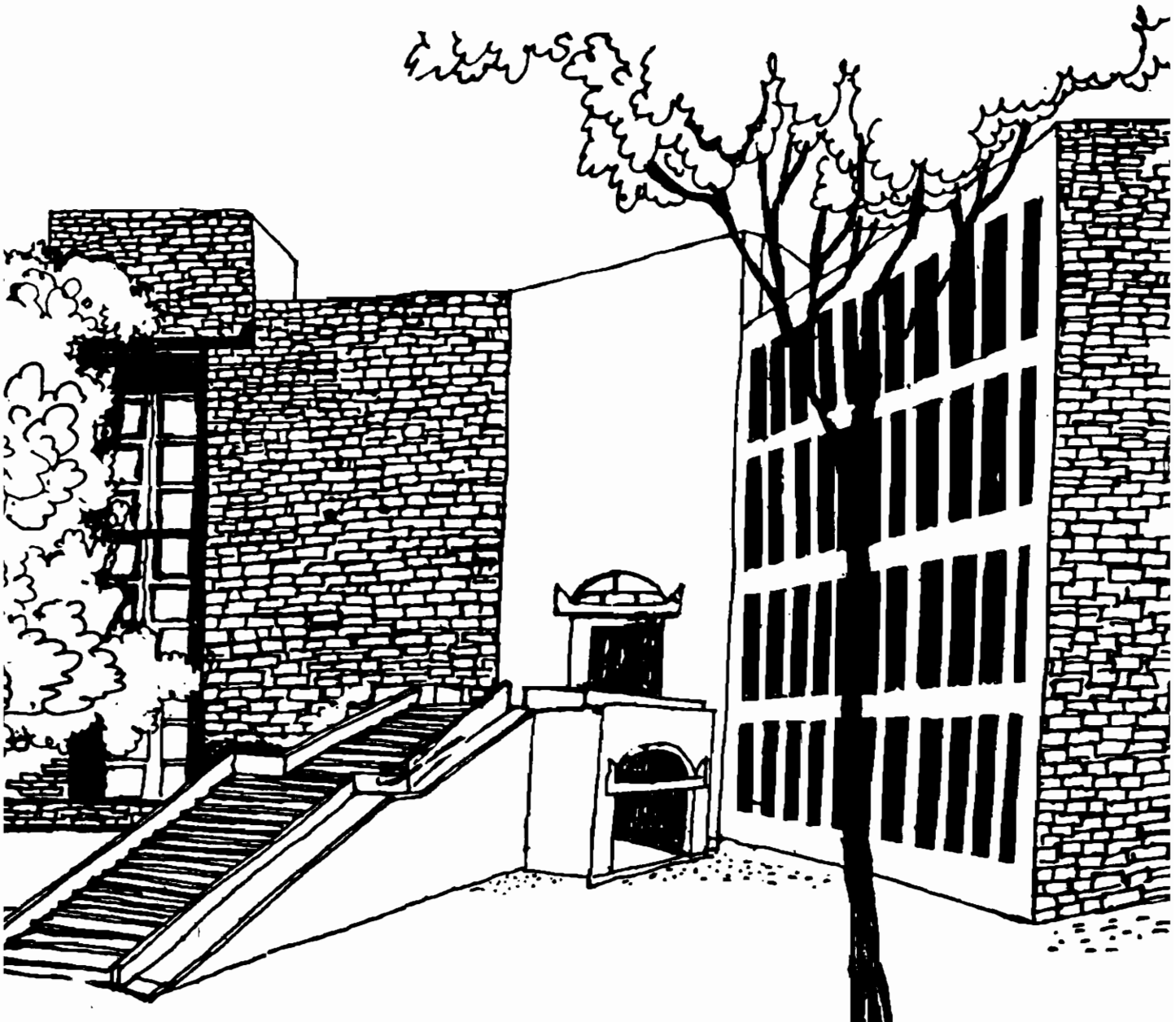




Working Paper



**Strengthening Primary Health Care Services:
Insights from Qualitative Research in West India**

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Introduction

Non-acceptance of or non-compliance with health care services is a major barrier to achieving health for all. Success of Primary Health Care approach in achieving the goals of Health for All by year 2000 depends both on strengthening health services delivery to ensure adequate access and ensuring that people in need would use the available services. Although rural health service delivery infrastructure in India has nearly tripled during the last decade, most national health programs have uneven coverage and are still under utilized^{1,2}. Coverage gaps are most wide in poor, difficult and far off areas. While under utilization is more of a function of access to service and people's perceptions of the quality of services and non-use are more complex problems.

This study aims to understand reasons for non-use of government health services and ways to address them. Such understanding can help develop a planning system to strengthen service delivery to reduce gaps in coverage of key PHC services taking in to account village level variations. We have developed and tested a methodology for such micro-level planning system³. Current health planning in India is fairly centralized. Most Public Health Programs have been developed at National level and a "blue print" is provided to the states along with some funds to cover additional resources required. States implement the programs in a uniform manner. Such centralized planning has its advantages but it also has led to reduced effectiveness. Monitoring of the programs is dictated by this 'blue print' approach and is largely done by evaluating percentage achievement against targets of service outputs. This target orientation has led to deterioration in quality of care with preference being given to achieving numerical targets⁴.

This paper presents results of the inquiry in to reasons for non-use of PHC services, using qualitative methods. We first present the research methodology in section II. Major insights from the study are discussed in section III. Their implications follow in section IV. Section V concludes the paper.

II. Research Setting and Methodology

This research was carried out in villages of two primary health centres (PHCs) located in northern part of the state of Gujarat. These two PHCs, referred to as PHC A and B, cover a population of about 50000 and 30000 in 41 and 45 villages respectively. PHC A is located in a socio-economically and educationally developed rural area which is well connected to near by towns. While the PHC B is in a backward area. Some villages of this PHC have scattered settlement pattern and are not so well connected to towns. The region is semi-arid with flat terrain. Most people are involved in agriculture related occupations.

The government health infrastructure is typical of the pattern in India. The PHC has one doctor, one health educator (Block Extension Educator), 2 supervisors and five male and five female multipurpose health workers (one each for about 5000 to 7000 population). Most villages also have day care centres for preschool children (called Anganwadi centres) run by part time workers under the Integrated Child Development Services Scheme which provide supplementary nutrition and assist in vaccination and other health activities. Some villages also had trained birth attendants (TBA, dais). The training of dais was done many years back without much follow up hence the usefulness of their training is doubtful at best. The village health worker (VHW) programme has been discontinued for last two to three years.

For this study we used a combination of focus groups and in-depth surveys for collecting information on use of health services, beliefs and attitudes towards various health technologies and reasons for non-use of services⁵. Five Focus Group Interviews were conducted in selected villages of each PHC area. The villages were selected based on their coverage gaps assessed from a quick sample survey done in all villages of those PHCs. The focus group interviews were conducted by trained female interviewers working in pairs. We invited women of reproductive age group using a sampling scheme but in most groups sampling could not be adhered to as sampled women could not come and some other women came to participate. Most focus groups discussions lasted for about an hour. Information was recorded on paper and using a taper recorder. Facilitators followed a guide line for directing the discussions.

