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A CROSS-SECTIONAL STUDY OF UTILIZATION OF PRIMARY HEALTH CENTRE SERVICES: A CASE STUDY OF ALIGARH DISTRICT

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ABSTRACT

Primary Health Centre (PHC) is the most vital constituent of Public Health Care System as it is the first place of interaction between the populations and the Public Health System. The government is trying to expand the delivery of health care services through various programmes, so as to improve the health status of people. The most important aspect of the success of health programmes is the extent of availing of public health services by the people. Thus, it would be essential to determine the reasons which help in better availability of public health care service by individuals particularly at PHC level, so that health for all is achieved. As the government is trying to address health issues of rural through National Rural Health Mission 2005, there is need to examine whether there is any association between the types of services and socio-economic variables of PHC, Jawaan Block of Aligarh District. The study also tries to know about people's knowledge about NRHM programme. The present paper tries to address these questions by using, statistical measures; simple percentage analysis, averages and the Pearson's Chi-square test for independence has been used to test the hypotheses. The study found significant association between the marital status, education, income and type of services. Gender, age, occupation and type of services doesn't show any significance. However in instance of socio-economic variable and knowledge about NRHM there is no significant association only income shows the significant association.

1. Introduction

Good health is a vital constituent of well-being. Nevertheless, developments in health status may be justified on purely economic grounds. It appears to be a coherent assumption that good health nurtures human capital levels and hence the economic productivity of individuals and a nation's economic growth rate. There is a developingattention at the domestic and global levels in health as a development matter, with specificorientation to government policies in relative to the planning and promotion of healthcare. Anabundant deal of literature on health planning and policy is available. It is basic to advance this discussion to a talk of wellbeing strategy at the state level in India at least for three reasons: i) under the constitution, the essential obligation regarding social insurance rests with state government. A state level investigation of execution, issues and prospects, will assess how this duty is being released; ii) Health ought to be a subject of premium not exclusively to the individuals from the expert therapeutic and wellbeing network, yet in addition to administrators, social labourers; and by and large to every single capable native. Indeed, even an outline of the circumstance in one's own state will be valuable in advancing and supporting enthusiasm for the subject, and iii) In India, there are various built up non-governmental organisations (NGOs); who are effectively occupied with essential medicinal services. By ethicalness of the experience they have picked up in the field, they are in a situation to contribute profitable contributions to health arrangement and to the design of health care programmes.

The Government of India after experimentations of different projects to enhance the quality of health including improved nutrition, sanitation, and cleanliness and safe drinking water has propelled the National Rural Health Mission (NRHM) on First April of 2005. The main objective of the Mission is to carry out necessary architectural correction in the basic health care delivery system. It goes for arrangement of far reaching and incorporated essential medicinal services to the general population, particularly to the provincial poor, ladies and kids. Additionally it goes for mainstreaming the Indian System of Medicine to encourage human services. The arrangement of Action incorporates expanding open use on wellbeing, diminishing provincial awkwardness in wellbeing foundation, pooling assets, reconciliation of authoritative structures, advancement of wellbeing labour, decentralization and region the board of wellbeing programs, network support and responsibility for, acceptance of the executives and monetary work force into area wellbeing framework, and operationalising Community Health Centres into utilitarian emergency clinics meeting Indian Public Health Standards in each Block of the nation.

India lives in its nearly 6.5 lakhs villages. If elementary healthcare does not touch the rural areas, no matter how much development is attained in the urban and semi-urban areas, the inclusive growth as a country will be underdeveloped. India has made momentous progress in improving healthcare. But improving access to basic healthcare services to the rural populace is feasibly one of the most pressing, from a direct human development viewpoint as well as to confirm a solid foundation for prospect economic growth. Healthcare indicators differbroadly across states, partly reflecting the different levels of resources available to state governments. But one trend that is totally consistent is that indicators are much worse in rural areas than in urban ones. The critical

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problem is that of availability and accessibility. An investment on health is an investment on human resource development. But in order to ensure that the health programs move as scheduled, and to bring about the requisite effort and direction in the wide-ranging health activities and in the government machinery itself, it is necessary to indicate the framework of health policy. The success of health plan depends on various factors, among which the choice of current policy is crucial. It is a well-recognized fact that the system of public delivery of health services in India today is in crisis. The public health care system is inadequate in quality as well as in quantity. India‗s economic growth is bringing with it an expected—health transition‖, in terms of shifting demographics, socio-economic transformations.

