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Rural Health Care - Challenges and Opportunities: Lessons Learned from the Villages in Rural Rajasthan

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Abstract

Rural Health Care: Challenges and Opportunities in the Villages in Rural Rajasthan—Lessons Learned from Field Work Practice. Rural communities, on average, have far less access to healthcare services than urban areas. Access to health care can prevent disease by means of early identification and treatment, as well as provide a higher quality of life and increase life expectancy for persons in the community. People and communities who lack economic clout and autonomy will inevitably have restricted or non-existent access to medical care. Here, the author highlights the various issues pertaining to health and mental health concerns of people living in the rural areas of Rajasthan, who often experience discrimination as well as social stigma towards services such as health, social, economic, and education.

Poor socioeconomic conditions, a lack of education, and poor health status are common among rural people living inside villages. The author emphasizes how discrimination and bias prohibit people from having equal access to healthcare services by preventing vulnerable populations from participating in the delivery of healthcare, limiting their legal access, or preventing them from entering healthcare systems altogether. The study was conducted in the village of Bandarsindri in Kishangarh Taluk, Ajmer district, Rajasthan. The study's aims consist of (a) to know the general health status of people living in the village (b) learn the mental health-related requirements of the individuals in the study location (c) to determine the pressing health problems of the children and women in the village (d) to understand the access to healthcare of the people in the rural areas and (e) to determine the scope of implementing a programme/intervention with the support of Central University of Rajasthan and the use of other local resources.

The methodology adopted for this study is qualitative, and the data were collected through individual interviews and focus group discussions. The researcher used a purposive sampling method for selecting the samples; the sample size for the qualitative interviews was 20, and the FGD was 3. The qualitative interviews were conducted among women, aged persons and the youth population in the village. Content analysis was performed for the qualitative study, and detailed notes were prepared for analysing the FGDs. The findings emphasize the urgent need to address the various health needs of the community and empower them to seek health care and support from government resources by building advocacy and networking activities by development professionals.

Keywords: Health Care System, Purposive Sampling, Advocacy and Development Professionals

Introduction

It is of paramount importance to study the most important health and mental health issues of people living in the rural areas of Rajasthan, who often experience discrimination as well as social stigma towards attaining services such as health, social, economic, and education. Most rural people live in remote areas of villages. In terms of various aspects, racism and discrimination directly impede equal access to health services by excluding groups from healthcare systems, limiting their access by law, or discouraging their participation. In a study conducted by the Department of Social Work, Central University of Rajasthan, 75% of the respondents reported that discrimination exists at higher levels in rural areas, and 25% of the participants reported that there is no discrimination in public places; however, the majority of

the data show discrimination against upper-aged people in rural areas, such as those in Durga Pooja, Ganesh Chaturthi, Gangore Dashra, and other social programs [1].

The available evidence indicates that there is a large system of health care delivery that is, nonetheless, highly dysfunctional in many respects, making reformation difficult. A recent survey of absenteeism in public health facilities in several Indian found a very high level of absence (43%) of health care providers in Indian primary health centers; a survey of private providers in Delhi revealed that 41% of providers are unqualified [2,3]. Sen, Iyer, and George (2002) used two NSSs separated by nearly a decade (1986--87 and 1995--96) to explore the relationship between income and access to health care and reported a worsening of inequalities in access to healthcare [4].

The Rajasthan state population was 68.6 million in 2011 across its 35 districts. The literacy rates of males and females are 80.51% and 52.66%, respectively, which are lower than the national statistics [5]. The state of Rajasthan has a poor health condition. In the state of Rajasthan, the most marginalized groups in society—women and children—are more prone to illness and death. Based on indicators of extremely high birth rates and infant death rates, India has identified 90 problematic districts, of which about one-fourth are in Rajasthan [6].This somewhat reflects the poor health status of this state. The schedule population was 19 million in 1951, which reached 84 million in 2011 in India. At present, 8.2% of the population is tribal, whereas in 1951, it was approximately 5% [7,8]. In India, approximately 75% of the scheduled caste population lives in 7 states that cover 15% of the geographical area, it is one of Rajasthan's 35 districts and is typically isolated and undeveloped.

