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GRADUATE SCHOOL OF DEVELOPMENT STUDIES

**Basic Health Units (BHU) in Providing Primary Health Care:
A Reality or Idealism?
A Case Study of 'Mastung' District Of Balochistan, Pakistan**

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“Tum hi say chal rahi hain saansai, tum ho to ham hain”

Dedicated to my sons

AbdAllah

Abdur Rahman

Table of acronyms and abbreviations

ARI	Acute Respiratory Infection
BHU	Basic Health Unit
CDD	Control of Diarrheal Diseases
DCO	District Coordinating officer
DHQ	District Head Quarter
EDOH	Executive District Officer Health
EPI	Extended Program on Immunization
GNP	Gross National Product
HIV/AIDS	Human Immune Virus/Acquired Immune deficiency Syndrome
IFC	International Finance Corporations
IMF	International Monetary Fund
IMR	Infant Mortality Rate
LIFE EXP	Life Expectancy
LHV	Lady Health Visitor
MCH	Maternal and Child Health
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MOPH	Ministry of public Health
NCSSH	National Center for Social Science and Humanities
NGO	Non Governmental Organization
NHP	National Health Policy
OED	Oxford English Dictionary
POP GRTH	Population Growth
PHC	Primary Health Care
PMA	Pakistan Medical Association
RHC	Rural Health Center
RKS	Rogi Kalyan Samiti
S&GAD	Services & General Administration
THQ	Tehsil Head Quarter
UNDP	United Nations Development Program
UNICEF	United Nations Children Fund
US\$	United States Dollar
WB	World Bank
WDR	World Development Report
WFP	World Food Program
WHO	World Health Organization

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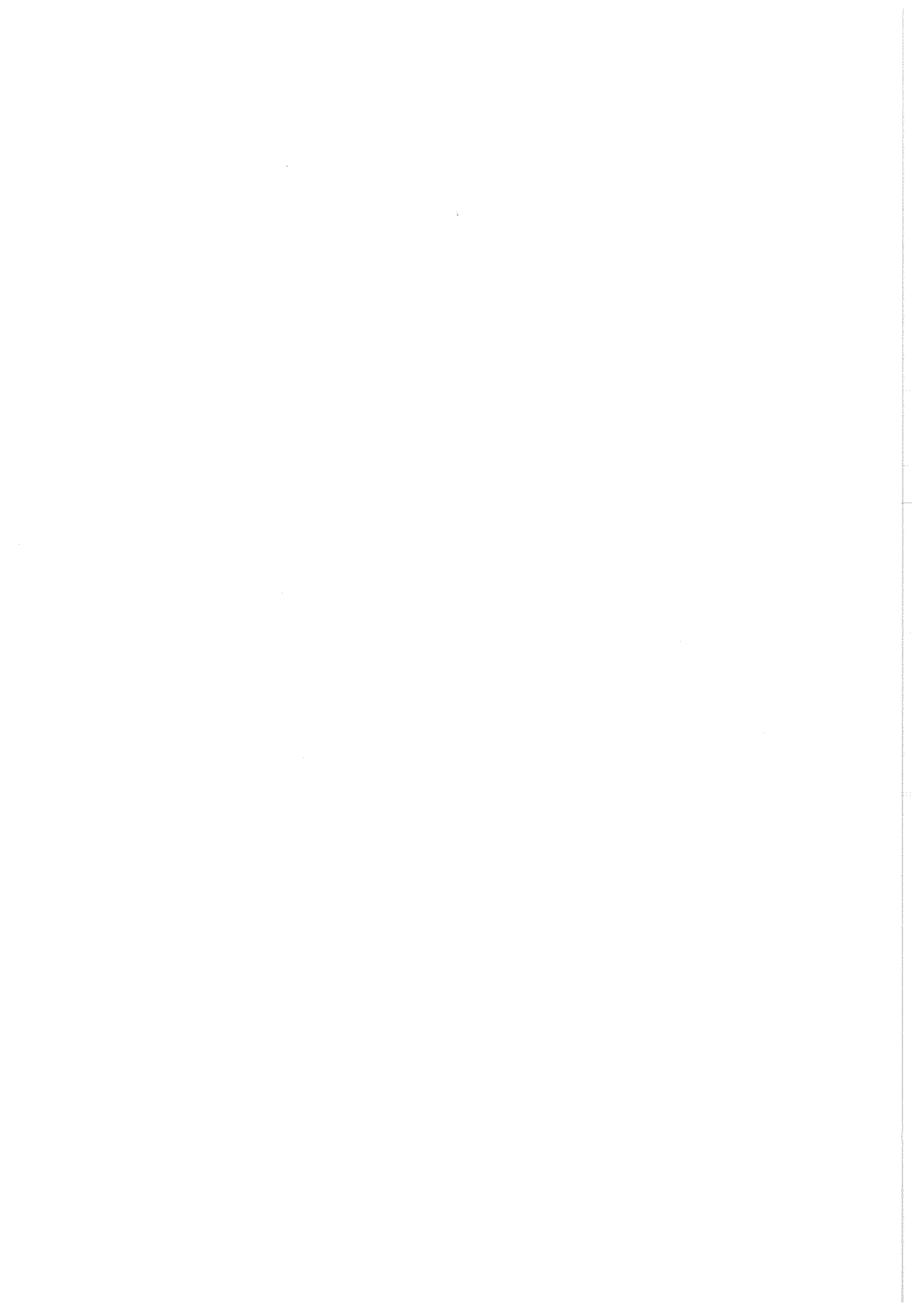
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Chapter 1 Introduction

1.1 PRIMARY HEALTH CARE SERVICES IN RURAL PAKISTAN

For health development of the people worldwide, the assembly for world health sat in 1977 to achieve the social developmental goals by the year 2000, this was known as “health for all by the year 2010” (WHO: 1984). Under this developmental program, United Nations Children’s Fund and World Health Organization (UNICEF & WHO) made a joint strategy to achieve the health developmental goals through primary health care (WHO:1996). For protection and promotion of the people’s health the primary health care program was expressed in Alma Ata in 1978. The main focus of Alma Ata declaration was an emphasis of nation’s development, addressing through health inequalities, the good planning in health care, social and economical well being, awareness of the state’s responsibilities for health service provisioning and community’s maximum participation in getting health (WHO: 1978, Koivusat: 1997, Gassanah: 2001). In most of the developing country’s health sector like in Pakistan, extensive support was aiming to achieve the goals of primary health care provisioning. This was especially demanded in rural parts of the developing countries where majority of the people lives. The vision of achieving the goals of primary health care was short lived in many developing countries and Pakistan (K.Sen: 2003) which demanded for extra health care resources.

Many factors were found responsible for obstructing in primary health care services provisioning to the rural population of Pakistan, like;

Firstly, consecutive military interventions in politics destructing the democratic processes, low economic growth, low infrastructural development, politician’s personal interests over peoples development and excessive spending on defense cutting the developmental expenditures leading to poverty in Pakistan (Mamoon D :2005).

Secondly, In Pakistan the population is growing rapidly with 1.9 % annually while health expenditures are decreasing continuously from 0.8 % of GNP in 1995-96 to 0.6 % of GNP in 2004-05 respectively (Planning and development division Pakistan: 2004).

Thirdly, the rural population of Pakistan is scattered extensively on spreaded land, lacking basic developmental infrastructure showing the less interest of state for its development.

