Attitude of Rural People in Puducherry Area Towards Primary Health Care Centre

G. Kumar & T.R. Jeyaraaj

Language in India www.languageinindia.com **ISSN 1930-2940 Vol. 13:7 July 2013**

Abstract

This paper is a part of doctoral research outcome, which traces the rural area people attitude towards primary health care Centre in Puducherry area. For this research the investigator collected 200 rural area people by simple random sampling technique. The sample consist various sub samples and due proportionate weight was given. The findings of the study reveal that 61% of the rural area people are not having favorable attitude towards primary health care Centres and 39 percent of rural area people are having favourable attitude towards rural primary health care centres. The sub samples selected for the present study based on general factor and economic factors do not differ significantly in their attitude towards Primary Health care Centres except family and house type.

Key words: Health care, cost.

Introduction

Primary health care has emerged as the leading strategy for meeting needs in developing countries. It offers the possibility of good access to the most cost- effective forms of intervention, even in the poorest countries. The term "Primary health Care" in part replaces the earlier term "basic health services" but is a much wider concept. The ideas for much of the new model of care are derived from an assessment of community health needs. The approach places emphasis on several activities that are not physician-centered, such as health education, preventive activities, family health care (including family planning), and use of indigenous health workers. Primary health care includes following elements (1) Community participation, (2) Universal coverage and accessibility, (3) Appropriate health technology, and (4) Care by community health workers or by traditional health workers.

Since 1975 WHO and UNICEF have actively promoted the notion of Primary Health Care (PHC) and the reassessment of health priorities and policies. National and regional meeting on PHC were scheduled by WHO and by other groups interested in health policy in order to develop background materials and to scrutinize ideas prior to the International Conference on Primary Health Care in 1978. These meeting expanded interest and discussion on alternative approaches to meeting health needs and developed the base of professional and political support necessary to effect a major shift in national health policies. The conference was the largest and most authorities international meeting on health care ever convened. It was attended by representatives of the ministries of health and of finance or planning from 134 countries. Delegates from 64 United Nations organization, specialized agencies and non-governmental organizations also participated. The conference unanimously human right and those governments should pursue policies to provide accessible, affordable, socially relevant health care to all. The Declaration's definition of primary health care stressed the need to adopt simple technologies, to promote broad public participation in the planning and operation of health care, and to expand the concept of health care to include not only personal health services and mass disease control but also nutrition, sanitation, water supply, family planning, and health and hygiene education.

Organization of Primary Health Care at Village Level

Primary health care is targeted primarily on the rural and semi-urban poor. As such, it represents only a modest threat to the economic and professional interests of the health professions; demand for their services in relatively wealthy, urban areas is likely to continue to outstrip supply for some time. Primary health care may even reduce pressures on organized by expanding effective supply in the under-served areas.

However, the absence of well-developed political mechanisms at the village level is also the major obstacle to implementation of primary health care. Much of the area to be served has no effective representation from or to government. Thus the administrative machinery for supervising staff and monitoring the distribution of materials and supplies does not exist. Supply depots, maintenance facilities, and transport are also lacking. The most serious deficiency,

however, is the lack of a responsive local constituency for health care. Because poor communities have received little attention from government in the past, they have not yet evolved leadership and organizations through which to express their priorities or dissatisfaction to public officials. Thus programs may not be responsive to needs recognized by the community. Moreover, a program may not be accepted as a legitimate solution to acknowledge problems, and/or accountability may not be maintained. It seems clear that sustained oversight of programs must come from the community, since over-the-shoulder formal supervision by the bureaucracy of ten is not practical.

Implications

The primary health care movement has developed a broad professional and bureaucratic constituency for accessible, low-cost health care. The resistance to simplifying health care technology seen earlier among the health professions and health bureaucracies has been neutralized, and in some instances reversed. Moreover the very vigorous support of WHO and UNICEF has given the movement professional legitimacy.

The major accomplishment to date has been to influence the politics of health in the direction of greater social justice, rather than merely to produce a call for greater budget allocation of additional external assistance to the sector. However, the task of translating the principles of primary health care into workable programs of training and service delivery has only begun. Almost no effort has been spent in developing strategic programs for implementing desirable changes.

Objectives

The investigator framed the following objectives for the present study.

1. To find out the level of attitude of rural peoples towards Primary Health care Centres.
2. To study the socio economic characters of sample respondents.

Hypotheses

The investigator of the present study framed the following hypotheses based on the objectives.

1. The attitude of rural peoples towards Primary Health Care Centres is favorable.
2. There is no significant mean difference between the socio-economic characters of sample respondents.

