

CHALLENGES TO RURAL HEALTH CARE: A SOCIOLOGICAL STUDY IN UDUPI DISTRICT, KARNATAKA

Dr DUGGAPPA KAJEKAR

Co-ordinator, P.G. Dept of Social Work

Govt First Grade College & Centre for Post Graduate Studies

Thenkanidiyur, Udupi District.Karnataka State, India 576106

Abstract of Paper

Indian Rural folk are suffering and dying from preventable diseases, i.e. malnutrition, gynaecological problems and non-communicable diseases. These people are also suffering from illiteracy, poverty, high rate of infant and maternal mortality. However, from the time of independence, several measures have been undertaken by the government of India to improve the health of the people, reduce the mortality rate, improve life expectancy, population control and improve the rural health. National Rural Health Mission (NRHM) was launched in the year 2005 that played a significant role in providing primary health care services in the rural areas of the country. According to Annual Report 2016-17 of Ministry of Health and Family Welfare, more than 9.43 lakh ASHA's are working across the countries who serve facilitators, mobilizes and providers of community health care.

This paper is prepared on the basis of data collected from 50 households in Udupi and Kundapura Taluk of Udupi district. Interview schedules were used for collecting the data. The major findings of the study are presented in the main paper. 48% of the respondents prefer Primary Health Centres for the treatment of minor health problems in the study area. 60% of households neglect to purify the drinking water. 52% of them reported that their nature of work is responsible for their problems like allergy and asthmatic problems. Majority of them have said that there is no alternative arrangement for disposal of wastes which is a major concern for deterioration of rural health. 52% of the people are moderately satisfied of the services of ASHA health workers, 48% of them are satisfied of their services. ASHA workers play pivotal role in the community Health services especially to the marginalized sections of the Rural India.

Although private and public health services co-exist, the public sector plays the pivotal role in extending health services in rural area. Moreover, access to health services in rural area not only related to physical proximity and travel time to service centres but also depends on economic and social conditions of people.

Key words: ASHA, NHRM, Primary health Centre, awareness.

Full Paper

Introduction:

Health must begin with the individual. Health is highly a personal responsibility on the one hand and on the other it is a major public concern. Although health is now recognized a fundamental right, it is essentially an individual responsibility. 'Self-Care' means those health-generating activities that are undertaken by the persons themselves. To these must be added family planning which is essentially an individual responsibility. Rural

health or rural medicine covers geography, midwifery, nursing, sociology, economics and telehealth. Hence it is a multidisciplinary study.

The villagers in India are suffering and dying from preventable diseases, i.e. malnutrition, problems related to mother and child, non-communicable diseases. These people are also suffering from low level of literacy, poverty, malnutrition, and high rate of infant and maternal mortality rate. However, from the time of independence, several measures have been undertaken by the government of India to improve the health of the people, reduce infant and maternal mortality rate, improve life expectancy at birth, population control and improve rural health. Lifestyle and personal health choices also affect the health and expected longevity of individuals in rural areas. Persons from rural areas report higher rates of smoking, exposure to second-hand smoke, and obesity than those in urban areas. Additionally, rural areas often have low rates of fruits and vegetable consumption even where farming is prevalent

National Rural Health Mission was launched in the year 2005, which played significant role in providing primary health care services in the rural areas of the country. The National Health Mission encompasses two sub-missions namely the National Rural Health Mission and National Urban Health Mission. National Rural Health Mission seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. The main aim of the mission is to establish a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels and to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition social and gender equality. Healthcare delivery requires intensive human resource inputs.

India is in the midst of an epidemiological transition, whereby poverty-linked infectious, maternal and nutritional diseases exist in conjunction with non-communicable chronic illnesses (H Stowe Mc Marry). In recent years, India's liberalized economy has spurred rapid diet and lifestyle changes and propelled a swift epidemiological transition, whereby the non-communicable diseases now account for a majority of deaths in India (WHO 2015). However, while India's burden of chronic disease is severe and growing, 31 per cent of the population still lives on less than Rs. 123.16 a day and 58 per cent people live on less than Rs. 200.94 a day (World Bank 2015). Our country still faces major challenges of pervasive poverty, resulting in a high burden of pre-transitional infectious and nutritional diseases.

