

INVOLVEMENT OF PRIVATE SECTOR IN HEALTH: SUGGESTED POLICY GUIDELINES AND MECHANISMS

M.C.Kapilashrami*, A.K.Sood and B.B.L.Sharma*****

ABSTRACT

During the recent years, countries all over the world at all levels of development are engaged in a creative search to find out better ways of organising and financing health care. The key concerns have been equity, efficiency and effectiveness. Simultaneously many developing countries are facing the burden of old unresolved problems and newly emerging challenges. Privatization, globalization and liberalization have become an important part of the political agenda in many countries. The private sector in India has emerged to play a significant role in the health care delivery system. It has been estimated that about 57 per cent of the hospitals and 32 per cent of total hospital beds are in the private sector. Since the responsibility of health lies jointly with the public and the private sector, an optimal public-private mix would be the best solution for the country. The present article analyses the role of private sector in health and suggests some policy guidelines and mechanisms for optimal utilization of private sector in health.

The country has well formulated policy guidelines in our Constitution for the development of health, population, nutrition, education, children, etc. The constitutional amendments from time to time provide an overall framework for health and development and reflect the political commitments. The Constitution of India also directs the States to increase the level of nutrition and standard of living of people. Since health is a State subject, the implementation aspect lies with the States. Inadequate resources in the States usually affect the policy implementation. It has been observed in various Five-Year Plans that private sector has contributed to health and family welfare activities in the country. The national health policy document also emphasizes the need to encourage private investment in the field of health. The responsibility of health lies jointly with the public and private sector and

*Director, National Institute of Health and Family Welfare, Munirka, New Delhi-110067

**Reader, National Institute of Health and Family Welfare, Munirka, New Delhi-110067

***Reader, National Institute of Health and Family Welfare, Munirka, New Delhi-110067

an optimal public-private mix would be the best solution for the country. Besides seeking private investments in health, certain essential structural and functional changes are mandatory for the public health system to meet the future challenges of health in the country.

The present article analyses the role of private sector in health and suggests some policy guidelines and mechanism for optimal utilisation of private sector in health.

Review of the Existing Health Care System in India

The health care system in the country can be broadly divided into four sectors:

- i. Public sector, including government run hospitals, dispensaries, primary health centres and community health centres, etc.
- ii. Private non-profit sector, including charitable institutions, NGOs, trusts, missions and churches, etc.,
- iii. Organised profit-making private sector, including private hospitals, clinics and private practitioners, etc and
- iv. Private informal sector, including practitioners not having any formal qualifications (traditional healers, herbalists, vaidyas, etc.),

The private sector in India has started to play a significant role in the health care delivery system. It has been estimated that about 57 per cent of the hospitals and 32 per cent of the total hospital beds are in the private sector. However, 85 per cent of the total hospitals in the private sector have a capacity of less than 25 beds. Of the registered doctors in allopathic system with the Medical Council of India, only 20 per cent are employed with the government agencies. Studies on utilisation pattern show that people generally prefer private health care facilities. The growth of private sector has raised several concerns about quality, cost, equity and efficiency of the health care.

However, the comparison of performance of public health sector and private health sector is not easy, as the goals of these two are different. The goal of private sector is profit oriented whereas, the public health sector is social-service oriented. The goal of private sector is more clear and specific as compared to public sector.

The public health sector attempts to provide health care, services for all citizens irrespective of the geographical location. Thus, in a mixed public and private system, such as in India, the private sector tends to focus on services which are easy to make quick profit and the public sector may have to carry the unprofitable activities.

Over the years, the country has expanded the health care delivery system. The country has 1,36,815 sub-centres, 22,962 primary health centres, 2,708 community health centres, 38,605 hospitals and 6.64 lakh hospital beds. The public expenditure on health care in India comprises spending by the Central Government, the State Governments and the local bodies. The health expenditure of the government has been ranging from 2.63 to 3.29 per cent of the GDP in the last two decades. It has been estimated that nearly 60 to 70 per cent of the government expenditure on health goes towards the payment of salary of the staff. This leaves a limited scope for improvement of logistics and supplies systems, equipment, etc., which are becoming costlier day-by-day.' As a result, the quality dimension of health services in the government sector remains neglected. The share of the total health expenditure, has been estimated to be 75 per cent by private out-of pocket -expenses, 16 per cent by the State Governments, 6 per cent by the Central Government and rest 3 per cent by the corporate sectors.

Conceptual Framework and Approaches for Privatisation in Health Sector

Presently, countries all over the world are engaged in innovative ways of organising and financing health care. As the key concerns have been equity, efficiency and effectiveness, many developing countries are simultaneously facing the burden of old, unresolved problems and newly emerging challenges like privatisation, globalisation and liberalisation.

Privatization in health care service may be achieved by way of change in ownership i.e. decentralisation or dis-investment. The other mechanism is liberalization or deregulation which means the activities organised by the State would be provided by the private sector e.g. allowing government doctors to do private practice after office hours, allowing private doctors to use public facilities, etc: Privatisation in health service' can also be done by the government by contracting out services to private agencies or by allowing the private sector to manage public health facilities:

Privatisation of health care financing may also be done by way of user charges. Providing free health care facilities may tend to stimulate demand by each and everyone, including the rich who can afford user charges: But charging the poor is not a rational decision in a democratic set-up and may go against their social, welfare. So, a system of differential fees, may be charged, based on certain criteria such as type of facility used, geographical location and socio-economic status of the

patients. The other way could be that the communities may contribute towards a collective fund which could be utilised by them whenever they fall sick.

Policy Concerns - Private Sector Investment in Health Sector

One of the most important policy concerns of the private sector with regard to health is to have suitable regulations to monitor and control its allocation of resources. Hence, proper registration of private hospitals, nursing homes and clinics by the appropriate authority may be done. Proper guidelines for private hospitals, nursing homes and clinics may be issued to ensure resources on manpower and equipment are properly spent to take care of the priority health problems with a view to provide maximum service to the maximum number of people.

Another concern is to have regulations for equal distribution of services in different geographical regions. The measure for this could be in the form of subsidies for land, water, electricity, etc. for opening health institutions in the backward, underprivileged, isolated, and difficult geographical regions. Licensing of private institutions would also ensure equal geographical distribution of health facilities. Moreover, tax rebates on income/profits for private health institutions can be extended to cover the poor and underprivileged population.

Quality of health care by the private sector is another crucial area. To ensure quality care, the government can think of measures such as accreditation of institutions, legislative measures to protect the rights of consumers such as Consumer Protection Act 1986; periodic monitoring of the facilities and services by appropriate technical authority, periodic training and continuing education programmes by professional bodies.

Suggested Mechanisms for Private Sector Investment in Health Sector

The corporate sector should be encouraged to take responsibility of health in a given geographical area. For this, the corporate houses and big industries in the country can be identified for assigning them responsibility. There are about 5,843 companies registered with the National Stock Exchanges (1998). These companies can be given the responsibility of sponsoring specific public health programmes in nearly 5,000 blocks in the country, depending upon their capacity to fund such activities. The government should extend all possible support to these companies which are dedicated to the improvement of public health programmes. For corporate hospitals, subsidised land, water, electricity or custom exemption on imported equipment, etc can be worked out. These hospitals may be allowed profit earning on 50 per cent of their beds. Twenty per cent of the beds can be used for the

government functionaries on nominal rates, which may be reimbursed by their employees and the rest 30 per cent of the beds should be used for the poor patients free of cost who come below the poverty line.

Similarly, interested non-governmental organisations (NGOs) can also be identified and allocated specific areas for specific services considering the local requirements of the health system. These NGOs can be given subsidized equipment, drugs and supplies along with the minimal parameters for performance output in the context of the specified health services.

The large number of private practitioners in the country also need to be involved in the national health programmes. The selection of private practitioners for their involvement in the national health programmes may be done based on certain criteria, such as the system of medicine practiced (allopathic, ISM, Ayurvedic or Homoeopathic, etc.) number of practitioners per area/zone, availability of the infrastructure with the private practitioners, years in practice; and previous work experience' in national health programmes. The private medical practitioners can be used for case identification and referral, IEC and health education activities, follow up of cases; blood smears for passive surveillance under malaria control activities; sputum smears for suspected cases of tuberculosis and follow up smear examination of confirmed cases; vaccination services to children and pregnant women in the area; distribution of condoms, oral pills and IUCDs. The existing infrastructure can be utilised for monitoring the activities of the private practitioners. At local level, medical officers of primary health centres/community health centres, panchayat members or municipal committees, etc. can be involved in the monitoring process. At district level, the district health officers, district ayurvedic officers, local NGOs, local professional bodies, etc. can be entrusted with this task and at the State level, the representatives from local professional bodies, eminent practitioners, NGOs working in health and family welfare, etc. may be given due consideration.

The incentives for private medical practitioners may include provision of logistics and supplies such as free or subsidised drugs, equipment, vaccines, IEC materials and maintenance of equipment related to national health programmes. The private medical practitioners may be allowed to charge nominal fees for the services rendered by them under the national health programmes. Poor patients may be exempted from the fees and the government may pay some honorarium for the services rendered free of cost to the poor patients. Government may provide a fixed monthly amount as honorarium or amount per unit of the services rendered for national health programmes subjected to a maximum amount per month. The private medical practitioners who have been involved in providing services under national health programmes may be given appreciation certificates or honorary designation in lieu of the services provided by them. The private medical practitioners or the representatives of their associations like Indian Medical

Association, etc. may be given due representation in the bodies involved in planning and monitoring of the national health programmes. Suitable orientation training programmes may be planned for the private practitioners in various aspects of national health programmes. Due attention may be given to cases referred by these private practitioners to designated government, hospitals for consultation by senior doctors in OPD or admission, in blood bank services, biochemical and lab investigations, pathological consultation, radiological consultation, etc. Nominal charges may be taken from the users seeking such services from government hospitals.

Recommended Essential Changes in Public Health System to Face Future Challenges

In a country like India, public as well as the private sectors have important roles to play, as far as the health is concerned. Since the concern of private sector is profit, its focus is on the curative services, whereas, the public sector can exclusively provide preventive, promotive and highly specialized medical, care services.

The public health system needs to address certain key issues such as:

- i. Regionalisation of health services with effective referral system.
- ii. Integrated holistic approach while addressing health problems in communities.
- iii. Development of linkages with other sectors (inter-sectoral co-ordination) to ensure decentralised developmental planning including health.
- iv. The health infrastructure and effectiveness.
- v. Strengthening of the community based schemes such as village health guide scheme, training of traditional birth attendants, etc.
- vi. Development of work culture, moral values and a sense of commitment amongst the employees in the public health system. Although there is a huge manpower in the public health system, its full potential remains to be utilised for the reasons.