Methodology

The present investigation has been undertaken by using normative survey as a method. The survey method gathers data from a selected sample number. The present study consists of 200 rural area people in Puducherry District. The sample was selected by using simple random sampling technique. The sample forms a representative sample of the entire population. In this present investigation the following statistical techniques have been used. Descriptive analysis - Measures of central tendency (Mean), Measures of variability (Standard Deviation), Differential Analysis - Independent sample's and 'F' test.

Description of Attitude towards Primary Health Care Centre Scale

One of the main objectives of the present investigation is to find out the attitude of rural area people towards primary health care centre and also to find out whether there is significant difference between the selected pairs of sub-samples with respect to attitude towards primary health care centre. For this, there is no suitable tool available. So, the investigator decided to construct and validate one in order to realize the objectives framed. The attitude scale consist of 25 items and each item in this scale set against five responses viz., "Strongly Agree", "Agree", "Undecided", "Disagree" and "Strongly Disagree". The maximum score for this scale is 125 and the minimum is 25. The average time required for complete this scale is 20 minutes. The score above 84 indicates favourable attitude and the score below 84 indicates unfavourable attitude towards primary health care centres.

Analysis and Interpretation of Data

The data collected was analyzed with the help of SPSS software and it is given in the following tables. The calculated mean score of total sample is found to be 77.50 and the S.D.

value is 17.62. The calculated mean value is less than the percentile 50 (84). Therefore the rural area people in Puducherry area are having unfavourable attitude towards Primary health care centres. It may be due to the lack of facilities and poor service in this area.

Table 1: Analysis of Attitude Scores of Rural People Based on their General Status of Different Sub-Samples

S. No.	Variable	Sample	N	Mean	S.D.	Critical Ratio Value	Level of Significance
1	Gender	Male	76	78.05	19.5	0.33	Not Significant (P= 0.742)
		Female	124	77.16	16.4		
2	Age	Up 20 years	40	75.95	18.8	0.598	Not Significant (P= 0.551)
		21 to 40 years	81	76.65	15.8		
		40 to 60 years	79	79.16	18.7		
3	Education	Primary	39	81.12	16.8	1.17	Not Significant (P= 0.312)
		High School	107	77.15	18.4		
		Diploma/ Others	54	75.57	16.3		
4	Occupation	Daily Wages	35	82.71	16.9	1.96	Not Significant (P= 0.143)
		Private	104	75.94	17.0		
		Self-employment	61	77.18	18.6		
5	Community	BC	28	73.07	14.2	1.10	Not Significant (P= 0.334)
		MBC	84	77.70	16.7		
		SC/ST	88	78.72	19.3		
6	Family Type	Nuclear	112	73.52	19.3	3.87	Significant (P= 0.000)
		Joint	88	82.56	13.7		
7	Marital Status	Unmarried	63	74.25	18.1	1.74	Not Significant (P= 0.084)
		Married	137	79.00	17.2		
8	House Type	Thatched	81	79.21	16.7	3.30	Not Significant (P= 0.039)
		Tiled	60	72.70	19.6		
		Concrete	59	80.05	15.8		
9	Entire Sample		200	77.50	17.6	-	-

Note: Sub-samples more than two analysis of variance (F test) used and other t test used. The calculated mean scores of different sub samples under general category fall between 72.00 and 82.71. These values are less than the percentile value 50 of the attitude scale value 84.

Hence, it is inferred that rural area people in Puducherry area irrespective of sub samples under general category have unfavourable attitude towards Primary health care centres.

The calculated mean scores of different sub samples under economic status fall between 74.18 and 80.46. These values are less than the percentile value 50 of the attitude scale value 84. Hence, it is inferred that rural people in Puducherry area irrespective of sub-samples under economic status have unfavourable attitude towards Primary health care centres.

The calculated "t" and "F" values of general status are found to be 0.33, 0.598, 1.17, 1.96, 1.10, 3.87, 1.74 and 3.30, respectively, for gender, age, education, occupation, community, family type, marital status and house type. These values are not significant at 0.05 levels except family type and house type. Hence, it is inferred that rural area people under family type and house type differ significantly in their level of attitude towards primary health care centres but the reaming samples do not differ significantly in their attitude towards primary health care centres.

The calculated "t" and "F" values of economic status are found to be 0.03, 0.14, 0.19, 2.01 and 2.05 respectively for household wealth, annual income, annual expenditure, annual savings and annual barrowing. These values are not significant at 0.05 levels. Hence, it is inferred that rural area people under family type and house type differ significantly in their level of attitude towards primary health care centres.

