The Fifth Pan-Commonwealth Forum

The Role of Open and Distance Learning System in Accelerating Health Care Services: An Empirical Study of the Reproductive and Child Health Programme in India

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THE ISSUE IN RETROSPECT:

In India poverty and unemployment are two major problems, consequently, fruits of economic development have not reached the country – side, particularly the weaker section. During the plans, inspite of massive endeavour by the Government to check exorbitant population growth rate, it still continues to pose an alarming signal in the state of Rajasthan in specific and India in general. It is an accepted fact that the rate of population growth is much higher among rural families corresponding to urban population. Consequently, population explosion has been pushing back our efforts channelised towards planned development and depriving the economy to enjoy full benefit of resources allocated during the process of economic growth.

The Family Planning Programme was started in 1951 as a purely demographic programme. Later on the element of public education and extension was included under it. In the seventies this programme was focused mainly on terminal methods. The intention of the Government was to encourage people through media of information, education and communication. Further, during the VII Plan there was a change in the approach of family planning programme to family welfare programme. Consequently, the health needs of women in reproductive age group, and of children below the age of 5 years on one hand, the other hand to provide contraceptives and spacing services to the desirous couples of reproductive age so as to stabilize population at a level consistent with the needs of national development. The Universal Immunization Programme (UIP) aimed at reduction in morality and morbidality among infants. The Oral Rehydration Therapy (ORT) was started in view of the fact that diarrhea was a leading cause of death among children. Besides, the Maternal and Child Health (MCH) was also implemented in the VII plan. These programmes proved a little beneficial impact and caused a lower degree of positive impact. During the eighties the National Health Policy was formulated. The Primary Health Centre (PHC) through network of infrastructure were re-designed in such a way so as to provide services to the doorsteps of population. The Child Survival and Safe Motherhood Programme (CSSM) was initiated in 1992 and Pulse Polio in 1996.

ANATOMY OF THE REPRODUCTIVE AND CHILD HEALTH (RCH) PROGRAMME:

The National Development Council (NDC) in the IX Plan considered mother and child health issue and gave effective recommendations on the lines of International Conference on Population and Development (ICPD) (1994). The ICPD Conference recommended a unified programme for Reproductive and Child Health with the objective in improving the health status of young women and children. The Programme proposed to help in reducing the costs of inputs to some extent because overlapping – expenditure would no longer be permitted to go on and integrated information would optimize outcomes at the field level. In the subsequent Plan attention was paid for reorganization and restructuring of existing health care infrastructure for delivering mother and child health services. More stress was given to Panchayati Raj Institutions (PRIs) to fix up local accountability of public health.

The programme is to provide to the need based, client centered, demand driven, high quality and integrated RCH services, hence it has been regarded as an integrated programme to serve better for health care of women and children. In the current XI Plan, this programme has inducted Accredited Social Health Activists (ASHA) under the National Rural Health Mission (NRHM) and continues as RCH Phase-II.

Under the programme, one of the activities are directed towards improving institutional deliveries. The Community Health Centres (CHCs) and Primary Health Centres (PHCs) with essential delivery services, where routine night

delivery is very low, are covered under the scheme. For the activity panchayats, are to provide referral transport to pregnant women of poor families for emergency obstetric care in 25 percent remote sub-centre areas. To improve the implementation of the scheme, the referral funds are provided to Auxiliary Nurse Midwifery (ANMs) of sub centres of the concerned Panchayats.

Besides, the 'Dai' Training Programme has been working towards improving delivery services in rural areas. Further, outreach services under RCH Programme have been directed towards awareness generation and improvement in quality of care and strengthen immunization. Different activities like registration of pregnant women, ANC check-up and services and immunization of children are being undertaken under the scheme. If required there is a provision of hiring of contractual staff: ANM, Lab Technicians, Anaesthetists to First Referral Units (FRUs) at CHC/PHCs.

RESEARCH METHODOLOGY AND SAMPLE:

The state of Rajasthan has poor and inadequate infrastructure facilities which stand in the way of its development. The study relates to the eastern belt of Rajasthan and the selected sample districts are Alwar and Bharatpur. In terms of quality of human resource, the percentage of literacy in the state recorded orded 61.03. In the sample districts it was 62.48% for Alwar district and 64.24% for Bharatpur district. Of the total population of the state the share of Alwar district was 5.3% and 3.72% for the district of Bharatpur. In terms of density Alwar had 357 and Bharatpur 414 against the state figure being 165. The sex ratio was much lower corresponding to the state as a whole being 922, this figure had been 887 for district Alwar and 857 for Bharatpur district. In terms of road length in the state Alwar district recorded 4.33% corresponding to 2.29% in the district of Bharatpur.

In the district of Alwar two tehsils Thangazi (villages- Lalpura and Pratapgarh) the other tehsil Kathoomar (village- Tasai and Masari) were surveyed. For the district of Bharatpur Deeg tehsil (Kathera and Konrer) and Kumher tehsil (Ussani and Bharatwali villages) were surveyed. In all 333 beneficiaries and 21 service providers were interviewed, through two schedules: Beneficiary Schedule and Service Provider Schedule framed for the study. For a sound theoretical background, secondary data was also used.