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हाल ही के वर्षों में विश्व के सभी देश विकास के सभी स्तरों पर स्वास्थ्य परिचर्या सेवाओं के संगठन तथा वित्तपोषित की दिशा में बेहतर तरीके की खोज में जुटे हुए हैं। इन प्रयासों का प्रमुख उद्देश्य समानता, दक्षता तथा प्रभावकारिता पर केन्द्रित है। साथ ही साथ नई चुनौतियों से जूझ रहे हैं। निजीकरण, वैश्वीकरण और उदारीकरण विश्व के सभी देशों के राजनैतिक एजेण्डे का प्रमुख विषय बन गए हैं। भारत में स्वास्थ्य परिचर्या सेवाएं उपलब्ध कराने में निजी क्षेत्र महत्वपूर्ण भूमिका प्रदान कर रहा है यह अनुमान लगाया गया है कि देश के कुल अस्पतालों में लगभग 57: प्राईवेट अस्पताल हैं और अस्पतालों में उपलब्ध कुल बिस्तरों में से 32: बिस्तर निजी क्षेत्र के हैं। स्वास्थ्य सेवाएं उपलब्ध कराने का दायित्व चूंकि सरकार और निजी क्षेत्र दोनों का सांझा है, अतः दोनों क्षेत्रों अर्थात सार्वजनिक क्षेत्र तथा निजी क्षेत्र की उपयुक्त भागीदारी ही इस देश के लिए उत्तम परिणाम दे सकती है। प्रस्तुत लेख में स्वास्थ्य क्षेत्र में निजी क्षेत्र की भूमिका का विश्लेषण करने के साथ-साथ निजी क्षेत्र का सर्वोत्तम सहयोग प्राप्त करने के लिए नीति, दिशा निर्देश तथा क्रियाविधि भी सुझाई गई है।

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DIMENSIONS OF TRIBAL HEALTH IN INDIA**

Salil Basu*

ABSTRACT

The widespread poverty, illiteracy, malnutrition, absence of safe drinking water and sanitary living conditions, poor maternal and child health services and ineffective coverage of national health and nutritional services have been traced out in several studies as possible contributing factors to dismal health conditions prevailing among the tribal population in India. In this article, the author focuses on certain interacting factors like the infant mortality rate, life expectancy, genetic disorders, sexually transmitted diseases, nutritional status, forest ecology, child health and health care practices which are generally responsible for determining the health status and health behaviour of tribal communities.

The tribal population groups of India are known to be the autochthonous people of the land. Tribals are often referred to as ADIVASI, VANYAJATI, VANVASI, PAHARI, ADIMJATI and ANUSUCHIT JAN JATI, the latter being the constitutional name. The concept of tribe emerged in India with the coming of the British. Gradually, the concept of reservation emerged and through that emerged the idea of scheduled tribe in independent India.

In India, 427 groups have been recognised as scheduled tribes. They form approximately 8 per cent of the total Indian population. These tribal groups inhabit widely varying ecological and geo-climatic conditions (hilly, forest, desert, etc.) in different concentration throughout the country with different cultural and socioeconomic backgrounds. Due to their remote and isolated living, tribal groups are difficult to reach.

There is bewildering variation in population size of the scheduled tribes, ranging from 31 Jarwas of Andaman and Nicobar Islands to more than 7 million Bhils of Rajasthan, Madhya Pradesh, Maharashtra and Gujarat (1981 Census). The highest number of tribes is represented by the State of Orissa (62) and the lowest of Sikkim (2). The largest tribal population around 15.4 million reside in Madhya Pradesh. Seventy four primitive tribal communities have been identified

* Senior Professor, FAITH Health Care Pvt Ltd, 57 Nehru Place, New Delhi-110019.

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by the Government of India in 15 States/Union Territories for taking up special socio-economic development programmes on the basis of (a) Pre-agricultural level of technology, following a hunting-gathering way of life, (b) Extremely low level of literacy, and (c) Small stagnant diminishing population (Report of the Working Group, 1989)⁴

The scheduled tribes differ considerably from one another in race, language, culture and beliefs. Notwithstanding so much diversity, there are certain broad similarities between the mutually divergent tribal groups. Striking similarities are noticed in their modes of living, each tribe lives in a definite area, has common dialect, cultural homogeneity and unifying social organisation.

The tribal population of India has been found to speak 105 different languages and 225 subsidiary languages indicating a great deal of variety (IGNOU, 1990). Languages spoken by Indian tribes can be classified into four major families of languages, namely; Austro-Asiatic family, Tibeto-Chinese family, Dravidian family and Indo-European family.

On the basis of racial features, Guha, B.S. (1935) considers that the tribal population of India belongs to three races namely the Proto-Australoids, the Mongoloids and the Negritos.

Literacy among the tribals is very low (25.9 per cent) and especially so among the tribal females (14.5 per cent) (NSSO, 1991). The level of education among the most of the scheduled tribes is upto primary level. The lowest level of literacy among females was found in Rajasthan (4.1 per cent).

Sex-ratio (females per thousand males) reflects the status of socio-cultural, maternal and child health care programmes existing in the population. In the 1991 Census, the sex ratio of the tribal population was 972 females per thousand males against 927 for the total population. The highest sex ratio for scheduled tribes among various States has been reported from Orissa (1002) and the lowest from Goa (889).

The scheduled tribes are at different stages of social, cultural and economic development. The cultural pattern varies from tribe to tribe and region to region. The economic life of the tribals is specific in nature. Based on the manner in which the tribals primarily and distinctly make their living, the Indian tribals can be classified into seven groups.

- (i) *Food Gatherers and Hunters*: For example Cholanaicken, Malapandaram and the Arahdan tribal groups of Kerala, Rajis of Uttar Pradesh, Birhor of

Bihar, Hill Maria of Madhya Pradesh, Juangs of Orissa, Chenchus of Hyderabad, Kadars of Cochin, Jenu-Kuruba of Karnataka, the Onge, the Jarwa and the Andamanese of Andaman islands.

- (ii) *Shifting (Jhum) Cultivators*: For example Khasis of Meghalaya, Nagas of Assam, Korwa of Bihar, Saora of Orissa, Muria and Maria of Madhya Pradesh.
- (iii) *Settled Agriculturists*: For example major tribes like Santhal, Munda, Ho, Oraon, Gond, Bhil, Mina, etc.
- (iv) *Artisans*: The number of tribes subsisting on crafts like basket making, tool making, spinning and weaving is small e.g. Kota of Nilgiri Hills, Birhor of Bihar.
- (v) *The Pastoralists and Cattle Herders*: For example Todas of Nilgiris, Gujar, the Bakerwal and Gaddi in Himachal Pradesh.
- (vi) *The Folk Artists*: For example Pradhans of Madhya Pradesh.
- (vii) *Wage Labourers*: Large chunks of tribal territories have come under plantations, mining and industrial development. Tribals of Chhotanagpur have gone to North East India to work on tea plantations. The Santhals have been employed in coal mines of Bihar.

Tribal scene does not present a uniform canvas. The Dhebar Commission (1961) observed four different layers among the tribal population. On top is the acculturated layer whose scheduled tribe members have adopted more or less the way of life of non-tribal sections forming the upper crust of the society, e.g. Minas. They have travelled the farthest from original tribal habitat. The second are the settled scheduled tribes agriculturists e.g. Santal, Munda, Oraon, Gond, etc. in the fringe plains who have come quite some way from the tribal highlander, being no longer isolated and they are in the process of transformation. The third category is that of the highlanders who having hardly shifted from their habitat, have undergone little transformation and may still practice shifting cultivation e.g. Khasis, Muria and Maria. The last category, (at the base) a class of tribals, which is in an extremely underdeveloped stage, isolated backward groups, including the so-called "primitive groups", who, encysted in their original habitat, have been little exposed and, consequently, preserve original socio-economic-cultural traits, e.g. Cholanacken, Kadars, Onge, etc.

Health and Its Correlates

Health is a pre-requisite for human development and is essentially concerned with the well being of common man. The UNDP Human Development Index (HDI) comprises three components i.e. health, education and income generating capacity. Health is a function, not only of medical care, but also of the overall integrated development of society - cultural, economic, educational, social and political. The health status of a society is intimately related to its value system, philosophical and cultural traditions, and social, economic and political organisation. Each of these aspects has a deep influence on health, which in turn influences all these aspects. Hence, it is not possible to raise the health status and quality of life of people unless such efforts are integrated with the wider effort to bring about overall transformation of a society. Health development can be integrated with the larger programme of overall development in such a manner that the two become mutually self-supporting. Good health and good society go together. This is possible only when supportive services such as nutrition and improvements in the environment and in education reach a higher level.

Health Culture

The culture of community determines the health behaviour of the community in general and individual members in particular. The health behaviour of the individual is closely linked to the way he or she perceives various health problems; what they actually mean to him or her, on the one hand, and on the other his or her access to various relevant institutions.⁷ The holistic concept of health culture provides a valuable framework for analysing the work of anthropologists in health fields. However, a very few studies are available in this direction, specially among the tribal population.

Health Problems

The health problems need special attention in the context of tribal communities of India. Available research studies point out that the tribal population has distinctive health problems which are mainly governed by their habitat, difficult terrains and ecologically variable niches. The health, nutrition and medico-genetic problems of diverse tribal groups have been found to be unique and present a formidable challenge for which appropriate solutions have to be found out by planning and evolving relevant research studies.

Primitive tribal groups of India have special health problems and genetic abnormalities like sickle cell anaemia, G-6-PD red cell enzyme deficiency and sexually transmitted diseases. (Commissioner Report for Scheduled Tribe and

Scheduled Caste, 1986-87). Insanitary conditions, ignorance, lack of personal hygiene and health education are the main factors responsible for their ill health. Some primitive tribal communities are facing extinction like the Onges, Jarwas and Shompens of Andaman and Nicobar Islands.¹¹

Some of the problems as indicated by investigations include (a) Endemic diseases like malaria, introduced from outside or otherwise like tuberculosis, influenza, dysentery, high infant mortality and malnutrition, (b) Venereal diseases, induced abortion, inbreeding, addiction to opium, custom of eating tubers of DIOSCERA (may cause sterility as they contain substances used in oral contraception), and (c) Disturbed sex ratio leading to shortage of women. Urgent studies are, therefore, required on different primitive tribal groups of India which are small in size.