The National Health Policy was endorsed by the Parliament of India in 1983 and updated in 2002. The National Health Policy is being worked upon further in 2017 and a draft for public consultation has been released. There are great inequalities in health between states. Infant mortality in Kerala is 12 per thousand live births, but in Assam it is 56. According to World Bank, the total expenditure on healthcare as a proportion of GDP in 2014 was 4.7 per cent. According to a 2005 report, 60 per cent of India's children below the age of three were malnourished, which was greater than the statistics of sub-Saharan African of 28 per cent. It is considered that one in every three malnourished children in the world lives in India. The estimates vary across the country. It is estimated that Madhya Pradesh has the highest rate of 50 per cent and Kerala the lowest with 27 per cent. Although India's economy grew 55 per cent from 2001 –2006, its child-malnutrition rate only dropped 1 per cent, lagging behind countries of similar growth rate. Despite health improvements over the last thirty years, lives continue to be lost to early childhood diseases, inadequate newborn care and childbirth-related causes. More than two million children die every year from preventable infections.

Review of Related Literature:

Good number of studies has been conducted on the importance of health and health related issues all over India. The major findings of a few works are summarized here. **Schultz (1961)** realized the importance of investment in health and found the linkage between health and economic growth. He argued that the large differences in earnings between whites' and blacks workings on comparable activities; between those in south and north or west, etc. are reflections of differences in education and health. Poor health, nutrition and education lower their economic productivity which effects the growth of the country. **Austere et al (1969)** showed the relationship between health inputs and health outcomes. Taking cross state regression model in the United States they found that there exist a relationship between medical care and improved health measured by age adjusted

mortality. However, the study also found that environmental variables are also found to be important resulting in health outcomes.

Lalonde (1981) opined that the good health is the backbone of the social progress. A nation of healthy people can do things that make life worthwhile, and as the level of health increases so does the potential of happiness. Good physical and mental health is necessary for the quality of life which everyone enjoys. According to him improvements of health depends upon health care system, standard of living, proper sanitation measures for protecting public health and advances in medical science. **According to Gopal (1987)**, investment in health ensures enriching human capital. When people are healthy they contribute to the quantity and quality of production and consequently the country will develop and people will be benefited with the improved standard of living. **Morgan and Scanzoni (1987)**, however, found support for the hypothesis that religiosity is related to lower labor force participation. They surveyed 325 female college students about their current religious devoutness and their intentions to enter the labor force and pursue a career. Religious devoutness combined religious values, feelings, and activities. **World Bank Records (1991)**, say that better diets, housing and control of communicable diseases have raised the quality of life everywhere. The benefits of good health flow well into the future as we know mother's health influences her child's health. Good Health confers on a person or group's freedom from illness and the ability to realize one's potential. Health is therefore best understood as the indispensable basis for defining person's sense of well being. **Alsan, Bloom, Canning and Jamison (2007)**, reviewed the relationship between health and wealth. According to them health is an important factor in strengthening economies and reducing poverty. Using data from many countries, they have found evidence of a strong causal relationship between health and wealth. They discussed the mechanism through which health may contribute to economic growth and poverty reduction. Healthier populations usually have higher labor productivity since workers are physically and mentally strong. People who are healthy live longer tend to save more, so increasing investment in physical and human capacity.

According to **Chatterjee (2009)**, the reasons for vulnerability of the unorganized workers are irregular work, low economic status, little or no bargaining power, and lack of control over earnings, need to balance paid work with care for children and home, little or no access to institutional credit, training and information and lack of assets. Annual Income of the family is an important indicator of economic status of the family. **Dubey (1975)**, in his work "Social mobility among the professions" is of the opinion that the class of the respondents is determined by the subjective assessment of their own status. Under non-traditional sources the respondents' family members earn from business, petty-shops, agricultural labour, handloom business, non-government jobs and such other occupations.

Objectives of the Study:

This study is carried out with the following objectives -

- To study the existing arrangements of rural health care in Udupi district.
- To examine the level of awareness on health among the rural people.
- To assess the commitment of primary health centers in community health care.
- To examine the methods adopted for household waste disposal in the study area.