EMPIRICAL FINDINGS:

To what the implementation of the RCH programme has been effective and efficient? It was noticed that Medical Officers occupied the first position followed by ANM in Alwar district whereas in Bharatpur district the services of Male Nurses-II (MN-II) played an effective role in Deeg tehsil. Besides, academic qualification, adequate training and professional qualification acquired by the medical personnel is more relevant. In this regard Bharatpur district excelled to the district of Alwar. The availability of public facilities / utilities, such as communication, television, fax, Computer were available in the sample tehsils of Government hospitals, however the position of district Alwar was seen more favourable than the district of Bharatpur. A number of services, such as distribution of contraceptives, tubectomy, immunization etc. were widely accepted by the beneficiaries, still traditional practices were seen in sample tehsils. However, women were also covered under Ante Natal Check-ups (ANC) and Post Natal Check-ups (PNC) during delivery. Why the respondents did not avail of the services under the programme, mainly due to illiteracy, ignorance, lack of information and difficulty to access the facilities available in the programme. For high infant mortality rate, the fatal diseases such as pneumonia, diarrhea, lack of vaccine for diseases, malnutrition, unsafe delivery were held responsible and lack of trained nurses and midwifery also aggravated the infant mortality rate. The reasons attributed to maternal mortality had been Anaemia, Toxemia of pregnancy, Ante Partum Haemorrahage (APH), Post Partum Haemorrahage (PPH), obstructed labour etc. It is a matter of satisfaction that periodic follow up of the programme was undertaken by the service providers, however, a few cases reported that no follow up was taken up.

Why there had been apathetic behaviour and insincerity of the service providers for the programme? The reasons indicated were: lack of proper facilities for execution of the programme, lack of incentives, appreciation and support from the superiors, over burden of work, no timely payment of Traveling Allowance and Daily Allowance (TA/DA) for camps organized and PRIs (81%) were not cooperative.

The concept of nucleus family has been getting popularity substituting the joint family by single family. Looking to economic constraints, change over in social fibre of the society; keeping a big family is getting away now. Although most of the cases were seen under the family size of 6 members including the couple, but, now preference has been towards small family, comparatively more cases were registered upto 2 children in the family. Still a strong preference for a male child prevails among the total cases surveyed. The 49.35% respondents were illiterate, whereas higher education formed just 4.80%. The awareness about the programme made available by ANM formed

42.04%, 18.91% from HC, and 14.11% from media, indeed more emphasis has to be stressed on Government machinery.

Regarding the magnitude and variety of services available in the programme, the foremost place among services occupied 69.06% for check ups, distribution of medicines 62.76%, oral pills 21.32%, condoms 20.42% and transportation registered 22.22%. In decision making for the programme, the first place was occupied by husband being 66.88%, it was just 13.63% that women could take their decision by own-self. Nearly 90% respondents favoured the programme, they adopted and liked it on its merit. For the last pregnancy beneficiaries were administered Tetanus Toxoid injection (82.88%) and Iron Folic Acid tablets (90.09%). During pregnancy period ANC (3 times) bagged 61.56% check-up by ANM 89% whereas in case by doctors it was just 27.27% and 20% women did not go for check-up.The respondents had adopted the programme, reasons being better health (84.08%), availability of services (90.09%), relief from economic constraint (72.67%), and preference for small family (11.11%). But who mobilized them for the programme? To this context ANM/Doctor were regarded the most active agent which formed 79.29%, unfortunately, Government did not contribute to the desired extent in popularizing the programme.

Where the last delivery had taken place? Delivery at home bagged 49.55%, Govt. hospitals 24.92%, private hospitals 13.81% and PHC registered only 8.41%. As per the medical science for the health of mother and child 3 years interval in between is recommended. It was found that for 2 years age group 45.04%. 2-4 years age group 50.75% and 4-6 years age group the percentage of interval was 2.7. It is, therefore, inferred that women are quite aware of the fact that a proper interval is necessary between current delivery and the age of last child for their health status. It is necessary to record health status of a child at birth - healthy child at birth 19.51%, normal child at birth 58.10% and child weak at birth formed 17.31%.

With regard to Family Welfare Programme (FWP) it was noticed that Tubectomy formed 34.23%, oral pills 27.83% Condoms 25.83%. Besides, there were 32.73% respondents who had not adopted any of the methods of FWP. With regard to common diseases found among children, it was 97.59% for Poliomelitis. Childhood TB formed 74.47%, Diptheria 63.36%, Pertussis 61.26, Tetanus 70.87, and Measles 54.95. It was noted that women were aware about dreadful effects of fatal diseases common among children, hence they had attempted to get their children to go for immunization as a preventive measure against fatal diseases. Besides, it was also found that Vitamin-A solution was administered to children, the percentage was 97.29. Polio is a fatal disease. To eradicate Polio 'Polio Campaigns' have been organized. In the tehsils of Alwar 69.47% respondents held that polio doses were administered to children upto 4 years of age corresponding to, it was 66.96% for sample tehsils of Bharatpur. In fact, Polio Campaigns have been very effective, doses of Oral Pulse Vaccination (OPV) to children upto 2 years of age formed 84.98%.

