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Original Research Article

A Cross Sectional Study to Assess the Utility, Acceptance and Operational Challenges in Delivering Services at Gram Arogya Kendra in Bhopal District, Madhya Pradesh

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Abstract

Introduction: The villages are the main roots of Indian civilization and about 83.3 crore population of India lives in villages (Census 2011).Even today, health services are out of reach for the vast majority of rural residents, despite the fact that the country's doctor-to-population ratio has reached 1:2545 (Census -2011). On October 2nd, 1975, the Government of India launched the 'Integrated Child Development Services' (ICDS) scheme in 33 pilot projects in accordance with the National Policy for Children. It is also an initiative to improve village-level convergence of health and ICDS services.

Objective: To assess the utility and acceptance of these Gram Arogya Kendra in village residents and health workers and to Understand operational Challenges in Delivering services of these Gram Arogya Kendra.

Methodology: This community based cross sectional study was conducted among 50 selected (i.e. 22 in rural and 28 in urban areas) Gram Arogya Kendra of Bhopal district.

Results: 58% of the ASHA have work experience of 5-10 years. about 98% ASHA responded that they are satisfied with the services being provided at GAKs. 76% of the ANM were educated up to graduate. Fig. 2 showed 96% of the ANM said that village resident were aware about various services provided by GAK in his/her village. Fig .3 showed,84.8% of the beneficiaries responded that they or their family members take medicines from GA. Fig. 4 showed 100% of MO said that GAKs were help in early primary treatment /early referral at village level.

Conclusion: The Gram Arogya Kendra is a unique concept to promote village based health and nutrition activities, and for involving the community in their own health.

Keywords: Gram Arogya Kendra, ASHA, ANM, ICDS, Challenges.

Introduction

The villages are the main roots of Indian civilization and about 83.3 crore population of India lives in villages (Census 2011).[1] They play important role in socio-economic development of country. As per census 2011 about 21.9% of villages population live below poverty line. "People are sick because they are poor, and they become poorer because they are sick," says the relationship between poverty and sickness.[2] In the past, their general well-being, including health, was severely neglected. Even today, health services are out of reach for the vast majority of rural residents, despite the fact that the country's doctor-to-population ratio has reached 1:2545 (Census -2011).[1] Furthermore, when a doctor who can provide health care is available in a rural area, he is preoccupied with providing medical relief at the PHC and has limited time and interest in preventive and promotional health care. Only 10% of medical care in India is provided by organised health services, 10% by qualified physicians, and the remainder is divided between home medical care and indigenous practises.[2]

On October 2nd, 1975, the Government of India launched the 'Integrated Child Development Services' (ICDS) scheme in 33 pilot projects in accordance with the National Policy for Children. With tremendous success in the early years, it was gradually expanded to the point where the ICDS scheme was universalized throughout the country in the Tenth Five Year Plan.[3] The Government of Madhya Pradesh's Department of Public Health and Family Welfare implements various components of the NRHM throughout the state. The innovation has been in actively promoting the convergence of health and ICDS, as well as in strengthening community ownership of village-level programmes. This is hoped to be accomplished by establishing Anganwadi-cum-Gram Arogya Kendra (GAK)/Village Health Centres in each village.[4] The primary goal of establishing these health centres is to raise community awareness of their health and environment, increase community ownership of village level programmes, and ensure proper delivery of health and nutrition services through community involvement and supervision.

Treatment of minor ailments and early referral for more serious illness, as well as health education towards a healthy lifestyle, are the two main areas of focus of activities. It is also an initiative to improve village-level convergence of health and ICDS services.[4]

Each project aimed to provide an integrated package of services to preschool children, expectant and nursing mothers, and women aged 15 to 44 years through the Aanganwadi Centers (AWCs). The goals of ICDS are to improve the nutritional and health status of all of the above-mentioned beneficiaries, thereby lowering the prevalence of malnutrition and related morbidities and deaths.[5] The use of ICDS services is determined by a variety of factors such as infrastructure, resource availability, and client satisfaction. Despite the fact that ICDS is the world's largest community-based child nutrition and development programme, a quandary remains regarding the extent of utilisation and quality of services provided through aanganwadis after more than 35 years of implementation.[6]

Therefore present study conducted with objective:

1. To assess the utility and acceptance of these Gram Arogya Kendra in village residents and health workers

2. To Understand operational Challenges in Delivering services of these Gram Arogya Kendra

Methodology

Ethical approval was obtained from institution ethical committee before commencement of this research study. This community based cross sectional study was conducted among 50 selected (i.e. 22 in rural and 28 in urban areas) Gram Arogya Kendra of Bhopal district. This study had been conducted in a one year period from April 2017 to March 2018. All selected Gram Arogya Kendra where both ASHA and ANM was present, were included in the study. The Gram Arogya Kendra where either post of ASHA or ANM was vacant were excluded from the study. questionnaire was prepared for ASHA, AMN, MO and village residents. Pre testing of questionnaire was done at 3 Gram Arogya Kendra based on these finding questionnaire was refined and redesigned. Visit of selected gram arogya Kendra was started in a planned manner i.e In Bhopal district there were two block Berasia and Fanda both the block comprised 437 GAKs i.e. Funda have 216 gram arogya kenda and Berasia have 221 GAKs, 10% of gram arogya Kendra were randomly selected out of total 437 GAKs so, a total of 50 GAK were selected out. Visit of selected gram arogya Kendra was especially done either on VHND or on immunization days so that both ANM and ASHA were present at GAK. At GAK, purpose of study was explained to the ASHA and ANM and verbal consent was obtained from them. Information from ASHA and ANM regarding services utilization, various challenges in delivery of the services and acceptance of GAKs was obtained using questionnaire. After the information gathered from GAK, 5 house-hold were selected randomly from the respective village.

For selecting five house hold any child seen within the village was called and asked to tell any number between 1 to 9.the number which he/she spoke was taken as first house hold to be interviewed. After that every fifth household were selected for interview and interview of house member was done using questionnaire regarding the GAK. Information from In-charge medical officer of selected GAK were also obtained by using pretested questionnaire. Thus 50 selected Gram Arogya Kendra, 50 ANM, 50ASHA, 5 Medical officers and 250 house hold was covered in duration of one year.

Data collected was entered in MS Excel, compiled and analyzed using epi Info (version 7.2.5.0).

Results

Table 1: Education and working status of ASHA workers

Education status of ASHA	
Education	**No. 50 (%)**
Graduate Or Postgraduate	3(6%)
Upto XII	23 (46%)
Upto X	20 (40%)
Upto VIII	4 (8%)
Work experience as ASHA	
Experience (years)	No. 50 (%)
<5 years	21 (42%)
5-10 years	29 (58%)