2. Review of Literature

Kaveri Gill (2009), presumed that the National Rural Health Mission is on the correct way of tending to the rural health care with the institutional changes it has brought inside the health structure. However, there are issues in utilization, so conveyance is a long way from what it should be as for physical infrastructure, medicines and financing. Though as for human resources and to the degree these effect real accessibility and availability of services, auxiliary issues of some multifaceted nature require watchful settling with a clear long haul interest in the preparation and training of paramedical and medical staff.

Srivastava R.K. et al (2009) study shown that the utilization of RCH services in the government amenities was greater among the backward classes than the general category; and greater the level of education the poorer was the utilization of the government services. Additionally the consumers were not satisfied with the services delivered by the governmental health servicesmainly with the behavior of medical officer and health workers and non-satisfaction was utmostamongst SC classification. Similarly authors reasoned that all the health amenitiesprerequisite to be complete functional according to the Indian Public Health Standards (IPHS) of National Rural Health Mission (NRHM).

Yadav, Jarhyan, Gupta and Pandav (2009) have examined the state of rural healthcare delivery in India. They establish that the rural health system of India is tormented by genuine asset setback and underdevelopment of infrastructure, which prompts inadequate healthcare for a greater part of India. The rural population of India still does not get the fundamental quality of primary health care as expressed in Alma-Ata conference attended by governments of 134 nations and severalwillful associations in 1978.The author is of the view that Indian health system is stagnated currently and it requires available of box considering. It expects changes to revive it. This is high time to identify and coordinate RHP with existing healthcare delivery system in rural regionswhich can be one of the answers for handling the deficiency in healthcare delivery system.

The Bhore Committee report in 1946 recommended, One Primary Health Centre should be there for population of 40,000 and each PHC should have staffed by two doctors, one nurse, four public health nurses, four midwives, four trained dais, two sanitary inspectors, two health assistants, one pharmacists and 15 other fourth class staffs. Subordinate health centre was too envisaged to provide support to PHC, and to coordinate and supervise their functioning.

Similarly in 1962, Mudaliar Committee suggested and highlighted that a PHC should not be made to cater to more than 40,000 population and that the curative, preventive and promotive services must be delivered at the PHC. One of the fundamentalpolicies for providing accessible healthcare to the population is to strengthen the sub-centres (SCs), primary health centres (PHCs) and community health centres (CHCs) – units where healthcare is actually delivered. (2011, Zakir Husain). So it's essential to identify health infrastructure and how efficiently they are working in rural areas. Primary Health Care is the first level of contact of the individuals, the family and the community with the public health system, which brings health care as close as possible to where the common people live and work. (1985, Roy, S.).

3. Statement of the Problem

Uttar Pradesh state which lies in north zone of the country with a total population of 199.8 million people as per the census 2011, it accounts for 16.49 per cent population of the country. Indeed, it is the most populous culturally rich and politically significant state of the country. Many scholars aptly described it as the heart of the country. The state is deeply diversein its geography, culture and way of living. In order to strengthen the primary health care services in the densely populated, the state government is strengthening the health infrastructure and improves health facilities in rural, hilly and tribal areas through National Rural Health Mission. Government is trying to enhance the health care facilities provided to its people by focusing on improving the primary health care system since independence. Despite concerted efforts by centre and state governments, the health status of people in rural areas has not enhanced to the preferred level. National Rural Health Mission was launched in the year 2005 with an objective to improve the access to quality health care for underprivileged people, women and children living in rural areas and to bring architectural correction in health delivery system. Although it is difficult to measure the full scope of NRHM and its impact on health delivery mechanism in rural areas. For effective program implementation, it is essential to understand the factors affecting the utilization of services provided by the government. There is a wide regional variation in healthcare utilization. Present study aims at analysing NRHM, services and utilization by rural population. Various health programmes launched by the government to achieve the objectives and strategies of the mission have also been analysed to judge its outcome on health indicators.

4. Objectives

1. To identify the socio-economic background of the sample respondents.
2. To study the knowledge of the National Rural Health Mission among the respondents.
3. To study the type of services availed by the respondentsin select PHC of Aligarh Districts.

5. Hypothesis

H_o: There is no significant relationship between socio-economic variables of the respondents and type of services.

H_A : There is significant relationship between socio-economicvariables of the respondents and type of services.

