PRIMARY HEALTH CENTRE AND RURAL WOMEN HEALTH

DR. P. B. DESAI*

*Assistant Professor,
Department of Sociology, Shivaji University,
Kolhapur - 416004, India.

ABSTRACT

BACKGROUND: Lack of inadequate resources, inadequate staff and many problems PHCs of India in general and PHCs of Karnataka are in particular are suffering. They are also not achieving the targets. But Primary Health Centre from Chinchali Village is exceptional one. Within this adverse condition it is working and achieving its target. This centre plays very important role to protect the rural health particularly health of women.

METHODS: The case study method was used. A single primary health centre was chosen for study and based on the both primary as well as secondary data.

RESULTS: India’s primary healthcare system is based on the Primary Health Centre (PHC) and these PHCs provide treatment free of cost. Primary care is focused on immunization, prevention of malnutrition, pregnancy, child birth, postnatal care and treatment of common illnesses. Majority of the women are poor and there are not able to pay heavy medical fees for private hospitals. They are getting the good medical treatment which helps them to improve their health status. Therefore medical care provided by this centre is taken into significant.

CONCLUSION: This centre plays very important role to protect the rural health particularly health of women.

KEYWORDS: Primary Health Centre, Rural, Women, Rural Women and Health.

INTRODUCTION

Today health has become a complex issue. Health is an essential integral component of all development work and multilateral linkages exist between health, social, cultural, economic and political sheers. Health is a state of physical, mental and social well-being. It involves more than just the absence of diseases. (Bhattacharya Sanjay: 2008). Primary health centers are the cornerstone of the rural health care system. By 1991, India had about 22,400 primary health centers, 11,200 hospitals, and 27,400 clinics. These facilities are part of a three tiered health care system that funnels more difficult cases into urban hospitals while attempting to provide routine medical care to the vast majority in the countryside. Primary health centers and subcenters rely...
on trained paramedics to meet most of their needs. The main problems affecting the success of primary health centers are the predominance of clinical and curative concerns over the intended emphasis on preventive work and the reluctance of staff to work in rural areas. In addition, the integration of health services with family planning programmes often causes the local population to perceive the primary health centers as hostile to their traditional preference for large families. Therefore, primary health centers often play an adversarial role in local efforts to implement national health policies. The Constitution charges every state with "rising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". The National Health Policy was endorsed by the Parliament of India in 1983 and updated in 2002. (www.wikipediadictionary.com)

Government hospitals, some of which are among the best hospitals in India, provide treatment at taxpayer expense. Most essential drugs are offered free of charge in these hospitals. Government hospitals provide treatment either free or at minimal charges. For example, an outpatient card at AIIMS (one of the best hospitals in India) costs a one time fee of rupees 10 (around 20 cents US) and thereafter outpatient medical advice is free. In-hospital treatment costs depend on financial condition of the patient and facilities utilized by him but are usually much less than the private sector. For instance, a patient is waived treatment costs if he is below poverty line. Another patient may seek for an air-conditioned room if he is willing to pay extra for it. The charges for basic in-hospital treatment and investigations are much less compared to the private sector. The cost for these subsidies comes from annual allocations from the central and state governments. The Indian healthcare industry is seen to be growing at a rapid pace and is expected to become a US$280 billion industry by 2020. Central government efforts at influencing public health have focused on the five-year plans, on coordinated planning with the states, and on sponsoring major health programs. Government expenditures are jointly shared by the central and state governments. Goals and strategies are set through central-state government consultations of the Central Council of Health and Family Welfare. Central government efforts are administered by the Ministry of Health and Family Welfare, which provides both administrative and technical services and manages medical education. States provide public services and health education.

The Fifth (1974-78) and Sixth Five-Year Plans and (1980-84) included programs to assist delivery of preventive medicine and improve the health status of the rural population. Supplemental nutrition programs and increasing the supply of safe drinking water were high priorities. The sixth plan aimed at training more community health workers and increasing efforts to control communicable diseases. There were also efforts to improve regional imbalances in the distribution of health care resources.