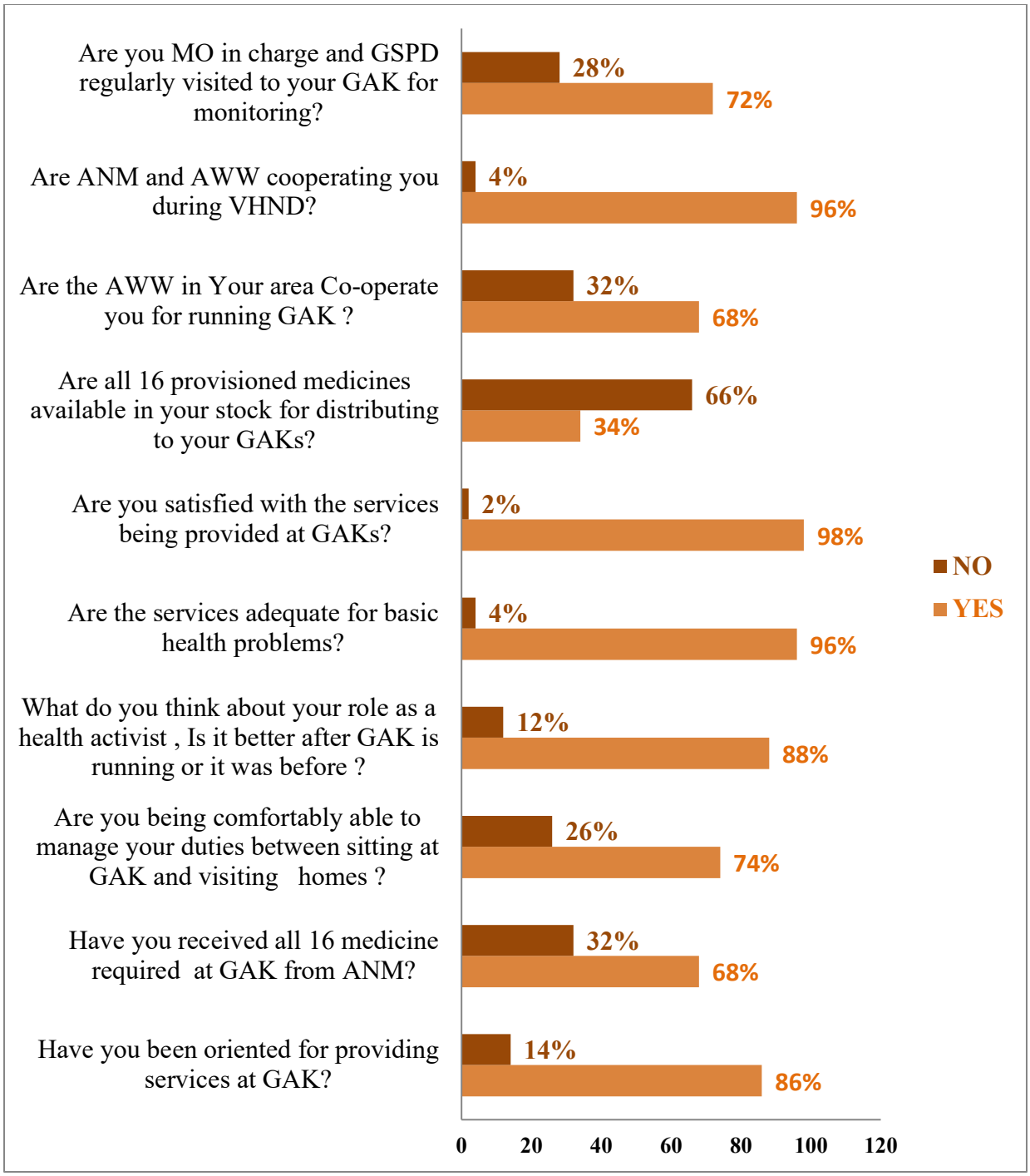

Figure 1: Responses received from AHSA workers about GAks

Table 2: Education and working status of ANMs

Education status of ANMs (No. 50)	
Education	**No. (%)**
Graduation /other	38 (76%)
X to XII	11 (22%)
Upto VIII	1 (2%)

Total	50 (100%)
Work experience as ANM (No. 50)	
Experience (years)	**No. (%)**
>5 Years	6 (12%)
5-10 Years	30 (60%)
11-20 Years	12 (24%)
21-30 Years	2 (4%)
Total	**50 (100%)**

