Access to Rural Health Care Services in **Lunglei Rural Development Block**, Lunglei District, Mizoram

Submitted in partial fulfilment of Bachelor of Social Work, 2023

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CERTIFICATE

This is to certify that the research in 'Access to Rural Health Care Services in Lunglei Rural Development Block, Lunglei District, Mizoram' submitted by R. Lalruatpuii for the partial fulfilment of the Bachelor of Social Work is carried out under my guidance and incorporates the student's bonafide research and this has not been submitted for any award for any degree in this or any other university or institution of learning.

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ACKNOWLEDGEMENT

First and foremost, I want to express my gratitude to Mr. R. Lallianzela for granting me the opportunity to conduct research on Access to Rural Health Care Services in Lunglei Rural Development Block, Lunglei District, Mizoram.

My sincere gratitude is extended to Mr. RTC Lalremruata, Assistant Professor, Department of Social Work, HATIM, who served as my supervisor and mentor during the course of my research. He gave me knowledge and gave me the determination to complete this research.

My heartfelt gratitude goes to the communities of Bualte and Mausen, the local authorities, and the respondents for their support and involvement during the research.

My heartfelt appreciation to my family for their unwavering emotional and physical support during my research. They provided me with all the equipment I needed to do my study.

Lastly, I would like to thank my classmates and fellow trainees for their collaboration and assistance whenever necessary, resulting in a successful research study to be conducted.

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CHAPTER I

INTRODUCTION

This study is an attempt to assess the service provided, facilities available, and barriers to accessing rural health care services in Rural Development Block, Lunglei District, Mizoram.

A person's health is more than just the absence of sickness; it is a condition of complete physical, mental, and social well-being. Health is a critical component of economic prosperity.

1.1 Rural Health

In medicine, rural health or rural medicine is the interdisciplinary study of health and health care delivery in rural environments. The concept of rural health incorporates many fields, including wilderness medicine, geography, midwifery, nursing, sociology, economics, and telehealth or telemedicine.

Rural health is the health of people living in rural areas, who generally are located farther from health care facilities and other services than people living in urban areas.

1.2 Health Care

The term "health care services" means any services provided by a health care professional, or by any individual working under the supervision of a health care professional, that relate to— the diagnosis, prevention, or treatment of any human disease or impairment; or the assessment or care of the health of human beings.

Any action performed to improve a person's physical, social, or emotional state is referred to as providing health care. It comprises a wide range of activities, such as long-term care, soothing, disease prevention, health promotion, and creative care rehabilitation. The provision of healthcare services aids in both preserving and regaining a person's health through various forms of therapy or disease prevention.

According to Healthy People (2020), the importance of healthcare access is based not only on physical, social, and mental health status, but also on the incalculable worth of disease prevention, diagnosis, and treatment of sickness, better quality of life, and life expectancy.

1.3 Health Sub Centres

Health Sub Centres are key players in enhancing community members' wellbeing. Sub-Centres are mostly outlying medical facilities that serve the rural population's medical requirements. The health care requirements of 5,000 people are met by one sub-centre, whereas 3,000 people live in mountainous, tribal, and underdeveloped areas. fundamental medications for mild illnesses are supplied to the Sub-Centres in order to address the fundamental medical requirements of men, women, and children. It is the community's most distant point of interaction with the main healthcare system.

Health Sub Centre serves as the initial point of contact and most peripheral link between the community and the primary health care system. Sub Centres are tasked with addressing

interpersonal communication in order to modify behaviour and offer services related to vaccination, nutrition, family welfare, maternity and child health, diarrhoea control, and infectious disease control.

There are 7821 SCs which are upgraded as Health and Wellness Centre-Sub Centres (HWC-SCs) out of total 157541 SCs functioning in rural areas of the country as on 31st March, 2019. The significant conversion of SCs into HWC-SCs have been observed in the States of Tamil Nadu (985), Maharashtra (939), Gujarat (813), Uttar Pradesh (726), Chhattisgarh (650), Assam (628), Andhra Pradesh (612) and Karnataka (571). Significant increase in Sub Centres are recorded in the States of Rajasthan (3000), Gujarat (1892), Karnataka (1615), Madhya Pradesh (1352), Chhattisgarh (1387), Jammu & Kashmir (1146), Odisha (761) and Tripura (433).

1.4 Anganwadi Centres

Basic healthcare facilities are offered by the Anganwadi centre. The Anganwadi Centres aim to reduce the rates of death, morbidity, malnutrition, and school dropouts; improve the nutritional and health status of children aged 0 to 6; establish the groundwork for a child's proper psychological, physical, and social development; and effectively coordinate policy and implementation across departments to support child development. Additionally, the centres seek to strengthen mothers' capacity to care for their children's regular health and nutritional needs by providing them with appropriate nutrition and health education.

The Anganwadi Centres (AWCs) offer a range of services, including Immunization, Health & Nutrition Education, Preschool Education, Supplementary Nutrition, Referral Services, and Health Checkups. The beneficiaries of the scheme are children 0-6 years old and Pregnant Women & Lactating Mothers.

1.5 Importance of quality healthcare services

The health of a nation's population determines its progress. As a result, a country should have enough healthcare facilities in both urban and rural areas. Access to quality healthcare services on time has a significant impact on all aspects of a person's health. Primary healthcare is a critical approach that serves as the foundation for health-care delivery.

Residents should ideally be able to obtain services such as primary care, dental care, mental health, emergency care, and public health services with ease and confidence. Access to healthcare is critical for overall physical, social, and mental health, disease prevention, sickness detection, diagnosis, and treatment, quality of life, avoiding premature death, and life expectancy.

Human resource health and well-being are crucial to the country's economic and social success. A proper healthcare infrastructure is critical to ensuring people's health. Inadequate infrastructure often leads to poor healthcare quality, which is detrimental to the health and well-being of the community as a whole. Even though 68% of India's population still lives in rural regions, healthcare infrastructure in these places is deplorable.

Healthcare is the right of every individual, but a lack of quality infrastructure, a shortage of skilled medical officials, and a lack of access to basic medications and medical facilities prevent it from reaching 60% of India's population. The bulk of the 700 million people reside in rural regions, where medical services are in poor shape. There is an urgent need for innovative techniques and processes to guarantee that excellent and timely treatment reaches the most impoverished areas of Indian communities. Though the government runs many policies and initiatives, the efficacy and usefulness of these programs are dubious due to gaps in execution. In rural India, where the number of Primary Health Care Centres (PHCs) is limited, 8% of PHCs lack doctors or medical personnel, 39% lack lab technicians, and 18% lack even a pharmacy.

Although 80% of experts live in cities, 70% of the population lacks access to specialized treatment. Only 13% of rural residents have access to primary healthcare facilities, 33% to sub-centres, and 9.6% to hospitals (NFHS-II). Many individuals are forced to seek private institutions due to poor quality services at state-run hospitals. Overall healthcare use is similarly poor; hardly half (52%) of Indian women obtain three or more antenatal checks; and only 43.5% of children in India receive all vaccines (NHFS-3, 2005-06).

According to Rural Health Statistics, 2019-20, there are 155404 Rural Sub-Centres, including 18610 Ayushman Bharat Health & Wellness Centres - Sub Centres (AB-HWC-SCs), 24918 Rural Primary Health Centres (PHCs), including 16635 AB-HWC-PHCs, and 5183 Community Health Centres (CHCs). Even if a well-structured public healthcare system exists, the infrastructure as well as the manpower necessary to offer healthcare services are insufficient from various aspects.

Special attention must be paid to rural health care in order to prevent the spread of illnesses and minimize the rising rates of mortality caused by a lack of suitable health facilities. The main issues in the healthcare sector include inadequate care quality, insufficient accountability, a lack of awareness, and restricted access to services.

