CHAPTER – VII

OBSERVATIONS, SUGGESTIONS AND RECOMMENDATIONS

In the present study, an attempt has been made to analyze the health status and factors that affect reproductive health of women (aged 15 to 49 years) in Dausa district of Rajasthan. The emphasis in this study has been on the understanding of various issues related to women's health in reproductive years of their lives. The researcher has made an effort to analyze the health expenditure on family in general and on women in particular. Besides issues related to availability and utilisation of health facilities have also been analyzed.

From the review of literature dealt in the first chapter, it becomes evident that there are many studies on women's health, but several questions remain unanswered. Therefore, the following have been objectives of the present study:

- To study government policies (central and state) and programmes regarding women's health and to evaluate the performance of government programmes especially related to reproductive aged women.
- To analyze the availability and utilisation of women's health facilities.
- To study the attitude and awareness of women and health service providers in Dausa district.
- To analyze the relationship of total family income with total family expenditure on family health and total family expenditure on women's health.
- To suggest various measures to improve health facilities and health status of women is also one of the objectives of the study.

7.1. Observations

In this study general health problems refer to short term or seasonal health problems, and other health problems refer to long term health problems which affect both men and women. Specific Reproductive Health Problems (morbidity) refer to diseases of the reproductive system that may or may not necessarily be a

consequence of reproduction. In the present study the following major indicators have been taken into consideration to analyze women's health status in Dausa district of Rajasthan:

Morbidity Indicators

- **Disease Specific Morbidity Rate:** On the basis of available data, out of total patients getting benefits from STD clinics, it has been found that the morbidity among women is higher than men. Secondary data shows that prevalence of STDs is considerably higher among women than men. As the percentage of female patients is almost 75% of total beneficiaries, the government has to consider the matter for broader policy concerns.
- **Percentage of Females Treated in Public Health Facility in Dausa as in-Patients and Out-Patients:** Data on attendance at Public Health Facilities in Dausa reveals that more men than women are treated as out-patients and percentage of women as in-patients is higher than that of men. It is a matter of further investigation to find the causes behind these differences - whether they are due to government policy of institutional delivery or women's ignorance to their health problems due to which they are hospitalized at the last moment.

Health Care Delivery Indicators

In Dausa district, it has been found that there has been no change in health care delivery indicators during the period 2007-2010, such as in the number of health facilities, per institute served area and per institute served population.

Utilisation Rate

- **Antenatal Care:** It is evident that Dausa district is far away from the average of Rajasthan. In accordance to DLHS-3, 60.2% of women delivered in an institution. Except in case of institutional delivery or assisted by any expert, Dausa district performs well. The proportion of pregnant women who receive ANCs in their first trimester is only 25%; it is lesser in rural area as compared to urban area. 12% have their home deliveries supervised by a

Trained Birth Attendant. In Dausa, 27.8% of women made at least 3 visits for antenatal care. The more antenatal visits, higher the chance of the birth occurring in a health facility or in the presence of a skilled personnel.

- **Methods of Family Planning:** Dausa district has only 50% residents who use contraceptives, total unmet need for Family Planning is 20%, of which 6.5% for spacing and 13% for limiting.

Environmental Indicators

There are significant differences in terms of infrastructure in rural-urban areas in Dausa district. Nearly 55% rural areas have electricity and only 4% have access to toilet facilities. As for piped drinking water (which affects women's health indirectly) only 8% of the rural areas have this facility. Public infrastructure investment has direct positive influence on the lives and routine of women.

Socio-Economic Indicators

The socio-economic indicators for women's reproductive health include female literacy rate, sex ratio, age of marriage, dependency ratio, work participation rate, food availability and standard of living. The female literacy rate in Dausa district is 52.33% which is a good increase in the recent decade. There is increase in sex ratio which is good. Sharp decline in decadal growth rate show the success of the governmental efforts to control the population. Decline in child sex ratio presents the status of women in society. Adverse sex ratio presents prolonged neglect of women.

In Dausa district the age at marriage is low. Girls' marrying before the legal age of 18 is 58% which is very high and this has a negative impact on the health outcomes. Female work participation rate was around 36 percent. In rural areas 78% families belong to low standard of living.

Health Policy Indicators

Different goals have been determined in the X plan, XI plan, National Population Policy, National Health Program and Millennium Development Goals for Infant Mortality Rate, Total Fertility Rate, Maternal Mortality Rate and institutional delivery. Dausa is far away from achieving the goals laid out in these plans. The government plans and policies should be designed in accordance with the target of fulfilling it, rather than nourishing the gaps in between. Setting realistic goals will provide a motivation for their fulfillment.

