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A CRITICAL STUDY OF RURAL HEALTH PROBLEMS IN VALSAD AND NATIONAL RURAL HEALTH MISSION

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Abstract:

This research paper conducts a comprehensive examination of the rural health issues prevalent in the state of Valsad, India, and evaluates the efficacy of the National Rural Health Mission (NRHM) in addressing these challenges. The study encompasses a critical analysis of healthcare infrastructure, accessibility, and quality of care in rural areas of Valsad, highlighting the prevailing health disparities. It also assesses the implementation and impact of the NRHM in the state, shedding light on the successes, shortcomings, and potential areas for improvement. By scrutinizing the interface between the state's rural health issues and the NRHM, this paper aims to contribute to the ongoing discourse surrounding rural healthcare in India, offering insights into strategies to enhance the health and well-being of the rural population. Both Primary and Secondary data have been used in this study. The primary data collected through structured questionnaire seeking information about their social background, educational status, economic conditions, age, income and employment status. The NRHM provides broad operational framework for the health sector, suggestive guidelines have been issued on key interventions like ASHA, Indian public health standards (IPHS), Institutional deliveries immunization, preparation of District Action plan, role of panchayat Raj institution etc.

Keywords: Rural Health, Valsad, National Rural Health Mission (NRHM), Healthcare Infrastructure, Healthcare Accessibility, Healthcare Quality

1. INTRODUCTION

1.1 OVERVIEW

Health plays a pivotal role in human resource development, and the provision of effective healthcare facilities and services is essential for fostering a healthy population capable of making significant contributions to social and economic progress. As urbanization, industrialization, and environmental changes continue to reshape societies, health-related issues become increasingly crucial for improving the quality of life. Health development is now acknowledged as a vital component of a nation's socioeconomic growth. According to the World Health Organization (WHO, 1983), the right to enjoy the highest attainable standard of health is a fundamental entitlement for all individuals, regardless of their race, religion, economic status, or social conditions.

Primary healthcare is a key element in the restructured 20-point program, following a national model consisting of a three-tier health infrastructure with sub-centers, primary health centers, and community health centers. Good health is an indispensable resource for an individual's survival and directly impacts a country's productivity. Ensuring a basic level of healthcare for the population is a critical aspect of the

development process. Unfortunately, there is a strong correlation between poor health and poverty.

Health is not just a fundamental human right; it is also the responsibility of the government to provide equitable healthcare to all citizens. Efforts to enhance rural health have a long history in India, dating back to the Bhore Committee in the 1940s, established by the British Government to assess the country's health situation. Since India's independence in 1947, various national health schemes and programs have been initiated to improve the living standards of rural populations. India was a pioneer in launching an official family planning program in 1952.

The Health Policy of 2002 explicitly recognized the importance of simultaneously implementing both the National Population Policy of 2002 and the National Health Policy of 2002 as foundational elements of any national strategy to elevate healthcare standards in the country. Initiatives like the Minimum Needs Programme in 1975 and the Janarogya Yojana in 1996-97, which provided medical insurance for the underprivileged, and the Rashtriya Swasthya Bima Yojana of 2008, offering health insurance to impoverished families unable to afford medical care or hospitalization, exemplify the government's commitment to improving healthcare access. In furtherance of this commitment, the Government of India launched the National Rural Health Mission on April 12, 2005.

2. LITERATURE REVIEW

Bhavsar, Shivangi (2023) This study explained into the realm of rural healthcare services, representing a primary research effort by the author aimed at comprehending the availability of healthcare services in rural areas, while also shedding light on the expectations and satisfaction levels of patients. Within the pages of this book, the multifaceted challenges confronting the rural healthcare sector are examined in the context of the SERVQUAL model of Services Marketing. The book further offers a comprehensive overview of health centers organized by zones in Valsad, as well as an exploration of the rural healthcare system in India. It provides insights into the consumption and accessibility of services in rural regions, accompanied by a critical assessment of available resources and their utilization. Throughout the book, the author presents thought-provoking and pragmatic solutions to address these challenges.

Prasad, Amit & Bhatia, Salima & Agrawal, Ritu (2013) In India, the management of public health falls under the purview of state governments. In 2005, the Indian government initiated the National Rural Health Mission (NRHM), aiming to emphasize grassroots planning and adaptable financial support to meet local healthcare demands. Our evaluation examines the impact of NRHM-driven interventions on maternal healthcare services and outcomes in states characterized by subpar health indicators.

Negandhi, Preeti & Sharma, Kavya & Zodpey, Sanjay (2012) The National Rural Health Mission (NRHM) envisioned the enhancement of health management in India by focusing on the ongoing development of healthcare professionals already in service and their roles within the public health system. Recognizing the critical need to address this matter, the Indian Government, under the NRHM, introduced a one-year Post Graduate Diploma in Public Health Management (PGDPHM) to impart knowledge and skills in public health management to these professionals within the state health services. In its inaugural year in 2008, four institutes partnered in this program. By the period spanning 2008 to

2011, this initiative expanded to include ten institutes, with a total of 386 students successfully completing the program. This program, distinct from other health management courses in the country, is uniquely grounded in the NRHM context, both in its content and teaching methodology. It presents a range of opportunities to encourage states and the central government to establish a specialized public health cadre that is urgently required in India. The program's endeavors place a strong emphasis on enhancing public health practice and provide a distinct pathway toward building a more robust healthcare system. Its multidisciplinary approach addresses the gap between the demand and supply of healthcare professionals capable of effectively contributing to the strengthening of India's public health system through proficient public health practices.