1.7 Tentative Chapter Scheme:

i. Introduction
ii. Review of Literature
iii. Methodology
iv. Results and Discussion
v. Conclusion

CHAPTER II

LITERATURE REVIEW

A theoretical framework is necessary for any kind of social work study in order to fully comprehend the concepts. However, secondary data is the sole source that enables the researcher to gather knowledge and examine the problem's current state within a theoretical framework. An overview of the literature and research gaps found from the perspectives of social policy and social work practice are presented in this section.

Kristin Burnett et.al (2020) with the topic "*Indigenous Peoples, settler colonialism, and access to health care in rural and northern Ontario*" states that despite the possibility of gaining access to a wider variety of health care services and providers in an urban-rural setting, the majority of Indigenous People interviewed in Thunder Bay lacked a long-term healthcare provider and frequently used walk-in clinics or went to the emergency room for treatment. The population reported having less access to services (such as physicians, relied on public health and emergency rooms) and had poorer relationships with providers. Many participants reported that they had not formed enduring and reliable connections with healthcare professionals due to racism and colonialism. People indicated a lack of comfort or trust in the absence of continuity of treatment or the time needed to build relationships with healthcare professionals. It is also mentioned that because they provide a wider variety and bigger quantity of services than rural areas, larger population centres are frequently considered to be preferable in terms of health care.

MOHD TAQI et.al with the topic "*Rural Healthcare Infrastructural Disparities in India: a Critical Analysis of Availability and Accessibility*" stated that even after decades of planned growth, the health care system in rural India has remained ineffective and subpar. The nation lags in terms of all areas of healthcare infrastructure accessibility and availability. Only seven states, Jammu and Kashmir, Himachal Pradesh, Uttarakhand, Rajasthan, Goa, and Kerala, have an excess of SCs, PHCs, and CHCs in terms of physical infrastructure availability. However, India still has a 20%, 22%, and 32% gap in rural regions for SCs, PHCs, and CHCs, respectively. Numerous underlying problems, including insufficient financial provisions, poor administrative administration, a lack of human resources, ineffective infrastructure, and the government's apathy and reluctance, may be to blame for the dire state of rural healthcare facilities. Furthermore, these healthcare organizations operate in a way that lacks transparency and accountability, which maintains them at their weakest.

Aminu Sulemana & Romanus D. Dinye in their works "*Access to healthcare in rural communities in Ghana: A study of some selected communities in the Pru District*" found that discovered that a variety of multifaceted, loosely linked variables, including physical accessibility concerns, low-income levels, technical limitations, and high illiteracy, are preventing the rural population from accessing health facilities and services. The scenario has a wide range of impacts, including delivery problems, an increase in newborn and mother mortality, adolescent pregnancies, and a high prevalence of social vices. Accessing health facilities is difficult due to the large distances (at least 20 Kilo meters) and inefficient

transportation networks; as a result, one only uses these services when their health is in grave danger or in an emergency. As a result of the expensive trip to the district capital and occasionally fatalities, health costs are increased. Residents' sole option for getting around in an emergency is to hire a tricycle driver or, occasionally, a boat, both of which are rather expensive for people who live in remote areas. Due to the seasonality of the rural residents' income, the situation is considerably worse.

M.M.H. Khan et.al on the topic "*Frequently used healthcare services in urban slums of Dhaka and adjacent rural areas and their determinants*" stated that many healthcare provisions are available for urban slum and rural areas in Bangladesh. However, the study found that despite the fact that many services are often free or inexpensive there, the government hospital was underused. The lowest proportion of satisfaction was recorded by visitors to government hospital facilities, which may be related to the lengthy wait times. Inconvenient hours, the absence of medications, corruption, and the rude demeanour of service providers can all contribute to reduced consumer satisfaction.

Susan L. Wilson et.al in their works "*Predictors of Access to Healthcare: What Matters to Rural Appalachians?*" stated that the majority of respondents in this survey did not believe that access to healthcare was an issue in their community, despite the existence of several factors that have been previously proved to impact access to healthcare. The study showed that some, but not all, people's views of access to healthcare were negatively impacted by financial and social determinants of health. Six characteristics—gender, income, education, insurance, financial difficulty paying for healthcare, and transportation—out of the twenty factors compared to perceived access to healthcare statistically increased the likelihood that there would be a problem. A slenderly significant predictor of perceived issues with healthcare access was gender. Contrary to expectations, those who were richer and better educated were more likely than those who were less educated and impoverished to identify an access issue in their neighbourhood. In addition, people without insurance, those with financial difficulties, and those who had mobility issues saw a difficulty with access to healthcare.

K.P. Asha (2014) in his study *"Efficiency of Anganwadi Centres–A Study in Thiruvananthapuram District, Kerala"* stated that more than half of the Anganwadi centres are effective, and only a small number are really effective. But more than a quarter of the Anganwadi centres do not perform services effectively. Additionally, 22% of Anganwadi centres were reported to lack weighing equipment, and the majority of these facilities lacked adequate benches and chairs as well as poor building facilities and poor service quality, such as unappealing food supplements and inconsistent government supplies of food and medicine.

Jyoti Smita Pathak et.al (2020) in their works "*Malnutrition and Household Food Insecurity in Children Attending Anganwadi Centres in a District of North East India*" stated that all kinds of undernutrition, with the exception of mild wasting, were more prevalent among the 510 children enrolled in Anganwadi centres. It was discovered that there was a statistically significant difference in the rates of malnutrition between the sexes. The rates of undernutrition among children belonging to various caste groupings varied significantly. Children of mothers with elementary level education or illiteracy were more likely to experience all kinds of malnutrition than children of moms with higher education. Additionally shown to be

statistically significant was this difference. A, it was discovered that male children had higher rates of several types of malnutrition than female youngsters. The households with the highest levels of household food insecurity were those from lower socioeconomic strata. Lower socioeconomic position may restrict the availability and price of certain food products and hence their consumption, leading to low nutritional status as a result.

Akash Malik ed.al (2015) in their study "*An assessment of facilities and services at Anganwadi centres under the Integrated Child Development Service scheme in Northeast District of Delhi, India*" stated that the AWCs lacked enough lighting and ventilation.56% of AWCs lacked a toilet facility, while 20% of AWCs lacked a toilet. There was no mention of kid-friendly restrooms in any of the AWCs in any of the studies. Other studies conducted in other Indian states have similarly noted the absence of adequate restrooms. In 20% of the AWCs, the methods for storing drinking water and extracting water were determined to be unsanitary. According to the results of the current study, over 30% of AWCs lacked weighing scales, growth charts, medication kits, and equipment for early childhood education.

Bayapa Reddy N ed.al (2012) in their works "*Study on the Availability of Physical Infrastructure and Manpower Facilities in Sub-centres of Chittoor District of Andhra Pradesh*" stated that only 3 (8.8%) of the SCs received a monthly visit from the medical officer on a set day. Only 21 (61.7%) of SCs had supervisors (male or female health assistants) who visited often. Of the 34 SCs examined, 17 (or 50%) were housed in government facilities, while the other 17 (or 50%) were run out of rented structures. Only 9 (26.4%) of the 14 (41.2%) SCs situated in authorized government buildings were in acceptable condition, with a living facility outfitted with all facilities for MPHW Female and a room outfitted with the necessary medical equipment. Overall, none of the SCs had delivery kits, and no SC was really doing any deliveries. All of the SCs received adequate supplies of the OPV, DPT, DT, TT, and Hepatitis B vaccinations from the PHC, however only 26 (76.4%) of the SCs received regular access to the BCG and measles vaccines.

