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PRIMARY HEALTH CARE SERVICES IN RAJASTHAN: A CASE STUDY IN RURAL RAJASTHAN

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ABSTRACT

The economic and social development of Rajasthan has been staggering leading to poor infrastructure development in village. Few studies depict that there is a severe lack of availability and accessibility of health care infrastructure for the population, even after introduction of many policies, schemes and programmes for the rural populace. The present study is an endeavour to study the problems faced by the rural populace in Bandarsindri Village of Kishangarh block, Ajmer District. The main of present study is to assess the availability and accessibility of public health care services among the residents of rural Rajasthan. Researcher adopted sample household was selected by cluster random sampling technique. The Bandarsindri panchayat population was divided in 15 clusters. In each cluster systematic sampling was applied where in ith item on the list of houses was taken according to the proportion. The result found that there are lack of public health care services and also lacking regarding for transportation. There are two major religions in Bandarsindri the Hindus and the Muslims , the total percentage of Hindus are 97.5% , and 2.5 % of Muslims, in which the percentage of various categories are OBC 60%, 30% of SC, General 4.5 % , ST 3% and Others 2.5 %. Majority of the family are joint families whose percentage is around 51%, where as nuclear families are around 49%. Around 42% of the Head of the families are still illiterate. Majority of the people are dependent on Agriculture and their yearly income is around Rs 30,000-100,000 where as Income source of family are 35% from agriculture, 11% from daily labor, 1% from salary, 1% from other sources and 52% respondent are belonging from both agriculture and daily wages.

Keywords: *Rural Rajasthan, Primary Health Care, Social Development and Poverty.*

Introduction

At present, there are 17,000 hospitals (34 per cent rural), 25,670 dispensaries (40 per cent rural) and about one million beds (23 per cent rural) for the country as a whole. In addition the rural areas have 24,000 PHCs and 140,000 sub-centers. There are 165 recognized allopathic medical colleges in the country producing over 20,000 medical graduates every year; and out of these, 75 per cent are produced in public institutions. However, the outturn from these institutions does not benefit the public health services because 80 per cent of the outturn from public medical schools either join the private sector or migrate abroad. Here it would be in order to provide a brief description of the private health sector and health insurance coverage in India. The private health sector in India, as indicated earlier, is very large, perhaps the largest in the world. In 1997 an estimated 68 per cent of hospitals, 56 per cent dispensaries and 37per cent of beds were in the private sector. An estimated 75 per cent of allopathic doctors were in the private sector, about 80 per cent of them being individual practitioners.

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World Health Organization (2009) in its study on increasing access to health workers in remote and rural health areas found that there is more a problem of geographical mal distribution rather than a lack of physicians. The movements of health workers in general, such as turnover rates, absenteeism, unemployment or dual employment has a correlation between the factors influencing the choices and decisions of health workers to practice in remote and rural areas and the categories of interventions that could respond to those factors. The deepest concerns of health workers when it comes to practicing in remote and rural areas are those related to the socio-economic environment, such as working and living conditions, access to education for children, availability of employment for spouses, insecurity, and work overload.

Health Care Delivery Issues

The studies depict various issues related to health care delivery in India. A survey was organized by Banerjee, A., Deaton, A., & Duflo, E. (2004) in rural Udaipur to gauge the delivery of health care and the impact it has on the health status of the largely poor population of the region. The study showed that the quality of public service was extremely low and that unqualified private providers account for the bulk of health care provision. The low quality of public facilities has also had an adverse influence on the people's health. In an environment where people's expectations of health care providers seem to be generally low, the state has to take up the task of being the provider or regulator.

Poor care seeking contributes significantly to high neonatal mortality in developing countries. A research study was conducted to identify care-seeking patterns for sick newborns in rural Rajasthan, India and to understand family perceptions and circumstances that explain these patterns by Ahuja et al (2008). They interviewed 290 mothers when the infant was 1 to 2 months of age. 202 (70%) reported at least one medical condition during the neonatal period that would have required medical care, and 108 (37%) reported a danger sign during the illness.