The global pattern of diseases is changing faslty. In most of the developing countries like in Pakistan, the burden of disease is turning from tuberculosis and malaria towards more western affluent society disease pattern like diabetes, cancer, and cardiac problems which lead to a condition which is very difficult to treat by the rural population within heir own financial limits.

Like in many African countries the decade of structural adjustment program in 1980s by International Monetary Fund and World Bank also worsen the economical situation in Pakistan. Thus devolution, trade liberalization, cutting food subsidies and export of crops deteriorated the condition of poor people in Pakistan (International Journal of epidemiology 2001: 30). Its impact on health sector lead a grave situation for poor in terms of high prices of medicine and monetary constrains which resulted in a high Infant and Maternal Mortality Rates with an enhancement of malnutrition in children and anemia in mothers (Bhutta ZA: 2000).The quality of food intake of the vulnerable was directly effected by the structural adjustment program through their household incomes, by decreasing their purchasing power in developing countries (Schadizzo PL: 1985). This generalized poverty through Structural Adjustment Program (SAP) also made difficult for states to provide quality health care services to all the population (Lancet: 1994, BMJ: 1995: 71-72, Bhutta ZA: 2001).To reduce the burden of poverty the introduction of market mechanism for health services provisioning became popular in 1980s in many developing countries aiming for better health services and to decrease the pressure on public Health sector. Thus introduction of user fees was an initial step to decrease the inequality in health services between poor and rich and rural and urban (Hanmar: 1994 :172) , but the user fees as cost sharing in health facilities increased the financial burden on poor in Pakistan (Bhutta :2001). For the developmental needs of the rural population, the rural community participation in Pakistan is lacking the collective action, especially

for their health. Because this needs the mechanism of individual coordination to achieve their goals where goals are the matter; easy goals are good to coordinate while hard hinder it (Luis Fernando: 2002) which is seen in Pakistan's rural atmosphere where people hardly made any collective voice for their problems reasoning many factors but above all is lacking awareness in the people about their rights.

Almost two decades ago Pakistan government introduced Basic Health Units for better primary health care services for its rural population as first level health facility. The objective of Basic Health Unit policy was to reduce the burden of diseases through curative and preventive health services in decreasing the mortality rates for well being of the rural people.

This study attempts to analyze the impact of Basic Health Unit (BHU) policy of Government of Pakistan on accessibility of first level health care provisioning in rural areas, utilization of the BHUs by the public for their health remedies, Basic Health Center's functioning capacity in context to the needs of rural population and motivation of the health workers to work in these Basic Health Units. In this study I also want to see that to which extent the Government's BHU policy is successful in providing health services to the rural population, prevention of diseases and motivation of the health workers to serve in rural parts of the country.

1.2 Statement of the problem

To reduce the burden of disease and accessibility of the healthcare at lower level in the community, Pakistan planned the Basic Health Units (BHUs) as the main focus of primary health care following the Alma-Ata declaration in 1978. However to confer Primary Health Care at Basic Health Unit level with special attention to rural population's health; the government's expenditures over rural infrastructure, medicine supply in rural centers, equipment and human resources remained very low. This may be due to very low health budget of 0.6 % of GNP (2004-05) by the state, most of which goes directly to the secondary and tertiary ¹level health care coverage leaving behind very low amount for primary health care (Economical survey of Pakistan 2004-05).

¹ In Pakistan's Health System, three levels of health care, primary, secondary and tertiary. Primary is first level health service, secondary is at district level and tertiary is urban located attached to medical colleges.

After two wars with India, from 1965 onward Pakistan's history is full of turmoil and institutional devastation. These serious political anarchies disturbed the whole developmental process of the country. Health sector also effected in addition to other sectors. Structural adjustment program deteriorated the condition further. Rehabilitation of the Basic Health Units, equipment and medicine deficiencies, access to the far situated health centers without transport communications, no clean drinking water, sanitation and electricity problems, all these problems triggered the already poor health condition of the people. The Infant Mortality Rate of 180 / 1000 and Maternal Mortality Rate of 800 / 100,000 in the rural parts of the country indicating how worse the rural health condition is when comparing it with rest of the country's IMR 74 / 1000 and MMR of 350 /100,000 (Journal of Pakistan Medical association PMA(51-10) 354-60). It's a grave comparison with any of the other developing country. In 2001 after many political gaps, Government of Pakistan announced its first National Health Policy to reduce the communicable diseases, address the inequalities in primary & secondary health care services, removal of professional and managerial deficiencies, gender equity, good nutrition to the target population, urban / rural differences, quality of health services, health awareness, quality and prices of drugs to achieve the targets of "Health for all" (MOH, National Health Policy of Pakistan :2001). This policy did not separately indicated any specification for the well being of the rural population and the primary health care facilities to them at Basic Health Unit (BHU) level. The problems of poor referral system from lower level to higher health center level, lack of any incentives for health workers motivation to serve in rural areas, drugs and equipment deficiencies and availability of health workers and their private practicing, that all are missing to address in National Health Policy of 2001. The supply of only 400 US\$ to 650 US\$² medicines for three months in a Basic health Unit (BHU) with a catchments of 8,000 to 10,000's population indicating how far effective will be the cure of diseases with this tiny amount of medicine.

The IMF and World Bank's agreement for privatization in health sector has been signed in 2001 in Pakistan but its implementation is in some parts of urban areas only. This implication is completely ignored in rural parts of the country except the introduction of user's fee. The policy which was adopted to improve the quality health services at Basic

² One US Dollar is equal to 58 Pak Rupees.

Health Unit (BHU) level accompanying the user fees was that, this would enable to improve the services in health sector reducing the Infant Mortality Rates, Maternal Mortality Rates, and burden of diseases in rural parts of the country.

Through states Basic Health Unit (BHU) policy the services have been improved or not? the population health needs, the running costs of the health facility, health workers motivation to work in BHUs, rehabilitation of the center and availability of equipments, drugs and Infant and Maternal Mortality Rates all have been improved or not?

1.3 Objectives of the study

The purpose of this paper is to evaluate the state's policy for BHUs in rural parts of Pakistan especially in context to the rural province of Balochistan. Whether the specification of BHUs by the state is fulfilling the health needs of the rural population?

An analysis of BHUs to find out the health workers morale and motivation to serve, primary health care provisioning in these BHUs, people's utilization of these health centers and disease prevention of the community through the policy of state has been mat? Through this analysis one can find that quality health care with equity and efficiency has been achieved in BHUs?

1.4 Research Questions

It can be said that this research comes in the aftermath of my shocking days of services for past ten years when I worked in a very hard rural area of Balochistan, Pakistan. After looking at the health condition of rural peoples the question arises that:

Has the state's policy about Basic Health Units fulfilled the needs of the rural population in terms of quality care health services and disease prevention in Balochistan?

Sub Questions,

- What is the existing situation of the Basic Health Units?
- Has the equipment and medicine availability situation has been improved in these Basic Health Units?
- To what extent the health workers are agreed to serve in these Basic Health Units?

- How should the rural health policy at BHU level be changed to improve the effectiveness of BHUs to give the quality care services to the rural people and motivation of the health workers to serve there?

1.5 Framework for assessment and analysis

This paper will assess the state's policy of rural health service provisioning as first level care at BHU level in Balochistan, which is according to the objectives of the state to provide better health to the rural people on equal grounds for well being and development. The current situation will be examined to point out the problems in rural health care system and in exploring the factors effecting the health care utilization in rural areas. In this context the concept of health as a 'public good' and the link in between health and income of rural people will be looked. Demand for health care services with supply of physicians, drugs and health centers will also be discussed. The concept of 'rural' and 'collective action' for community participation will be the essence of this paper in rural health care provisioning. And at the end privatization in the health sector will be seen in relation to the rural parts of the country.

