

Community Health Center: Transforming Healthcare Access and Rural Health, A Scenario of Haryana

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Abstract

The study investigated the role of Community Health Centres (CHCs) in rural Haryana, with a focus on Tigaon Gram Panchayat in Faridabad. It used a mixed-methods approach to collect data on healthcare service availability, accessibility, quality of care, community engagement, and health education initiatives. The findings show that CHCs play an important role in providing essential healthcare services to the rural population, including maternal care, prenatal care, immunization programs, child healthcare, and disease management. Community engagement and participation in healthcare initiatives have been identified as critical factors in the success of CHCs. However, the study also identifies challenges such as inadequate infrastructure, limited resources, and the need for better coordination among different levels of healthcare providers. The study makes recommendations to improve CHCs, such as improving infrastructure, ensuring availability of skilled healthcare professionals, and encouraging collaboration among government agencies, non-governmental organizations, and community organizations. Overall, this study emphasizes the importance of accessible and high-quality healthcare services in improving rural communities' health outcomes. Policymakers, healthcare administrators, and stakeholders can use the findings to strengthen rural healthcare systems and promote community-based healthcare delivery models.

Keywords: Community Health Center, Rural Health Service, Community Engagement, Health Challenges, Community Health Workers, Accessibility of Healthcare.

INTRODUCTION

The Alma-Ata Declaration emphasized the importance of equitable and cost-effective primary healthcare. India has an uneven distribution of healthcare facilities and services, with some areas having more than they require. Despite India's dedication to the Alma Ata Declaration, the nation still has difficulties achieving this objective. The Indian Government's National Rural Health Mission aims to offer complete and efficient primary healthcare to underprivileged groups of society, especially women and children. The mission is centered on methods like inter-sectoral convergence, bolstering public health infrastructure, community involvement, training health professionals, and improved program management.

India's Rural Health Care System

Everyone has the right to healthcare, but 60% of Indians do not have it because of inadequate infrastructure, a lack of qualified medical personnel, and a lack of access to affordable medications and healthcare facilities. The majority of the 700 million people live in rural areas, where the quality of healthcare is subpar. In light of the depressing picture painted by the facts, new techniques and processes are urgently required to ensure that timely and high-quality healthcare reaches the underprivileged areas of Indian villages.

The effectiveness and viability of these initiatives, despite the government's extensive use of programs and policies, are in question due to poor execution. 39% of Primary Health Care Centres (PHCs) in rural India, where there aren't many of them, lack lab technicians, and 18% don't even have chemists. 8% of PHCs are short on medical professionals. The majority of maternal fatalities occur in India. They are most frequently found in rural areas with poor maternal healthcare.

Table 1.1. Population Norms for Health Care Centre in India, 2005

Centres	Population Norms	
	Plain Area	Hilly/Tribal/Difficult Area
Sub Centre (SC)	5,000	3,000
Primary Health Centre (PHC)	30,000	20,000
Community Health Centre (CHC)	1,20,000	80,000

Source: <https://main.mohfw.gov.in/sites/> (“Rural Health Statistics 2018-19”) Ministry of Health and Family Welfare, 31 March 2011.

Sub-centres are the main point of contact for the primary healthcare system in a community. They are staffed by health professionals and provide services related to maternal and child health, family planning, nutrition, immunization, diarrhoea control, and communicable disease control. They also provide basic medications for minor illnesses and receive central support from the Ministry of Health and Family Welfare. As of 2011, there were 148,124 functioning Sub-Centers in the country.

PHCs are primary health centers in rural areas that provide integrated curative and preventive healthcare. They are created and maintained by the state government through initiatives like BMS and MNP. PHCs have 4-6 patient beds and serve as referral centers for six Sub-Centers. In 2011, there were 23,887 PHCs operational in India.

Community Health Centers (CHCs) are established and maintained by the state government under the MNP and BMS programs. They must have at least 21 paramedical and support staff members and four medical specialists. CHCs offer obstetric care and specialist consultations and act as referral hubs for four PHCs. There were 4,809 operational CHCs in the nation as of 2011.