Why there has been poor health of child and mother? To this effect four reasons were identified: malnutrition 52.55%, lack of proper medical care 47.44%, poor standard of living 52.25% and improper caring at home registered 29.42%. The programme witnessed that 2 visits by ANM 9.30%, 2-3 visits 39.93% and 3-4 visits formed 32.12% by medical personnel. To publicize the RCH programme camps were organized, but the respondents to the tune of 51.35% had no information about these camps.

DIAGNOSTIC APPROACH:

How to make the RCH programme more stronger and effective? To attain better results from the programme and wider acceptance by people, it needs an effective coordination between PRIs and Health System. Besides, more efforts should be mobilized to popularize the programme through boosting awareness among the villagers. Adequate medical assistance as well as regular supply of medicines should be made available only then it may stand on a sound footing and fulfill the aim to eradicate / cure diseases. For health of mother and child proper nutrients should be made available during child bearing / rearing period. The socio-economic constraints have to be taken proper care by the Government. Besides, medical personnel should work towards the optimal use of resources available to their disposal and mobilise them to work with the programme more efficiently.

Further, the medical colleges' should direct students to come forward to cooperate during their free time. Rather, some modifications are required to be incorporated in their syllabi. Active participation in the Government launched health programmes may be made to them mandatory. The duration of training could be for 2-3 weeks which should form a part of their result sheet. Only after completion the training in rural health programmes they may be eligible for declaration of result and award of the degree.

The Non Government Organization (NGO) should actively participate to intensity the programme. The medical personnel should work sincerely to propagate the programme among people and also to divert preferences of the beneficiaries for venue of delivery in Government institutions. Moreover, the medical personnel should convince women about the advantages of delivery at Govt. hospitals instead delivery at home. For wider acceptance of FWP it

is essential that greater emphasis be laid down to the Govt. agency to attain the objective laid down under FWP. It is also true that due to mass illiteracy, the programme has not been able to mobilize the masses to a desirable extent, hence be pulled together towards 'mass education' enabling the common masses to understand the spirit of the programme. Let it enjoy 'People's Participation Programme' rather, merely a Government exercise.

People who are aware of the local conditions, local dialects and local culture may be entrusted the door-to-door publicity work, for more effective and result – oriented than the task is taken by purely external agencies. To improve functional efficiency of the health care system reliable health management information system may be given more emphasis. An integrated network covering health services research, awareness of the community through health education has to be created in a more powerful manner. The PRIs should be entrusted accountability and responsiveness to health needs of the people in local planning and monitoring community resources towards operational efficiency to ensure quality services. Efforts must be channelised to establish more health centres, if not possible in village-wise, may be established on cluster – villages basis. More visits say 3-4 visits in a month must form a guideline to medical personnel – especially doctors must pay at least one visit in a month to villages under their operational coverage, enabling women to maintain healthy status of child at birth and to provide necessary preventive measures against fatal diseases through immunization.

CONTRIBUTION OF ODL SYSTEM TO HEALTH SECTOR:

In India, the networking of ODL system has been mounting. In the initial phase distance institutions were engaged in designing the conventional courses to distance learners. For past a decade a change has been witnessed, emphasis of distance learning institutions has been towards professional and vocational courses. To be contextual, now various open institutions have launched courses related to health sector.

In the country ODL has been an effective system to impart Health Education. To illustrate, Indira Gandhi National Open University (IGNOU), New Delhi has launched a number of courses under the head "Health, Hospital and Child Care Programme". such as: B.Sc. in Nursing (B.Sc. N.), B.Sc. (Hons.) in Ophthalmology (B.Sc. HOT), PG Diploma in Mother and Child Health (PGDCHM), P.G. Diploma in Hospital and Health Management (PGDHHM), Diploma in Family Education and HIV (DAFE), Diploma in Nutrition and Health Education (DNHE) ; Certificate Courses: Health Care Waist Management (CHCWM), HIV and Family Education (CAFÉ). Similarly, V.M. Open University Kota has also introduced Diploma in Nutrition and Health Education (DNHE), Certificate Course in Food and Nutrition (CFN) and Diploma in HIV (DHIV). These courses have been very popular among distance learners and their placements have been done by a number of companies of repute.

FINAL REMARKS:

The RCH programme lacked attachment by people. The resources were not utilized as per the norms, rather mis-utilisation, over lapping of expenditure were noticed. To overcome these problems, fiscal discipline, regular monitoring, fixing accountability could be certain measures. These steps would ensure efficiency, better utilization of resources and put the programme on the right track. Thus, the programme would accomplish better implementation alongwith quick delivery mechanism in the state of Rajasthan.

In fact, the programme has been able to mobilize rural – population, but not to the extent it wanted so. Hence, more efforts are still needed to convince people to regard the programme as their own. The Non-governmental Organisations should also prove effective agency, therefore, they should also take a lead to adopt villages for the programme as per their convenience and availability of resources in their respective area of operation.

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