H_o : There is no significant association between socio-economic variables of the respondents and knowledge about NRHM.

H_A : There is significant association between socio-economic variables of the respondents and knowledge about NRHM.

6. Data base and Methodology

The study was conducted in Jawaan Block of Aligarh District, Uttar Pradesh. In Aligarh there are 12 Blocks. On the basis of lottery method one Block and one PHC has been selected for study. The total population of Aligarh district according to census 2011 is 36.74 lakhs. Out of the total population, 33.13 per cent lives in urban and 66.87 per cent rural regions. The Jawan Sikanderpur's total population is 268492 out of which, 142017 are males while the females count is 126475. Currently there are four PHCs working in Jawaan Block from which one PHC (Cheerat) has been taken for study. The study was to cover seekersutilization of services from

PHC and to know about knowledge about the NRHM programme. Data for this analysis was collected from primary survey through interview schedule. The sampling chosen, consisted of 110 sample respondents. The type of sampling used is random sampling. The data was collected during the months, between Octobers to December, 2018. The data collected was analyzed with the help of statistical measures; simple percentage analysis, averages and the Pearson's Chi-square test for independence has been used to test the hypotheses. The analysis was done through the computer using statistical package SPSS (windows version 20.0).

7. Analysis and Result

Table 1: Demographic Profile of the Respondents

Variables		Frequency	Percentage
Gender	Male	39	35.0
	Female	71	64.5
Age	Below 20	16	14.5
	21-30	44	40.0
	31-40	28	25.5
	41-50	09	8.2
	51-60	06	5.5
	Above 61	07	6.4
Marital Status	Married	79	71.8
	Unmarried	31	28.2
Education	Illiterate	34	30.9
	Only Literate	18	16.4
	Below Primary	22	20.0
	Middle School	15	13.6
	Secondary	11	10.0
	Senior Secondary & Above	10	9.1
Occupation	Unemployed		
	Agriculture Labour	07	6.4
	Daily Wage Earner	36	32.7
	Job Private/Govt.	15	13.6
	Non Worker	08	7.3
	Self Employed	33	30.0
		11	10.0
Income	Below 5000		
	50001-10000	27	24.5
	10001-15000	65	59.1
	Above 15001	11	10.0
		07	6.4

Source: Based on Field Survey

Table 2: Know about NRHM Programme

NRHM Programme	Frequency	Percentage
Yes	65	59.1
No	45	40.9
Total	110	100.0

Source: *Based on Field Survey*

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Table 2 shows that among 110 respondents, 59.1 per cent knows about NRHM programme.

Table 3: Type of Services Availed by the Respondents

Type of Services	Frequency	Percentage
Delivery	08	7.3
Antenatal Check-ups	25	22.7
Pain	27	24.5
Cold Fever & Headache	27	24.5
BP & Diabetics	07	6.4
Respiratory Diseases (TB)	06	5.5
Immunization	10	9.1

Source: *Based on Field Survey*

Table 4: Result of Pearson Chi-Square testing

Variable tested	Pearson Chi-Square Value	df	Significance	Remark
Gender X Type of Services	13.155	18	.752	Not Significant
Age X Type of Services	29.613	30	.486	Not Significant
Marital Status X Type of Services	23.930	6	.001	Significant
Education X Type of Services	97.009	30	.001	Significant
Occupation X Type of Services	32.578	30	.341	Not Significant
Income X Type of Services	42.175	6	.001	Significant

Source: *Based on Field Survey*

The result shows the association between socio-economic variables and type of services availed by the respondents. The Pearson Chi-Square result for marital status, education and income is less than 0.05 (5%) level of significance, which means there is significant relationship. However in case gender, age and occupation the Pearson Chi-Square result is greater than 0.05 (5%) level of significance which means there is no significance relationship with type of services. The result manifest that in case of marital status married people are more likely to get benefits from PHC as compare to unmarried. 71.2 per cent are married respondents. Women respondents avail the services more because it is nearby and for routine checkups of antenatal, children immunization, pain (stomach, headache, etc) especially during pregnancy and for delivery. It is noted from the above table-4, that the p-value is less than 0.5 in case of education and income also which means hypothesis is rejected and alternative hypothesis is accepted. Hence the hypothesis is not accepted it means there is significant relationship between education, income and marital status and type of services availed by them. Hence treatment availed at PHC is unequal to them. However, the p-value in greater than 0.5 in instance of gender, age and occupation which means the hypothesis is accepted and alternative hypothesis is not accepted. Hence there is no significant relation between (gender, age, occupation) and type of services availed by them. Hence treatment availed at PHC by them is equal to all. All the value of Pearson Chi-Square is given in above table.