The health and nutrition problems of the vast tribal population of India are as varied as the tribal groups themselves who present a bewildering diversity and variety in their socio-economic, socio-cultural and ecological settings. Nutritional anaemia is a major problem for women in India and more so in the rural and tribal belt. This is particularly serious in view of the fact that both rural and tribal women have heavy workload and anaemia has profound effect on psychological and physical health. Anaemia lowers resistance to fatigue, affects working capacity under conditions of stress and increases susceptibility to other diseases. Maternal malnutrition is quite common among the tribal women especially those who have many pregnancies too closely spaced.

Tribal diets are generally grossly deficient in calcium, vitamin A, vitamin C, riboflavin and animal protein.

Child Bearing and Maternal Mortality

Child bearing imposes additional health needs and problems on women - physically, psychologically and socially.

Maternal mortality was reported to be high among various tribal groups but no exact data could be collected. The chief causes of maternal mortality were found to be unhygienic and primitive practices for parturition. For example, it was observed that among Kutia Khondhs the delivery was conducted by the mother herself in a half squatting position holding a rope tied down from the roof of the hut. This helped her in applying pressure to deliver the child. In complicated labour, obviously it might lead to maternal as well as child mortality. Similar crude birth practices were found to exist in other tribal groups like Kharias, Gonds, Santals, Kutia Khondhs of Orissa, Santals, Jaunsaris, Kharias, etc.). Expectant mothers to a large extent are not inoculated against tetanus. From the inception of pregnancy to its termination, no

specific nutritious diet is consumed by women. On the other hand, some pregnant tribal women, (that is, Dudh Kharias, Santals) reduced their food intake because of simple fear of recurrent vomiting and also to ensure that the baby may remain small and the delivery may be easier. The consumption of iron, calcium and vitamins during pregnancy is poor. The habit of taking alcohol during pregnancy has been found to be usual in tribal women and almost all of them are observed to continue their regular activities including hard labour during advanced pregnancy. More than 90 per cent of deliveries are conducted at home attended by elderly ladies of the household. No specific precautions are observed at the time of conducting deliveries which resulted in an increased susceptibility to various infections. Services of paramedical staff are secured only in difficult labour cases.

As far as child care is concerned, both rural and tribal illiterate mothers are observed to breast-feed their babies. But, most of them adopt harmful practices like discarding of colostrum, giving prelacteal feeds, delayed initiation of breast-feeding and delayed introduction of complementary feeds. Vaccination and immunization of Infants and children have been inadequate among tribal groups. In addition, extremes of magico-religious beliefs and taboos tend to aggravate the problems.

The Infant Mortality Rate (IMR)

The tribal population has much lower IMR as compared to the scheduled castes but moderately higher than the other population.

Tribal Households

About half of the population of Andhra Pradesh, Madhya Pradesh, Bihar and Orissa enter their dwelling units by bending or crawling only. In Gujarat, Rajasthan and Maharashtra about a quarter of the population has such dwelling units. Most of these houses lack adequate ventilation or natural lighting. A sizable population of tribes share the living rooms with cattle, Bihar (40%), Madhya Pradesh (36%), Rajasthan (44%) and in Andhra Pradesh, it is very low (7%).

Life Expectancy

The expectation of life is the average number of years remaining to be lived by those surviving to that age.

Basu and Kshatriya (1989) while studying the Bastar tribal groups of Madhya Pradesh found the average life expectancy at birth based on q5 values for Muria (males 37.56 years and females 40.07 years), Maria (males 40.26 years and females 41 years), Bhattra (males 43.68 years and females 45.30 years), and Halba (males 38.6 years and females 41.46 years) and 41.1 years for all the four tribal

groups combined. Although these figures are comparable to the rural non-tribal population of Madhya Pradesh, they are far below the average life expectancy at birth of 58.6 years for the Indian population.

Genetic Disorders

Genetic disorders specially sickle cell disease and G-6-PD have been found to occur in high frequency among various tribal groups and scheduled caste population. The sickle cell disease has been found in 72 districts of Central, Western and Southern India. About 13 lakh G-6-P D deficient are present in tribal population. The prevalence is specially high among the tribes and scheduled castes of Madhya Pradesh, Maharashtra, Tamil Nadu, Orissa, Assam (more than 15 per cent) specially in hyperendemic malarial zones (DST, Report 1990). Prevalence rate upto 40 per cent of sickle cell trait has been reported in some tribes i.e. Adiyan, Irula, Paniyan, Gonds.

Sexually Transmitted Diseases (STDs)

Sexually transmitted diseases (STDs) are most prevalent disease in the tribal areas. VDRL was found to be positive in 17.12 per cent cases (reactive in dilution of 1:8 or more) of polyandrous Jaunsaris of Chakrata, Dehradun. Out of 17 per cent, 9.92 per cent was found among males and 7.19 per cent among females. Among the Santals of Mayurbhanj district, Orissa, 8.90 per cent cases (reactive in dilution of 1:8 or more) of VDRL were observed, out of which 4.99 per cent were females and 3.91 per cent were males.

Forest Ecology and Women's Health

The forest based, tribal economy in most parts of the world was women-centred. Women made provisions for the basic necessities like food, fuel, medicine, housing material, etc. from the forest produce. Food was obtained from shifting cultivation and from minor forest produce (MFP) like flowers and fruits collected from the forest. Extraction from herbs, roots and animals were used for medicine. All these efforts incurred an excessive workload on women.

Because of extensive cutting of trees by vested interests, the distances between the villages and the forest areas had increased, forcing the tribal women to walk longer distances in search of minor forest produce and firewood. In this rapidly changing milieu, tribal women were confronted with an extraordinary workload. A study on the Kondhs revealed that women put in an average of 14 working hours per day as compared to 9 hours put in by men. Given this additional workload, even women in advanced stages of pregnancy were required to work in the agricultural fields or walk great distances to collect fuel and minor forest produce.

The over strain on tribal women however, was not adequately compensated due to the non-availability of minor forest produce and decrease in foodgrain production.

To add to the malnutrition and additional workload, there was destruction of traditional herbs through deforestation and the lack of access of the tribal to modern medicine. This along with the increasing ecological imbalance, resulted in diseases such as TB, stomach disorders and malaria.

CONCLUSION

The scheduled tribes are at different stages of social, cultural and economic development. The cultural pattern varies from tribe to tribe and region to region. The economic life of the tribals is specific in nature. Based on the manner in which the tribals primarily and distinctly make their living, the Indian tribals can be classified into seven groups.

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अध्ययनों के माध्यम से यह निष्कर्ष सामने आये हैं कि व्यापक निर्धनता, निरक्षरता, कुपोषण, स्वच्छ एवं सुरक्षित पेयजल का अभाव तथा अस्वच्छ आवासीय पर्यावरण की स्थिति, वातावरण, मातृ एवं शिशु स्वास्थ्य संबंधी अपर्याप्त सेवाएं और राष्ट्रीय स्वास्थ्य एवं कुपोषण सेवाओं का अप्रभावी कवरेज आदि ऐसे पक्ष हैं जो आदिवासी लोगों की कमजोर स्वास्थ्य स्थिति के लिए उत्तरदायी है। प्रस्तुत लेख में लेखक द्वारा आदिवासियों के स्वास्थ्य स्तर और उनके स्वास्थ्य व्यवहार को प्रभावित करने के लिए सामान्यतया उत्तरदायी कारकों जैसे शिशु मृत्यु दर, जीवन प्रत्याशा, आयु आनुवांशिकी विकारों यौन संक्रमितरोगों, पोषण स्तर, वानिकी परिवेश, शिशु स्वस्थ तथा स्वास्थ्य परिचर्या संबंधी आदतों पर प्रकाश डाला गया है।

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USER CHARGE: A POLICY OPTION FOR HEALTH SERVICE DEVELOPMENT IN DEVELOPING COUNTRIES LIKE INDIA

T. Bir*

ABSTRACT

Though the developing countries including India have been facing economic crisis and population growth but they provide health care services either free or at a little cost to the people. In order to raise resources to meet the recurrent costs of good quality diagnostic and curative health care services, the author feels that these countries may make the people to pay for health care services, at least those who can afford. Though there are other scopes of health financing such as taxation, insurance, community financing, etc., the feasibility of collecting user charges from patients (except those below the poverty line) may be considered as one of the potential options. The reallocation of resources by the government to the health sector may not be possible at the cost of another government sector. With user fees, unnecessary use of public health services can be prevented and necessary services can be provided to those in real medical needs.

In many developing countries including India, the pattern of financing of health care is characterised by population growth, unemployment, living conditions of the people, particularly those who live below the poverty line, etc. The governments of these countries are the major health care providers. The health care services are provided to the people either free or at a little cost. The annual outlays or budgets have been limiting the ability of the governments to improve and even to maintain the existing level of health care services. In India, for example, the total plan outlay for health in the Sixth Five Year Plan (1980-85) was Rs.1821.00 crore which was only 1.87 per cent of the total outlay of the entire budget. In the Eighth Five Year Plan (1992-97), it increased to Rs. 7582.20 crore and it was only 1.75 per cent of the total outlay of Rs.4,34,100.00 crore. But in real term, it decreased by 0.12 per cent. Again in the Ninth Five Year Plan (1997-2002), the total health outlay was Rs.5,118.19 crore. Health care expenditure in relation to the Gross National Product (GNP) in India was about 0.98 per cent in the Seventh Five Year

*Senior Lecturer, Department of Social Sciences, National Institute of Health and Family Welfare. Munirka, New Delhi-110 067

Plan as compared to 0.91 per cent in the Sixth Five Year Plan. However, the Ministries of Health in the developing countries are being asked to find their own solutions for the development of health care services. Moreover, the basis for planning in these countries is a perplexity of scarce resources connected with enormous health care needs. As a result, the government sectors plan "Health For All" seems to be an addition to the existing programmes (for example Reproductive Child Health Programme in India) rather than redistribution of resources. Under pressure from the structural adjustment, government's health budget has suffered real cut in recent years. Thus, there is an abrupt increased interest within the governments regarding the issue of how the health sector could be financed in the developing countries.

In fact, those governments which have been facing the crisis in economic, political, administration and high population growth may have to manage "Health For All" programmes without depending upon the foreign aids. This is possible only when we make the people to pay for their health care services - specially, those who can afford. Of course, there are some other scopes of health financing such as taxation, insurance, community financing, etc. Reallocation of resources to the health sector may not be possible at the cost of another government sector. That is why, the World Bank has been advocating the introduction of 'user charge financing mechanism as an agenda reform in the developing countries since 1987. But, in the Ninth Five Year Plan (1997-2002), the Government of India has clearly put forward user charge as a strategic decision. In order to raise resources to meet the recurrent costs of good quality diagnostic and curative health care services at the tertiary level, the feasibility of collecting user charges from patients (except those below the poverty line) is being explored by some States. The operational strategy for the Ninth Plan period has been built up to update the technical capabilities and to evolve and implement a rational user charge policy.

