2. Review of literature

Review of Literature

(Gautham et al., 2011): The study demonstrates that the rural population seeks their primary level health care outside public health care system and is not doctor-centric. A proximate health care provider, available at any hour of time, responding to phone call and providing quick fix to their health related problems at lower cost without diagnostic tests, involving no transportation cost was the first choice even if such health care providers were not qualified and skilled. The study also found that such health care providers were Non-Degree Allopathic Practitioners (NDAPs). The tribal sought less help from traditional healers than non-tribal. Interestingly NDAPs and qualified doctors worked as complement to each other.

(Ahmad et al., 2010): In India 20% of maternal deaths is due to anaemia. The study was conducted in the Maternity Clinic of Pravara Rural Hospital (PRH), Loni, Ahmednagar, Maharashtra. Only pregnant women who were 12-20 weeks of conception were included in the study. The study found that 75% of women were anaemic. Mother’s age, educational and socioeconomic status, religion, and Body Mass Index (BMI) were significantly associated with anaemia while family structure and size, dietary habits were not significantly associated with anaemia.

(Phalke et al., 2006): The study was undertaken in area of Jakhinwad, a village in Maharashtra to examine practice of Self Medication. Self-Medication was defined as “Medication that is taken on patient’s own initiative or on advice of a pharmacist or lay person”. All 515 households of the village were included in the study. Heads of the families were interviewed using pretested questionnaire. It was found that 81% of the respondents were practicing self-medication. Various reasons observed for practicing self-medicine were: financial constraints, non-availability of health care facility, advertisement of medicine and chemist’s shops. The article in its concluding remark states that although WHO promoted self-medication due to inaccessibility and lack of affordability of health care services, its adverse effects should also be assessed.

(Chaturvedi et al., 2007): This study was undertaken in the rural areas of Ahmednagar district in Maharashtra in 2006 to review the maternity services under public health system.
Fourteen health centres and 3 rural hospitals were selected. The study used 3 questionnaires in the format prescribed under the Right to Information Act of the Government of India, 2005. It was found that in 21% of cases, no iron supplement was available, district headquarters did not receive iron supplement from higher authority and majority of deliveries took place at home and at private health care system. Emergency obstetric care services did not exist. Thus NRHM (National Rural Health Mission) intervention is required to address the issue of safe motherhood.

(Kermode et al., 2007): The paper documents the study undertaken in rural Maharashtra with 3 main objectives 1) To explain the factors contributing to mental illness to 32 women respondents associated with Primary Health Care (PHC) in this study. 2) To identify causes of depression, suicide, violence and review the existing and potential community level strategies to handle them. 3) To explore the impact of the PHC program on individuals and community. The perception of respondents was that the mental health was the outcome of socio economic and cultural factors. Poverty, conflicts with spouse and in-laws, violence etc. contributed to mental illness. Empowerment of women can be ensured by education, employment, no discrimination to caste or sex and promotion of mental health of an individual and of the community.

(Atre et al., 2009): This paper tries to address the stigma associated with TB. A sample of 160 non-TB respondents was observed which included 80 men and 80 women. The respondents were made aware of symptoms of TB and drew their attention to stigma associated with the disease. After interaction with respondents it was found that the fear of being socially isolated results in hiding of the disease. As compared to men women were more vulnerable. The most common concern among TB patients was marital problems. The study concluded that community based intervention is required to address irrational isolation of the patients of TB so that early detection of the disease and timely medical treatment can be ensured.

(George et al., 1993): The article compares some of the indicators such as 88% of hospitals and 91% of dispensaries in Maharashtra are in urban area while 85% of dispensaries in Punjab are in rural area, Bed ratio : 1:5096 in rural Maharashtra , 1:1596 in rural Punjab, 1:520 in rural Kerala. Maharashtra and Punjab both lead in per capita income and economic growth while Kerala with its low per capita income leads in Infrastructure. Maharashtra is
plagued by urban-rural divide, commercialization of health care delivery and lack of control
and regulations on private health sectors.

(Pokarel, 2000): The article evaluates the outcome of decentralization of health services in
India (Kerala), Nepal, Bangladesh. Unlike many other countries, in Nepal, Village
Development Committees spend Rs.5, 00,000 (as allotment by Government) according to
local needs. Kerala launched “People’s Campaign for Decentralised Planning” to bring about
devolutionary reforms in institutions. In 9th – Five Year Plan Kerala is considered best model
for empowering local government.

