Original Article

Community perspectives on primary health centers in rural Maharashtra: What can we learn for policy?

Sudha Ramani[1], Muthusamy Sivakami[2]

[1]School of Health Systems Studies, Tata Institute of Social Sciences, [2]Center for Health and Social Sciences, School of Health Systems Studies, Tata Institute of Social Sciences, Mumbai, Maharashtra, India

Abstract

Introduction: Primary Health Centers (PHCs) are intended to be the "backbone" of the Indian public health system. Yet, these do not get utilized as frontline institutions for basic curative care. As we embark on comprehensive primary health care initiatives, it is important to understand people's perceptions on PHCs; and design services that cater to their felt needs. **Aim:** In this paper, we examine explanations that communities give for the use or bypass of PHCs. From these perspectives, we derive some policy directions for improving basic curative care services at PHCs. **Methods:** This qualitative study is based on data from 14 Focus Group Discussions in a rural area in Maharashtra in the catchment area of 8 PHCs (total 91 community participants). The discussions were coded and analyzed thematically with the aid of a qualitative software. **Results:** PHCs were not viewed as first-access points for health care, though these were valued for specific services. The limited use of PHCs was attributed to the lack of availability of drugs/services of perceived relevance to communities; prevalent healing norms that mismatched with PHC services; doctor-patient interactions that were colored with mistrust; and widespread poor opinions of public-sector services in health. **Conclusions:** Currently, there seems to be little in the design of PHC services- that appeals to the "felt" needs of communities. Thus, the proposed Health and Wellness Centers (HWC) initiative resonates with people's expectations. In addition, staff at the periphery must provide "attentive" care and be prepared to contend with pre-existing poor expectations of care.

Keywords: Community, health and wellness centers, primary health centers, qualitative

Introduction

The rural public health system in India has a three-tiered, pyramidal structure-consisting of primary, secondary and tertiary care.[1,2] A well distributed network of Primary Health Centers (PHCs) and its outreach teams are intended to form the "backbone" of this pyramidal structure and be connected to specialty care through seamless referral mechanisms.[2] PHCs are also considered as first-access points of patients to allopathic doctors within the public system.[3] Hence, these centers are intended not only for the provision of "preventive" services, but also for primary-level clinical care.[2-4]

Address for correspondence: Ms. Sudha Ramani, School of Health Systems Studies, Tata Institute of Social Sciences, Mumbai - 400 088, Maharashtra, India.
E-mail: sudha_ramani@yahoo.com

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However, in reality, Primary Health Centers (PHCs) are fraught with many infrastructural and human resource lacunae.[5-7] These centers have been reduced to operationalizing a few national programs.[4,8] PHCs currently, do not get utilized as "frontline" institutions for basic curative care. Care for routine, "day-to-day" ailments in rural India is mostly sought by communities from the private sector; and often in the hands of informal (and sometimes untrained) health practitioners.[9,10] An analysis of the National Sample Survey (NSSO) data 71st round 2014 showed that while 28% of healthcare is accessed from the public sector, only 11.5% happened at primary-care level.[11] This brings us to the question—how do we then design PHCs that cater better to the primary-level, curative care needs of the population?

In this paper, we examine explanations that communities give for the use or bypass of PHCs. In addition, we look at community

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expectations of care from PHCs. From the above perspectives, we derive some policy directions for improving basic curative care services at PHCs.

In another recently published paper, a historical document review of PHCs in India has been combined with field perspectives—to highlight some constraints that PHCs face.[8] However, a detailed account of community perspectives on PHCs merits a stand-alone discussion. The strength of this paper is in trying to capture perspectives of the community on PHCs beyond generic lamentations of poor infrastructure. Such an account of community perspectives has current relevance because, under the recent Ayushman Bharat healthcare initiative, there has been a move towards strengthening and converting PHCs and their outreach centers (sub-centers) to "Health and Wellness centers (HWCs).[12,13] These converted centers are intended to deliver comprehensive services close to the community, including care for non-communicable diseases[14] Indeed, there has been recent emphasis on designing comprehensive, "futuristic" models of primary health care in international as well as Indian forums.[15,16] At this juncture, it is important to examine if community expectations from PHCs resonate with the above-proposed policy directions.