Meaning of User Charge in Health Services

The essence of user charge is to generate revenue for cost recovery in the health sector. In most of the poor developing countries, the main way of supplementing tax-based funding of health care has been by changing user fees in government health care facilities. The government health services can be effective and efficient with an user fees system. The community pays for services, it learns to demand and value them. The real medical needs of the people who are in critical situation and even want to pay for health care services can be met by avoiding or discouraging people for minor problems such as headache, backache, etc.

In this regard, it is also realised that only limited amount of revenue for cost recovery can be generated for the health system. But the government funding will be

the main funding source, unless health insurance scheme as another alternative device for health financing is fully introduced. Certainly, such an improvement depends on collecting sufficient funds from users and using it to improve the perceived quality of health care in the developing countries.

Why User Charge?

According to Abel-Smith (1993), the case for charging individual patients not using special facilities - such as private beds, sophisticated medical care, etc. has some basic reasons. Unnecessary use of government health services can be prevented and be used by those in real medical needs with the governmental subsidies, if possible. Patients are already paying for health care services in the private sector. For example, in India the private sector accounts for over 75 per cent of the expenditure which implies that the share of the government is confined to a mere 25 per cent. Due to this reason there is an increasing number of sophisticated nursing homes, missionary hospitals and traditional healers in the developing countries. In fact, the similar charges could be made for the government services as well. Most patients should at least pay the marginal costs of what is provided.

Theoretical Perspective of User Charge

In the 'principles of demand' analysis, two rules - 'price effects' and 'income effects' are very important. It is commonly known that if price rises by certain amount, the demand for health care services will fall by that much. The value of economics can help the health planners to quantify the price and income effects and to understand their broader implications in the society.

In the 'principles of pricing and revenue', the cost-based approach may have little application in government health care services. It may be very useful because it gives us an idea that at the time of setting price the health service providers or government can keep in mind the costs of services, consumer's willingness to pay and what other alternatives are available to consumers⁵. If costs cannot be recovered at any price, then the government should decide whether a subsidy is required. For example, in India a substantial proportion of total subsidies given to health sector goes to curative care in urban areas. A dual pricing system wherein the poor users pay lower charges would be a more equitable form of charging for public health care services, though its implementation would be difficult to some extent.

Due to low price or no price for government health care services, there is an excess 'demand'. The consumers want more of the health care services than what the government as a provider can supply. Therefore, user charge as a new

allocation mechanism can provide the ways of how to avoid lines, how to control seeking special favours and how to manage shortage of drugs.

People are very much sensitive to prices. Small change in price can bring a big change in demand that is termed as the price elasticity of demand. It can also be stated that severe health problems like cardiac attack, cancer, etc. are considered to be 'in-elasticity' of demand of the people. In such a case, people can sell their properties like cattle, land, etc. to meet even the higher prices of health care services. But the price elasticity of demand is related to income. If the user fee for medical care services is increased by the same rate for both rich and poor, the decline in demand will be more substantial among the poor. If the rich can be charged a higher price and the poor a lower price, even then fewer poor will not be able to use the services: But the total revenue will be much higher than under uniform fee system for both poor and rich.

Empirical Implications of User Charge

Studies have been conducted on the practical utility of user charges for the last fifteen years. Creese has reviewed the experiences and conducted empirical studies in developing countries to know the effect of introduction of user charges in public health facilities. According to him, the studies conducted in Malaysia (by Heller-1989) and Philippines (by Akin et al, 1986) measured the elasticities of demand with respect to number of factors, such as cash price of services, time and income of household. The studies conducted in Ghana (1989), Peru (1987), Switzerland (1990) and Zaire region (1989) revealed that quality of health care is a significant factor in influencing demand for health care. A study conducted by Mwabu and Mwango (1986) in Kenya affected the welfare effects of user fees under the assumption that user fee is used to improve the quality of services in government health care centres. So, with the introduction of user fees, quality of health care services in government own hospitals should be improved in parallel and both should be complimentary to each-other. While levying user charges on health care, it should be essential to look into the equity aspects of health care as it may affect the lower income group adversely.

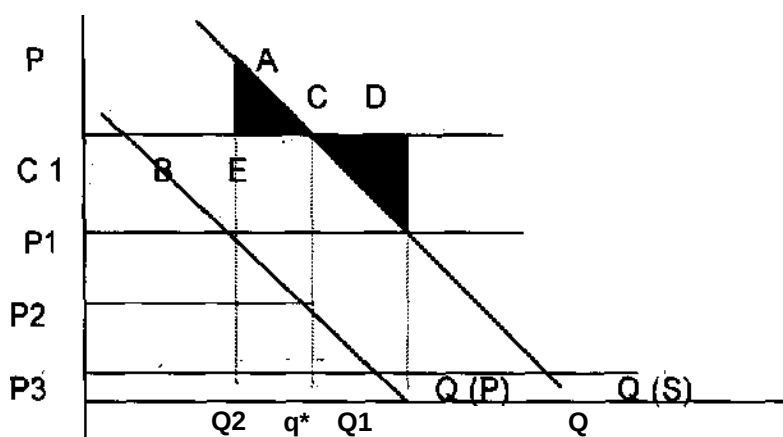
In the Indian context, an earlier study by Deolalikar and Vashishtha, 1992 has revealed that the price elasticity of demand for primary health care services is virtually nil, implying that an increase in user cost will not adversely affect the demand for such services.

McPake has explored the concept from the theoretical models that price elasticity of demand for health is likely to be higher for lower income groups. User charge, therefore, is unlikely to promote equity between the utilisation rates of the rich and poor: She found empirical evidences to confirm this equity issue. But user

charges in many developing countries provide the scope, for welfare gains for the majority of the people if the emphasis is given on ensuring quality improvement rather than superficial financing measures.

Again the World Bank reveals that the health sector of the developing countries are facing problems such as central financing of health services, mis-allocation of resources between primary and tertiary, over centralization of decision -making, under financing of special complementary Inputs (e.g. drugs), etc. In such a situation the new approach of user charge financing would provide the efficiency in both allocation of resources and proper use of resources so as to remove all kinds of problems to a great extent. In this context, the existence of positive externalities has been considered as the most powerful argument for the efficiency of subsidy in the health sector.

Besides, Jimenez formulated a condition for an efficient production and allocation of goods in the presence of externalities as follows:



[Sources; McPake (1993) - User Charges for Health Services in Developing Countries: A Review of Economic Literature, *Soc. Sci. Med.* Vol. 3 no. 11].

From the above graphic picture, it can be understood that the optimal level of utilisation is at q , when the marginal cost of delivery C equals the social marginal valuation. This level of utilisation can be achieved by the pricing of services at p_2 per unit, implying a subsidy per unit of services ($P-C_1$). Even, where health services are usually free there is some private costs involved in gaining access to them. If this is higher than p_2 (example p_1), then, there is under utilisation, q_2 and q^* can be achieved by the payment of an incentive to utilisation of (p_1-p_2). If the private cost

of access is lower (example p3), there is over-utilisation (q1) and user fee (p2-p3) is efficient. It is clear that the most efficient level of fee (or incentive payment) is determined by the degree of externalities. In the absence of externality, the model predicts that the setting price equal to marginal public cost is the most efficient policy.

Griffin has extracted the ideas of experts that user charges increase the efficiency of health services because they cut out the economic losses associated with other allocation methods. 'Waiting' for health care in a row to complete simple procedures is an inefficient use of time. People should pay for the time prices of waiting to get services. Due to this, some patients are giving up to see the health care providers, but the thing is that the providers are not affected in anyway and can not use it to finance delivery. An extremely ill person might be waiting to pay a substantial amount of cash to see a doctor while someone with a minor headache might not be willing to pay any thing. This might be the other way round but usually it does not happen as such.

Assessment of User Charge for Health Services

The conceptual framework of user charge is already discussed with theoretical and empirical perspectives. To assess its potentials in the development of health service systems of the developing countries, there should be some criteria by which the assessment can be possible to a great extent. In this regard Green has developed some criteria. According to him⁵, the choice of user charge system is value loaded and involves a major political decision.

Validity and Reliability of User Charge System

Bureaucratic Mechanism: At the time of introducing user charge, the Ministry of Health has to consider its bureaucratic mechanism by which the policy decision on user fees will be implemented. In most of the developing countries, the top to bottom approach of decision making process is existing. Decentralised health service systems are also existing in some countries. In this process the civil servants play the dominant role. The basic requirement of user charge financing system is that it can be made functional. But according to Green, there are a number of user charge systems facing difficulties over the practical application of exemption to the poor.

Pricing System of Services: The Working Group Report on Health Financing and Management for the Eighth Five Year Plan (1990-95) says that government may give a large subsidy to health care services. The payment should be graded; for example, the people below the poverty line must get the health services totally free of cost. The graded user charges should be linked with equity and efficiency.

For the Government of India, some recent suggestions to overcome the financial hardship were centered around increasing user costs as a measure to reduce the sole dependence of public health institutions on government funding. Though cost recovery seems an alternative and attractive solution, it cannot tackle the numerous problems faced by the health sector. Given due consideration, government hospitals are largely used by the poorer sections, an increase of user cost may affect them adversely. A dual pricing system in which even the rich people want to be recognised as poor so as to get the health care facilities free of cost which must be looked into seriously.

The proceeding of the recently held National Workshop on Health Finance, co-hosted by VHA and the Ford Foundation reports that despite the institution of progressive fee structures, in which fees vary with income level, the premise that communities pay for their own health care was highly controversial. But, after studying the financing mechanism of 14 voluntary health organisations, Priti Dave found that hospitals rely heavily on user fees as a source of income. The experiences show that these fees can be highly progressive, with the poorer subsidising the poorest. However, most of the organisations are struggling with how to assess people's ability to pay.

Levels of Health Services: However, in India the easy option of increasing the user charges across the board should be desisted. This enhancement should recognise the location specific characteristics of the clientele using these services as well as the type of services provided by the public sector. The government's policy is not to charge for services provided at the primary level. This includes those services provided at the sub-centres, primary health centres and community health centres upto 100,000 population. Fees are charged at the level of community hospitals and above, including secondary and tertiary hospitals. However, the range of services for which fee charged are limited and many diagnostic and treatment services are not charged at all.

A dialogue on health sector development policy between the World Bank and the Government of India started in 1992. Finally, the World Bank has been catalytic in setting up a framework for reviewing user charge policies and practices in the four States in India where the health system project is placed. Each of the four States, Andhra Pradesh, Karnataka, Punjab and West Bengal, has adopted a system of user charges at the secondary level hospitals that continue to subsidise the cost to the patients. It implies that the patients pay only a part of the costs of health care services. These States are improving the mechanisms for revenue collection. They are lessons for other States.

