



**A STUDY OF RURAL HEALTHCARE SERVICES: WITH  
SPECIAL REFERENCE TO SHIVAMOGGA DISTRICT IN  
KARNATAKA, INDIA**

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**Abstract:**

India has a large public health care system. Rural healthcare service is provided through a Network of sub-centers, primary health care centers, community health centers and District hospitals. NRHM aims at strengthening of PHCs for quality preventive, promotive, curative, supervisory and outreach services to achieve and maintain an acceptance by standard of quality of healthcare, to make the services more responsive and sensitive to the needs of the communities. The literature review shows that earlier research mainly focused on macro level financing of rural health care and enough studies have not been made to understand the micro level issues. Very little research was attempted on managerial aspects of rural health care service delivery in India. In this context the general principles suggested by the WHO needs to be studied in Indian context. Therefore, there is a need to study the rural healthcare services in the new context and with new perspectives. An appropriate scaling technique were used to measure the response and all existing relevant document and reports were consulted and field visits were made to obtain first-hand knowledge of issues, problems and concerns. Discussions were held with the state, district and block level with current and former policy-makers. Purposive sampling method were used to select two villages in Shivamogga District; one each based on economic backwardness and other demographic factors. Stratified sampling method will be used at block level and village level. The study took sample of 210 from different select components of the rural healthcare services.

**Key Words:** Rural Healthcare Services, Primary Health Centre, ANMs & NRHM

**Introduction:**

India has a large public health care system. Rural healthcare service is provided through a Network of sub-centers, primary health care centers, community health centers and District hospitals. The Alma Ata Conference defines Primary Health Care as essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both the country's health system, of which it is the central function and the main focus of the overall social and economic development of the community. In rural areas, most primary health care is provided either by sub enters or primary health care centers; where as in urban areas it is provided via health posts and family welfare centers. Before the economic reforms in the mid-1980s, public spending on healthcare in India had peaked at about 1 percent of GDP and 4 percent of the government budget. During the 1990s, government health spending did not keep up with the expanding economy and budget, with the result that by 2001 public spending on health constituted only 0.9 percent of GDP and 2.7 percent of the government budget. These numbers fell further to 0.8 percent and 2.4 percent, respectively in 2007-08. The government of India in an articulation of the commitment of the government to raise public spending on health from 0.9 of GDP to 2.3 of GDP. WHO suggested some general principles of rural healthcare development:

- ✓ Increasing involvement of the community in all aspects of programme
- ✓ Adaptation of local health service personnel to primary health care
- ✓ The closer links of rural healthcare with general development and
- ✓ Need of national resources and political will to support primary healthcare.

NRHM was initiated by government of India in the year 2005 for strengthening healthcare facilities in rural India this mission program will support the rural healthcare services in India for seven years. National rural healthcare mission has proposed strengthening of sub centers in the form of financial support of Rs.10000 per annum. This amount has to be utilized for local needs and maintenance of the sub center. NRHM aims at strengthening of PHCs for quality preventive, promotive, curative, supervisory and outreach services to achieve and maintain an acceptance by standard of quality of healthcare, to make the services more responsive and sensitive to the needs of the communities.

**Review of Literature:**

According to Papiya Mazumdar (2006) the issue of rural health care has assumed greater significance in the developing world, mainly due to changing role of the state in providing health care. Observed that among the states, the relatively poor ones were found to be spending more on rural healthcare, both per capita and as a proportion of GDP, compared to the richer states. It was seen that expenditure on health by the state had not

grown adequately along the path of overall economic prosperity, and private out-of-pocket expenditure seemed to be on the rise.

Choudhury, Mita (2006) dealt with the problems of a rural healthcare system and impact of financing on health care performance. It examined why people chose alternative arrangements, either in markets or through the political process. In addition, it demonstrates the link between financing of rural healthcare and methods of payment for health care and, in turn, the link between payment and the supply decisions of health care providers.

