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ROLE OF PRIMARY HEALTH CENTRE AND RURAL WOMEN: SOCIOLOGICAL ANALYSIS

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ABSTRACT

Health has been considered as a fundamental right of human beings. The state has greater responsibility in providing health care facilities. As there was national commitment to improve health different approaches to providing health care came into existence. The Government of India built up a vast infrastructure of rural health services based on primary health centres and sub- centres in order to provide health care.

The primary health care infrastructure provides the first level of contact between the population and health care providers up to and including primary health care physicians and forms the common pathway for implementation of all the health and family welfare programmes in the country. It provides integrated promotive, preventive, curative and rehabilitative services to the population close to their hearth and home. Majority of the health care needs of the population is taken care of by the trained health personnel at the primary health care level. Those requiring specialized care are referred to secondary or tertiary care.

Introduction

Health is a state subject as per the constitution of India and the main responsibility for providing health services lies with the state. The Health Minister is the politicalhead of the Health Department and is responsible for formulation of health policies. The success of the Health and Family Welfare Department depends on the Director of Health.

The basic territorial unit of administration in India is the district. The district health office is the nerve center of the health care delivery system. It acts as an intermediary between the state and the grass root level health organizations. The District Health Officer provides leadership to the district health care delivery system and functions under the supervision and controls the chief enforcement officer of Zilla Panchayat. Health infrastructure in rural areas is of prime importance for attaining the goal of 'Health for All'. PHC is the facility at the first contact level and seeks to provide a full range of health promotion and preventive services, as well as curative care, limited to ambulatory patients. The PHC has a multidisciplinary team capable of providing this range of services.

In India with the recommendation of Bhore committee in 1946 the concept of PHC came into existence. To provide comprehensive, curative and preventive health services in rural areas this committee recommended. Initially all these programs run independent of each other and staff recruited under each programs. As per the government direction in Karnataka there is one PHC for every 30,000 populations in plain and for 20,000 in hilly and tribal area. In Karnataka there are 1676 PHCs are working. And there are sub-centres for every 5,000 populations in plain and for every 3,000 populations in hilly and tribal areas. And in each of this sub-centres team of one male and a female are working.

Primary Health Centre

The concept of primary health Centre is not new to our country. Sir Joseph Bhore committee provides the concept of primary health care center as a basic unit that provides curative and preventive health care to the rural people. Several committees and health policies recommend their own recommendation as result of their study. Important committees are…Bhore committee [1943-46], Mudaliar Committee (1959-61), Chadha committee (1963), Mukherjee Committee (1966), Kartar Singh committee (1972-73),Shrivastava Committee (1974-75), National health policy (1983)and NationalHealth policy (2002). As per the government direction in Karnataka there is one PHC for every 30,000 populations in plain and for 20,000 in hilly and tribal area. In Karnataka there are 1676 PHCs are working. And there are sub-centers for every 5,000 populations in plain and for every 3,000 populations in hilly and tribal areas. And in each of this sub-centers team of one male and a female are working.

The main functions of PHCs are as follows MedicalCare, Maternal and Child Health Services, School Health Services, Family Planning, Control of Communicable Diseases, Environmental Sanitation, Health Education and Vital Statistics etc.,

Review of literature

Mridula Bandyopadhyay and **Stewart McPherson** in ***WomenandHealth: Tradition and Culture in Rural India[1998]*** focused on the influence of socio-economic and cultural factors on maternal and child health care practices health care behaviour, reproductive health, family planning and utilization of health care resources and the study reveals that health behavior changes with increase in socio-economic status of the small family norm and more utilization available health care resources.

N.D. Kamble in ***Rural Health [1984]*** links the socio-economic factors with morbidity in rural areas. This book provides the description about the health services in Karnataka variables among morbidity and environment and also the influence of consumption pattern on health and the availability of medical facility and economic position of the patients that largely influence in getting better treatment.

Importance of the Study

Role of PHC is of very much important in providing health facilities to the rural people in general and women in particular. As development of any country depends on the health of its human capital, and women constitute 50% of the total population and women is one who gave birth to child that is the future generation. If our population is to be healthy women must be healthy. A healthy woman only can give birth to healthy and bright baby. Thus, it is clear that the health of women is at most important.PHC provide preventive and curative health services to the rural people. Role of Primary Health Center is more effective in making women physically and mentally healthy. It is thus very important to find out the drawbacks and problems of Primary Health Centres in providing health care services and to find suitable measures to overcome from the problems and serve effectively to the needy.