The Seventh Five-Year Plan (1985-89) budgeted Rs 33.9 billion for health, an amount roughly double the outlay of the sixth plan. Health spending as a portion of total plan outlays, however, had declined over the years since the first plan in 1951, from a high of 3.3% of the total plan spending in FY 1951-55 to 1.9% of the total for the seventh plan. Mid-way through the Eighth Five-Year Plan (1992-96), however, health and family welfare was budgeted at Rs 20 billion, or 4.3% of the total plan spending for FY 1994, with an additional Rs 3.6 billion in the non-plan budget. (ibid)
PRIMARY HEALTH CARE: Primary health care has been defined as essential health care made universally accessible to individuals and acceptable to them through their full participation and at a cost the community and country can afford. It is provided by city and district hospitals and rural primary health centres (PHCs). These hospitals provide treatment free of cost. Primary care is focused on immunization, prevention of malnutrition, pregnancy, child birth, postnatal care and treatment of common illnesses.

RURAL HEALTH CARE SYSTEM IN INDIA:

The health care infrastructure in rural areas has been developed as a three tier system.

**TABLE- 1**

<table>
<thead>
<tr>
<th>Centre</th>
<th>Population Norms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plain Area</td>
</tr>
<tr>
<td>Sub-center</td>
<td>5000</td>
</tr>
<tr>
<td>Primary Health Centre</td>
<td>30,000</td>
</tr>
<tr>
<td>Community Health Centre</td>
<td>1,20,000</td>
</tr>
</tbody>
</table>

SUB-CENTRE: The Sub-Centre is the most peripheral and first contact point between the primary health care system and the community. Each Sub-Centre is manned by one Auxiliary Nurse Midwife (ANM) and one Male Health Worker/ MPW (M). One Lady Health Worker (LHV) is entrusted with the task of supervision of six Sub-Centres. Sub-Centres are assigned tasks relating to interpersonal communication in order to bring about behavioural change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhoea control and control of communicable diseases programmes. The Sub-Centres are provided with basic drugs for minor ailments needed for taking care of essential health needs of men, women and children. The Ministry of Health & Family Welfare is providing 100% Central assistance to all the Sub-Centres in the country since April 2002 in the form of salary of ANMs and LHVs, rent at the rate of Rs. 3000/- per annum and contingency at the rate of Rs. 3200/- per annum, in addition to drugs and equipment kits. The salary of the Male Worker is borne by the State Governments. Under the Swap Scheme, the Government of India has taken over an additional 39,554 Sub Centres from State Governments / Union Territories since April, 2002 in lieu of 5,434 numbers of Rural Family Welfare Centres transferred to the State Governments / Union Territories. There are 1,45,272 Sub Centres functioning in the country as on March 2007. (http://www.indianhealthcare.in)

PRIMARY HEALTH CENTRES (PHCS)

Primary health centre is not new to India. The Bhore Committee in 1946 gave the concept of a primary health centre as a basic health unit, to provide, as close to the people as possible an
integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care for 10,000 populations. The health planners in India has visualised the primary health services to the rural population. The Central Council of Health Services to the rural population. The Central Council of Health at its first meeting held in January 1953 had recommended the establishment of primary health centres in community development blocks to provide comprehensive healthcare to the rural population. The number of primary health centres established since then. The Mudaliar committee in 1962 had recommended that existing primary health centres should be strengthened and the population to be served by them to be scaled down to 40,000. The Declaration of Alma Ata conference in 1978 setting the goal of Health for All by 2000 A.D. PHC is the first contact point between village community and the Medical Officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The PHCs are established and maintained by the State Governments under the Minimum Needs Programme (MNP)/ Basic Minimum Services Programme (BMS). At present, a PHC is manned by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 Sub Centres. It has 4 - 6 beds for patients. The activities of PHC involve curative, preventive, primitive and Family Welfare Services. There are 22,370 PHCs functioning as on March 2007 in the country. India’s primary healthcare system is based on the Primary Health Centre (PHC) which is not spared from issues such as the inability to detect diseases early due to lack of multi-disciplinary medical expertise and laboratory facilities and insufficient quantities of general medicines. At the same time, patients usually do not visit PHCs in the early stages of their diseases, while healthcare providers (if at all present) are forced to focus only on seriously ill patients due to the volume of cases.

