

A Reviewed Article on Reason for Failure to Educate Rural Population of India in Health Aspect

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Abstract

In health & education of rural areas are so backward due to lack of awareness, lack of infrastructure & ignorance by the government. In health education aspect all the health programme & policies are success in urban areas but all failure rate of programme came through rural areas because lack of facilities, awareness & most of population do not know about how to approach, & availability of resources. Reason for failure to educate rural population of India in health sector shortages of work force, faulty health education intervention, lack of total coverage, lack of quality assurance / approach framework, shortage of basic health infrastructure, lack of effective span of control and poor management, low education level, shortage of the basic facilities, shortage of financial resources, and lack of awareness among population.

Keywords: Health Education; Rural Population; Health Aspect.

In India, though health education has been a lowest priority. Thus it has been an integral part of all national programmes. Lack of information is the major barrier to the effective access to services. However, various efforts have been made by the government to improve health through Information Education Communication activities.

Four Population Education Projects at Schools, Universities, Adult and Technical Education level (through NCERT, DAE, UGC, DGE&T) with UNFPA assistance remained under operation in States/UTs for integrating population issues in various curricula for school students, youth and women, live entertainment programmes, Family Planning counselling, HIV/STD counselling and

distribution of educational materials.

New Delhi (2015): Prime Minister Narendra Modi said the prime reason for India's backwardness was neglect of the two major sectors of health and education.

"I agree with the contention of Nobel laureate Amartya Sen that the neglect of health and education sectors since independence was the prime reason for backwardness of the country," he said after giving away awards to the winners of the Maulana Azad Essay Competition.

Need of the Study

- In India 72% population stays in rural areas. Where as rural India is under-developed and lack of resources as compared to urban area.
- There is huge differences and gap in development in between rural & urban areas in each and every aspect. In health scenario & education pattern of rural areas are so backward due to lack of awareness, lack of infrastructure & ignorance by the government.
- In health education aspect all the health program & policies are success in urban areas

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but all failure rate of programme came through rural areas because lack of facilities, awareness & lack of approach most of population do not know about how to get the things, & availability of resources.

- Failure of health education due to illiteracy is most common factor on rural India due to lack of women education in respected areas.
- So to make effectiveness & efficiency of programme & policies it is necessary to find out reasons of failure of health education in rural India.

Reason for Failure to Educate Rural Population of India in Health Sector

Shortages of Work Force

Prof Mohan Rao, PhD, Dr Krishna D Rao, (January 2011) human resources for health in India, the Lencet, India has a severe shortage of human resources for health. It has a shortage of qualified health workers and the workforce is concentrated in urban areas. Bringing qualified health workers to rural, remote, and underserved areas is very challenging. Many Indians, especially those living in rural areas, receive care from unqualified providers.

Many rural areas experience shortages of health care workers including, among others, physicians, dentists, nurses and pharmacists. As a way to reduce such shortages, the Federal government, as well as state and local entities, have developed programs to encourage individuals to pursue education in health profession fields by offering programs to assist with the cost of education. These programs can take the form of grants, loans, fellowships, scholarships and loan repayment programs. Some programs have special conditions such as a specified term of service in an underserved area. General student financial aid is also available to qualified applicants.

Faulty Health Education Intervention

A reviewed article of recent health education articles indexed in CINAHL and MEDLINE revealed that most of the current health education interventions are only knowledge based interventions rather than based on skill based. As per the best of our knowledge we could find only a valid intervention that used community diagnosis and participation in planning the intervention and another one that used information, motivation and

behavioural skills model in designing the intervention.

Most of the campaigns and health information dissemination in the government sector as well as the non-governmental sector use newspapers, posters, internet and pamphlets.

Almost 42% percent of the Indian population is illiterate and use of print media to impart health messages is not useful for them. Further, 60% of promotions do not exhibit adequate complete and comprehensive information. Hence the information dissemination campaigns fall short in reaching the vulnerable sections of the community

Lack of Total Coverage

Mass media campaigns have not been successful in reaching rural populations living in far hilly, desert, forest and vulnerable areas. Gupta and Sharma (2011) found that only one fourth of health education functionaries in the government sector were placed at the rural level while three fourths of the population is rural. This big gap of allocation of resources is a weakness of the health education in India.

Lack of Quality Assurance / Approach Framework

An article reviewed of Bruce (2014) Fundamental elements of the quality of care: a simple framework, Studies in Family Planning, revealed that even though having a large manpower of functionaries that perform health education but there is no quality assurance. That is another weakness of health education in India. The system of continuing education is largely but non-existent.

The system of continuing education is largely disorganized with no association or holding of annual meetings. Educators and colleagues have pointed out weakness of postgraduate medical and health education in India. They observe that training is in apprenticeship style format rather than appraisal style format and selection of assessment tools is not guided by modern educational theory. This is also a weakness of health education in India, where more emphasis on current theories in teaching health education needs to be done.

Shortage of Basic Health Infrastructure

An article reviewed of Ashok Vikhe Patil, R. C. Goyal (2002) Current health scenario in rural India revealed that about 75% of health infrastructure,

medical man power and other health resources are concentrated in urban areas where 27% of the population live. Contagious, infectious and waterborne diseases such as diarrhoea, amoebiasis, typhoid, infectious hepatitis, worm infestations, measles, malaria, tuberculosis, whooping cough, respiratory infections, pneumonia and reproductive tract infections dominate the morbidity pattern, especially in rural areas.

Delivery of health education programs as vertical programs relying on techno-managerial approaches has been pointed by some thinkers particularly Banerji as a potential threat. Banerji points out that delivery of several programs such as Universal Immunization Program (UIP), control of diarrheal diseases, acute respiratory infections, AIDS, tuberculosis, leprosy, malaria have been a dismal failure because these programs fail to build the essential infrastructure at the grassroots level and merely provide "band-aid" kind of token solutions.

