Journal of Cardiovascular Disease Research

ISSN: 0975-3583,0976-2833 VOL13, ISSUE 08, 2022

Health Care accessibility among Rural Population in Mayurbhanj and Jagatsinghpur district of Odisha: A mix-method study

[1]Dr Rekharani Sethy, [2]Dr. Ajaya Bhatta, [3]Dr. Sudhira Kumar Parida, [4]Dr Somanath Sethi

[1]C/O- Eng.Harihar Sethy, At/Po- Rajendra Nagar, Via- Madhupatna, Dist- Cuttack, Pin-753010, Odisha,

[2]Asst. Prof. , Community Medicine,PRM Medical College, Baripada, Odisha-757107

[3]Assistant Professor, Department of Community Medicine, P.R.M. Medical College, Baripada, Odisha-757107

[4]Asst. Professor, Dept. Of Community Medicine, Prm Medical College And Hospital, Baripada- 757107,

Corresponding Author

Dr Somanath Sethi

Asst. Professor Dept. Of Community Medicine Prm Medical College And Hospital, Baripada- 757107,

Abstract

Background: For human productivity, the "development" process, and the economic and technological advancement of both the individual and the country, good health is crucial. A healthy community is beneficial to the country. Individuals's health is a key indicator of a country's growth since healthy people can contribute to the advancement of their country.

Objectives: To assess the existing socio-economic status, adequacy and utilisation of health services provided by NRHM in the two selected blocks of Mayurbhanj & Jagatsinghpur district in Odisha.

Methodology: This mixed-method study was carried out in the districts of Mayurbhanj and Jagatsinghpur in Odisha's Erasama Block and Baripada Block, respectively. For the study, both primary and secondary data were employed. An in-depth interview and a focused group discussion were done with a subgroup of research participants as part of the qualitative component. The study was carried out in Ambiki village and Rangamatia in the blocks of Erasama and Baripada from April 2018 to March 2019.

Findings of study: The majority of ASHAs serve populations larger than the required minimum of 1,000 people. Antenatal women' transportation was discovered to be a significant issue. Each month, ASHAs were paid a relatively small sum in total. The community's, Panchayati Raj institutions' (PRI), community-based organisations' (CBOs), and ANMs' support was insufficient. Village health, nutrition, and sanitation committees' implementation and operation had flaws (VHNSC).

Conclusion: A crucial process for the program's success should be maintained is interdepartmental integration and coordination. A concerted effort should be made to include community input in the planning process at all stages. For community monitoring and social audit to be successful, PRI members and community leaders should be appropriately oriented.

ISSN: 0975-3583,0976-2833 VOL13, ISSUE 08, 2022

IEC and BCC activities must be central to all health care planning in order to raise health care literacy, utilisation, and awareness among the general public.
Key words: VHNSC, NHM, NRHM, Healthcare, and Odisha.

Introduction:

The National Health Mission is regarded as the state's comprehensive public health initiative. The National Rural Health Mission (NRHM) for rural India and the National Urban Health Mission (NUHM) for urban India are currently active under the NHM Flagship Program due to collaboration between the state and central governments. According to the NHM, everyone will be able to access fair, affordable, and high-quality healthcare services that are accountable and sensitive to the requirements of people. The NRHM's mission is to offer rural residents in the nation's 18 "Special Focus States" access to cheap, high-quality services, with a focus on the population's needs.(1)

The programme is based on responsible, innovative, and comprehensive strategies for funding, creating new institutions, decentralisation, and providing new ideas and resources for health. The state government strengthens the health framework and improves health service in rural, remote, and outreach areas through the National Rural Health Mission in order to strengthen essential health care services in inadequately populated and remote areas.(2) The National Rural Health Mission (NRHM) is a long-running initiative aimed at establishing universal healthcare access in India. The performance of the health system has been adversely affected by a number of factors, including a lack of medical infrastructure and staff in rural and neglected areas, the promotion of profit-driven private business models in the health system, and weak governance.(3,4) Although NRHM services have been deployed nationwide, there are still gaps that must be identified and closed in order to provide high-quality healthcare. The present study is carried out to evaluate the status of NRHM services in the rural areas from selected blocks in Mayurbhanj and Jagatsinghpur district of Odisha. The study will also assess the adequacy and utilization of healthcare services in government facilities and the policy measures needed for effective implementation of NRHM in the district and state.

