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Problems faced by health care service providers in rural communities of Haryana and Rajasthan

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ABSTRACT

Three tier field based rural health care infrastructure has been created. However, notion exists that health care service providers at these centres face problems. A study was conducted with a sample of 40 officials (10 each from 2 districts of Haryana and 2 districts of Rajasthan) involved in providing health care services. Data were collected using a structured interview schedule. The problems faced by the respondents were taken on a three point scale and categorized as severe, moderately severe and least severe by calculating weighted mean scores. Administrative problems like excessive paper work and repetition of work by different agencies were observed as severe problems while coordination and manpower related problems were only moderately severe in both states. Under equipment, supplies, and furniture, problems of availability of family planning devices and tools were reported as moderately severe in both states. Space related problems like examination room, indoor beds, waiting space for outdoor patients and ventilation were reported in both states as moderately severe. Though financial problems emerged as least severe but problem of delay in allocation of funds in Haryana and purchase procedure in Rajasthan was found as moderately severe. Transport related problems like non-availability of ambulance and vehicle for field work were severe problems of respondents. Problem of sanitary conditions at health centers were reported as a severe problem in Rajasthan and moderately severe in Haryana. Sensitization, commitment and will at policy and field levels can help to a great extent in overcoming these problems.

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The approach to community health care during the first and second five-year plans was mainly 'clinical' under which facilities for provision of services were created. However, on the basis of data brought out by 1961 census, 'clinical' approach adopted in first two Five Year Plans was replaced by 'Extension and Education Approach' which envisaged expansion of services, giving priority to women's education and launching of measures for improving maternal and child health services, supplementary feeding for children, and expectant and nursing mothers. In 1975, inspite of the emphasis on maternal and child health, health care services continued to be heavily biased in favour of sterilization, financial incentives and target achievement. An expanded programme on immunization (EPI) was launched in 1978. The shift in approach from 'welfare' to 'development' of women could take place only in the Sixth Plan (1980-85) which adopted a multi-disciplinary approach with thrust on three core sectors namely, health, education and employment. This focus continued in Seventh and Eighth Five Year Plans (1985-95), which promised to enable women to function as equal partners in the development process. During the Ninth Plan period (1997-2002), several new initiatives were taken. Reproductive and Child Health (RCH) Programme was implemented in 1997. In order to make it broad based and client friendly, all the interventions of erstwhile programme of Child Survival and Safe Motherhood (CSSM) became a part of RCH. Reduction in fertility, mortality, and population growth continued to be the major objectives of Tenth Plan (2002-2007). The focus was on improving access to health care services and to meet the health care needs of women and children. In 2005, Government of India launched the National Rural Health Mission (2005-2012) for providing integrated comprehensive primary healthcare services especially to the poor, women and children residing in rural areas throughout the country.

In nutshell, the emphasis shifted from hospital based urban health care to field based rural health care, with time. A broad based three tier infrastructure *viz.* community health centers (CHCs), primary health centers (PHCs) and sub-centres (SCs) was created for taking primary health care services to the people nearer to their homes at a cost within their reach. The target of having a sub-centre (SC) over 5000 population, a primary health center (PHC) over 30,000 population and a community health center (CHC) over 50,000 population has been largely achieved for the people residing in the villages. Ratnaja (1995), Dasgupta (1996), Padmnabhan (1996), and Ramchandran (1997) observed that over the last eight