The rural health care system in Haryana is comprised of approximately 2500 sub-centers, 500 primary health centers (PHCs), and 100 community health centers (CHCs). Villages are served by sub-centers, a block of PHCs is served by CHCs, and a group of villages is covered by PHCs. These clinics offer standard medical care, vaccinations, maternity care, and treatment for common illnesses.

Theoretical Framework

According to the sociological theory known as structural functionalism, society is a complex system made up of interconnected pieces that all work together to keep the whole stable and in balance. Regarding the availability of healthcare in rural Haryana. According to a structural functionalist viewpoint, poverty prevents people from having access to resources that are essential for their health, such as wholesome food, clean water, and medical care. This interferes with society’s ability to function as a whole. Due to limited financial resources, people in rural Haryana, where poverty rates are higher than in urban areas, may be unable to receive preventive services or timely medical attention. This throws the healthcare system’s balance off, resulting in different health outcomes for people living in rural and urban areas. Through socialization and skill development, education helps people become productive members of society. People in rural Haryana are not well-informed about health-related issues, preventive measures, and available healthcare services. This is especially true for girls and marginalized communities where educational opportunities are limited. Because people may not understand the value of seeking medical attention or may not be equipped to navigate the healthcare system, a lack of education contributes to cycles of poor health outcomes. Employment offers people access to employer-sponsored healthcare benefits, social status, and financial stability. However, a large number of people work in hazardous conditions without access to social security or health insurance in rural Haryana, where agricultural labor is the predominant labor force and formal employment opportunities are scarce. Healthcare access barriers are made worse by this structural inequality in employment opportunities, as people may choose not to seek medical attention out of fear of losing their jobs or an inability to pay for out-of-pocket costs.

REVIEW OF LITERATURE

Gupta, Narendra, Pal, Pritam, Bhargava, Madhu and Mahesh Daga (1992)

In the study they examined indicators such as total literacy, female literacy, infant mortality, sex ratio, fertility, decadal variation, and couple protection rate and discovered no correlation between these variables. One such claim is that increased female literacy reduces infant mortality. However, the study found that some districts, such as Ajmer and Kota,

have very high infant mortality rates despite having a high female literacy rate. While districts such as Churu and Nagaur have very low female literacy rates but relatively low infant mortality rates, indicating a lack of medical infrastructure. The state has 598 PHCs and 4,792 Sub-centres, which is only half of what is needed. According to standards, the state falls up to 50% short of infrastructure needs.

Mahadevia, Darshini (2000)

In his study, the researchers compare the health-care facilities in Gujarat to those in India. He discovered that Gujarat had a higher infant mortality rate than India in 1971, but that due to improvements in health care facilities, Gujarat had a lower infant mortality rate than India in 1990. He also compares Gujarat to Kerala, indicating that Gujarat is still a long way from matching Kerala's health achievements. He also discovered that the infant mortality rate in Gujarat is approximately 3.5 times that of Kerala, and he discussed public health expenditure. He discovered that in the mid-1980s, about 8% of the total budget was allocated to the health sector in Gujarat, but this had decreased by the mid-1990s. In terms of public health expenditure, the state never regained that position. In this study, she concluded that Gujarat's health-care facilities are improving at a glacial pace.

Ahmad, Ateeque and Shamim, Syed Kausar (2004)

studied the spatial distributional pattern of health facilities in Meerut district of Uttar Pradesh. They found that there exists a wide gap in distribution of health facilities. These facilities are concentrated mainly in urban areas or in larger settlements which reveals the uneven distribution in the study area. The significant gap between the distribution of settlements and settlements having the health facilities has also been noticed which reveals that this gap increases with the higher order and lower order of function.

Ansari, S.H. (2009)

The researchers found in his study which is conducted in jind district of Haryana that there is disparity in the distribution of health care facilities. On the basis of eight indicators and composite index study found that there is only one block in the category of developed health care functions which is Safidon due to high literacy and high urbanisation. While five blocks fall under developing health care functions which are Narwana, Uchana, Jind, Alewa and Pillukhera. Julana block is the only block which falls under less developed category due to low literacy and low infrastructure. He concluded that medical functions have spatially unbalanced distribution in different blocks of Jind district.