Lack of Effective Span of Control and Poor Management

The reluctance of health teams to serve in rural areas has become a major impediment in the Government's ability to provide health education to the rural population. A study conducted by the World Bank showed absenteeism ranging from 40% to 45% among health team members working in primary health centers. Lack of professional approach, low pay and lack of appreciation also deter trained and skilled personnel to work for the government, and even when hired, there is high absenteeism.

Low Education Level

Based on a Study undertaken by Mrs. Sarita on Education aspects of meeting demand for family planning, in 2 districts of Maharashtra, it has been noted that education is the most important variable which affects fertility. To control the escalating population the need of the hour is to make women aware of their reproductive rights. Education in terms of reproductive responsibility is of crucial importance for all adolescent students in High schools who are prospective parents.

The Major Findings of the Study are as Under:

- 62.5% of women and 28.2% men in the villages in Maharashtra are illiterate. Education in terms of good living, social studies, community living and hygiene can be imparted through radio

programmes.

- Women who had gone to school for 8 years are the ones who are mothers of 4 children. Those with no years of school are generally found to have 4 or more children. It is proved that higher school education provides a mental maturity to young girls who would be prospective mothers.
- Man who had more than 8 years at school are fathers of less than 3 children. Those with less than 5 years of education are mostly fathers of more than 4 children. Thus, for effective family planning both men and women should be educated.

Shortage of the Basic Facilities

The calculations in also show that the number of health facilities needed is far in excess of what is provided in the rural areas. Moreover, the available PHCs and CHCs lack several infrastructural facilities. If the health education service is to be qualitatively satisfactory, the health facilities should be strengthened not only in terms of quantity, but also in terms of numerous essential infrastructures. Thus, the costing of the facilities needs serious upward revision and the budget provision should be realistic to reflect better infrastructure accompanying the creation and installation of new facilities.

We have assumed that the maintenance, improved management, better mass communication, public awareness campaign, cost of medicines and kits, and other operating charges for infrastructural facilities are, Rs.40 thousands for a sub-centre, Rs.0.5 million for a PHC, and Rs.3 million for a CHC. We present our estimates of additional requirement of expenditure.

Shortage of Financial Resources

The total additional requirement of financial resources in the health sector is estimate excludes the cost of training and increasing the supply of doctors, specialists, and paramedical personnel in the rural areas. Moreover, we have again worked out these estimates applying the current levels of remunerations and salaries of the medical and paramedical personnel.

It is interesting to compare this additional requirement with the existing budget allocation in the two states for health and related sectors. Data provides the similar budget allocation for All-India, (Centre & States) combined for the year 2013-14, in

particular, allocates only Rs.1683 per capita to social sectors and only Rs.280 per capita to medical and public health. Recognizing the problems arising out of deficiency of fiscal capacity and low expenditure preference, the i.e., roughly six times the current per capita health spending. It is, therefore, possible to generate some resources by carefully reallocating the budget, particularly by cutting unproductive expenditures. The Indian government too should step in and increase its programs. The remaining amount can be generated through international funding of specifically designed projects to scale up the healthcare services in rural areas

Lack of Awareness among Population

A reviewed study conducted by Thakur. V. (2012), Reasons of less coverage of immunization under UI Programme. In study on the Immunization Coverage relating to the six vaccine preventable diseases was carried out in an urban, semi urban and rural area and the results from the three areas were compared and discussed. The percentage of fully immunized children was similar in all the three areas and it was quite high. Coverage of measles vaccine was high in the Health Unit, where health education activities were carried out by the interns. The awareness about vaccine preventable diseases was more in the urban and semi-urban areas. The drop out rate for DPT and OPV was also less in urban and semi-urban than in the rural areas. More than 50% of the households in urban, semi-urban and rural areas were unaware of the diseases prevented by DPT vaccine. Intense Health Education Campaign can definitely improve the immunization coverage further in a state which has already attained total literacy.

Discussion

The percentage of children who were fully immunized was almost similar in all the three areas and it was above 75%. In a similar study in Calcutta (3) only 30-40% of urban children and 11-18% of rural children were fully protected by immunization. In the present study, the percentage of partially immunized children was lower in the urban area when compared to semi-urban and rural areas. This indicates that those children who received immunizations in urban area were more regular in completing the doses than the children of semi-urban and rural areas.

Podder (2011) in a comparative study on the

immunization status of children in rural and urban areas, reported that the mother's knowledge as well as their children's full immunization coverage with individual vaccines was more in the semi-urban and 142 rural areas than in the urban areas. In the semi-urban area, the coverage of measles vaccine was more than 90% in contrast to the low coverage (18%) reported (3). This remarkably high coverage of measles vaccine as compared to other parts of the country might be the outcome of the intense health education activities undertaken by the interns and the periodic immunization camps arranged in different areas as part of the interns training programme. The drop out rate of DPT and OPV was also more in the urban and rural areas as compared to the semi-urban areas. This is also in contrast to the results reported earlier. An attempt was also made to assess the awareness about the vaccine preventable diseases in the households. There was adequate awareness about measles and poliomyelitis, even though half of the households could not mention the diseases prevented by DPT vaccine.

Conclusion

Hence it prove that reason for failure to educate rural population of India in health aspect as mentioned above if any government take initiative to improve health aspect through health education, government should short out all the reasons and improve workforce shortage, proper infrastructure, effective coverage, appropriate quality approach framework, improve basic facilities, proper financial resources, my motto to this review this article to improve health aspect if country and provide statically proved concept to different reviewers as concern to reasons behind the failure to educate rural population if country in health aspect.

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