Janki Bartwal ed.al (2019) in their study "*An Assessment of Facilities Available at Anganwadi Centres in Urban Area of Garhwal Region, Uttarakhand*" showed that The AWCs were all managed from rented one-room apartments. There was no separate kitchen or storage space in any of these AWCs. 22 (75.9%) have appropriate ventilation, 26 (89.7%) have adequate day light, and 23 (79.3%) have artificial light. Drinking water with a candle filter was found in 23 (79.3%) of the AWCs. Toilet facilities were provided at all 29 (100%) AWCs. Sitting arrangements were offered in 21 (72.4%) of the AWCs, where children sat on mats laid on the floor. There are no tables and chairs for children in any of the AWCs. 25 (86.4%) AWCs contain both a Salter and an adult bathroom scale. All 29 (100%) AWCs have non-formal preschool education (NFPSE) tools. Medicine kits were found in 15 (51.3%) of the AWCs, whereas growth charts were found in 27 (93.1%). The evaluation of infrastructure and amenities found that AWCs are not built in accordance with standards. Regular supervision is required to acquire information regarding the reasons for the reduced number of beneficiaries attending AWCs.

D.K. Pal ed.al in their study "*Functioning of the Sub Health Centres (SHCs) in Mandla District*" stated that all 40 SHCs performed badly, owing to the lack of HW(F)s at the time of delivery, a limited proportion of births being institutional, and an overreliance on family members or trained birth attendants to handle the deliveries. In postnatal care services, over half of the SHCs (52.5%) performed well (12.5%) or well (40%). Immunization performance was assessed as good (67.5%) or adequate (17.5%) for 85% of the SHCs, with more than 70% coverage for specific vaccines, while only 15% of the SHCs performed badly. Only 35% of the SHCs investigated had regular water supply, a place for female patient inspection, and a storage area for pharmaceuticals and other materials, whereas 45% of the SHCs had toilet facilities and electricity. On the contrary, more than 90% of SHCs had a consistent and sufficient supply of family planning products.

Uday W. Narlawar et.al in their study "*Assessment of Physical Infrastructure of sub-centres in Central India as per Indian Public Health Standards 2012 Guidelines: A Cross Sectional Study*" stated that all 13 (100%) sub-centres evaluated were located in conveniently accessible areas and had their own designated building with complete construction. Compound walls were present in 10 (76.9%) of the sub-centres, whereas plaster on the wall was in excellent condition in 8 (61.5%) of the sub-centres and the floor was in good condition in 11 (84.6%). A total of 9 (69.2%) sub-centres were positioned in such a way that there was no waste dump, cow shed, or stagnant pool close. Out of the 13 sub-centres evaluated, all 13 (100%) had a conspicuous display board displaying service availability, a clinic room, and 11 (84.6%) had a labour and examination room. According to IPHS, toilet facilities were only accessible in one sub-centre (17.7%). Out of the 13 sub-centres evaluated, all 13 (100%) had power in all areas, water supply, and a cell phone, and 12 (92.3%) had waste disposal, an overhead tank, a pump, and a residential facility for workers. There were no landline phones in any of the sub-centres (0%).

Dr. Vimal Arya et.al (2018) in their works *"Gaps in functioning of sub-centres in rural area of Jhansi, Uttar Pradesh"* revealed that at the sub-centre level, there were large disparities in all IPHS-related indicators. Infrastructure, equipment, medicine supply, communication, and prompt referral and transport services are still lacking. However, as seen by the statistics, many sub-centres lack basic amenities like as water, power, or toilets, raising severe concerns about the quality of care delivered. Subcentres have a significant shortage of health workers. A long-term policy for human resource planning, including transfer and recruiting plans, must be devised.

Arun Kumar (2011) in their study "*Gaps in facilities available at health sub-centres as per Indian public health standards in a district of Haryana*" revealed that at the sub-centre level, there were large disparities in all IPHS-related metrics. In terms of infrastructure, just one sub-centre had a government building that met IPHS standards, while two others were under development. Residential, water, and energy supplies, as well as sanitary services, were inadequate. These amenities are critical for providing excellent services and instilling trust in recipients to use these services. Only three sub-centres have telephones for communication reasons during emergency scenarios. Significant deficits in personnel persisted, particularly in terms of the availability of male and extra female workers, as witnessed in many other states.

Rimakhi Borah (20180 in his works "*A study to evaluate the effectiveness of sub-centres in delivering rural healthcare services in Sonitpur District of Assam*" revealed that many sub-centres have populations that exceed the prescribed population standards and lack sufficient infrastructural facilities, making it impossible for them to offer the needed services to the community. Problems with the usability of washroom facilities, a lack of electricity, a lack of proper drinking water, a lack of quality equipment and medicines, and a low density of health workers in many sub-centres are some of the reasons that have come to light as a barrier to providing efficient services to the community. Aside from the limitations, the study has revealed the favourable impact of sub-centre services.

Tirupati M. Mahalakshmi et.al (2017) in their works "*A Comparative Study to Assess the Nutritional Status among Preschool Children Attending Anganwadi Centres of Selected Urban and Rural Areas of Tirupati*" stated that in both urban and rural preschool children, 14% (7) were extremely malnourished based on height for age, and weight for age and mid arm circumference indicate Rural preschool children were extremely malnourished at a rate of 14% (7) higher than urban preschool children. In urban regions, just 8% (4) are extremely malnourished. In urban regions, 12% (6) were highly malnourished, but in rural areas, only 10% (5) were severely malnourished. The study's findings also demonstrated that mother's education, father's work, and sleeping pattern had a significant connection with nutritional status in both rural and urban preschool children. Undernourishment was more likely in people with low socioeconomic level. Then there's the great economic position. As one gets older, the difference becomes statistically significant. Even though the other demographic factors were not found to be significant, there was a link between demographic characteristics and children's nutritional status.

Manas P Roy ed. al (2014) in their study "*Sub Centre Support, Need of the Hour: A Comparative Study from Lucknow"* showed that the government have yet to provide the fundamental health services required of them for the rural population. Although NRHM was established with a comprehensive approach, several fundamental challenges, such as the availability of appropriate infrastructural support at peripheral health centres, have to be addressed. IPHS for SCs (Indian Public Health Standards for Sub Centres) offers a glimmer of hope if implemented in its entirety throughout the country. Labor rooms, as well as services such as running water and power, should be given special consideration. In order for services to be delivered optimally, especially when considering institutional delivery, ANM should reside in the village where the SC is located, providing that provision for her stay has been made at each SC.

Chifa Chiang ed.al (2013) in their study "Barriers to the use of basic health services among women in rural southern Egypt (Upper Egypt)" stated that twenty-four to forty-two percent of women recognized that each of structural, financial, and personal/cultural barriers was preventing them from seeking health services. It was reported that structural barriers, namely distance and transportation to health facilities, commonly impeded the use of maternal health services in many low- and middle-income countries. The findings showed that the financial barrier was strongly associated with the use of medical treatment services. Private health service providers played a major role in the Egyptian health service system, as shown in

the fact that private providers cover more than half of the use of health services. Personal/cultural barriers to women's use of health services have been investigated in various studies, which pointed out that women could not always have access to appropriate health services because of social and cultural constraints. results revealed that structural and financial barriers were standing in the way of improvement of women's access to basic health services in the rural Upper Egypt, while the associations between personal/cultural barriers and use of the services were not verified.

CHAPTER III

METHODOLOGY

This chapter deals with the statement of the problem, objectives of the study and field settings. It deals with the methodological aspect such as research design, sampling, method of data collection and data processing and analysis.

3.3 Statement of the problem:

Rural communities sometimes face healthcare challenges that limit their capacity to access the treatment they require. Access to healthcare indicates that healthcare services are readily available and easily accessible. However, rural communities frequently face impediments to healthcare access. Even when there is an adequate supply of healthcare services in the community, various obstacles may restrict healthcare access in rural locations.