Saikia, Dilip and Das, Kangkana (2014)

The researchers discovered that many states had not yet met the population coverage standards in one or more categories of health facilities. Many states lacked critical health-care facilities and equipment. As a result, they advocated for the urgent need for serious efforts to strengthen the rural healthcare system; the development of a roadmap to prioritise the important areas; and the implementation of more direct policies aimed at the establishment of new health centres and the advancement of the status of existing centres by state governments. Furthermore, the current health facilities must be fully equipped with all necessary amenities and machinery.

Kumar, Suresh and Shobana.D. (2024)

A large section of the population in India depends on the rural healthcare system to have access to high-quality medical care, especially those from underserved and marginalized communities. India's rural areas face particular healthcare issues, such as unequal healthcare systems, restricted access to care, and inconsistent health results. To address these issues, the Indian government has introduced a number of healthcare programs and initiatives, including Ayushman Bharat and the National Rural Health Mission. This study sheds light on the efficacy of government initiatives and how they affect rural populations' health and well-being. In rural India, sub-centers and primary health centers serve as the initial point of contact between the community and healthcare systems. PHCs are intended to offer a greater range of medical services, such as vaccinations, patient services, immunization, maternal and child health care, family planning, and basic diagnostic facilities. These findings serve as a valuable resource for policymakers, stakeholders, and healthcare professionals working towards improving rural healthcare in India.

OBJECTIVE

- Assess the current healthcare infrastructure and resources available within Selected Gram Panchayat to identify strengths, weaknesses, and gaps in service delivery,

- To inquire about the intra performance of the community health workers, and
- Empower the community through increased awareness and participation in healthcare initiatives, ensuring equitable access to quality healthcare services and promoting preventive health measures.
- The Broader Objective of the Study is to Analyse Healthcare Facilities in Rural India as Basic Needs.

METHODOLOGY

According to the 2011 census, Haryana has 2, 53, 51,462 people. Haryana state shares a common capital, Chandigarh, which is also a union territory. At present, in 2011, the state has 4 divisions, 21 districts, 57 subdivisions, 74 tehsils, 44 sub-tehsils and 119 blocks. The state has 154 towns and 6841 villages.

Study Area

General Profile of Faridabad District: The district Faridabad is one of the six divisions of Haryana state. The Delhi-Mathura National Highway 2 (Sher shah Suri Marg) passes through the centre of the district, which occupies an area of 741 square kilometres and has a population of 18, 09,733 which makes it the most populous district of Haryana. It has a rural population of 3, 70,878 and an urban population of 14, 38,865 people which is concentrated entirely in Faridabad city. Faridabad is also a major industrial hub of Haryana. Faridabad is famous for henna production from the agricultural sector; while tractors, motorcycles, switch gears, refrigerators, shoes and tyres constitute its primary industrial products. It is the oldest district in Haryana. Suraj Kund, Badkhal Lake, Rani Ki chhatri and many more are the main tourist places in District Faridabad. The district has three subdivisions: - Badkhal, Faridabad, Ballabgarh. There are three blocks: - Ballabgarh, Faridabad, Tigaon.

Health Care Facilities in Faridabad District

There is one District hospital in the district. Civil Hospital which is located near city park, Ballabgarh. There are 4 CHC in the district viz; Kurali, Pali, Kheri Kalan and Tigaon followed by 16 PHCs, 58 sub centres. According to the district wise community health centres/primary health centres /sub centres in Haryana as on 01 January 2022.

Tigaon Gram Panchayat

Tigaon Village, Faridabad Tehsil, population is expected to be 23,995 in 2023. According to the 2011 census, this Village has a population of 19668 people, with 10530 males and 9138 females. In 2022, the population of Tigaon is 22,028 people. Literate persons number is 13672 out of 8117 males and 5555 females. Tigaon residents rely on a variety of abilities; there are 5959 workers in total, with 5054 men and 905 women. A total of 929 cultivators relies on agriculture cultivation, with 819 being men and 110 being women. In Tigaon, 366 people work as agricultural labourers, 302 of whom are males and 64 of whom are women (Tigaon Population 2023, Village in Faridabad Tehsil - Haryana).