Table 2: Analysis of Attitude Scores of Rural People Based on their Economic Status of Different Sub-Samples

S. No.	Variable	Sample	N	Mean	S.D.	Critical Ratio Value	Level of Significance
1	Household Wealth	Upto 1,00,000	102	77.76	18.6	0.033	Not Significant (P= 0.968)
		1,00,001 to 2,00,000	70	77.07	16.7		
		Above 2,00,000	28	77.64	16.7		
2	Annual Income	Upto 12,000	65	78.46	18.0	0.142	Not Significant
		12,001 to 48,000	84	78.98	17.0		

		Above 48,000	51	77.13	18.2		(P= 0.868)
3	Annual Expenditure	Upto 12,000	54	76.27	15.5	0.197	Not Significant (P= 0.821)
		12,001 to 48,000	107	78.13	18.0		
		Above 48,000	39	77.48	19.3		
4	Annual Saving	Upto 10,000	60	80.46	18.2	2.01	Not Significant (P= 0.136)
		10,001 to 25,000	94	77.54	17.2		
		Above 25,000	46	73.06	17.0		
5	Annual Barrowing	Upto 25,000	63	80.61	14.5	2.05	Not Significant (P= 0.131)
		25,001 to 50,000	78	77.50	19.0		
		Above 50,000	59	74.18	18.3		
6	Total Sample		200	77.50	17.6	-	-

Note: Sub-samples more than two analysis of variance (F test) used and other t test used

Summary of Findings

The hypotheses formulated at the beginning of the study have been examined in the light of the data gathered. The following are the main findings of the present investigation.

1. Rural people in Puducherry are having unfavourable attitude towards primary health care centres.
2. The sub samples of gender, age, education level, occupation, community and marital status of rural area people under general status do not differ significantly in their attitude towards primary health care centres.
3. The sub samples of family type and house type of rural area people under general status differ significantly in their attitude towards primary health care centres.
4. The sub samples of household wealth, annual income, annual expenditure, annual savings and annual borrowings of rural area people under economic status do not differ significantly in their attitude towards primary health care centres.
5. The attitude level of joint family system is better that the nuclear family system.
6. The attitude level of thatched and concrete sample is better than their counterpart.

Recommendations

The present study gives a clear-cut view about people attitude towards primary health care centres in rural area at Puducherry. Based on the important findings stated earlier the following recommendations were made.

1. Rural area people in Puducherry are having unfavorable attitude towards primary health care centres. So, the facilities in PHC should be improved for the needs of the rural area people in the study area.
2. The sub samples of gender, age, education level, occupation, community and marital status of rural area people under general status do not differ significantly in their attitude towards primary health care centres. So, the policy frame workers should consider these variables while planning to improve the status of PHC in this area.
3. The attitude level of joint family is better than the nuclear family. It may be due to the economic status of the people the study area.

==========

Select References

1. Alastair Ager and Katy Pepper, (2005) **Patterns of health service utilization and perceptions of needs and services in rural Orissa.** Health Policy Plan., May 20: 176 - 184.
2. Varm .G.R and B.V. Babu, (2007), **Contraceptive Services of the District Health System in Tribal and Rural Areas of Visakhapatnam District, Andhra Pradesh.** Journal of Health Management, 9: 399 - 419.
3. Kumar.G and Arunkumar (2012), Health status of children: with special reference to urathur village keerapalayam block Cuddalore District, unpublished M.A thesis Annamalai university Annamalai nagar.
4. Government report (2012), Statistical Hand Book published by Economic and Statistical Department of Puducherry.
5. Babu,S.K (1994), Health Problems and Health Care of the Tribal Population of India in: Tribal Economy, Health and Wasteland Development. Ed. N.Mahanti, Inter-India Publications, New Delhi, p.137
6. Gopal Chandra Mandal and Kaushik Bose (2010), Undernutrition among the Rural Preschool Children (ICDS) of Arambag, Hooghly District, West Bengal, India, using

New Head Circumference Cut-Off points. International Journal of Current Research 10:7-11.

==========

G. Kumar, M.A., M.Phil., Ph.D.
Assistant Professor
Department of Economics
Annamalai University
Annamalai Nagar 608002
Tamilnadu
India
drkumarau@gmail.com

T. R. Jeyaraaj, M.A. (Economics), M.A. (Development Studies), M.A. (Sociology) M.Phil. (Economics), Ph.D.
Professor
Department of Economics
Annamalai University
Annamalai Nagar 608002
Tamilnadu
India
trjeeyaraj@yahoo.com