Poverty is the real context of India. 3/4 of the population lives below or at subsistence levels. This means 70-90 per cent of their incomes go towards food and related consumption. In such a context social security support for health, education, housing etc. becomes critical. Ironically, India has one of the largest private health sectors in the world with over 80 per cent of ambulatory care being supported through out-of-pocket expenses. The public health services are very inadequate. The public curative and hospital services are mostly in the cities where only 25 per cent of the one billion populations reside. Rural areas have mostly preventive and promotive services like family planning and immunization.

Primary Healthcare Services in Rural Rajasthan

The landlocked state of Rajasthan is the largest state in the country with an area of more than 342 thousand square kilometers. About one-third of its area is covered by desert and Aravalli range of hills and hillocks run across the state making it a part of both the arid zone and a tribal belt. Population density is very low in Rajasthan although the population growth in the state between 1991 and 2001 is as high as 28.33%. Economically, Rajasthan is one of the low income states in the country. Water in general and drinking water in particular is extremely inadequate and Ground water in the same areas has excess fluoride exposing the population to high risks of osteo-fluorosis and related diseases. Given such physical constraints, however, there exists a huge network of public healthcare facilities in rural Rajasthan. As of September, 2005, there are 328 Community Health Centers (CHCs), 1713 Primary Health Centers (PHCs), and 10512 Sub-Centers (SCs) with aggregate bed capacity of 38.7 thousand. Population per doctor is as high as 9228 and per bed is 1491. About 78% of CHCs and 84% of PHCs are in government buildings, whereas most of the remaining ones are functioning in the rent free panchayat or voluntary society's buildings.

- **Rashtriya Bal Swasthya Karyakram (RBSK)**

Under National Rural Health Mission, significant progress has been made in reducing mortality in children over the last seven years (2005-12). Whereas there is an advance in reducing child mortality there is a dire need to improving survival outcome. This would be reached by early detection and management of conditions that were not addressed comprehensively in the past. According to March of Dimes (2006), out of every 100 babies born in this country annually, 6 to 7 have a birth defect.

- **Yashoda**

A paid performance linked voluntary support worker placed under NPI at Health Facilities. Support to nursing staff. Intervention started in 3 NPI Districts-Aug 2008 and Up-scaled in all Districts in July 2009. The Objective of this programme is to Provide special care and support to mother and newborn, Care of mother and newborn and immunization, breast feeding and family welfare.

- **Mukhya Mantri Balika Sambal Yojana**

Started-1st April, 2007 to promote girl child and providing economic support to her. Eligibility- Any couple undergoing sterilization operation after one or two female child (no male child). Objectives of the scheme is to provide Govt.'s effort in contributing towards overall development and education of girl child, Motivating parents to curb child marriage and Restrain falling sex ratio and population growth. Bhamashah Kalyan Beema Yojana In case of death or any complication due to sterilization operation in hospital or within 7 days of discharge Rs. 2,00,000/- Payment of Rs.50,000/through bank immediately given after taken from Insurance company, Death within 8-30days-Rs. 50,000/, Failure of operation- Rs. 5,000/-1 years of operation Rs.30,000/- Complications within 8-30days of operation- actual expenditure with upper limit of Rs. 25,000/- Indemnity Insurance per doctor/institute(not more than 4 in a year)- Rs.2,00,000/-.

Research Methodology

Aim of the Study

- To assess the availability and accessibility of public health care services among the residents of rural Rajasthan.

Objective of study

- To understand the demographic and socio-economic characteristics of residents living in rural Rajasthan
- To assess the availability and accessibility of public health care services among the residents of rural Rajasthan
- To assess the felt healthcare needs, utilization and perceived relevance of available healthcare services
- To identify the barriers deterring the rural residents' to access the healthcare services
- To review the existing modes of communication and IEC strategies by the health system and to identify the strengths and gaps in reaching the rural population

Sampling Technique

Researcher adopted sample household was selected by cluster random sampling technique. The Bandarsindri panchayat population was divided in 15 clusters. In each cluster systematic sampling was applied where in ith item on the list of houses was taken according to the proportion. One adult family member between the age group of 30 to 50 years from each selected family was interviewed.