Willingness to Pay for Services: The case studies of 16 voluntary organisations in India were assessed and it was found that at the community level people were less

willing to pay for preventive and promotive health care. The Indian mode of spending on health suggests that the consumers would be willing to pay for government health care services, as they are already paying a high price for private health care, provided they are qualitatively good.

The National Institute of Health and Family Welfare, New Delhi, recently conducted a study entitled "Willingness and Economic Capacity of the People to Pay for Health Care Services" in the States of Assam, Gujarat, Madhya Pradesh, Uttar Pradesh and Tamil Nadu. Out of 811 households interviewed from rural and urban areas of Indore district, Madhya Pradesh, about 80.3 per cent were willing to pay for user charges for health care services provided by the government. Most of the illiterate and less educated respondents (68% out of 811) were willing to pay for user charges in comparison to those with intermediate and graduate levels of education.

For the out-patient services in Delhi State, a recent study shows that the households in organised and unorganised sectors were willing to pay for user charges irrespective of their socio-economic status, 55 per cent in organised and 61 per cent in unorganised sectors respectively. Nearly 79 per cent of the households were willing to pay for in-patient care in the former and 60 per cent in the latter, provided good quality of care, less waiting time and improvement in physical facilities are ensured.

User Fee and the Poor. Huber revealed the facts from the impact of user fees introduced in Kenya that the Ministry of Health had to withdraw user fees except X-ray fees within two years of its introduction. He argues on the issue that the exemption of user fees for the poor should not be based on only socio-economic and income characteristics.

Similarly in Thailand, it has been observed in a study that due to charges for medical services, about 60 per cent of the patients sold their property (land) for treatment of illness. While, in Kenya it was about 24 per cent. Again, it is seen that about 6 out of 7 households had debts 4 times more than their monthly income in Bangladesh. In Peru, due to user charge for the out-patient services in the hospitals, the poor patients dropped by 7.8 per cent while the richer increased for the same by 6.5 per cent. In Tanzania, it was found that 60 per cent of households had borrowed or made special sales to pay health care bills. From all these, it shows that the poor people get less access when user charge is introduced in the health sector. The efficiency and quality whatever improved does not make any difference to them for better utilisation of health services.

Exempting the Poor People: The fundamental difficulty with any system is how to exempt the poor. There is an argument that the health problems of the poor can be protected at the cost of those who can afford to pay. The World Bank advocates that the user fee will not be established in a public system without giving due regard to the poor. In this regard there is relevant equity issue whether free system or user fee system is better and the user fee system may be established with a lesser fee for the poor.

From the case studies of 16 voluntary organisations in India, it has been observed that the protection of the poor from user charges in a systematic manner was a major concern of those implementing user fees. All organisations had mechanisms in place for protecting the poor from damaging costs - especially of inpatient care. These included waiving fees either partially or totally for those patients judged to be unable to pay.

Revenue Generation Ability of User Charge

The user charge system should have net revenue generating ability. The net revenue means the revenue that remains after deduction of the cost of operating system. Operating cost means the administration cost. So the user charge rates should be more costly than the administrative. If there is no net revenue how can the quality of health services be improved. Rather the problems of scarce resources in the health sector would remain the same.

In India, for example, the Working Group on Health Financing and Management for the Eighth Five Year Plan (1990-95) suggested that it is necessary to keep the revenue collected with the institutions rather than depositing to the State general fund. Funds collected at the hospital level go to the Finance Department of the State Government, where they become part of the general revenue. However, under the State Health System Development Projects, the four State Governments have undertaken to retain the funds collected either at the institution level or at the district health committee which will be reallocated to institutions on the basis of need and level of revenue collection.

The World Bank advocates that the revenue collected from the user fee will be allocated for primary health care facilities. In this regard it was observed that some countries have made concerted efforts to reduce the hospital budgets. The best way to reduce hospital budgets and the problem of subsidy is to charge for hospital services. However, in most of the developing countries it can have a greater effect on how to re-direct health sector subsidies to the rural poor than any other short-term policy.

Effects on Health Service Provision

Effectiveness of Health Services: The effects of user charge financing should increase the effectiveness and efficiency of the health care services. This may have effects on the pattern of services. When medical care is a single good or service from the user charge point of view, it can be classified into different categories. They are hospital inpatient care; preventive care in which there are pre-natal care, immunizations, health education, etc; acute curative care, completely optional services (e.g. cosmetic surgery); predictable attendance (e.g. obstetrical care); pharmaceuticals; medical appliances; and public health interventions (e.g. water, sanitation, malaria spraying, etc.). Even within these categories there are a number of services. According to all these categories, there can be different ranges of user charges. This suggests that hospital revenue raising potential is enormous. Small fees in hospital can produce a high amount of revenue.

Improving the Quality of Health Care Services

The availability and accessibility of the physicians have to be increased when the people pay for health care services. In most of the developing countries, the doctors are busy with the payee patients outside the public sector. In the context of India, the Working Group on Health Financing and Management for the Eighth Five Year Plan (1990-95) stated that while considering this alternative, it is important to think of providing free or nearly-free health care services to the poor.

It has been observed in Sudan that the government has got some profits after introducing the user fee. There are also better seating arrangements with the: television sets in the waiting rooms of the hospitals.

Health professionals are basically concerned with measures and strategies of welfare that are directly related to health. They are not bothered about how many people are served after introduction of user charge or their pre-natal visits rise or fall or how many babies receive immunization, etc. But in Tanzania, the complain of the people regarding health care services after introducing user charge was that drug supplies were not available. The main reason for not purchasing essential drugs was financial constraint. Patient had to buy medicines from outside public sector, they wanted to pay if drugs were available in government health centres.

With user fees, the hospital environment can be improved quite a lot by way of cleanliness, purchasing essential drugs and supplies, etc. Thus, it can improve conditions at all levels. The main quality problem of health care is the shortage, of drugs. Charging for drugs will be a potential revenue for the health centres. As it has been observed in India, more households (84%) were willing to pay for health care services in rural areas than in urban areas (75%).

Management of User Charges

Who will be responsible for making the decision regarding how much one should pay for what type of services? The Ministry of Health is solely responsible for this task. If the health sector is decentralized, then the local health authority can take the decision on fixing up the price rate for the services they can provide. The type of services and the rates for services can also be instructed by the Ministry. The World Bank suggested that fixing up price for different health care services is a careful job. A little misleading information can create a big problem affecting the entire system of the user charges.

In Kenya, publicly it was held that the user fees mechanism was abused by the medical officers. They did not play humane attitude towards patients. The rate of exemption to the poor was closer to zero. On the other hand, the health personnel did not accept the exemption mechanism.

At this junction, if the accounting mechanism for collection of fees, training for the personnel and supervision are not well committed; the user fees financing may have some critical or negative impact on the utilisation pattern of health care services.

CONCLUSION

In conclusion, it can be stated that the user charge has both positive and negative implications in the socio-economic, socio-cultural, political, administrative and. management dimensions. Apart from the implications associated with user charges for reducing the financial burden, particularly, in hospitals, user fee can be a powerful option for improving the quality of health care services in the developing countries, including India. The implementation of user charge requires a strong political will and commitment of the ruling party. The acceptance of user charge will be ensured if the quality of services is improved, in terms of availability and accessibility. It has been observed in India that a higher percentage of respondents from farmer families are willing to pay for user fee. Similarly, a higher percentage of younger respondents are willing to pay for health care services.

Thus, it may be stated that there will be a universal acceptance of paying fee by the people for medical health care services like any other consumable goods and services in the market system, provided they are satisfied with quality of services rendered as well as the cost is reasonable.

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भारत जैसे विकासशील देशों को यद्यपि आर्थिक संकट और जनसंख्या वृद्धि जैसी विकट समस्याओं का निरन्तर सामना करना पड़ रहा है, फिर भी यह देश लोगों को स्वास्थ्य परिचर्या सेवायें निशुल्क अथवा बहुत कम कीमत पर उपलब्ध करा रहे हैं। लेखक का यह मानना है कि स्वास्थ्य संबंधी अच्छे स्तर की नैदानिक एवं उपचार सेवाओं पर होने वाले व्यय की पूर्ति हेतु वित्तीय स्रोतों को बढ़ाने के लिए इन देशों द्वारा लोगों से सेवा प्रभार लिया जाना चाहिए, कम से कम उन लोगों से अवश्य लिया जाये जो साधन-सम्पन्न हैं यद्यपि वित्तपोषित के लिए अन्य विकल्प—जैसे कराधान, स्वास्थ्य बीमा और सामुदायिक वित्त पोषण आदि जैसे कुछ अन्य उपाय भी उपलब्ध हैं, किन्तु रोगियों से (गरीबी की रेखा से नीचे रहने वालों को छोड़कर) प्रयोक्ता प्रभार लेने के विकल्प पर भी विचार किया जाना स्रोतों का पुर्ननिर्धारण सदैव संभव नहीं होता है। प्रयोक्ता प्रभार लगाकर जनस्वास्थ्य सेवाओं के दुरुपयोग पर रोक लगाई जा सकती है और इस प्रकार जिन्हें वास्तव में चिकित्सा सेवाओं की आवश्यकता है, उन्हें ये आवश्यक सेवाएं उपलब्ध कराई जा सकती हैं।

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A STUDY OF CLIENT SATISFACTION WITH SERVICES PROVIDED BY SUB-CENTRES IN TWO DISTRICTS OF ANDHRA PRADESH

Pratima Mittra*, K.S. Nair and Ramesh Gandotra*****

ABSTRACT

This paper analyses the client satisfaction with the services provided by the sub-centres in two districts of Andhra Pradesh, namely, Vishakhapatnam and Guntur. Record study, interview and observation techniques were used to collect data. The study revealed an improvement in the utilization of sub-centre facilities by the beneficiaries. The services such as ante-natal care, intra-natal and post-natal care, immunisation and family planning had received much attention in the community. The study brings out the fact that the in-service training and attitude of health functionaries are important determinants for improving the quality of services provided at the peripheral level.

Sub-centre, as the nearest available health care facility of the health care delivery system to the community in rural areas of the country, plays an important role in providing health and family welfare services to the people. With the inception of community development movement in India in 1952, primary health centre and sub-centre became an integral part of the socio-economic development framework in block and village levels.