Access to health care services is a critical essential factor and a crucial issue in removing obstacles to rural health care. Access to health care entails making timely use of personal health services in order to get the greatest health outcomes.

This study will focus on the access to healthcare facilities, services, and barriers in rural communities in Mizoram. Understanding these will allow us to recognize what is and is not lacking, as well as provide solutions for the community's growth. The goal of this study is to look at the availability of healthcare services, facilities, and barriers in two villages in the Lunglei District.

3.4 Objectives of the study:

1. To identify the facilities available among Health care service providers in rural area.
2. To assess the services provided by Anganwadi Centre and Health Sub-centre.
3. To identify the barriers in access to health care services in rural area.

3.1 Field Settings:

3.1.1 Mausen

Mausen is a village in Lunglei Block, Lunglei District, Mizoram State, India. It is located 15 kilometres north of the district headquarters in Lunglei. 16 km from Lunglei. 93 km from the state capital, Aizawl. Mausen pin code is 796691, and the postal head office is Zotlang.

Mausen is a medium-sized village with a total of 63 families residing. The Mausen village has a population of 263, of which 142 are males and 121 are females, as per the 2011 Population Census.

3.1.2 Bualte

Bualte is a medium-sized village located in Lunglei Block of Lunglei District, Mizoram, with a total of 97 families residing there. Bualte village has a population of 437, of which 224 are males and 213 are females, as per the 2011 Population Census.

It is situated 26km away from Lunglei, which is both the district and sub-district headquarters of Bualte village. There are about 97 houses in Bualte village. The pin code of Bualte village locality is 796691.

3.2 Methodology:

3.2.1 Research Design

The study employs descriptive research design. The data mainly consists of primary data collected using quantitative method.

3.2.2 Sampling

The study adopted Multistage Random Sampling. Firstly, Lunglei Rural Development Block was selected due to its proximity with the District Headquarters. Secondly, two villages were selected where one village is adjacent to the RD Block and another village is far from the RD Block. Thirdly, Selection of respondents was done using Systematic Random Sampling. A total number of 20 households were selected from both the villages. The household constitutes the sampling unit and all the households within the selected RD Block constitutes the population. The sample size is 40.

3.2.3 Data collection

Primary data was collected using quantitative method. Primary data was collected using structured interview schedule.

3.2.4 Data processing and analysis

Qualitative data are processed and analyzed using MS Excel and SPSS. Processed data are presented in the form of simple percentages, frequency and mean.

CHAPTER IV

RESULTS AND DISCUSSION

This chapter presents the findings and discussion, which were divided into sections such as the profile of the respondents, economic status, services provided, facilities, infrastructure of Anganwadi and Health Sub Centers, and community barriers to accessing the services provided by Anganwadi and Health Sub Centers.

4.1 Profile of the respondents:

Profile of the respondent were divided into two sub sections viz, Demographic characteristics and Economic characteristics.

4.1.1 Demographic characteristics

The demographic characteristics of the respondents includes – Age group, sex, education, marital status, types of family and forms of family.

i) Age Group

In terms of age group 15% of respondents are under the age of 30, 25% are between the ages of 30 and 40, 27.5% are between the ages of 40 and 50, and 32.5% are beyond the age of 50.

ii) Sex

The distribution of sex among the respondents indicates that more than half of the total population (87.5%) of the respondents are female and less than half of the total population (12.5%) of the respondents are male.

iii) Education Qualification

More than half of the population (77.5%) are below HSLC mean while 15% of the respondents completed their HSLC and the rest 7.5% of the respondents have completed their graduation. As can be observed, that vast majority of the respondents did not complete their Matriculation.

iv) Marital Status

More than two-third of the respondents (82.5%) are married, 15% are not married, and 2.5% are divorced. As a consequence of the above results, we may conclude that the majority of respondents are getting married.

v) Types of family

In terms of family types, 82.5% of respondents are from a nuclear family, while 17.5% are from a joint family. The majority of the respondents come from a nuclear family structure, with the remainder from joint families.

vi) Forms of family

In regards to forms of family, more than half of the population (92.5%) are from stable family and 5% of the respondents are from dysfunctional family and the rest 2.5% are from reconstituted family.

4.1.2 Economic Characteristics

The economic characteristics of the respondents includes – occupation of family and socio-economic status.

i) Occupation of family

In terms of family occupation, 42.5% of respondents are from farmer families, 35% are wage laborers, 15% work for the government, and the remaining 7% work in business.

ii) Socio-economic status

The population is classified as poor (PHH & AAY) or non-poor (non-NFSA). The respondents from Poor (PHH & AAY) contributes 82.5% and the rest 17.5% falls under the category of Non-Poor (Non-NFSA).

4.2 Services Provided by Anganwadi:

The services provided by Anganwadi Centre was studied in terms of the regularity, quality and adequacy of the service. The regularity of the service was measured using three-point scale viz Never, Sometimes and Always. The quality and adequacy of the service was measured using five-point scale viz Highly Satisfactory, Satisfactory, Neutral, Dissatisfactory and Highly Dissatisfactory.

4.2.1 Supplementary Nutrition

In terms of regularity, the majority of respondents (75%) reported receiving appropriate additional nutrition through AWCs, whereas 20% reported receiving insufficient nutrition and the other 5% received none at all. In terms of quality, 32.5% of respondents are highly satisfied, 7.5% are highly dissatisfied, and 27.5% said it was neutral. The level of adequacy indicates that 45% of the respondents are highly satisfied, 22.5% are highly dissatisfied, and 15% are neutral.

4.2.2 Health Check-Up

In terms of regularity, 30% of the respondents received appropriate health check-up mean while 50% of the respondents received insufficient health check-up and the remaining

20% received none at all. In terms of quality, 12.5% of the respondents are highly satisfied, 25% said it was neutral and 20% were highly dissatisfied. The level of adequacy indicates that 12.5% of the respondents are highly satisfied, 20% are neutral and 32% are highly dissatisfied.

4.2.3 Immunization

In terms of regularity, 75% of the respondents received regular immunization, 15% received inadequate immunization and the rest 10% received none at all. In terms of quality, 47.5% of the respondents are highly satisfied mean while 5% of the respondents are highly dissatisfied and 20% of the respondents stated neutral. The level of adequacy indicates that 47.5% of the respondents are highly satisfied, 17% stated neutral and 12.5% are highly dissatisfied.

4.2.4 Health Education

Among the respondents, 30% received regular health education, while 20% received none at all. In terms of quality, 22% of the respondents are satisfied, while 17% are highly dissatisfied. The level of adequacy indicates that 22.5% are satisfied and 25% of the respondents are highly dissatisfied regarding the adequacy of health education.

4.2.5 Nutritional Education

In terms of regularity, 20% of the respondents always received nutritional education, while 40% of the respondents received none at all. In terms of quality, 22% of the respondents are satisfied, and 45% of the respondents are highly dissatisfied with the nutritional education provided. The level of adequacy indicates that 22.5% of the respondents are satisfied, while 50% of the respondents are highly dissatisfied with the adequacy of nutritional education.

4.2.6 Non-formal preschool education

In terms of regularity, 75% of the respondents always received non-formal preschool education, while 2.5% of the respondents received none at all. In terms of quality, 50% of the respondents are highly satisfied, while 7.5% of the respondents are dissatisfied. The level of adequacy indicates that 47.5% of the respondents are highly satisfied, while 5% of the respondents are highly dissatisfied.

4.2.7 Referral Services

All of the respondents (100%) do not receive any referral services at all.