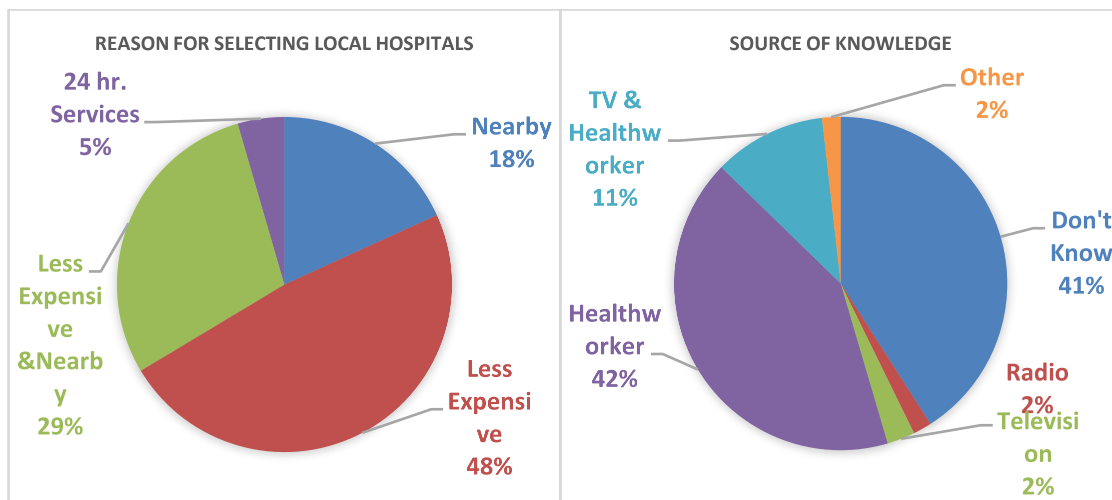

Figure-1: *Shows reason for going local hospitals.* ***Figure-2***: *Shows source of information about NRHM.*
Source: *Based on Field Survey*

The Figure-1 shows that 48 per cent of the sample respondents choose PHC because of the less expensive, 29 per cent respondents chooses both less expensive and nearby whereas 18 per cent go to PHC because it is nearby to their

locality and only 5 per cent owed to services available for 24 hr. The Figure-2 shows, source of information about NRHM programme. 42 per cent respondents knows through health workers (ASHA, Anaganwadi workers) about NRHM. Knowledge about NRHM programme, 59 per cent knows about the programme which is reasonably decent result. It indicate that people are getting gradually aware of the programme.

Table 5: Result of Pearson Chi-Square testing

Variable tested	Pearson Chi-Square Value	df	Significance	Remark
Gender X Heard about NRHM	0.688	1	.407	Not Significant
Age X Heard about NRHM	3.198	5	.669	Not Significant
Marital Status X Heard about NRHM	0.323	1	.570	Not Significant
Education X Heard about NRHM	7.117	5	.212	Not Significant
Occupation X Heard about NRHM	3.027	5	.696	Not Significant
Income X Heard about NRHM	11.192	3	.011	Significant

Source: *Based on Field Survey*

The above table-5, shows the association between socio-economic variables and people know about National Rural Health Mission (NRHM). It found that socio-economic namely gender, age, marital status, education and occupation there is no significant relationship. The p-value is greater than 0.5 significance of level. Whereas income shows the significant relationship with knowledge because the value is less than 0.5 level of significance and the null hypothesis is rejected and alternative hypothesis is accepted. Hence the respondents who has less income than 5000 are not more aware about programme. Table-1 shows the income groups of the respondents and 24.5 per cent are below 5000 in the classification.

8. Conclusion

The study found that the age group between 31- 40 are 40 per cent and this is more productive age. Married respondents are more which 71.8 per cent is. Mostly people are known about NRHM programme through health workers. The study found significant association between the marital status, education, income and type of services. Gender, age, occupation and type of services doesn't show any significance. However in instance of socio-economic variable and knowledge about NRHM there is no significant association only income shows the significant association. The study also found that commonly patients prefer because of they get free medicines and it is less expensive.

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