In terms of health indicators mentioned above, the study has focused on reproductive aged women's health status. On analysis of secondary data it has been found that women's health status in Dausa is not satisfactory. The researcher has conceptualized the above indicators to make an in-depth study of the health status of the women in Dausa. Therefore, it also seemed necessary to review the government and state policies for public health. In addition to it, there is an essentiality to study the implementation of these policies with regard to improved health status of women. However, these policies do not emphasize on improving the women's health status. Studying such policies will throw light on actual need for work in improving women's health status.

Implementation and effectiveness of health policies and programmes for women's health

Woman's health issues have attained higher international visibility and renewed political commitment in recent decades. In chapter three, some of the policies National Population Policy 2000, National Health Policy 2002 National Policy for Empowerment of Women 2001, Population Policy of Rajasthan and programmes have been discussed which have been crucial in determining the health status of woman under the National Rural Health Mission and Integrated Child Development Scheme. The major paradigm shift from the earlier target oriented to a Target-Free Approach (TFA) in 1996 and then to a client centered and demand driven Community Need Assessment (CNA) approach (which was later renamed as

Reproductive and Child Health (RCH) approach in 1997) were initiated to translate the promises made at Cairo into policies and programme actions in India.

Women's Reproductive Health Problems other than motherhood attracted special attention of the policy makers. The application of free market concepts to health services decreased the gap in access to health care services between the rich and poor/ male and female. It is appreciable that these are on a path way to decrease the gaps. The policy makers realize that development cannot take roots if it bypasses women, who represent the very kernel around which social changes must take place.

The five-year plans have been paying special attention to women's welfare emphasizing all aspects of their overall status. Many departments have different plans aiming at ameliorating the condition of women, directly as well as indirectly. The ultimate goal is to achieve gender sensitivity in health programmes. Gender mainstreaming in public health means addressing the role of social, cultural and biological factors that influence health outcomes and in doing so, improving programme efficiency, coverage and implementation of such programme is important. Due to limited resources the programmes have their limits.

The National Population Policy 2000 provides an analysis for the high population growth rate. Stabilizing population is an essential requirement for promoting sustainable development. The policy has the key objective to bring down the fertility rate to replacement level by 2010 and to achieve a stable population by the year 2045. The main objective of the revised National Health Policy 2002 has been to achieve an acceptable standard of good health among the general population of the country and has set goals to be achieved by the year 2015.The National Policy for Empowerment of Women 2001 speaks of the declining female-male sex ratio as an instance of gender disparity. The National Policy for Empowerment of Women 2001 committed itself to the elimination of all type of violence against women.

Main health programmes and schemes for women in Rajasthan are Family Welfare Programme, Integrated Child Development Scheme, National Rural Health Mission and Rajasthan Health System Development Programme. In Integrated Child

Development Scheme the adolescent girl child has been taken up into special focus. Efforts have been made to bring down the population growth rate through *Jan Mangal* couples.

Janani Surakha Yojana is another important component under National Rural Health Mission. *Janani Surakha Yojana* is a centrally sponsored scheme to benefit pregnant women. The government has introduced the *Janani Surakha Yojana* to provide comprehensive medical care during pregnancy, child birth and postnatal care and thereby endeavor to improve the level of institutional deliveries in low performing states to reduce maternal mortality.

The field of women's health in India has been full of resounding policies and research silences, misdirected and partial approaches, and insufficient attention to critical issues such as co-morbidity or the reversal of the traditional gender paradox in health. In many ways, these problems in India mirror a global lack of attention to gender equity in health. But the acute nature of gender bias and preference for son in the country has made their consequences even more severe.

Availability of Health Facilities

It is clear that women have a high mortality and morbidity rate particularly during reproductive age. Availability of required health facilities has its importance to improve woman's health status. In chapter four, the researcher has discussed the available health facilities in public and private sectors, which includes infrastructure, human resource and provided services in public health facilities and also the functioning of Non Government Organizations in health services.

In Dausa district public health sector provides its services through Sub Centers, Primary Health Centers, Community Health Centers and District Hospital. There is need to bring these facilities in accordance with the Indian Public Health Standards (IPHS). It is evident that these health facilities are not sufficient to provide health care that is quality oriented and sensitive to the specific needs of women. Special features of public health services are mass healthcare programmes, largely of a preventive and promotive nature like selected disease control programmes, Family

Planning and Reproductive and Child Health programmes (contraception, immunization, Ante Natal Care (ANC), Post Natal Care (PNC), and *janani suraksha yojana* etc.).