Pilot Study and Pre-test

Pilot study was conducted by researcher for understanding for universe of the study and to check whether people would answer or not. Through pilot study researcher felt confident that he is able to collect the data. Pre-test mean researcher goes to community and collect the some sample and then find these questions are relevant or not. There must be doing add or rejects some question. Hence, Pre-test also important for collect the relevant and appropriate data for the study.

Sample Size

A total of 100 houses were selected randomly by Proportion to Size of cluster. One adult family member between the age group of 30 to 50 years from each selected family was interviewed. The study focus on availability of health care resources within the reach of rural populace, challenges faced by these people in accessing the health care. Since the research trainee is interested in describing the phenomena of health care accessibility and availability among the rural population.

Methods of Data Collection

A cross sectional survey method was adopted, wherein, interview method was used for collecting the data. The reason being, the village respondents were not able to read and write. A structured survey schedule was prepared by the research trainee. The interview schedule have, wherein quantitative data pertaining to socio-economic, demographic details, healthcare seeking behavior, accessibility, availability of the respondents for health care was elicited.

Tool of Data Collection

A self-administered survey schedule was utilized to collect data. First part deals with the house conditions, personal details of the respondents and in the second part questions were framed based on the accessibility, availability of public health care services and barriers to access the public health care services.

Data Analysis

The collected data was edited, coded and entered into master chart (excel spreadsheet) and the subjected to analysis with the help of tables and percentage interpretation.

Result

Present study conducted in rural area of Rajasthan to understand about availability and accessibility of public health care services among the residents in rural Rajasthan. 100 samples were selected [illegible] clusters from four villages are named as Bandarsindri, Kheda, Ganeshpura and Khatoley. [illegible]

[illegible]

Table 1 describe the socio demographic profile of respondents from the study area. [illegible] 73 respondents (73%) from Bandarsindri village, 14 respondents (14%) from Kheda village, 7 respondents (7%) from Ganeshpura, 6 respondents (6%) from Khatoley. [illegible] describing about anganwadi center [illegible] 91 respondents (91%) accepted that there was a anganwadi center in the study area. While describe age of respondent 54% comes under the 20-35 age group, 12% comes under the 35-45 age group and 34% were above the 45 age group.

While describe religion of respondent 97% of Hindu and 3% is Muslim. [illegible]

[illegible]

Table 1: Personal Details of the Respondents

Personal Details	Response	Number of Respondents	Percent
Village	Bandarsindri	73	73.0
	Kheda	14	14.0
	Ganeshpura	7	7.0
	Khatoley	6	6.0
	Total	100	100.0
Anganwadi Centre	Yes	91	91.0
	No	9	9.0
	Total	100	100.0
Age of The Respondent	20 - 35	54	54
	35-45	12	12
	45 and above	34	34
	Total	100	100.0
Religion	Hindu	97	97.0
	Muslim	3	3.0
	Total	100	100.0

Community	ST	3	3.0
	SC	29	29.0
	BC	64	64.0
	General	4	4.0
	Total	100	100.0
Family Type	Nuclear	49	49.0
	Joint	51	51.0
	Total	100	100.0
Type of House	Kutcha	11	11.0
	Semi-pucca	14	14.0
	Pucca	75	75.0
	Total	100	100.0

While describe about Education Level of Head of Family Member 42% respondent illiterate, 4% respondent read & write, 18% respondent passed 1-5 standard, 2% respondent passed 6-7 standard, 23% respondent passed 8-10, 5% respondent passed inter school, 6% respondent passed Graduate & above. While describe about Education Level of Respondent 30% respondent illiterate, 2% respondent read & write, 18% respondent passed 1-5 standard, 1% respondent passed 6-7 standard, 30% respondent passed 8-10, 14% respondent passed inter school, 5% respondent passed Graduate & above.