K. Kananatu (2000) presents an overview of the India healthcare system and its method of financing. The development of the healthcare delivery system in India is commendable. However, the strength and weaknesses of the public healthcare system and the financing problems encountered are also discussed. Cost of healthcare and funding of both the public and private sectors were also revealed. One must optimise the advantages of operating a health financing scheme which is affordable and controllable which contribute towards cost-containment and quality assurance. Thus, there is a need for the establishment of a National Healthcare Financing, a mechanism to sustain the healthcare delivery network and operate it as a viable option. A model of the National Health Financing was proposed in their paper.

Ravi Duggal (2007) opined that the way in which healthcare is financed is critical for equity in access to healthcare. At present the proportion of public healthcare resources committed to healthcare in India is one of the lowest in the world, with less than one-fifth of health expenditure being publicly financed. India has large-scale poverty and yet the main source of financing healthcare is out-of-pocket expenditure. This is a cause of the huge inequities in accessing healthcare. The article argues for strengthening public investment and expenditure in the health sector and suggests possible options for doing this. It also calls for a reform of the existing healthcare system by restructuring it to create a universal access mechanism which also factors in the private health sector. The article concludes that it is important to over-emphasize the fact that health is a public or social good and so cannot be left to the vagaries of the market.

T. V. Sekher (2002) explained that the delivery of rural healthcare services in India remained poor, particularly in rural areas, due to lack of infrastructure and personnel, financial constraints, lack of awareness, poor accountability and transparency. Though the networks of the department have spread to almost every village, the availability and utilization of the services continue to be very poor and grossly inadequate. In this situation, he explored the possibility if the panchaytraj institution (PRIs) makes a difference in the delivery of rural healthcare services. This article attempts to explore these issues in the context of Karnataka in India.

#### **Significance of the Study:**

The forgoing discussion brings out the following issues in rural health care service delivery in India:

- ✓ While there is a strong need to increase the allocation of funds more equitably, the state governments alone cannot provide funds required for meeting the NRHM objectives.
- ✓ The states have not adopted the general principles suggested by the WHO in rural health care.
- ✓ Attracting funds largely depend on effective management of rural health care service delivery

The literature review shows that earlier research mainly focused on macro level financing of rural health care and enough studies have not been made to understand the micro level issues. Very little research was attempted on managerial aspects of rural health care service delivery in India. In this context the general principles suggested by the WHO needs to be studied in Indian context. Therefore, there is a need to study the rural healthcare services in the new context and with new perspectives.

#### **Objectives:**

- ✓ To analyse the participation of community in the rural healthcare system.
- ✓ To analyse the benefits received by the community from rural healthcare system.

#### **Hypothesis:**

- ✓ Active involvement of community and stakeholders as proposed by W.H.O in the management of rural health care will provide an effective delivery of rural health care services.

#### **Scope of the Study:**

The study of rural healthcare services in Karnataka will be made by considering various factors. The scope of the study was covered select components of the primary, Community and sub centre healthcare in Karnataka.

#### **Research Methodology:**

According to the purpose of the study, it is proposed to be cross-sectional and diagnostic study drawing from both qualitative and quantitative inputs. The study aims to test the above mentioned hypothesis in select components of rural healthcare services. Data sources are primary healthcare, community healthcare, sub centres and Beneficiaries of services. Secondary data would be collected from annual reports. Publications of the financial healthcare service sector, Government agency and management educational institution. Healthcare documentation and other government departments' plan reports, books and journals. Data collection instruments are Personal interview, Group discussions and healthcare record/document scrutiny using checklist.

An appropriate scaling technique were used to measure the response and all existing relevant document and reports were consulted and field visits were made to obtain first-hand knowledge of issues, problems and concerns. Discussions were held with the state, district and block level with current and former policy-makers.

**Sample Method:**

Purposive sampling method were used to select two villages in Shivamogga District; one each based on economic backwardness and other demographic factors. Stratified sampling method will be used at block level and village level. The study took sample of 210 from different select components of the rural healthcare services.