1.6 Methodology and sources of data

This paper's methodology based on qualitative primary data, secondary data and literature which is reviewed for health as a public good and rural health services. Most of the information obtained from ISS library, other libraries, MOH government of Pakistan especially from directorate general health services of government of Balochistan. Essence of this study is based on the analysis of the interviews asked from various stakeholders at different BHUs of a rural district³ of Balochistan. In this paper I have seen the situation of health service provisioning at the BHU level in Balochistan right after the slogan of primary "health care for all" after Alma-Ata, and the current situation after NHP 2001 for BHUs. This study also focuses the quality of health services, people's choices for utilization of health services, human resource problems at BHU and political influence at

³ District is the smallest administrative unit in Pakistan.

the health center. Basically this study is done to see the sufficiency of the BHU services, its effectiveness in terms of needs of health facilities to the rural people.

The government of Pakistan requires a serious attention in analyzing the data from various stakeholders at BHU to assess its policy regarding BHUs, that how this policy meets its objectives. For evaluation of state's BHU policy regarding rural health services I have looked into different BHU centers and observed their utilization under certain indicators like, medicine and equipment availability, rehabilitation situation of the health center, the presence of health workers, the safety nets for poor who are unaffording their health expenses and services utilization by the people. I have also looked at the health indicators such as, IMR and MMR under health services utilization in BHU.

I have concluded this paper by analyzing my own information obtained through interviews, the qualitative data, observations and other resources in finding the answers.

1.7 Justification of this study

Being a student of developmental studies I have seen that developed countries are working as a welfare state for their people. Pakistan like many other developing countries has a huge burden of poverty, lacking proper social security for the poor and with an insufficient income a burden of diseases on the rural population. The state's BHU policy has wondered when looking at the poor health and developmental infrastructure, user fees on already deprived people, lacking collective action by the community, deficiency of the perception of health as public good, inequity and inefficiency in health sector, burden of diseases in rural areas, slow privatization in health sector. I have therefore needed to find out the state's BHU policy in addressing the rural population's health needs is a right policy?, fulfilling the needs of the rural people and attracting the people and health workers in utilizing the services at BHU level, decreasing the burden of diseases with equity and 'health for all'

1.8 Organization of the paper

This study is organized in five chapters,

First chapter consists of an introduction of the research, the methodology, and the data collection method with the questions asked in this paper.

Chapter 2 illustrates the framework for analyzing various concepts as: health a public good, health care system, the rural and rurality, human resource in rural health, role of public health infrastructure, health and development with income linkages, health care demand and supply, health as public subsidy of private provisioning, health care financing in developing countries, equity in health, collective action system and privatization.

The second part of this chapter explores the rural health problems in developing countries with various countries' responses.

Third chapter gives the health structure of Pakistan in connection with health care provisioning in rural province, Balochistan, Pakistan.

Fourth chapter confers the findings of a rural district of Balochistan according to the state's provided BHU policy.

Last and fifth chapter gives the impact of BHU policy of state in fulfilling the needs of the people with conclusions and recommendations.

Chapter 2

Framework for analyzing the rural health services at BHU level

2.1 Introduction.

This chapter is based on theoretical frame work for evaluation of BHU centers in conferring health care services to the rural community of Pakistan under states prescribed policy for BHUs.

Health as a public good and better health as key component of human development. Factors affecting health care utilization with an important link with Basic Health Units. First part of this chapter will explain some basic concepts used in this study while the second section of this chapter discusses the rural health problems in developing countries with examples of certain countries and their responses.

2.2 Peoples well being and human development

“Well being” has many meanings used to refer in evaluation on people’s being (Gasper 2002:18). Easily the well being can be understood as how well the people live or what others done to help the poor, while OED defines well being as happiness, health and prosperity” (Gasper 2004: 3)

“Well being is a process of enlarging peoples choices by expanding human functioning and capabilities” (UNDP: 2000, 17 & Gasper: 2002, 15) “Well nourished healthy, educated and the skillful labor are the most important assets of human development” (NCSSH / UNDP 2004:14)

Amartya Sen explains the relevance of well being and quality of life, “how people actually live and what kind of freedom they have in choosing their own way of living” (Van staveren, Gasper 2002: 4) and the formation of human capabilities are important in the well being, e.g. The capabilities of health, knowledge and their productive usage in social and political activities with equality. (UNDP 2001; 14)

By Diane Elson (in Gasper 2002:30) it is emphasized also that “it is not enough to call for more public investment in health and education but also necessary to examine the nature Of social institutions through which personal care is provided to those who cannot care for themselves” is the well being and development.

2.3 A public Good

“Goods” are defined as anything that produces a benefit, be it a physical commodity or service. (R. Smith, Beaglehole, Drager 2003:4) and their consumption can be withheld until in the exchange of payment is made and once consumed, cannot be consumed again. The word public good can better understand by its counterpart, private goods. “Private goods are traded in markets, buyers and sellers meet through price negotiations. If agreed the use of goods (services) can be transferred. The private goods are excludable, they have their clearly specified owners while public goods are non excludable” (Inge Kaul: 2000) once they have existed, it’s for all to enjoy. The global public goods are those goods whose benefits can be taken across the borders, populations even generations.

Many of the public goods are those who require private goods to access them, e.g. television needs broadcasts, computer-internet and infrastructure for access to clean drinking water. Such private goods are the access or intermediate goods here.

Health a global public good?

Nationally or individually health is not a public good. For a person’s status of health in the sense is a private good that he / she is the primary beneficiary of it. The health of an individual primarily benefits to that individual although some externalities may result from it such as communicable diseases. For provisioning of good health it is necessary to provide goods and services in terms of food, shelter and usage of health services, “while health is often rival and excludable between individuals and nations” (Woodward & Smith 2003:) therefore it demands interventions to improve health.

Here “The word externalities refers to some positive and negative effects of production or consumption on a third party who does not control or play an active part in that action” (ibid).

2.4 Public Health Infrastructure

Rutherford explained infrastructure as “the basic services or social capital of a country, or part of it, which make economic and social activities possible...” (Rutherford 1992: p 226 and J. Powles 2003: p 160) in context to public health, are the formal and enduring structures that support the public health, inside and outside the government sector.

The public health infrastructure elements mostly concerned with communicable disease control, mother’s health protection and environmental contamination in addition to non communicable diseases as:

- Institutional capacity to respond to these problems by state.
- Knowledge by general population and professionals through staff’s education and training.
- Necessary commodities (resources) or physical infrastructure.

(ibid)

2.5 Concept of ‘Health’

The World Health Organization’s definition of health is “a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. (WHO:1988)

“Health is not a biological norm but the product of complex social and biological valuations. A view of health as solely a matter of biomedical factors tends to minimize the social basis of health and may obscure its distributional issue” (Fabienne Peter & Timothy Evans 2001:26)

“Health is a state of being over which an individual has only partial control throughout the life course. We are born with a social and a biological heritage that leaves an indelible imprint on the health projection of our lives” (Barker: 1994)

2.5.1 Equity and inequality in Health

Equity in health took the idea from what is 'fair' Sen argued that "assessment of health equity must be beyond the health care receiving in addition to other ways of improving health outcomes (e.g. education) and freedom of choice. (Timothy Evans et al 2001:4) while inequality in health tells the differences in health between groups independent of any assessment of their fairness. (ibid) In Oxford reference the equity is defined as the application of general principles of justice to correct or supplement the law, and the inequity means not fairly distributed or lack of equity in any respect.