Second set of data was collected by in-depth interviews with systematically selected random sample of women (one in every 8 women listed in eligible couple register) in reproductive age, using a semi-structured questionnaire. One third of the villages were randomly chosen for these interviews. Interviews were conducted in the women's homes by trained female interviewers. Each interview took one to one and half hours. Areas covered in the interview were basic socio-demographic information, recent illness, use of curative services, attitude, knowledge and use of family planning services, maternal and child health services including immunization, antenatal and delivery care and reasons for non-use of any service. Each important answer was probed to understand the reason for the given answer. Any significant health related episodes were noted and explored to gain insights into health and illness behaviour of the family. In all 371 in-depth interviews were done in 30 villages of these two PHCs.

Analysis of the quantifiable and structured part of the questionnaire was done using personal computers and standard software. The focus group and the qualitative information from the survey were analyzed by reading through and indexing the written materials and listening to the tapes.

III. Results and Major Issues

The analysis shows the coverage of various services and levels of gaps (Table 1). The levels of gaps in service coverage are quite substantial for most of the services. Reasons for these gaps were also analyzed. Reasons for non-use (gap) for MCH services differs from reasons for gaps for Family planning services. The former are more supply related reasons while the later are more demand related reasons.

Table 1:

In-depth Results

	Need (%) out of total EC	Served (%) of need	Gap (%) of need	Major Reasons for Gap	Freq	% out of gap
1 Sterilization	228 (61)	276 (77)	52 (22)	* Waiting for child to grow * Sterility has set in * Poor health * Family/Husband opposes	11 12 5 5	21 22 10 10
2 Spacing	49 (12)	3 (6)	46 (94)	* Prefers rhythm method * Post-Partum Amenorrhoea * Not contacted * PPA period is long * Fear of side effects	9 10 7 7 6	18 20 14 14 12
3 Tetanus Toxoid	163 (44)	One dose 21(13) Complete 83(51)	54 (33)	* Not aware of importance * Worker does not visit * Client refuses * Vaccine not available	19 19 7 6	35 35 13 11
4 IFA	163 (44)	96 (59)	61 (37)	* Worker does not visit * Not given * Not aware of importance	26 18 7	43 29 11
5 BCG	121 (33)	63 (52)	39 (32)	* Unaware of importance * No time * Worker does not visit * Vaccine not available	25 12 12 7	32 15 15 9
6 DPT	121 (33)	At least one dose 74 (61) All dose 44 (36)	32 (26)			
7 Polio	121 (33)	At least one dose 76 (63) All dose 47 (39)	31 (26)			
8 Measles	90 (24)	37 (41)	45 (50)			

Programme Outreach:

The PHC programme has a substantial component of outreach in form of workers visiting the villages and the paying home visits. For about 5000 population (about 1000 households) there is one male multipurpose worker (MPW) and one female multipurpose worker who are full time employees of the health department. The female MPW is a auxiliary nurse mid-wife with training

of one and half years. While male MPWs were recruited under various vertical programs and hence have varied backgrounds such as malaria worker, family planning worker, vaccinator, sanitary inspector etc and then all had a short (few months) multipurpose worker training to integrate them in the health program. Four male and four female workers are supervised by a male and female supervisor respectively. The male workers are allotted work of malaria programme, family planning program and environmental sanitation, while the female MPW is allotted MCH and family planning work, while immunization is usually done by male and female worker along with the supervisor once every month in every village. The male MPW is supposed to do active surveillance for malaria by visiting each house in this area once every 15 days as per the Time-Place-Movement (TPM) chart which specifies in detail which 70-100 houses he has to visit every working day. The male worker does not have any fixed center to work from, he is to be in the field every day. The female worker operates from the sub-centre head quarter. She runs clinics at the sub-centre and in various villages allotted to her. She is also supposed to pay home visits to pregnant women, post-natal women, high risk children, target couples for family planning etc. But unlike the male worker she does not have a fixed schedule of home visits.

The general impression was that the workers were visiting periodically most of the houses. Only 7% of the women reported that the male MPW does not visit or they don't know of his visits, while this proportion was 23% for female workers suggesting that male workers home visits are more regular perhaps due to the TPM. Substantial proportion of the women reported that the workers visit once a week - 33% for male workers and 24% for female workers. If this is true, it is surprising that such a large proportion of women are visited so frequently. To assess the rapport of the worker with the community we asked the women whether they knew the name of the workers who visit their area. Many more women know the name of the male worker as compared to the name of the female worker. This probably reflects the fact that most male workers have served for many years while the female workers are usually young and have short duration of service. It was surprising that some women who did not know the name of the female worker knew her caste or her village of residence. In villages there is a reluctance to ask the name of an unknown person especially if he/she is a government official.

We asked the women what services the workers were offering while they visited the village. Most women perceived that the male MPW only inquired about cases of fever and if there was one he would take blood sample and give medicine. So still the male multipurpose worker is thought as doing only malaria work. Actually the villagers know him as "malaria doctor" or "Malaria" or "Malario". As yet, villagers don't perceive him as a health worker. On probing most people also admit that he does "come to collect cases" meaning motivate people for sterilization. The female workers is perceived to be giving vaccination and motivating women for operations. Very few people mention any other health related work being done by the Multi Purpose Workers. It reflects the priority given by the health department to various programs and consequently the actual work being done by the workers in the field. The extension work is restricted to three programs: family planning, immunization and malaria. And in each programme only a few activities are being carried out. For example in spite of 30 years of Malaria control program most villages don't know that mosquitoes only breed in water - the common misbelief is that mosquitoes breed in garbage, animal faeces or in vegetation. This is because the malaria program has concentrated on active surveillance and treatment of each case of fever with chloroquine - neglecting health education and control of breeding places. The malarial surveillance strategy a remnant of malaria eradication program has to be re-evaluated with change in goal to malaria control.

In spite of these short comings of the extension work, most women said "yes" when we asked whether they were satisfied with the services the workers were providing. But the general

complaint against the workers was that their visits were very short and they visited only for a specific purpose. The workers never spend time to explain things to the people. It was also reported by the people that workers will not visit each area or house but will only visit some houses in each village where they have developed some good rapport or friendship and spend most of the time there. It is not clear how common this is.

Extension work in rural areas is difficult as transport is not frequent and reliable. Workers have to visit villages by using public transport or walk. Even within the village some hamlets may be 1-3 kilometres away from the main village and in some areas the villages have scattered settlement requiring walking several kilometres within the village to cover all the houses. Female workers have additional problem that some villages and certain areas are very difficult for them to visit because of possibility of drunkards and other antisocial elements teasing the women workers and issues of physical safety of women going alone in such areas. But probably such areas are few.

Substantial proportion of houses are closed during the day as both men and women go to the fields to work especially in some seasons where there is more agricultural work. In such situations organizing health education programs or vaccination sessions becomes difficult as people are very busy till late in the evening. The way health services are organized it is very difficult to organize any activity at night when people have time. Variation in agricultural activity has to be taken in to account in organizing community health activities only then will they be really accessible to the people.

Despite many difficulties, as noted earlier, the programme outreach was considerable. However, its quality and content needs to be improved. The qualitative data provided important insights for planning to improve quality of outreach and programme operations. From the analysis a major theme emerged for each of the services which is described below.