While describe about Income source of family 35% from agriculture, 11% from daily labor, 1% from salary, 1% from other sources and 52% respondent from both agriculture and daily wages.

Table 2: Education Level and Income Sources in Family

Education Level and Income source in Family	Response	Number of Respondents	Percent
Education Level of Head of Family Member	Illiterate	42	42.0
	Read & Write	4	4.0
	1-5 Standard	18	18.0
	6-7 Standard	2	2.0
	8-10 Standard	23	23.0
	11-12 Standard	5	5.0
	Graduate & Above	6	6.0
	Total	100	100.0
Education Level of Respondent	Illiterate	30	30.0
	Read & Write	2	2.0
	1-5	18	18.0
	6-7	1	1.0
	8-10	30	30.0
	Intermediate (11-12th)	14	14.0
	Graduate	5	5.0
	Total	100	100.0
Income source of family	Agriculture	35	35.0
	Daily Labor	11	11.0
	Salary	1	1.0
	Other Sources	1	1.0
	Agriculture and also wages	52	52.0
	Total	100	100.0

While describe about family member with problem visit to Hospital 3% respondent have problem with heart problem, 1% respondent has Diabetes problem, 1% respondent has Blood pressure problem, 3% respondent have T.B. problem, 0% respondent has cancer problem, 2% respondent have Asthma problem and 2 % respondent have other problem.

Table 3: Family Member Chronic Health Problem and Frequent Visit to Hospital

Health Problem	Response	No. of Respondents	Percent
Family Member With Heart Problem	Yes	3	3.0
	No	97	97.0
	Total	100	100.0
Family Member With Diabetes	Yes	1	1.0
	No	99	99.0
	Total	100	100.0
Family Member With Blood pressure	Yes	1	1.0
	No	99	99.0
	Total	100	100.0
Family Member With T.B. Problem	Yes	3	3.0
	No	97	97.0
	Total	100	100.0
Family Member With Cancer Problem	No	100	100.0
Family Member With Asthma Problem	Yes	2	2.0
	No	98	98.0
	Total	100	100.0
Family Member With Other Problem	Yes	4	4.0
	No	96	96.0
	Total	100	100.0

While describe about regular source of medical care in which 1% respondent regular using of Y.N. hospital and 99% respondents are using of Y.N. , sub center Govt. and private hospital (Both). While describe about believe in spiritual/faith by respondents in which 30% respondent often use of spiritual/faith, 53% respondent sometime use of spiritual/faith and 17% respondent never use of spiritual faith. While describe about reason for regular use of facility in which 1% respondent regular use of facility for general treatment for common disease and 99 % respondent regular use of facility for pregnancy and general treatment (Both).

Table 4: Regular Source of Medical Care

Health Problem	Response	No. of Respondents	Percent
Regular source of Medical Care	Y.N.	1	1.0
	Y.N., Sub-center, Govt. and private hospital (Both)	99	99.0
	Total	100	100.0
Visit to Spiritual/faith Healer	Often	30	30.0
	Sometime	53	53.0
	Never	17	17.0
	Total	100	100.0

While describe about need of large hospital in 5-10 km in which 2% respondent agree for large hospital and 98% respondent strongly agree for large hospital in 5-10 km. While describe about need of ambulance in 10 minutes in which 2% respondent agree for this, 97% respondent strongly agree for Ambulance should be available in 10 minutes and only 1% respondent disagree for need of Ambulance in 10 minutes. While describe about need of PHC in village in which 3% respondent agree for need of PHC, 95% respondent strongly agree for need of PHC in village but 2 % respondent disagree with need of PHC. While describe about feel for private hospital in village in which 91% respondent agree for feel about private hospital in village, 7% respondent strongly agree for private hospital and 2 % respondent disagree with feel of private hospital. While describe about required health need in home and village in which no one respondent give answer about question

