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Access to health care among rural population: A comparative study in Mayurbhanj & Jagatsinghpur District of Odisha

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Abstract--Background: Good health is very important to human productivity and the “development” process, economic and technological development of the individual as well as for the nation. A healthy community is an asset to nation. The progress of nation is measured by health of its people because healthy people can contribute for the betterment and progress of the nation. Objectives: To assess the existing status, adequacy and utilization of health services under NRHM in the selected areas in Mayurbhanj & Jagatsinghpur district of the state, Methodology: This is a mixed-method study conducted at Erasama block of Jagatsinghpur District & Baripada Block of Mayurbhanj district in Odisha. Both Primary and secondary data has been used for the study. As a part of qualitative component, n-depth interview and Focussed group discussion were conducted among a subgroup of study participants. Study was conducted from April-2018 to March -2019 in Ambiki village and Rangamatia of Erasama and Baripada Blocks respectively. Findings of study: Most of the ASHAs are providing services to a population of

more than the specified standard of 1,000. Transportation of antenatal mothers was found to be a major problem. The total compensation ASHAs receive for each month was comparatively low. The support from the community, Panchayati Raj institutions (PRI), Community based organization and ANMswas not satisfactory. There were gaps in implementation and functioning of Village health nutrition and sanitation committees (VHNSC). Conclusion: Interdepartmental integration and co-ordination should be maintained as key process for success of the program. Attempt should be made to involve community participation in planning process at all levels. PRI members and community leaders should be sufficiently oriented for community monitoring and social audit to be successful. IEC, BCC activities must be core activities in all health care planning to increase the health care knowledge, utilization& awareness at grassroot level.

Keywords---ASHA, VHSC, NRHM, Availability, Adequacy and Utilization.

Introduction

National Rural Health Mission (now National Health Mission from 2013) has been considered as a comprehensive intervention by the state in the field of public health. Presently, Under the NHM Flagship Program two sub programs e.g., National Rural Health Mission (NRHM) for rural India & National Urban Health Mission (NUHM) for urban India has been operational through collaboration between the state and central government. The goal of the NRHM is to provide affordable and quality services to rural population with attention towards the poor and the vulnerable population of 18 'Special Focus States' of the country.(1) The program is based on responsible, innovative and comprehensive strategies for providing funds, creating new institutions, decentralization and providing new ideas and resources for health with an in order to strengthen essential health care services in inadequately populated and remote areas, the state government strengthens the health framework and improves health service in rural, remote and outreach areas through the National Rural Health Mission.(2)

National Rural Health Mission (NRHM) has been a long-acting initiative in the direction of achieving all-inclusive healthcare delivery in India. However, several issues like shortage of health infrastructure and manpower in rural and underserved areas, promotion of profit-oriented private business models in health system and poor governance has negatively impacted the health system performance. (3,4) Although, NRHM services has been implemented across the country, there is a need to identify these existing gaps and work upon them to achieve quality health care.

Objectives

1. To evaluate the status of NRHM services in the villages from selected areas in Mayurbhanj & Jagatsinghpur district of the state.

2. To assess the adequacy and utilization of healthcare services in public health facilities.
3. To suggest policy measures for effective implementation of NRHM in the district and state.

Methodology

This is a mixed-method study conducted in Ambiki village (total population-987) under Erasama block of Jagatsinghpur District and Rangamatia Village (total population-870) under Baripada Block of Mayurbhanj (Table no.1). The study is based on the of both primary and secondary data. Duration of study was from April-2018 to March -2019. The data was collected from the beneficiaries with the help of a semi-structured pre-tested questionnaire. A total of 40 participants were recruited from each village (N=80) through multistage random sampling. In addition to this from both districts, 10 allopathic doctors, 4 AYUSH doctors, 4 pharmacists, 4 staff nurses, 2 ANMs, 2 Multipurpose health worker (Male) were also part of separate in-depth interviews and focused group discussions. Total of 110 respondents has been interviewed in this study. Verbal informed consents were taken from each of the study participants. The data was analysed by SPSS 16.0.

Table No-1 List of Selected Study Areas (village) (N=40 from each district)

Sl.No	Name of the district	Name of the block	Name of the Sub-centre/vilage
1	Jagatsinghpur	Erasama	Ambiki Village (Population-987)
2	Mayurbhanj	Baripada Block	Rangamatia Village (Population-870)

Results

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

Study of the profile of the respondents in terms of age, education, marital status, caste, poverty status and income level are important as it might have a bearing on their functional efficacy. The analysis of the profile has been presented in Table No-2

Table No-2 The profile of respondents in the Rangamatia & Ambiki village of the district (N=80)

Profile	Districts				Total	
	Jagatsinghpur District Erasama Block Ambiki village (n=40)		Mayurbhanj District Baripada Block Rangamatia village (n=40)			
Age group in yrs.	Frequency	%	Frequency	%	Frequency	%
11-18	10	25.0	24	60.0	34	42.5

19-29	13	32.5	7	17.5	20	25.0
30-39	9	22.5	5	12.5	14	17.5
40-49	8	20.0	4	10.0	12	15.0
Total	40	100.0	40	100.0	80	100.0
Education						
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
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

Age distribution indicates that nearly half of the respondents are in the age group 25 -29, a quarter in the age group 30-35, some in 35-39 and some in the 40-44 age bracket. Thus, the age structure of the respondents can be considered to be young as nearly 70% are below 35 years. This is a major strength of the programme. However, the age composition in rural Jagatsinghpur is bit older than the tribal Mayurbhanj district. Nonetheless in rural Jagatsinghpur, the age composition of the respondents is also young with 57.5% below 35 and none above 44 years. Surprisingly, in the tribal Mayurbhanj district, the level of education is much better than the rural Jagatsinghpur district. The marital status reveals that majority (72.5%) is married, very few are separated and some are widows. The caste composition reveals that the SCs (22.5%) and STs (30%) together constitute more than half of the total sample, while OBC and General Castes are 21.3% and 26.3% respectively. In the tribal district, the SCs (10%) and STs (57.5%) together constitute about 70%, while the OBCs and General Castes are 15% and 17.5% respectively. Around three fourths of the respondents belong

to below poverty line and nearly a quarter belong to the above poverty line (APL) category.