Methodology Adopted:

This study was conducted in Udupi and Kundapura Taluk in December 2017. The Interview schedule was used as the Technique of Research. Primary data was obtained by preparing Interview Schedules and about 50 households were interviewed in Kallianpura, Uppuru, Havanje, Vandse and Kemmannu Gram Panchayats. Random sampling was used for data collection. Among the total 50 respondents, 68 percent are males and remaining 32 percent are females. Since most of the villagers are depending on agriculture the male members were available at home during the day time. Secondary data was used from leading journals like Economic & Political Weekly, Samaja Shodhana and website of Ministry of Health, Govt of India. The data collected through the interview method edited and tabulated for analyzing the data. The data reveals that the people of this area

have their own style of life. Since the random sampling method was followed, 72 per cent of the respondents belonged to Udupi Taluk, remaining 28 per cent of them was from Kundapura Taluk particularly from Vandse Gram Panchayat.

DATA ANALYSIS:

Occupation of Respondents:

Rural areas often have fewer job opportunities and higher unemployment rates than urban areas. The professions that are available are often physical in nature, including farming, forestry, fishing, manufacturing, and mining. These occupations are often accompanied by greater health and safety hazards due to the use of complex machinery, exposure to chemicals, working hours, noise pollution, harsher climates, and physical labor. Rural work forces thus report higher rates of life-threatening injuries. The data in this study shows that the religion of the people also played an important role in deciding to take up the work they do. The data shows that among respondents interviewed, 40 per cent are the farmers, 36 per cent of them are wage earners, and 12 per cent were working in allied occupations. 10 per cent of them belonged to salaried class (Government employee), and only 02 percent respondents in nonfarm sector.

Occupational Status of Rural Women:

The question related to the occupational status of the women is also asked by the researcher. In the study area 98 percent of the respondents are from Hindu religion, remaining 2 percent respondents from Islam and nobody from other religions working in this capacity. In the area taken for the study population of Hindu religion is high. A minute percentage of women from Islam dwelling around the factories stick on to beedi-rolling and other self-employment activities. The women from Hinduism also actively involved in Self-helps groups. They have their savings in SHGs and some of them have availed loans from Self Help Groups for their personal reasons. A small percentage of women are indebted. The Hindu women depending on beedi-rolling have less income and they said it is not possible to maintain their family expenditure, other works like coolie for daily wages, agricultural work, working under contractors felt hard to them. Thus most of them choose this work as an alternative to beedi-rolling. The women in beedi-rolling are more prone to asthmatic problems. The working conditions are another important aspect of the unorganized sector, and are of particular importance to the manual workers. The assessment of working conditions of labourers is also important to have a deep understanding of their life. The working conditions imply the duration of working hours, nature of work, terms and conditions of payment and overtime payment etc.

Health Issues among the rural folk:

The data shows that among the respondents 08 per cent respondents have said that in last one year they/family members suffered from malaria, 04 per cent respondent said that they suffered from typhoid, no respondents suffered from jaundice, respondent 04 per cent suffered from chicken pox, 32 per cent suffered from other diseases than the one mentioned above (kidney stone, diabetes, allergy, ligament injury, throat infection, severe blood pressure), remaining 52 per cent of the respondents have said that they/family members did not suffer from any disease from past one year. It is seen from the information collected that 52 per cent of the respondents did not suffer from any disease for past one year. This shows the importance given by these people to their health and the care taken by them in order to remain healthy. According to Dr Amartya Sen "Development is not only progress in infrastructure, but also the ability of a person to lead a healthier life for long span of time". (Chandrashekhar T.R.).

Preference of Health Centers by the People:

The above table shows that among 50 respondents, 48 per cent of them have said that they preferring Primary Health Centre for the purpose of treatment, 36 per cent of them prefer Private Hospitals/Clinic and remaining 16 per cent of them have said that they prefer Government hospital for their treatment. It is because most of them are not aware of the difference and functions of private and government health centers. Few of them do not have the other options for their poverty. But the PHC plays a pivotal role in making the rural people to avail the

facilities given by Government for uplifting the health of rural people. Marginalized groups also find it more comfortable for approaching the nearby PHC due to its people-friendly treatment and their availability.