Dhingra, Bhavna & Dutta, Ashok (2011) The state of health-related indicators in our country remains far from satisfactory, with a significant burden of global diseases still affecting the nation. Challenges such as limited accessibility, a scarcity of available healthcare services and personnel, as well as low service quality, particularly in remote rural and underdeveloped urban areas, have posed significant hurdles to delivering high-quality healthcare in a vast, culturally diverse country characterized by regional disparities and inequalities. The already overburdened public healthcare system has struggled with issues related to linkages with critical health determinants, a substantial deficit in infrastructure, and the underutilization of financial and human resources. Revitalizing the existing primary healthcare infrastructure under the National Rural Health Mission (NRHM) is poised to address longstanding structural deficiencies in the healthcare sector, ultimately providing accessible, affordable, accountable, effective, and dependable healthcare services, particularly for the underprivileged segments of society. The NRHM is founded on the principles of decentralizing the healthcare system, empowering communities and panchayati raj institutions. It also focuses on the effective integration of health considerations with other determinants such as sanitation, hygiene, and nutrition through district health planning.

Kumar, Arun (2009) The underperformance of the Indian Public Health System is widely recognized. Analysts have attributed this underachievement to a multitude of factors, encompassing critical elements that make a healthcare system effective, including infrastructure, human resources, logistics, and community involvement. Nonetheless, some place primary blame on the historically low and diminishing public investments in healthcare, with secondary emphasis on structural and managerial deficiencies within the system. After grappling with these challenges for many years, planners have introduced a comprehensive, mission-driven strategy to revitalize the rural healthcare delivery system, aptly named the National Rural Health Mission (NRHM) [Box 1]. This mission was initiated on April 12, 2005, with a seven-year timeframe for completion. As of the end of 2008, the mission had reached its halfway point. This juncture presents an opportune moment to assess the successes and accomplishments while subjecting the failures and shortcomings to rigorous critical analysis.

3. METHODOLOGY

3.1 Sources of data

In this research, primary and secondary data were also employed. The main data was gathered using a standardized questionnaire that inquired about the respondents' age, income, work position, social background, and level of education. Information was also gathered on their knowledge of the NRHM

program, ASHA workers, and health center performance. The Ministry of Health and Family Welfare of India, government of India publications, the National Sample survey report, books, journals, and other published sources are the sources used to gather the secondary data.

3.2 Sample Selection:

The National Rural Health Mission was the only significant health initiative included in the study's universe. Using a straightforward sampling technique, five (Pardi, Vapi, Dharampur, Kaprada, Umargam) talukas are covered in the final sample. Two villages are chosen from each taluka, and using a basic random sampling technique, five percent of the sample beneficiaries are picked from these villages. There are 300 samples in all.

3.3 DATA ANALYSIS

The information about the variables of the analysis is obtained by tabulating the acquired data. Simple percentage, average, and person's Chi-square test were the methodologies used in this investigation.

4. RESULTS

In this, we go over the respondents' socioeconomic backgrounds in the Valsad district region. It should be mentioned that I spoke with 300 responders, all of them were from the Valsad district. The goals of a research project are both directly and indirectly related to the respondents' socioeconomic background. As a result, the profile of the sample respondents has been provided with regard to the household population, family size, gender, community, literacy, occupation, income, and expenses. ASHA employees' roles and the health center's performance.

Table 4.1 Distribution of Respondents by sex

Sl. No	No. of Respondents				
	Male	Percentage	Female	Percentage	Total
1.	50	17	250	83	100
Total	50	-	250	-	300

The distribution of respondents by sex is shown in Table 4.1. For this survey, 300 responses are gathered. There are 250 female responses and 50 male responders out of them. Since women benefit from NRHM programs and are familiar with JSY, Madilu Kit, and ASHA workers, it is preferable that there be a higher proportion of female responses in this case.

Table 4.2 Age of the Respondents

Sl.No	Age Structure	No.of the Respondents	Percentage
1	20-30	150	50

2	30-40	95	41.66
3	40-50	25	8.3
Total	-	300	100

Table 4.2 shows that, of the 300 respondents, the age group between 20 and 30 has the highest percentage (60), followed by the age group between 30 and 40 (41.66%), and the age group between 40 and 50 (8.3%). Within the 20–30 age range, a greater proportion of married women have benefited from JSy, MadiluKit, and ASHA workers.

Table 4.3 Caste Structure of the Respondents

Sl. No	Caste Structure	No. of the Respondents	Percentage
1.	General	75	25
2.	SC	40	13.33333333
3.	ST	125	41.66666667
4.	SEBC	60	33.72
Total	-	300	100

The respondents' caste system is shown in Table 4.3. In this case, the vast majority of respondents—33.72 percent—belong to the OBC caste, followed by the SC caste (13.33%), the General Merit caste (25%), and the ST caste (only 41.66 percent).

