HOUSEHOLD SURVEYS AS A SOURCE OF INFORMATION TO SUPPORT PRIMARY HEALTH CARE: *A LESSON FROM BASRAH*

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ABSTRACT

The present paper reports selected results of a series of household surveys carried out in Basrah over the period 1993-1998. The surveys were carried out on selected areas in Basrah City and its suburabs covering 2645 households with 20393 members. The results showed that primary health care services were reasonably accessible to the population and used for specific needs in a high percentage of cases (high coverage rate for different immunizations, antenatal care, and delivery services). Use of primary health care centres for curative care was less significant. Services as such, were used in only 32.9% of acute illnesses. The prevalence of breast-feeding whether exclusive or mixed was 82.3%. These results help in identifying gaps in the performance of primary health care services, which need to be bridged in the near future.*

**The details and the data of those surveys are available at the Department of Community Medicine*

INTRODUCTION

Primary health care as a strategy to deliver essential health care to people in accordance with their needs, resources and acceptable level of quality, requires, among many supportive programmes, a flow of health information for effective planning, management and evaluation of health care services. Such information can be based on routine sources and/or household surveys[1]. Household surveys provide information, which is very helpful in a variety of ways to consolidate the process of planning, management, and evaluation. Examples of relevant uses of household surveys may be listed as below[1-4]:

1. They help in measuring population health problems, needs for health care, and help in identifying the appropriate health care services to meet needs.
2. They help in identifying special target groups who may need special care.
3. They assist in getting the opinion of people about health care. Such opinion is probably best been obtained in household surveys. Their satisfaction, though subjective, is an indicator of the problems people may experience in obtaining care.
4. Household surveys, however, do have certain problems related to the validity and reliability of people reporting about their health. Such problems can be reduced by careful designing and executing surveys[1,5,6].

METHODOLOGY

During the period from march 1993 to April 1998, a series of local household surveys were carried out in Basrah by the department of community medicine, college of medicine, university of Basrah in collaboration with the directorate general of health services in Basrah governorate. The surveys covered defined population from several residential areas representing different levels of socioeconomic development. Description of these areas is given in Table 1. The choice of these areas was made on the basis of agreement between the college of medicine and the health authorities in Basrah, to serve special interests of the two partners and to achieve special local and general objectives.

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OBJECTIVES OF THE SURVEYS

1. To describe the demographic, socioeconomic, and health characteristics of the population.
2. To measure in quantitative terms each of the following:

a. Reported episodes of acute illnesses in two weeks period.
b. Prevalence of chronic illness, physical disability, and mental disability.
c. Different aspects of mortality: mainly infant mortality rate, crude death rate, and age specific death rates.
d. Fertility as indicated by crude birth rate and general fertility rate.
e. Utilization of health services including antenatal care, delivery care, immunization, and outpatient curative care.
f. Estimation of prevalence of breast feeding of infants.

In addition, these surveys were practical experience for fourth year medical students who participated actively in the process of data collection. This was part of their practical training in community medicine and epidemiology. In this paper we shall present part of the results of these series of household surveys. The details are available elsewhere[7,8].

Data collection

The questionnaire form: A special questionnaire form was designed and field tested in a small – scale pilot study before it was finally typed and used in the proper household surveys. The questionnaire form consisted of two parts: part one contained questions related to characteristics of the house (location, type, ownership ... etc) and three specific questions related to births, deaths and pregnancies in the household. Part two covered detailed information on each member of the household regarding age, sex, education, occupation, health status and use of health services of different kinds.

The field work: Teams of the fourth year medical students, each consisting of two male students and one female student, were defined and carefully instructed on how to approach families, to put questions and to record answers, and to check forms for completeness and accuracy. Each 5 -10 teams were accompanied by a faculty member from the department of community medicine who remained with the students throughout the working time in the field every day. All forms filled in one day were checked in the following day by the supervising staff to make sure that they were properly filled and in order to provide field workers with any suggestions and feedback. A random small sample of households was re-visited by different teams to check for the accuracy of information obtained by the field teams. The results were remarkably close, a point, which provided us with great confidence in the data obtained.

The data analysis

Data analysis was made in the department of community medicine by members of the department with the help of computer staff.

RESULTS

General demographic and health characteristics:
Table 2. shows that the average size of households is 8.1 persons an indication of relatively big family size. Children aged less than five years constitute 12.8% while elderly (65+) represent 3.0% only. The population experience high literacy rate reflecting the educational policy of Iraq. Nearly 10.7% and 10.5% of people reported to have acute and chronic illness, respectively.