Methods

This qualitative study is based on data from a rural area in Maharashtra[1]. Maharashtra is the third largest state in India and does better than Indian averages on indicators such as female literacy, IMR and MMR.[17] The state has good health infrastructure and a strong network of PHCs[2,17]—hence in this study, we could move beyond generic expositions of infrastructural handicaps at PHCs.

Between April-September 2018, we held 14 Focus Group Discussions (FGD) with rural communities (total 91 participants) in the catchment area of 8 PHCs. We used principles of maximum variation sampling to select places for doing FGDs in the community (See Tables 1 and 2). Permissions for the FGDs were sought beforehand from the local self-government head; and informed consent was taken from all participants. Recruitment of persons for FGDs was done through an experienced social worker. A topic guide was used to introduce themes into the discussion. Basic demographic information—age, education, marital status, and caste—was also collected from the FGD participants.

FGDs were recorded and translated verbatim into English before analysis. The analysis of the FGDs consisted of interpreting "explanatory sets" of statements made by different people, to identify recurrent themes that constituted a groups' beliefs and ideas. For analyzing the data, we used the three steps suggested by Miles and Huberman—data reduction (reading and summarizing the data), data display (arranging it in a logical manner) and drawing conclusions.[18] The software Nvivo 12 was used for aiding the qualitative coding process.

Ethical review statement: Ethical approval for the study was taken from the Institutional Review Board at the Tata Institute of Social Sciences, Mumbai, India, in April 2018.

Table 1: Selection of location for Focus Group Discussions (FGD)

	FGD3	FGD4	FGD5	FGD 12,13	FGD1,2	FGD6	FGD7	FGD 8,14	FGD 11	FGD9	FGD10
Block	BLOCK 1: Remote block, very far from district headquarters and tertiary care facilities (around 60-75 km). Access to district headquarters/highway difficult				BLOCK 2: Far from district headquarters (> 40 km) but has a private medical college-non-profit hospital accessible (10-30 km). Connections through highway easy.					BLOCK 3: Very close to district head- quarters and government district level hospital	
PHC description*	PHC 1: Block PHC intended to have better facilities, full staff, good PHC. Old.		PHC 2: New, Average PHC	PHC 3: Average, Old PHC	PHC 1: Average PHC, full staff, Old.	PHC 2: Good PHC, full staff present. Relatively new PHC (<10 years)			PHC 3: Average, Old PHC	PHC 1: Good, Old PHC	PHC 2: Average, New PHC
Location of PHC	Block PHC close to highway,		Far from highway	Far from highway	Close to highway	Remote, far from highway				Close to town	Close to town
Distance of FGD location from PHC	7 km, remote	Same village,	Same village	3 km	Km but transportation available	5 km	4 km, highway to cross for access	<1 km	10-12 km	Same village	3 km
Private doctors	3 km, but doctors do home visits.	1 km	Same village.	3 km	6 km	5 km	Private doctors on the same side of the highway	Same village	Same village	Town	Town
Gender M-Male F-Female	Mixed	Mixed	Mixed	FGD 12: F FGD 13: M	FGD 1: M FGD 2: F	Mixed	Mixed	FGD 8: Mixed FGD 14: F	Mixed	Mixed	Mixed

*Description of PHC is based on discussions with health system staff and social workers (since the field realities were different from official documentation on these centers)

Findings

Community health seeking patterns and the role of PHCs

During our discussions, we found that people wanted PHCs to be "good small hospitals" for "small ailments". There was an understanding that PHCs were "small" and hence, these centers could not help with complicated health issues. So, people did not expect staff at PHCs to treat all ailments. However, there was a shared perception that even with regard to "small ailments", the treatment given by PHCs was lacking in many ways.