Table 4.4 Availability of beds, medicines in PHC

Sl. No	Availability of beds, medicines	No. of the Respondents	Percentage
1.	Yes	250	83.33
2.	No	50	16.66
Total		300	100

The availability of beds and medications in PHC is shown in Table 4.4. According to 83.33 percent of respondents to our poll, the health center's availability of nurses, beds, and medications is excellent. It displays the excellent facilities and infrastructure in the health industry.

Table 4.5 Proper delivery facility in Health Center

Sl. No	Proper delivery facility in health center	No. of the Respondents	Percentage
1.	Yes	200	66.66
2.	No	100	33.33
Total		300	100

The appropriate delivery facility at the health center is given in Table 4.5. Proper delivery facilities at health centers are deemed important by 66.66 percent of respondents in our research area. A person's health is their fundamental infrastructure. It demonstrates how the infrastructure for healthcare has developed recently.

Table 4.6 Health center improves the institutional Delivery

Sl. No	Improve institutional delivery	No. of the Respondents	Percentage
1.	Yes	240	80
2.	No	60	20
Total		300	100

The appropriate delivery facility at the health center is given in Table 4.5. Proper delivery facilities at health centers are deemed important by 80 percent of respondents in our research area. A person's health is their fundamental infrastructure. It demonstrates how the infrastructure for healthcare has developed recently.

Table 4.7 Health Center improves Health Infrastructure

Sl. No	Health center improves Health Infrastructure	No. of the Respondents	Percentage
1.	Yes	234	78
2.	No	66	22
Total	-	300	100

Table 4.7 illustrates the enhancement of health infrastructure in rural areas via health centers. Of the 300 respondents, 78 percent believe that health centers enhance rural areas' health infrastructure, while just

22 percent disagree, stating that PHC does not. The majority of respondents felt that the health center enhances the infrastructure for healthcare.

Table 4.8 Availability of Ambulance in Health center

SI. No	Availability of Ambulance	No. of the Respondents	Percentage
1.	Yes	250	83.33
2.	No	50	16.66
Total	-	300	100

Based on data from Table 4.8, 83.33 percent of the 300 respondents reported having access to ambulance services, while 16.66 percent did not. The main health center lacks ambulance facilities, whereas only the community health center has them. Should an emergency arise, contact the Community Health Center.

Table 4.9 Village health and sanitation samiti of the respondents

SI. No	Village health and sanitation samiti	No. of the Respondents	Percentage
1.	Yes	50	16.66
2.	No	250	83.33
Total		300	100

Only 16.66 % of the 300 respondents in our field survey were aware of the village's health and sanitation samiti, and 83.33% of respondents were unaware of it. This is the largest percentage of respondents who were unaware of the samiti.

Table 4.10 Availability of ANM in health centre

SI. No	Availability of ANM in sub center	No. of the Respondents	Percentage
1.	Yes	230	76.66
2.	No	70	23.33
Total	-	300	100

Of the 300 responders, Table 4.10 shows the availability of ANM at the health facility. ANM is available at subcenters, according to 76.66 percent of respondents, while 23.33 percent of respondents had unfavorable opinions about it.

Table 4.11 Free medicines from health the center

SI. No	Free medicines from health center	No. of the Respondents	Percentage
1.	Yes	300	100
2.	No	-	-
Total	-	300	100

The aforementioned chart demonstrates that the health facility has all medications accessible. Out of the 300 respondents to our poll, all respondents (100%) said that the health center offers free medications for common illnesses including fever, diabetes, and hypertension. This demonstrates how the health facility has improved recently.

Table 4.12 Medicines for cancer epilepsy and mental illness from PHC

SI. No	Medicines for cancer, epilepsy and mental illness	No. of the Respondents	Percentage
1.	yes	-	-
2.	No	300	100
Total	-	300	100

The medications for mental health, cancer, and epilepsy at PHC are presented in Table 4.12. According to our field study, the health facility does not have any supplies of medications for mental disease, cancer, or epilepsy. For treatment, PHC and CHC direct patients to the district hospital.

5. CONCLUSION

In conclusion, this research has delved into the state of rural healthcare in Valsad and the impact of the National Rural Health Mission (NRHM) in addressing the pressing health challenges in the region. We have highlighted the importance of addressing rural health problems, given their direct link to the overall well-being of the population and the nation's socio-economic development.

Through an in-depth analysis, we have observed that there are significant health disparities in rural areas

of Valsad, where factors like healthcare infrastructure, accessibility, and quality of care play a crucial role. The NRHM has been a significant initiative aimed at improving healthcare in these underserved regions, aligning with the principles of decentralization, community empowerment, and a mission-oriented approach.

Our study has shown that while the NRHM has made substantial strides in improving rural healthcare, challenges persist. The system's effectiveness depends on various factors, including the proper utilization of resources, infrastructure development, and efficient management. Additionally, the unequal distribution of health facilities and resources among different regions and communities is a notable concern that must be addressed.

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