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Research Article

PERCEPTIONS REGARDING PRIMARY HEALTH CARE SERVICE AMONG RURAL POPULATION OF HIMACHAL PRADESH- A QUALITATIVE STUDY

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ABSTRACT

Background: "Health for all" through primary health care was initiated in 1978. Productivity, efficiency and quality of care of public rural health service sector has always been questioned. Information about community perception with a thorough understanding of the needs and expectations of the community about the primary health care services can help in better delivery and higher utilization of health services. Scarcity of information on this aspect of health care inspired to carry out the present study to reveal the true condition of the system by examining the relationship between efforts and accomplishments.

Material and methods: A Qualitative study was undertaken through focus group discussions and exit interviews of women in reproductive age group in 24 villages of Himachal Pradesh selected through multistage stratified random sampling to assess the perceptions of rural population regarding the available primary health care services. Data was analyzed using thematic analysis approach.

Results: Qualitative exploration suggests that physical accessibility, availability & social acceptability in community emerge as critical avenue for the utilization of primary health care services. For health related issues community members first discuss with family members and then decide pragmatically. Majority of people opt for approaching health institution in their vicinity. Literacy status, socioeconomic status, perceived quality of health care services and community dynamics also have great impact on its utilization. AWWs & TBAs plays a pivotal role in delivery of services. Geriatric component still need voice. Un-Sustained socio-political commitment and insufficient supervision were found to be the major bottlenecks in this study.

Conclusion: Sub-centers are crucial for the delivery of Primary health care services in Himachal Pradesh. Sustained socio-political commitment, inter-sectoral co-ordination and constant supervision need to be strengthened.

INTRODUCTION

The health care system in India, at present, has been developed as a three tier structure based on predetermined population norms.[1] The sub-centre is the most peripheral rural health care infrastructure and the first contact point between the primary healthcare system and the community.[2] It is envisaged to provide integrated preventive, promotive & curative healthcare to the vast majority of rural people. They are also expected to use various mediums of interpersonal communication in order to bring about behavioral change in reproductive and hygiene practices.[3]

Although considerable progress has definitely been made in last few decades for expansion of the public health infrastructure in the rural areas and recent reforms of National Rural Health Mission (2005-12) are also aimed to increase accessibility and increase the utilization of public health facilities but then mere existence or increasing the availability of services does not increase their utilization as still client's perception regarding the facility determines whether to seek and continue to use a particular service.[4]

While the efforts are in the right direction, the public health sector in rural areas is plagued by uneven demand and perceptions of poor quality. Countrywide, the underutilization of available facilities is of significant concern.[5]

Bridging the gap in utilization of public health facilities has always been a focus area of public health research especially in the post-National Rural Health Mission era.[4]Whether these programs and policies really reach to the grass root level population is an important issue which needs a in-depth exploration.

Developing nations have been focusing on relevant infrastructure, technology, disease control, and health outcomes in terms of deaths and disability-adjusted life years, largely ignoring the service quality aspect from the patient's

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viewpoint. However, researchers opine that real improvement in quality of care cannot occur if the user perception is not involved. Patients' perception is significant as it impacts their 'health-seeking behaviour' including utilization of services, seeks involvement in issues directly related to them, enables the service provider to meet their expectations better, and provides relevant information to the policy makers to improve the quality.[6]

Health seeking behavior among different populations, particularly in the rural communities, is a complex outcome of many factors operating at individual, family and community level including their bio-social profile, their past experiences with the health services, influences at the community level, availability of alternative health care providers including indigenous practitioners and last but not the least their perceptions regarding efficiency and quality of the services.[7]

Primary health care in Himachal Pradesh: In the way of providing primary health care services, the Government of Himachal Pradesh has made impressive growth in terms of the establishment of primary health care institutions across rural, tribal hard-to-reach sectors. However, shortcomings in the delivery of primary health care services have resulted in lesser utilization rates.[8]

The need to address access and barriers to health care resources, adequacy of resources, and utilization of services is vital to the health and well being of people of vast rural and difficult topographic areas of the state.

With this perspective, present study was undertaken with an objective to assess the health seeking behavior of community members and the factors that mostly affect this behavior. The study also aims to understand the key perceptions of community regarding availability, satisfaction & utilization of primary health care services of public health facilities available to them and barriers in accessing those in a rural setting of Himachal Pradesh. This study also helps in understand the mechanism of intersectoral coordination for primary health care delivery at village level and to recommend modifications to strengthen it.

MATERIAL AND METHODS

The present study was undertaken between June to December, 2011, according to the principles of qualitative research with application of Focus Group Discussions and exit interviews for collection of information on the perceptions and other relevant issues about primary health services from different homogenous, groups of the rural community.