Knowledge and Awareness of Respondents regarding the health care services

The respondents have been interviewed to assess their knowledge about their health care services delivered in their community. (Table no. 3)

Table No- 3 Respondents knowledge about their health care services available in Community

SL. NO	Type of Response of Respondents	Name of the district				Total	
		Jagatsingpur (n=40)		Mayurbhanj (n=40)		(N=80)	
		Frequency	%	Frequency	%	Frequency	%
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 planning and prevention of STIs	32	80.0	33	82.5	65	81.3
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 were asked about the various health related activities being undertaken in the field and the result is tabulated in table no- 4.

Table No. 4 The core activities undertaken in community by village healthstaffs

SL. NO.	Activities under taken 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

The most common activities reported by the ASHAs were accompanying the pregnant women to the health facility (92.5%), counseling on ANC, PNC and safe delivery (84%), distribution of IFA and oral contraceptive pills (87.5%), registration of ANC mothers (68.8%) and conducting immunization sessions (80%). Approximately half (43.8%) of the ASHAs have had the opportunity to accompany pregnant women to hospital for delivery. Only 3.8% have accompanied malaria and high fever cases, and 2.5% had supported TB patients for Social Acceptance and Community Support.

Health care service utilization in community

It has been revealed that all most all ASHAs (98.8%) paid visit to all household in the village, barring one exception who states that “she did not feel the necessity to visit rich household”. The ASHAs were required to work in the community among the rural underserved population. They have to educate every household and generate awareness in the community for various maternal and child healthcare services available to them. Eight FGDs that were conducted revealed that ASHAs are recognized as a prominent face of health system in the community and considered as a friend to many households, especially for the pregnant and lactating mothers. The PRI members, SHG members, community leaders, and mothers who participated in the FGDs, appreciated ASHAs for their services.

Beneficiaries & ASHAs' Association with Village Health Sanitation Committees

Field Study (N-80) revealed that association of the ASHA with VHSC is one of her assigned responsibilities. But ironically, most of the ASHAs (82.5%) have indicated that the villages do not have a VHSC. Only some (14 out of 80) of the ASHAs have indicated about the existence of VHSC. The poor scenario of VHSC has also been reflected in the FGDs among the community members.

Client satisfaction and Expectations from health system

The level of client satisfaction is judged by community members and the PRI members, representative of the CBOs, and FGD with AWWs and community. Four out of five PRI and two out of three CBOs are happy with the functions of the ASHAs as the community is satisfied with the work, while the third CBO feels that is it only somewhat satisfactory.' "They are the potential link between the community and health sector. Presently, their function is developing," remarks the CBO of the Erasama Block in Jagatsinghpur district. All of them have emphasized on the role of the ASHA as a facilitator for maternal and child health care services and as pillar of primary health care system.

Discussion and Recommendations

This study highlighted the implementation status of NRHM services at the grassroot level from both provider and beneficiary perspective. In addition to this it also presented various limitations and challenges faced by frontline health-care workers (FLWs). Due to higher population coverage by ASHAs and poor financial compensation, certain section of the population remained un-served and un-reached. This has also been highlighted in a study done by Sundararaman et al. (5) A redistribution of FLWs can help in solving this problem to large extent. Capacity building of ASHAs on a continuous basis is also needed to reduce the knowledge gap reported in our study which has also been concluded by a study done by Rohith et al. (6) Our findings of ASHAs being more inclined towards activities linked to financial incentives and neglecting other essential job responsibilities like strengthening VHNDs and implementing village health plans has been supported by Sharma et al. (7) The lack of coordination between FLWs and PRIs has affected the timely implementation of many health programs at village level. Jha et al had reported similar findings in their study done in West Bengal. (8) Inadequate service utilization by the beneficiaries has been attributed various socio-demographic factors like poverty, illiteracy, trust deficit etc. This has been reported by a similar study done by Singh et al. (9) The VHNSCs has been lagging behind in making a sustainable effort towards improving health status of their villages as concluded by Saxena et al. (10) Our study findings suggest necessity of a holistic approach towards rural healthcare with integration various innovations and best practices in improving the service delivery models. Following are the recommendations generated from our study.

1. PRIs need to be sensitized and involved in every stage of planning, implementation and monitoring of VHSC.

2. ASHAs should be given regular refresher training with emphasis on effective community education, communication skills and financial resource utilization.
3. A continuous channel of communication should be established between beneficiary population and service providers involving FLWs and PRI members.
4. Supervision and monitoring of VHNSCs should be strengthened to improve the service quality.
5. Local CBOs and SHGs should be involved in planning and implementations of various health programs at village level.

Conclusion

The most government health facilities have reported increased utilization and foot-falls, year on year without showing the significant improvements in health under the any health policies & programs. Urgent review of the policy and the planning process should be done in all levels of health care. Finally, a potent social vision and an effective governance mechanism is extremely important for the success of NHM in achieving universal health coverage in India.

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