(Duggal, 2005): The article points out that the poor had to pay for medical treatment by
borrowing loan from market. The article focuses on inadequate budgetary allocation (17%) to
NRHM in 2005-2006 while 83% of funds were allocated to AIDS/HIV, AYUSH (Ayurvedic,
Yoga, Unani, Siddha and Homeopathy Systems of Health), RCH (Reproductive and Child
Health) and Medical education.

(Datar et al., 2007): In India, large number of rural children is not being immunized under
Universal Immunization Programme which is 100% centrally sponsored programme. According to study of 43,416 children, higher rate of immunization was achieved if hospitals
and Primary Health Centres were located within 2-5 km of distance. It was also found that a
boy child was more likely to be immunized than a girl child. Educated mother was more
likely to get her child immunized than illiterate mother.

(Banerjee et al., 2004): The paper describes the status of healthcare delivery on the basis of
the study conducted on 100 families, largely consisting of the tribal population with high
incidence of female illiteracy in Rural Udaipur. According to the findings of the survey, the
people rely more on private healthcare facility (by paying Rs.84/visit) and on traditional
healer called ‘BHOPA’ (by paying Rs, 61/visit) rather than on public healthcare facility (by
paying Rs.71/visit, actually it should be free) .The rich visits public healthcare more than the
poor. The sub centres were largely found to be deficient in their services due to high
absenteeism and low quality of medical service.

(Tiwari, 2010): This paper describes a healthcare delivery model based on mobile
technology as an information transmission tool between rural patients and centrally located
providers. A hand held device was designed to capture health information. This device
supported biometric identification of all users, thermal printer, smartcard reader and writer and USB ports for connecting external diagnostic devices. The data collected by these mobile devices got accumulated on web based EMR (Electronic Medical Record) that could be remotely accessed and served by the doctors. The printer attached to device allowed printing of authorised prescriptions, collection receipts and referral notes. Linkage with financial services facilitated collection of payments and delivery of an innovative micro-insurance scheme. Thus use of mobile devices promoted access, affordability and quality of healthcare delivery.

(Krishnan et al., 2010): The Comprehensive Rural Health Services Project (CRHSP) at Ballagarh, Haryana run by All India Institute of Medical Sciences provides health care delivery to two Primary Health Centres in 2008. Data collection, data storage, data retrieval, data processing are the major components of this Health Management Information System (HMIS). Computerization of HMIS results in saving of time, more effective and efficient health care delivery and monitoring of the system.

(Bagchi, 2006): The paper demonstrates that Telemedicine can provide the cheapest and fastest way to address rural-urban inequality in health care delivery. A telemedicine system requires a personal computer, customized software connected to medical diagnostic instruments. Patient reports are sent to specialist doctors through satellite-based communication link and specialist doctors suggest treatment via video-conferencing after examining the reports.

(Deolalikar et al., 2008): In order to achieve universal health across all states various measures may be taken such as focusing on weak states first, providing incentives to state governments to achieve the desired health outcome, use of centrally sponsored schemes and improving the quality of publicly financed services. In conclusion, the article states that public spending on health should be increased from 1.1 per cent of gross domestic product (GDP) to roughly 2–3 per cent within five years.

(Kesterton et al., 2009): This paper explores rituals and traditions which are potentially harmful to new-born. The data was collected by taking interviews of mothers, grandmothers and helpers at the time of child birth. Among the potentially harmful practices to new-born in
the study area are unhygienic cord cutting, delayed breastfeeding and early bathing. Gradually these practices are reducing with increased maternal literacy.

(Kapoor et al., 2004): Sanjay Gandhi Postgraduate Institute of Medical Sciences (SGPGIMS), the first tertiary care hospital in public healthcare sector in India adopted Information Technology (IT) for healthcare delivery. The software, ‘Hospital Information System’, (HIS) was developed in-house in collaboration with Centre for Development of Advanced Computing (C- DAC), Pune. It was designed to record, store, process and retrieve health data of all the patients. Regular tele-healthcare and tele-educational services were introduced for the postgraduate students of medical colleges of Orissa. The institute also has a campus for school of telemedicine so as to provide more skilled manpower in the field of telemedicine and e-health.

(Sharma et al., 2011): The paper investigates health care quality in Rural India based on age, gender and education. Although perception about health care differed, the public health care delivery by the public institutions was the prime concern among the people. With increase in income and education, expectations of people increased from public health care providers. The population wanted access to health care facilities even by paying any cost. The general perception with respect to healthcare delivery was in favour of Primary health centres rather than Community Health Centres.

(Zubair et al., 2003): The paper tries to ascertain whether sustained administering of Measles Vaccine is effective in reducing child mortality or not. The study was conducted in April and May 2000, at Ballabgarh from rural northern India. The study revealed that it was 3 times likely that non-vaccinated child in age group of 12-59 months would die of measles than those vaccinated against measles. The vulnerable group of population, especially from lower caste should be brought under measles victimization programme. The paper found need of conducting vaccine trials by considering nutritional status of the children.