During the last 50 years of India's independence, different committees, particularly, Mukherjee Committee (1964), Kartar Singh Committee (1974) and Srivastava Committee (1975) had suggested several measures for the development of rural health services. Alma Ata declaration (1978) and National Health Policy (1983) have further suggested reforms in primary health care to enhance the health care services. Bajaj Committee (1987) stressed the importance of health manpower development in its recommendations¹. In view of its recommendations, large portion of the budget of the health sector (approximately 80%) is being spent on health personnel. Development of infrastructure and health personnel has been attempted with support from various international agencies like the World Bank, WHO, DANIDA,

* Reader, Department of Community Health Administration, NIHFW, New Delhi 10067.

**Assistant Research Officer, Department of Planning and Evaluation, NIHFW, New Delhi-110067.

*** Research Assistant, Department of Management Science, NIHFW, New Delhi-110067.

UNICEF, etc. in order to improve the quantity as well as quality of health and family welfare services through area projects in some selected States. Greater emphasis has been given on the training of health functionaries at various levels to improve their knowledge and skills in different components of health care under these projects. The India Population Project VI was one such project which focussed on human resource development for health services through training. The project covered only three States namely, Andhra Pradesh, Madhya Pradesh and Uttar Pradesh. Under IPP- VI, an attempt was made to improve the quality of maternal and child health services provided at the PHC and sub-centre levels by including performance-based task-oriented clinical skill training for the service providers.

The CSSM Programme, which started in 1992, also gave emphasis on training of health service providers at the peripheral level. Following the completion of CSSM Programme, the countrywide reproductive and child health programme with a number of additional components was started in October 1997 in India. The emphasis of this programme is particularly on improvement of quality of services provided at the peripheral levels.

Since the focus of this programme is to improve the quality of maternal and child health services as part of its integrated package, various types of training for different categories of health personnel have been included in this programme to strengthen the competency of the service providers.

The State Government also introduced an insurance scheme for the poor. The eligibility of availing of this insurance benefit has been linked to the family planning programme. Couple belonging to the below poverty line and who undergo sterilisation operation after one or two children become eligible for this scheme. The scheme provides insurance coverage of medical expense upto Rs.20,000/- for a period of five years. For one single year, the coverage will not exceed Rs.4,000/-. The premium is expected to be Rs.75.00 per family.

In Andhra Pradesh, 73.1 per cent of the population lives in rural areas (1991 census). As on December 1997, there were 10,568 sub-centres functioning in the rural areas, each of which serves on an average, 4,600 population. This is one of those States which was covered under IPP- VI and had received additional inputs for strengthening the health care delivery system in the rural areas. In addition, this State also introduced various special programmes such as the Maternity Benefit Scheme and Janambhumi Scheme which focussed on reduction of fertility rate and DWACRA for the development of women and children in the rural areas.

Different projects/schemes introduced by various international agencies and the State Government aimed at improving the delivery of health and family welfare services, particularly at peripheral levels, in Andhra Pradesh. These projects

concentrated on various issues concerning the smooth delivery of health and family welfare services to the community. The IPP-VI in Andhra Pradesh specifically focussed on strengthening of both knowledge and skills of healthcare functionaries working at different levels so as to provide quality health care services to the people. According to the available literature no study has been attempted so far to probe how for the IPP-VI project in Andhra Pradesh has performed in terms of providing satisfactory service to the clients and its improvement.

METHODOLOGY

The study was conducted in Vishakhapatnam and Guntur districts in July, 1999. The districts were selected at random. From each district, two PHCs and from each PHC, two sub-centres were also randomly selected. In each selected sub-centre, one of the adjoining villages was selected for the study. A purposive sample of 20 households was selected from each village, taking into account (i) pregnant women; ii) mothers having children below the age of 5 years; and iii) eligible couples using family planning methods. Thus, 80 households from each district were interviewed. The sample of the households was identified from the records available at the selected sub-centres.

Apart from interviewing the beneficiaries, ANMs, designated as Multi Purpose Health Assistants (MPHAs) in the selected sub-centres were also interviewed to assess their competency in providing MCH and family planning services. The equipment, infrastructure and other facilities available at the selected sub-centres were also observed.

In order to study the beneficiaries perception about the utilisation of various sub-centre services, an interview schedule was developed and used for collection of data regarding age and education of the respondents, suitability of timings of the sub-centre, time taken to reach the sub-centre as well as availing of services, availability of medicine, behaviour and attitudes of ANMs and details about her home visits and follow-up visits related to various services. Besides, questions were also asked to know whether any improvement had occurred in the service delivery at the sub-centre during the last three years.

FINDINGS

Profile of the Beneficiaries

Out of 160 respondents, 38.75 per cent were sterilized women, 28.75 per cent were pregnant women, 3 per cent each were Oral Pill and IUD users and the rest of the women had children below the age of 5 years and not included in any of

the above mentioned categories. The mean age of the respondents in the study was 22.8 years. Nearly 22 per cent of the respondents were less than 20 years of age. Nearly half of the total respondents were illiterates, 25 per cent had completed primary education and the rest of the respondents had more than primary school level of education (Table 1).

TABLE 1
PROFILE OF THE BENEFICIARIES
(No. - 160)

Items	Percentage
Age	
i. Below 20 years	21.25
ii. 20-25 Years	56.25
iii. Above 25 years Education	22.50
i. Illiterate	52.50
ii. Primary	25.00
iii. Middle	15.00
iv. Secondary	03.75
v. Sr. Secondary	03.75
Sample Break-up	
Sterilized women	38.75
Women using temporary F.P. methods	06.00
Currently pregnant women	28.75
Mothers with <5 years children and not included in the above categories	26.50

Accessibility of Services

Almost all the respondents in the study area were satisfied with the timings of the sub-centres. As most of the sub-centres are conveniently located at the centre of the villages, the beneficiaries did not face any accessibility problem. Moreover, 90 per cent of the ANMs were staying in the sub-centre residential quarters and they all were available to the community round the clock. All the sub-centres were easily approachable by roads.

Since most of the villages were located within 2 to 3 kms of radius of the sub-centres, majority of the beneficiaries did not face any problem in reaching the sub-centres. Only 25 per cent of the respondents took more than 30 minutes to reach the sub-centres. More than 80 per cent of the respondents visited the sub-centres on foot. However, 11.25 per cent used public transport/ buses. A small percentage of them (6.25%) reported that they used bicycles and rickshaws as

modes of transport to reach the sub-centres. The respondents reported that they need not wait for a long time to consult the ANM. More than 70 per cent had to wait less than 15 minutes for their consultation with the ANM. Almost all the respondents were satisfied with the behaviour and quality of services being provided by the ANMs (Table 2).

TABLE 2
ACCESSIBILITY TO SUB-CENTRES

Details	Percentage
a) Timing suitability of the sub-centres	100.00
b) Time Taken to Reach the SC	
i. < 10 minutes	37.50
ii. Between 10 and 20 minutes	25.00
iii. Between 20 and 30 minutes	12.50
iv. More than 30 minutes	25.00
c) Means of Transport To Reach SC	
i. On foot	82.5
ii. By bus	11.25
iii. By cycle/rickshaw	06.25
d) Waiting Time at the Sub-Centre	
i. < 10 minutes	71.25
ii. Between 10 and 20 minutes	16.25
iii. Between 20 and 30 minutes	10.00
iv. More than 30 minutes	2.50

Competency of the Service Providers

When the respondents were further probed about the competency of the service providers in delivering various MCH services, there were different views. The service providers were competent in (i) conducting deliveries (80%), (ii) Identification of high-risk cases and referrals (80 %), (iii) providing adequate and proper health education (82.50%), and giving appropriate medicines for common ailments (45%) (Table 3). The ANMs were also interviewed for assessing their task performance competence and it was found that about 75 per cent of them

possessed adequate knowledge for providing quality maternal health services, immunisation and family planning.

TABLE 3
COMPETENCY OF THE SERVICE PROVIDERS

Reasons	Percentage*
i. Appropriate medicine for common ailments	45.00
ii. Conducting deliveries	80.00
iii. High risk cases and referrals	80.00
iv. Appropriate health education	82.50

(* Multiple Responses)

A majority of the respondents reported that the ANMs frequently visited their villages, once in a week by 27.5 per cent, once in a fortnight by 42.5 per cent and once in a month by 30 per cent. According to 85 per cent of mothers, the health workers made home visits for providing post-natal care. This figure is quite high as compared NFHS, 1992 for Andhra Pradesh (50 %) (Table 4).

TABLE 4
FREQUENCY OF HOME VISITS BY ANMS

Frequency of visits	Percentage
i. Once in a week	27.50
ii. Once in a fortnight	42.50
iii. Once in a month	30.00

During their home visits, ANMs provided various MCH services. About 80 per cent of the respondents reported that the ANMs were providing health education related to ante-natal care, intra-natal care, post-natal care and nutrition. It was also found that during their home visits, the ANMs also provided IFA tablets, checked blood pressure and gave medicine for common ailments. In addition, according to 65 per cent of the respondents, the ANMs undertook motivational activities for family planning (Table 5).

TABLE 5
SERVICES TO COMMUNITY BY ANMS DURING HOME VISIT

Advice/Service	Percentage*
i. Health education/nutrition/child health and maternal health	80.00
ii. Motivation for family planning	65.00
iii. Gives medicine for common ailments	37.50
iv. Care of ANC/PNC	77.50
v. Care for babies	85.00
vi. I.F.A. tablets,	100.00
vii. T.T. injection	100.00
viii. B.P. check-up	75.00
ix. Weight	80.00

(* Multiple responses)

It was also observed that nearly 50 per cent of the sterilized women were in the average age of 25 years. It is encouraging to know that 87 per cent of the sterilization was done at the PHCs, CHCs and F.P camps. A majority of the family planning cases also availed of the monetary benefits from different schemes. The respondents preferred temporary methods. However, one of the respondents, in spite of the repeated visits by the ANM did not receive ante-natal care service due to some religious reasons.

The respondents who were having children below 5 years of age were asked about the immunization services. It was found that all the children were immunized as per the schedule. About 80 per cent of mother's were having immunization card. It was also observed that the ANM informed the beneficiaries about the immunisation days well in advance.

Attitude of the Service Providers

The attitude of the service providers towards clients was also assessed in this study. It was found that almost all the ANMs exhibited polite behaviour towards the clients. They had good interaction with mothers. Almost all the ANMs in the selected sub-centres had good inter-personal relationship with the TBA and other non-health functionaries. It was also found that the TBA of the sub-centre village was present in the sub-centre along with the ANMs during their visits. All the ANMs were found to be taking interest in clients and listening to them carefully. More than three-fourths of ANMs were found giving necessary information and advices to their clients. Almost all of them were found taking appropriate action (Table 6).