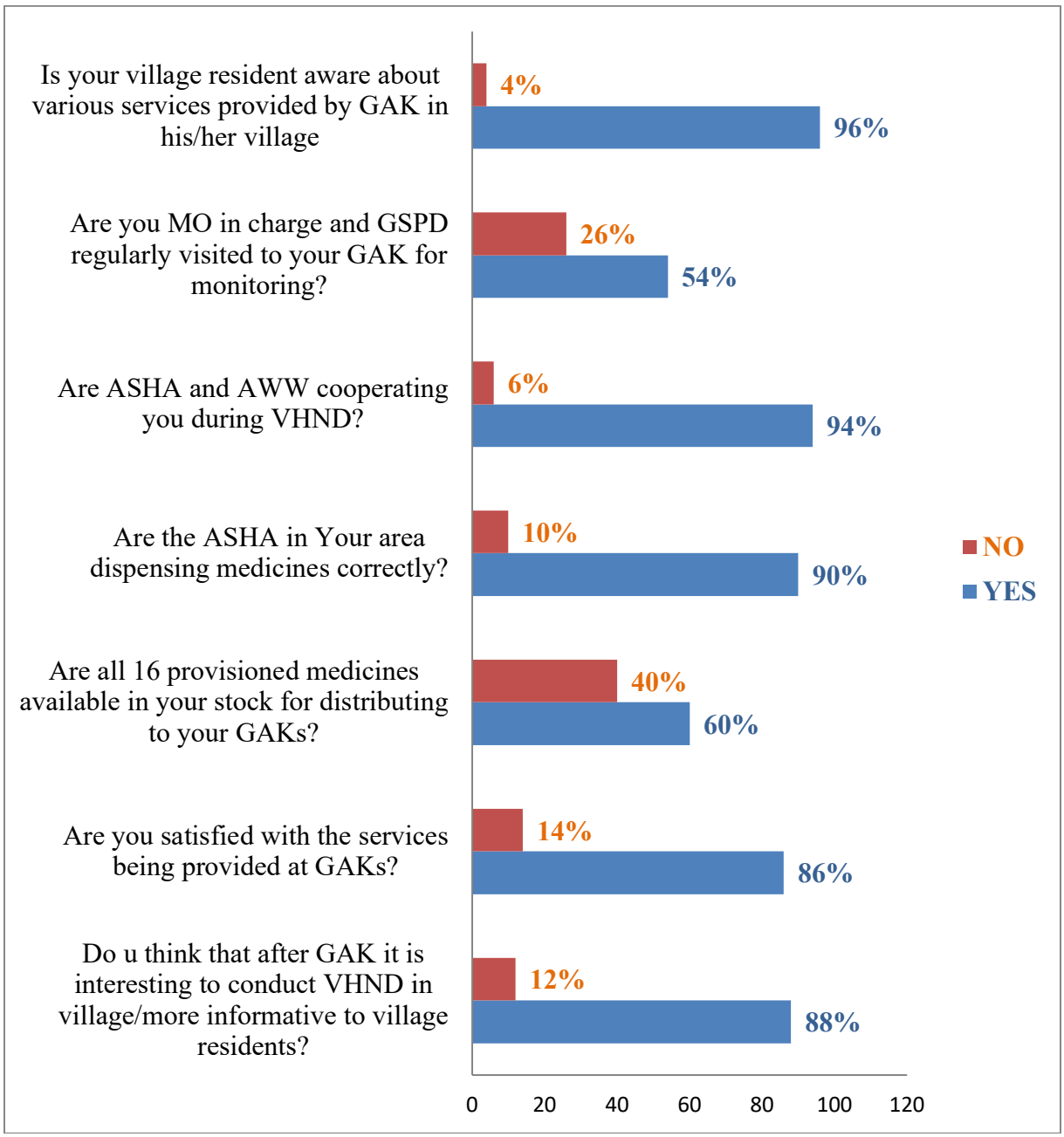

Figure 2: Responses recieved from ANMs about GAks

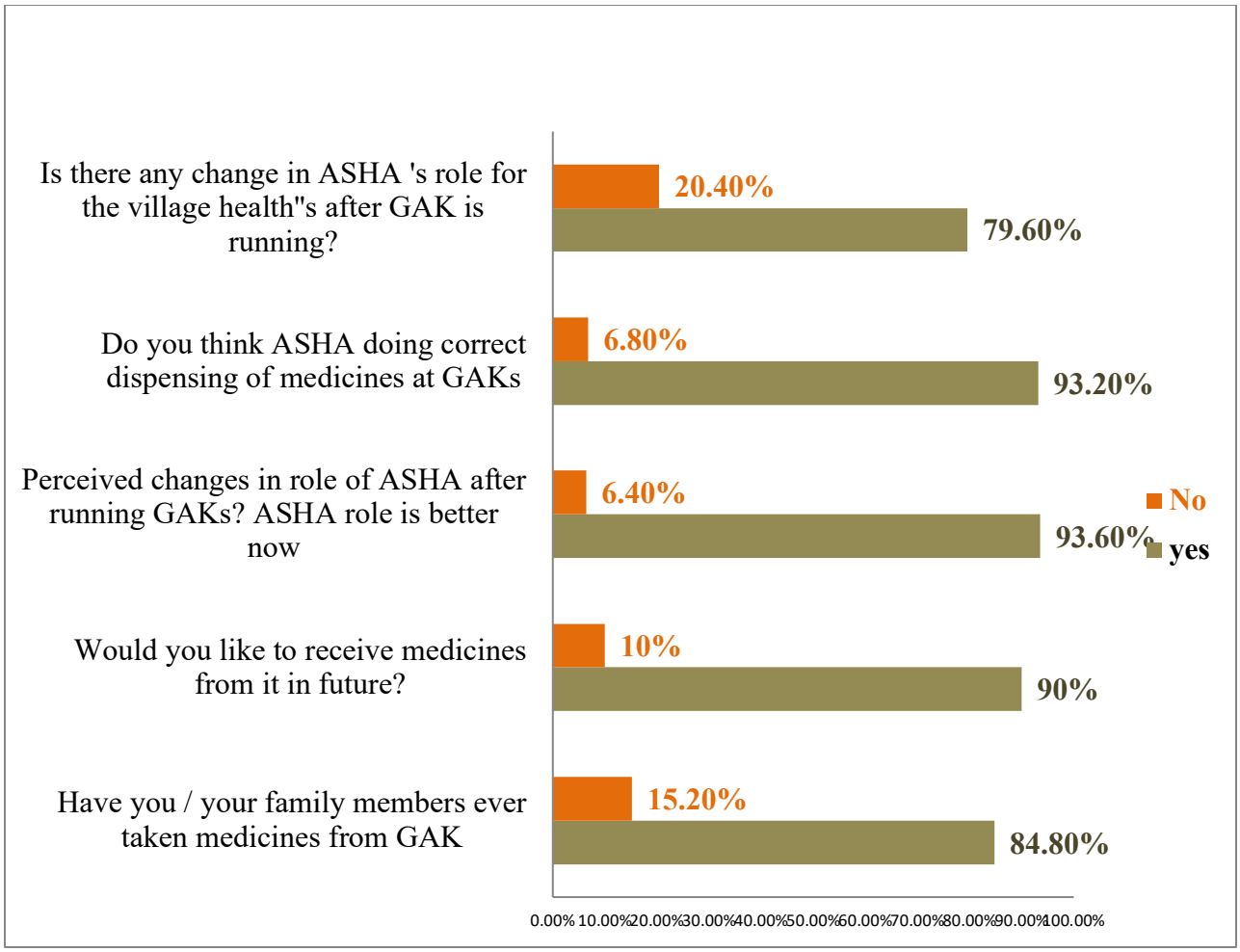

Figure 3: Distribution of responses from Beneficiaries of GAKs in the village about GAks