Immunization: high acceptance but need institutionalization

Most (more than 90%) of the women know about immunization, and will accept it if it is available at their door steps. The government service statistics has been showing more than 85% target achievement for immunization for last couple of years at National and State level⁶. Yet, the survey shows a substantial drop out in actual vaccination coverage. Sixty one percent of the 6-36 month old children had received first dose of DPT while only 36% had completed the three doses. Even though 82 % of 1 to 3 year olds had received at least one vaccine only 29% had completed all the required primary vaccinations. Although almost all mothers accept vaccination for their children, a majority of them don't know even the basic details regarding immunization schedule. Only 31 % of the mothers knew the names of more than two diseases out of six against which vaccination is available. More than half of the women did not know the correct dosage schedule for vaccination. The most common reason (32%) for incomplete vaccination was that they did not know the importance of completing the vaccination schedule. Many women reported that the workers and even private practitioners did not explain to them the importance of vaccination, the dosage schedule etc. Other important reasons for incomplete vaccination was lack of time or being out of station (15%), and worker does not visit or vaccine not available (26%). Similar coverage levels and reasons for non-immunization were reported in the review of the immunization programme in India done by National Institute of Health and Family welfare in 1988⁷. Joshi et al also found similar reasons for non use of immunization in Allahabad district⁸.

If people have to come forward for vaccination on their own they ought to know the vaccination schedule more thoroughly which will require better health education and information

dissemination. The current system of just distributing cards and giving vaccines without explaining it to the mothers is not enough. There is no system of communicating to the people when is the next vaccination day is. Most villagers know of vaccination on the day it is done when the worker goes around and calls the mothers and children.

More intensive outreach has been implemented to achieve the national target of near-universal immunization coverage. Although it may achieve the target, it is quite resource intensive process taking up substantial time of the PHC staff. Rough estimates shows that PHC staff spends between a fourth to a third of their time in immunization. Secondly doing vaccination at the house of the children makes maintaining cold chain and sterility of the needles more difficult leading to higher risk of failure and side effects.

What needs to be done is to institutionalize the Immunization services i.e. offer immunization at one place in the village instead giving it house to house. But this will have be backed up by well planned demand generation activities so that people will come to fixed facilities/locations to get vaccination. Thus freeing up time of the health workers to attend to other programmes. There is a need to achieve 100% coverage with decreasing programme efforts as such coverage levels have to be sustained for long periods of time. If women are convinced of the need for vaccination, know the schedule and have convenient and reliable fixed services then it will be possible to institutionalize immunization services. The programme has now fixed days for immunization in the villages. However, to institutionalize immunization, these services would have to be made reliable and would have to be supported by intensive community preparation efforts. Such approaches have been successfully tried at various places^{9, 10, 11}.

Distribution of Iron & Folic Acid tables is not likely to reduce Anaemia:

Because of poor compliance, the programme of distribution of Iron Folic acid (IFA) tablets has not made much impact in India¹² and the experience at other places is similar, although anaemia in pregnant women is an important public health problem^{13, 14, 15}. Our in-depth interviews show that even though most women did get IFA tables (60%), majority of them did not complete the required course of treatment. Only 12% of those who got IFA took it for more than 3 months i.e. 7.2% of the eligible women completed the course, the rest discontinued or did not get the tablets. Even though there figures are somewhat better than that reported in the Evaluation of the National Programme of Prevention of Nutritional Anaemia done in 1986, they are overall very poor (12). This is in spite of the fact that socially taking "Energy giving Tonics" and special diets is quite acceptable. Unfortunately anaemia is not perceived as a important problem and hence taking IFA is not a felt need for women. Major reasons for discontinuation of iron therapy were side effects and dislike for tablets; some were taking treatment from private sources. If the women are convinced of the importance of treating/preventing anaemia then it is likely that the compliance will increase. The current target oriented system has no incentive for the worker to make sure that the women is taking the IFA which is given to her. As there is no monitoring of haemoglobin levels in pregnancy, the actual benefit of the therapy remains uncertain. Even the supervisors don't seem to be paying much attention to the IFA programme.

Supply problems periodically crop up as IFA is purchased by Central government and distributed to states. During substantial part of the last year the district was in short supply of IFA perhaps leading to non-distribution of it to the beneficiaries. Some distribution problems could be due to the operational policy that IFA is only distributed by female health worker - who is not able to visit scattered areas and far off villages. Making IFA available through male workers, anganwadi workers, village health workers and TBAs will increase its availability to the pregnant women.

Better management of logistics at the higher levels to ensure regular supply is crucial to effective program management.

As anaemia is a very common problem in women, trying to treat/prevent it during pregnancy alone is insufficient. Some have argued that pregnancy is not the optimal time to treat anaemia¹⁶. Screening women in active reproductive life for anaemia and treating them before they become pregnant should be added to the program of preventing anaemia during pregnancy. Compliance with iron therapy is crucial as it is a long term treatment. Even though we did not find any evidence of women avoiding IFA tablets due to the belief that they will cause bigger baby and hence difficult delivery as noted by Nichter, it is important that health education and counselling be based on people's cultural beliefs and traditions¹⁷. Better health education and follow up can increase the compliance as shown by small scale experiments in voluntary sector¹. Public health measures like fortification of salt with iron has shown encouraging results but has not been incorporated in the national programme¹⁸.

Low demand for antenatal care:

Modern antenatal care (ANC) is still not a well accepted concept in rural areas in spite of its advantages. Village women do not perceive any benefit of preventive antenatal checkups in absence of any problem.

" What is the need to be examined? if there is some bad experience in the past then only care should be sought. Otherwise why should anyone go for examination?"

This is a common reply to questions regarding antenatal care in the villages we surveyed. Women don't feel the need to undergo examination if there is no problem during pregnancy. Care is only sought when the problem arises. Ramchandran observed that rate of registration of ANC is much higher among women having problems during pregnancy as compared to those without problem in Tamilnadu¹⁹. Some problems during child birth are well recognised but problems during pregnancy are not so well recognized in this community. And women do not perceive that examination during pregnancy can help predict and prevent problems during delivery. Most women were not able to tell the benefits of antenatal care. Only 30% reported that examination can reveal mal-position of the baby that can lead to difficulty during delivery.

This lack of felt need for ANC gets reflected in low use of ANC. Only 46% of the eligible women had at least one ANC visit. Of the ANC users most (69%) had depended on private providers. As private care is expensive it suggests that only the well off sections use ANC.

This low level of use of antenatal check ups is in spite of the fact that 64% of women had received one or more doses of Tetanus Toxoid (TT) vaccine. The recent push for immunization under UIP has focused efforts to increase TT coverage but unfortunately it is seen as single intervention rather than part of comprehensive antenatal care. The increasing emphasis on family planning and the pressure to achieve targets seemed to have indirectly reduced the priority that the workers give to ANC. This lack of priority for ANC by the health personnel and low demand in the community has lead to low use of ANC. Another important factor leading to low use of ANC is that in most villages ANC clinic is not held, hence women have to go to the Sub-center, PHC or

¹ Action Research in Community Health, a NGO working in Mangrol, Bharuch district has successfully tried to increase compliance with IFA using health education based on peoples perception and beliefs.

the nearest private doctor for ANC all of which costs in terms of time and money. Transport in rural areas is infrequent and overcrowded and may involve walking several kilometres to the main road. There is no provision of special seats for women in public transport which are usually crowded and not so regular. Women have to compete with men to get the available spaces in the bus which is specially difficult for pregnant women. In many areas women will have to be accompanied by some one to go to the nearest health facility. All these factors increase the opportunity cost and contribute to the low use of ANC. Given the low use of ANC the high risk approach for improving pregnancy outcomes seems to be difficult to apply as it requires universal coverage.

