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Research Article

KNOWLEDGE OF PRIMARY HEALTH CENTRE SERVICES, ITS UTILIZATION AND BARRIERS FOR UTILIZATION AMONG ADULTS IN SELECTED AREAS AT MANGALURU

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ABSTRACT

Health is a best condition for happiness and progress in the life of an individual as well as a community. Every human being is responsible for his own health. In humans it is the ability of individual or communities to adapt and self- manage when facing physical and mental and social challenges (Gulani, 2006). The World Health Organization (WHO) defines Health as its broader sense in its 1948 constitution as "a state of complete physical, mental, social and spiritual wellbeing and not merely in the absence of disease or infirmity" (Park, 2011).

The Primary Health Centre is the basic structural and the functional unit of the public health services in developing countries. PHC's were established to provide accessible and available primary health care to the people, in accordance with the Alma Ata Declaration of 1978 by the member nations of the World Health Organization (IPHS).

The Medical Officer appointed to run the PHC must be a MBBS degree holder. In addition to provision of the diagnostic and curative services, the Medical Officer is the primary administrator of the PHC. The primary staff, who provide outreach services, are called 'ASHA (Accredited Social Health Activist)' depend on the Indian state where the PHC is located (IPHS).

A non-experimental descriptive design were adopted. Data were collected from purposively selected 100 adults from Bagambilla Community, Mangaluru, using structured knowledge questionnaire. The result revealed that majority (68%) of adults had average knowledge, 23% had poor knowledge and 9% had good knowledge regarding Primary Health Centre Services. So the study indicates Average knowledge among adults and it varies with demographic variables.

INTRODUCTION

Health is the level of functional or metabolic efficiency of living organisms. Health is a best condition for happiness and progress in the life of an individual as well as a community. Every human being is responsible for his own health. In humans it is the ability of individual or communities to adapt and self-manage when facing physical and mental and social challenges. Primary health care is defined as the: 'Essential health care made universal and available to individuals and acceptable to them, through their participation and at the cost of the community and country can afford'. Health is that balanced condition of the living organisms in which the integral and harmonious performance of the vital functions tends to the preservation of the organisms and the normal development of the individuals (Park, 2011).

The Indian health care system has serious problems with safety and quality that can be reduced by quality improvement activities. On effective way to attack these problem is through the method of quality improvement. Government responsibilities to protect and advance the interests of society include the delivery of good quality health care because the market alone could not ensure all Indians access to quality health care (Tang, Eisenberg and Meyer, 2004).

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The government must preserve the interests of its citizen by supplementing the market where there are gaps regulating the market where there is inefficiency or unfairness. The ultimate goal is to achieve the high quality of care will require strong partnerships among federal state, the local governments and private sector. Translating general principles regarding the appropriate roles of government into specific actions with a rapidly changing decentralized delivery system will require the combined efforts of the public and private sectors (Tang, Eisenberg and Meyer, 2004).

The practice of public health has been dynamic in India and have witnessed many hurdles in the attempt to affect the lives of the people of this country. Since Independence major community health problems like Malaria, TB, Leprosy, high maternal and child mortality and lately Human Immunodeficiency Viruses (HIV) has been addressed through a concerted action of the government (Lakshminarayan, 2011).

A typical Primary Health Centre cover the population of 20,000 in hilly, tribal or difficult areas and 30,000 populations in plain areas. It act as a referral unit for 6 sub centers and refer out cases to Community Health Center, 30 bedded hospital and higher order public hospital located at sub district and district level. Due to over emphasis on preventive programs especially family planning, the Primary Health Centre's quarantine role has been neglected and weakened. There was no monitoring of how many patients come to the Primary Health Centre and what treatment they get. Currently Primary Health Centers are the seal by the community as a place of sterilization, immunization and malaria treatment. Because of various problems in the Primary Health Centre system including non-availability of doctors and medicines, poor quality of services and indifferent human interactions they have lost credibility in the community (Singh, 2011).

In the developing and developed countries many rural individuals travel substantial distances for primary medical care and requiring significantly longer travel times to reach rural than the urban counter parts. Rural areas are having more population compared to the urban area. But the health services are more in urban area so there is a need to improve health services in rural areas (Chandramouli, 2011).

MATERIALS AND METHODS

A non-experimental descriptive design was adopted for the study. 100 adults in Bhagambilla community at Mangaluru were selected by using non-probability, purposive sampling technique. Data collection were done by using demographic proforma and structured knowledge questionnaire. The content validity of the research tool was established by the help of experts from the related field. Reliability of the tool was established by the split half method. The reliability was found to be 0.71 which indicated that the tool was reliable. Pilot study was conducted on 19th June 2016 among 10 adults in Kinya community, Mangaluru. After analysis of the data of the pilot study, found that the study was feasible.

The researcher obtained permission from the respective authority of the Primary health centre, Kotekar. Informed consent were obtained from the participants and data collection was done on 19-24th June 2016. The data is analyzed by both the descriptive and the inferential statistics.

RESULTS

Demographic characteristics of the adults

The findings of the study demonstrates that 100 adults were surveyed, a vast majority of subjects (40%) were in the age group of 31-40 years, maximum number of subjects (80%) were females, many of the subjects (64%) were Muslims, most of the subjects (48%) were living in joint family, about (27%) were employed in private sector, most of the subjects (45%) were educated up to primary school, about (45%) had a family income between Rs. 8,001-10,000 and about (27%) had information about Primary Health Centre Services through mass media.

Level of knowledge regarding PHC Services

Findings of the study revealed that 23% of the adults had poor knowledge, 68% had average knowledge and 9% adults had good knowledge.