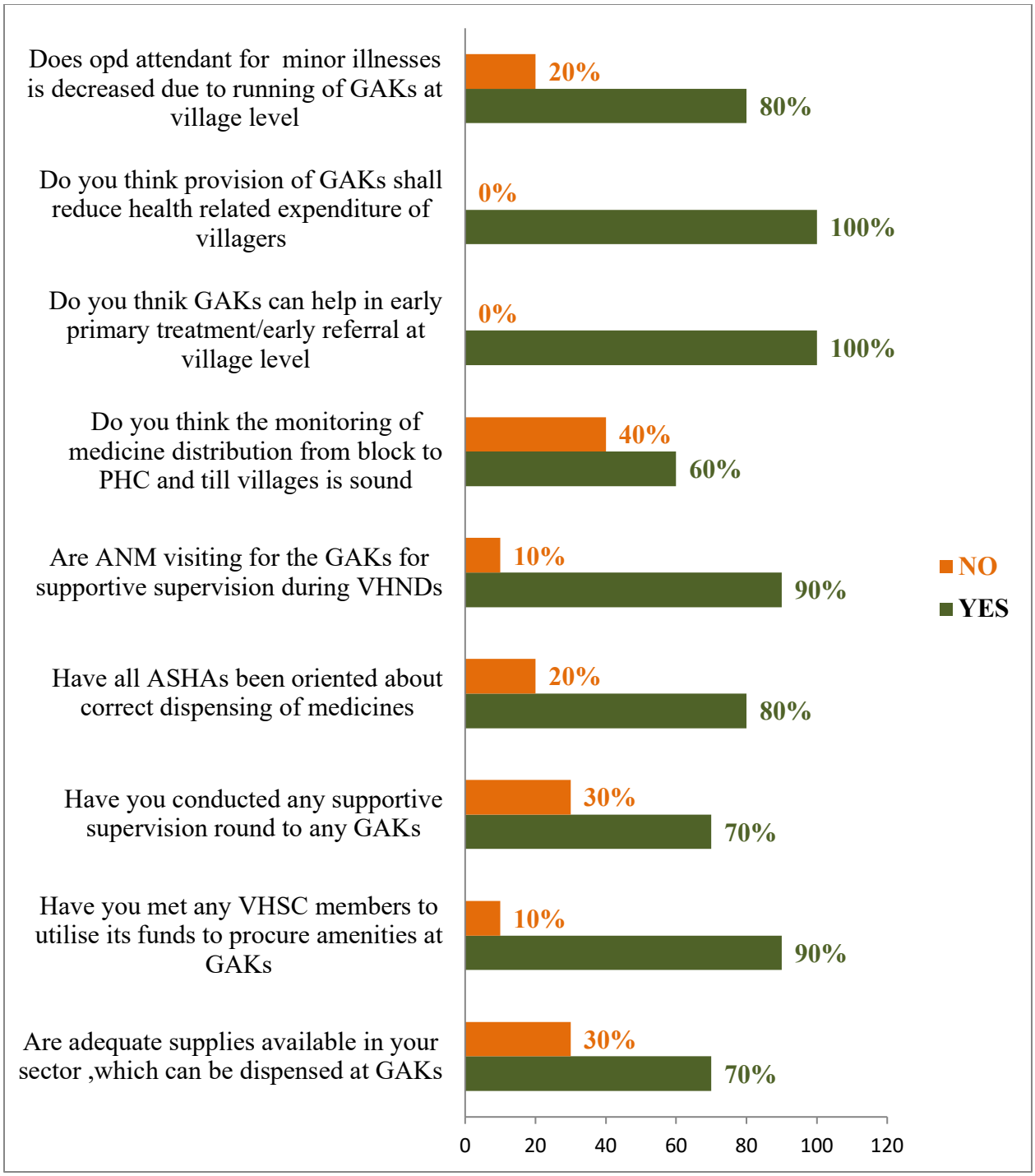

Figure 4: Distribution of Response from medical officer about GAKs

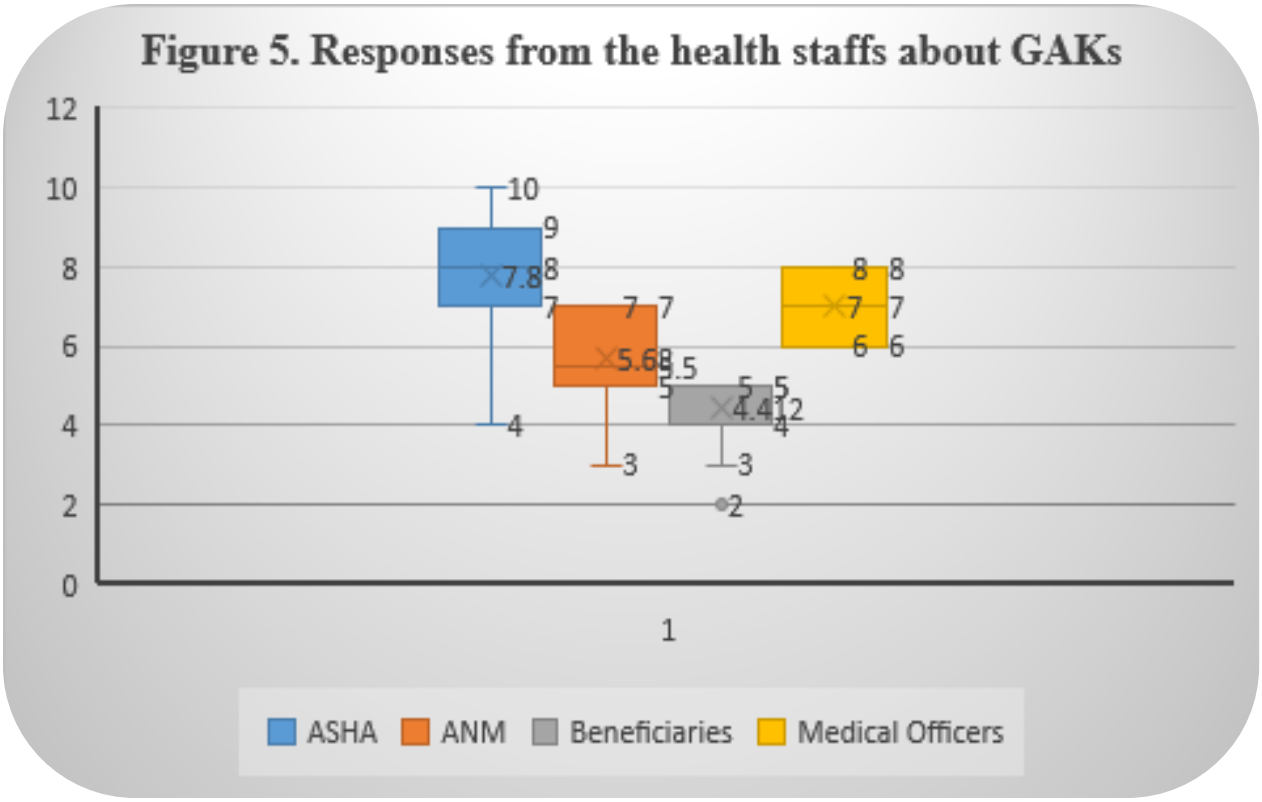

Figure 5: Responses from the health staffs about GAKs

Table 4: Table-Problem/challenges faced by health functionaries in delivering services at GAKs

Health Functionaries	Problems	%
ASHA	To manage their work	**32%**
	Seek more support from ANMs	**26%**
	Fixed remuneration for this activity with provision of more dedicated space.	**67%**
	Irregular supply of medicines	**66%**
ANM	Records updating by ASHA at GAKs	**53%**
	Medicines dispense by ASHA at GAKs	**25%**
Medical Officer	Management of supplies and monitoring visits by themselves and ANMs a challenge	**72%**
Village Residents	Demand for more medicines and for more time spent by ASHA	**81%**
	Medical officer's visit at least once a month	**49%**

ASHA: Table shows the distribution of problem faced by health functionaries in delivering services at Gram Arogya Kendra showed that 32% of the ASHA faced difficulty to manage their work. 22% of the ASHA said that they have to take more support from ANMs and 67% of the ASHA demand extra incentive for the GAks.

ANMs: 53% of the ANMs responded that record maintained by ASHA was still a big challenge and 25% of the ANMs said that

ASHA still faced difficulty in correct dispensing of medicines at GAKs.

Medical Officers: 72% of the medical officers said that management of supplies and monitoring visits by medical officer and ANMs a challenge.

Village Residents: 81% of the village residents said medicines supply at GAKs was irregular and ASHA need to spend more time at gram arogya Kendra. 49% of the village residents said that Medical officer's visit at least once a month.