The majority of the scheduled caste population resides in 11 districts, which constitute approximately 8% of the total population. Since most Indians cannot afford private healthcare facilities, they still rely on government institutions for their medical requirements. But most Indians prefer private hospitals, and the majority of those who can afford expensive treatment go to private hospitals for better medical care because government hospitals are usually overcrowded and ill-equipped with the newest medical devices, technologies, and medications.

One of the most important communities living in the nearby areas of Bandarsindri, Ajmer district, called 'Raj Nat' is one of the most dominant communities in the rural area of Rajasthan, and the majority of them fall under the other schedule castes (SCs). The Scheduled Castes (Raj Nat community) is a group of historically disadvantaged people known by the Composition of Rajasthan or the people who are located at the lowest level of the old-style caste system, and most of them live in the interior parts of the villages. The houses may not have windows, urinaries, latrines or drains. They urinate and defecate in the open space, and waste is also thrown on the roads. They do not have a good hand pump for taking g of water. They live in unhygienic conditions because of poverty; they are often victims of malnutrition and undernourishment.

Application of Framework

Rural Social Determinants of Health: Medical Care:Rural health is often associated with various factors, including social factors, which closely connect with the health determinants in society. Accordingly, the theory itself states that the ability of people to obtain health services and meet their fundamental needs—such as clean water and safe housing—which are necessary for maintaining their health is impacted by a number of factors, including income level, educational attainment, race/ethnicity, and health literacy. Poverty is one of the main social variables that affects health more frequently in rural areas. The obstacles that are already present in rural locations, such as fewer alternatives for obtaining healthy food and restricted public transportation options, might exacerbate the impact of these issues. The Bandarsindri village is backwards in attaining educational reach, health attainment, drinking water issues, waste management concerns and less availability of other general basic amenities. The village requires better support from various agencies and other stakeholders to attain a good level of facilities by inculcating various programmes with effective community participation.

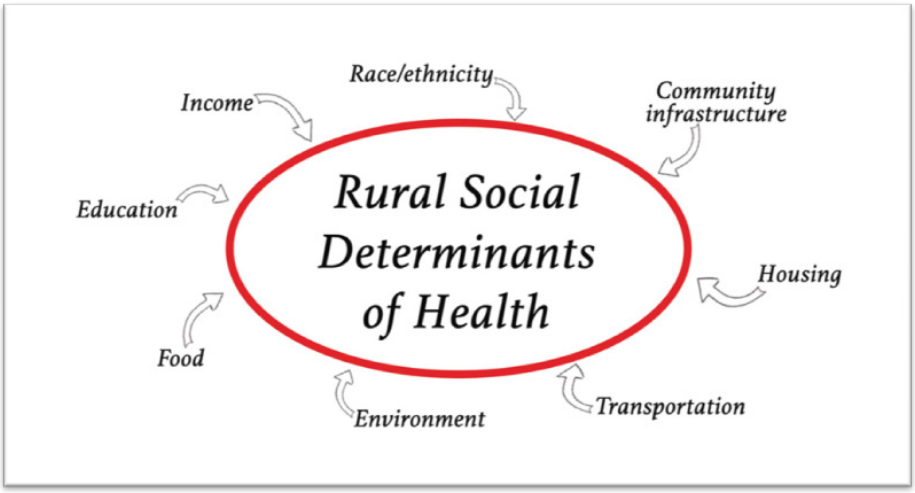

Figure 1: Social Determinants of health (SDOH) World Health Organization -2012 [9]

The graphic depiction shows the various factors that are interlinked to achieve the social determinants of health. An intervention with the aim of integrating all these components is essential to achieve healthy and sustainable health for all stakeholders, which will lead to good standards of rural health among villagers.

The objectives of the study are (a) to understand the general health status of people living in the village, (b) to be aware of the mental health needs of the villagers, (c) to determine the pressing health problems faced by the children and women in the village, (d) to understand the access to healthcare of the people in the rural areas, and (e) to determine the scope of implementing an intervention with the support of Central University of Rajasthan and using other local resources.