**Analysis and Interpretation:**

Table 1: Health Professionals

| S.No | Particulars                  | No. of Respondents | Percentage of the Respondents |
|------|------------------------------|--------------------|-------------------------------|
| 1    | Anganawadi Workers           | 62                 | 46.62                         |
| 2    | Traditional Birth Attendants | 4                  | 3.01                          |
| 3    | Private Practitioners        | 3                  | 2.26                          |
| 4    | Traditional Healers Pandit   | 1                  | 0.75                          |
| 5    | Ahsa Workers                 | 60                 | 45.11                         |
| 6    | Any Other Specify            | 3                  | 2.26                          |
|      | Total                        | 133                | 100                           |

It is clear from the table that Anganawadi workers and Asha workers having large share in the study area about 46.67% and 43.81% respectively. Apart from these professionals traditional birth attenders, Private practitioners and traditional healers or pandits constitute very less share about 9.52%.

Table 2: Services given by NGOs

| S.No | Particulars                                | No. of Respondents | Percentage of the Respondents |
|------|--------------------------------------------|--------------------|-------------------------------|
| 1    | Conducting health checkup camps            | 50                 | 23.81                         |
| 2    | Giving information on health issues        | 79                 | 37.62                         |
| 3    | Giving personal referrals                  | 11                 | 5.24                          |
| 4    | Providing assistance when visiting doctors | 29                 | 13.81                         |
| 5    | Providing free medicine                    | 21                 | 10.00                         |

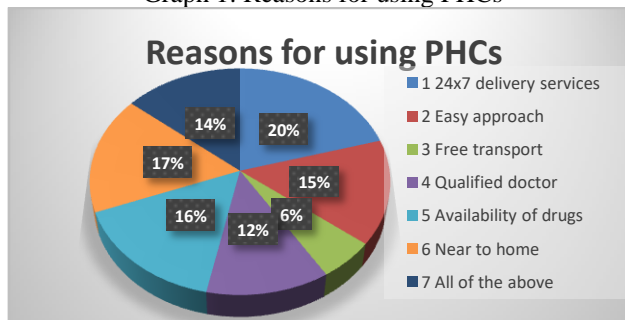
The table explains that NGOs are giving more services with relates to conducting health checkup camps and giving information on health issues about 23.81% and 37.62%. The other services given NGOs are giving personal referrals, providing assistance when visiting doctors and providing free medicine.

Table 3: Services given to community by ANMS / Heath inspectors

| S.No | Particulars                         | No. of Respondents | Percentage of the Respondents |
|------|-------------------------------------|--------------------|-------------------------------|
| 1    | Health Education                    | 66                 | 31.43                         |
| 2    | Motivation for family planning      | 47                 | 22.38                         |
| 3    | Tablets                             | 39                 | 18.57                         |
| 4    | Care of pregnant women's            | 25                 | 11.90                         |
| 5    | Care of babies                      | 49                 | 23.33                         |
| 6    | Injection                           | 6                  | 2.86                          |
| 7    | General Check up                    | 21                 | 10.00                         |
| 8    | Gives medicines for common ailments | 41                 | 19.52                         |

The table shows that diverse services are given by the ANMs or Health Inspectors to the community. 26.67% are getting health education, 19.52% are having care of Babies, 19.05% are getting motivation for family planning and 17.14% are getting at Necessary time. The other minor services are care of pregnant women, general checkup and injections at needy time.

Graph 1: Reasons for using PHCs



The above graph explain that out of 210 respondents, 15 were agreed all the reasons given in the table. The 21% of total use the PHC for the reason of getting 24x7 delivery services. Least number of respondents (5.61%) are using PHC for the reason of free transport.

