Primary Health Care

Please use the health services – more and more
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A project in Kheda district, Gujarat, India, has been designed to improve the utilization of health services through an educational drive at the grass-roots level, in which a key role is played by women recruited from the local population and trained to serve as village family welfare workers. Substantial progress has been made, although much longer than the project’s planned duration of three and a half years would probably be required for the gains made to be consolidated and the full potential realized.

In India the national health care services are not reaching their programme goals because of poor utilization. Provision and utilization can only be brought into balance if there is an understanding of people’s health-seeking behaviour and the felt needs of communities. In 1992 this realization led to the introduction of an educational project in 30 villages of Kheda district, Gujarat, where there was already a well-established network of primary care centres. The intention was to create a demand among villagers for measures that would lead to improved health, in particular contraception and immunization.

In the long term the main objectives were that family size should be reduced and that the people’s quality of life should be raised. More immediately the aims were to:

- bring about an increase from 48% to 73% in the use of modern family planning methods;
- reduce the mortality rates of infants and of children aged under five years to below the country’s rural averages;
- sensitize, motivate and improve the capabilities of students and faculty members in the Pramukhswami Medical College and of personnel in the primary health care system with a view to achieving an integrated approach to family welfare;
- raise the status of women.

The project was undertaken by the Charutar Arogya Mandal Trust, a nongovernmental organization, and financed by this body together with the United Nations Population Fund, the Australian International Development Assistance Bureau and the Indian government. It sought to utilize the infra-

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structure of the district’s milk cooperatives in order to generate a demand for family welfare services in the general population through a programme of home visits, group discussions, debates, demonstrations and video films.

**Village family welfare workers**

Women serving as village family welfare workers are the key persons in the project. They are selected jointly by the milk cooperatives and the Faculty of Community Medicine in the Pramukhswami Medical College and are trained by the Faculty and the Tribhuvandas Foundation, another non-governmental organization. When making home visits they give advice on:

- family planning in relation to maternal health;
- safe delivery;
- immunization, nutrition, personal hygiene, oral rehydration therapy and other factors affecting child survival;
- the desirability of having small families;
- the education of female children to an adequate standard;
- not marrying at too young an age;
- delaying first deliveries;
- child spacing.

With the support of their supervisors, called village organizers, they also conduct group meetings of up to nine women.

Drawn from the communities and presenting their views in a non-coercive way intended to create a demand for services, they have gradually gained the confidence of the people. Villagers often ask them to solve problems relating to illness, family and marital life, property disputes, contraception, and so on. To an increasing extent, project staff are being approached by workers in primary care centres for help in devising motivational activities related to family planning.

The village family welfare workers can be consulted throughout the day and night, and basic drugs are also available at all times. An example of what can be done occurred recently, when these workers were asked for advice on the control of scabies. The matter was put to the project and primary care personnel, and a successful outcome was achieved through efforts involving the project, the primary care system, voluntary agencies and interns.

**Central team**

A central team, based at the medical college and comprising a nutritionist, a video technician and a doctor as project manager, makes scheduled visits to the villages, where the following activities are performed:

- the preparation of cheap, simple, locally acceptable and nutritious meals is demonstrated;
- short films on health education are shown on video;
- group discussions and motivational meetings are organized.

Initially the films were obtained from the government of Gujarat; later, films of more direct relevance to the project, made in Kheda district, were introduced. The subjects covered are:
- limited resources and the population explosion;
- the economic benefits of having small families;
- delayed marriage and childbirth;
- the adverse effects of early pregnancy and repeated pregnancies on bonding between husband and wife;
- mistaken notions about contraceptives;
- the functions of the reproductive organs;
- childbirth;
- immunization, contraception and other matters connected with family welfare, as discussed by groups of women.

The central team also provides support for the village workers by answering their queries and providing training or retraining.

**Interns**

On a rotational basis, groups of six to eight interns from the medical college voluntarily accompany the central team for periods of a month and participate in all activities associated with the project. Some groups of interns have made video films on problems affecting the family welfare programme, and these have been well received by the villagers.

This involvement has exposed and sensitized the interns to the behaviour of villagers vis-à-vis the provision and utilization of services and has helped them to relate theory to practice.

**Constraints**

The principal difficulties affecting the project are outlined below.

- A major effort was necessary to convince the milk cooperatives of the value of the project before their participation could be secured.
- A major effort was also required in the education and training of the village family welfare workers.
- Power cuts in some areas led to the cancellation of film sessions, consequent annoyance among villagers who had wished to attend, and setbacks in health education.
- Because the maintenance of records was difficult and excessively time-consuming for the village family welfare workers, an effort was made to simplify the procedures to the greatest possible extent. In some villages, however, it was necessary to ask the village organizers to perform the task of record-keeping.
- The project was scheduled to last 42 months, yet up to 30 months were required to train the village family welfare workers. This meant that its full potential was unlikely to be realized. Probably at least 10 years are necessary for attitudes to change sufficiently and for adequate development of the demand for services. Much time is also required if such programmes are to become self-sustaining.
- It was hard to maintain the enthusiasm of the village family welfare workers, the village organizers and the milk cooperatives, largely because of the indirect nature of the benefits accruing from the efforts in health education. Furthermore, the slowness of the gains made it difficult for the general public to appreciate them.

**Provision and utilization can only be brought into balance if there is an understanding of people's health-seeking behaviour and the felt needs of communities.**
Improvements

Notwithstanding the problems indicated above, the project demonstrated that motivated and informed female health workers, leading to improved utilization of those already available and encouraging health programmes to respond to felt needs.

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with roots in the rural communities they served, could win the trust of the people through sustained educational endeavours. In this way a demand for services was produced, Movement towards optimal benefit from financial, human and technological resources undoubtedly occurs when such a situation is created.

Acknowledgements

The authors are grateful to the United Nations Population Fund, the Australian International Development Assistance Bureau, the Tribhuvandas Foundation, the Charutar Arogya Mandal Trust, Pramukhswami Medical College, the government of Gujarat and the government of India for assistance in the project described in the present article.

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Diarrhoea

Diarrhoea is a leading cause of illness and death among children in developing countries where an estimated 1.3 thousand million episodes and 3.2 million deaths occur each year in those under five years of age. Overall these children experience an average of 3.3 episodes of diarrhoea per year, but in some areas the average exceeds nine episodes per year. ... Diarrhoea is an important cause of malnutrition. This is because patients with diarrhoea eat less and their ability to absorb nutrients is reduced; moreover their nutrient requirements are increased as a result of the infection. Each episode of diarrhoea contributes to malnutrition; when episodes are prolonged their impact on growth is increased.