Satisfaction with the Treatment and Medicines in PHCs:

The opinion regarding the satisfaction of the respondents on treatment in PHCs is collected. 64 per cent of them replied that they are satisfied with the treatment they received and remaining 36 per cent have said that they are not satisfied about the type of treatment they had. Majority of them are satisfied with the treatment because the clinics or Hospitals are fully equipped for medical services. Another reason for their satisfaction is the duration of curing their sickness. Quality of services rendered by the medical staff and cheaper medication may also be the reasons for their satisfaction.

The data shows that among the respondents interviewed, 80 per cent of them have said that they know about preventive measures taken for diseases and remaining 20 per cent of them have replied that they are not having the knowledge of preventive measures. Majority of the respondents know the preventive measures to maintain their health due to the awareness given by the health workers under National Rural Health Mission. Some of them also come to know from their elder persons in the community who are well versed of the homely medicine. The measures taken by Government for leading a disease free life is also a reason.

Sanitation Facilities:

The researcher tried to collect information regarding the sanitation facilities. Among the interviewed 52 per cent of them have said that they know about scientific sanitation facilities and remaining 48 per cent do not know about scientific sanitation. It is because the rural people are not so much educated on the health and sanitation issues. Sanitation is one of the important issues that play a significant role in making the surrounding clean and keeping human being free from diseases.

Source of Drinking Water:

Source of drinking water is also a factor in determining one's health. The above data shows that 44 per cent of the respondents have good source of drinking water, 40 per cent of them rely upon pipe/tap water connection provided by the Panchayat, 12 per cent of them have tube wells, and remaining 4 per cent of households are depending upon a neighboring pond. Since the plot of land in rural areas is very small about 40 per cent respondents are not in a position to dig an independent well, so they are depending on pipe connection from Panchayat. Many of them opined that the water normally comes once in 03 days which is problematic to lead a comfortable life. Meanwhile increase in population and number of houses requires more water from day by day; it is another reason why pure drinking water is not available to all.

The question is also asked on the purification of water. Data shows that, among the respondents, majority i.e. 60 per cent of them have responded that they are not purifying the water before drinking; only 40 per cent of them have said that they are using boiled water for drinking. None of them are filtering or using any chemicals for water purification. For majority of the respondents using the raw water has become a habit for them and their family members. This is a major risk in attracting the water-borne diseases.

Knowledge of National Rural Health Mission:

It is also proved that 76 per cent of them are aware of National Rural Health Mission and remaining 24 per cent of them are not aware of the same. Majority of them have access to primary Health Centers. PHC personnel provide adequate information about various facilities coming under National Rural Health Mission through their pamphlets, posters and handbills to these rural people. The data also shows that 72 per cent of the rural people prefer allopathic treatment and 16 per cent of them prefer Ayurvedic medicines and remaining 12 per cent of them prefer homeopathy treatment. Since the allopathic treatment is more common in PHCs, rural people have preferred it not only due to its availability but also for the speedy recovery from their health problem.

Availability of Health Services to rural people:

People in rural areas generally have less access to healthcare than their urban counterparts. Fewer medical practitioners, mental health programs and healthcare facilities in these areas often mean less preventative care and longer response times in emergencies. The lack of healthcare workers has resulted in unconventional ways of delivering healthcare to rural dwellers, including medical consultations by phone or internet as well as mobile preventative care and treatment programs. There have been increased efforts to attract health professionals to isolated locations, such as increasing the number of medical students from rural areas and improving financial incentives for rural practices. Health services in the near vicinity and its availability is another factor in maintaining the health of the people. 84 per cent of them have said that they are aware about the health institutions present in their village and the other 16 per cent have said that they are not having clear information about health services available. This is due to the regular approach of health workers, ASHA workers in order to build awareness among the rural people to safeguard their health. For 92 percent of the households the distance from their home to PHC is less than 05 kms, remaining 08 per cent of them have said that distance from their home to PHC is more than 05 kms. Since majority of them have the accessibility of services of medicine they feel it is comfortable to get effective treatment and also to avoid further deterioration of health after taking suitable precautionary information and medical aids from PHCs. More over the services are economical; the economically marginalized or poor people can afford and make the best use of various schemes related to community health. 52 per cent of them are satisfied with the functioning of ASHA workers. Since ASHA workers are having good rapport with the rural community they are appreciated for their work and also the awareness built by them regarding different schemes related to community health.