Methodology:

This mixed-method study was conducted in two blocks, Baripada block in Mayurbhanj and Erasama block of Jagatsinghpur. The study was carried out from April-2018 to March -2019 in two villages; Rangamatia Village (Population-870) in Mayurbhanj and Ambiki village (Population-987) in Jagatsinghpur (Table No.1). From each village, a total of 40 individuals (N=80) were selected using multistage random sampling. In this study both primary and secondary data were used and the data was collected from the beneficiaries using semi-structured questionnaire. In both of this study districts, we have included ten allopathic doctors, four AYUSH doctors, four pharmacists, four staff nurses, two ANMs, two multipurpose health workers (Male). Data from them were collected using separate in-depth interviews and focused group discussions. In total, 110 individuals were questioned for this study. Each participant in the study verbally consented after being fully informed. The data were entered into excel sheet and the statistical analysis was carried out in SPSS software.

ISSN: 0975-3583,0976-2833 VOL13, ISSUE 08, 2022

Table-1 List of included Study block and villages (N=40)

Sr.No	District	Block	Village
1	Jagatsinghpur	Erasama	Ambiki Village (Population-987)
2	Mayurbhanj	Baripada	Rangamatia Village (Population-870)

Results:

Socio-demographic distribution of participants in the sample district (N=40 from each district)

Studying the respondents' demographics—including age, education, marital status, caste, level of poverty, and income—is crucial since it may affect how effectively they perform their jobs. The analysis of the sociodemographic profile has been presented in Table-2

Table No-2 The Socio-demographic profile of study participants in the Rangamatia and Ambiki village (N=80)

Profile	**Districts**				**Total**	
	Jagatsingpur Ambiki village (n=40)		**Mayurbhanj District Rangamatia village** (n=40)			
Age group	Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)
11-18 years	10	25.0	24	60.0	34	42.5
19–29 years	13	32.5	7	17.5	20	25.0
30–39 years	9	22.5	5	12.5	14	17.5
40–49 years	8	20.0	4	10.0	12	15.0
Total	40	100.0	40	100.0	80	100.0
Education level						
Illiterate	14	35.0	6	15.0	20	25.0
Primary/Middle/Secondary	11	27.5	15	37.5	26	32.5
Higher secondary and above	15	37.5	19	47.5	34	42.5
Total	40	100.0	40	100.0	80	100.0
Marital status						
Married	22	55.0	36	90.0	58	72.5
Separated	5	12.5	2	5.0	7	8.8
Widow	13	32.5	2	5.0	15	18.8
Total	40	100.0	40	100.0	80	100.0
Caste						
SC	14	35.0	4	10.0	18	22.5
ST	1	2.5	23	57.5	24	30.0

ISSN: 0975-3583,0976-2833 VOL13, ISSUE 08, 2022

OBC	11	27.5	6	15.0	17	21.3
General	14	35.0	7	17.5	21	26.3
Total	40	100.0	40	100.0	80	100.0
Economic Status						
Below poverty line (BPL)	22	55.0	37	92.5	59	73.8
Above-poverty line (APL)	18	45.0	3	7.5	21	26.3
Total	40	100.0	40	100.0	80	100.0

The age distribution of the respondents shows that 42.5% in the 11-18 age group, a quarter are in the 19-29 age group, 17.5% in the 30–39 age group, and 15% in 40–49 age group. As a result, because over 70% of the respondents are under 35 years old, the age distribution of the respondents might be deemed young. This is one of the program's key strengths. However, compared to the tribal Mayurbhanj district, the age distribution in rural Jagatsinghpur is slightly older. However, the respondents in rural Jagatsinghpur are young, with 57.5 percent being under 35 and none being over 44. Surprisingly, the education level is substantially higher in the tribal Mayurbhanj district than in the rural Jagatsinghpur area. The majority (72.5 percent) are married, 8.8% are separated, and 18.8% are widows, according to the marital status data. The caste breakdown shows that SCs (22.5%) and STs (30%) together make up more than half of the entire sample, while OBC and General Castes make up 21.3% and 26.3%, respectively, of the sample. The SCs (10%) and STs (57.5%) combined make up around 70% of the tribal district, while the OBCs and General Castes make up 15% and 17.5% of the population, respectively. Nearly a quarter of respondents fall into the above poverty line (APL) group, while roughly three-fourths of respondents fall into the below poverty line (BPL) category.