Table 5: Perceived Health Care Needs

Perceived Health Care Needs	Agree	Frequency	Percent
Need of large hospital in 5- 10 km	Agree	2	2
	Strongly Agree	98	98
	Total	100	100
Need of Ambulance in 10 minutes	Agree	2	2
	Strongly Agree	97	97
	Disagree	1	1
	Total	100	100

Need of PHC	Agree	3	3
	Strongly Agree	95	95
	Disagree	2	2
	Total	100	100
Feel for private hospital	Agree	91	91
	Strongly Agree	7	7
	Disagree	2	2
	Total	100	100
Required HC, need in home/ village	99	100	100

While describe about delivery in which 51% respondent are going to sub center for delivery, 23% respondent While describe about fulfill need available health care unit in which 1% respondent agree with fulfill need available health care unit in village and 99% respondent disagree with fulfill need available health care unit in village.

While describe about pregnancy in which 17% respondent not aware about pregnancy related health care needs, 59% respondent go to pregnancy at sub center, 14% respondent go to pregnancy at Y.N. , 8% respondent go to pregnancy at private hospital and 2% respondent have not about pregnancy.

While describe about utilize of health scheme in which 1% respondent is using of BJY, 64% respondent are using of BJJY and 35% respondent was not used any health scheme. While describe about how availed health scheme in which 35% respondent was not benefited any health scheme , 42% respondent was availed scheme benefited by ASHA and 23% respondent was availed scheme benefited by hospital. While describe about difficulties in availing health scheme in which 35 % respondent was not benefited any scheme and 65% respondent have not difficulties in availing health scheme. While describe about medical insurance in which 5% respondent have medical insurance for treatment and 95% respondent have not any kind of medical insurance . Only those people have medical insurance who work in Govt. Sector.

Discussion

Many studies conducted on availability and accessibility of public health care service. So there may be similarity or may be deference between this study and earlier studies. Researcher used and read out many earlier articles for getting the knowledge on this phenomenon. This research focus around the availability of health care resources within the reach of rural populace, challenges faced by these people in accessing the health care services. This study also further help in understanding the treatment seeking behavior of villagers Present study reveals that people are not satisfied with available health care services and they are also facing difficulty regarding transportation A study was organized by Banerjee, A., Deaton, A., & Duflo, E. (2004) in rural Udaipur to gauge the delivery of health care and the impact it has on the health status of the largely poor population of the region. The study showed that the quality of public service was extremely low and that unqualified private providers account for the bulk of health care provision. The low quality of public facilities has also had an adverse influence on the people's health. In an environment where people's expectations of health care providers seem to be generally low, the state has to take up the task of being the provider or regulator. Utilisation of the state health services by them is quite low. The study told that the level of awareness about the government health system and the facilities available was extremely poor in the people of these areas. Another reason for not utilising health services was the faith these tribal people have in the traditional healers like the bhopas (faith healers) and herbalists. Another reason for their not utilising the state health set-up is the indifferent attitude of the providers towards these people. After study we fount that people are not aware about health facility and faced many problem regarding access of health care services in which specially regarding to transport facility then people still believes in spiritual/faith by respondents in which 30% respondent often use of spiritual/faith, 53% respondent sometime use of spiritual/faith and 17% respondent never use of spiritual faith.

Conclusion

Disadvantaged rural health reflected by significantly higher mortality rates and other communicable disease in rural areas which indicate less attention paid by the government. The issue of health disadvantage to the rural area in the country is far from settled. The public expenditure on health in India is far too inadequate, less than 10% of the total health budget is allocated to rural area where 75% people live. In spite of rising budgetary provision, many of the rural populace dies without any medical attention. Access to high quality health care services plays an important part in the health of rural communities and individuals. Resolving the health problems of rural communities will require more than

simply increasing the quality and accessibility of health services. Until governments begin to take an 'upside-down' perspective, focusing on building healthy communities rather than simply on building hospitals to make communities healthy, the disadvantages faced by rural people will continue to be exacerbated.

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