Data Collection

A well-structured survey/interview was done with the categories chosen to assess their perspectives, patterns of healthcare utilisation, and satisfaction with community health centre services in order to gather primary data. Face-to-face administration of the survey's questionnaire ensured accurate representation of each category. In-depth interviews were conducted with medical professionals, community health centre staff, in-patients, and out-patients to learn more about their perspectives on the role of community health centres in rural areas. The plan survey was carried out at the chosen site, and its outline is shown in Table. 3.3. To evaluate infrastructure, facilities, and service delivery, healthcare facilities and services were seen. Relevant documents, reports, and records were analysed to compile further data about the centres.

The researcher has opted for interview schedule and have included three categories of respondent i.e. Doctors/ Profession Staff, Community Health Workers and In-Patients/Out-Patients.

Table 3.3. Shows the outline of detailed plan survey

S. No.	Day of Visit	No. of respondents interviewed (Patients)	No. of respondents (Doctors/ Professional staffs)	No. of respondents (Community Health Workers)
1.	15.05.2023 (Monday)	45	03	04
2.	16.05.2023 (Tuesday)	35	02	---

3.	17.05.2023 (Wednesday)	40	04	02
4.	18.05.2023 (Thursday)	50	---	03
5.	19.05.2023 (Friday)	30	01	01
6.	Total	200	10	10

Data Analysis

The quantitative data from the interviews and surveys was analysed by using statistical software to generate the appropriate descriptive statistics, frequencies, and percentages. The data was organised and tallied in order to find patterns, trends, and associations. Qualitative data from interviews and observations were transcribed and thematically analysed to identify emerging themes, categories, and patterns. The combination of these quantitative and qualitative findings improved the present study’s validity and reliability and provided a thorough understanding of the research topic.

The responses of the participants were compiled and organised into tables. Many statistical methods were used to create important statistical measures that could be analysed and interpreted. This technique may help researchers derive important insights/conclusions from their data.

Table 4.1. Depicts the current state of infrastructure facilities at the Tigaon Community Healthcare Facilities study site.

S. No.	Questionnaires	Response	
		Yes	No
	Where is this CHC located?		
1.	i. within Village Locality	Yes	
	ii. Far from village locality		No
	Building		
2.	i. Is a designated government building available for the CHC?	Yes	
	ii. Area of the building (Total area in Sq. mts.)	Nearly 3 acres	
	iii. What is the present stage of construction of the building		
	Construction completes	Yes	
3.	i. Compound Wall / Fencing (1-All around; 2-Partial; 3-None)	1	
	ii. Condition of plaster on walls (1- Well plastered with plaster intact everywhere; 2- Plaster coming off in some places; 3- Plaster coming off in many places or no plaster)	1	
	iii. Condition of floor (1- Floor in good condition; 2- Floor coming off in some places; 3- Floor coming off in many places or no proper flooring)	1	
	Whether the cleanliness is Good/ Average/ Poor? (Observe)		
4.	OPD	Good	
	OT	Good	
	Rooms	Good	
	Wards	Good	
	Toilets	Good	
	Location		
5.	i. Whether located at less than 1 hours of travel distance from the farthest village? (Yes/No)	Yes	
	ii. Whether the district headquarter hospital is located at a distance of less than 2 hours travel time? (Yes/No)	Yes	
6.	Registration counters	Yes	
7.	Separate public utilities for males and females	Yes	
8.	Suggestion / complaint box	Yes	