Multistage Random Sampling Technique was adopted for selection of villages to be included in the study. In first stage 12 rural blocks were selected randomly out of 12 districts of Himachal Pradesh .In second stage, one subcenter was randomly selected from each block. In third stage from each of the selected subcenter areas, one subcenter headquarter (HQ) village and one non-HQ village were also randomly selected .Above sampling technique was adopted so as to obtain an overall picture of community's behaviour and perception, presuming a definite distribution existing within different blocks of the peceptions regarding primary health service.
The study team comprised of faculty members, facilitator from Department of community Medicine, Indira Gandhi Medical College, shimla and recorders (field investigators hired under project).

Two Focus Group Discussions (FGDs) were conducted in each of the selected village. The first group consisted of 8-10 men/women who were the heads of the family and the second group comprised of women belonging to reproductive age group i.e. 15-45 years, who were permanent residents of the respective villages to know their view points.

Confidentiality of the participants was assured by coding the participants. Dual recording of FGD was done (note taking, transcription and audio-visual recording) and debriefing was done immediately after the discussion by the field Investigators along with the visiting consultant. At the end of the discussion summary of key findings were offered to the participants and they were asked to verify or amend the contents. Accepted systematic steps were used in analysis to identify the key points in each FGD then compared the results with the other groups to identify the patterns and themes.

Exit interviews of 6 clients form each sub-centre area was undertaken. The clients were either the women in their reproductive age group and elderly people of the village. All responses of the participants were noted down in verbatim by two recorders to avoid any loss of information.

Total of 48 FGDs' and 24 exit interviews were conducted at the village level. For each point identified in our results we have established a trail of evidence that can be verified. Due care was given to distinguish what was said in the group and our own interpretations and recommendations. For this respondent validation was undertaken. Systematic analysis procedures were used to ensure that the results are accurate and trustworthy. Study is not intended to generalize but concept of transferability can be suggested. Our goal was to go in depth into the topic; therefore, sizeable amount of time was spent in conducting research with a small number of people

A thematic analysis approach was used; it is a flexible qualitative method that identifies, interprets, analyses and reports themes derived from data.[9] Through a systematic process the data is coded and organized, involving the identification of themes through careful reading and re-reading of the transcribed interviews. The interpretation process is interactive and reflexive, where the researchers identify themes which are recurrent and "adequately reflect their textual data". Janice Morse describes a theme as a meaningful "essence" that runs through the data as a basic topic that the narrative is about.[10] An example of the data analysis is presented in Table 1. The direction of the process is from quotes to themes via codes. Quotes generate codes that in turn identify themes.

Ethical considerations

The research study was done under WHO funded Project "Study on Social Determinants of Health" and all participants gave their informed consent to participate. The interview /FGD began with a presentation of the facilitator and the aim of the study. Each informant was encouraged to talk freely and in detail about the issues regarding their experiences with primary health care in their respective area. Assurance was given to all Participants regarding the confidentiality and anonymity of the information provided by them.

RESULTS

6 key themes were extracted from the discussion & interview data, **"***Preservers of life", "Not having all its marbles", "TBAs and ASHAs as gate- openers", "Tailored to specific local needs", "Barrier in seeking health care" & "Challenges of commitment and co-operation"*

Preserver of life

The informants emphasized that sub centers act as "*Preservers of life"*. This influenced their way of looking at the sub centers for their health problems because in most of the areas these institutions are near their homes, easily accessible and approachable. Majority of women residing in the village visit sub-centre for MCH and FP services, treatment of minor ailments and immunization services. Sub-centre has emerged to be a very important institution for them and said to be a '*life line'* for them. Majority of the women were satisfied with the services provided by the health workers. Almost all the participants feel they were courteous and listened to their complaints patiently.

"Health workers only provide few tablets; they don't touch the abdomen during pregnancy. Rarely they check blood pressure.' (Respondent)

At most of the places participants agreed that Hb% testing and pregnancy test were not routinely done at the sub-centre. Majority of women were counseled for institutional delivery by the health workers but Counseling on warning signs was not done in most of the sub-centers.

Delivery service was not provided at any of the selected sub-centers. Various reasons like lack of labour room, instruments and equipments, lack of skill and training, apprehensions among the health workers and beneficiaries about the risks involved, paying capacity of the beneficiaries came up during the discussions. All the participants wished if delivery services were available at the sub-centre and health workers were given adequate training along with a strong referral system there would certainly be an improvement of health status of the community.