As per 2010 data, the projected population of Dausa district on March 2010 is 1606100. According to Indian Public Health Standards norms, there is a requirement of 13 Community Health Centers, 54 Primary Health Centers and 321 Sub Centers in Dausa district. Functioning of different health facilities in Dausa is given below.

Public Health Facilities:

- **Sub Centre**: As on March, 2010, a total of 238 Sub Centers are functional, the shortfall of 83 Sub Centers and the services provided by them are much below the standards set by IPHS. Dausa district in which 90% of the population lives in rural areas, Sub Centre is the first contact point and ANM is the resource person who satisfies the demands for health services of reproductive aged women. A woman faces so many challenges from both demand and supply side. Initially in a Sub Center there are no key persons, especially to provide care counseling for women suffering from Reproductive Health Problems. There is lack of techno-medical knowledge regarding their health needs; even the ANMs and LHVs are not able to well deliver the services to them in a proper manner.

Due to the absence of male health workers at Sub Centers, most of the Sub Centers are running with just one ANM (shortfall of 64). The centers are usually open for half of the day for just two or three days in a week. The ANMs spend their maximum time in field visits followed by record keeping, attending meetings, immunization, clinical work and in traveling.

In this situation the availability of health providers at Sub Centers is more difficult. It is equally difficult to treat all health problems suffered by women. No deliveries take place at these centers. Most Sub Centers are not equipped for deliveries. The success of any health programme depends largely on the well functioning of the Sub Centers.

- **Primary Health Centre**: The numbers of PHCs functioning are 29. PHCs are the keystone of rural health services-a first port of call to a qualified doctor for the female and those who directly report or are referred from the sub-centers. PHCs are unable to perform up to the expected level due to reasons such as non availability of doctors at PHCs, especially the Lady Medical Officer who, even if posted, does not stay at the PHC headquarter and the lack of set standards for monitoring the quality of care.

- **Community Health Centre (CHC):** There are only 8 operational CHCs while total number required is 13. The condition of 8 CHCs, supposed to provide specialized medical care, is equally appalling. In reference to the IPHS norms the vacant posts at the available CHCs in Dausa district are about 75% of surgeons, 88% of obstetricians and gynecologists, 37% of physicians and 88% of pediatricians. There is a severe shortage of specialists, with only 9 specialists recruited against a requirement of 32. Shortage of doctors is more acute in interior areas, Sikrai tehsil being one of them.

There is a provision of First Referral Unit (FRU), but no institution is functioning as a FRU and there is no facility of blood transfusion services. There has been tremendous load on CHCs due to increase in institutional deliveries. For the improvement of women's health and increase in the utilisation of health facilities used by women, it is important to increase the availability of health care providers i.e., an obstetrician and a gynecologist. There are only two gynecologists at Mahwa and Lalsot, while 6 more are needed to be recruited.

- **District Hospital:** The district hospital is the secondary level referral centre for the public health institutions. The functioning of the Dausa district hospital is not up to the expectation especially in relation to service availability, accessibility, quality, the staff strength, equipment and drug supply. District Hospital has one separate operation theater especially for gynecological purpose; laboratories, X-ray and ultrasound, one aseptic labor room, linked with blood bank, has two gynecologists, one anesthetist, two surgeons, two physicians, two pediatricians and

one pathologist. Despite the availability of such facilities there was not even a single cesarean delivery section conducted in 2010.

During the study it was found that mostly women health programmes which were according to the district socioeconomic conditions were implemented very well. However, there are various other issues related to reproductive aged women which need to be addressed. Availability of medicines and support services which mainly include diagnostic needs and MTP are to be ensured at all facility levels.

Private Health Facilities:

The responsibility of the private sector is likely to increase as there is continuous demand for high-quality medical care in Dausa district. Over the years, the private health facilities have spread much largely than the public sector. Concentration of private health facilities (where assurance of some technical personnel is possible) is in those places where already some infrastructure is established. Private health care is found to be inadequate and unreliable in meeting the huge demand of women's specific Reproductive Health Problems.

Private hospitals which are registered or are not registered in Family Welfare Programmes provide services to improve women's health. In Dausa three hospitals (Shyama Devi hospital, Kesar Devi hospital and Krishana hospital) which are registered under the Family Welfare scheme doctors with gynecologist are functioning.