Awareness on Pulse Polio Drops:

Knowledge on Polio drops are also asked with the respondents and the information reveal that all of them have the knowledge about polio drops. This is due to the regular awareness created by Government through mass media and by the health workers (ASHA workers). NGO's also collaborated with Government to make this vaccination drive reach the grass root people. The 56 per cent of the respondents have come to know about polio vaccination through TV/radio announcement, remaining 44 per cent of them came to know about polio vaccination from health workers who visited their home for building awareness about the same. From the above data it is clear that 96 per cent of them have gone for complete child immunization. This is given more stress by the Government through National Rural Health Mission. Health workers regularly conduct home visits and inform about the same. Rural people have started cultivating awareness about the ill effects if the child is prevented from getting suitable immunization.

Attending the Health Camps:

The researcher observed the respondents utilization of health camps. 36 per cent have attended the health camps during last one year and remaining 64 per cent of them did not attend the health camps. This is due to the lack of awareness and lack of information about the health camps. Even if some of them know about, they do not find time to attend the camps. Occupation of rural people also matters the health of rural folk. 52 per cent of them suffered from different health problems due to their occupations during the past 10 years. This may be because of the hazardous occupations that the people are engaged. Respondents engaged in the occupations like carpentry, construction works, Beedi rolling, cashew processing etc have more complaints of ill health.

A few interesting cases of health issues are also reported here. (i)SulochanSuvarna one of the respondents has reported that due to his occupation (climbing coconut tree). He had suffered from kidney stone and took treatment from Private Hospital in Brahmavar. (ii) Another respondent Sri Jagajeevan, runs a small tailoring shop (working alone), has said that due to the continuous dust from the clothes he suffered from dust allergy. He is taking medical treatment from nearby PHC continuously. (iii) GopalMarakala is a having a cycle repair shop and he has reported that due to the contact with Greece and other oils he has suffered from skin allergy.

System of Domestic Waste Disposal:

Waste disposal is the activity and action required to manage waste from its inception to its final disposal. This includes amongst other things collection, transport, treatment and disposal of waste together with monitoring and regulation. It also encompasses the legal and regulatory framework that relates to waste management encompassing guidance on recycling. The study also shows that among the respondents, 36 per cent of people dispose their domestic waste to nearby free land as they are not getting the arrangements by their Panchayats for waste disposal, 28 per cent of them have told that suitable arrangements have been made by their Panchayat for disposing the waste but 36 per cent of them have indifferent attitude towards waste disposal who are of the opinion that they burn the solid waste and make manure of the degradable ones. But burning of wastes gives rise to respiratory disorders and also maximizes air pollution. According to a study published in British journal LANCET, in 2015 there were 25 lakh premature deaths in India due to air pollution.

Food consumption and health:

Many of the villagers are prone to neglect their own dietary needs. They feel that they are too busy to eat right, used to putting the needs of their family first, or trying to adhere to an extreme diet that leaves them short on vital nutrients and feeling cranky, hungry, and low on energy. The specific needs are often neglected by dietary research, too. Studies tend to rely on different things that are stable and predictable, thus sometimes making the results irrelevant or even misleading to their needs. All this can add up to serious shortfalls in a woman's daily nutrition.

While what works best for one may not always be the best choice for another, the important thing is to build their dietary choices around their vital nutritional needs. The question is whether they are looking to improve their energy and mood, or to combat stress. A question was asked to study how many times the women workers consume food per day. The data to this question indicates that 4% of respondents are consuming food only one time per day, 66% of respondents consume two times a day, 26% of respondents consume food three times and remaining 4% respondents are consume food for four times. Another important problem with these women is drinking very less amount water; most of them skip the break intervals. Non-availability of pure drinking water is another problem of the factories in this area.