Need to Improve Delivery Care:

Still delivery at home is the rule in rural areas. Eighty one percent of the deliveries in the study area occurred at home, 12% were conducted in private institutions and the rest (7%) occurred at government facilities. The common attendants of the delivery were traditional birth attendants (46%), private doctors (24%) and relatives (18%). ANMs conducted only 3% of the deliveries while PHC doctors conducted 3% of the deliveries. This pattern is not much different from what was observed in the National Collaborative Study of High Risk Families done in 1981-83²⁰. Normal delivery is not perceived as a risky event by mothers. Unless problems develop - mainly delay in delivery – people don't feel need for expert help. One of the reasons for this attitude is that professional help is not easily available and comparatively expensive in rural areas. Communications is difficult and most can't afford private care which is perceived to be of good quality but is expensive. Commonly reported reasons for not calling ANM for delivery are 'she stays far off' (26%), 'it is a tradition to call Dai' (26%), 'not aware that ANM conducts deliveries' (24%), 'ANM does not visit or is irregular' (16%). Due to lack of communication calling for expert help is an involved procedure. Some one has to go the ANM's village and provide her a vehicle to come. And after all these efforts she is not able to do much more than the TBA as she does not have the required skills and equipments to intervene in most of the obstetric complications. In some villages where telephones are available people prefer to call a near by village doctor who comes with his vehicle, gives "hot" injections to hasten delivery and if that does not help takes the patient in his vehicle to the near by town to get expert help from a private obstetrician. Because of several such reasons the community does not perceive that ANM can help in complicated delivery and in normal delivery people feel that TBA can do equally well.

Some dais were "trained" years ago by a three month training program conducted by the PHCs. But due to lack of follow up and supervision and probably poor quality of training how much of it is being practised is a question. Secondly at-most of the places people don't seem to make or recognize any difference between "trained" and "untrained" dai. Hence we have not tried to make a distinction of trained and untrained dais. Only one third of the mothers reported use of new razor blade to cut the cord. This could be a measure of prevalence aseptic delivery practices and indirectly reflect on effectiveness of the TBA training program. Fortunately most women know where help is available in case of difficulty in delivery. Most common source of help is private medical practitioner in the near by village who comes and delivers the women at her home.

The main issue is how to improve the coverage by trained birth attendants and how to stream line transfer to higher level care in case of emergency. The strategy for doing this should be tailored to the specific situation of each village. Villages which have some public health facility like sub-center, PHC or government hospital near by should be encouraged to use the facility. Such facilities should be strengthened and made functional to handle complicated deliveries appropriate to the level of the facilities. Conduction of deliveries should be encouraged by including it as one

of the parameters for evaluation of the staff. Villages which are far off or have no communication should be targeted for intensive retraining of TBAs and development of referral system in case of difficulty. People will only use government services if they provide good quality (technical and human) services and value-for-effort/cost.

Sterilization is widely accepted but many fears remain

Indian family planning program is heavily dependent on sterilization; around 78% of contraceptive prevalence was due to sterilization in 1988 ²¹. Government has been actively promoting sterilization, though different methods of sterilization have been emphasised at different periods in the past. With the introduction of Laparoscopic female sterilization in early 1980s it has become the most common method of sterilization. Vasectomy has lost its popularity following excesses done during 1976 and now it contributes to a very small fraction of the sterilization acceptors.

There is still considerable unmet need for family limitation. Our quick survey showed that (33%) and (18%) of couples who did not want additional children (15% and 12% of total) have not yet accepted sterilization in the two PHCs respectively. The common reason for not undergoing operation were 'waiting for child to grow' and 'waiting for appropriate time' in one PHC(A) and 'poor health' and 'fear' in the other PHC(B). Substantial proportion of women (14% & 22%) not wanting more children and yet not operated reported that they felt that they had become sterile and hence did not need sterilization operation²².

The in-depth survey and the focus group explored the issue of sterilization further. Almost all knew both methods of female sterilization while 90% knew about male sterilization. It is clear, as is also shown by other surveys, that knowledge of sterilization is universal (21 ORG p.51). Of the sample 61% of the women did not want additional children and of them 77% had accepted sterilization leaving a unmet need or gap of 23%. Seventeen percent of the women had Tubectomy, 26% had laparoscopic sterilization, while 3% women's husbands were vasectomized adding up to 46% protected by sterilization (95% confidence interval of 41 to 51). These rates are similar to other survey based estimates for districts in Gujarat ²³. The important reasons for gap were 'waiting for the child to grow', 'secondary sterility', 'poor health', 'family members refuse', 'fear of operation'.

To understand the fear of operation we asked the mothers about their knowledge of problems with operation. Many women knew about side effects, problems and complications of each method of sterilization - some of which are well recognized while others are probably misconceptions. The data in table 2 clearly show that the pattern of problems related to sterilization perceived by the women differs by method of operation. Method with least perceived problems is abdominal tubectomy - about two thirds don't perceive any problem with this method. While for other methods about one fourth feel the method does not have any problems.

Table 2: Knowledge of Problems with Sterilization Methods.

Type of problem	for Tubectomy %	for Laparoscopy %	for Vasectomy %
<u>Known complications:</u>			
Failure	1	20	4
Sepsis, rest etc	19	-	-
<u>Misconceptions:</u>			
Burns Blood/Uterus	-	41	-
Weakness/Inability	7	2	56
Other	10	21	13
<u>No problem</u>	38	8	6
<u>Don't know</u>	23	16	25

The women seemed not to prefer vasectomy for their husbands. The commonly reported problems with vasectomy were that it may cause "weakness" or inability to do hard work. The most common response was that "men have to do hard work in the fields; if some thing happens to them who will work the fields?" and by implication - feed the family?. Even though all women work at home - which could be quite strenuous - and they many also work in field as labourers, women perceive men's work as more crucial for family's survival and perhaps harder. This probably reflects the general attitudes of a highly male dominated culture where women's role and work are less valued.

The second important reason commonly expressed in focus groups is that if vasectomy fails and the wife becomes pregnant, and there were instances cited of this, then the husband and the society immediately suspects the character of the women and she is accused of having extra-marital sex, which in a traditional Indian culture is a very bad thing. Such a incident of failure may destroy women's life leading to divorce. Just the fear of this keeps women from accepting vasectomy for their husbands. Some section of women also expressed the fear that vasectomy may cause impotence. The expression that vasectomy causes 'weakness' could mean impotence besides physical incapacity. What is surprising is that in the same society many vasectomies were done in large numbers only 8 to 10 years back. It is not clear how this shift has occurred? Perhaps backlash of vasectomies done under coercion and availability of laparoscopic sterilization which is much simpler, contributed to this drastic shift from vasectomy to female sterilization.