Sometimes the doctors provide inaccurate treatment like removal of uterus on a complaint of stomachache or lower abdominal pain. The private sector is not adequately regulated and recorded. All types of health service providers provide medical services whether qualified, semi-qualified or unqualified. It has been found that the service quality and the standards are not up to the mark and the quality of services vary from place to place and from provider to provider; and it is far from satisfactory level. It indicates that improvements are required to achieve high-quality health care services in the private sector and increase loyalty among patients.

Inadequacies in the existing health infrastructure have led to an unmet need of health services, and there is an obvious gap in coverage and outreach.

Non Government Organizations (NGO):

Role of NGOs is more important due to scare government resources. Programmes implemented or supported by these NGOs have grave concern of its proper implementation. In Dausa district, NGOs are involved in the department's programmes in mobilizing resources to develop reproductive health awareness through awareness camps. NGOs involved in training of ASHA Sahayogini and Skilled Birth Attendant and are also working for Family Welfare.

Voluntary Health and Sanitation Committees are making conscious efforts to generate awareness in rural population to control these health problems caused due to unhygienic living conditions. Through Smile foundation a massive campaign has been started for the promotion of the use of sanitary napkins. Health service providers and users complained about the quality of these napkins and demanded improved quality. To recognize the special needs of adolescents, a meeting in a week is held with adolescents to make them aware towards their own health. But in Dausa district adolescents do not actively participate in these meetings. It is obvious in the socio-cultural set up of Dausa. These initiatives are good and NGOs have to do a lot for improving poor health status of women in Dausa district.

Utilisation of Health Facilities by Women

In chapter five, association between variables has been analyzed with the help of Chi-squire test to understand the utilisation pattern. It has been found that women in Dausa face many health problems, sometimes these health problems are not as much serious or not life threatening so they take it as a part of life.

Self reported health problems are collected and divided broadly in three categories, namely Reproductive Health Problems, General Health Problems and Other Health Problems. In Reproductive Health Problems, white discharge, menstruation related problems, pregnancy, DNC, infertility, miscarriages and under nutrition are included. 30% cases are in this category. 53% cases report General

Health Problems which include gastro intestinal problem, fever of any type, diarrhea, dysentery, cold, skin diseases, eye ailments, accidents, aches, pains (headache, body ache, stomachache etc.) and long duration illnesses such as diabetes mellitus, blood pressure, psychiatric disorders, diseases of joints and bones, tuberculosis, cardiovascular diseases 17% cases report this type of Other Health Problems. Main findings of the household survey and focused group discussions with women can be summarized as below. Statistical test was done on 95% confidence level:

- From the responses of 566 ailing cases it has been found that area and health problems are not statistically significantly associated when health problems are taken in broad three categories. But when taken separately, they show significant statistical association between these two variables. General Health Problems are highly prevalent in rural and urban areas. Febrile illness and undiagnosed ailments are more specific to urban areas; while gastro intestinal problems are more prevalent in rural areas. Reproductive Health Problems are dominant in rural areas due to poor and unhygienic living conditions.

- It appears in the study that disease pattern is gender specific. There is a statistically significant association between gender and health problems - whether taken in categories or separately, the results are the same. The morbidity among women are higher than that of men; especially, the Reproductive Health Problems, lack of knowledge regarding body and safe sexual life, birth control measures being the primary reasons.

- It has been found that percent of utilisation and non utilisation of health facilities is almost equal in rural and urban areas; that is, 77% utilized and 23% not utilized health facilities for their ailment.

- There is a statistically significant association between gender and utilisation/non utilisation of health facilities. It is evident that the case of non utilisation of health facilities by women is greater than their male counterparts. It is seen that non utilisation of health facilities in case of Reproductive Health Problems is significantly high among women constituting 32% of the ailing cases.

Women continue to ignore their deteriorating health condition till it becomes life threatening. Lack of education, financial resources, required health facilities, exposure to media with shyness, high preference to family care, low value in family and self esteem and ignorance about the value of own health are a few of the reasons why women avoid medical care.

- Non utilisation of health facilities is much higher in case of eye ailments, white or any other vaginal discharge, psychiatric disorder, menstruation related problems, dizziness, weakness, low body immunity, disease of urinary system and undiagnosed ailments. Whereas in case of tuberculosis, jaundice, diabetes mellitus, accidents, injuries, fractures, diarrhea, dysentery and fever utilisation of health facilities is almost 100%. In case of health problems like febrile illness, cold, cardio vascular diseases, DNC, infertility, miscarriages treatment has been utilized by 90% ailing cases.

