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Original Article:

Knowledge, Atitude and Perception regarding National Health Programmes among villagers of Chauras, Tehri-Garhwal, Uttarakhand

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Abstract:
Background and Objective: Since India became independent, several measures have been undertaken by the national government to improve the health of the people. Prominent among these measures are the national health programmes. The main objective of these National Health programmes are protection and promotion of national and individual health. The main objective of this study was to assess the knowledge, attitude and perception regarding various national health programmes among the villagers. **Methods:** It is a descriptive and observational study. The study subjects comprised 273 respondents belonging to 15 to 64 years age group. The collection tool used was a pre designed questionnaire, which was pre-tested. **Results:** 60% of respondents were adults, about 16 percent were educated up to primary level and more than 40% belonged to scheduled castes. Nearly 20% were aware about National AIDS Control Programme and 6.59% had clear knowledge about HIV/AIDS. Only 4.02% knew about the national vector borne disease control programme and 24% women clearly knew about exclusive breast feeding. Peripheral health workers were the most common source of information regarding these programmes. 64% of respondents opined that these national health programmes are good. **Conclusion:** Low level of knowledge was observed among the respondents regarding National Health Programmes.

Key Words: National Health Programme, Knowledge, Attitude, Perception, Respondent

Introduction:

Health care systems are composed of individuals and organizations that aim to meet the health care needs of target populations. There are a wide variety of health care systems around the world. In some countries, the health care system planning is distributed among market participants, whereas in others, planning is made more centrally among governments, trade unions, charities, religious, or other co-ordinated bodies to deliver planned health care services targeted to the populations they serve. However, health care planning has often been evolutionary rather than revolutionary.[1]

In terms of emergency services, although there have been isolated attempts to address emergency care in India, these could not be scaled up to cater to all sections of community, and address all kinds of emergencies. The present service levels are primitive and suffer from operational deficiencies of legal, administrative, police and fire services, accreditation of ambulan ces, education and training standards for paramedics, pre-hosp ital care etc.

In other parts of the world, a centralized emergency management system is helping save lives on a day to day basis. In Andhra Pradesh, Gujarat, Uttarakhand, Rajasthan, Tamil Nadu, Goa, Karnataka, Assam and Meghalaya, the number 108 is used as the centralized Helpline for Medical, Police and Fire emergencies. 108 service has helped save over 20,000 lives and responded to 500,000 emergencies out of 10 million calls with 652 ambulances. Emergencies can happen at any time, to anyone, anywhere. In most cases, they cannot be predicted or prevented but they can be managed to minimize losses to life, health, property, order and daily life.[2]

Health and wellness are prime concerns of the Government of India and the issue of health comes under the purview of the Ministry of Health and Family Welfare. Since India became independent, several measures have been undertaken by the national government to improve the health of the people. Prominent among these measures are the national health programmes, which have been launched by the central government for the control/eradication of the communicable diseases, improvement of environmental sanitation, raising the standard of nutrition, control of the population and improving rural health. Various international agencies like WHO, UNICEF, UNFPA, World Bank, and also a number of foreign agencies like SIDA, DANIDA, NORAD and USAIDS have been providing technical and material assistance in the implementation of these programmes.[3,4]

Today India is facing lots of problems like hunger, poverty, communicable and non communicable diseases. In order to tackle these, not only huge expenditure but also elaborate planning and coordination are required. Hence they have to be organized at the central or national level, though their implementation is done at state level. The National health programmes launched so far include the National AIDS Control Programme, National Cancer Control Programme, National Filaria Control Programme, National Iodine Deficiency Disorders Control Programme, National Leprosy Eradication Programme, National Mental Health Programme, National Programme for Control of Blindness, National Programme for Prevention and Control of Deafness, National Tobacco Con-

trol Programme, National Vector Borne Disease Control Programme (NVBDCP), Pilot Programme on Prevention and Control of Diabetes, CVD and Stroke, Revised National TB Control Programme and Universal Immunization Programme.[5]

Materials and Methods:

Study Area: The study has been carried out at the VCSG Govt. Medical Sciences & Research Institute, Srikot-Srinagar, Pauri-Garhwal, Uttarakhand.

Study Period: From 20th August 2009 to 19th February 2010. Total study period was six months.

Study Design: It is a descriptive and observational study.

Sample size and sampling: The study subjects comprised 273 respondents belonging to 15 to 64 years age group. As the Knowledge, Attitude and Perception (KAP) of respondents involved multiple issues, no consolidate data could be found from past literature about proportion of women with such KAP pattern. Therefore, to determine sample size, P was taken as 0.5, considering the theory of probability 50%, which also gives the maximum sample size. Thus sample comprised 273 villagers, considering 95% confidence interval and allowing 10% error.

Study tools and Technique: The collection tool used was a pre designed questionnaire, which was pre-tested. Data collected as such was compiled into an Excel sheet for easy comparison, reference and analysis.

Results:

Nearly about 60% of respondents were adults and about 16 percent were educated up to primary level. More than 40% respondents belonged to the scheduled castes (Table 1).