2.6 Health Care System

"It is considered as subsystem of the welfare state which is defined fully as a system of medical services that is paid wholly or in majority by public funds. This publicly funded medicine is often referred to as socialized medicine but this can be termed in national health service or single health care as part of welfare state".(Michael Morgan 1995:767, Thi Huyen:2004)

2.7 Human Resource in Health Development

It's a broad concept covering a vast range of social and economical developmental process mainly concerned with education, health and nutrition. (UNDP 1991:5) It can be defined as the process of enhancing the potential of the people to perform bettering in health sector. The people's potential could be increased through capacity building, trainings, access to opportunities and environment which gives support in development.

(ibid)

2.8 Factors affecting health care utilization

"Socioeconomic and demographic factors have an effect on utilization of health care services. Those with higher incomes were more likely to acquire health care expenditures than those with lesser incomes. Education is also found more likely to incur health care costs than those with less education" (Wolfe & Goddeeris: 1991, Hurd & Mc Garry: 1997, Cifaldi: 2001)

For health care utilization health status is the strongest predictor with three dimensions; general health, functional status of health and chronic illness. (ibid)

Having access to care is also an important demand to acquire health care expenditures one needs access to system for its utilization. Rowland and Lyons noted out that “access problems are indicative of problems in gaining entry to the health care system which involves trouble in getting care, delay in care due to financial constraints and transportation.(Bierman, et al:1998, Cifaldi:2001- p127). Supplemental medical insurance study found that “the insured patients are more likely to use health care services than were the uninsured.” (Davis & Rowland: 1983). These factors are affecting the health care utilization and expenditures in the elderly is a complicated process., the most important factors are the health status, demographic and socioeconomic factors in addition to income, education, age and smoking status (ibid). All these factors are effecting the utilization of health care services in the many developing countries.

2.9 Income- health linkages

An important correlation exists in between health and income of the individuals. Overtimes and across the countries it is observed that “any strategy to improve health is broadly based economic development” (William Jack 1999:27)

Gertler and Van Der Gaag (1990) analyzed the link between per capita gross GNP and health status for a sample of 34 countries in 1975. The findings explained that, an average 10 % income increase is associated with one extra year of life expectancy, 8.3 % lowers the IMR, 14.2 % lowers the child mortality rate and 1.5 % lowers in crude death rate. As income increases the consumption of health improving goods and services also increases. A useful way of examining the income and health link is to see first the consumption of certain goods and services affecting health. Most important input is medical services including both curative and preventive treatment. These services can be without any significance if other services or goods not used effectively, like; clean drinking water, nutrition, effective and safe shelter etc (ibid) all indicating a strong relationship of health and income.

2.10 Demand for health care services

Health care is only valuable when it improves the health, so health is the basic needs in the list of consumer's preferences. Gertler and Hammer (1997) expressed that higher the general prices of goods reduces the demand for medical care but on average, the size of the peoples demand varies according to the income, age, gender, and on the supply side it depends on type of health care facility. Gertler and Hammer (1997) also indicated that the poor tend to have more price elastic demand than the rich while children's utilization suffers more in price rise response than that of adult.

2.11 Supply of Physicians services, Drugs and Hospitals

Inputs into production of health care

The medical care providers (health workers) in relation to their patient means that demand is in the functioning behavior of the suppliers. The consumers can purchase more medical care by physicians if they were fully informed about the usefulness of the physicians. The lack of health care information about the cause, nature and treatment of disease by the individual, unlike the demand for food, clothing and other commodities; individuals have very poor preferences over health care services(William Jack1999:120). Looking at these features, physicians play two kinds of roles one they provide information and advise to patients and secondly physical services in form of surgery, administering the injections and drug prescription. If consumers are fully aware of effects in improving their health they would not require first kind of service by the physician.

One important substitute for physician is paramedical staff providing lower level services at appropriate time with a possibility to substitute the uses of a physician. In production of health services the medical supplies, drugs, instruments and capital equipments are essential inputs.

Drug supply

The modern drug therapies play an important role in disease treatment. These are complementary inputs to physicians, evidenced by positive correlation between supply of drugs and demand for health facility visits. (WB: 1994)

Hospitals

Hospitals treat a variety of conditions and diseases for the population. For allocation of resources to and within the hospitals it is necessary before to measure their performance and these institutions work. These are not for profit organization. Hospitals produces health and the amount of production depends on the admittance of the patients, their health status and inputs they use and how they use them, and the treatment of different illnesses.

2.12 Health services and privatization

For target provisioning of health and social care for vulnerable people in world, the debate opened during 1990s on health policy. Special attention given to developing countries for poverty reduction and social well being of vulnerable people (WB 1993, Baru: 1995, Sen: 2003) and privatization was amongst one of the mechanisms. Privatization of health services means contracting out different components of health care services, increasing co payments by patients, rationing services for sick and increasing the role of private sector in health care system.

“Privatization involves the transfer of state’s function to voluntary organizations or to private or non profit making enterprises with a valuable degree of government’s regulation” (Koivusalo & Ollila: 1997-156). The international finance cooperation’s (IFC) investments in health care are all financial investments in private facilities, usually private hospitals or clinics providing certain services to private patients.

2.13 Collective action and public goods

Mancur Olson and Thomas Schelling have expressed the collective action as “It’s a mechanism through which individuals and organizations coordinate in the pursuit of their goals, but these goals themselves matter; the easy goals facilitate coordination while hard goals obstruct it.”(Luis Fernando: 2002) Paul Samuelson in 1954 argued that “there are two classes of goods consumption, public and private. Samuelson assumed that one can divide and allocate the private consumption goods to various consumers while the

collective consumption goods are those all enjoy simultaneously that no subtraction from any other individual's consumption of that good assumed" (Elinor Ostrom:2002)

Alberto Melucci (1996) argued that "increased significance of cultural collective action makes the empirical destruction between protest and marginality much more difficult thus recent forms of collective action have often ignored the formal political system. Linked to this is participation and direct action with a rejection of representation or mediation but the collective action must understand the nature and political system which are challenged".

2.14 The word 'rural' or 'rurality'

In order to discuss the rural health problems and workings for its solutions one must understand the term 'rural'. Certain important qualitative indicators needed to understand it. The following indicators can make the index for:

- Where health needs are substandard (mortality ratio)
- Distance and location as geographical remoteness
- Population and the size of the community
- Specific circumstances affecting the communities such as size of the indigenous people and environment

Certain factors like population density, community resources, transport and communication all plays an important role in deciding to formulate an area as rural. For health status and health needs the geographical location is very important in addition to rural environment, life style and economy of that area (Humphrey J.S 1998: 212-216).