- There is no statistically significant association between area and utilisation of different health facilities. The study shows that utilisation of health facilities is not affected by geographical factors. The use of medical care is determined by the kind of health problems and not by the area. It is highly influenced by psychological factors. It is embedded in the attitude of the people to seek medical attention only in acute sickness. Health facilities include Public Health Facilities, Private Health Facilities, Untrained Practitioners and Chemists.

Out of 456 rural ailing cases, 23% do not utilise any health facilities, 27% give preference to Public Health Facilities, 30% go to Private Health Facilities and 13% go to Untrained Practitioners and 7% to Chemists. In urban areas, out of 110 ailing cases those who utilize health facilities constitute 31% from Public sector, 34% from Private sector, 5% from Untrained Practitioners and 6% from Chemists.

- It is evident that health problems have significant effect on the type of utilized health facilities. Cases of non utilisation of health facilities or utilisation of Private Health Facilities are almost equal. Out of the 566 ailing cases, 181 had Reproductive Health Problems and out of them 34% do not utilize any of the above

given health facilities, 23% give preference to Public Health Facilities, 33% go to Private Health Facilities, 6% utilize Untrained Practitioners and 4% consult and take medicines from Chemists.

- In all, Public Health Facilities are more utilized in jaundice, diabetes mellitus, tuberculosis, pregnancy, diarrhea, dysentery, cardiovascular diseases. Whereas, Private Health Facilities are frequently used by the ailing persons for DNC, infertility, miscarriages, accidents, injuries, fractures, blood pressure, cold etc.

- It is evident that in urban and rural areas the main reasons behind the non utilisation of health facilities are financial (50% cases in urban and 35% in rural areas) and the non serious attitude towards illness.

- In Dausa district, deficient financial resources is the main reason for men (39%) and women (37%) and non serious attitude towards health (31%) is also an important reason for non utilisation of health facilities for women.

- In the field survey, it has been found that almost 80% of women suffer from white or any other kind of vaginal discharge problem in varying degrees. There is no significant difference in utilisation of Public (17%) and Private Health Facilities (15%) for the treatment of these health problems. People have the general perception that discharge is not a health problem. Generally, utilisation of health facilities depends on the availability of health facilities and the cost of the treatment.

- Public Sector is preferred over Private Sector for health services, because of the free medical services provided particularly for pregnancy. But Sub Center and non-Sub Center villagers are discouraged from using free government facilities due to the costs that occur in the form of transportation, accommodation, food and beverage etc.

- It is evident that recognized health facilities and confidence on health facilities or on health service providers play an important role among the urban respondent in this study. Rural respondents consult health facilities mainly on the

basis of confidence on health service providers and recognized health facility. Distance is also an important factor for rural as well as urban respondents.

- Faith on the health service providers is the most important reason for women. 28% women prefer those health service providers, where women are safe and secure and they get the rational treatment which is beneficial for them. The recognised health facilities are also preferred by women because the general opinion about these facilities is good and this is due to the availability of specialists and modern technological facilities.

- Confidence on service providers is one of the major factors in choosing a particular health facility in rural areas. On the other hand, urban respondents are inclined towards recognised health facility. It might be better awareness and high level of literacy around urban ailing persons.

- Along with lack of awareness about their diseases which require medical services, acceptability of service providers, family support, service quality as perceived by women are the main reasons for the non utilisation of health facilities. The survey has also examined the reasons for the non utilisation of health facilities and found that non serious attitude towards illness and financial constraints are the most important reasons.

- It is evident that the shortage of the Public Health Facilities and services are the main reasons for neglecting health care needs of poor women.

- Apart from distance of the Public Health Facilities from their residence, credit facility is another reason which affects selection of service provider. In those villages where availability of Public and Private Health Facilities are scarce, villagers prefer Untrained Practitioners because they provide them treatment on the basis of delayed payment. They treat their patient according to patient's psychological satisfaction like drip, injections, etc. One of the most important reasons to utilize their inappropriate treatment is that it is made available at the

patients' homes as and when they require, and in return they pay for it when they have money in their pockets.

- People take treatment from different health providers simultaneously because they require quick relief. They utilize medicines from chemists for fever or seasonal ailments. Poor people avoid Public hospitals in these ailments because of the non availability of free medicines and also the burden in payment of Rs. 2 in the form of registration fee.