Materials and Methods

The methodology adopted for this study is qualitative, and the data were collected through individual interviews and focus group discussions. The researcher used a purposive sampling method for selecting the samples; the sample size for the qualitative interviews was 20, and the FGD was 3. The qualitative interviews were conducted among women, aged persons and the youth population in the village. Content analysis was performed for the qualitative study, and detailed notes were prepared for analysing the FGDs. The findings emphasize/urgently address the various health needs of the community and encourage them to seek health care and support from government resources by building advocacy and networking activities by development professionals.

Results and Discussion

This section presents an analysis of the major findings derived from the qualitative study to understand the needs and challenges of primary health care in the rural villages in Rajasthan. The major themes transcribed from this study include healthy life, awareness about chronic diseases, communicable diseases and noncommunicable diseases, HIV/AIDS awareness, usage of alcohol and tobacco products in the community, role of health centers, pregnancy-related issues, transportation problems, health problems of women and children, mental health needs, social support in health programs, youth involvement in health and related activities, NGO intervention, participation in government health-related activities, public campaigns/medical camps, medication of common diseases, etc., are presented in the interviews and focus group discussions conducted among various target groups in the rural areas of the village.

The health status of people living in the village was assessed via qualitative interviews. Many of them opined that (approximately 70% of the respondents interviewed in qualitative sessions and FGDs) their health conditions were not good and faced issues such as general health problems, respiratory issues commonly seen in children and women, and the presence of tuberculosis. Generally, the health condition of villagers is not satisfactory, and they are reluctant to take medicines and are not aware of their health. They were quite interested in obtaining knowledge about various aspects of health, such as good medical care, nutritional habits, pregnancy-related health tips, and awareness of chronic diseases, and communicable diseases among the villagers were very rare. The villagers were not free from seasonal illness and had less knowledge about the management of modern treatment and about the control of communicable diseases. In Bandarsindri, two cases of HIV infection were reported, so there is a vital need to increase awareness of the impact of the infection and further consequences. Another notable factor is that the application of traditional knowledge of medication for common diseases in the Raj Nat Community in rural areas is common. Alcoholic consumption among youth and adults has significantly increased, and surprisingly, there is no such mechanism that exists to control their usage in villages. Many people are not bothered by depositing or segregating waste, and waste and related substances can often be seen in front of houses, resulting in severe health issues in the village, with most children and women being victims.

Awareness of the mental health needs of the villagers is assessed by asking questions. There is clear evidence that awareness of mental health needs is very low and that they have less knowledge about the mental health care delivery system available to them at the taluk/district level. Few cases related to school dropout issues, early marriage, and extramarital relationships were reported in the village, which resulted in isolation, minor mental health issues and associated problems. Intervention by the central university initiated the development and strengthening of support systems in villages, and among the needy people, this is an important sign of addressing these problems to a great extent. The intervention helped identify two cases in the village of Bandarsindri and referred to it for better medical care, and follow-up was also taken up by the university as a part of the extension activities of the department.

Health problems faced by the children and women in the village are another striking area identified in the interviews and discussion. Maternal mortality is one of the biggest health gaps between affluent and poor people, according to the World Health Organization. There are more maternal deaths in India than in Europe throughout the year. The primary causes of maternal death are inadequate services for identifying and treating problems, inappropriate care throughout pregnancy and for the health of the unborn child. Compared to women in urban areas, women in rural areas were far less likely to receive medical care. According to Bhalla (1995), 16% of people living in rural areas are more than 10 kilometres away from a medical centre[10]. This was also emphasized in this study; many respondents opined that maternal health services are very poor; most villagers depend on nearby health centers for delivery and after-care services. However, the facilities in health centers have comparatively low levels of both manpower and materials.