Part II

Rural health problems in developing countries

According to the geographical situation and different nature of rural environment, the health care issues and health status varies accordingly. The rural health services, their problems and a solution with planning, entirely depend on the geographical location because of the environment of that area effecting its economy and life style. This is reflected through the health status of the rural inhabitants. (ibid)

Despite urbanization the population growth in cities will slow, implying that in the coming 20 years the majority of the population in developing countries will still live in rural areas and this majority will continuously bear the health problems. This urban- rural bias is one vital reason for not having enough health service providers to rural population (Peabody 1999:319). In many developing countries even if overall supply of health professionals is quite reasonable the rural area shortage of human resources remained as it is. The traditional management skill in rural services by the health worker is also lacking. The expertise in financing, budgeting, economical principal to health care, communication or interpersonal skills all are externally important for management (ibid). Since 1977, access to the primary health care was emphasized greatly by the international community. As most of the developing countries have rural based population, the access to primary health care through private sector is not possible.⁴ On the other hand public sector intervention has manifested a very low graph of success in providing health services in rural areas. Several problems are reasoning for disappointing results, the supply of staff and their postings in rural areas, absenteeism of the staff, and quality care with lack of medicines, civic amenities and lack of rural infrastructure (Jeffery S. Hammer WB 2001:1). Due to empty health centers without equipments and medicines, patients bypass the public health centers and pay for the services in the private clinics. In developing countries the impact of PHC depends on the health service demands and interaction of these services with supply and prices of health services in private sector (Deon Filmer, J.Hammer, L.Pritchett: 1997).

The low impact of primary health care on the health development of developing countries is mainly due to low allocation of the budgets, less public sector efficiency, market impact of consumer demand for services and health impact of services.(ibid) Low socioeconomic conditions are directly linked to an increase in mortality rates in developing countries.(ibid) The role of social and potential factors are obvious in generating the high quality of services which is lacking in developing countries (Heller:1996).The privatization and imposition of user fees did not produced any positive impact on health sector in many developing countries after which utilization of health

⁴ Because the developing countries have a poor economy especially in rural parts and private sector is purely working on profit basis.

centers, rehabilitation of the health centers and motivation of the health workers remained always a question (Gassanah: 2001). Under institutional arrangements the public sector efficiency is very low in many developing countries resulting in a poor health policy to implement, and there is no demand based focus to intervene by the state in health with no alternative choice with power in the hands of the consumer (Deon Filmer et al: 1997:49). Many developing countries are ineffectively investing in secondary and tertiary health care located in urban areas leaving the primary health care in a lurch.

2.15 How countries responded:

In many parts of various countries, the condition of health services is poor despite heavy investment in health sector. The access and use of services varies significantly across the population, countries and regions. The geographical, economical, social and cultural factors vary with an indirect impact on health seeking behavior of the population worldwide. Many countries of the world are working on efficient and equitable health care provisioning and implementing new health programs and policies. (Seeta K 2000:11)

2.15.1 The Cuban Health Strategies

The Cuban health system has a history from 1902. The history of Cuban health system is rich source of knowledge, experience and historically lessons learnt. Cuba being a developing country faced many economical crises and health problems during last three decades. The population problems with high birth rates, high mortality rates, low life expectancy and the burden of various infections and parasitic diseases. During the sanctions against Cuba (1962) the government of Cuba adopted two main principles for Cuban public health system according which the Cuban health system will be totally financed by the state budget and secondly all health services will be free of charges, ensuring universal coverage.

Different health indicators showing progress in the health sector of Cuba in 2001

TABLE 1: Health Indicators of Cuba

IMR	7.2/1000
Mortality Under 5	9.1/1000
Children Survival under 5	98.9 %
Physicians/ 10,000	58.2
Dentist / 10,000	8.9
Nurses / 10,000	74.3
Medical Beds / 1000	5.2
Literacy Rate	96.2 %
Population with safe drinking water	95 %

(Source: Pan American health organization 2001)

Cuba formulated the priorities aiming to continue the development of its health system and improving its health indicators.

- 1) The health system reorientation towards primary health care and ensuring the family physicians and health workers as its core.
- 2) Improvements in hospital care through secondary services.
- 3) Awareness of research institutes and hi tech programs within the health system.
- 4) Appreciated the programs of traditional and natural medicines and drugs.
- 5) Priority given to dental system and eye care.
- 6) For medical emergency and urgent cases an integrated system has been introduced.
- 7) Other individual programs were also supported like; mother and childhood programs, chronic non transferable disease programs, transferable disease program etc.

The care strategy for implementation involved the municipal health system, actively community participation in municipal and local health councils.

- 8) Priority of treatment based on availability of drugs, opportunities for education and technical training for health workers.
- 9) Social security system successfully provided coverage of about 50 % to all paid workers; this was dealing with 'state pensions' professional insurance and workers insurance.

The success of the Cuban health system entirely depends on governments will to confer this system on priority basis with sufficient funding for development of peoples health

while the unity of the society as whole is also important in working collective action successful (Felix J. Sanso 2003: 187).

2.15.2 Medical Care in India

After independence in 1947 the Indian health sector improved much fastly. IMR, MMR, decreased half with an increase in life expectancy, but very slow improvement have been seen in rural health care. Widespread communicable diseases are still great threat to the rural population with infectious diseases, tuberculosis, malaria and leprosy are major risks to the population. Cancer is killing 1.5 million each year with 100,000 women die each year due to pregnancy related causes (Krishnamurthy G.2004:4, WHO:2004). The urban-rural health financing differences by state, human resource problems in rural areas, low quality of services, burdon of private hospitals, quack treatments and lack of infrastructural development are important rural health service problems in India.

In Indian health care system the private sector is dominated over public health care system which deteriorated the public institutes by the structural adjustment programs. The structural adjustment program had adverse impacts on priorities in health sector with Declined allocations noted for control and prevention of communicable diseases.

Introduction of privatization by IMF and WB increases the inequity in health care services in India (Narayana 2003:230). To increase the quality care health services to the rural population the Indian government provided many plans implemented by various states.

- 1) Many states tried to adopt the “bare foot doctor” approach that worked successfully in China. Different states selected various peoples from their communities, they collectively pay to that person for some of their basic health trainings which later work for their community.(Carr Marilyn:1989)
- 2) India tried to mainstream those untrained traditional quacks to give them some proper trainings of modern health care practice to provide community health service.

- 3) The approach of telemedicine⁵ has also been introduced in Indian health sector. This program is running successfully in 25 states.
- 4) India also tried to involve the community to finance in basic health services at their own.
- 5) The community participation in Rogi Kalyan Samiti (RKS) policy to improve local financing in health care, management, fund generations and active community organization, fairness and equality in health care through RKS system of health services.(Sunita Tripathi 2004:52)

2.15.3 Thailand and Universal Health Coverage

Thailand with a small population has shown high economic growth. Despite this economic growth, the inequality and income disparities are seen in Thailand health care system. Health resources, (personal facilities and medical technology) is concentrated in urban areas (31 % of the population) with access to health care problem in rural parts. The poor rural people cannot pay for the services where private sector does not expand its services. The private hospital expansion in urban locations encouraged the doctors to remain stick in urban areas avoiding to serve the rural population. Inequality is also seen in terms of health expenditure per capita among selected health benefit schemes.

In Thai health care system financing in health care is regressive to income (Rehnberg & Pannaruno: 1998) and health delivery system favors only the rich people. Poor health security policy of universal health coverage for poor; one third of the population is unprotected by any health benefit schemes. To reduce the inequality in health and access to the use of services Thai government gave attention to universal coverage of health for all people without socioeconomic differences.

Thai Ministry of public health (MOPH) introduced the voluntary health card among rural population. MOPH also expanded the health centers and community hospitals almost in all villages and districts. Different benefit packages introduced by various health schemes. The low income and public health schemes provided free care in health centers.