MEDICAL AND PUBLIC HEALTH SERVICES RURAL HEALTH PROGRAMME IN KARNATAKA

The Directorate of Health and Family Welfare Services is providing comprehensive health care and services to the people of the State through its network. The state has an extensive network of 293 (176 Government) hospitals, 1,297 Primary Health Centres, 622 Primary Health Units/dispensaries and 7,793 Sub-centres with more than 50,000 bed strength. The state is following the National pattern of three-tier health infrastructure in rendering Primary Health Centres, Health Units, Community Health Centres and Sub-Centres. The policy of the Government is to establish one Primary Health Centre for every 30,000 population and one primary health unit for every 15-20 thousand population and a Sub-Centre for 5,000 populations. The Community Health Centre (CHP) for every one lakh of population or one out of four PHCs. to be formed to cater to the health care of the rural mass. In Karnataka there are 1297 Primary Health Centres. Out of total primary health centres they are 36 PHCs are located in Belgaum district. (www.karnataka.com)

SIGNIFICANCE OF STUDY

Women constitute half of total population of India. Women health, particularly rural women is very important. To improve the rural women health primary health centre are playing very important role in rural areas. In this view this is more important because it addresses role of
one primary health centre from Chinchali Village in Belgaum District, Karnataka State in providing health facilities and improving the health status of rural woman.

**STATEMENT OF PROBLEM**: The present study aims to know the role of primary health centre of Chinchali Village in providing the health services in general and rural women in particular.

**OBJECTIVES**

- To know the health services and programmes of PHC
- To understand how these activities and programmes helps to improve the health status of women.

**STUDY AREA**: The present study was conducted at Primary Health Centre of Chinchali Village in Belgaum District. Location of Village

**LOCATION OF VILLAGE**: Chinchali Village is one of the 58 villages of Raibag Taluka in Belgaum district. It is located on the Karnataka Maharashtra boundary. It is situated 10 km. away from Raibag and 110 km. away from Belgaum. Its nearest railway station is Chinchali railway station and village latitude is 74° 45, 50 N and longitude of the village is 16°30’ to 47’.

**METHODOLOGY**

**RESEARCH DESIGN**

Descriptive type of research design is used for present research.

**SOURCE OF DATA**

The present study is based on the primary as well as secondary data.

Primary Data: Primary Data is collected through fieldwork.

**TOOLS AND TECHNIQUES OF DATA COLLECTION**:

To collect primary data is collected through Observation and informal discussions.

**DATA ANALYSIS AND INTERPRETATION**

Analysis of the data was made with reference to the purpose of the study.

**PRIMARY HEALTH CENTRE OF CHINCHALI VILLAGE AND RURAL WOMEN**:

Women constitute half of population. Women’s participation in economic activities is more than men. Majority of women from rural areas as well as urban areas are participating in economic activities as well as household activities. Majority of women from rural areas are working in the unorganised sector and paid less. They are suffering from many hazardous
diseases and their health status is degrading. Water borne diseases also contribute 70% of the health risk to the community in the village. To tackle the all health problems of villagers in general and women in particular Primary Health Centre in Chinchali Village is playing very important role to provide the health facilities to rural people. The Primary Health Centre is well flourished and extended by nearly two three small villages. Primary Health Centre in Chinchali Village is established in 2002 with population 84,200. Its main centre is located in Chinchali Village which is divided into two parts viz Chinchali-1, Chinchali-2. Other three villages viz Kudachi, Bekkari and Shiragure are also connected to this centre. It is the one of the biggest and prominent health centre in Raibag taluka. Treatment is given in this Primary Health Center is good in the comparison to other. Most of people prefer to take the treatment from this centre. Its participation to improve the health status of villagers in particular and women in general is to the great extent.

TABLE-1
STAFFING PATTERN FOR PHC OF CHINCHALI VILLAGE

<table>
<thead>
<tr>
<th>Staff</th>
<th>Existing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Officers( Residential)</td>
<td>02-Male-1, Female-1</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>01</td>
</tr>
<tr>
<td>Auxiliary Nurse Midwives (ANMs)</td>
<td>01</td>
</tr>
<tr>
<td>Health Workers</td>
<td>06-male-3, female-3</td>
</tr>
<tr>
<td>Village Level Worker</td>
<td>01</td>
</tr>
<tr>
<td>Supervisor</td>
<td>01</td>
</tr>
<tr>
<td>Laboratory Technician</td>
<td>01</td>
</tr>
<tr>
<td>Class-IV</td>
<td>01</td>
</tr>
<tr>
<td>Driver</td>
<td>01</td>
</tr>
<tr>
<td>Community Felicitator</td>
<td>01</td>
</tr>
</tbody>
</table>