Finally, respondents were also asked, about their opinion regarding whether they noticed any improvement in service delivery at the sub-centres over the period of last three to four years. As expected, all the respondents reported that there is much improvement in overall services provided by the sub-centres. More availability of MCH services, immunization, health advice by-ANMs and availability of medicines for common ailments were reported as the reasons for-the improvement in the perceptions of the respondents.

TABLE 6
ANMS ATTITUDE TOWARDS CLIENTS

Attitude	Percentage
I. Interested and listen carefully	87.50
II. Gives required information and advice	72.40
III. Takes appropriate action	87.50

With the implementation of IPP-VI, most of the ANMs in the selected sub-centres had undergone different types of training which contributed in improving their knowledge, skills, attitudes and performance in the delivery of health care services in the study area. Almost all the ANMs in the selected sub-centres had adequate knowledge of various activities related to ante-natal care, intra-natal and post-natal care. However, all of them did not have adequate knowledge about various diseases which cause complications in pregnancy. ANMs were also actively involved in various family planning services, including IUD insertion. But their knowledge about the complications of IUD and oral pills needs to be improved. Also, training is required for updating their knowledge about maternal and child health in the perspective of RCH programme components and applications.

Availability of Equipment and Materials

It was observed that almost all the sub-centres had sufficient equipment for providing MCH services and treatment of minor ailments. Almost all the selected sub-centres had weighing machines, B.P. apparatus, test-tubes, urine testing materials, delivery kits, enema can and tubes, new blades, scissors, gauzes, gloves, soaps, kidney trays, catheters, cotton, chittle forceps, plastic aprons, and baby-

weighing scales. However, it was found that due to unavailability of complementary supplies, some equipments were not being used. For example, stoves without kerosene oil, etc. However, since the ANMs were residing in the sub-centre quarters, they were using their own cooking stove for sterilising the syringes and needles. It was also found that all equipment in the sub-centres were well maintained.

DISCUSSION

The illiteracy among mothers has been observed to be a predominant factor in the study area (52%). However, their awareness of various MCH services available at the sub-centre is comparatively higher. This could be due to the intensive efforts made by ANMs who reside in the village itself and provide all kinds of services required by the mothers at any point of time. They were also more efficient in providing services like identification of high risk cases and referrals, rendering adequate and proper health education and giving appropriate medicines for common ailments. The health education activities provided by the ANMs to the mothers regarding ante-natal care, intra-natal care, post-natal care and nutrition may have helped the mothers to understand the importance of these crucial issues to help themselves as well as their children. For example, even the mothers have undergone sterilization operation below the age of 25 years. The mothers were also satisfied with the quality of health care services provided by the ANMs simply because they had very good knowledge about various MCH issues which was imparted to them through under IPP-VI project. The sub-centres also had all the facilities and the ANMs could do their best. The location of sub-centre was also an added advantage to the community to avail of all the services provided by the centres.

CONCLUSION

This study concludes, that utilisation of sub-centre facilities by the clients had improved after the in-service training provided to the health functionaries in the study area under IPP-VI. The community also had the knowledge of various types of services available/provided at the sub-centres. The services provided by the ANMs such as ante-natal care, intra-natal care, post-natal care, immunisation and family planning had received much attention in the community. The study also brings out the fact that in-service, training and the dedication of the health personnel are important determinants in improving the health care services at the sub-centres. Refresher training courses in all related areas for updating the knowledge and skills of health functionaries are required for providing quality health care at the peripheral level.

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प्रस्तुत लेख में आन्ध्र प्रदेश के विशाखापटनम और गुंटूर जिलों में स्थित उप-केन्द्रों द्वारा प्रदत्त स्वास्थ्य सेवाओं के बारे में लाभानुभोगियों के संतुष्टि स्तर का विप्लेषण प्रस्तुत किया गया है। उप-केन्द्रों के रिकार्ड के अध्ययन, साक्षात्कार और प्रेक्षण तकनीक के माध्यम से आकड़े एकत्र किए गए थे। अध्ययन से प्राप्त निष्कर्षों से पता चलता है कि लाभानुभोगियों द्वारा उपकेन्द्रों में प्रदत्त सेवाओं के उपयोग की स्थिति में सुधार आया है। प्रसवपूर्व, प्रसवकालीन और प्रसवोत्तर परिचर्या सेवाओं, टीकाकरण और परिवार नियोजन संबंधी सेवाओं की ओर समुदाय द्वारा उपेक्षाकृत अधिक ध्यान दिया गया था। अध्ययन से यह तथ्य भी सामने आया है कि निचले स्तर पर प्रदान की जाने वाली सेवाओं की गुणवत्ता में सुधार के लिए स्वास्थ्य कर्मिकों का सेवाकालीन प्रशिक्षण और स्वास्थ्य कर्मियों का व्यवहार महत्वपूर्ण कारक है।

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A STUDY OF ADOLESCENT GIRLS IN RUNE

Ratna Majumdar* and S.K. Ganguli**

ABSTRACT

This study was carried out in SNDT Arts College of Pune, Maharashtra. Out of 243 girls studied, the findings show that (i) majority of them i.e. 120 in number (49.4%) belonged to the lower middle social class; (ii) 154 (63.4%) belonged to nuclear families; (iii) almost equal number of girls were vegetarian and non-vegetarian and they liked fast foods like pizza, potato chips, pav bhaji, chocolates, etc.; (iv) puberty reported between 12 and 16 years of age with a mean age of 14 years; (v) a higher proportion of girls, numbering 166 (68.3%) experienced pre-menstrual, symptoms; (vi) out of 230 girls checked, 105 were found anaemic; (vii) majority of them, numbering 197 (86.7%) knew that breast milk is ideal for infants; (viii) knowledge of sex and reproduction was poor among them; (ix) a fewer number of girls, only 47 (19.34%) had some knowledge of contraception; and (x) most of them, 208 (85.60%) knew about the modes of transmission of HIV/AIDS.*

Adolescence is the phase that comes during the second decade of a human being's life (10-19 years). This is a period of rapid growth when young people acquire new capacities and physical changes with many new characteristics that create not only opportunity for their progress but also create problems to their health and well being, if they are not taken care of. During this period, the growth is accelerated by major physical changes in both boys and girls.

The rapid growth occurs during adolescence and demands extra nutritional requirements. During this period, more than twenty per cent of the total growth in the stature and up to fifty per cent of adult bone mass are achieved. Adolescent girls also need additional requirements of iron, up to fifteen percent to compensate the monthly physiological blood loss. Adolescence is a time of mental and psychological

*Lecturer, Department of Preventive and Social Medicine, M1MER Medical College, Talegaon Dabhade, Pune, Maharashtra.

**Ex Professor and Head, Department of Preventive and Social Medicine, MIMER Medical College. Talegaon Dabhade, Pune, Maharashtra.

adjustment, a situation of being no longer a child but not yet an adult either.

Globally, the current generation of 10-19 year old is more than a billion strong and will be the largest generation in the history to make transition from childhood to adulthood. Globally, 14 million adolescent girls become mothers each year, out of which 5 million are in Asia.

In India, it is estimated that adolescents (10-19 years) constitute 21.8 per cent of the total population, i.e. 207 million. Married adolescents comprise 20 per 1000 population. Data for 1992-1993 reveal that 6 per cent of the urban and 21 per cent of the rural women aged between 15 and 19 years are married before the age of 15 years.

In India, of the estimated 4.5 million marriages that take place every year, almost 3 million involve girls in the 15-19 years of age group and about 28 per cent women deliver before 18 years of age. Fewer than 5 per cent of both married and unmarried adolescents use some form of contraception.

From childhood, girls are brought up for their imminent identity as wives and mothers. Gender construction is an on-going process but during adolescence, the primary aim of gender construction is to harness and manage sexuality in girls until it is channelled through marriage. Regulation of a girl's conduct, talk, clothing, social interaction, mobility and use of time are various means used to control and construct her sexuality.

Adolescent health and nutrition are important issues which have not received any attention though they are important in our country, especially in the context of the girl child. Amongst adolescent girls, early marriage is an age-old tradition in India. However, now-a-days, this is changing. At the same time, the mean age of the onset of puberty is declining and the mean age of marriage is rising resulting in an unprotected sexual activity by this group.

Thus, the adolescent girls are a selected high-risk group, next only to neonatal period and early infancy. Therefore, in this study, an effort is made to study the belief, customs, health, food habits and ambition of adolescent urban girls in Pune, Maharashtra.

METHODS AND MATERIAL

The girls of SNTD Arts College, Pune, were contacted with the permission of the Principal. They were explained the objectives of the study. A pre-tested questionnaire was issued to them in batches and they were asked to fill it up. The

principal investigator answered queries of the students after they filled up the questionnaires. A total of 243 girls were the subjects of the study.- Haemoglobin level of 230 girls were estimated by Sahli's method. The study was carried out during July, 1999.

As satisfactory scale to determine the social class is not available over and above the per capita income; occupation of guardians and other factors' like possession of house; transport, telephone and visit to foreign country were taken, into consideration to evolve a new scale.

FINDINGS

A total of 243 girls participated in the study. The girls were between the age of 16 and 20 years and studying in the Arts stream. Majority of the girls, numbering 234 (96.3%) were Hindus, 5 (2.06%) were Muslims, 2(0.82%) were Christians and 2 (0.82%) were in other category. Only 38 girls (15.6%) belonged to SC/ST/NTA/JNT category and 205 belonged to open category.

Social Class: The social classes of girls are determined by a scale evolved by taking into consideration of the occupation of guardians, per capita income, possession of house, transport, telephone, etc.

Only two girls (0.83%) belonged to upper class, 81(33.33%) belonged to upper middle, the majority belonged to lower middle 120 (49.38%) and the rest 40 (16.46%) were in the lower social class (Table 1).

TABLE 1
DISTRIBUTION OF GIRLS IN DIFFERENT SOCIAL CLASS

Social Class	No. of Girls	Percentage
Upper	2	0.83
Middle	81	33.33
Lower middle	120	49 38
Lower	40	16.46
TOTAL	243	10000

Family Type: A large number of students, numbering 154 (63.4%) belonged to nuclear family, 61 (25.1%) belonged to joint family and only.28 (11.5%) were from extended family.

Food Habits: Majority of the girls, numbering 117 (48.14%) were vegetarian, 109 (44.85%) were non-vegetarian and only 17(7.01%) were vegetarian but occasionally consume eggs. The pattern of intake of food is distributed between breakfast, lunch and dinner.

The fast, foods like pizza, potato chips, ice cream, pav-bhaji, vada-pav, chocolates, etc. were found very popular among the subjects, Generally the students consume fruits. The study found that two hundred seven girls (85.6%) consume fruits regularly, 225 girls (92.6%) like spicy oily food and 231 girls (95.06%) enjoy good/fair appetite.