Table 4: Reasons for not using PHCs

| S.No | Particulars               | No. of Respondents | Percentage of the Respondents |
|------|---------------------------|--------------------|-------------------------------|
| 1    | Long waiting hours        | 52                 | 50.49                         |
| 2    | Poor supply of drugs      | 33                 | 32.04                         |
| 3    | Unaware of services       | 14                 | 13.59                         |
| 4    | Bad behaviour of employee | 4                  | 3.88                          |
|      | Total                     | <b>103</b>         | <b>100.00</b>                 |

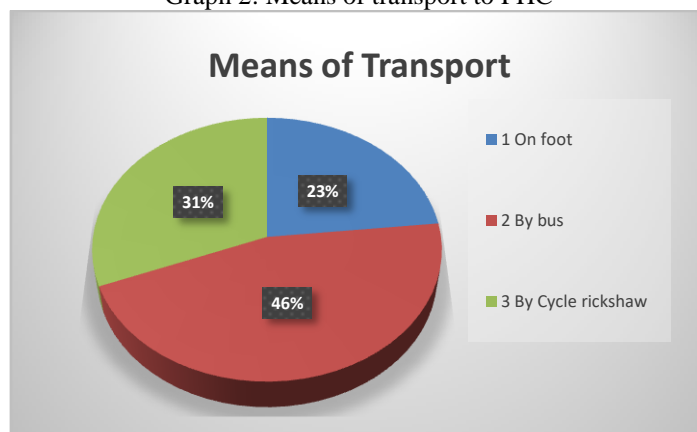
The table shows that about 51% of the respondents are not using PHCs for long waiting hours, 32% are for poor supply of drugs and 14% are for unaware of services.

Table 5: Reasons for unsuitable timings of PHCs

| S.No | Particulars                 | No. of Respondents | Percentage of the Respondents |
|------|-----------------------------|--------------------|-------------------------------|
| 1    | Too early                   | 42                 | 34.71                         |
| 2    | Engaged in agriculture work | 43                 | 35.54                         |
| 3    | Went for daily wages        | 15                 | 12.40                         |
| 4    | Return to home is too late  | 21                 | 17.36                         |
|      | Total                       | <b>121</b>         | <b>100.00</b>                 |

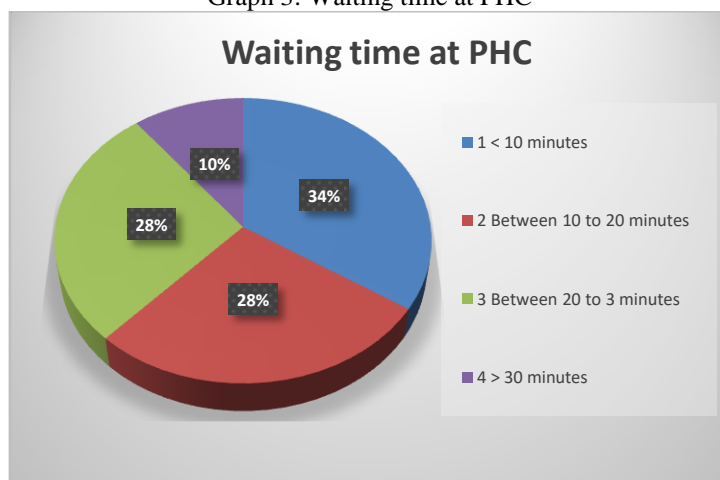
The 36% of the sample gave the main reason for unsuitable timings of PHCs is most of them are engaged in agriculture work. The respondents about 35% gave reason that it is too early timings for them.