There are fifty four Accredited Social Health Activists (ASHA) are working in this centre. ASHA would act as bridge between the ANM and the village and be accountable to the panchayat. Anganwadi Teachers are also acting as bridge between villagers and primary health centre. The services of Accredited Social Health Activists (ASHA) and Auxiliary Nurse Midwives (ANMs) are made available conducting deliveries in cases where women cannot
access health institutions. In such cases, health workers extend all support to ensure safe deliveries.

HEALTH SERVICES PROVIDED BY PHC IN CHINCHALI VILLAGE

MEDICAL CARE/GENERAL TREATMENT: This centre is playing very important role to provide medical care to the villagers. OPD services are provided for four hours in the afternoon/evening. This is time schedule of the primary health. 24 hours emergency services are provided in the case of management of injuries and accident, First aid stabilisation of the condition of the patient before referral, dog bite/snake, scorpion bite cases and other emergency. It is here to mention that all primary centres are providing the services to the villagers. But this PCH is providing the service with sincerely and without fail. There are nearly fifteen private doctors running their own clinic center. Primary Health Center, but they prefer private hospitals sometimes because of sudden treatment they need in the night and holiday especially Sunday. Medicine provided in Primary Health Centre is free of cost. Majority of the women are poor and there are not able to pay heavy medical fees for private hospitals. They are getting the good medical treatment which helps them to improve their health status. Therefore medical care provided by this centre is taken into significant.

MATERNAL AND CHILD HEALTH SERVICES

Great emphasis is laid on improving the health of the mother and child.

MATERNAL HEALTH: It is important and essential service provided by PHC. Following services are provided to the rural women.

- Early registration of pregnancy and minimum 3 antenatal checkups.
- Minimum laboratory investigations such as haemoglobin, urine, albumin and sugar and RPR test for syphilis.
- Nutrition and health counselling
- Supplementation of folic acid and iron tablets and tetanus toxid immunisation
- Identification of high risk pregnancies and appropriate management to first pregnancies.
- Every woman who delivers a child in a PHC or a government hospital is given a cash incentive of Rs. 750 under the NRHM. Besides, women from BPL families, those belonging to the Scheduled Castes and Scheduled Tribes are given a post-natal care kits under the “Madilu” and “Prasuthi Aaraike” schemes. Every woman who delivers a child in the home is given a cash incentive of Rs. 700 and Sesser case she will get 1500 rupees under the NRHM.
- 100 Mother Cards were given.
Mothers’ meetings were conducted.

POST–NATAL CARE

- A minimum of two post-partum home visits, first within 48 hours of delivery and second within seven days through sub-centres staff.
- Initiation of breast-feeding within half hour of delivery.
- Education of nutrition, hygiene and contraception.
- Forty deliveries were conducted and sixty the family planning cases were handled for months. Out of them six are vasectomy cases.

NEW BORN CARE

- Essential newborn care.
- Facilities and Care for neonatal resuscitation
- Management of neonatal hypothermia and jaundice.

CARE OF CHILD

- Emergency care of sick child including Integrated Management of Neonatal and Childhood Illness
- Care of routine childhood illness.
- Promotion of breast feeding illness for six months.
- Care of routine childhood illness
- Under these programmes, children are immunized against Tetanus, T.B, Polio, Measles, Diphtheria, and Pertussis. Pregnant women too are immunized against Tetanus. Under the National programme of Prevention of Blindness, Vitamin ‘A’ concentrate is being distributed to the children.

