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A Study On Satisfactory Survey Regarding Services Provided By Community Health Officer (CHO) Among Residents Of Villagers At Selected Community Area At Meerut.

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Abstract: Health care in India is delivered through a three tier structure of health services comprising the primary, secondary and tertiary health care facilities with the objective of bringing health care services within the reach of the people of both the rural and urban areas. The primary tier would have three types of health care institutions, namely, a Sub-centre (SC)for a population of 3000-5000, a Primary Health Centre (PHC) for 20000 to 30000population and a Community Health Centre (CHC) as referral centre for every four PHCs. The district hospitals are to function as the secondary tier for the urban population. The tertiary health care is to be provided by health care institutions in urban areas which are well equipped with sophisticated diagnostic and investigative facilities. Roles and responsibilities of CHO is evolving concept in health care sector and their roles and responsibilities are purely population oriented in public health. Objectives of the study is to find out the level of satisfaction of resident of villagers regarding services provided by community health officer. To find out the association between level of satisfaction with selected demography variables. In the study quantitative descriptive approach was considered as appropriate to find out the level of satisfaction of resident of villagers. Research design was selected for the study is a descriptive research design. This study was conducted in selected community areas at Meerut. Population refers to all the villagers of community area at Meerut. Sample size is the present study consist of 100 villagers residing in selected community area at Meerut. In the present study a random sampling technique is used. This study was conducted in Multan Nagar Meerut. TOOLS was consists of two parts that is Demographic variables, Checklist to assess the satisfaction level of resident of villagers regarding services provided by CHO. The table depicts frequency and percentage wise Distribution of people according to their age in years shows that 10% of them were in the age group of 21-25 years, 30% were in the age group of 23-27 years, 39% were in the age group 28-32 years and 21% were in the age group 32-40 years. According to their gender shows that 42% of them are male and 58% of them are female. According to their occupation shows that 29% of them are self employed, 36% of them are government service, 35% of them are graduate and 11% of them having no formal education. According to their education shows that 14% of them are in higher secondary, 31% of them are in senior secondary, 44% of them are graduate and 11% of them having no formal education. According to their areas of living shows that 49% are living in urban area and 51% are living in rural area. According to their choice of health facilities shows that 8% of them prefer private sector, 70% of them prefer government sector and 22% of them prefer both private and government sector. The data presented that the level of satisfaction of

community people is majority 60% satisfied and 40% is very satisfied and not satisfied is nil. The data depicts that the satisfaction level of community people is satisfied. The demographic variable are such as Age, Gender, Occupation, Education, Area of living and Which health facility you will go for check up calculated chi-square value was less than the table value and P> 0.05, hence there was no significant association between satisfaction and selected demographic variables at 0.05 level of significance. Thus, the research hypothesis was rejected. The result of the study reveals that the resident of villagerswere satisfied regarding the services provided by Community Health Officer.

Index Terms – Community health officer, services, residents.

I. INTRODUCTION

Health care in India is delivered through a three tier structure of health services comprising the primary, secondary and tertiary health care facilities with the objective of bringing health care services within the reach of the people of both the rural and urban areas. The primary tier would have three types of health care institutions, namely, a Sub-centre (SC)for a population of 3000-5000, a Primary Health Centre (PHC) for 20000 to 30000population and a Community Health Centre (CHC) as referral centre for every four PHCs. The district hospitals are to function as the secondary tier for the urban population. The tertiary health care is to be provided by health care institutions in urban areas which are well equipped with sophisticated diagnostic and investigative facilities. However, inspite of a vastnet work of health care institutions in India , there exists a wide gap between the rural and urban areas in terms of availability and accessibility of health care infrastructure, as the urban areas are found better equipped with these facilities. Moreover, health being a state subject, there are imbalances and variations in availability and accessibility of these services in therural areas across the states. Childhood and adolescent health care: Adolescent health counselling, identification of drug abuse, detection of any deficiency, nutritional supplement and referral services. Reproductive health care: Family planning, prevention and management of STI, identification of gynecological problems and referral services. Communicable diseases: Diagnosis and treatment of vector or water borne diseases, provision of DOTs and DPMR (disability prevention and medical rehabilitation) services for leprosy along with referral services.

Illness and minor ailments: Identification and management of fever, respiratory infection, diarrhea, cholera, skin rashes, pain, typhoid, etc. Non-communicablediseases: Screening, prevention, control and management along with follow up andmaintenance of treatment modalities. Eye and ENT: Screening along with primary care ofophthalmic and ENT problem and referral services of any emergency. Oral health: Regularcheckup and screening of oral health. Geriatric and palliative care: Health camp organizationroutine checkup. Emergency services: Burn, injury, trauma along with first aid managementMental health care: Screening and counselling along with referral services.The role of Community Health Workers (CHWs) in improving access to basichealthcare services, and mobilising community actions on health is broadly recognised. ThePrimary Health Care (PHC) approach, identified in the Alma Ata conference in 1978,stressed the role of CHWs in addressing community health needs. Delegation of tasks tocommunity level health workers has more recently been considered as a response to theglobal shortage in human resources for health and a key strategy to improve access to qualityhealth services.

Literature on CHWs principally focuses on a few key aspects, including their tasks andactivities, selection and recruitment process, training, remuneration (volunteer versus paidworkers), and support system. CHW training, in turn, generally seeks to develop newknowledge and skills related to specific tasks and to increase CHWs' capacity tocommunicate with and serve local people. Improving access to basic training has alsobeen found to be an important element of improving CHW retention.