The main focus of the present study is on Role of Primary Health Centres and Rural Women, with special reference to Bhadravathi Taluk. In the study efforts were made to understand the various activities of the PHCs including the punctuality, commitment and efficiency of the staff I delivering their responsibilities. Efforts are also put to understand the health status of rural women and the practice of availing the services of PHCs. Mainly concentrated on the analysis of the above issues keeping in view of the Sociological impact of health in rural areas on women.

For the purpose of the study data were collected regarding the quality of services rendered by the health centers through all sources and scientifically analysed. Required information about the facilities of PHCs in improving the health status of women are

also collected through PHC staffs and rural women in the study area that is Bhadravathi taluk.

Although Primary Health Centres are working for the improvement of health status of rural people in general and women in particular but 100% improvement has not been recorded. Therefore, in the study the opinions of the women and health centers staff are collected to know about the reason behind the failure in rendering the quality health services and in strengthening the health care system for Rural Women.

Objectives of the Study

As present study is a sociological study there is necessary to concentrate on various facts. Having this in mend following objectives have been formulated.

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- To know the rural women's knowledge and the utilization of facilities of PHCs
- To know about the medicines and other facilities available for rural women in PHCs,

Sampling

As the present study aims to study the socio- economic and health of rural women in rural areas, sample survey was made to collect the primary data. That is the researcher chosen five villages from one PHCs, that is B R Project (Singanamane) at Bhadravathi Taluka of Shivamogga District.The total sample size of this study is 50respondents.

Table No.1.Age Structure of the Respondents

Age	Frequency	Percentage
21-30	06	12.00
31-40	21	42.00
41-50	10	20.00
51-60	09	18.00
61-70	03	06.00
70+	01	02.00
Total	**50**	**100.00**

It is evident from the above table that12 percent of the total members belong to the age group of 21 to 30, of them 31 belongs to the age group of 31 to 50 and 62 percent belongs to the age group of 51 to 70 and 12 members belong to the age group of70+. Lowest percentage is in the age group of 21 to 30 and 51+. It is quite clear that the younger women are more vulnerable to health disorder and the behaviour of taking care of their own health and health of their children particularly and family in general is the responsibility of women.

Table No.2.Occupational structure of the respondents

Occupation	Frequency (respondents) (n=50)	Percentage	Frequency (respondent's husbands) (n=36)	Percentage
Agricultural labour	42	84.00	31	86.11
Lorry/taxi driver	-	-	01	02.78
Street vender s	06	12.00	04	11.12
Agriculture	12	24.00	05	36.11
Unemployed	33	66.00	26	72.22

The above table shows that 84 percent of the total members mentioned their occupation as agricultural labourers and the 86 percent of husband's occupation is also agricultural labourers. Only 06 women are doing Street vender s and only three members husband's occupation is Street vender s. It shows till to this date agriculture is the main occupation in rural area

Details about the facilities at PHC

PHCs are established to provide health service to the rural poor. It is necessary to evaluate the facilities rendered by these PHCs and quality of these facilities.

Table. No.3. Facilities available in the Primary Health Centres

Facilities	Yes	No	If yes				Frequency & Percentage
			Excellent	Good	Average	Bad	
Availability of physician	40 (80.00)	10 (20.00)	--	24 (60.00)	11 (27.50)	05 (12.50)	40 (100.00)
Availability of staff	45 (90.00)	05 (10.00)	--	32 (71.11)	09 (20.00)	04 (08.89)	45 (100.00)
Medicines	30 (60.00)	20 (40.00)	--	19 (63.33)	08 (26.67)	03 (10.00)	30 (100.00)
Clean and hygiene	32 (64.00)	18 (36.00)	02(06.25)	17 (53.12)	07 (21.88)	06 (17.75)	32 (100.00)
Furnitures	38 (76.00)	12 (24.00)	--	23 (60.53)	12 (31.58)	03 (07.89)	38 (100.00)
Building	42 (84.00)	08 (16.00)	01 (02.38)	31 (73.80)	18 (42.86)	02 (04.76)	42 (100.00)
Experienced Nurses	33 (66.00)	17 (34.00)	06(18.19)	13 (39.40)	06 (18.19)	07 (21.22)	50 (100.00)
Health Education	32 (64.00)	18 (36.00)	03(09.38)	21 (65.62)	05 (15.62)	03 (09.38)	50 (100.00)
Immunisation	30 (60.00)	20 (40.00)	--	18 (60.00)	07 (23.34)	05 (16.56)	50 (100.00)
Creating awareness about Family Planning	35 (70.00)	15 (30.00)	07 (20.00)	21 (60.00)	07 (20.00)	--	50 (100.00)
Maternity Facility	20 (40.00)	30 (60.00)	--	11 (55.00)	06 (30.00)	03 (15.00)	50 (100.00)
Treatment during emergency	18 (36.00)	32 (64.00)	--	08 (44.44)	05 (27.78)	05 (27.78)	50 (100.00)