9.	OPD rooms / cubicles (Yes/No) (Give numbers)	Yes, 2	
10.	Adequate no. of windows in the room for light and air in each room (Yes/No)	Yes	
11.	Family Welfare Clinic (Yes/No)	Yes	
12.	Waiting room/area for patients (Yes/No)	Yes	
13.	Emergency Room / Casualty (Yes/No)	Yes	
14.	Separate wards for males and females (Yes/No)	Yes	
15.	No. of beds: Male + Female	15 +15	
Operation Theatre			
16.	i. Operation Theatre available (Yes/No)	Yes	
	ii. Lack of equipment / poor physical state of the operation theatre		No
	iii. Is the generator available for OT? (Yes / No)	Yes	
	iv. Is emergency light available in OT? (Yes / No)	Yes	
Labour room			
17.	i. Labour room available? (Yes/ No)	Yes	
	ii. If the labour room is present, arc deliveries carried out in the labour room? (Yes/ No)	Yes	
18.	Laboratory (Yes/No)	Yes	
19.	Blood Storage Unit	Yes	
	i. Blood Storage Unit available (Yes/No)	Yes	
	ii. Is the CHC having a linkage with the district blood bank? (Yes / No)	Yes	
	iii. Is regular blood supply available? (Yes / No)	Yes	
20. Water supply			
	i. Source of water (1- Piped; 2- Bore well/ hand pump / tube well; 3- Well; 4- Other (specify))	2	
21.	Laundry facilities (Yes/No)	Yes	
22. Communication facilities			
23.	ii. Telephone (Yes/No)	Yes	
24.	iii. Personal Computer (Yes/No)	Yes	
25.	iv. E-Mail (Yes/No)	Yes	
26.	v. Is CHC accessible to all by road (Yes/ No)	Yes	
27.	Vehicles, if running Ambulance (in number)	1	
28. Accommodation facility for families of admitted patients			
	i. Facility for stay available (Yes / No)		No
	ii. Attached toilet available (Yes / No)		No

The above table 4.1 depicts the current availability of infrastructure facilities in Tigaon CHC. CHCs are located within villages and operate from authorised government facilities. Tigaon CHC is surrounded by a compound wall and a complete wall boundary. The floor surface and cleanliness of several locations, including the Outpatient Department (OPD), Operation Theatre (OT) room, ward room, and toilets, were found to be satisfactory, with regular water supply. Furthermore, the CHCs' strategic location ensures that residents from the farthest region served by this CHC can access it within one hour. Outpatient registration is facilitated by a dedicated counter, and CHCs have separate public utilities. A suggestion/complaint box is also available to address patient feedback.

The CHCs have family welfare clinics and a waiting room for patients. There are emergency/casualty rooms as well as male and female wards with 15 beds each. The CHCs have operational operating rooms, and the labour room was discovered to be operational during the survey. The Tigaon CHC has provided some photographs of the well-maintained facilities (Photographs at Annexure 1). A laboratory and a blood storage unit are available, and water is supplied by a tube well. Personal computers and telephones are available and in good working order. A cement road connects the CHCs, and ambulance services are available. There are no accommodations available on the CHC grounds for families of admitted patients.

Table 4.2. shows the status of availability of Health Care Services in Selected Tigaon CHC

S. No	Coverage of Services		
1.	Number of PHCs served by CHC	4	
2.	Distance and time taken from District Hospital (in kms)	7 kms and 20mins	
3.	Pharmacy/Medicine	Yes	
4.	Surgery	Yes	
5.	OBG (obstetrics and gynaecology)	Yes	
6.	Paediatrics	Yes	
7.	Emergency services (24 Hours)	Yes	
8.	New-born care	Yes	
9.	Blood storage facility	Yes	
10.	Referral transport service	Yes	
11.	Average daily OPD Patients	120	
12.	Indoor Patient Treated (Monthly)	75	
13	Service availability		
	i. Ante-natal Clinics	Yes	
	ii. Post-natal Clinics	Yes	
	iii. Is separate septic labour room available	Yes	
	iv. Availability of facilities for out-patient department in Gynaecology/ obstetric (Yes / No)	Yes	
	v. Institutional Delivery (Yes/No)	Yes	
14	Are prescribed medicines available in health centre (Yes/No) if available upto what extent		
	i. Almost of them	Yes	
	ii. Half of them		
	iii. None of them		

Tigaon Community Health Centres serve a large population in the surrounding areas. They are conveniently located 7 kilometres from the District Hospital. Tigaon CHCs provide comprehensive healthcare, including surgical services, obstetrics and gynaecology, paediatrics, 24-hour emergency services, and institutional delivery services. They also have a well-stocked pharmacy, a blood storage facility, and referral transport services. The CHCs effectively handle an average of 75 inpatients per month, indicating their capacity to admit and treat patients requiring more intensive care. The availability of specific services improves the comprehensiveness of care.