- Illness affects women's productivity as well as their efficiency to work. Attitude and awareness of women and attitude of health providers towards women's health is very important; but, unfortunately it is usually ignored by all.

- People are reluctant to go to government health facilities because of the poor infrastructure, dissatisfaction with the doctors and the non-cooperation from the staff.

- Increased community awareness of routine immunization, acceptance of ANCs and growing perception about PNC services is almost universal, but for poor rural villagers lack of cheep or free transportation facilities for pregnant women, and opportunity cost in form of loss of wage force them to home deliveries.

- Reproductive aged women have their concentration on special needs. They demand guidance and help to adopt a healthy lifestyle. If there is proper counseling on health issues like nutritious food for good health, hygiene and sanitation, use of different contraceptives for spacing and limiting the birth and regarding unwanted pregnancy then RTI/STI and further effects can be prevented.

- The ailments arise due to lack of knowledge, false knowledge, unhygienic living conditions, socio-cultural taboos, culture of silence, lack of proper health care facilities in easy reach, lack of sanitation and financial resources all of which influence the health status of women to a very large extent.

- Reproductive Health cannot be a substitute for a women's health programme, it is only a component of it. Reproductive Health Problems are common among women and they have serious consequences on their health. Illnesses due to complications of pregnancy, childbirth, unsafe abortions, unsafe deliveries, diseases of reproductive tract, effects of harmful contraceptives, are the major causes of ill health of women. Women face more obstacles in acquiring good health because men are not sensitized to their needs.

Responses of Health Service Providers

- According to health service providers 80% ladies suffer from problems like discharge of any type, menstrual problems, dizziness, weakness, headache, body ache, backache, stomach pain, lower abdominal pain etc. due to unhygienic conditions during menstruation, unsafe and unhygienic sexual relations, delivery in unhygienic conditions, lack of nutritious diet etc.

- Comprehensive health education is required for women; majority of young women and adolescents lack knowledge and continue to be moulded in superficial traditional values that aggravate the already deteriorating health. Various misconceptions act as obstacles in utilisation of health facilities and nullify all efforts taken by the government in this direction.

- There is lack of encouragement and incentives for good performance because government is interested only in sterilizations and record keeping and nothing else.

- Social factors play a dominant role in how well, how much and when these services will be utilised. Hence, it is not only about making the facilities available but more to do with educating people on myths related to their use. Several reasons behind poor health status of women are rooted in the women and their families' attitude. Dausa has a large population of SC, ST and SOBC who have their own strong culture, strong mental and attitudinal set up. Sexual differences in male and female are universal but socially promoted differences between men and women are the main cause of the poor health status of women.

- Apart from this, some other important aspects are lack of education, financial resources, appropriate health facilities in rural areas, technical persons at the grass root level, government policy concerns to their specific health needs, and excess burden on Public Health Facilities- all result in low quality and inefficiency of services which indirectly affect the health status of women in Dausa.

- Health service providers have many complaints such as paucity of equipment, drugs etc. and most importantly, lack of referral back-up. The health workers were of the view that all these factors lead to people losing faith in the Public Health Facilities.

- Most of the service providers had a view that due to their over busy schedule they are not able to provide health services effectively and timely and this has also distorted their image in the eyes of the local public. They have to cope with the rush in Public Health Facilities and their duty towards performing the National Programmes.

The social, economic and political reasons pooled adversely affected healthcare seeking and providing behavior cited: location of the health institution, lack of community-friendly component in health services and resources, poverty, high healthcare cost, political interference etc. are the dominant issues. Even for very basic health problems they relied solely on Private Health Services because of non availability of specialists in the Public Health Centre. Women's health is greatly affected by the ways in which they are treated and the status they are given by society as a whole. Women's awareness and community support remained the key factors in improving the status of women's health.

Family Health Expenditure

Chapter six deals with ratio analysis to find the income share of health expenditure in a family, share of women health expenditure in Total Family Health Expenditure, Correlation between Total Family Income and Family Health Expenditure/Family Health Expenditure on women, Regression Analysis to find the

relationship between Total Family Health Expenditure/Total Family Health Expenditure on women and age, area, marital status, education, duration of illness. Major findings are given as below.

- It has been found that in Dausa district, in the lowest income group, 58% families spend more than 5% of their income on health care. High proportions of expenditure on health by families at a very low level of income suggest that the poor families are forced to spend more on health care services due to lack of financial resources which leads to their weaker health status and thus higher frequency of falling ill.

