

ORIGINAL ARTICLE

Utilization of primary health centre services amongst rural population of northern India - some socio-demographic correlates

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Article Cycle

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Abstract

Objective: To assess the awareness and utilization of Primary Health Centre (PHC) services by the rural community. **Methods:** This was a cross-sectional study conducted in the villages of rural areas. The subjects residing for at least six months in the area was considered as a resident and included in the study. A predesigned and pretested interview schedule was used to elicit information on socio-demographic characteristics, awareness and utilization. **Results:** A total of 585 subjects were interviewed about their knowledge of health facility. Majority (76.2%) of the subjects was aware about the existence of PHC services in their area however, the utilization of services by them was only 36.3%. The awareness was lower among those subjects who were illiterates. Similarly, the utilization of PHC was high among literates. There was association between socio-demographic characteristics and awareness as well as utilization. The main reason for non-utilization of PHC services was distance from their living place. **Conclusion:** Though the awareness about PHC services is higher amongst people in the rural areas, the utilization of its services is quite low among the community.

Key Words

Primary Health Centre; Awareness; Utilization

Introduction

Primary Health Care is defined as "Essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation, and at a cost that community and country can afford" has been recommended as a set of health services that can meet the challenges of a changing world.(1) The World Health Organization (WHO) in its latest report has called for a revival of primary health care.(2)

The Primary Health Centres (PHCs) play the central role in delivering health care to rural India, with no exception in Uttar Pradesh. The PHCs, are supposed to deliver preventive, promotive and curative health care to the community. Apart from mere delivery of direct services to individuals visiting the centre, the PHCs provide health education, nutrition promotion, immunization, mother child and family welfare services, and information on basic sanitation.(3) Although health is a state subject in India, the major allocation of funds

for development of health infrastructure in the state is by Govt. of India under National Rural Health Mission.(4)

Over the last decade, many developing nations have embraced primary health care within their national health plans. In contrast to earlier approaches to national health development, the primary health care emphasizes community participation and basic health care for the poorer segments of the society. A study in Nepal revealed a contradiction between the stated intentions of the programme to address local interests and promote community participation on the one hand, and the actual approach taken on the other hand.(5) In general, PHCs are encountering problems in developing countries for three reasons: (i) PHC fails to appreciate villager's values and their own perceived needs. In particular, PHCs are organized primarily to provide health education, whereas villagers value modern curative services and feel little need for new health knowledge. (ii) lack of local cultural beliefs and practices as resources to facilitate dissemination and acceptance of modern health knowledge. (iii) In attempting to incorporate traditional medical practitioners into the program, PHC has mistakenly assumed that rural clients passively believe in and obey traditional practitioners. In fact, clients play active roles and are themselves in control of the therapeutic process. Thus, instead of attempting to recruit traditional practitioners to do its work, PHC should recognize the precedent for community participation in traditional medical system and develop the respect for villager's own ideas and values that traditional practitioners already possess.

Aims & Objectives

Keeping in mind the above facts, the present cross-sectional study was conducted to assess

the awareness and utilization of primary health centre (PHC) services in the rural community.

Methods

Study design: This was a cross-sectional survey conducted in the villages in the area of Primary Health Centre in the vicinity of field practice area of Department of Community Medicine, Hind Institute of Medical Sciences, Barabanki. The informed consent was taken from each subject after explaining the objective of the study.

A person residing for at least six months in the area was considered as a resident and included in the study. The subjects whose native place was other than present place of residence but the duration of stay was more than six months were also included in the study. Those subjects living in the area for less than six months were not included in the study.

Tools of investigation: A predesigned interview schedule was used to elicit information on socio-demographic characteristics, awareness and utilization. The schedule was pretested and necessary modifications were made in the schedule to overcome the difficulties encountered during pretesting.

Sampling: The households were selected using stratified random sampling method. The stratification was done on the basis of distance of the villages from the PHC viz. <1 km (nearby), 1-5 km (in between) and >5 km (far away). A list of villages was prepared under the identified areas falling in these three groups and two villages from each group were selected randomly. Thus a total of 6 villages were included in this study. The sample size was calculated on the basis of 48% knowledge of health services in a study in Andhra Pradesh 2 with 90% power and 5% significance level which came to be 433. Applying 10% non-response, the final sample was estimated to be

476. As the total number of households of the selected villages was 1134, it was decided to cover every alternate household so as to have the desired sample size. The first household of the sampled villages was selected randomly and then every alternate household was surveyed till the whole village was completed.

Data collection: The interview was taken with the head of the household, and if head of the family was not available, next to him person in the family was interviewed. Each participant was explained about the purpose of the study prior to administration of tool. The confidentiality was assured. Interview was started with general discussion to gain confidence and it slowly extended to the specific point.

Data Analysis: The data collected was entered in Microsoft Excel and checked for any inconsistency. The analysis was carried out by using SPSS 16.0 version.

Result

Of the 1134 households in the 6 villages, a total of 585 subjects could be covered and interviewed about their knowledge about Primary Health Centre (PHC). Majority (76.2%) of the subjects was aware about the PHC in their area and utilization of its services was found to be 36.3%.

The association between demographic profile and awareness as well as utilization of PHC is depicted in [Table 1](#). The awareness was higher among the subjects of >50 years (81.9%) than <30 (73.2%) and 30-50 (70.8%). Not much difference was observed in the awareness among the subjects belonging to different religious and castes. The awareness was lower among those subjects who were illiterates compared with literates. The awareness was also almost similar among different occupational levels and the awareness about

PHC was lower among those who were living far from the PHC.