Exploring this perception of weakness after vasectomy further, suggests that the root lies in the commonly understood meaning of the words used for sterilization which is "Nas Bandhi". The word "Nas" in the locally understood concept of body physiology means nerves or muscle tendons or some times blood vessels. "Bandhi" means to tie off. So "Nas bandhi" is understood locally as tying of off nerves/tendons/vessels. This understanding of sterilization leads to the belief that it causes weakness in the affected parts of the body as "nas" carry vital fluids or energy. One women in a focus group clearly expressed this by saying

"In Nas bandhi they tie off dhori nas (vital nerve/vessels) going to the legs and hence weakness is bound to occur"

How prevalent this basis of understanding of the fear of weakness after vasectomy is not

clear. But if people understand the basic physiology of reproduction and exactly what is cut and tied off in the vasectomy operation then this fear may decline. It may be useful to persuade a few strong men from the community to undergo vasectomy to create a demonstration effect to show that weakness does not occur. The fear of failure and its consequences will have to be tackled by improving the technical quality of services, by proper case selection and counselling the couple to reduce failure rate and its consequences, if vasectomy acceptance is to increase.

Laparoscopic sterilization is quite popular and women like it because it does not require hospitalization which disturbs the work at home. It is very convenient to women who do not have any other women kin at home to look after household work. Men do not seem to take up this responsibility in this society. In spite of this advantage Laparoscopy is widely thought to cause long term problems besides well recognized higher rate of failure. Forty percent of women reported that 'blood or uterus gets burnt' in this procedure. 12% said that health deteriorates after this operation. What women mean when they say 'blood burns' is not clear. The effects are generally described as gradual deterioration of health, weakness and such vague symptoms and effects. One woman reported that it causes black coloured menses.

The above beliefs do not have any rational explanation from allopathic view point or from the traditional local medical understanding. On further exploration, we found that the roots of this belief which is so wide spread seems to be in the misunderstanding caused by the local word used for this operation -- "Light-nu Operation" -- which means operation done by light. The English word 'Light' is very well accepted in the local language and even the villagers use this word. But it is used to express two different meanings; one is 'light' or 'brightness' and the second meaning is 'electricity'. And the second meaning of "Light" is much more popular in the rural areas. We feel, and some health workers also agreed, that people's understanding of the laparoscopic sterilization is that it is done with help of electricity as "light" means electricity in local language. And people must have thought that only way electricity can close the "Nas" is by burning it. Many women said that in laparoscopy operation electricity is introduced in the body and internal organs are burnt hence blood burns in this operation. It means that large portion of the women do not understand the basis of laparoscopy - possibly because the programme has not explained the procedure to them. It would be interesting to observe if the same misbelief is found in the other states with different languages where the word used for laparoscopic operation does not mean electricity.

Tubectomy done by open surgery is perceived to have less problems. In the local language it is called 'Tanka-nu' or "Hath-nu" operation - meaning operation done with stitches or done by hands. The problem reported with this is that woman has to take rest for many days. Firstly she has to stay in the hospital for 7 days till stitches are removed and then take rest at home for several weeks and then avoid heavy work for months. This kind of convalescence is possible only in small proportion of the joint families where there are other women in the home to take care of the household chores. Other problems are that it causes weakness, health deteriorates and local wound problems like sepsis and 'breaking of stitches' possibly meaning wound dehiscence.

Other problem reported during focus group discussion, but infrequently in in-depth interviews, was that after female sterilization some women develop menstrual problems and they then require "The Big operation" meaning hysterectomy. This belief seemed to be quite strong in some villages. The doctors of the health department told us that some private gynaecologists in the near by town promote this belief to get more cases for hysterectomy - the indications for which are fairly vague. Any menstrual disturbance in a woman who has undergone sterilization is blamed on this operation. As 44% of this population have had sterilization many women requiring hysterectomy would have been sterilized in the past which gives support to this belief. It would be

worth while to review and if needed study long terms effects of female sterilization in developing countries even though the studies in western countries have not detected any increase in rate of hysterectomies or menstrual disturbances among the sterilized but the evidence form developing countries so far is mixed regarding changes in menstrual pattern. Studies have shown that 10 to 50 % of women observe changes in menstrual pattern after operation but they are equally divided between increase and decrease in menstrual problems ^{24, 25}.

In spite of more perceived problems associated with laparoscopic sterilization majority of the women prefer this method to surgical tubectomy mainly because they can not afford to spend seven days in a hospital. It is a trade-off between ideal and practical. The general view seemed to be that if they could afford the luxury of 7 days in hospital they would prefer surgical tubectomy to laparoscopic sterilization. Due to these perceptions popularity of laparoscopic sterilization is declining. If this is to be arrested then improving quality of laparoscopic sterilization and countering specific misconceptions has to be done. Laparoscopy is a technology which is safe, effective, acceptable and efficient and it should not be allowed to be discredited.

Diet and Operation:

There are deep rooted beliefs regarding diet to be followed after operation. The most commonly prescribed food item "ghee" (butter oil) and milk and recipes made out of them. Some of the other items prescribed are dry coconut, edible gum. The idea is to give nutritious food to combat weakness caused by the operation. Similar beliefs also prevail regarding diets during pregnancy and lactation ²⁶. In this culture only certain food items are considered nutritious or strength giving. And "ghee" is the most important among them. People do not believe that oil, which has the same caloric value as 'ghee' could be equally effective in giving strength. People believe that taking good food after operation will reduce possibility of complications. Hence those who are poor often feel that they are more likely to get complications after operation as they will not be able to afford better food. It is commonly believed that wound sepsis after operation is caused by eating sour things or certain pulses. These beliefs would have to be changed to overcome fear of operation especially among the poor. But health education and counselling should take in to account these beliefs while spreading the correct knowledge.

Potential for fertility reduction through sterilization alone is constrained:

Still most village women prefer to have two male children. But some do accept that one boy and one girl are enough. The commonly desired family size is 3 children - 2 male and 1 female. There are very few women who would accept sterilization with no male children. This clearly depicts strong son-preference. The program should work to reduce this son-preference, but in the short run it can concentrate efforts on motivating couples with at least one male child. Secondly those who have been operated with one male child should be paid special attention to prevent any chance of death or disability of the male child as such deaths would lead to lot of grief and repentance for having been sterilized. In general most people do feel that large families are a economic burden and would like to avoid it. Such pressure is more felt in villages where land is limited and unproductive.

However, communication between couples about family planning has also been limited at best. In spite of continuous efforts through mass media and the health staff to popularise family planning it still remains a sensitive subject in the Indian community. In our study only sixty percent of the couples had ever talked about family planning with each other. Frequent conversation about it was uncommon. Inter-spousal communication is an important indicator of the

acceptance of the idea of family planning in the social and cultural context. It provides background for decision making regarding use of contraception. It is clear that husband's consent is a must before use of any method. Elder's consent is not so essential for use of spacing methods but it is generally required for sterilization. We were surprised to find some old stories of vasectomy being accepted without the knowledge of the wife or any one else in the family. It seemed that men could decide on their own to undergo vasectomy when it was popular. But for female sterilization husband's and perhaps the elder's consent is essential. This has a bearing of motivation and education activities in the family planning program.