⁵ Telemedicine is popular in 25 states of India, in which doctor gives advise to the patient who is far from him in touch through internet.

The national health insurance act has been drafted and verified by many parties including political, government and NGOs. A fund has also been reserved for the policy through tax revising schemes e.g. general taxes and taxes from cigarettes were assigned to every family member to make health care accessible to all. The choice has given to the consumer to choose their family physician and these physicians has right to refer the uncured patient to another hospital public or private. Ministry of public health has given more emphasis on quality care in hospitals, quality management, hospital accreditation and clinical audit yearly. The Thai health care system is promoting universal health coverage to all citizens regardless to socioeconomic status to address the inequalities in health and access problems to the people. (Sanguann & Supasit, Sen. K 2003:212)

Different countries responded differently but their basic aim is the promotion of health care with an emphasis of community participation, states sharing and economical position of the people for the well being of the population.

Chapter 3

Healthcare Provisioning in Pakistan

3.1 Introduction

This part of the paper reviews the health care system in Pakistan that how government is providing health services to its people for their well being and development. An overview of the health delivery policy before the National Health Policy of 2001 and afterwards, the role of various actors in health care provisioning, in addition to the distribution of the providers. Health in context to rural poverty and the reasons of the National Health Policy: 2001. The second part of this chapter reviews the health profile of a rural province of Pakistan, Balochistan in context of rural health services in the country.

3.2 Healthcare in Pakistan

In 1947 Pakistan started its health services provisioning to its people with a very weak base. This structure was comprised only with few doctors but with burden of communicable diseases. Provisioning of the facilities and manpower in health sector remained very slow due to less attention and privilege given by state. The preventive and primary health care was neglected in first three decades, with only curative services remained in the focus. This trend changed the focus after Alma Ata declaration in 1978 with priority given to BHUs and RHCs at rural level to provide primary health care.

3.2.1 Current Situation

Health sector of Pakistan is working to achieve the aim of improving the standard of living with provisioning of better health services to the population. Health care development is in process but it is not showing that better picture of its health indicators which to some other developing countries have the population growth of 1.9 %, IMR of 74 / 1000, MMR of 350 / 100,000 and life expectancy of 63 years (World Development Report: 2004).

In Pakistan the health care is provided by both public and private sectors.

A) PUBLIC HEALTH CARE SERVICES

The public health care services are provided at three levels. The first level care
Provided through

- I- Basic Health Units (BHU)
- II- Rural Health Centers (RHC)

These centers are providing services for outpatients and limited inpatients. Each BHU serves a population of 5000 to 10,000 while each RHC serves a population of 25,000 to 40,000. In giving primary health care services a BHU is the entry point for receiving first level health care facilities in the country. 65 % of Pakistan's population (98 million) is living in rural areas, receiving health care services through these BHUs. The main function of the BHUs is preventive as well as curative health coverage to reduce the burden of disease. Doctor is the incharge of the center working with other Para medical staff. No admission facility for patients, no ambulance service and no laboratory facilities are prescribed in these BHUs. Without any health expertise for females, pediatric health, emergency minor surgery and dental care the only tool of the doctor has are the medicines. Each BHU receives a quarterly quota of medicine of US\$ 400-650 averaging US\$130-215 for one month. The only two room health center with no any accommodation facility is available for health workers

- III- Tehsil Head Quarter (THQ) hospitals and
District Head Quarter (DHQ) hospital

These are the secondary level health care centers with limited patients' admission facilities from 50-100 beds. These are the higher level health centers giving health care services of all types except teachings to under medical graduates. These hospitals are giving services to the population from 50,000 to 2 million.

- IV- Teaching Hospitals

The tertiary level health care centers are urban situated hospitals mostly attached with teaching medical institutions. These are the highest level health centers in the country.

The figures of various health facilities and human resources in the country are as in the table.

TABLE 2: HEALTH FACILITIES AND HUMAN RESOURCE

Registered doctors -	01,635
Registered dentists-	5,068
Registered nurses-	44,520
Population per doctor-	1,466
Population per dentist-	29,405
Population per nurse-	3,347
Hospitals-	906
Dispensaries-	4,590
RHCs-	550
BHUs-	5,308
Beds-	98,264

Source: Ministry of Health, Government of Pakistan

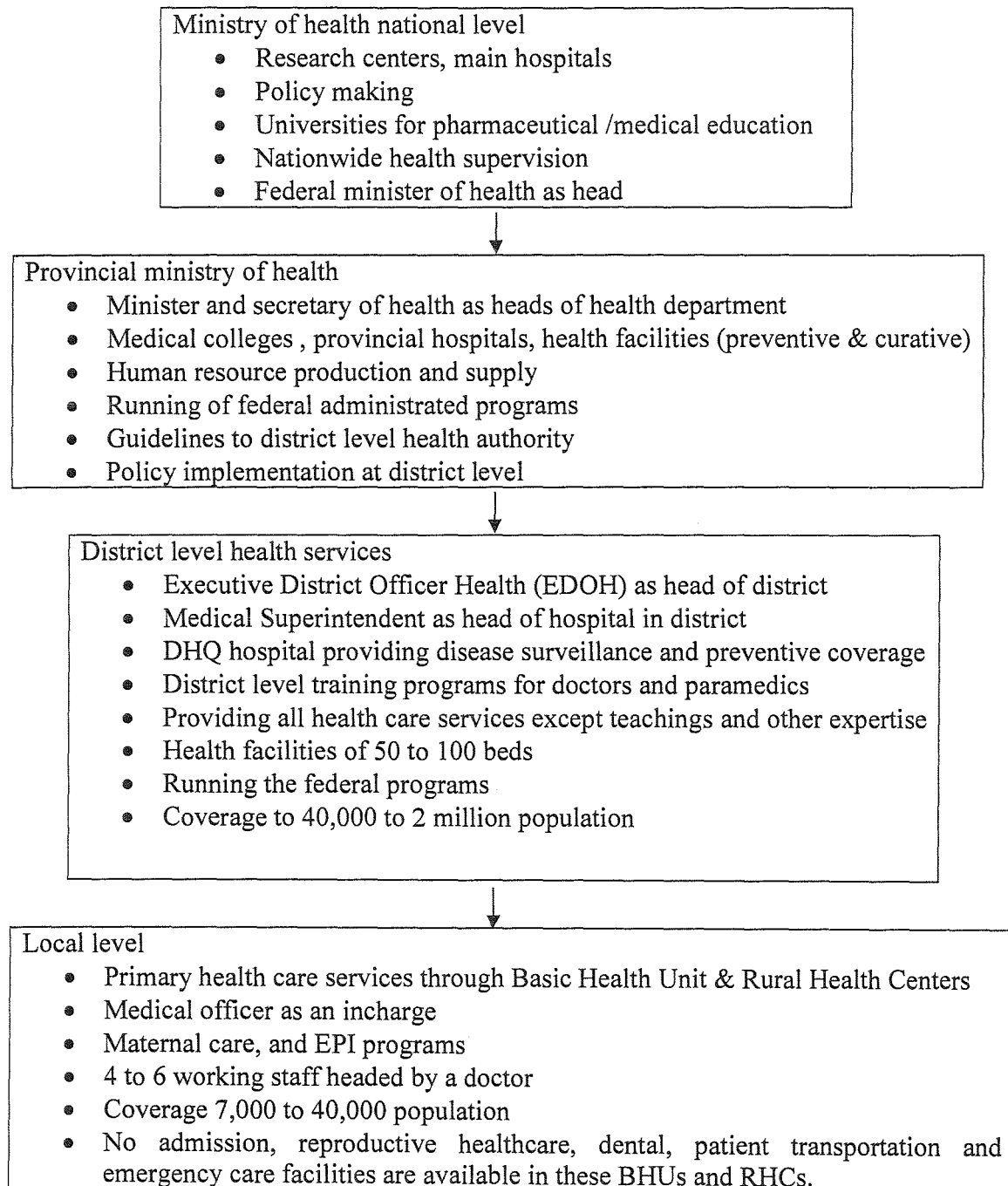
B) PRIVATE HEALTH SECTOR WITH NGOs & COMMUNITY PARTICIPATION

Like in many other developing countries Pakistan's private sector is dominating in providing health services to the population. More than 70% of health services are provided through this sector. 21000 clinics are running privately in the country in addition to 520 private hospitals with admission facilities. These all are present mainly in urban locations.