The access to healthcare of people in rural areas is most significant. 33 districts, 237 blocks, 9,188-gram panchayats (village councils), and 41,353 villages make up Rajasthan, according to statistics [11]. In the public health sector, there are 33 district hospitals, 144 sub divisional hospitals, 327 CHCs, 1,499 PHCs, and 10,612 SCs (29). Apart from PHCs and SCs, the state also has establishments that practice Indian medical systems at the first-contact level. These include 3,496 Ayurveda dispensaries, 92 Unani dispensaries, and 147 homeopathic dispensaries. According to the data, the state's primary health infrastructure has expanded three to four times in the past 20 years.

In rural areas, there are fewer transportation facilities than in urban areas. FGDs reveal that due to fewer transportation facilities, people, especially poor women and older people, hesitate to leave for treatment and other matters. "I never visited a village outside my home for 25 years of my marriage; even for an emergency, I was dependent on others for support, owing to lack of education and day-to-day engagement in agricultural activities; she says, I am not bothered about my health". This is an illustration made by women in the village of Kheda, Bandarsindri.

The creative and effective role of youth involvement in health and related activities, NGO intervention, and participation in government health-related activities are the other themes derived from the discussion and interviews. The youth are showing interest and willingness to be involved in their village's socio-health and economic backwardness and showing the right attitude towards the welfare of their village. Local clubs and other civil society organizations associations are yet to be born in these villages. The initiation of youth club by Central University of Rajasthan created an atmosphere of building strong community foundations in the villages that can ensure youth participation in various activities of the villages.

The scope of implementing an intervention with the support of Central University of Rajasthan and using other local resources is most significant and appropriate in this context. Central University of Rajasthan has intervened in the nearby community since its inception; the Department of Social Work is keen in including field activities as part of field work practices. The Department of Social Work organized various programmes with the participation of community members. A day-long 'General Health Camp' in collaboration with Mahaveer Cancer Hospital, Jaipur and YN. Hospital, Kishangarh, Rajasthan on 14th October, 2012, at Bandarsindri village and the university campus is a notable activity in making a good rapport with the community. More than 500 people attended the event, which was a huge success. They benefited from free general health examinations and medication at the health camp.

- The health camp substantially achieved the goal of raising public awareness of cancerthrough exhibitions that emphasized the value of diet, physical exercise, and lifestyle choices in the prevention and treatment of diseases linked to a certain way of life.
- Free examinations, diagnosis, and counselling: The Central University of Rajasthan provided financial support to the campaign.
- To raise public awareness of the Social Work Department. Many individuals from many areas visited CURAJ for medical examinations, and while they were there, they also saw the exhibition, which the Department of Social Work had arranged to raise awareness of various diseases. A few social work department students gave them an explanation of the exhibition's goals as well as the causes, symptoms, and preventative measures of several diseases.

Recommendations and Conclusion

Extending support activities to address health and other areas effectively is the major concern of the Department of Social Work, Central University of Rajasthan. Henceforth, the recommendations based on this study are long-standing and targeted. First, local capacity needs to be improved in terms of providing timely knowledge skills/technical awareness among youth and other stakeholders. The lower number of opportunities and lack of technical and problem-solving skills are other notable problems faced by the youth group. Therefore, youth development can be achieved by strengthening the capacity of youth in leadership, communication and other relevant areas through training and knowledge-building exercises. The effective participation of women should be ensured through the formation of self-help groups. ASHA workers in health centers can be helped by youth volunteers in identifying remote areas and extending health promotion activities with community participation. The village sarpanch and ward members should be sensitized to various aspects of health, including organizing health sensitization programmes, health camps, coordinating government health programmes, preparing IEC materials, and health education programmes. Facilities in health centres should be improved with local support and networking/advocacy with civil society organizations at the district and state levels and the government.

In conclusion, local villages require a large amount of support from multiple stakeholders, including government agencies and civil society organizations, to understand, analyse and determine ways to meet the challenges of individual, family and community health. Ultimately, it is the responsibility of the local community to raise their voices to attain standards of health by meeting their fundamental needs associated with their general health. By joining hands, academic institutions play the primary role in supporting the local community by creating an environment to promote better health and thereby ensure the sustainable life of people living at the heart of rural India.

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