Doctors/Professional Staff

Table 4.3. General Characteristics on Doctors and Professional Staff at CHC, Tigaon

S. No	General Characteristics on Doctors and Professional Staff		No. of respondents	Percentage
1.	Age Groups	A.< 20 years	0	0
		B.20-29 years	5	50
		C.30-39 years	3	30
		D.40-49 years	2	20
		E.50 year or more	0	0
2.	Gender	A. Male	6	60
		B. Female	4	40
3.	Education	A. Primary Education	0	0
		B. Secondary Education	1	10
		C. Bachelor’s degree	7	70
		D. Master degree	2	20
4.	Residence	A. Village	3	30
		B. Town	7	70

Source: Primary data

Table 4.3 provides insights into the age and gender representation of doctors and professional staff at CHC, Tigaon. The majority of respondents fall within the 20-39 age range, with experienced individuals in the 40-49 age range. None of the respondents have only primary education, indicating a high level of educational attainment among the medical personnel. The presence of professionals with master’s degrees signifies the commitment to continuous learning and specialisation. The data shows a diverse and well-rounded healthcare workforce, with a significant representation of young professionals and a strong educational foundation. These insights highlight the importance of a skilled and diverse workforce in delivering comprehensive healthcare services.

Table 4.4. Specific Characteristics of Doctors/Professional Staff at CHC, Tigaon

S.No	Specific Characteristics of Doctors/Professionalstaff		No. of respondents	Percentage
1.	Accessibility	A. Very accessible	7	70
		B. Moderately accessible	3	30
		C. Not accessible	0	0
2.	Infrastructure and Resources	A. Well - equipped with Adequate resources	4	40
		B. Adequate resources but limited infrastructure	5	50
		C. Insufficient resources and infrastructure limitations	1	10
3.	Functionality And Effectiveness of the CHCs	A. Highly functional and effective	5	50
		B. Moderately functional and effective	5	50
		C. Inadequate functionality and effectiveness	0	0
	Protocols and Guidelines are Followed By the CHWs	A. Well-defined protocols and strict adherence	10	100
		B. Some protocols but inconsistent adherence	0	0
		C. Lack of clear protocols and limited adherence	0	0
5.	Strengths And Weaknesses of CHCs	A. strong strengths and minimal weaknesses	5	50
		B. Balanced strengths and	5	50
		weaknesses		

Source: Primary data

Table 4.4 provides insights into the accessibility of healthcare services, infrastructure and resources available, functionality and effectiveness of CHCs, and adherence to protocols and guidelines. The majority of respondents believe that CHC, Tigaon’s services are easily accessible. The CHC is well-equipped with adequate resources, but there were infrastructure limitations. CHCs are highly functional and effective, with a strong commitment to following well-defined protocols with strict adherence. The assessment of strengths and weaknesses provides a comprehensive picture of the CHCs’ performance, emphasizing the need for ongoing improvement and optimization.

Community Health Worker

Table 4.5. General Characteristics of Community Health Worker at CHC, Tigaon

S. No.	General Characteristics of Community HealthWorker		No. of respondents	Percentage
1.	Age Groups	A.< 20 years	1	10
		B.20-29 years	4	40
		C.30-39 years	3	30
		D.40-49 years	1	10
		E.50 year or more	1	10

2.	Gender	A. Male	3	30
		B. Female	7	70
3.	Education	A. Primary Education	1	10
		B. Secondary Education	1	10
		C. Bachelor's degree	6	60
		D. Master degree	2	20
4.	Residence	A. Village	4	40
		B. Town	6	60

Source: Primary data

Table 4.5 provides an overview of Tigaon Community Health Workers' age groups, gender distribution, educational background, and residence. The data shows that 70% of CHWs are female, with the remaining 30% being male. 60% have a bachelor's degree, and 40% live in villages. This diverse residence pattern ensures that CHWs have a comprehensive understanding of both urban and rural contexts. Recognizing the diversity of the CHW workforce allows healthcare administrators and policymakers to customise policies to maximise the potential of each CHW.