Spacing Methods: Low level of knowledge and demand:

Spacing methods of contraception still remain a sensitive matter to talk about in the villages. Women generally feel shy in discussion about these methods and do not come out with the names of these methods easily. On probing and asking direct questions whether they know IUD, pills or condoms one gets a response. If there are male members or elders of the family around then many women will not show knowledge of such methods while in private they may say that they have heard of such methods. Such hesitation is now not experienced while discussing about sterilization. This suggests that the family planning program's communication strategy has not been able to desensitize the discussion of spacing methods. This is partly because two of the three currently available spacing methods viz. condoms and IUD are directly related to sexual act or sex organs hence in a traditional society there is great reluctance to discuss such methods.

Knowledge about spacing methods is still quite short of universal. In our sample of respondents, 71% knew about IUD, 63% knew about condoms and 51% knew of contraceptive pills. Comparing these with national estimates of awareness of these methods, which were 48%, 60%, 53% respectively for rural populations in the 1988 survey, except for IUD awareness, there is not much difference (ORG). Some women know of pills to be taken to change the length of menstrual cycle so that the periods can be avoided during some important religious or social occasions. But they did not know that these pills were meant for contraception. A few women also reported that the ANM also distributes these pills for such non-contraceptive purposes.

Most women felt that spacing methods were not needed as the natural interval between their children which was 2 to 3 years was enough. They did not perceive great advantage of having longer gap between the children. Most felt that rather than bothering about spacing method, which many felt had side effects, it would be better to have as many children as one wants and then get sterilized. Some women did feel the need for spacing who started to menstruate within a few month of delivery and hence had conceived quickly after the first birth.

Unfortunately substantial proportion of women had heard of side effects of spacing method especially IUD. 23% reported that IUD causes excessive bleeding or pain. 21% reported various misbelief like IUD can shift up in the abdomen, it spoils the uterus or it causes weakness. Some felt that if IUD suits to a particular women and then it does not cause any problem and if it does not then it causes problems. One women also reported that IUD causes pricking pain when the women bends forwards for example to pick up fodder. In a few focus groups women reported that IUD causes difficulty in intercourse. Going into details of the difficulty it was found that women reported that IUD can get 'hooked to the husband' during intercourse. A few women also reported that the IUD can rust in the body and cause problems including tetanus and cancer.

The most common side-effect of the pills was that it was "hot" for the body (17%). "Hot" and "cold" are deep rooted cultural beliefs regarding food and medicines²⁷. "Hot" things cause

skin eruption, burning sensation, vaginal bleeding, abortion and enhance labour pains; while "cold" things cause common cold, cough etc. Women also believed that good food can counter act the side effects of the pills. The main problem seemed to be with remembering to take pills. Some women and a few health workers reported irregular bleeding due to pills which is probably due to irregular use.

Of the women we interviewed, 135 (36%) wanted more children, of these 49 (13% of total) wished to space their next child. The use of spacing methods was quite low (<1%). Two women were using IUDs and one women was on pill. Even use in the past was low. The main reasons for not using any method among those who wanted to space the next child were - Postpartum amenorrhoea (20%), Prefer to use rhythm method (18%), 'no need as amenorrhea is long' (14%), not contacted by worker (14%), Afraid of side effects (12%). Forty percent of the women who did not want to space could not give a reason for it. Some said that their last child was already 3 years and hence did not want to wait. Over all this depicts the low demand for spacing and for spacing methods.

Many women reported that instead of using these methods it is better to be careful. This is expressed in terms of a local phrase "Sachvi-leva-nu" which means "to be careful". When explored in depth we found that this "being careful" means to avoid intercourse during certain period of the menstrual cycle. The general belief was that if intercourse is avoided in the first few days after menses is over then pregnancy does not occur. The range varies from 5 to 15 days after menses. Women seem to believe that conception occurs immediately after menses is over and hence that is the most vulnerable period. This mistaken belief of ovular cycle is also shared by women of Bharuch district in south Gujarat ². It is not clear why this belief has arisen. National survey also showed that 5% of the couples use traditional methods of contraception (ORG). It may be useful to give correct knowledge of the safe period to the women and men so that those who want to space their children but don't like the methods can practice rhythm method correctly. Secondly emphasising health benefits of spacing would induce some couples to practice spacing.

Advice regarding use of spacing methods should be geared to the pattern of resumption of menses after birth. Advising women to use spacing method only after first menses following a birth may be a good strategy as it will avoid unnecessary use of a method and women are more likely to accept a method once they have started to have periods ²⁸. This will reduce the number of women eligible for spacing and hence the worker can give more time to each women.

Private practitioners, the main source of curative services

Primary health care infrastructure was designed to provide basic curative care to the rural areas. But this goal seems not to be fulfilled. Most of the people go to private practitioners for care during illness - minor as well as major. Out of the 38% of the families that reported some illness during last one month two thirds took treatment from private practitioners. Only 19% reported taking treatment from government sources, of which 10% used the hospitals. Only 3 % used the PHC and 6% used the paramedical workers of the PHC for treatment. This finding supports the thesis that most people do not use government PHC for curative care. The same pattern is seen for about preference of using private care in case of major health problem. 20% would prefer government hospital in this situation as against 69% preferring private care. Reasons for preferring private care during major illness were - more effective (50%), quick (35%), better care (18%), easily accessible (9%). Those who preferred government care for major illness preferred it because

² Personal communication from Ashok Bhargava, Action Research in Community Health, Mangrol.

it is - economical (30%), effective (29%), good care (28%), quick service (10%), easily accessible (6%).

People clearly prefer private care for illness in spite of the fact that government care is free and the providers are generally better qualified than private practitioners. Government providers are generally not motivated to provide curative care because their evaluation is mainly based on preventive/promotive care and no attention is paid to curative care. While curative care is the only source of income for the private practitioner hence he has to satisfy the patient. The target oriented health care system feel the patients as necessary evil who have to be treated some how. PHC has lost its credibility as center for curative care because of the following reasons. At the PHCs patients are treated impersonally. A women put it succinctly referring to PHC she said "it is a dispensary for cattle. if you go there and wait no one will pay any attention". The attitude to patients is casual at best. Privacy is usually absent. Patients are very cursorily examined and treated. The social distance between the doctor or nurse and the poor patient is so much that communication is hampered. Many times medicines are out of stock and equipments are not working. In the new PHC pattern there is only one doctor per PHC as compared to previous three. Hence the doctor is not available at PHC for several days in a month due to sterilization camp (once every week), district level meeting, leaves, field work etc. Nurses are neither trained nor allowed to provide curative care independently at the PHC when the doctor is absent. Emergency services are only available if the doctor and the nursing staff are living in the PHC campus or the village. Again because the PHC can not charge money there is no incentive for the doctor to provide good emergency care. One of the PHC is located at far end of the village away from the main highway so that people have to walk about 1 km through the village to reach the PHC. The PHC was located in such a place because of the government's policy to build PHC on land which is available free and such land is usually away from the main village center.