Table 1 Frequency and percentage distribution of subject according to the level of knowledge

Level of knowledge	Scores	Frequency (f)	Percentage (%)
Poor	1-9	23	23%
Average	10-19	68	68%
Good	20-29	9	9%

Level of utilization regarding PHC Services

Findings of the study showed that 1% of adults had poor utilization, 92% had average utilization and 7% had good utilization.

Table 2 Frequency and percentage distribution of subjects according to the level of utilization of Primary Health Centre Services

N=100

Checklist for utilization	Score	Frequency (f)	Percentage (%)
Poor	1-9	1	1%
Average	10-19	92	92%
Good	20-28	7	7%

Level of barriers regarding PHC Services

Findings of the study found that 18% of the adults had poor barrier for utilization, 80% had average barrier and 2% had good barrier for utilization.

Table 11 Frequency and percentage distribution of subjects according to the level of barriers for utilization towards Primary Health Centre Services

Checklist for barriers for utilization	Scores	Frequency (f)	Percentage (%)
Poor	1-11	18	18%
Average	12-21	80	80%
Good	22-31	2	2%

Association between level of knowledge and the selected demographic variables

Findings of the study revealed that there was no association between the knowledge scores and the demographic values, age x^2=0.160, table value x^2=3.84; p<0.05, gender x^2=0.693, table value x^2=3.84; p<0.05, religion x^2=0.186, table value x^2=3.84; p<0.05, education x^2=0.909, table value x^2=3.84; p<0.05, occupation x^2=0.136, table value x^2=3.84; p<0.05, source of information x^2=0.625, table value x^2=3.84; p<0.05. There was no association between the knowledge scores and the demographic values.

Correlation between knowledge and utilization

Findings of the study revealed that the correlation between knowledge and utilization was 0.108, which suggest that there was a negative correlation between them.

Correlation between knowledge and barriers

Findings of the study revealed that the correlation between knowledge and barriers was 0.056, which suggest that there was a negative correlation between them.

Correlation between utilization and barriers

Findings of the study revealed that the correlation between utilization and barriers was 0.353, which suggest that there was a positive correlation between them.

DISCUSSION

Findings of the study found that 9% of the adults had good knowledge, 68% had average knowledge and 23% adults had poor knowledge.

The following study support the findings of the current study. The study is conducted by Gupta A, Chellaiyan V, Lohiya A, Rizwan SA, Upadhyay RP, Palanivel C in rural Puducherry, South India. To assess the knowledge on distribution and burden of diseases in the community is essential for planning of public health services. A total of 68,818 episodes of illness are treated. This knowledge would help in planning health services to meet the patients needs and also helps in training health staff (Gupta *et al*, 2014).

In the study found that 92% of the subjects had average utilization followed by 7% of the adults having good utilization and 1% had poor utilization of Primary Health Centre Services.

The findings were consistent with the study of Mahfouz AAR, Hamid AM, which is conducted in Abha, Saudi Arabia, among the 227 families, 1443 persons attending the Al-Mahal primary health care centre during August 1991. Summer visitors added an excess load on Primary Health Centre services, 1.8% for the preventive activities, 3.3% for the diagnostic activities and 17.4% for the curative activities (Mahfouz and Hamid, 1993).

In the study found that 80% of the subjects had average barrier for utilization, 18% had poor barriers and 2% had good barrier for utilization.

The following study support the findings of current study. The study is conducted by Anitha CV, Dr. Thimmaiah N to investigate the accessibility of Primary Health Centre services in kadakola, Mysore district. The reason for not accessing PHC services in the study area are recognized as income level, distance and educational level. The distance to the PHC is found as a major determinant to the access of health care services from the PHC, as it is found to be significant at 10% level (Anitha and Thimmaiah, 2013).

Analysis of association between the level of knowledge and selected demographic variables exposed that there was no association between the level of knowledge and age, gender, religion, type of family, occupation, education, income of family and source of information regarding Primary Health Centre Services (p>0.05).

A study is conducted to assess the effectiveness of the Computer assisted teaching programme regarding knowledge on available health services at the PHCs among the ASHA workers in the selected PHCs of Holenarasipura. Data collected from 50 ASHA workers by using simple random sampling technique. Analysis of the data shown relationship between age and knowledge of PHC (chi-square 6.49, p<0.05) and relationship between education and knowledge of PHC (chi-square 9.28, p<0.05). The study concluded that there is significant association between the pre test and the post test knowledge scores and there selected demographic variables (Nithyashree and Saraswathi, 2015).

Findings of the study revealed that there was a negative correlation between knowledge and utilization.

Findings of the study revealed that there was a negative correlation between knowledge and barriers.

A study is conducted in Southern regions in Ghana involving 64 primary health facilities. Spearman's rank correlation test was used to found associations between perceived and technical quality care proxies in health facilities. Negative association is found between technical quality and client-perceived quality care (p< 0.0001) (Alhassan *et al*, 2015).

Findings of the study revealed that there was a positive correlation between utilization and barriers.

A study is conducted by Majumder A, Upadhyay V to analysis of primary health care system in India with the focus on reproductive health care services. Positive correlation is found between utilization of services and doctors, education rate, population density and quality of care (Majumder and Upadhyay, 2004).

CONCLUSION

The findings of the study illustrate that nominal number of adults are having average knowledge on Primary Health Centre Services and which indicates that there is a lack of adequate knowledge. Thus, the health education programs are required to enhance the knowledge regarding Primary Health Centre Services among adults in community areas. The best place to impart education is rural community. Nursing students, peer group and health personnel could be motivated to conduct educational programs. Governmental and non-governmental organization

should take initiation to create awareness regarding Primary Health Centre Services. In addition to this, further researches can be conducted to cover other community areas and different part of country in terms of knowledge, utilization and barriers for utilization towards Primary Health Centre Services.

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