(Devadasan et al. 2009): This study examines various dimensions of Community Health Insurance (CHI) such as financial security, quality of health care provided and access to health care. CHI was launched by Government as a component of National Rural Health Mission (NRHM) so as to reduce out of pocket expenditure on health care by households. The study conducted panel survey of ACCORD-AMS-ASHWINI(EEE) CHI scheme and it
was found that with its reliable, effective and low indirect costs, the poorest could access quality health care with financial impunity.

(Dalal, 2005): The paper seeks to find the possibilities of including traditional systems of healing in health care delivery system. It is pointed out that medical services largely depend upon western medicine. In order to improve the quality of health care and well-being of the people, a ‘hybrid’ model of health care services should be developed. Sri Lanka and Indonesia have this creative collaboration of traditional healers and modern medical sector. In order to make this model successful, the community health worker can prove to be an important link between local people and health care providers.

(Chattopadya et al., 2005): The paper is based on data of ‘Survey of cause of death(rural)’ for the period of 1966-1994. The major causes of death are attributed to poverty, aging population, gender discrimination, rural-urban gap and ineffective government policies. The mortality and disability rate is twice that of China.

(Vikhe Patil et al., 2002): The paper states that about 75% of health infrastructure, medical man power and other health resources are concentrated in urban areas where 27% of the population live. The health status of the rural population is still a cause for grave concern. It is required to shift focus from the current ‘biomedical model’ to ‘socio cultural model’ which should bridge the rural-urban gap and improve quality of rural life. A revised National Health Policy which addresses the existing rural urban gap is needed for improved rural health care.

(Panchapakesan et al., 2009): This paper seeks to establish various components of service quality in Indian hospitals from the point of view of patients and their family members/friends (referred to as ‘attendants’). The paper proposes two mechanisms to measure quality of health care service provided by hospitals. The comparison of the viewpoints of patients and attendants can help the hospital administrators in allocating the resources optimally. Such exercise can help the hospitals to create their own standards in setting up quality parameters to face the competition.

(Tabish, 1998): This paper seeks to focus on need of employing multi disciplinary professionals who can effectively allocate the available limited hospital resources for quality health care delivery. Management of scarce resources become imperative since there is no
possibility of new resource generation in short period of time. Also, with increasing demand for specialized and quality health care, such exercise gains immense importance.

(Devi et al., 2005): The paper proposes Multi Agent System (MAS) technology which can help doctors in rural area to acquire timely consultation of experts working in hospitals like Postgraduate Institute of Medical Research, Chandigarh or the All India Institute of Medical Sciences, New Delhi. The software is designed to bring the knowledge together to serve the underserved rural population. The effective implementation of MAS requires physical computing, networking infrastructure and proper training to doctors. Proper implementation of the technology can potentially deliver quality health care to rural population at par with developed nation.

(Vinekar, 2011): The paper explains IT – based tele-ophthalmology initiative, first of its kind, currently world’s single largest hospital-managed tele- Retinopathy Of Prematurity (ROP) to prevent infant blindness in rural area. The project ‘Karnataka Internet Assisted Diagnosis of Retinopathy of Prematurity (KIDROP) was initiated by one of the leading private tertiary eye care providers in India, Narayana Nethralaya Postgraduate Institute of Ophthalmology, Bangalore. KIDROP project trained non physicians in capturing, validating, storing, analyzing and processing images of the retinas of infants in the rural centres itself. The images were then sent to experts for diagnosis.

(Narang, 2010): The paper evaluates the perception of health care delivery by a tertiary health centre, a state medical university and two missionary hospitals in Lucknow on 20 point scale. Five hundred users were covered in this exercise. “Health care delivery” and “health personnel and practices” were statistically significant. The response to “adequacy of doctors for women” and “access to services” were less positive. It was found that services of tertiary health centres were poorer than medical university and missionary hospitals.

(Chhanabhai et al., 2010): In developing nations majority of people live in rural area who are generally poor. In remote areas, access to health related information and services are inadequate. The focus of this paper is to highlight the impact of Information and Communication Technology (ICT) on accessing health related information to the rural community. Mobile phones and social networks can be used to reach out to the underserved
population, thereby overcoming geographical divide. Access to health related information contributes in development of health education and health promotion which promotes patient care. In order to implement ICT based solutions in providing health care services, certain issues such as connectivity, Information Technology literacy and cost must be addressed.