From the above table we can come to conclusion that all 50 members are in positive opinion on various facilities of the PHC. Physicians availability,80 percent of members opined physician provide good quality of services. Over 90 percent of the total members have positive opinion about the other staff members of the PHC. As per 60 percent of the total members availability of medicines are good, and26.67 percent of the total members graded as average. It is clear from the above table that PHCs are lagging behind in the matter of hygiene and clean as majority of i.e., 21.88 percent opines it can be graded average.

Although on furniture availability only 76 percent of the total members gave good grade and 31.58 percent of the total members opined average grade with regard to furniture. In case of building only 84 percent of total members felt that building issomeold, reconstructed and then need of reconstruction. Only 66 percent of the total members get good treatment by nurses. 18.19 percent of the members are of opinion that average. Other facilities such as Immunization, creating awareness about family planning programme maternity and treatment during emergency. The Immunization facility is according to average percent of members and also total members of opinion as emergency treatment is not bad.

For the emergency and serious illness women does not consult PHC and during pregnancy also women prefer private nursing home rather than PHCs. This is because lack of adequate equipment and neglecting attitude of PHC staff. On the other hand, private nursing homes although cost more but provide good and qualitative services to the patients.From analyzing the views of women we can come to conclusion that facilities at PHCs are only nominal on the papers only but in reality it is not like that. PHC

staffs are no available even since morning to evening as most of them are not residing at the place of their posting but residing in nearby towns. Most of their time and energy spends in traveling.

As medicine facilities are not good at PHCs for this they said Government is not providing sufficient stock. They will ask patients to buy medicines only during stock is nil. And during emergency for which medical treatment could not provide as because of lack of facilities they refer them to consult district hospital or private hospitals. PHC staffs opined that patients are usually good and women are the largest in number to consult PHC rather than men and they follow their suggestion but some time they will not take medicines and required food diet also not followed.

The Primary Health Centres are in need of staff, they are lacking in staffs. To some extent the Medical Officer's behave good towards women but the behaviour of other staff is not satisfactory according to the study. The facilities at the Primary Health Centres are not fully provided; there is lack in the equipments in laboratory, medicine facility also not adequate.

From analyzing the views of women we can come to conclusion that facilities at PHCs are only nominal on the papers only but in reality it is not like that. PHC staffs are not available even since morning to evening as most of them are not residing at the place of their posting but residing in nearby towns. Most of their time and energy spends in traveling.PHCs are not working 24-07 as problems may occur any time.Women thought that these PHCs are not reliable. PHC staffs particularly physician behave courteously with patients but some of them feel uncomfortable to discuss their problems with male physician most of the women are in need of lady physician.

Rural women opined that they are in need of lady physicians, better maternity facility and good building and adequate staff so that they may not wait for hours together to get treatment. PHC staffs on the other hand gave information that they are providing medical services regarding general diseases, maternity, immunization, vaccination, leprosy and almost all the general diseases, but they are of opinion that emergency medicines like snakebite are not provided since 02- 03 years. PHC staffs also are of the opinion that large number of patient consults PHCs for general disease like fever, cough, cold or either to get vaccination and immunization.

It is clear from the study that PHCs are not providing qualitative service it fails in its goal of improving the health status of the rural people particularly of women. Emergency care facility is also very poor in PHCs although facilities are not adequate, they are not partial in providing treatment. It is very important to take care of the health of women. Rural women are more vulnerable to diseases because of poverty, illiteracy. Therefore, they are in more need of public health care centres that cost less. PHC provide cost-effectives healthcare to the population in general and women in particular.

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