4.3 Services provided by Health Sub-Centre:

The services provided by Health Sub-Centre was studied in terms of the regularity, quality and adequacy of the service. The regularity of the service was measured using three-point scale viz Never, Sometimes and Always. The quality and adequacy of the service and was measured using five-point scale viz Highly Satisfactory, Satisfactory, Neutral, Dissatisfactory and Highly Dissatisfactory.

4.3.1 Supply of medication

In terms of regularity, 25% of the respondents always received medication, while 45% of the respondents did not receive any at all. In terms of quality, 10% of the respondents are satisfied with the quality of the medication, while 50% of the respondents are highly dissatisfied with it. The level of adequacy indicates that 12.5% of the respondents are satisfied, while 52.5% of the respondents are highly dissatisfied with it.

4.3.2 Vaccinations to pregnant women

In terms of regularity, 100% of the respondents stated that there is always a regular vaccination for pregnant women. 70% of the respondents are highly satisfied with the quality of vaccines, and 15% are neutral. 72.5% of the respondents are highly satisfied with the adequacy of the vaccines, and 15% of the respondents stated they were neutral.

4.3.3 Vaccination to children

The whole population (100%) stated that there is always a regular vaccination for children; 70% of the respondents are highly satisfied with the quality of the vaccine; and 12.5% of the respondents are neutral. 72.5% of the respondents are highly satisfied with the adequacy of the vaccines, while 2.5% of the respondents are dissatisfied with the adequacy.

4.3.4 Health Sensitization programme

Less than half of the respondents (47.5%) stated that there is sometimes a health sensitization program, while 27.5% of the respondents stated that there is no health sensitization program. From the total population, 27.5% of the respondents are satisfied with the quality and adequacy, while 25% are highly dissatisfied with it.

4.3.5 Medications to pregnant women

More than half of the respondents (85%) stated that there is always regular medication for pregnant women, while 7.5% of the respondents did not receive any at all. In terms of

quality, 60% of the respondents are highly satisfied, while 7.5% of the respondents are highly dissatisfied with it. In terms of adequacy, 62.5% of the respondents are highly satisfied, while 12.5% of the respondents are highly dissatisfied with it.

4.3.6 Albendazole for children

More than half of the respondents (87.5%) stated that there is always regular provision of albendazole to children, while 7.5% of the respondents did not receive it at all. In terms of quality, 60% of the respondents are highly satisfied, while 7.5% of the respondents are highly dissatisfied with it. In terms of adequacy, 60% of the respondents are highly satisfied, while 10% of the respondents are highly dissatisfied with it.

4.3.7 Screening test for non-communicable diseases

More than half of the respondents (60%) stated that there is sometimes a screening test for non-communicable diseases, while 12.5% of the respondents did not have any knowledge at all. In terms of quality, 35% of the respondents are satisfied, 30% are neutral, and 7.5% are highly dissatisfied with it. In terms of adequacy, 37.5% of the respondents are satisfied, 27.5% are neutral, and 12.5% are dissatisfied with it.

4.3.8 Family planning services or schemes

Half of the respondents (52.5%) stated that the family planning services provided were regular, while 7.5% of the respondents did not receive them at all. In terms of quality, 25% of the respondents are satisfied, 37.5% are neutral, and 10% of the respondents are dissatisfied with it. In terms of adequacy, 25% of the respondents are satisfied, 32.5% are neutral, and 15% are dissatisfied with it.

4.3.9 Disinfecting mosquito net

More than half of the respondents (67.5%) stated that there is always regular disinfection of mosquito nets, while 5% of the respondents stated there is none at all. In terms of quality, 50% of the respondents are highly satisfied, while 2.5% of the respondents are highly dissatisfied with it. In terms of adequacy, 52.5% of the respondents are highly satisfied, while 2.5% of the respondents are highly dissatisfied with it.

4.3.10 Spraying of DDT

More than half of the respondents (70%) stated that there is always regular spraying of DDT carried out by the Health Sub-Centre, while 5% of the respondents stated there is none at all. In terms of quality, 52.5% of the respondents are highly satisfied, while 2.5% are highly dissatisfied with it. In terms of adequacy, 55% of the respondents are highly satisfied, while 2.5% are highly dissatisfied with it.

4.3.11 Enrolment of pregnant women

Among the respondents, 97.5% stated that enrolment of pregnant women is carried out on a regular basis.

4.3.12 Checking of birth and death registrations

More than half of the respondents (95%) stated that checking birth and death registration is carried out on a regular basis. In terms of adequacy, 72.5% of the respondents are highly satisfied, while 2.5% of the respondents are highly dissatisfied with it.

4.4 Availability of facilities in Health Sub Centre:

The availability of the facilities provided in the Health Sub Centre was studied and measured as never, sometimes, and always.

4.4.1 Lightning and ventilation

In terms of quality, 22.5% of the respondents are highly satisfied, while 47.5% of the respondents are highly dissatisfied with the lighting and ventilation of the Health Sub-Centre. In terms of adequacy, 22.5% of the respondents are highly satisfied while 47.5% of the respondents are highly dissatisfied with it.

4.4.2 Growth charts

In terms of quality, 27% of the respondents are highly satisfied with the growth charts present, while half of the total population (50%) is highly dissatisfied with them. In terms of adequacy, 27.5% of the respondents are highly satisfied while 50% of the respondents are highly dissatisfied with it.

4.4.3 Child friendly restrooms

All of the respondents (100%) stated that there are no child-friendly restrooms to be found in the sub-health centre.

4.4.4 Safe drinking water

Majority (77%) of the respondents stated that there is always safe drinking water in the sub-health centre while 20% of the respondents stated that there is no safe drinking water available at all. In terms of quality, 52.5% of the respondents are highly satisfied, and 22.5% of the respondents are highly dissatisfied with it. In terms of adequacy, 55% of the respondents are highly satisfied, while 22.5% of the respondents are highly dissatisfied with it.

4.4.5 Testing Kits

Among the respondents, 30% are satisfied with the quality of testing kits in the sub-health centre, while 27.5% are highly dissatisfied with them. In terms of adequacy, 30% of the respondents are satisfies while 27.5% of the respondents are highly dissatisfied with it.

4.4.6 Trash disposal bin

Among the respondents, 65% are satisfied with the quality while 12.5 are highly dissatisfied with it. In terms of adequacy, 65% of the respondents are highly satisfied while 12.5% of the respondents are highly dissatisfied with it.

4.5 Availability of facilities in Anganwadi Centre

The availability of the facilities provided in Anganwadi Centre was studied and measured as never, sometimes, and always.

Among the respondents, 90% stated that toilets are always accessible in the AWC, while 5% stated that toilets are never available. Of the respondents, 90% stated that water is always available in the restrooms, while 7.5% stated sometimes. More than half of the population (67%) stated that the classroom is sufficiently large, while 30% are not quite satisfied with it. In terms of parent restrooms, all respondents (100%) stated that there are no restrooms for parents waiting for their children. Half of the respondents (50%) said there are enough benches and chairs in the AWC, while 45% said there aren't enough. Of the respondents, 95% said there is always safe drinking water in the AWCs, while 2.5% said there isn't enough safe drinking water. According to 32.5% of respondents, first aid is always available, whereas 40% stated that there aren't enough first aid kits at the AWC. More than two-thirds (90%) of respondents answered that there is always an acceptable trash bin on the AWC, whereas 5% stated that the trash bin is not appropriate on the AWC.

4.6 Barriers:

Barriers to accessing the services provided by the sub-health centres were studied and measured as strongly disagree, disagree, neutral, agree, and strongly agree.

From the respondents, 97.5% strongly disagree that financial difficulty is not a barrier to accessing sub-centre services, and the rest, 2.5%, strongly agree with it. More than half of the population (67.5%) strongly agreed that there was no rude demeanour from the service providers, while 12.5 of the respondents strongly disagreed about it. Among the respondents, 67.5% strongly disagreed with the equipment available in the sub-centre, while 5% were strongly agreed with it.