(Sharma et al., 2011): This paper highlights patient satisfaction in a multi-specialty hospital in North India. The questionnaire was given to patients after their consultation to doctor. It was found that 33:20 minutes were spent for registration, 80 % of the patients were satisfied with overall conduct of doctor, 55% of patients felt that doctors showed little interest listening to their problems, 67% felt that doctors used medical terms to explain their ailment, 70% of patients were satisfied with laboratory and security staff, 80% of the patients were satisfied with basic amenities.

(Marks, 2005): The “Health for all” notion envisions realization of health outcomes of all people of the world so that they can lead socially and economically productive life. But the wide disparities in accessing health care services across the globe make this concept a distant dream. The paper focuses on potential directives in achieving this goal through improved health promotional efforts.

(Jackson, et al. 1996): Rural China depends upon paramedics called ‘barefoot doctors’. In the sample of 519 village doctors, it was found that majority of doctors were males. 86 % of them worked in the same village where they lived. 87 % of these doctors were allocated land but they spent less than 25% of their time on farming. Forty one percent of western medicine practitioners also prescribed Chinese medicines. The village doctors felt that there should be regulations laid down at the entry point in this profession.

(Rohini et al., 2010): This paper tries to identify social responsibilities of 5 not-for-profit hospitals in Bangalore. Seventy nine physicians, one hundred and four managers and stakeholders participated in the study. It was found that top management involvement with stakeholders is very important for effective dissemination of social responsibility of providing health care services to society. The study also revealed that the hospitals must take into consideration various social, cultural and financial characteristics of the stakeholders while dealing with them.
The paper seeks to find solutions of providing health care solutions to underserved rural populations. According to 2007 statistics, there is a deficit of 8% doctors in Primary Health Centres (PHC), 65% for specialists at Community Health Centres (CHC), 55.3% for health workers (male), 12.6% for health workers (female). The situation will remain the same since qualified doctors are not willing to serve in rural areas due to lesser remuneration, lack of social and clinical infrastructure. The Ministry of Health proposed to introduce a cadre of doctors willing to serve in rural areas after basic training of only three years known as Rural Health Practitioners (RHPs) but professional bodies like Indian Medical Association (IMA) protested. The introduction of RHPs is the positive step in absence of any other feasible solution. The existing unqualified practitioners should be roped in for training and accreditation as RHPs.

This paper reviews the impact of decentralization in the public health care system. Various studies have found that decentralization helps in enhancing quality of health care services provided to the people. The study is pertaining to Nepal with the objective of improving health services. But successful implementation requires proper resource management and to broaden the organizational capability.

The paper brings out the scenario of health care services in the state of Uttar Pradesh. The paper identifies availability of doctors, equipments and drugs; conduct of health workers, health care delivery, and cleanliness as important factors from user point of view. The sample of 500 respondents revealed negative scores on “availability of adequate medical equipments” and “availability of doctors for women”. The analysis of the data established that education, gender and income had significantly impacted user perception. The paper suggests that incentives to doctors may be given such as early promotion, transfers to hometown after certain period, leave for higher studies after completion of certain period of time etc.

The paper examines strength, weakness, inadequacy, disparity and utilization of health care services in three districts of West Bengal in 2006. Out of the total of 672 cases of illnesses, 221 did not seek any medical help. The tribal community depended upon home remedy only. While among the remaining 451 cases, 39% depended upon public health care system, 29% on quacks due to less cost, 27% on qualified doctors in private sector and only 4.88% on AYUSH (Ayurvedic, Yoga, Unani, Siddha and Homeopathy Systems of
Health). The factors which contributed to patient satisfaction were cleanliness of the premises, clean toilets, safe drinking water and good ambience.

(Coruh, 1996): The concept of Total Quality Management in health care delivery was introduced in the hospital of Ankara, Turkey to bring about improvement in various sections of health care delivery system. TQM was also introduced as a tool to control health care cost. The TQM exercise made the section heads more quality conscious which resulted in improved bed occupancy rates. As a result demand for health care services increased and more out-patient facilities was employed. To meet growing demand of health care services, there was need felt to build new hospital. Thus TQM led to optimum use of resources with an objective to create culture of quality in providing services to their patients.

(Parmar, 2010): Awareness of Primary health information to rural women is of prime importance. The paper attempts to present a user centric framework for information for maternal health delivery. The paper presents the study in three parts. First part consists of study of existing knowledge of women and accordingly drafting a Primary Health Information System (PHIS) fulfilling their requirements. Second part explains the PHIS which were developed in a village over a period of 16 months. Third part gives the detail of impact of PHIS on knowledge level of rural women. PHIS attempts to address the issue of creating awareness about maternal health information among rural women.