On the other hand it is evident that higher income family's health expenditure is 1%. Although health expenditure can affect health conditions, but for low income group families, even relatively small expenditures on health can be financially disastrous. In this condition, deficient financial resources are used for basic needs and they are thus less able to cope with even very low health expenditure compared to richer households.

- Though the proportion of income spent on health expenditure is higher in poor families in comparison to rich families but the absolute amount on health expenditure is high in rich families and low in poor families.

- Free government health services are available to poor people but they are not fully used by them due to non availability of physical, technical and human resources in public health facilities. Majority of people use public hospitals for maternal or obstratic health services as they can escape from the huge hospital bill levied by private hospitals as well as for the fear of inappropriate treatment.

- Out of 290 families, 34% families' 100% health expenditure is only on women, 9% families' women health expenditure is more than 90%. In all the income groups 50% to 60% families' health expenditure is on the women. On the other hand, 14% to 30% families have zero expenditure on women health problems. We

have two extremes here showing maximum and minimum expenditure both on women's health.

Reasons behind maximum women family health expenditure is approaching for the treatment only when the health conditions are serious and minimum being the non-serious attitude towards the ailment. A number of women have some or the other ailment but they do not take it seriously until it is aggravated.

- The reasons for income wise differences are very complicated. Probably quality and quantity of publicly provided health care that is available in Dausa is low and not sufficient, resulting in a higher reliance of households on the private sector. High cost of treatment is bearable by high income groups but not by low income groups. Poor households are less likely to seek care when they become ill, the prevalence of illness is higher and the severity of illness is greater in low income group then in high income group. The severity of illness suffered by poor people is because they delay the use of health facilities.

- In all the income groups, especially the poor prefer Public Health Facilities if required services which are demanded by them are available, otherwise they avoid getting treatment or they prefer to go to Chemists for some remedy to make them ready to work. In the higher income group men as well as women prefer private practitioner/hospital due to their proper concern or family tradition.

- After free government services, more than 60% families spend maximum on women's health in all the income groups. This indicates that in reproductive age group, women require more health services due to more health problems.

- Multiple Regression equation explains 15.4% variation in TFHE (at 99% confidence level) from given variables, in which family expenditure on women, age and education show negative relationship and TFI, area, marital status, household size and duration of illness show positive relation.

- TFI, duration of illness (at 99% confidence level) and area (at 95% confidence level) have been found to be statistically significant determinants of TFHE.

- On the basis of gender we can say that TFHE on women is lower by Rs. 1085 in comparison to men.

- Education decreases the TFHE because of better understanding of nutrition, sanitation, and cleanliness etc. Duration of illness also increases the TFHE.

- Multiple Regression equation explains 16.6% variation in TFHE on women (at 99% confidence level) from given variables, in which age and education has negative relationship and TFI, area, marital status, household size and duration of illness have positive relation.

- TFI, duration of illness, area, and marital status (at 95% confidence level) are statistically significant in case of TFHE on women. In this model education and household size have been found to be insignificant.

- As age increases health expenditure decreases because pregnancy related requirement are fulfilled in early age. After that, as age increases they avoid health expenses especially on Reproductive Health Problems. In rural areas comparatively long distance of health facilities from their residence results in indirect cost of treatment in the form of transportation and associated charges. Apart from this, repeated utilisation of inappropriate treatment by untrained practitioners due to easy availability is also one of the factors which have increased TFHE on women. The model also suggests that TFHE on women increases with the level of TFI.

7.2. Suggestions and Recommendations

Better quality of public services would have a higher utilisation rate and also cost cutting for women, especially the poor. This is very important from the policy point because unless the public is satisfied with the provided public services they do not utilize these facilities even if they require health services, and obviously efforts

made by the government would be wasted. Policy makers should address factors responsible for the spread of diseases as well as the socio-cultural dimensions of women health. More innovative and systematic intervention is required.
Some recommendations are as below:

- It is recommended that the level of public expenditure on health should be enhanced considerably. Most of the policy documents including National Health Policy (2002) and the National Rural Health Mission (2005-2012) have recommended increasing health expenditure to around 3% of GDP. This recommendation should be adopted with immediate effect.

- To reduce gap between rural-urban regarding health services. The pace of implementation of the National Rural Health Mission should be speeded up so that the access to health services by the rural people in general and poor in particular gets improved.