In terms of the irregularity of the health sub centre, 37.5% of the respondents strongly agree, and 20% strongly disagree with it. In terms of ignorance of the services of health sub

centre, 82.5% of the respondents strongly disagree and 12.5% agree with it. In terms of negligence, all of the respondents (100%) disagree with it.

4.7 Service provided by Anganwadi centre across Bualte and Mausen community.

To evaluate the difference between services provided by Anganwadi Centre across Bualte and Mausen communities, an independent t test was considered. The test of homogeneity of variance shows that the data is homogenous. The Kolmogorov Smirnov and Shapiro Wilk tests were used to test normality. Both tests' results show that the data is not normally distributed. Thus, the Mann Whitney U test was utilized. The test revealed significant differences in service quality perception between Bualte community (median = 8, n = 20) and the Mausen community (median = 6, n = 20), U = 62.500, z = 3.792, p =.001, r = 0.599620493.

4.8 Service provided by Health Sub Centre across Bualte and Mausen community.

To evaluate the difference between services provided by Health Sub Centre across Bualte and Mausen communities, an independent t test was considered. The test of homogeneity of variance shows that the data is homogenous. The Kolmogorov Smirnov and Shapiro Wilk test were used to test the normality. Both the tests' results show that the data is not normally distributed. Thus, Mann Whitney U Test was utilized. The test revealed significance differences in service quality perception between Bualte community (Median = 4, n = 20) and Mausen community (Median = 7, n = 20), U = 62.500, z = 3.792, p = .000, r = 0.599.

4.9 Accessibility of Health Sub Centre across Bualte and Mausen community.

To evaluate the difference between accessibility of Health Sub Centre across Bualte and Mausen community, an independent t test was considered. The test of homogeneity of variance shows that the data is homogenous. The Kolmogorov Smirnov and Shapiro Wilk test were used to test the normality. Both the tests' results show that the data is not normally distributed. Thus, Mann Whitney U Test was utilized. The test revealed significance differences accessibility perception between Bualte community (Median = 4, n = 20) and Mausen community (Median = 7, n = 20), U = 48.000, z = 4.168, p = .000, r = 0.659.

Table 4.1 Socio-Demographic profile of respondents.

Sl. No	**n=40**	
	Characteristics	**Percentages**
I	**Sex**	
	Male	5(12.5)
	Female	35(87.5)
II	**Age Group**	
	Below 30	6(15.0)
	30 - 40	10(25.0)
	40 - 50	11(27.5)
	50 and above	13(32.5)
III	**Educational Qualification**	
	Below HSLC	31(77.5)
	HSLC	6(15.0)
	Above HSSLC	3(7.5)
IV	**Marital Status**	
	Married	33(82.5)
	Unmarried	6(15.0)
	Divorced	1(2.5)
V	**Types of Family**	
	Nuclear	33(82.5)
	Joint	7(17.5)
VI	**Forms of Family**	
	Stable	37(92.5)
	Dysfunctional	2(5.0)
	Reconstituted	1(2.5)

Source: Computed Figures in Parenthesis represent Percentages.

Table 4.2 Services provided by Anganwadi Centre.

4.2.1 Regularity

Regularity		**n=40**		
Sl. No	**Particulars**	**Never**	**Sometimes**	**Always**
I	**Supplementary Nutrition**	2(5.0)	8(20.0)	30(75.0)
II	**Health Check Up**	8(20.0)	20(50.0)	12(30.0)
III	**Immunization**	4(10.0)	6(15.0)	30(75.0)
IV	**Health Education**	8(20.0)	20(50.0)	12(30.0)
V	**Nutritional Education**	16(40.0)	16(40.0)	8(20.0)
VI	**Non-Formal Preschool Education**	1(2.5)	9(22.5)	30(75.0)
VII	**Referral Services**	40(100.0)	0	0

Source: Computed Figures in Parenthesis represent Percentages.

4.2.2 Quality and Adequacy

Sl. No	**Particulars**	**n=40**					
		Quality/ Adequacy	**Highly Dissatisfactory**	**Dissatisfactory**	**Neutral**	**Satisfactory**	**Highly Satisfactory**
I	**Supplementary Nutrition**	**Quality**	3(7.5)	6(15.0)	11(27.5)	7(17.5)	13(32.5)
		Adequacy	9(22.5)	5(12.5)	6(15.0)	3(7.5)	17(42.5)
II	**Health Check Up**	**Quality**	8(20.0)	7(17.5)	10(25.0)	10(25.0)	5(12.5)
		Adequacy	13(32.5)	5(12.5)	8(20.0)	9(22.5)	5(12.5)
III	**Immunization**	**Quality**	2(5,0)	3(7.5)	10(2.5)	6(15.0)	19(47.5)
		Adequacy	5(12.5)	5(12.5)	7(17.5)	4(10.0)	19(47.5)
IV	**Health Education**	**Quality**	7(17.5)	6(15.0)	12(30.0)	9(22.5)	6(15.0)
		Adequacy	10(25.0)	4(10.0)	11(27.5)	9(22.5)	6(15.0)
V	**Nutritional Education**	**Quality**	18(45.0)	7(17.5)	3(7.5)	9(22.5)	3(7.5)
		Adequacy	20(50.0)	5(12.5)	3(7.5)	9(22.5)	3(7.5)
VI	**Non-Formal Preschool Education**	**Quality**	1(2.5)	3(7.5)	2(5.0)	14(35.0)	20(50.0)
		Adequacy	2(5.0)	2(5.0)	4(10.0)	13(32.5)	19(47.5)
VII	**Referral Services**	**Quality**	39(98.0)	1(2.5)	0	0	0
		Adequacy	40(100.0)	0	0	0	0

Source: Computed Figures in Parenthesis represent Percentages.

Table 4.3 Facilities provided in the Anganwadi centre.

n=40				
Sl. No	**Particulars**	**Never**	**Sometimes**	**Always**
I	**Toilets**	2(5.0)	2(5.0)	36(90.0)
II	**Restrooms**	1(2.5)	3(7.5)	36(90.0)
III	**Classrooms**	1(2.5)	12(30.0)	27(67.5)
IV	**Restrooms for parents**	40(100.0)	0	0
V	**Adequate Benches and Chairs**	2(5.0)	18(45.0)	20(50.0)
VI	**Safe Drinking Water**	1(2.5)	1(2.5)	38(95.5)
VII	**First Aid Kit**	11(27.5)	16(40.0)	13(32.5)
VIII	**Appropriate Trash Bin**	2(5.0)	2(5.0)	36(90.0)

Source: Computed Figures in Parenthesis represent Percentages.

Table 4.4 Services provided by Sub Health Centre.

4.4.1 Regularity

n=40					
Sl. No	**Particulars**	**Regularity**	**Never**	**Sometimes**	**Always**
I	**Supply of Medication**	**Regularity**	18 (45)	12(30)	10(25)
II	**Vaccinations to pregnant women**	**Regularity**	0	0	40(100.0)
III	**Vaccinations to children**	**Regularity**	0	0	40(100.00
IV	**Health sensitization programme**	**Regularity**	11(27.5)	19(47.5)	10(25.0)
V	**Medications to pregnant women**	**Regularity**	3(7.5)	3(7.5)	34(85.0)
VI	**Albendazole for children**	**Regularity**	3(7.5)	2(5.0)	35(87.5)
VII	**Screening test for non-communicable diseases**	**Regularity**	5(12.5)	24(60.0)	11(27.5)
VIII	**Family planning services**	**Regularity**	3(7.5)	16(40.0)	21(52.5)
IX	**Disinfecting Mosquito net**	**Regularity**	2(5.0)	11(27.5)	27(67.5)
X	**Spraying of DDT**	**Regularity**	2(5.0)	10(25.0)	28(70.0)
XI	**Enrolment of pregnant women**	**Regularity**	0	1(2.5)	39(97.5)
XI	**Birth and Death registration**	**Regularity**	0	2(5.0)	38(95.0)

Source: Computed Figures in Parenthesis represent Percentages.