The availability of curative care at the sub-centre is also limited because many places the sub-centres don't have buildings or the ANM is not staying in that village. The ANM also visits villages and has to attend sterilization camps and meetings etc hence her availability in the sub-centre is uncertain. Secondly the medicines at sub-centre are limited so are her skills in curative care. The male worker is busy with active surveillance of malaria and family planning work and usually does not carry any medicines except chloroquine - even though he is part of the sub-centre and is supposed to be a multi-purpose Health worker. Many male workers also do not live in the villages which they serve hence making them accessible only during the few hours they are in the field. The tour programme of the workers or the doctor is not actively communicated to the community in advance hence the people are not able to take advantage of their presence in the villages and they are disappointed when they go to the PHC or the sub-centre and find out that the staff are not available because they have gone to the "field". Target oriented programmes have made the workers neglect the curative care as part of PHC.

The village health worker - the fundamental component of Primary Health Care - who will make basic health care available at the community level and generate community participation and serve as a link between the community and the health system, was put on suspension in the state for last three years. In 1988-89 central government who was paying for the meagre honorarium of Rs 50 per month decided to close down the scheme probably feeling that it was not getting its 'money's worth'. It was left to the states to run the community health guide scheme. The state of Gujarat pondered upon the idea for two years and then decided that they will only continue female VHGs - thinking that male VHGs were not doing their work. During these two years that went by village health workers did not receive any honorarium or medicines and hence have stopped working. In some villages we visited we were told that male VHGs were providing useful service as they were available in the village at any time and could treat minor illness. The discontinuation

of the scheme meant that in villages where there is no private doctor available there is no village level care - people have to go to near by town or village to get treatment. The demise of village health worker scheme again points to the fact that much less priority is given to basic curative care in health planning in India.

Cost of treatment is substantial. In our survey we found that 22% of those who had a illness episode in last one month had spent more than 100 Rs. on treatment and 5% had to spend as much as 500 Rs. Only a third had to spend less than 10 Rs. Most common illness was fever - many of the cases could have been malaria. We heard many stories of fever being treated with intravenous fluids - mainly 5% glucose - being given for 'weakness'. One tribal reported that he would walk one and half kilometres, take a vehicle and go to nearby town to a private doctor who would give him a intravenous drip for 'Shakti' - energy and treat his fever then he would make the same trip back. This continued for three four days and in the process he spent several hundred rupees. Misuse of IV fluids is rapidly increasing in rural areas. Earlier doctors were misusing injections to earn, now they are using IV fluids. The disposable plastic set technology has made giving IV fluids very easy. It is easy to convince the rural people to think that IV glucose gives 'energy' and helps in curing the disease faster. Any fever which is not cured in 2-3 days seems to be treated with IV fluids. Such irrational practice seems to be encouraged by pharmaceutical manufacturers by rewarding doctors who prescribe or use more drugs of their company.

Because the government health services are not providing good quality curative services, they have lost credibility among the people²⁹. Preventive and promotive services that the government provides are also discredited due to the general image of the health service. Curative health services are a felt need of the people and those worker or doctors that can provide such services develop good rapport with the people - which can be used as a leverage to convince people for accepting preventive and promotive services including family planning. But most of the PHC staff does not offer such curative services and hence is not able to meet the felt need of the people. So when they go to the community to recruit cases for family planning or immunization they don't get adequate community response. In both the PHCs it was reported by the doctors that the workers who had the best performance in family planning were the workers who were providing good maternal and child care services. The idea behind the multipurpose worker scheme and integration of health and family planning was to use curative services to promote preventive services. But due to the weakness of the curative services such synergy does not seem to be happening.

In the process of upgrading the curative aspect of the PHC to upgrading one out of four PHC to Community Health Center (CHC) with specialist care the policy makers neglected the link between the curative and the preventive aspects of health care. The CHCs are now only offering higher level of curative care and the preventive and community part has been taken away by shifting the health workers to other new PHC. So in fact the CHC works like a rural hospital with hardly any link with the Primary Health Care programme. Currently one of the PHCs we studied is under going such change. We feel that such separation of curative care from preventive and community care will be counter productive. Strong curative care support is required to deal with complications of sterilization, IUD etc and also for any health problems arising among the sterilized as it is most commonly ascribed to sterilization. Currently PHC system is incapable of dealing with such cases and they have to seek private care, which discredits the family planning program. Lastly treatment of sterility, even though is part of the government family welfare program at least on paper, is in practice not implemented. On several occasions women confronted us with the question that 'government is telling every one to have less children - what about those who are not getting any children? - should the government not do any thing for them?'. Sterility in rural areas is not

uncommon. Social life of women who has no children is threatened as she is blamed for sterility and remarriage by the husband is socially accepted ³⁰.

IMPLICATIONS

In summary, the following insights emerged from the in-depth survey and focus groups (Table 3). The most common reason for incomplete vaccinations was that the worker had not visited the households for vaccinations. Providing vaccinations at the household level is likely to impose considerable burden on the health system and it is now necessary to institutionalize immunization service delivery at one place in the village. As a large number of women do not complete IFA dosage, the programme needs to rethink its strategy to reduce anaemia among pregnant women. The demand for antenatal care is very low and considerable efforts would be required to improve ANC services coverage and its quality. As most of the deliveries are conducted at home, reducing maternal mortality would require well thought out strategy for improving delivery care.

Table 3. Summary Findings From Qualitative Research

Service	Major Finding	Action Required
Immunization	High acceptance but need institutionalization	Community preparation
Iron and Folic Acid	Widely distributed but will not reduce anaemia because of low compliance	Counselling, consider alternative strategy
Antenatal Care	Low demand	Community preparation
Delivery care	Mostly provided by local personnel	Develop a system of delivery care
Sterilization	Widely accepted but fears remain	Improve quality of care, Counselling
Spacing methods	Most feel they are not needed	Counselling, follow up
Curative care	private practitioner is the main source	Establish curative-preventive linkages

Sterilization is a widely accepted method but many fears remain and need to be addressed through community preparation and counselling. On the other hand, both knowledge and demand for spacing method remains low. Several beliefs regarding spacing methods need to be addressed as well as quality of care for these methods need to be improved to allay the fears of women. But beyond service delivery, the potential for contraceptive use is constrained as two male children is still the desired goal and inter-spousal communication about planning families remains low.

The main sources of curative care are the private practitioners. Although the programme seems to have good outreach in these areas as evidenced by frequent visits of the male and female health workers, they are mainly perceived as providing immunizations, IFA tablets, malaria tablets and family planning services. Most of the delivery care is through dais (and private hospitals if

complications arise) and curative care through local medical practitioners or private nursing homes. This division of tasks in the health care has led to fragmentation between preventive and curative care.

Above findings have several implications (Table 4). The study suggests ways to remedy the widely known weaknesses in communications activities of the health and family welfare programme. It also shows directions in which the programme operations need to be modified to become more responsive to people's needs to achieve its service coverage goals. But beyond these immediate concerns, it raises broader issues of establishing linkages between curative and preventive care having implications for programme evolution in the nineties and beyond.

Table 4. Actions to Improve Service Coverage

Activities	Focusing on Services
Community Preparation	Immunization, Antenatal care
Counselling	Iron and folic acid tablets, Spacing methods
Quality of care	Sterilization
Develop service delivery system	For delivery care

Community Preparation and Counselling.