Graph 2: Means of transport to PHC



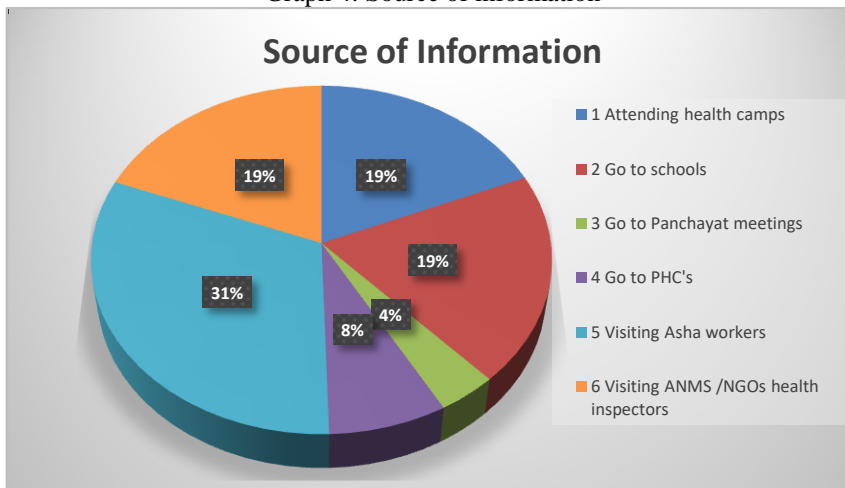
The graph explains that 46% of the respondents use bus for their means of transport to PHCs. 31% use cycle rickshaw. It indicates that transport facility is good at the study area.

Graph 3: Waiting time at PHC



The graph shows that 72 respondents expressed that they wait for less than 10 minutes at PHC whereas 58 viewed that they wait between 10 to 20 and 20 to 30 minutes time at PHCs. It shows that quick health services are given at PHCs.

Graph 4: Source of information



Majority of the respondents (31.43%) expressed that they are getting information from that the visit of Asha workers. Only 08 respondents (3.81%) told that they are getting information from Panchayat meetings. It is noticed that Panchayats are playing very less role in the health services.

Table 6: Place of delivery

| S.No | Particulars         | No. of Respondents | Percentage of the Respondents |
|------|---------------------|--------------------|-------------------------------|
| 1    | Government hospital | 128                | 60.95                         |
| 2    | Private hospital    | 50                 | 23.81                         |
| 3    | Home and other      | 3                  | 1.43                          |
| 4    | Not applicable      | 29                 | 13.81                         |
|      | Total               | 210                | 100.00                        |

The 128 respondents are opinioned that the place of delivery is at government hospitals. Only 03 respondents expressed the place of delivery as home. It indicates in the study area government hospital played major role as delivery centres.

Table 7: Frequency of home visit by ANMs / Health inspector

| S.No | Particulars         | No. of Respondents | Percentage of the Respondents |
|------|---------------------|--------------------|-------------------------------|
| 1    | Once in a week      | 48                 | 22.86                         |
| 2    | Once in a fortnight | 20                 | 9.52                          |
| 3    | Once in a month     | 142                | 67.62                         |
|      | Total               | 210                | 100.00                        |

The table shows 68% of the respondents said ANMs or Health Inspectors visit the home once in a month, 9% once in a fortnight and 23% once in a week.

**Findings:**

- ✓ Out of 210 respondents, 133 opinioned that they are aware about the working of health professional in their village. The 77 opinioned that health professionals are not working in their village.
- ✓ Among the respondents, 102 are agreed that there is health education in the school. But 60 are opinioned that there is no health education in the school. Among the total sample, 48 are not having any school going children.
- ✓ The 73.33% respondents expressed that Gram Panchayats are not organizing meetings for health issues and 26.67% that Gram Panchayats organizes meetings for health issues.
- ✓ The 75.71% agreed that Asha Workers are regularly visiting the houses. This shows that role of Asha Workers is prominent in the study area.
- ✓ In the study area it is noticed that NGOs are not working on health issues. Because 72.86% of the respondents opinioned NGOs are not working on health issues.
- ✓ The primary data inform that only 50% of the respondents are using the PHC services. This shows that there is need for health awareness among the people in the study area.
- ✓ The 58% of the sample noticed that the timing of PHCs are unsuitable for them, whereas 42% accepted suitability of the timing of PHCs and the 49% said that PHCs have trained staff.

**Limitation of the Study:**

Though the study is very comprehensive in nature it is subjected to certain limitation. As the study covered one state in India it will be relevant only to those areas in India which reflect similar conditions as resource constraint does not permit to study at national level.

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