planning services in India has been made by Bhaswati Gangopadhyay and D.N.Das (1997). A total of 125 female users between 15-45 years of age were interviewed. They
were mainly from low income under privileged groups. Information regarding source of family planning information indicated that neighbors and relatives were the most frequently mentioned sources followed by doctors and electronic media. Regarding choice of FP methods cafeteria approach was not being practised in reality. The counseling received by them was of poor quality and did not adequately address the doubts and fears of the respondents. By consulting private facilities better quality of consultation and saving of time was possible. The findings also revealed that birth spacing does not receive much emphasis in the family welfare programme. The authors conclude that the service providers should treat their clients with understanding and sensitivity taking some time to give good pre-acceptance counseling including information about side effects as also proper post acceptance follow-up.

Studies on eye care, blindness and particularly on eye camps are very few. These are usually conducted by community health departments of medical colleges and the community ophthalmology wings and not by pure social scientists. The studies are done recently after the national Programme for Control of Blindness (NPCB) is tackling the problem of blindness with more rigor and there there is an impetus in the blindness control activities in the country.

Hans Limburg (1997) has written about the dynamics of cataract blindness. India has the dubious distinction of having the highest number of blind persons due to cataract. The latest National survey on blindness in the country was done in 1986-89 and reported a total 11.4 million persons blind of which 9.17 million (80%) were blind due to cataract. In 1997 it is going to be 11.5 million persons blind by cataract. The number of cataract surgeries was 5 lakh in
1981 and since 1989 there has been a steady increase of at least 10% per year and in 1996-97 it reached 2.7 million. Most importantly cataract blindness is highly dynamic in the sense that every year there are new additions to cataract blindness.

Bobby Joseph et al (1997) have studied the determinants of the utilization of an eye disease screening camp in urban slum. The study examines the factors that hindered the utilization of free eye health screening service that was provided to an urban slum. Among the reasons identified for non use were personal commitments like household related work, lack of knowledge of the camp, lack of family support and commitments at work. These factors should be taken into account while planning for these programmes.

A study is conducted by Sanjeev Gupta and G.V.S Murthy (1995) of Dr Rajendra Prasad centre for ophthalmic sciences AIIMS, New Delhi, about the 'distance traveled to reach the surgical eye camps'. The authors write that nearly 17.5 million Indians are blind and 80% of them are cataract blind. Most usually impaired people in India are concentrated in relatively inaccessible rural areas. The eye camps that bring the urban based surgeons to the rural people is now the only solution. The authors opines that proximity of the health facility determines the utilization. Thus these scholars have made an analysys of the distance that the clients are willing to travel for treatment which is essential for planning, the surgical eye camp location. They chose 240 patients by systematic random sampling from the camps conducted between Sept 1993 to April 1994 for their study.
The study revealed that the average distance traveled by beneficiaries to reach the camp site was 15 kms and the average age of the beneficiary was 66 years. Women traveled significantly further than men and little more than half of the beneficiaries were women. In correlating the ocular status with the distance covered it was found that 38% of the respondents had already been diagnosed as suffering from cataract. Most of the patients diagnosed within last two years lived within 4 kms of the camp site where as nearly half of those longer standing diagnosis traveled more than 15 kms to attend. It was also observed that people with advanced cataracts or severe visual impairments in both eyes traveled greater distances in reach of surgical treatment. The authors say that people tend to ignore diminished vision as inconsequential until blindness sets in. They suggest that the spacing of surgical eye camps at distances of 30-50 kms in sequential fashion is more beneficial to the rural population. This broadly coincides with the jurisdiction of primary health centre comprising the facilities at PHC to conduct eye camps would go a long way towards integrating cataract surgery into the general health services.

The review of related literature on the general studies on Medical Sociology, studies on public health policy and health care delivery system in India, the utilization of health services in India and family planning and eye camp studies, all those have provided the theoretical basis for the proper understanding of the field of study. On the basis of the literature studied, the researcher has framed hypotheses which will be tested in the study and analysis of the data collected from the field.