The private health sector in Pakistan is providing only low level of quality care to the population. Private health sector is very expensive in treatment while the provisioning of health services through Non Governmental Organization (NGO) s are insufficient and lacking skills and capacity to serve in the country. The problem of funding with them and lacking good relations and trust with state and following only the policy of the donors. The community participation in health services is not the states agenda. The community is lacking the empowerment of action. Government and NGOs lacking trust on community efforts. The indigenous politics in rural areas hinders the community participation in health services. Although the improvement has seen in health care system but the inequality is still present in rural areas where poor, despite their health needs, have very low capacity to pay for their health illness and treatment.

The following table is showing that how health system works in Pakistan.

TABLE 3 HEALTH SYSTEM IN PAKISTAN



Source: Ministry of Health, Government of Pakistan 2001-2002

3.3 Healthcare Financing

Challenges in Healthcare and NHP 2001

The National Health policy of Pakistan has announced in 2001 to address the problems of management deficiencies, planning, referral system in health, poor and inequality of financing in health, insufficient facilities of safe drinking water, sanitation, environment, quality and price control of drugs, unregulated private practice, quakes, difficult health system research, lacking health management information system, drug abuse, malaria, HIV/AIDS and hepatitis in health sector of the country.

This policy was announced on the basis of “health for all” approach. This was viewed as part of poverty alleviation program and implemented through primary and secondary level healthcare system. Good governance and quality healthcare was the main motto of this policy. In addition to targeting at various modalities, this policy addressed inequalities at primary and secondary healthcare levels to identify the equipment, medicine and human resource deficiencies at BHU and RHC. And to look at absenteeism, emergency care, surgical services, laboratory services and referral system operation difficulties at THQ and DHQ level too.

In National Health Policy of 2001 no any specific change has been made in running the previous policy for BHUs. The description and specification of BHUs remained the same. After passing three years of National Health Policy, Pakistan’s current indicators have improved but it has not given good response that our neighboring countries have achieved.

TABLE 4: SOCIAL INDICATORS OF PAKISTAN 2005

COUNTRY	MMR	LIFE EXP	IMR	MORTALITY BELOW 5	POP GRTH
Pakistan	350	64	74	98	1.9
India	440	63	63	87	1.5
Sri lanka	60	74	13	15	1.2
Bangladesh	600	62	46	69	1.7
Nepal	500	60	61	82	2.2
China	-	71	30	37	0.6
Bhutan	500	64	70	85	2.6
Thailand	-	69	23	26	1.6

Source: world development report: 2005

3.4 Health provisioning in Balochistan, a rural province of Pakistan

Balochistan is the largest province amongst four provinces of Pakistan covering 47% land of whole Pakistan; with only 5 % of whole country's population.

Total population	6.51 million
Urban population	1.51 million
Rural population	5.00 million
Annual growth rate	2.42 %
Population density	19 persons/sq km
Provincial area	3, 47,190 sq/km
Average household size	6.4 persons
Literacy rate	26.6 %
IMR (Balochistan)	180 / 1000
(Pakistan)	74 / 1000
MMR (Balochistan)	800 / 100,000
(Pakistan)	340 / 100,000
Per capita income (Balochistan)	US\$ 54
(Pakistan)	US\$ 736

ADMINISTRATIVE PROFILE OF BALOCHISTAN⁶

Districts	26
Tehsil/ sub Tehsil	119
Municipal corporations	01
Municipal committees	15
Town committees	30
Union councils	369

(Source: Government of Balochistan 2003)

The health care services in Balochistan are provided by Balochistan health department which is established in 1971. This department's aim was protection and promotion of people's health through development, progress and improvement under good health planning and management. The districts in Balochistan are the major operational level in health care provisioning headed by an Executive District Officer Health (EDOH). These preventive and curative healthcare services are provided by various health centers. The additional programs of Extended Program on Immunization (EPI), Control of Diarrheal Diseases (CDD), Malaria control, Acute Respiratory Infection (ARI), and HIV/ AIDs are also provided in these centers through primary, secondary and tertiary health care levels. The table is showing total number of health centers working in Balochistn. The number of 510 Basic Health Units showing that a large number of population is living in rural areas receiving health services through these BHU.

⁶ The union council is the smallest unit of administration in the district. From union council to town committees, than municipal committee, than municipal corporation, than sub Tehsil and Tehsil.

TABLE 5: NUMBER OF HEALTH FACILITIES IN BALOCHISTAN

No	Name of Institution	Number
1	Tertiary hospital	04
2	District hospital	21
3	Tehsil hospital	11
4	Rural Health Center	71
5	Basic Health Unit	510
6	TB clinics	21
7	Mobile dispensaries	21
8	Civil Dispensaries	596

Source: Directorate of Health Services, Balochistan

Para medical school in Quetta (the capital) producing medical health force to assist in the healthcare service provisioning. The paramedical staffs are midwives, Lady Health Visitors (LHV), Health technicians, nurses, dispensers and technical assistants.

Looking at the health system of Pakistan it is a well organized system but lacking vital determinants for good coordination, cooperation, investment and quality care. Lacking financial support to the rural health care is no doubt a major issue reflecting through its rural health indicators even after National Health Policy of 2001.

Chapter 4

Basic Health Units in Balochistan

Findings and analysis of BHUs in 'Mastung' (a Rural District) of Balochistan.

4.1 Introduction

Many countries are striving to facilitate its rural people with good health services and organizing its health delivery system in such a manner to provide quality health care with limited resources. Part of this is happening in south Asia, Pakistan where Basic Health Units are providing health services to 65 % of its rural population.

The province of Balochistan is almost half of Pakistan's land where more than 75% of its people are living in rural areas with a minimum infrastructural development. BHUs are the first and last hope of their health remedies where doctors have to serve the poor people without any tools. The depth of the rural health problems cannot be explored and solved without knowing the reasons.

Case Study:

For case study one rural district of Balochistan 'Mastung' has been selected. This district has a rural tribal system⁷ with a population of about 200,000 and an area of 5,896 sq km. Population density is 34 persons sq km having a cold climate with fruit, wheat and vegetables are the main crops showing an agriculture based economy. Mastung district has 258 primary schools for boys and girls while Mastung city is the headquarter of this district with a population of 28,600. This district has 429 villages with two rural health centers and 14 Basic Health Units. In both RHCs and BHUs⁸ 23 doctors are serving. Yearly health expenditure of the district is Rs. 1, 88, 67,196 (US\$ 3, 14,500). Each BHU is providing health coverage to a population of 7,000 and each RHC is serving for 16,000's population. The whole district has only 288 km of road in its mountainous land. Most of the population is remote with an average household size of 6.9 which is growing with an average of 7 % annually. The 429 villages are small in size and scattered in the

⁷ According to Irwin T.Sanders (Rural society 1977, Prentice-Hall Englewood Cliff New Jersey) Rural is defined as size & density of settlements having a way of life different from residents of city & towns.