Table 2: Information about participants in the study

Category	Numbers	
Total number of FGDs	14	
Number of participants per FGD	5-12	
Total participants	91	
Gender	Males: 40 Females: 51	
Religion and caste*		
Other backward classes	43	
Scheduled castes	19	
Nomadic tribes	10	
Muslims	8	
Forward castes	8	
	Males	**Females**
Age (years)	46.7±15	45.3±15
Education		
No school	2	19
Primary	5	13
High School	15	14
Graduate	18	5
Marital Status		
Married	33	49
Unmarried	7	-
Widowed	-	2

*3 data points missing

Our community discussions revealed the following about utilization of PHCs:

- For the treatment of what people called as "small ailments" like cold, cough, fever, generic pain, and skin infections, people reported mainly going to local private practitioners. Hence, PHCs were not considered as "first" access providers for most routine ailments
- However, our discussions also revealed that for specific requirements like tubectomy or for treatment after animal bites; or for the treatment of diseases such as malaria or tuberculosis, PHCs were acknowledged as important; in fact, a slight preference for PHCs was reported in these cases. (Table 3 summarizes why people preferred PHCs for these services.)
- People decided, mostly based on their prior experiences, severity and duration of an ailment whether it was a "big" one. For ailments considered as "big", people reported seeking care at the district hospital or at a non-profit hospital-and bypassing PHCs. In other words, people generally did not think of PHCs as entry points into the health system
- During pregnancy, women said that they registered for antenatal care at PHCs and used its immunization services. But for delivery, the district hospital (or another non-profit hospital) was reported as preferred
- For non-communicable diseases such as diabetes or hypertension, care-seeking behavior was unclear; some people reported accessing private practitioners if their budgets allowed. A few people reported getting stocks of long-term drugs from the district hospital; but these drugs were reportedly consumed for as long as stocks lasted and refilled at irregular intervals. We also found case-instances

Table 3: Community perspectives on why people preferred PHCs for certain services

Service	Reported reasons for accessing these services at PHCs
Family planning (Tubectomy)	- PHCs had a good reputation historically of doing tubectomy - These services at the PHC were reputed to be even better than that of the private sector, even while costing nothing. (Incentives were given for tubectomy) -Regular camps were held for performing the operations. Women were picked up from their houses, dropped back, and given meals. - PHC doctors were considered as "experts" in conducting the family planning operation since he had a lot of practice. Sometimes additional experts were called in to supervise. -All records on family planning were kept well. -There was no waiting period at the PHC for performing the operation.
Animal bites vaccination	- Things had "always been that way" and everyone today knows that government hospitals are the best place for the treatment of animal bites. -Private practitioners usually did not have the vaccines or the drugs to deal with animal bites; these were available only with the government doctors. Even when people went to private practitioners for the treatment of animal bites, they were directed to the government facilities. -Government hospitals dispensed drugs and vaccinations after animal bites free-of-charge.
Immunization for children and pregnant women	People reported that they did not want to spend money on vaccinating children and pregnant women from the private sector, when it was available free of cost at PHCs, sub centers and during outreach camps. (Immunization was not really a "felt" need of the community, it was just a service that was taken from PHCs.)
Seasonal diseases like Malaria, Dengue and Chikungunya	- PHCs were believed to work on preventive issues for the above diseases and people had seen advertisements regarding these diseases at the PHCs - PHC had strong drugs for these diseases, which resulted in quick recovery of patients.

of people who had discontinued drugs without medical supervision.

These reported health-seeking patterns highlight the following. First, people shared that private practitioners—and not the public primary care system—served as first-access points for healthcare. Second, for certain select services, PHCs were considered as good options. Third, people did not think of PHCs as "gate-keepers" and reported that they accessed higher tiers of the system directly. Lastly, people often shared instances of hopping between providers—public and private. All this speaks to an attenuation of the intended roles of PHCs as providers of good primary-level clinical care.

How do communities explain their limited use of PHCs for basic curative care?

In this section, we examine some explanations given by communities for the limited use of PHCs as frontline care providers for "small ailments" (Also see Table 4).