Knowledge and Awareness of Respondents regarding the health care services

The purpose of the interviewing the respondents was to gauge their level of familiarity with the health care services offered in their neighbourhood. (Table- 3)

Table- 3 Respondents knowledge about health care services available

Sr. No.	Response of Participants	Name of the district				Total	
		Jagatsingpur (n=40)		Mayurbhanj (n=40)		(N=80)	
		Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)
1	Create community awareness on determinants of health	15	37.5	24	60.0	39	48.8
2	Counsel community on safe delivery practices, ANC/PNC services, breastfeeding, immunization, Family	32	80.0	33	82.5	65	81.3

ISSN: 0975-3583,0976-2833 VOL13, ISSUE 08, 2022

	planning and prevention of STIs						
3	Community mobilization	8	20.0	26	65.0	34	42.5
4	Developing village health plan under VHNSC	3	7.5	7	17.5	10	12.5
5	Accompany pregnant mothers to hospitals	34	85.0	33	82.5	67	83.8
6	Providing medicines for common ailments and Providing DOTs for TB	10	25.0	26	65.0	36	45.0
7	Motivating the community for construction and use of household toilet	15	37.5	24	60.0	39	48.8
8	Inform AWW/ANM about birth and deaths	3	7.5	6	15.0	9	11.3

Activities undertaken by the health care staffs (ASHA & AWW) in the village:

The participants' responses to questions about the various health-related activities carried out in the field are listed in table no. 4.

Table No.-4 The core activities in community by village healthcare staffs.

Sr. No.	Activities by health staffs (ASHA &AWW)	Name of the Districts					
		Jagatsingpur (n=40)		Mayurbhanj (n=40)		Total (N=80)	
		Frequency	%	Frequency	%	Frequency	%
1	Registration of pregnant mother	21	52.5	34	85.0	55	68.8
2	Counseling on ANC, PNC, safe delivery	31	77.5	36	90.0	67	83.8
3	Accompany pregnant mother to hospital	37	92.5	37	92.5	74	92.5
4	Distribution of IFA, Oral pills, ORS	35	87.5	35	87.5	70	87.5
5	Distribution of DOTS	5	12.5	26	65.0	31	38.8
6	Inform AWW/ANM on birth and death	3	7.5	4	10.0	7	8.8
7	Help AWW in supplementary nutrition feeding	11	27.5	18	45.0	29	36.3
8	Motivate for construction of latrines	17	42.5	17	42.5	34	42.5
9	Help ANM for immunization	33	82.5	31	77.5	64	80.0
10	Education to adolescent	1	2.5	6	15.0	7	8.8
11	Motivate the couple for family planning	0	0	6	15.0	6	7.5

ISSN: 0975-3583,0976-2833 VOL13, ISSUE 08, 2022

The majority of the ASHAs' activities were to accompany expectant mothers to the medical facility (92.5%), provide ANC, PNC, and safe birth counselling (84%) and provide IFA and oral contraceptives (87.5 percent). Other activities reported were registration of ANC mothers (68.8%) and conducting vaccination sessions (80%). ASHAs who have the opportunity to accompany pregnant women to the hospital for delivery make up about half (43.8%) of the total. Only 3.8 percent of cases of malaria and high fever were accompanied, and 2.5 percent of TB patients were supported by the community and society for social acceptance.

Health care service utilization in community:

With one exception who claims that "she did not feel the obligation to visit rich household," it has been shown that nearly all ASHAs (98.8%) visited every residence in the community. The underserved rural population was where the ASHAs were required to work. They must inform every home and raise awareness of the many maternity and child healthcare services that are available in the community. ASHAs are seen as a major representation of the health system in the community and are seen as friends by many homes, particularly by expectant and nursing mothers, according to eight FGDs that were conducted. PRI participants, SHG participants, community leaders, and mothers who took part in the FGDs expressed gratitude for the services provided by ASHAs.

Beneficiaries & ASHAs' Association with Village Health Sanitation Committees

According to the results of the field study (N-80), one of her designated roles is to associate the ASHA with the VHSC. Ironically, however, the majority of ASHAs (82.5%) have reported that the villages lack a VHSC. Only a few ASHAs (14 out of 80) have acknowledged the existence of VHSC. The FGDs among community people have likewise mirrored the bad situation at VHSC.

Client satisfaction and Expectations from health system

The community, PRI members, CBO representatives, and FGD with AWWs and community members assess the level of client satisfaction. While the community is delighted with the work being done, only one out of three CBOs and two out of five PRI find the functions of the ASHAs to be fully satisfactory. They could serve as a bridge between the community and the health sector. Their role is currently evolving, according to the CBO of the Erasama Block in the Jagatsinghpur district. They have all stressed the importance of the ASHA as a support mechanism for primary healthcare and as a facilitator of services for maternal and child health.