Table 4.6. Specific Characteristics of Community Health Worker at CHC, Tigaon

S. No.	Specific Characteristics of Community Health Worker	No. of respondents	Percentage	
1.	Role As a Community Health Worker in The Rural community	A. Essential and impactful	8	80
		B. Moderately significant	2	20
		C. Insignificant or unclear	0	0
2.	Primary Responsibilities and Tasks Assigned to You in Delivering Healthcare Services at The CHCs	A. Comprehensive healthcare services	8	80
		B. Limited tasks and responsibilities	1	10
		C. Unclear or undefined responsibilities	1	10
3.	Provide Quality Care	A. Regular training and education programs	8	80
		B. Self -study and personal initiatives	1	10
		C. Limited access to medical knowledge updates	1	10
4.	Challenges or Difficulties You Encounter While Performing Your Duties as A CHWs	A. Minimal challenges or difficulties	2	20
		B. Some challenges but manageable	8	80
		C. Significant challenges impacting performance	0	0
5.	Impact And Effectiveness of Your Interactions with Patients, At Both as In - Patients and Out -Patients, At the CHCs	A. Positive impact and high effectiveness	3	30
		B. Moderate impact and effectiveness	7	70
		C. Limited impact and effectiveness	0	0

Source: Primary data

Table 4.6 provides insights into the roles, responsibilities, training, challenges, and impact on patient interactions of Community Health Workers (CHWs) at CHCs in Tigaon. 80% of respondents consider their role to be important and impactful in meeting the healthcare needs of the rural population. CHWs have a wide range of responsibilities, ensuring that the community receives holistic care. They attribute their quality care to regular training and education programmes, while 10% rely on self-study and personal initiatives to stay current. In terms of interactions with patients, 70% report a moderate impact and effectiveness, and 30% perceive a positive impact and high effectiveness. By addressing challenges and providing ongoing training and support, healthcare administrators and policymakers can improve the effectiveness of CHWs and ultimately improve healthcare outcomes. The data shows that CHWs contribute significantly to the well-being of the community they serve.

Patients and Community Members

Table 4.7. General characteristics of Patients and Community Members at CHC, Tigaon

S. No	General characteristics Patients and Community Members	No. of respondents	Percentage	
1.	Age Groups	A. < 20 years	16	8
		B. 20-29 years	90	45
		C. 30-39 years	80	40
		D. 40-49 years	8	4
		E. 50 year or more	6	3
2.	Gender	A. Male	116	58
		B. Female	84	42
3.	Education	A. Primary Education	20	10
		B. Secondary Education	120	60
		C. Bachelor's degree	40	20
		D. Master degree	20	10
4.	Residence	A. Village	3	30
		B. Town	7	70

Source: Primary data

Table 4.7 provides an overview of the demographic profile of patients and community members at CHC in Tigaon, focusing on age groups, gender, education, and residence. The 20-29 age group accounts for the largest proportion of respondents, with 58% male and 42% female. 60% of respondents have secondary education, with 20% having a bachelor's degree or higher. 70% live in towns, while 30% in villages. The CHC serves a diverse population from both rural and urban settings, providing healthcare access to individuals from various residential backgrounds. By understanding the demographics of the patient population, healthcare providers and policymakers can tailor their services and interventions to better meet the specific needs of different age groups and educational backgrounds. This data serves as a valuable resource for healthcare administrators in planning and implementing targeted healthcare initiatives to address the diverse needs of the community members and ensure equitable access to quality healthcare services.