Prevalent healing norms did not match with care provided by PHCs

During the discussions, people shared that "small" ailments interfered with daily routines of life. Most people said that it was important to feel better as quickly as possible—since each day of not being well implied a loss of wages (for both men and women) or not being able to cope with the stress of daily household chores (mainly women). Hence, there was a feeling that "rest" as a way to recovery was a luxury that only the "rich" could afford. This loss of wages/inability to do chores appeared to influence care-seeking choices for "small" ailments to a large extent. For one, it meant that people were willing to spend money and go to private practitioners in the vicinity to "get well" quickly; the private practitioners' fees was looked upon as an investment for "feeling better at once". Secondly, each visit to the doctor implied a day away from work/household duties; and hence people wanted the doctors' diagnosis, report, medicines, and injections—available at one place—and all investigations completed in fewer visits. This was reported as something that did not happen in PHCs.

"They give the same tablets for all ailments. Tell me, do we all have the same disease?"

People reported experiences of being prescribed the "same drugs" for all ailments they sought care for at PHCs. This treatment, people said, starkly contrasted with the treatment of private practitioners who prescribed "strong" and "different" drugs to them. People shared that except for a few tonics, syrups and skin-creams, the drugs given to them at PHCs were of no use. For non-communicable diseases-people shared that no medicines were given at PHC- level (even if they had been screened for these ailments at PHCs). Further, this perception about being given the "same" drugs for all ailments made people feel that many doctors at PHCs either did not have adequate knowledge about different ailments; or were not bothered to diagnose their ailment. All this, along with some concerns about the general poor quality of medicines in a public set-up, make people decide that no relief was likely to be obtained from the drugs given to them at PHCs.

Table 4: Illustrative quotes from the community on why they did not use PHCs for many of the ailments

Theme	Illustrative quotes
Rest and recovery are for the rich	P6: Money has no value before any illness, money is less before illness, but we want the result which we do not get there. If there is no relief, there is no earning. Moderator: But can you take some rest and recover slowly? P6: Madam, rest and recovery are for the rich. P2: It is like this. The private doctor in (name of place), it is like some people are poor, some are rich. So, the rich ones go to this (name of a private doctor) and those who are poor they go to (another private doctor) (FGD 3)
Same drug for all diseases	P1: … it is like diseases are all of different types. Then they (at the center) give 2 medicines to all type of illness. All are similar they don't change; this is what he wants to say. Moderator: Doesn't it happen in private? P4: In private, tablets are powerful. Whatever the disease is medicine for that disease only it is given, here it is not like that. P5: Quick difference is not felt in government. P1: The power of government medicines is less. They are all simple. The medicines are very normal. What they say in government, same type of medicine is given no matter which disease you go for…. the tablets are same only and we don't get any difference that fast. (FGD 8)
No guarantee of the doctor's presence at PHCs	P4: accident happens, the child gets hurt, when taken there, it's a government hospital. Saying what happened? How it happened? One by one people come and ask, till that time the child will die. Be it any hospital- Firstly see the patient. Don't ask us, what happened and how it happened. Moderator: doesn't happen in private? P4 P6: doesn't happen. P1:…there is no guarantee, if from (village name) we go to all the way to the PHC, whether there is any nursing staff or not, doctor is there or not? There is no guarantee that it will happen today or not, that's why everything goes up and down. (FGD 1)
Public sector employees shirk work	Moderator: - Are private doctors good or the government ones? P5: Private Doctors are good because government doctors are not available anytime and there is no facility. P8: Even if we go there, they (don't care if we) die there, they get a fixed salary, so they don't care about anything. (FGD 5)

"No guarantee of the doctor's presence at PHCs"

The reported timing of the PHC Outpatient Department (OPD) clinic (10 am to 12.30 pm) at PHCs did not suit many people; who preferred evening or night OPDs.

Also, in some of the FGDs, people reported instances of going to PHCs only to find out that OPD services were not happening on that particular day. In addition, they shared that support staff who were present there were sometimes not willing to disclose if the doctor would be available on a particular day. Without the guarantee of a doctor's presence, people felt that accessing PHCs was not of much use.

Public sector staff give less attention to patients

During the discussions, people often reported that doctors at PHCs did not give them adequate "attention". The concept of "attention", as understood by patients, was complex- and included the following: using the stethoscope, touching patients, checking blood pressure, giving strong drugs, and listening to them carefully. There were deeply entrenched beliefs in the community about the lax attitudes of public sector employees, who were believed to have no incentives to conform to duty hours or attend to patients attentively (since these employees were given a fixed salary). In the same line of thought, referral to higher centers were viewed by people as a means through which doctors shirked work. People did demonstrate an understanding that PHCs could not do everything- and specialist support from higher tiers was required; despite this understanding, the motives of PHCs doctors when they referred patients were not above suspicion.