Regarding Acceptance of Gram Arogya Kendra:

- An overall positive attitude and acceptance of Gram Arogya Kendra among village respondents was observed, which is backed by good utilization of existing services as well as willingness of utilization in future.
- The ASHAs perceive their role better now with a responsibility of providing medication to villagers.
- The ANMs find their workload to have reduced, however with added responsibility of monitoring ASHAs work.
- The Sector Medial Officers appreciate the GAKs and find it a good concept to reduce geographical limitation and out of pocket expenditure for basic health problems.

Discussion

In our study to access the utility, acceptance and challenges, 50-ASHAs, 50-ANMs, 5-MO, and 250 house-hold enrolled to covers 50 GAKs.

Table no.1 showed literacy status of ASHA revealed that , most (46%) of the ASHA were educated up to higher secondary , 40% of them was literate up to higher school .6% of the ASHA were Graduate or Postgraduate whereas only 8% were educated up to eight standard . In study of Vineeta Pandey *et al*. reported 50% of the functionaries were educated upto senir secondary followed by middle level(31.8%) while 13.6% percent were matric.[7] The inability to relax the educational level where needed and raising the educational level even higher, as in west bengal to class x has resulted in failure to find ASHAs in some of the needy areas (NHSRC, 2011) [8].

Table no.1 also showed the distribution of ASHA According to duration of work as ASHA, Which shows that 58% of the ASHA have work experience of 5-10 years where 42% of the ASHA had experience less than 5 years .The study of Vineeta Pandey *et al*. found that majority (78.7%) of the functionaries had 6-10 years of work experience while 13.6 per cent had 11-15 years. Only 7.58 per cent had work experience less than 5 years. [7]

Fig.1 showed the responses from ASHA about challenges in delivery of service in Gram Arogya Kendra, that about 98% ASHA responded that they are satisfied with the services being provided at GAKs, 96% ASHA said that ANM and AWW are co-operating her during VHND and services are adequate for basic health problems, where as 88% ASHA said there role is better after GAKs is running. 86%of the ASHA responded that they are provided orientation training for providing services at GAK. 34% of ASHAs told that they had all 16 provisioned medicines available in her stock for distributing at GAK. Rakesh Parashar et al. in their study found that 100% of the ASHA have been oriented for providing services at GAK.75% of the ASHA said that they received all 16 medicine from ANM required at GAK where as 70% said that she were confident in correctly dispensing all 16 medicines.60% of the ASHA agreed that they are being comfortably able to manage her duties between sitting at GAK and visiting homes in the village.60% of the ASHA think

that her role as a health activist are better after GAK being established.70% of the ASHA responded that services are adequate for basic health problem.[9]

Table no. 2 Literacy status of ANM showed that maximum 76% of the ANM were educated up to graduate where as 22% of the ANM were educated up to XII and only 2% ANM were educated up to eight class and more than half (60%) ANM have working experience of 5-10 years followed by 24% of ANM have work experience between 11-20 year and only 4% of ANM have work experience between 21-30 year remaining 12% of ANM have working experience less than five year. Study conducted by Vineeta pandey *et al* in (2016) [3] found that More than half (54%) of ANM had working experience of 5-10 years followed by 24% ANM have work experience between 11-20 year and only 4% ANM have work experience between 21-30 year reaming 12% ANM are working more than five year.[7]

Fig. 2 showed the responses received from ANMs about GAKs functioning, that were 96% of the ANM said that village resident were aware about various services provided by GAK in his/her village. 94% of the ANM said that ASHA and AWW were co-operating her during VHND. Regarding dispensing of medicine 90% of ANM said that ASHA in her area dispensing medicine correctly. 60% of ANM responded that they have all 16 provisioned medicines available in stock for distributing at GAK. 86% ANM were satisfied with the services being provided at GAKs. 88% ANM said that after GAK had been established it is interesting to conduct VHND in village and well and more informative about health services being given to village residents. Regarding monitoring of GAKs 54% ANM said that MO in charge and GSPD regularly visit GAK for monitoring. A study of Rakesh parasher *et al*. **f**ound that 80% 0f the ANM were satisfied with the services being provided at GAKs. Whereas 60% of the ANM said that all 16 provisioned medicines available in stock for distributing at GAKs. And 60% of the ANM agreed that ASHA in her area dispensing medicines correctly. [9]

Fig .3 showed, beneficiaries very well utilized the GAKs services, which is evident as 84.8% of the beneficiaries responded that they or their family members take medicines from GAK. Whereas 90% wish to receive medicine from GAK in future. 93.2% of the beneficiaries said that ASHA doing correct dispensing of medicine at GAKs where as 93.6% of the beneficiaries Perceived changes in role of ASHA after running GAKs because ASHA role is better after implementation of Gram Arogya Kendra. Study of Rakesh Parashar *et al*. found that 76% of the beneficiaries response that they or their family member have taken medicine from GAK. Whereas 96% of the beneficiaries wish to received medicine from GAK in future.