- For improving the quality of health services on priority basis, the government should fill all the vacant posts of medical personnel particularly doctors and nurses, improve the quality of infrastructure and availability of medicines. In order to improve reproductive health indicators it is necessary not only to ensure that 100% of villages are covered by Sub Centers but they also have adequate medical supplies, and technically sound manpower.

- Private sector has emerged as the major provider of health services in Dausa district. With a view to control private sector on account of price, quality of services and unethical practices, it is recommended to evolve an effective regulatory mechanism.

- There is also a need for gender specific resources and capacity-building efforts. Improved gender sensitivity could be achieved by adopting a proactive approach towards achieving gender balance within the social system.

- Recommendations include the improvement of infrastructural facilities at the PHCs, continuing medical education for PHC doctors and ANMs, improving stocks of medicines at PHCs, and a re-evaluation of the links between emoluments and quality of care delivered by medical and para-medical staff.

- It is suggested that the image of Public Health Center services in the minds of the community be improved. This study indicates that we are far short of meeting reproductive health care needs in every sense.

- There can be different types of awards emphasizing different aspects of the quality of healthcare service like cleanliness, cure, disease control, patients' satisfaction, etc. to motivate the health service providers. All such awards should be distributed among the relevant staff in the winning health facility.

- The public-private partnership is also expected to improve the efficiency of health care delivery system, while the optimum utilisation of the existing infrastructure would help improve the health status of women.

- The availability of reliable datasets relating to key social, economic, demographic and health indicators is crucial for planning and monitoring of area specific developmental goals.

- Premarital and marital counseling may reduce the misconceptions of reproductive aged people and overcome the related health problems. Limited knowledge of reproduction, contraception, family planning, dietary intake during different phases of body development or lack of it because of no permission to open discussion on it, women automatically suffer which affects women's health. Proper counseling services for men and women may overcome the problems.

- The findings indicate that government policies do not have a significant influence on the health status of women at large. Lack of awareness and hesitation to avail these facilities is one of the root causes of the existing poor condition of women in rural area. So government has to concentrate on it.

- Lack of information is the major barrier to effective access to services. It is suggested to intensify Information Education Communication activities through *helakhyal, nukkarnatak, chaupals,* etc especially for those people who are not well connected with media, focusing on the benefits of the government run programmes with special attention to clearing the myths and misconceptions rooted in cultural practices. Different agencies should be involved to raise awareness among the illiterate people of the region.

- ASHAs have poor knowledge about JSY related concepts, components and provision. All recruited ASHAs, AWWs and ANMs should be trained within a time frame so that the services to reproductive aged women's reproductive health problems are treated in more user friendly manner. The above three are close to rural villagers and they are frequently sought for health problems. For awareness generation and greater utilisation of health facility, the role of these three 3 As (ASHAs, AWWs and ANMs), role is the most important.

- Health facilities should be upgraded and strengthened according to IPHS norms to meet the increased public needs because effective implementation of government programmes is only possible when these decided norms are achieved in actual sense and not on papers. The government should take adequate steps to improve the facilities of the existing rural health care services both quantitatively and qualitatively by opening more rural based health centers with sufficient health staff which will enable the people to get enough health care services.

- Early marriage and early pregnancy are rooted in social backwardness which can be changed only through social changes and better education especially for women.

- Men's role in Family Planning should be stressed.

- Many doctors and other key staff do not stay at the place of posting and hence are not available to provide services most of the hours during the night and at

times also during the day. Investments made on buildings and equipments do not provide adequate returns as they are under used due to unavailability of services.

The results of the study point out that gender issues have become central in policy arena. Many efforts have been made at International, National and State levels to move towards better women's health status. Hence we can conclude that education in general and women education in particular must be encouraged in rural areas, because it breaks the vicious circle of less financial resources, unemployment, decision making, social bottlenecks etc. gradually. Village-level meetings to interact with women, educating them and clarifying issues related to Mother and Child Health care are recommended.

The Rajasthan government has passed the budget for 2012-13 in which many new initiatives have been taken. In the entire state a new scheme namely *Mukhya Mantri Nishulk Dava Yojana* has been started to improve the health status of people. It is a very good scheme, in which more than 200 essential medicines are freely provided as and when required. There is a remarkable response among all the people towards the scheme. To promote safe deliveries of babies and to ensure the safety of mother, the state government has also started Rajasthan *Janani Shishu Suraksha Yojana*. In this scheme free medicines and free investigation facilities are provided at government-run hospitals. Free food and free transport from their homes to the hospital and back is also provided to them.