Government facilities are crowded, and staff don't work: Bribes or threats are needed

People, through past experiences and hear-say, had fixed ideas about what to expect in PHCs. They were willing to contend with "crowds" and with "waiting for the doctor" —since they shared that one had no choice but to put up with these inconveniences in government institutions. People also firmly believed that in order to get attention from staff in any government hospital, there was a need to resort to either bribes or threats. Many people reported threatening to recruit local political support to put pressure on the doctor to deliver what they believed to be "good" services (including giving them Intra-venous hydration fluids, injections, and drugs). Threat as a tool to demand services appeared to have roots in deeper beliefs in communities that public sector employees tend to shirk their work. People did, however, acknowledge exceptional doctors at some PHCs, who, despite being paid a fixed salary, were dedicated, paid attention to patients and conformed to mandated workhours. But in general, the community-staff relationship was colored with suspicion; leaving little space for a relationship of trust.

"In private, one gets saline. And tablets also. Strong tablets": Private practitioner-community relationships

In all FGDs, people reported going to private practitioners for small ailments. We tried to analyze why private practitioners were preferred to PHCs—and several issues emerged. For one, private practitioners' timings often suited people and they did home visits if required. Secondly, as discussed previously, the healing norms of the community leaned towards "instant" relief and private practitioners often catered to such needs. It was reported that private practitioners often prescribed strong drugs and injections—and administered intravenous rehydration solutions on demand—which PHCs did not do.

People's expectations from PHCs

People shared that it was like an established "system" now, to not access PHCs—since they had few expectations of treatment from these facilities. When asked what kind of PHCs would people be willing to use as first-access, people shared the following:

- Doctor's presence must be guaranteed at PHCs, and the doctor must give attention to patients. Support staff must follow the doctor's advice.
- Stronger drugs and more "variety" must be available at PHCs. The same drugs must not be given for all diseases. All laboratory reports must come on time and there must be no delay.
- Instant relief must be obtained; PHCs must dispense drugs that guaranteed quick healing.
- Patient must not be asked to come again and again. All completed all investigations must be completed in one visit without referring or asking people to do follow-up visits.

Even if a PHC was geographically a little distance away, people expressed willingness to travel- if good drugs and services were provided at the center.

Discussion

Several studies highlight that PHCs face structural constraints—in terms of equipment, human resources and basic drugs-and this naturally deters the utilization of these institutes.[5,6,19,20] Sometimes, structural deficiencies in PHCs are so conspicuous that it becomes difficult to look beyond these issues. In Maharashtra, however, this is not the case—and PHCs can be considered as "well-functional". However, the usage of this term "well-functional" masks the fact that even PHCs in this state are utilized by the public only to limited extents. One analysis of Maharashtra data (NSSO 2014) shows that for ambulatory care, only 7.5% of people used primary-level public tiers; 10.4% used public hospitals; and the rest accessed private care.[21] This clearly highlights the need for interventions at PHCs beyond improvements in structure. How do we go about this?

Currently, there seems to be little in the design of PHC services—that appeals to the "felt" needs of the people (See Box 1 for a summary). People, during the discussions, spoke about the restricted variety of drugs at PHCs; and often believed that these drugs did not work for them. For people to access PHCs, it is clear that PHCs must be designed to cater to a larger number of ailments with appropriate drugs. Prior studies have

Box 1: Summary of community viewpoints on PHCs

1) A PHC is ok for "small things" and does not "have much" in terms of services
2) One can visit a PHC if it is located close by (walkable) or if one is going near the PHC location for some other work.
2) The PHC is not usually the first place to go to for "small" ailments. The doctor at the PHC does not give attention-and there are no strong drugs there. So, if immediate and good attention is required or it is financially possible, it is better to go to a local private doctor.
3) For animal bites/immunization, tubectomy, and some seasonal diseases, one can use the PHC. Why pay for these at a private facility, when you get treatment at the PHC free?
4) When a doctor at a PHC does not want to treat you, he tells you to go "upwards" (higher tiers). Sometimes, if one does not have money to go to a private doctor, it is better to directly go "upwards" than go to the PHC -since there is guarantee of finding a doctor there.
5) If the care requirement is not urgent and one want tonics/skin creams or cough syrups, one can stock these up by visiting a PHC.