Menstrual History. Age of menarche of 220 girls is shown in Table 2. Twenty three girls did not give this information. 166 girls (68.3%) complained of pain in abdomen, headache and giddiness as symptoms before the onset of menstruation and the rest 77 did not experience any symptoms. 116 girls (47.7%) were using sanitary pads during menstruation and the rest 127 (52.3%) were applying used cloth. Only 20 girls (8.2%) had complains regarding vaginal discharge.

TABLE 2
AGE OF GIRLS AT MENARCHE

Menarche		
Age in completed years	No. of girls	Percentage
12	30	13.6
13	38	17.3
14	67	30.5
15	66	30.0
16 above	19	8.6
Total	220	100

Weighted mean -14 years

Hemoglobin Level (Anemia): The level of blood hemoglobin was estimated for 230 girls 105 girls (45.7%) showed hemoglobin below 12 gm/dl and considered anemic as per WHO expert group. It is observed that the prevalence of anemia increases with decrease in social class (Table 3).

TABLE 3
BLOOD HAEMOGLOBIN LEVEL AND SOCIAL CLASS

Hemoglobin level	Social Class			Total
	Upper middle	Lower middle	Lower	
12g/dl & above	50(64.1)	63(54.3)	12(33.3)	125(54.3)
Below 12g/dl	28 (35.9)	53(45.7)	24(66.7)	105(45.7)
Total	78(100)	116(100)	36(100)	230(100)

(Figures in parentheses indicate percentage)

PERSONAL HYGIENE

Bath: The study revealed that out of 243 girls, two hundred forty one girls were taking bath daily and two girls on alternate days.

Cleaning of Teeth: The study found that all the girls were cleaning their teeth regularly. Majority of them, numbering 153 (63.8%) were brushing their teeth twice a day and 88 (36.2%) once a day. Two hundred thirty nine girls (98.3%) used tooth brush and paste and the rest used *datun/mishri*.

Hair Washing: It was observed in the study that one hundred thirty two girls (54.3%) washed their hair daily, 85 (34.9%) twice a week and 26 (10.7%) once a week. 135 girls (55.5%) used shampoo, 40 (16.5%) soap, 86 (35.4%) *shikakai* and the rest *besan* (powdered gram flour).

Lice Infection: Only 13 girls (5.5%) reported the presence of lice in their scalp.

Hand Washing: It was interesting to note that two hundred thirty seven girls (97.53%) used soap for washing their hands before taking food.

Physical Exercise: One hundred fifteen girls (47.32%) practice some form of exercise.

History of Previous Illness: The students were asked to recall different diseases they suffered in the past. Most of them, numbering 104 (42.83%) were not affected by any kind of illness during the past. The disease that affected the highest proportion of girls was chicken pox (27.99%) followed by typhoid (10.69%). 7.82 per cent of the girls reported to have been suffered from jaundice and 6.18 per cent from measles during the past (Table 4).

TABLE 4
DISTRIBUTION OF GIRLS ACCORDING TO DISEASES

Disease	No. suffered	Percentage
Typhoid	26	10.69
Mumps	4	1.6
Measles	15	6.18
Chicken pox	63	27.99
Jaundice	19	7.82
Diarrhea chronic)	02	0.83
Others	05	2.05
None	104	42.83
Total	243	100

History of Addiction: The authors felt very happy to observe in this study that no girl was indulging in any kind of addiction like smoking, *gutka* chewing, etc.

Concept of Child Rearing: It is encouraging to know that 197 girls (86.78%) opined that breast milk is ideal for newborns. Cow milk was favoured by 26 girls (11.45%) and only 4 girls (1.76%) opted for tinned baby food. Out of those opted for breast milk for infants, 51 girls (44.74%) opined to continue this for 6 months, 63 girls (55.26%) opined that it should be continued beyond six months and the rest did not offer any opinion.

Attitude towards Parents and Others: Majority of the girls showed love and respect towards parents, love towards siblings and casual attitude towards friends.

Group Activities: Eighty eight girls (36.22%) participated in singing, 90 girls (37.04%) in dramatics (dance and drama), 38 girls (15.64%) in debate and some took part in elocution.

Aims and Ambition: Only 166 girls expressed to have aims in their lives. Out of them, 81 (55.48%) wanted to become executives, 55 (37.67%) opted to become housewives, 27 (18.49%) wanted to become teachers and 3 (2.05%) wanted to become nurses.

Knowledge of Sex and Reproduction: The girls had poor knowledge of their own sexuality and physical well beings, the study revealed.

Preferable Age of Marriage: 167 girls (68.72%) wanted to get married between 21 and 24 years of age and 60 girls (24.69%) above the age of 24 years but only 16 girls expressed preferable age of marriage between 18 and 20 years. 59 girls (37.39%) wanted handsome husbands, 44 girls (27.85%) rich husbands and 55 girls (34.81%) intelligent/educated husbands.

Knowledge of Contraception: Only 47 girls (19.34%) had some knowledge of contraception.

Family Size: The expected number of children in family as expressed by 235 girls is very interesting. One child was preferred by 110 girls (46.81%), 2 children by 124 girls (52.77%) and 3 children by only 1 girl. The sex preference of off springs was expressed by 204 girls. Out of them, 89 (43.63%) wanted female child 34 (16.66%) male child and 81 (39.71%) both male and female children. They desired at least 3 years of spacing between the pregnancies.

Knowledge of HIV/AIDS: From among the subjects, 208 girls (85.60%) were aware of the AIDS and its transmission through sexual relationship, contaminated blood transfusion, needle and from infected mother to infant. 17 girls (6.9%) were completely unaware of methods of transmission of HIV/AIDS. 143 girls (58.83%) know that AIDS is caused by a virus, 151 girls (62.14%) were sympathetic with AIDS victims and were willing to allow them to work in schools, colleges, restaurants; hospitals and offices. However, 77 girls (31.69%) were unwilling to allow them to work in above places.

Knowledge of Sexually Transmitted Diseases: Most of the girls were ignorant of sexually transmitted diseases, only a few girls knew about syphilis and gonorrhoea.

DISCUSSION

In this study, 166 girls (68.3%) were complaining of pain in abdomen, headache and giddiness as symptoms before the onset of menstruation. Similar findings were noted in a study conducted in a rural area of Delhi⁵. The prevalence of dysmenorrhoea in 70.8 per cent of the girls who reached menarche was observed. Dysmenorrhoea as the commonest complaint in gynaecological practice in USA was also noted. In one study it was observed that the first menstruation occurs between 11-15 years with a mean age of 13 years. It is more closely related to bone age than chronological age. For the past couple of decades the age of menarche is gradually declining with an improvement in nutrition and environmental condition. In this study menarche was reported between 12 and 16 years and above with a weighted mean of 14 years. In this study only 20 girls (8.2%) complained of vaginal discharge. As the puberty approaches there may be excessive production of mucus from cervical glands and increased transudation from vaginal epithelium.

Nearly half of the subjects, i.e. 105 girls (45.7%) were found anaemic. Dr. Sultana Khanum, Regional Adviser - Nutrition, WHO/SEARO, stated that iron deficiency is one of the major nutritional problems which affect adolescents. The prevalence of anemia in the adolescent age group is reported to be 27 per cent in developing countries and 6 per cent in developed countries. A study in Srilanka indicated that 59 per cent of the school girls, aged 14-18 years, have low iron stores.

More than 50 per cent of the girls suffered from common childhood diseases (Table 4). The health of adolescent has been somewhat neglected in the past, due to the fact that they are perceived to be relatively free from diseases which is also evident from morbidity and mortality statistics.

As per the National Family Health Survey (NFHS), more than half of women, aged between 20 and 24 years married before the age of 18 years. In the

present study, 68.72 per cent of girls expressed their opinion to get married between 21 and 24 years of age. The National Family Health Survey also states that women in India have an average of 3.4 children. The girls in this study projected expectation of one child by 46.81 per cent and 2 children by 52.77 per cent. It was found that knowledge of sex and reproduction was limited among the girls. Similar observation was also made by other workers. The authors feel that efforts should be made to educate the girls about the importance of sex and reproduction.

It is encouraging to note that 85.60 per cent of girls were aware of AIDS and its mode of transmission. It indicates that the motivational activity undertaken by media about HIV/AIDS is adequate and these girls may have had an opportunity to know more about this disease. It is in contrast to the findings of other workers who found poor knowledge among nursing students, pregnant women and undergraduate students in Delhi and Rajasthan.

CONCLUSION

The study concludes that majority of the girls numbering 166 (68.3%) experienced premenstrual symptoms. Out of 230 girls checked, 105 were found anaemic. Majority of the girls, numbering 197 (86.7%) knew that breast milk is ideal for infants and knowledge of sex and reproduction was poor among them. A fewer number of girls, only 47 (19.34%) had some knowledge of contraception and most of them, 208 (85.60%) knew about the modes of transmission of HIV/AIDS.

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यह अध्ययन महाराष्ट्र के एस.एन.डी.टी. आर्ट्स कालेज में किया गया था। अध्ययन के लिए चुनी गई 243 लड़कियों पर किए गए सर्वेक्षण से प्राप्त निष्कर्षों से पता चलता है कि: (1) अधिकांश लड़कियां अर्थात् 120 (49.4%) निम्न माध्यम सामाजिक वर्ग से थी, (2) लगभग 154 (63.4%) लड़कियां मूल परिवारों से संबंधित थी, (3) निरामिष तथा सामिष लड़कियों की संख्या लगभग समान थी और वे पीजा, आलू के चिप्स, पाव भाजी और चाकलेट आदि जैसे फास्ट फूड (व्यंजन) पसन्द करती थी, (4) यौवनारम्भ की आयु 12 और 16 वर्ष के बीच पाई गई थी तथा मध्य आयु 14 वर्ष पाई गई थी, (5) एक उच्च अनुपात में अर्थात् 166(68.3%) लड़कियों द्वारा मासिक स्राव—पूर्व के लक्षण अनुभव किए गए थे, (6) जांच की गई 230 लड़कियों में से 105 लड़कियों में खून की कमी पाई गई थी, (7) उनमें से अधिकांश अर्थात् 197 (86.7%) लड़कियों को इस बात की जानकारी थी कि शिशुओं के लिए माँ का दूध ही सबसे अच्छा आहार होता है, (8) कामवृत्ति और प्रजनन के बारे में जानकारी बहुत कम थी, (9) बहुत कम अर्थात् 47 (19.34%) लड़कियों को गर्भनिरोधक उपायों के बारे में जानकारी थी, तथा (10) उनमें से अधिकतर अर्थात् 208(85.6%) लड़कियों को एच.आई.वी./ एड्स के कारणों के बारे में पता था।

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