Discussion and recommendations:

This study focused on the NRHM services' degree of implementation from both the provider and beneficiary perspectives. Additionally, it detailed various restrictions and difficulties faced by front-line healthcare staff (FLWs). Certain segments of the population were left un-served and un-reached as a result of ASHAs' increased population coverage and insufficient financial recompense. This was also emphasised in a study by Sundararaman et al.(5) A major portion of this problem can be resolved with the help of a redistribution of FLWs. To close the knowledge gap noted in our study—which was also identified by a study conducted by Rohith et al.—ASHAs must continuously develop their capacity. (6) Sharma et al. have confirmed our findings that ASHAs tend to prioritise tasks with financial rewards while

ISSN: 0975-3583,0976-2833 VOL13, ISSUE 08, 2022

ignoring other crucial job duties including bolstering VHNDs and carrying out village health plans.(7) The timely implementation of numerous health programmes at the village level has been hampered by the lack of coordination between FLWs and PRIs. Similar results were obtained in a study conducted in West Bengal by Jha et al.(8) Various socio-demographic characteristics, including poverty, illiteracy, a lack of trust in the system, and others have been linked to recipients' inadequate service utilisation. Similar research by Singh et al. has reported this..(9) According to Saxena et al., the VHNSCs have been lagging in their efforts to sustainably improve the health status of their villages.(10) The results of our study point to the importance of a comprehensive strategy to rural healthcare that incorporates a variety of innovations and best practises in order to enhance service delivery models. The recommendations resulting from our investigation are listed below.

1. Every level of the development, execution, and monitoring of VHSC requires the involvement of and sensitization of PRIs.
2. Regular refresher training should be provided for ASHAs, with a focus on efficient community education, communication abilities, and resource management.
3. The benefit population should create a constant line of communication with service providers, including FLWs and PRI members.
4. To raise the level of service, VHNSC supervision and monitoring should be strengthened.
5. The development and implementation of various health programmes at the village level should involve local CBOs and SHGs.

Conclusion:

Without demonstrating appreciable health improvements under any health policies or programmes, most government health facilities have claimed higher utilisation and foot traffic year over year. All levels of the health care system should immediately assess the policy and the planning procedure. The success of NHM in providing universal health care in India depends greatly on a strong social vision and an efficient governance system.

References

1. Ministry of Health and Family Welfare (MoHFW) 2005, National Rural Health Mission: Meeting People's Health Needs in Rural Areas Framework for Implementation 2005-2012. pp. 1-20, GOI, New Delhi.
2. Ministry of Health and Family Welfare (MoHFW) 2008a, NRHM Common Review Mission, Draft Report of a Review Study of NRHM commissioned by the Ministry Health and Family Welfare (MoHFW), GOI.
3. Common Review Mission Report. 2017 Ministry of Health and Family Welfare Government of India.
4. National Rural Health Mission: Meeting people’s health needs in rural areas, Framework for implementation (2005-12): New Delhi: Government of India, Ministry of Health Family Welfare.
5. Sundararaman T, Ved R, Gupta G, Samatha M. Determinants of functionality and effectiveness of community health workers: results from evaluation of ASHA program in eight Indian states. BMC Proc. 2012 Sep 28;6(Suppl 5):O30.
6. Sharma R, Webster P, Bhattacharyya S. Factors affecting the performance of community health workers in India: a multi-stakeholder perspective. Glob Health

ISSN: 0975-3583,0976-2833 VOL13, ISSUE 08, 2022

Action. 2014 Oct 13;7:25352.

7. Jha SS, Dasgupta A, Paul B, Ghosh P, Yadav A. Evaluation of village health and nutrition day program in a block of Hooghly District, West Bengal: A mixed-methods approach. Indian J Public Health [serial online] 2021 [cited 2022 May 31];65:130-5.
8. Singh MK, Singh J, Ahmad N, Kumari R, Khanna A. Factors Influencing Utilization of ASHA Services under NRHM in Relation to Maternal Health in Rural Lucknow. Indian J Community Med. 2010 Jul;35(3):414-9.
9. Saxena V, Kumar P, Kumari R, Nath B, Pal R. Availability of Village Health and Nutrition Day services in Uttarakhand, India. J Family Med Prim Care. 2015 Apr-Jun;4(2):251-6.
10. Rohith M, Angadi MM. Evaluation of knowledge and practice of ASHAs, regarding child health services in Vijyapaura District, Karnataka. J Family Med Prim Care. 2020 Jul 30;9(7):3272-3276.