Table 4.8. Specific Characteristics of Patients and Community Member at CHC, Tigaon

S. No.	Specific Characteristics of Patients and Community Members	No.of respondents	Percentage	
1	Accessibility of the Community Health Centre in Terms of Distance, Transportations and Affordability.	A. Highly accessible in all aspects	160	80
		B. Moderately accessible in most aspects	20	10
		C. Not accessible in terms of distances, transportation, or affordability	20	10
2	Experiences With the Healthcare Services Provided by The CHCs.	A. Highly satisfied with the care received	140	70
		B. Moderately satisfied with some areas for improvement	40	20
		C. Dissatisfied with the care received	20	10
3	Interactions with Healthcare Professionals at the Community Health Centre, Both As In -Patients and Out-Patients.	A. Positive changes in interactions	140	70
		B. some changes, both positive and negative	50	25
		C. No noticeable changes in interactions	10	5
4	Challenges Or Limitations You Face in Accessing Healthcare Services at The Community Health Centre in Rural Area.	A. No significant challenges or limitations	124	62
		B. Some challenges but manageable	66	33
		C. Significant challenges impacting access to healthcare	10	5

5	Functioning of the Community Health Centre to Better Serve The Healthcare Needs of Rural Community	A. Expanded services and resources	120	60
		B. Better staff- patient communication	60	30
		C. Enhanced accessibility and affordability options	20	10

Source: Primary data

The CHC in Tigaon is highly accessible to patients and community members, with 80% finding it convenient and affordable. 70% of patients are extremely satisfied with the healthcare services provided, but 10% are dissatisfied. In terms of interactions with healthcare professionals, 70% report positive changes in communication and engagement. 62% report no significant challenges or limitations in accessing healthcare, but 5% face significant barriers. 60% suggest expanding services and resources to improve the CHC's operation to better serve the rural community. 30% emphasise the importance of improved staff-patient communication, and 10% suggest improving accessibility and affordability options. By understanding these characteristics, healthcare providers and policymakers can work towards enhancing healthcare access, improving patient satisfaction, and optimizing overall functioning. Table 4.8 provides valuable insights into patient and community member characteristics and suggestions for improving CHC functioning.

OBSERVATIONS AND FINDINGS

Several noteworthy observations can be made in the context of a Community Health Center (CHC) revolutionizing healthcare access in rural Haryana. Unquestionably, the CHC's founding has improved underprivileged communities' access to healthcare significantly. Because residents can now access basic healthcare services more easily, they are using healthcare facilities more frequently and taking a more preventive approach to healthcare. Additionally, it is possible that efforts to increase capacity, such as training local healthcare providers and staff, have raised the standard of care while also generating jobs for the community. Technology integration has improved healthcare delivery by increasing its efficiency and accessibility. Examples of this include telemedicine and electronic health records. But even with these improvements, there are still a few flaws. Obstacles like inadequate funding, a scarcity of medical professionals, and cultural barriers that prevent people from accessing healthcare remain formidable. Furthermore, there might be deficiencies in data collection and monitoring, making it more difficult to precisely track health indicators and assess the effectiveness of interventions. It will take sustained investment, legislative backing, and community engagement to address these shortcomings and guarantee long-lasting gains in rural health outcomes and healthcare access.

CONCLUSION

The study discusses the availability of healthcare services, characteristics of healthcare professionals, community health workers, patients, and community members at the Tigaon CHC. The CHC is well-equipped to cater to the healthcare needs of the local population, but there is still room for improvement. The characteristics of doctors and professional staff provide valuable insights, with a diverse mix of experienced practitioners and young professionals. Community health workers play a crucial role in delivering healthcare services in the rural community, and ongoing training and support are necessary to improve their skills and knowledge. The article also highlights the importance of promoting gender diversity and increasing female representation among healthcare professionals. Overall, the CHC's healthcare services are effective in providing comprehensive and culturally sensitive care. However, initiatives should be put in place to help with the recruitment and retention of CHWs from diverse backgrounds, and to ensure equitable representation and foster community engagement.

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