also shown that drugs are the biggest contributors to people's out of pocket expenditures on health[22,23] —and the non-availability of drugs deters health-seeking.[23]

Secondly, certain services available at PHCs- treatment for vector-borne diseases and tuberculosis, and family planning services- were appreciated by people. On being asked why PHCs were utilized for these services, people had put forth a variety of reasons; all revolving around the idea that PHCs had, over the years, not only offered these services- but had also built a reputation for providing these services well. This highlights the importance of building a repute at PHCs for not just a few services, but for all primary-level services.

Thirdly, doctor-patient relationships at PHCs were colored with mistrust. The use of threats or bribes to demand services from PHC doctors was acknowledged openly. Literature on the experiences of PHC doctors that speaks of their frustration with clinically irrational demands from people complements these findings.[24-27] How can this issue be dealt with? For one, we found people gave much importance to "doctor's attention" during the discussions. While PHC doctors reportedly attended to primary care ailments in a cursory manner and prescribed few drugs; people expected to be spoken to at length, checked carefully and given instant relief treatments. This mismatch in the expectations of care needs to be dealt with. In addition, we found that people had pre-conceived notions about doctors in PHCs; since these doctors were viewed as part of a "government" system that paid them regardless of the quality of their work. Another study in Urban Pune too highlights these pre-conceived notions.[28] Mistrust of public sector services colored all doctor-patient interactions at PHCs. Few PHC doctors were able to break through this pre-existing mistrust- and gain the confidence of patients. Hence, interventions targeted at improving community perceptions on public health services are a must.

What drives people to the local private sector instead of PHCs? We found that the lack of availability of drugs/services at PHCs, community norms that did not match what PHCs offered, doctor-patient interactions colored with mistrust; and general poor perceptions of the public sector- played a role in this. It was interesting to note that many people thought of private practitioners as "money-minded" —yet, people had faith that private doctors' treatments would lead to an early recovery. This perceived effectiveness of treatment as an important factor for choice of a health center has been pointed out in other studies also.[29] People did not appear to have this faith with regard to treatment at PHCs.

Our findings underscore that a lot needs to be done at PHCs if these are to be the vibrant providers of healthcare visualized in national policies. While PHCs are intended to provide both preventive and curative care, it is the OPDs (drugs, doctors' interactions) that become the "face" of PHCs; and hence, determine much of communities' viewpoints on its functioning. Also, people reported limited access to long term treatment for NCDs—and we could not observe a clear health seeking pattern in this regard. This finding implies that that there is a "gap" in healthcare provision for NCDs that is currently not being addressed adequately—despite evidence of increasing burden.[30,31]

Given this, expanding primary-level curative services clearly holds merit. People's expectations do resonate with the general direction of the HWC initiative. Pilot studies on HWC have shown some promise[32] Our study highlights that, in addition to offering comprehensive services, HWCs must provide attentive care as per people's felt needs, deal with clinically irrational demands with sensitivity, and contend with the pre-existing poor expectations of care.

The Alma Ata declaration and the World Health Report 2008 emphasize on the need to design health services around "peoples' needs and expectations".[33,34] In the light of India's commitment at Astana in 2018, this becomes even more important.[35] This study highlights how far-removed currently offered services at PHCs are from community expectations. It endorses the need to develop services at PHCs that take into account people's expectations—even as these centers deal with health system priorities.

Endnotes

1. We have masked the name of the rural area so as to protect the identity of participants. We chose a rural area that had above-average rural indicators and good health facilities (though not the best in the region). This is because we wanted to move the conversations with people beyond infrastructural constraints.

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Declaration of participant consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the participants has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal.

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Conflicts of interest

There are no conflicts of interest.

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