As per NHP, the total number of registered allopathic doctors was 1,041,395 andAyush doctors was 773,668 as up to 2017. These statistical data speak about existing numberof doctors and nurses towards the number of populations, when we deeply look into ruralhealth care services, sub-centres are not having doctors and many of the PHCs are seriousneed of doctors. The current scenario of our rural health care system, there are seriousrequirement of doctors but presently our country is not having enough number of doctors, tocome

across this deficiency the use of graduate nurses as community health officer afteradditional training would be more betterment than nothing.

So, community health officer willbridge the gap between population and sub-centre, primary health centre and communityhealth centre. CHO's are permitted to serve the community independently to diagnose,manage and treat minor ailments and impairments and also engage in preventive Expended service and promotive aspects of the community. Their expanding roles are more helpful forlow- and middle-income countries, as a strategy 5 to overcome the shortage of health careworkforce challenges and improve access to essential health care services. Despite the issuesand controversies surrounding the use of community health officer in rural setting, we haveno doubt that this workforce model is effective for rural health system.

I. RESEARCH METHODOLOGY

3.1Population and Sample

In the study, population refers to all the villagers of community area at Meerut. Sample size is the present study consist of 100 villagers residing in selected community area at Meerut. A random sampling technique is used in the study.

3.2 Data and Sources of Data

The data collection procedure included the following steps :

1. Collection of demographic variables by self –administered checklist .

2.Conduct self-administered checklist to find out the level ofsatisfaction of resident of villagers regarding services provided by CHO.

The data collection for the main study was done from a villagers. The participants for the main study were selected by random sampling technique among all the people in a selected community areas in Meerut who fulfilled the inclusive criteria.

RESEARCH SETTING

This study was conducted in Multan Nagar Meerut.

DEVELOPMENT AND DESCRIPTION OF THE TOOLS

The instrument selected in a research must be the vehicle that obtains best data for drawing conclusion of the study (Treeze and Treeze, 1986).

Instrument consists of two parts:

SECTION A *:Demographic variables*

It consists of demographic variables such as age, gender, occupation,education, area of living and which health facility you will go for checkup.

SECTION B :*Checklist to assess the satisfaction level of resident of villagers regarding services provided by CHO*

It consist of 25 statement , each statements having scores. Maximum score of the structured checklist were 50 to find out the level of satisfaction.

SCORING AND INTERPRETATION

Score – YES – 2, NO – 1, DON'T KNOW – 0

Level of satisfaction – very satisfied – 34 to 50, satisfied – 17 to 33 and not satisfied – 0-16.

IV. RESULTS AND DISCUSSION

4.1 Results of Descriptive Statics of Study Variables

TABLE 1

Findings related to demographic variables of the villagers.

N=100

S.NO.	SOCIO DEMOGRAPHIC VARIABLES	FREQUENCY (F)	PERCENTAGE (%)
1.	**Age In Years**		
	a.21-25 yrs	10	10%
	b.26-30 yrs	30	30%
	c.31-35 yrs	39	39%
	b.36-40yrs	21	21%
2.	**GENDER**		
	a. Male	42	42%
	b. Female	58	58%
3.	**OCCUPATION**		
	a. Self employed	29	29%
	b. Government service	36	36%
	c. Private service	35	35%
4.	**EDUCATION**		
	a. Higher secondary	14	14%
	b. Senior secondary	31	31%
	c. Graduation	44	44%
	c. No formal education	11	11%
5.	**AREA OF LIVING**		
	a. Urban area	49	49%
	b. Rural area	51	51%
6.	**WHICH HEALTH FACILITY YOU WILL GO FOR CHECK UP**		
	a. Private sector	8	8%
	b. Government sector	70	70%
	c. both	22	22%

The above table 1depicts frequency and percentage wise distribution of village people according to Age, Gender, Occupation, Education, Area of living and Which facility they go for check up.

- Distribution ofpeople according to their age in years shows that 10% of them were in the age group of 21-25 years, 30% were in the age group of 26-30 years,39% were in the age group 31-35 years and 21% were in the age group 36-40 years.
- Distribution of people according to their gender shows that 42% of them are male and 58% of them are female.

- Distribution of people according to their occupation shows that 29% of them are self employed, 36% of them are government service, 35% of them are graduate and 11% of them having no formal education.
- Distribution of people according to their education shows that 14% of them are in higher secondary, 31% of them are in senior secondary, 44% of them are graduate and 11% of them having no formal education.
- Distribution of people according to their areas of living shows that 49% are living in urban area and 51% are living in rural area.
- Distribution of people according to their choice of health facilities shows that 8% of them prefer private sector, 70% of them prefer government sector and 22% of them prefer both private and government sector.

Finding related to satisfactory scale regarding services provided by CHO.

- This section deals with the data pertaining to the level of satisfaction of the villagers. The data analyzed by using descriptive statistics & presented in terms of frequency and percentage.
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- **TABLE2**
- **Figure 7: Finding related to satisfactory scale regarding services provided by CHO**
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S.No	Level of satisfaction	Frequency	percentage%
1.	Very satisfied (34-50 %)	40	40%
2.	Satisfied(17-33%)	60	60%
3.	Not satisfied (0-16 %)	0	0%

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- The data presented in the above table depict that the level of satisfaction of villagers is majority 60% satisfied and 40% is very satisfied and not satisfied is nil. The data depicts that the satisfaction level of villagers is satisfied.

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