Finding revolved that 88% of the beneficiaries said that ASHA are doing correct dispensing of medicine at GAKs where as 68% of the beneficiaries Perceived changes in role of ASHA after running GAKs because ASHA role is better after implementation of Gram Arogya Kendra.[9]

Fig. 4 showed response from medical officer on various aspect of gram arogya Kendra.100% of MO said that GAKs were help in early primary treatment /early referral at village level. Regarding health related expenditure 100% of the MO's fully agreed that GAKs were reducing the out of pocket expenditure and were of health related expenditure of the villagers. 80% of the MO said that GAKs were decreased the OPD attendant for minor illness.

Regarding the availability of consumable&medicine70% of the said that adequate supplies available in there sector for dispensing at GAKs where as 60% of MO responded that the monitoring of medicine

distribution from block to PHC and till villages is sound. 90% of the MO said that they have met any VHSC members to utilize its funds to procure amenities at GAKs where as 80% of the said that all ASHA in there sector have been oriented about correct dispensing of medicines. Regarding the monitoring of GAKs. 70% of the MO conducted supportive supervision round to any GAKs at least once in a month and 90% of the MO said that ANM visiting for the GAKs for supportive supervision during VHNDs. Study conducted by Rakesh Parashar *et al*. found that 100% of MO agreed that GAKs were help in early primary treatment /early referral at village level.

Regarding health related expenditure 80% of the MO said that GAKs reduced the health related expenditure of the villagers because they don't have to visit PHC or CHC for treatments. 60% of the MO said that ANM was visited GAKs for the supportive supervision during VHND. Regarding the availability of consumable & medicine 100% of the said that adequate supplies were available in there sector for dispensing at GAKs where as 60% of MO responded that the monitoring of medicine distribution from block to PHC and till villages is sound and also 60% of the MO said that they have met any VHSC members to utilize its funds to procure amenities at GAKs whereas 80% of the said that all ASHA in there sector have been oriented about correct dispensing of medicines.

Service availability at gram arogya Kendra according to response from medical officer.80% of the MO found that services availability were adequate at gram arogya Kendra whereas 30% of the MO felt that there still need to improve the service availability. There were good utilization (60%) of the services by the village beneficiaries from gram arogya Kendra. 60% of the MO conducted supportive supervision round to any GAKs at least once in month. [9]

Conclusion

The Gram Arogya Kendra is a unique concept to promote village based health and nutrition activities, and for involving the community in their own health. By co-locating the AWC and GAK, all women and child-related services are made available in one place, and the community can more easily understand the links between health and its determinants like nutrition, water and sanitation.

It is also in line with the 12th Plan priorities for system strengthening through decentralization, community involvement, and by improving Interdepartmental co-ordination. During the early phase of planning, recruitment of ASHAs in the villages where it was not present, mobilization of guidelines from district to the level of each sector medical officer, ANM and ASHA as well as printing and display of GAK related IEC material all was coordinated by the district teams. Further, mobilization of essential instruments, drugs and consumables was catalyzed.

The major changes have been brought about in improving the functionality of VHSCs, availability of essential equipment's like BP machine, Stethoscope, Thermometers, Uristics for testing glucose and albumin in urine, Malaria testing kits, medicines like albendazole, cotrimoxazole and family planning material. These changes have been further translated into better service delivery by hands on trainings to AHSAs and ANMs. Further a regular follow up with the supportive supervision cadre of the GAKs which includes Block Community Mobiliser, Sector Supervisors and Sector Medical Officers. At this point of time, the efforts are still continued to further keep improving the service availability, access and quality of services. Extended and decentralized service

delivery can improve level of health equity and outcomes through improved access and coverage. Village-level health units in Madhya Pradesh, India have shown good acceptance by and large from the beneficiaries and health workers. Continuity of availability of provisioned medicines and supplies with monitoring and measurement of service delivery, utilization and service quality needs to be continuously improved for effective service delivery at these village level units**.**

Recommendations

- ASHA should be provided timely incentive for running GAKs and specific working hour should be allotted for GAKs activities.
- Continuing education is an important component and has to be supplemented with appropriate reading materials/on the job tools that are easy to comprehend. Regular meetings of ASHAs at block level need to be organized. Hence, it is recommended that the state should put together appropriate reading materials to be shared with ASHAs during the monthly meetings. This will also help in reinforcing knowledge in key areas and will help in removing bottlenecks.
- Provision of government building for running of GAKs activity should made necessary so that the activity can be carried out without any hurdles.
- More information should be transmitted to the village beneficiaries about utilization of GAK services.

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