4.4.2 Quality and Adequacy

n=40							
Sl. No	**Particulars**		**Highly Dissatisfactory**	**Dissatisfactory**	**Neutral**	**Satisfactory**	**Highly Satisfactory**
I	**Supply of Medication**	**Quality**	20(50.0)	1(2.5)	12(30.0)	4(10.0)	3(7.5)
		Adequacy	21(52.5)	5(12.5)	7(17.5)	5(12.5)	2(5.0)
II	**Vaccinations to pregnant women**	**Quality**	20(50.0)	1(2.5)	12(30.0)	4(10.0)	3(7.5)
		Adequacy	0	0	6(15.0)	5(12.5)	29(72.5)
III	**Vaccinations to children**	**Quality**	0	0	5(2.5)	7(17.5)	28(70.0)
		Adequacy	0	1(2.5)	5(12.5)	5(12.5)	29(72.5)
IV	**Health sensitization programme**	**Quality**	10(25.0)	4(10.0)	10(25.0)	11(27.5)	5(12.5)
		Adequacy	10(25.0)	6(15.0)	9(22.5)	11(27.5)	4(10.0)
V	**Medications to pregnant women**	**Quality**	3(7.5)	1(2.5)	3(7.5)	9(22.5)	24(60.0)
		Adequacy	5(12.5)	1(2.5)	3(7.5)	6(15.0)	25(62.5)
VI	**Albendazole for children**	**Quality**	3(7.5)	0	3(7.5)	10(25.0)	24(60.0)
		Adequacy	4(10.0)	0	3(7.5)	9(22.5)	24(60.0)
VII	**Screening test for non-communicable diseases**	**Quality**	3(7.5)	3(7.5)	12(30.0)	14(35.0)	8(20.0)
		Adequacy	4(10.0)	5(12.5)	11(27.5)	15(37.5)	5(12.5)
VIII	**Family planning services**	**Quality**	3(7.5)	4(10.0)	15(37.5)	10(25.0)	8(20.0)
		Adequacy	3(7.5)	6(15.0)	13(32.5)	10(25.0)	8(20.0)
IX	**Disinfecting Mosquito net**	**Quality**	1(2.5)	0	7(17.5)	12(30.0)	20(50.0)
		Adequacy	1(2.5)	0	7(17.5)	11(27.5)	21(52.5)
X	**Spraying of DDT**	**Quality**	1(2.5)	0	6(15.0)	12(30.0)	21(52.5)
		Adequacy	1(2.5)	1(1.25)	5(12.5)	11(27.5)	22
XI	**Enrolment of pregnant women**	**Quality**	0	0	2(5.0)	9(22.5)	29(72.5)
		Adequacy	0	1(2.5)	1(2.5)	9(22.5)	29(72.5)
XI	**Birth and Death registration**	**Quality**	0	0	2(5.0)	9(22.5)	29(72.5)
		Adequacy	0	1(2.5)	1(2.5)	9(22.5)	29(72.5)

Source: Computed Figures in Parenthesis represent Percentages

Table 4.5 Facilities provided in the Sub Health Centre.

n=40							
Sl. No	**Particulars**		**Highly Dissatisfactory**	**Dissatisfactory**	**Neutral**	**Satisfactory**	**Highly Satisfactory**
I	**Lightning and ventilation**	**Quality**	19(47.5)	2(5.0)	2(5.0)	8(20.0)	9(22.5)
		Adequacy	19(47.5)	2(5.0)	3(7.5)	7(17.5)	9(22.5)
II	**Growth charts**	**Quality**	20(50.0)	3(7.5)	4(10.0)	2(5.0)	11(27.5)
		Adequacy	20(50.0)	1(2.5)	4(10.0)	4(10.0)	11(27.5)
III	**Child friendly restrooms**	**Quality**	40(100.0)	0	0	0	0
		Adequacy	38(95.0)	0	1(2.5)	0	1(2.5)
IV	**Safe drinking water**	**Quality**	9(22.5)	0	1(2.5)	9(22.5)	21(52.5)
		Adequacy	9(22.5)	0	0	9(22.5)	22(55.0)
V	**Testing kits**	**Quality**	11(27.5)	2(5.0)	6(15.0)	12(30.0)	9(22.5)
		Adequacy	11(27.5)	2(5.0)	6(15.0)	12(30.0)	9(22.5)
VI	**Trash disposal bin**	**Quality**	5(12.5)	0	0	9(22.5)	26(65.0)
		Adequacy	5(12.5)	0	0	9(22.5)	26(65.0)

Source: Computed Figures in Parenthesis represent Percentages

Table 4.6 Barriers in access to services provided by Health Sub Centres.

n=40						
Sl. No	**Particulars**	**Highly Dissatisfactory**	**Dissatisfactory**	**Neutral**	**Satisfactory**	**Highly Satisfactory**
I	**Improper road connectivity**	39(97.5)	0	0	0	1(2.5)
II	**Rude demeanour of service providers**	31(77.5)	2(5.0)	3(7.5)	2(5.0)	2(5.0)
III	**Inadequate physicians**	24(60.0)	1(2.5)	0	4(10.0)	11(27.5)
IV	**Financial difficulty/condition**	39(97.5)	0	0	1(2.5)	0
V	**Ignorance**	33(82.5)	1(2.5)	0	5(12.5)	1(2.50
VI	**Negligence**	40(100.00	0	0	0	0
VII	**Lack of trust/comfort**	27(67.5)	1(2.5)	3(7.5)	4(10.0)	5(12.5)
VIII	**Irregularity**	8(20.0)	5(12.5)	5(12.5)	7(17.5)	15(37.5)
IX	**Lack of proper equipment in Sub Centre**	2(5.0)	2(5.0)	3(7.5)	6(15.0)	27(67.5)

Source: Computed Figures in Parenthesis represent Percentages.

Table 4.7 Service provided by Anganwadi centre across Bualte & Mausen community.

4.7.1 Tests of Normality

Community		Kolmogorov-Smirnov[a]			Shapiro-Wilk		
		Statistic	df	Sig.	Statistic	df	Sig.
Service Provided rating AWC	Bualte	.215	20	.016	.929	20	.146
	Mausen	.189	20	.059	.872	20	.013

4.7.2 Test of Homogeneity of Variance

		Levene Statistic	df1	df2	Sig.
Service Provided rating AWC	Based on Mean	.241	1	38	.626
	Based on Median	.200	1	38	.657
	Based on Median and with adjusted df	.200	1	36.438	.657
	Based on trimmed mean	.250	1	38	.620

4.7.3 Ranks

Community		N	Mean Rank	Sum of Ranks
Service Provided rating AWC	Bualte	20	27.38	547.50
	Mausen	20	13.63	272.50
		40		

4.7.4 Test Statistics

	Service Provided rating AWC
Mann-Whitney U	62.500
Wilcoxon W	272.500
Z	3.792
r	0.599620493
Asymp. Sig. (2-tailed)	.001

Table 4.8 Services provided and accessibility of Health Sub Centre across Bualte & Mausen community.