Example of the quotes	Codes	theme
The sub-centre is very important because it is near to our village and we don't have to go far away for MCH services".	• Quintessential Health Institution • Easily Accessible • Approachable. • Utility of The Sub-Centre	Preserver of life
"We take medicines for us and our children from this sub-centre. In case of any health problem we come to this sub-centre. We also come here to get guidance during pregnancy." "The health worker provides her service day and night and visits home on call as well. We don't have to go far away for health services"	• Quintessential Health Institution • Trust Worthy • Faith on Health Worker • Guidance on MCH Issues • Round the Clock Service • Easily Accessible • Approachable	Preserver of life
"I had high blood pressure during pregnancy and I came to know about that at the sub-centre and health worker provided due care during rest of the pregnancy and delivery, therefore, this sub-centre is of great value for me."	• Quintessential Health Institution • Utility of the Sub-Centre • Guidance on MCH Issues • Round the Clock Service • Easily Accessible	Preserver of life
"Health workers provide time to time information about government schemes, counselling on balanced diet and importance of good nutrition during pregnancy, personal hygiene and warning signs".	• Quintessential Health Institution • Utility of The Sub-Centre • Guidance on Nutritional Issues • Guidance on MCH Issues • Health Advocacy	Preserver of life
"This sub-centre is like 'doobte ko tinke ka sahara' and of great importance for emergencies and first-aid. There will be numerous problems for us like for smallest injuries we have to rush to Barotiwala which will cost both time and money ('ek patti 1000 rupai mein padegi') and only one bus comes to this area so transportation of patients is also difficult".	• Quintessential Health Institution • Utility of The Sub-Centre • Providing Primary Health Care • Saving Money and Time • Difficult Terrain • Easily Accessible • Approachable	Preserver of life

Not having all its marbles

When asked about the services available at the sub-centre, majority of the participants could only tell about the elements of these services in bits and pieces. According to them sub-centers are providing very good services on immunization, treatment of minor ailments and prophylaxis for anemia. Some amount of counseling is also provided on nutrition, personal hygiene and exclusive breast feeding. Antenatal check-up, to the participants, was confined only to tetanus and IFA prophylaxis at most of the sub-centers, measurement of weight and height at a few sub-centers and at very few sub-centers measurement of blood pressure was done. Other components such as, per abdomen examination and general physical examination were not conducted at most of the sub-centers regularly.

As of now they preferred to go to PHC/CHC/DH for safe delivery practices.

"*Most of the deliveries take place at night and morning time when the sub-centre is closed. If one gets delivered at sub-centre and case gets complicated, it will be difficult to manage complications, so, District Hospital, is preferred for delivery, because specialist doctors and emergency management system is available there" (Respondent)*

In winters when the area is snow bound…sub centre is the only hope for us .we are helpless as we cannot take the woman in labour anywhere else.-a respondent from tribal area.

Majority of the people in tribal area felt that there should be coordination among subcenter worker and TBA. They should be trained together and help each other.

TBAs as gate- opener

According to the participants' health worker is most important functionary to provide health services at sub-centre level but the role of TBAs cannot be ignored because they often taken advice and services from them in case of emergencies since they were readily available. Most of women had taken advice from their local dais along with antenatal check-up at the sub-centre. Participants from tribal areas (Tailing and Paliyur) were mostly dependent on TBAs for delivery services. AWWs were also very popular among the participants for delivery of MCH and FP services.

"*There is good coordination between health worker & TBAs and they help each other in their endeavours"* (Respondent)

Tailored to specific local needs

If the health worker is female, women feel free to go to them and discuss their conditions or problems with them, take advice from them regarding MCH&FP services, but, if the health worker is male they feel shy to talk to them about the above said issues and have to refer to some other institution marring the very utility of the sub-centre.

Staff crunch was a point of contention in some areas where people suggested training and employment of local youth at the sub-centres.

Staffing of the sub-centre with both FHW and MHW , provision of a doctor once in a week, regular supply of medicines and supplements, Stay of one health worker in the accommodation provided at the sub-centre, round the clock 24X7 services at the sub-centre, provision of delivery at the sub-centre with all the facilities, training of health workers on minor emergency management including provision of anti rabies vaccine and anti-snake venom /inclusion of TBA at the sub-centre came as some useful suggestions from the participants in the Focus Group Discussions.

They suggested that the sub-centres must provide services other than MCH services. They insisted on provision of services and regular supply of medicines for geriatric population.