OTHER SERVICES

- Health Education
- Nutrition Services: Diagnosis and management of malnutrition.
- School Health Services: Medical examinations are conducted for children in all the primary and higher primary schools in the rural areas. Immunization against DT and TT,
treatment of ailments, health education to teachers and students etc., are included in this School Health Programme

- Adolescent healthcare

- Collection and reporting of vital events

- Promotion of sanitation including use of toilets and appropriate garbage disposal: Water supply and sanitation in India is a matter of concern. As of 2003, it was estimated that only 30% of India's wastewater was being treated, with the remainder flowing into rivers or groundwater. The lack of toilet facilities in many areas also presents a major health risk; open defecation is widespread even in urban areas of India and it was estimated in 2002 by the World Health Organisation that around 700,000 Indians die each year from diarrhoea. No city in India has full-day water supply. Most cities supply water only a few hours a day. In towns and rural areas the situation is even worse. To tackle this problem a project was initiated by this primary health centre in collaboration with KLE. Village Health and Sanitation committee was formed under the guidance of Health and Family Welfare Department, Karnataka government. Under this committee sanitation campaigns were conducted to provide the safe drinking water, sanitation facilities and sanitation awareness. Fifteen members were given the training.

- Testing of water quality and disinfection of water source

PROGRAMMES OF PRIMARY HEALTH CENTRE OF CHINCHALI VILLAGE

All National Health Programmes such as Revised National Programme for Control of tuberculosis National Vector Borne Disease Control Programme, National Vector Borne Disease Control Programme are implemented by central government as well as state government are also applicable to this centre. For the last year 12 malaria patients, 540 fever patients, 12 leprosy patients, 8 T.B. patients in first phase and 4 T.B. patients in second phase and one leprosy patient were recorded.

PHC AND RURAL WOMEN HEALTH

All health services and programmes of PHC are directly or indirectly related to the women health. They are playing important role to improve the health status of women. In the village out of total population, 48% of population is women population and majority of them are belonging to the agricultural families. These women are working in home as well as fields in the day and night. Due this work load they are suffering from many diseases. Health status of the women that from BPL families is worse. Lack of nutritious food and work these women are suffering from diseases. Women’s health is always neglected due patriarchal mode of family system in rural areas. Sometime because of economic problem women are also not ready to take the treatment from private hospital which costs too much. In such conditions efficient and flourished government hospital are essential to protect ant improve the health status of women. In this view PHC of Chinchali Village is playing a key role. Great emphasis is laid on improving the health of mother and child through Maternal and Child Health Services. These services are
provided to the village women with sincerely. Many women from this village express their thanks for this centre and medical officer Rangannavar who is playing an important role to extent this PCH and to provide health services to all in general and women in particular. Infant mortality and maternal mortality rate has been decreased. Sanitation promotion including use of toilets and appropriate garbage disposal and sanitation awareness was initiated by Health and Sanitation Committee, Karnataka State, through PHC also helps to improve the health status. Earlier open defecation was wide spread which creates many health problems among rural women. By promotion of sanitation including use of toilets decreases the health problems of women. Testing of water quality and disinfection of water source also helps to decrease the water borne diseases in general all and particular women.

Cash incentive is given to the women from BPL families at the delivery gives some relief to them.

PROBLEMS ARE BEING FACED BY PHC OF CHINCHALI VILLAGE

PHCs from all over Karnataka are facing the problems. The lack of accountability stems from the fact that there is no formal feedback mechanism and incentive to treat citizens as clients. Patients often complain of rude and abrupt health workers that discriminate against women and minorities from scheduled castes or tribes. The lack of accountability leads to absentee doctors; as it is difficult to attract qualified doctors to rural areas, unresponsive ANMs, inconvenient opening times and little or no community participation. All these are the general problems of PHCs in Karnataka State. But PHC from Chinchali Village is suffering from another problem that is opposition from private practitioners.

SUGGESTIONS

- This PHC should extent to the extra nearby villages.
- More community participation.
- OPD must be on the shift basis. It is from 8’O, Clock morning to 8’ O, Clock Night.
- Other than general treatment specialised treatment should also provide in PHC on visit basis.

CONCLUSION

To tackle the all health problems of villagers in general and women in particular Primary Health Centre in Chinchali Village is playing very important role to provide the health facilities to rural people.

REFERENCES

• Afshan Yasmeen,” Primary health centres to be upgraded”, THE HINDU, Wednesday, Jan 13, 2010.


• NATIONAL HEALTH POLICY – 2002.


• Shankar Bennur, 200 primary health centres in State to function round the clock” THE HINDU, Tuesday, Mar 09, 2010.


• http://www.indianhealthcare.in/index.php

• http://www.karnataka.com/govt/health

• http://countrystudies.us/india/36.htm