4.8.1 Tests of Normality

Community		Kolmogorov-Smirnov			Shapiro-Wilk		
		Statistic	df	Sig.	Statistic	df	Sig.
HSC services rating	Bualte	.218	20	.013	.903	20	.047
	Mausen	.284	20	.000	.864	20	.009
HSC Accessibility rating	Bualte	.228	20	.008	.908	20	.058
	Mausen	.284	20	.000	.864	20	.009

4.8.2 Test of Homogeneity of Variance

		Levene Statistic	df1	df2	Sig.
HSC services rating	Based on Mean	2.774	1	38	.104
	Based on Median	2.280	1	38	.139
	Based on Median and with adjusted df	2.280	1	30.562	.141
	Based on trimmed mean	2.343	1	38	.134
HSC Accessibility rating	Based on Mean	3.068	1	38	.088
	Based on Median	2.761	1	38	.105
	Based on Median and with adjusted df	2.761	1	30.951	.107
	Based on trimmed mean	2.768	1	38	.104

4.8.3 Ranks

Community		N	Mean Rank	Sum of Ranks
Service Provided rating AWC	Bualte	20	27.38	547.50
	Mausen	20	13.63	272.50
	Total	40		
HSC Accessibility rating	Bualte	20	12.90	258.00
	Mausen	20	28.10	562.00
		40		

4.8.4 Test Statistics

	Service Provided rating AWC	HSC Accessibility rating
Mann-Whitney U	62.500	48.000
Wilcoxon W	272.500	258.000
Z	3.792	4.168
r	0.599	0.659
Asymp. Sig. (2-tailed)	.000	.000

CHAPTER V

CONCLUSION

This chapter presents the conclusions from the study which was divided into two sections major findings and conclusions.

5.1 Major Findings:

The majority of the respondents are female, and one-third of the respondents are male. More than half of the population is below matriculation, and more than two-thirds of the respondents are married and are from a nuclear family. In regards to forms of family, more than half of the population is from stable families, and in terms of occupation, most of the respondents are farmers and wage laborers. In terms of socio-economic status, more than half of the total population falls into the category of poor. (AAY and non-NFSA).

More than half of the respondents are satisfied with the quality, regularity, and adequacy of the services provided by health sub-centres. This indicates that the service provider put their emphasis on meeting the needs of the community members in terms of the supply of medications, health sensitization, screening tests for NCDs, and family planning programs.

In terms of services provided by Anganwadi centres, most of the respondents are satisfied in terms of the regularity, quality, and adequacy of the services they provide for the community. This indicates that the service providers put their emphasis on meeting the needs of the community in terms of health check-ups, health education, nutritional education, and referral services.

In regards to facilities provided by health sub centres and Anganwadi centres, most of the respondents are satisfied in terms of quality. This indicates that the service providers put their emphasis in regards to first aid kit, lightning and ventilation. Majority of the respondents do not have barriers in accessing the services provided by sub health centres. This indicates that emphasis should be put towards the service providers in regards to regularity, inadequacy and rude demeanour of the service provided.

The majority of respondents are satisfied with the level of services offered by health sub centres and Anganwadi centres. This indicates that the service providers put their emphasis on first aid kits, lighting, and ventilation. The majority of respondents report having no trouble using the sub-health clinics' services. This indicates that the focus should be on the service providers in terms of the consistency, sufficiency, and uncivilized manner of the service delivered.

5.2 Conclusion:

The study highlights rural health care services from an epidemiological viewpoint on the regularity, quality, and sufficiency in Bualte and Mausen community. On various scales, services offered, facilities available, and barriers are studied and measured. The research findings indicate that there are notable differences in the perceptions of service quality between the two communities about the services offered by the Anganwadi and health sub-centers, as well as the accessibility of the health sub-centers. The vast majority of respondents are satisfied with the level of quality, regularity, and sufficiency of the services provided by Anganwadi services and the majority of respondents express dissatisfaction with the health sub-center's services in terms of their regularity. The majority of respondents express dissatisfaction with the facilities of Anganwadi and the Health Subcenter in terms of their quality. The majority of respondents are happy with the services offered and delivered by health sub centres, although some of them are not entirely satisfied with the facilities, regularity, and sufficiency of service providers there. As a result, the residents of their community must go in another location to access these services.

APPENDICES

i. References

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ii. Semi-structured interview schedule

Access to Rural Health Care Services in Lunglei Rural Development Block, Lunglei District, Mizoram

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(The statement below are confidential and it will be used for research purpose only)

I. Profile of the respondents

Sl.No.	Particulars	Response
1	Age	
2	Sex	1) Male 2) Female
3	Religion	1) Christian 2) Hindu 3) Muslim 4) Others
4	Marital Status	1) Married 2) Unmarried 3) Divorced
5	Educational Qualification	1) Illiterate 2) Below HSLC 3) Between HSLC & HSSLC 4) Above HSSLC
6	Family Types	1)Nuclear 2) Joint 3) Extended
7	Forms of Family	1) Stable 2) Dysfunctional 3) Reconstituted 4) Others
8	Family Occupation	1) Govt Employee 2) Business 3) Wage Labour 4) Farmers 5) Others
9	Socio-economic Status	1) Poor 2) Non-Poor

II. Please rate the service provided by Anganwadi Centre

Sl.No.	Service Provided	Regularity **	Quality *	Adequacy *
1	Supplementary Nutrition			
2	Health Check-up			
3	Immunization			
4	Health Education			
5	Nutritional Education			
6	Non-Formal Preschool Education			
7	Referral Services			

*Highly Dissatisfactory (1), Dissatisfactory (2), Neutral (3), Satisfactory (4), Highly Satisfactory (5)
**Never (0), Sometimes (2), Always (3)

III. Please rate your opinion on the facilities provided in the Anganwadi Centre

Sl.No.	Facilities	Regularity **	Quality *	Adequacy *
1	Toilets are available in Anganwadi			
2	There is water in the restrooms			
3	The classroom is sufficiently large for kids			
4	Rest room are available for parents who are waiting for their children			
5	There are adequate benches and chairs			
6	Safe drinking water is available			
7	First Aid kit is available			
8	There is appropriate trash bin			

On a scale from one to ten (1 being worse and 10 being the best), please rate the services provided by the Anganwadi Centre. _____

IV. Please rate your opinion on the infrastructure and facilities provided in Sub Centre

Sl.No.	Infrastructure and facilities	Regularity **	Quality *	Adequacy *
1	Supply of medication for mild conditions such as cold, fever or diarrhoea			
2	Vaccinations to pregnant women			
3	Vaccination to children			
4	Health Sensitization program			
5	Provide pregnant women with iron, folic acid, calcium and albendazole			
6	Albendazole for children			
7	Screening test for non-communicable disease			
8	Family planning, services or schemes			
9	Disinfecting mosquito net			
10	DDT Spraying carried out by the HSC			
11	Enrolment of pregnant women			
12	Checking of birth and death registration			
13	Lightning and ventilation			
14	Growth charts			
15	Child-friendly rooms			
16	Safe drinking water			
17	Testing kits			
18	Trash disposal bin			

*Highly Dissatisfactory (1), Dissatisfactory (2), Neutral (3), Satisfactory (4), Highly Satisfactory (5)
**Never (0), Sometimes (2), Always (3)

On a scale from one to ten (1 being worse and 10 being the best), please rate the services provided by the Sub Centre. _____

On a scale from one to ten (1 being worse and 10 being the best), please rate the accessibility of the Sub Centre. _____

V. Please rate your opinion on the followings:

Sl. No	Barriers	1	2	3	4	5
1	Improper Road Connectivity					
2	Rude demeanour of service providers					
3	Inadequate physicians					
4	Financial difficulty/conditions					
5	Ignorance					
6	Negligence					
7	Lack of trust/comfort					
8	Irregularity					
9	Lack of proper equipment in Sub Centre					

Strongly Disagree (1), Disagree (2), Neutral (3), Agree (4), Strongly Agree (5)