Table 1: Demographic and Socio-economic profile of respondents

Particulars	Number (Total = 273)	Percentage
Age of respondents in completed years		
≤ 19 years	n=36	13.18
20 – 24 years	n=163	59.70
25 – 29 years	n=67	24.52
30 years and above	n=7	2.56
Socioeconomic status of respondents		
Upper class	n=02	0.73
Upper middle class	n=11	4.02
Middle class	n=23	8.33
Lower middle class	n=215	78.75
Lower class	n=22	8.05
Caste		
Scheduled caste	n=113	41.39
Scheduled tribe	n=42	15.38
Other backward classes	n=81	29.67
General	n=37	13.55
Educational status:		
Illiterate	n=189	69.23
Primary	n=43	15.75
Middle level	n=23	8.42
High school and above	n=18	6.59
Gender		
Male	n=183	67.03
Female	n=90	32.96

Regarding the knowledge of various national health programmes, nearly 20% were aware about National AIDS Control Programme and only 6.59% had clear knowledge about causes of HIV transmission, its prevention, testing and ART centre. Only 4.02 % knew about the National Vector Borne Disease Control Programme, but not even a single respondent had knowledge about the diseases included in this programme. One fifth of the respondents were aware of the National Malaria Control Programme, and one tenth knew about the government treatment center & about prevention of malaria (Table 2).

Table-2 (a): Knowledge of national health programme among respondents (n=273)

Knowledge about various National Health Programmes	Number	Percentage
National AIDS Control Programme		
Aware about programme	56	20.51
Know about HIV transmission, treatment, prevention & ART Centers	18	6.59
National Vector Borne Disease Control Programme		
Aware about programme	11	4.02
Know about disease included in this programme	0	0
National Malaria Control Programme		
Aware about programme	49	17.94
Know about its treatment & prevention.	29	10.62

About exclusive breast feeding, 24% women clearly knew that it should be continued up to 6th months, only 12 respondents knew that it should be continued up to 12 months and 27 respondents knew that it should be continued up to 7-8 months.

And 42.49% respondents had knowledge about swine flu and nearly 50% were aware about the 108 services.

Among the respondents, 30% were aware about the Universal Immunization Programme and knowledge about the other national health programme were very low (Table 2b).

Table-2 (b): Knowledge about other health related event/programme amongst the respondents (n=273)

Knowledge about	Number	Percentage
Exclusive breast feeding	67	24.54
Swine flu	116	42.49
'108' emergency ambulance service	129	47.25
Family welfare program	71	26.0
Universal Immunization Programme.	84	30.76
National mental health programme.	05	1.83
National cancer control programme.	03	1.09
National programme for control of blindness.	19	6.95

Peripheral health workers like ANM/Dai/ASHA/AWW were the most common source (70%) of information regarding these health programmes (Table 3).

Table-3: Distribution of respondents according to source of information about health related event/programme amongst the respondents (n=273)

Source of information	Number	Percentage
Doctor	5	1.83
ANM/Dai/ ASHA/ AWW	189	69.23
Pamphlets / Holding	21	7.69
Neighbors / Friends / Relative	63	23.07
Any other	13	4.76

Nearly 64% of respondents opined that these national health programmes are good (Table 4)

Table-4: Perception about other health related event/programme amongst the respondents (n=273)

Comments	Number	Percentage
Very good	49	17.94
Good	174	63.73
Bad	0	0
Can't say anything	50	18.31

Discussion:

Present study focuses on the knowledge, attitude and perception regarding national heath programmers among villagers along with their socio- demographic profile.

Approximately two third of the respondents were illiterate and below one tenth were educated up to middle level only. According to Census-2001, the literacy in Uttarakhand is 72.28%[6] but in the present study, literacy rate among the

respondents were low, possible causes being the hilly and difficult area and accessibility of the school being very difficult.

Approximately two fifth of the respondents belonged to the scheduled castes. The caste wise distributions in this study are similar to the census 2001 for Uttarakhand.[7]

Nearly one fifth respondents were aware about National AIDS Control Programme and few respondents knew about the causes of HIV transmission, its prevention, testing and ART centre and similar results were found in others studies.8

Nearly 18% respondent villagers were aware about the national malaria control programme and only 10.62% were aware about the government treatment center & about its prevention; the findings of the present study contradict that of the other study in india.[9]

In the present study, more than one fifth of respondent villagers were aware about exclusive breast feeding, similar to the findings observed in other study.[10]

42% respondents knew about swine flu as a disease and few knew preventive measures against swine flu.[11]

26% of respondents knew about family welfare programmes and their benefits. More than one third respondent knew about Universal Immunization Programme. Knowledge about other National Health Programmes were very low, although three fifth of respondents opined that these National Health Programmes are good. The low level of knowledge is possibly due to low level of literacy among the respondents. Main source of information regarding the various National Health Programmes were peripheral health workers (70%), so these workers should be regularly trained from time to time in imparting such knowledge to the villagers.

Conclusions and Recommendations

- The message regarding National Health Programme should be disseminated by "one to one approach" by organizing small groups at work place and small gatherings at village level, colleges etc.
- Mass media, both print and electronic, should be utilized and community organizations mobilized to disseminate correct and relevant information about national health programmes.
- The IEC strategy must include the celebrities from different aspects of life to promote the utilization of National Health Programmes.
- Educational programmes needs to be designed and implemented within the ambit of National Health Programmes to the students in high schools and colleges so as to increase awareness and competence in National Health Programmes.
- Research should be promoted to know the reasons for not accepting the national health programmes in order to select suitable strategies to sustain regular practice over time.
- A regular training program needs to be designed and implemented with the aim of capacity building of the peripheral health workers, so as to make them competent and to update their knowledge in the National Health Programmes, thus enabling them to teach the various advantages of these National Health Programmes.
- In addition, further studies are recommended to explore the reasons of low knowledge regarding the National Health Programmes in the general population, especially those from rural area where two thirds of the Indian population resides and where access to information is still a challenge.

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