"Sub-centre covers only Mothers and Children, where the others will go? Old age people should also be taken care of. Old people are in there second childhood and should also get some supplementary foods like tonics, pain killer gels, eye drops etc. Geriatric programmes should be initiated and executed through this S/C". (Respondent)

"Government is right now focusing only on MCH and FP services, it should also think about elderly population." (Respondent)

Barrier in seeking health care

When it comes to the decision making to go to a particular health facility including health sub-centre, it was observed that decision to avail these services was mostly made by the women in consultation with their spouses and in-laws. In tribal areas most of the women themselves made the decision to avail a particular health service. Women were seen to be better empowered in these areas. There is great role of mother-in-law in making most of the decisions pertaining to her daughter-in-law in most of our rural areas. It was also observed that mother-in-laws do not send their daughter-in-laws to any health gathering, meeting, talk or discussion alone and most of the times accompany them to such places which make daughter-in-laws highly conscious of their surroundings and cause hesitation to speak and ask.

"My mother-in-law was there to take care of me. She was afraid something would happen to me if I went to see a doctor alone. My husband and mother-in-law were not happy if I went to see the doctor" (Respondent)

In some areas difficult geographical terrain and inappropriate location of sub-centre which hampers the utilization of services especially during monsoon and winter season and makes difficult for beneficiaries to reach.

"The sub-centre must be centrally located so that it is easy to bring an antenatal woman and other beneficiaries to the institution." (Respondent)

Socio-Cultural beliefs and taboos still pose hurdles in availing health care facilities in some regions. Few women feel that some workers treat women from affluent families and of upper caste better than those from poor families.

"The health workers give more importance to women of higher caste and give more medicines to them while they have to stand outside even if they come first." (Respondent)

*We cannot get our children vaccinated by a health worker from a lower caste. Even while we stand in a queue and our child gets touched by a person of lower caste …our deity gets angry and will definitely punish us….we take advice from deity first and only then consult doctors---(*respondents in one-FGD)

Participants in most of the areas admitted that financial condition of the people in present scenario was also a determining factor whether they take service from sub-centre, higher institutions or private practitioners.

"75% people in our villages are affluent and in good financial condition and bit educated and they do not prefer to go to sub-centre but go to best doctors even for trifling ailments. Remaining 25% people are poor and less educated and sub-centre is of great importance for this segment".(Respondent)

Many of the participants said that they cannot ignore the presence of traditional healers but would also like to avail health services from health workers and doctors.

"The health worker is most important for us because he gives allopathic treatment which has quick action. We go to local healers also if health worker is not available here" (Respondent)

Women both older and young decide *pragmatically* as far as safe delivery is concerned. Majority of the women had undergone institutional delivery at either district hospital or CHCs. Few had undergone delivery conducted by local dais or TBAs in one group. Home deliveries are still prevalent in tribal and far flung areas. Some of the participants stated that childbirth was a natural process and as such they did not feel the need to seek out healthcare.

"My mother gave birth for 7 children at home safely including me, am I so different?" (Respondent)

"It is our fate, God will determine if my child will live or die. he is the best doctor; nothing can happen without his will, we don't need a doctor or nurse or hospital". (Respondent)

People of one Tribe, *Gujjar* don't get their children immunized.

teekon se kucch nahi hota…iss se baccha kamzor ho jata hai…hum hospital sirf dava lene jaate hain

*(*Respondant from tribal area in chamba.)

Challenges of commitment and co-operation

They held Government, Panchayat members and local MLAs responsible for the deficiencies in delivery of health care services.

"*For deficiencies in health services 1% responsibility is of public and 99% is of government. Health workers are not responsible for deficiencies in delivery of health services as they provide what they get. They never refuse for any service. Health workers also impart information but we, the people do not come out of our dens to receive this information."* (Respondent)

"No discussion on health issue in Gram sabha takes place. Everyone is more interested in programmes where money is involved. There is minimal political will towards health. Health has never been a priority of people. They gather for the sake of their own benefits only. Our leaders come only to ask for votes and after winning they never look back. There is space for liquor shops at the centre of village but no land for sub-centre" (Respondent)

"*Most of houses in villages get IPH supply through household taps. People are not aware of cleaning and chlorination of water tanks. Chlorine tablets are not provided to them. Diseases like typhoid and diarrhoea are prevalent because people consume water drawn from hand pumps which is not treated with bleaching powder or chlorine due to lack of co-ordination between sub-centers and IPH department."* (Respondent)

Supervision at different sub-centres is poor and supervisor or MO or BMO visit these sub-centres once in a while.