Our discussions with the officials suggests that the programme's current communications activities at the field level seem to be restricted to a few 'shibirs' (generally one large and few small orientation training camps for each PHC) and worker contact with households. As reported by women, both of these are directive in nature. The contact with worker is usually of short duration and is directed at specific service use. Our findings show that two types of activities need to be carried out to strengthen communication activities: community preparation and counselling.

Community preparation activities would comprise intensive contact with its various segments (including leaders, government functionaries and social organizations) to educate and enable the community to demand and utilize these services. At current juncture, the community needs to be prepared to institutionalize immunization services, increase demand for ANC and delivery care, inform about nature of laparoscopic operation, and type of care to be sought for common ailments such as malaria, diarrhoea and skin diseases.

Counselling, as distinct from community preparation, requires intensive dialogue with targeted beneficiaries. The study suggests two foci of counselling: need to reduce anaemia in pregnant women through consuming a full course of IFA tablets and on use of spacing methods (including safe period).

Both community preparation and counselling require that communication skills of all personnel involved be increased and their work routines are reorganized. Specific plans need to be drawn up for community preparation in each village, perhaps once in three years. The villages could be prioritized based on their service coverage. A procedure for community preparation needs to be planned, funded and monitored. Counselling would require setting specific time aside for spending an hour or more with each targeted beneficiary. In a subcenter area of around 5,000 population, there would be around 150 pregnancies in a year and around 120 couples wishing to

space children (section III). Therefore, on an average two counselling sessions would have to be planned in each field visit to a village (assuming around 150 village visits in a year). Such worker time can only be freed up if immunization services are delivered at a village post and do not require house-visits to follow-up and collect children for immunization.

Responsive Programme Operations

The programme operations need to be refined if it is to respond to people's needs. Earlier we discussed the need for community preparation to support programme's institutionalization strategy for immunization and ANC. The programme needs to seriously reconsider its IFA distribution strategy. Perhaps pregnancy is not the best time and it may be worthwhile to provide IFA tablets during inter-pregnancy interval and to adolescent girls to boost up their iron reserve.

Delivery care needs to be systematized. Training dais alone would not suffice. NGO experiences³ show that a continuing link between them and health services needs to be maintained and reassuring referral care needs to be ensured when there is a risk of a complication during the delivery. The programme's strategy of identifying at-risk pregnant women and suggesting referral to them when many are not screened and large proportion of the screened are classified at-risk needs to be carefully investigated. Unless this is done, maternal mortality is not likely to decline.

Beyond strengthening communication, quality of care for sterilization and spacing methods needs to be improved. Better technical quality of laparoscopic operations so as to minimize failure rate is one clear priority. There should be independent quality assurance teams set up at state level which would carry out such technical inspections at randomly selected locations and work with the government system to build quality consciousness in the functionaries. The study shows that women generally did not feel a need for contraception to space unless menses returned early after pregnancy. Such cases should be identified and special attention needs to be given to them.

Programme's outreach was considerable despite many difficulties. But the quality of worker-contact was poor as evinced by their very narrow focus (malaria and family planning for male workers, immunization and family planning for female workers) and short durations of visits. The excessive focus on targets, while increasing emphasis on these services, has reduced programme's responsiveness to people's other health needs including treatment of minor ailments or chronic diseases like TB. Excessive pressure to achieve targets have demoralized the workers. The study strongly indicates a need for the programme to reorient its planning and monitoring procedures to become more responsive to people's needs.

Beyond Primary Health Care: Programme Evolution in the Nineties.

Beyond the above immediate concerns, the beneficiary response to programme services also raises strategic issues about the direction of future programme evolution. Although the rural health infrastructure has expanded considerably (around three times in terms of numbers of female health workers and PHCs), it focuses on a narrow range of services. In response to this focus, people seek to meet their various health needs from diverse sources. Broadly speaking, three major sources of services emerge: immunization, malaria and family planning from the government programme; minor ailments care and major diseases treatment from local medical practitioners (not

³ SEWA Rural at Jhagadia, KEM Hospital research center, Vadu and Ashish Gram Rachna Trust at Pachod have successfully trained TBAs for aseptic delivery and early referral.

always well trained), and private doctors in the near by towns; and delivery care from local dais and private hospital, if necessary.

Although the programme's operations during the eighties were modelled after highly successful primary health care experiences, mainly from NGOs, the fragmentation of services has nearly severed the link between preventive and curative care. Nearly 70% of all curative services were sought from the private sector which seems to have provided little preventive care. The case for integrated primary health care services was made on several grounds. Besides meeting felt needs of people, curative services were to both provide credibility of and opportunity for preventive and promotive care. Several NGOs have successfully done this. While government's village level minor ailment care services have been disabled by virtual demise of village health worker system, it continues to expand indoor-care facilities at community health centres. Given the current level and perceived quality of curative care at sub-centres and PHCs, one would need to carefully examine utilization of such indoor facilities, and their cost-effectiveness.

There has been considerable debate in the literature about relative merits and demerits of 'selective primary health care' which argued for focusing on a few selected services depending upon epidemiological and economic considerations³¹. The primary health care evolved when most of the major communicable diseases had been either eradicated or brought under control (e.g. small pox, malaria). and incidence of several others were considerably reduced so as to make special disease-oriented vertical programmes both less efficient as well as less effective. But this situation seems to be again changing. Although reliable estimates are not available, malaria seems to be resurgent. AIDS incidence is also likely to increase considerably and both tuberculosis and eye-care require special attention. Does this mean that primary health care services would need to increasingly emphasize care for these selected disease?

What role should government health services play has also been increasingly questioned as most governments faced resource scarcity during the last decade. Many have argued that public sector should deal with public goods (characterized by non-competitive consumption and nonexcludability) such as vector control or non-personal preventive care, and on communicable diseases which have large externalities. Some have argued for an expanded role of public sector to provide curative care to poor on grounds of equity and merit goods.

Thus the evolution of health sector in nineties is likely to be shaped by three forces -- continuing need for preventive care, particularly for MCH; growing disease-control programmes; and increasing economic rationale for limiting the role of public sector. Clear policy choices need to be made if the current muddling through scenario is to be averted.

CONCLUSION

This research study has raised several issues based on in-depth survey and focus-group discussions. These include need for institutionalization of immunization; limited efficacy of IFA distribution in reducing anaemia among pregnant women; low demand for ANC; need to improve delivery care; necessity of addressing many fears related to sterilization even though it is widely accepted; low level of knowledge and near negligible demand for spacing methods; and the need to increase and improve curative care so as to establish synergistic linkages with preventive care. In this process, the narrow focus and poor quality of otherwise considerable programme outreach effort also need attention.

The programme needs to respond to these concerns of people if it is to achieve its objectives. The study points out several directions for change -- strengthening communication activities through intensive community preparation and counselling; and orienting programme operations of IFA distribution, delivery care, sterilization and spacing towards a higher level of quality and efficacy. These were discussed in detail in the previous section.

The study found that government services were perceived to have narrow focus and majority of curative care needs were met from private sector thus seemingly breaking linkages between preventive and curative care. These forces as well as reemergence of malaria and other diseases threatens the government's policy of extending primary health care services in rural areas. A clearer definition of policies is called for if the national policy goal of 'health for all' is to be achieved by the end of the century.

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