Women give less importance to midday meals and they lack awareness of nutrition. The reason for less amount midday meal is that they think taking the full meal will affect their afternoon work. The reason for consuming less amount water is non-availability pure drinking water. There are companies giving mid-day meals to its employees. But the number of companies is less. The data shows that ratio of Cashew Processing factory facilitating midday meal. Only 10% (05 factories) of Cashew Processing factories provide midday meal facility to its workers and remaining 90% Cashew factories do not provide this facility.

The general observation on the data makes the three sections namely cutting, peeling and grading. Three sections also providing wages based on piece rate wage system. The choice of the sections depends on workers. The wages is different from one section to another section, but earning depends on individuals. In streaming, loading, unloading and roasting sections gents are working for daily wages. Those who are working in cutting section, there are chances to be met with small injuries due to work burden but in peeling and grading section very less chances of accident. As per data 56% of respondents are working in Cutting section, 20% of respondents are working in peeling section and 24% respondents are working in grading section. DrNagaraj who is working under this NRHM Udupi District said that Private organizations and NGOs should collaborate with NRHM to make the services reach the grass root level at a higher frequency.

Conclusion:

Research shows that the healthcare needs of individuals living in rural areas are different from those in urban areas, and rural areas often suffer from a lack of access to healthcare. These differences are the result of geographic and demographic diversities. Government should invest more to uplift and safeguard the health of rural people. Awareness of health must be increased among the rural people. National Rural Health Mission

(NHM) is playing significant role in making rural marginalized people to get accessibility and availability of effective health care services. But still the staff working under this mission is having double work and half salary which is a major issue. This is the main reason why majority of the contract laborers and part time ASHA workers are unable to give their fullest contribution to the community.

Panchayats should take major responsibility for the scientific disposal of household wastes. This can also reduce the menace of burning plastics which contributes for respiratory disorders and also depletes the Air Quality Index (AQI) leading to air pollution. More and more health camps should be organized in Panchayats in collaboration with voluntary organizations, youth clubs, NGOs etc in order to create awareness among rural households about regularly monitoring their health. Panchayat should make scientific arrangements for the disposal of waste either by giving contract to self-help groups or by their own interference. Udupi City Municipal Corporation has put a full stop to this headache in their limits. A vehicle run by the City Municipal Corporation by playing awareness music travels each ward and public have to be ready with their waste packets to put inside this vehicle. The amount towards collecting the waste is collected with the house tax.

People living in rural areas also tend to have poorer socioeconomic conditions, less education, higher rates of tobacco and alcohol use, and higher mortality rates when compared to their urban counterparts. In this study majority of the respondents do not use any methods for purifying drinking water in the rural area. In rural India at the present context, unsafe drinking water is responsible for multiple episodes of diarrhea and still others fall ill on account of Hepatitis A, enteric fever, intestinal worms and eye and skin infections caused by poor hygiene. Insufficient maintenance of the environment around water sources, groundwater pollution, excessive arsenic and fluoride in drinking water pose a major threat to India's rural health.

References:

- Chatterjee, M. and Macwan, J., (1988), '*Occupational Health Issues of Self Employed Women: Agarbatti and Masala Workers of Ahmedabad*', National Commission for Self Employed Women Workers.
- Hanumappa, H.G., (1996), '*Agarbatti: A Bamboo-Based Industry in India*', International Network for Bamboo and Rattan (INBAR).
- Government of India (GOI). (2008). "*Bulletin on Rural Health Statistics in India: March 2008.*" New Delhi: Rural Health Division, Government of India
- Morgan, M. Y. and J. Scanzoni. 1987. "*Religious Orientations and Women's Expected Continuity in the Labor Force.*" Journal of Marriage and the Family.
- Nath, Anna, (2009), '*Health Services Missing for Women Workers in India*', One World South Asia.
- Neera Desai and Usha Thakkar 2001, "*Women in Indian society*" National book trust India Publications, New Delhi.
- Sankar, Deepa and Vinish Kathuria (2004): "*Health System Performance in Rural India: Efficiency Estimates Across States,*" Economic & Political Weekly, Vol 39, No 13, pp27-33.