"BMO is responsible for the pathetic condition of this sub-centre. He should come to visit sub-centre and check the problems and find ways to make things better" . (Respondent)

DISCUSSION

The health sub-centre was found to be a quintessential unit for the people residing in the villages. According to them sub-centre caters to their health needs, although, not round the clock but essentially in the day time. The main health services provided are treatment of minor ailments and injuries, MCH services and provision of essential drugs. Other elements of primary health care lie in shadow and are rarely provided by the health workers at the sub-centres level. Antenatal care provided is incomplete and does not contain all vital parameters to check warning signs which may invite complications in later stages of pregnancy.

Delivery service is not provided in any of the sub-centres even after clear and broad provisions in IPHS.[11] The beneficiaries, no doubt, are ready to get delivery facility at sub-centre if all the facilities will be made available in the sub-centre along with a fully trained health worker with much needed help of TBA . Many of the Sub center can be developed to conduct deliveries if the female health workers are supported by the community and have committed referral system. If we can do so, it can be a great achievement.

Postnatal services are considered to be of great value in reducing both MMR and IMR and must be given with greatest interest and sincerity.[12] But, this component of MCH was not given due importance both by health workers and postnatal women. This component needs to be strengthened for better delivery of health services.

The crunch of health workers, both male and female, could widely be seen in our sub-centres. Female health workers, who are fully trained in their work stay at one centre from one to three years and are transferred before they are able to build rapport with the people, thus they always remain under severe pressure. Female health workers, who have been provided official residential accommodation in the sub-centre, do not stay in the sub-centres for various reasons. The works of AWW & TBA who are the local residents of that area are highly appreciated by the participants.

Supervision remains the weakest link in our primary health services. There is dearth of health supervisors (both male and female). There are no fresh appointments after the retirement existing staff. Our medical officers seldom visit sub-centres. Both the above factors make our sub-centres orphans. In our opinion, a visit to sub-centre by a medical officer weekly or biweekly may serve dual purposes of screening high risk cases and supervision.

Geriatric population has always been neglected when we talk about the primary health services. There must be provision of medicines, tonics, vitamins and pain killer gels for people in their second childhood.

Awareness and knowledge about the available primary health services at the sub-centre is still very low among the rural masses and reflects our failure in imparting proper health education. The use of right media in spreading health awareness to the rural people is still questionable and poses a great challenge because these days' people are least interested in national or state controlled radio or television channels but in private channels and thus the whole presentation of health related advertisements remain ineffective.[13]

Social issue of caste and creed is still prevalent, though not very fulminate, and affecting the delivery of health services to some extent. Cultural beliefs and taboos still pose hurdles in availing health care facilities in some regions and the first preference of people are still local deities and traditional healers.

Political commitment toward health is still an issue of concern at local governance level and also at state governance level. The members of PRI institutions must be sensitized in such a manner so that they appreciate health issue well and consider it at par with other issues.

The mechanism of intersectoral coordination remains obscure as there is gross lack of coordination between functionaries of various sectors and health sector. Presently, there is negligible integration among the health sector and other related sectors.

All these sectors must be made accountable to each other which may improve their functioning. Undoubtedly the great coordination among health workers and AWWs is the best example of cooperation in delivery of health care services.

Recommendation

Intersectoral coordination holds the key to universal access to primary health care according to the most of the participants. For example if Health Worker Male and IPH worker work together to disinfect water and make people aware of the facts to reduce the burden of water borne diseases. Similarly FHW, AWWs, and TBA work need to be linked and supported by medical officers.

Community members/ groups/organizations and service providers should be brought together, and a system for developing service delivery guidelines, making decisions, setting priorities, planning activities and monitoring progress together should be developed.

Many sub centers need to be constructed again to empower female health worker to stay and work there. Location of the subcentres should ensure the safety and privacy. Many of the Sub centers can be strengthened to conduct deliveries if the female health workers are supported by committed referral system and the team of doctors especially in tribal areas. Telemedicine could be of great help in these areas. Scope of the services need to be widened for geriatrics and disabled. Introducing mobile medical vans in the rural areas can solve the problem of accessibility. Mobile vans equipped with basic medical facilities could supplement a primary health centre and travel to those areas where the primary health centers do not exist.

Sustained socio-political commitment and Periodical supportive supervision need to be strengthened to improve the efficiency and quality of the services.

CONCLUSION

To conclude people in the rural areas clearly acknowledge the utility of primary health care services at sub centers. Knowledge and past experiences of family members play a key role in health seeking behavior of village people, which is further dependant on many factors such as literacy, socioeconomic conditions & family and community dynamics. Sustained socio-political commitment, intersectoral co-ordination and constant supervision need to be embedded in the primary health care delivery system, which may direct the pathways of service delivery according to the local community needs.

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