[Table 2](#) describes the reasons for utilization of PHC services by families in relation to their distance from PHC. The main reason for the utilization of services among living nearby PHC was free treatment (20%). However, this was availability of qualified doctors (22.3%) at PHC among living in between distance from PHC. The main reason for the utilization of PHC services was availability of 24 X 7 delivery services (22.9%) among living far away from the PHC.

The main reason for non-utilization of the PHC services was long waiting hours among all the families living nearby (43.9%), in between (46.8%) and far away (47.4%) ([Table 3](#))

Discussion

The health services utilization model developed by Anderson (8) proposes three factors that can influence the utilization of a health service use. They are:

- Predisposing factors: this includes the factors such as age, gender, religion, ethnicity, education, occupation, social capital, knowledge and prior experience about the illness and health service
- Enabling factors: this refers to factors such as availability of services, affordability, health insurance and social network support.
- Need factors: these factors refer to the perception of severity of illness, days lost due to illness, outside help for care.

Further modification in the above mentioned model has identified factors from the health systems such as policy guidelines, health resources, and organization of health system and health care delivery also influence the utilization of a particular model of health care.(9)

The present study focused on the awareness and utilization of PHC services by the rural community. The majority (76.2%) of the subjects were aware about the PHC in their area whereas its utilization was only 36.3%. The study, also highlighted that the awareness was lower among illiterates particularly among those living far from the PHC. Lindstrand, et.al(10) described that the possible determinant for choosing a specific healthcare provider may be the education level of the household. Education is considered as the most important determinant of health care after the economic status. The utilization of the health services helps to prove the importance of some socio-economic differences in health and in use of health services. Poorer sections of the society made more use of the public healthcare facility than the economically well off sections of the society.(11) In this study also, there was association between socio-demographic correlates with the utilization of PHC services. In a study in West Bengal (12), none of the respondents did seek care from any health facilities for treatment in case of 221 (32.9%) episodes; especially from tribal areas where in majority (76.2 %) did not seek any health care from any health facility and depended more on their home remedies. In rest of episodes the (451), majority (38.6%) preferred to go to government health facilities followed by unqualified practitioners (29.3 %) due to low treatment cost as well as living in close proximity. Only 27.3% preferred to go to a qualified private practitioners and only 4.9% preferred AYUSH, as a first choice for treatment. The referral was mostly by self or on the advise of close relatives/families (61%) and not by a doctor.

Analyzing the various reasons given by the respondents in choosing PHC helps to understand the driving force behind the choice of a particular health care. It is evident from

the response that among the respondents, trust and distance are the major driving force.

Conclusion

The awareness about the PHC services and its services is high, however, the utilization of its services is quite low among the community.

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Tables

TABLE 1: DEMOGRAPHIC PROFILE OF THE SUBJECTS IN RELATION TO AWARENESS & UTILIZATION OF PHC SERVICES

	No. of respondents interviewed	Awareness		Utilization	
		No.	%	No.	%
Age in years					
<30	71	52	73.2	17	32.7
30-50	243	172	70.8	73	42.4
>50	271	222	81.9	85	38.3
Religion/Caste					
Hinduism	544	419	77	165	39.4
Upper Caste	108	88	81.5	26	29.5
Backward Caste	261	210	80.5	86	41.0
Scheduled Caste	175	121	69.1	53	43.8
Islam	41	27	65.9	10	37.0
Education of head of family					
Illiterate	178	109	61.2	31	28.4
Junior High school	117	85	72.6	27	31.8
High school	110	86	78.2	32	37.2
Intermediate	98	87	88.8	43	49.4
Graduate +	82	79	96.3	42	53.2
Occupation of head of family					
Unemployed	281	224	79.7	81	36.2
Unskilled	146	84	57.5	40	47.6
Semi-skilled worker	58	44	75.9	10	22.7
Skilled worker	56	55	98.2	23	41.8
Clerk/Shop-owner/Farm owner	16	15	93.8	9	60.0
Semi Professional	15	13	86.7	8	61.5
Professional	13	11	84.6	4	36.4
SES					
I & II	30	27	90.0	10	37.0
III	88	75	85.2	27	36.0
IV	324	243	75.0	98	40.3
V	143	101	70.6	41	40.6
Distance from PHC (in kms.)					
<1	242	212	87.6	110	51.9
1-5	178	132	74.2	37	28.0
>5	165	102	61.8	28	27.5
All villages	585	446	76.2	175	39.2

TABLE 2: REASONS FOR UTILIZATION OF PHC SERVICES OF BY FAMILIES IN RELATION TO THEIR DISTANCE FROM PHC

Reasons for Utilization	Respondents and the distance of their villages from PHC							
	Nearby (n=110)		In between (n=37)		Far away (n=28)		Total (n=175)	
	No.	%	No.	%	No.	%	No.	%

24 X 7 delivery services	21	19.1	9	24.3	10	35.7	40	22.9
Easy approach	23	20.9	1	2.7	4	14.3	28	16.0
Free treatment	25	22.7	6	16.2	4	14.3	35	20.0
Qualified doctors	23	20.9	13	35.1	3	10.7	39	22.3
Availability of drugs	18	16.4	8	21.6	7	25.0	33	18.9

TABLE 3: REASONS FOR NON-UTILIZATION OF PHC SERVICES OF BY FAMILIES IN RELATION TO THEIR DISTANCE FROM PHC

Reasons for Non-utilization of PHC	Respondents and their distance from PHC							
	Nearby (n=132)		In between (n=141)		Far away (n=137)		Total (n=410)	
	No.	%	No.	%	No.	%	No.	%
Long waiting hours	58	43.9	66	46.8	65	47.4	189	46.1
Poor supply of drugs	30	22.7	17	12.1	15	10.9	62	15.1
Unaware of services	10	7.5	12	8.5	50	36.5	122	29.8
Bad behavior of employee	18	25.7	46	32.6	7	5.1	37	9.0