Table 2. *General characteristics of the study populations.*

Statistics obtained	
Average household size.	8.1
Percentage of under fives.	12.8
Percentage of people aged 65 years and over.	3.1
Literacy rate among those aged above 6 years.	84.8
Percentage of people reporting acute illness during the two-week recall period.	10.7
Percentage of people reporting chronic illness.	10.5

Action in response to acute illness:

Nearly 16.2% of people with acute illness did nothing to their illness. Another 19.0% used self-medication (taking drugs without prescription by physician). Local primary health centres were visited in 32.9%, private clinics in 23.7% and other governmental sources of health care in 8.2%. The details are shown in table 3.

Table 3. ***Types of action taken in response to illness in the two-week recall period, Basrah 1992-1998.***

Nature of action	Number	%
No action	369	16.2
Self-medication	432	19.0
Visit to local primary health centre	749	32.9
Visit to private clinics	539	23.7
Visit to other health care sources	186	8.2
Total	2275	100.0

Immunization coverage:

Table 4. summarises the coverage rates for different immunizations adopted in the EPI. The rates were 94.8% for BCG, 91.5% for first dose of DPT and oral polio, 77.2% for second dose and 69.1% for third dose. For measles immunization, the rate was 64.1%.

Table 4. ***Coverage rates by immunization for the Targeted disease in the EPI, Basrah 1992-1998.***

Type of vaccine	Number of children studied	Coverage rate (%)
BCG	334	94.8
DPT+Polio: 1st dose	298	91.5
DPT+Polio: 2nd dose	250	77.2
DPT+Polio: 3rd dose	187	69.1
Mealses	108	64.1

Use of antenatal care:

Table 5. presents the pattern and sources of antenatal care for currently pregnant women. Nearly two thirds (65.6%) were using antenatal care. Nearly 69.1% of them were using antenatal care at local primary health care centres and 30.9% at private clinics. Of the total pregnant 34.4% were not using antenatal care.

Table 5. ***Antenatal care: coverage and source of care of current pregnant women: Basrah 1992-1998.***

Variable	Number	%
A-use antenatal care:		
using	191	65.6
not using	100	34.4
Total	291	100.0
B-sources of antenatal care:		
local primary health centre	132	69.1
private clinics	59	30.9
Total	191	100.0

Place and attendant of delivery:

More than three quarters of deliveries (76.2%) took place at hospitals and 23.8% at home. With respect to attendants of deliveries, 87.6% were attended or supervised by medically qualified personnel, and only 12.4% were attended by untrained birth attendants. Table 6.

Table 6. ***Place of delivery and type of attendants (supervisors) Basrah 1992-1998.***

Variable	Number	%
Place of delivery:		
Hospital	486	76.2
Home	152	23.8
Attendants at delivery:		
Medically qualified staff		
Unqualified traditional birth attendants	559	87.6
	79	12.4
Total	638	100.0

Pattern of infant feeding:

The pattern of feeding of infants is described in Table 7, with exclusive breast feeding being used in 65.1%, mixed feeding in 16.7%, and exclusive artificial feeding in 17.7%.

Table 7. ***Pattern of infant feeding, Basrah 1992-1998.***

Variable	Number	%
Exclusive breast feeding	122	65.6
Mixed feeding	31	16.7
Exclusive artificial feeding	33	17.7
Total	186	100.0

DISCUSSION

Primary health care strategy has been adopted in Iraq since Al-Ma-Ata declaration in 1978 and a wide network of health care services was established to provide essential health care to population. The success of such policy depends, among many other factors, on effective flow of information which can be obtained from routine statistics supported by household surveys[2,6,9,10]. The results in this paper represent part of what household surveys can provide to support primary health care. A health provider would like to know to what extent the services are accessible and actually used by the population in the catchment area. That is exactly what household surveys can provide. In the results of this paper, the response of people to acute illness is clearly described (Table 3) and clearly indicate that local health centres contribute substantially to curative care needed by local people but these centres are by passed or ignored by a high percentage of ill people. This might indicate the failure of local health centres to accommodate population needs. On other hand local health centres seem more successful in providing preventive measures such as immunization (Table 4) and antenatal care (Table 5) and in promoting hospital and medically supervised delivery (Table 6) as well as promoting breast feeding (Table 7). Those indicators of coverage by preventive measures and of breast-feeding are much higher than they were one decade earlier[11,12]. The prevalence of breast-feeding found in the present studies is also higher than that reported in other Arab countries[9,10]. The results, meanwhile, pinpoint the gaps in health care use. For example the coverage for measles vaccine is still far beyond the targeted level and nearly 34.4% of pregnant women did not use antenatal care. In addition, about 12.3% of deliveries are not attended by any qualified staff. These indicators of service utilization and lack of utilization are unlikely to be obtained without household surveys. That is why we have promoted and supported such practice during the last seven years as part of Basrah College of Medicine policy to enhance primary health care.

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