⁸ No admission facilities are available in BHUs while in Rural Health Centers limited admission possible

district ranging from 10- 250 houses in one village (Government of Balochistan, statistics division: 2005). The health condition of this rural district is very poor. The public sector health human resource of the district is as under,

TABLE 6: HEALTH CENTERS & HUMAN RESOURCE MASTUNG DISTRICT

Health centers	No of doctors Male/ female	No of nurses	Paramedical staff	Bed availability
DHQ hospital	27 / 2	35	65	20
Dispensaries	12 / 0		12	
RHCs	9 / 0		-	4
BHUs	14 / 0		14	
MCH centers	-		3	
Total	64	35	94	24

(Source: Directorate health services, Balochistan: 2004)

The per doctor population ratio is 3278, population per nurse is 6,000 and per bed occupancy ratio is 8,330 (only public sector hospitals). The major diseases of the area are respiratory, gastro intestinal and malarial. WHO, UNICEF and WFP are helping the health department in various programs running in the district of Mastung.

4.2 The reality on Ground

After Alma Ata declaration the important change took place in primary health care provisioning worldwide. After this government has selected the BHUs as the main source to provide primary health care in most of the rural parts of the country. This paper has shown a conceptual framework for assessing the BHU policy of the state in providing better health coverage to the rural people on equality grounds for their well being. In this context the BHU policy will be assessed that whether the existing BHU policy is fulfilling the needs of rural people in providing quality care and disease prevention, willingness of health workers to serve in BHU, availability of medicine and equipment. And how this BHU policy can be improved in effectiveness of BHUs to give the quality care services, decreasing the mortality rates, burden of diseases and health workers

motivation to serve in rural BHUs. The rural level politics has a direct influence over the rural development so I have also looked at the local political influence on the functioning of BHUs.

4.3 The experiences of various stakeholders

In evaluation of the states policy regarding BHUs this research had selected its various stake holders the doctors, the Para medical working force, participation of the people, the indigenous political persons and health officials in finding of the answers of the questions.

4.3.1 The Health professionals

“Physicians occupy an unusual spot in the social structure of rural community. From an economic standpoint they are successful entrepreneurs, well paid business people similar to bankers and lawyers. On the other and they are also social servants like policemen and teachers”

(William Jack: 1999)

In all 14 BHUs the medical officer is working as an in-charge. 13 doctors were interviewed. All indicated different problems and vigorous feeling. 70 % of the doctors are not happily working their reasoning various problems. The location of the health workers posting decision is one of the challenging for the health officials in health care services (W.Jack 1999: p 126) because of access problems to the hospital, medicine deficiencies in the rural centers, and laboratory deficiencies, all decreases the health workers interests to serve in the rural BHU.

The health professionals' presence in the center is an obvious benefit for the rural population in the BHUs in terms of their health facilities (Gasannah 2001:36). All the doctors interviewed are reluctant to serve in BHU because of personal and family problems in addition to the social, accommodation problems, children's education, lack of higher education facilities, family adjustments, low financial support by the state and above all the infrastructural deficiencies in these parts where to serve. All the doctors

preconditioned their services for rural parts of the country on the availability of required daily needs with quantify and standard.

The availability of the drugs is still poor even after the introduction of NHP. The need of equipments and medicine is great in providing quality health care to the population. Like in many other developing countries, in rural centers the situation of medicine is worse. (Kiwanuka 1998, Gasanah 2001) The quarterly medicines of US\$ 400 to 650 is absolutely insufficient for an increasing population of 7,000 to 10,000. The monthly demands of the medicine by the indigenous politicians and tribal chiefs are excessive which finishes the drugs quota too earlier than for three months therefore rest of the period its burdon on population to purchase the medicine in any way. (Interviews: 2005) 70 % of the doctors defended for their private practice because in public sector health care services state is not providing sufficient salaries to compensate their daily needs. The supportive financial packages by the government could change their behavior following private practice. 100 % of the doctors working in the BHUs argued that state is not providing sufficient amount in terms of salaries to maintain their economical viability, domestic traveling costs, family expenses, children education, household, lacking civic amenities, social life with no attractive career during rural service.

In Mastung district 75 % of the BHU doctors are doing private practice. The following table is showing their private practice earnings.

TABLE 7: PRIVATE PRACTICE OF PUBLIC SECTOR DOCTORS

Practicing Hours	3 - 6 hours
Daily Patients	20 - 100
Charges per patients	Rupees 20 – 50
Daily earning	Rs. 50 - 1000
Monthly earnings	Rs. 2000 20,000

Source: Personal interviews in the field, 2005

Beside private earnings they are getting Rupees 10,000 to 19,000 in terms of monthly salaries serving in the BHUs by the state. All the doctors are regular in their public

hospital duties but not punctual in their timings to come in BHUs; performing public sector duties in morning hours while involved in evening private practice. This leads to inequalities in providing health care services. All the doctors agreed on that health development in rural areas by the state is biased to urban areas where selected persons are adjusted with nepotisms which shows that “health of the people is more effected by politics and economics rather than doctors and medicines.

In addition to BHU doctors ten urban doctors were also asked regarding health problems in a comparison to rural health care services. All are posted in capital city ‘Quetta’ but for five it is not their native city to serve. All are serving since 2 to 17 years of their service career. 75 % of them have a rural work experience. Nine out of ten doctors do not want to serve in rural area because of civic facilities, a social life, children’s education, well settled families in city, charm of private practice and in touch with latest professional skills and knowledge in the cities which are not available in remote parts of the country.

During the serving period of urban doctors in rural BHUs, they faced the problems of medicine deficiencies, lack of skilled staff, human resource deficiency and access problems to the health centers, above all very low salaries in BHUs. All this affects on the health of people, strongly determined by their working and living condition, the quality of their socioeconomic environment and the quality care services (WHO: 2004) Even they do not want to serve again in rural BHU but these urban doctors truly agreed for the modification of BHU policy by the state, emphasizing on the provisioning of sufficient medicine, equipments, latest technological care, well trained staff and incentives for health workers for motivation to serve in BHU, in addition to the developmental infrastructure which is the basic demand for quality care provisioning and development. 50 % of the urban doctors agreed to serve in BHUs but conditioned their postings with the promotions in next grades of service, health infrastructure and civic amenities in rural life.

4.3.2 Rural people at BHU

“ Rural people bear the greatest burden of diseases, mainly because rural people bear the greatest burden of poverty. The point is to understand the health and health care needs of rural people (which mean assessing the needs of the population not the services)” (Harrison David: 1997)

27 people were asked regarding their health services and health problems. “Health problems are major problems in our lives and state is doing nothing for the poor rural people just because we are poor” (common statement of all interviewed people).

Almost all the BHU visiting people argued that situation in BHU is not good. The deficiency of medicines, waiting hours for doctors, laboratory and x ray deficiencies and poor behavior of staff are major problems they are facing in the BHUs. The availability of drugs is important in curative services and the medicine which is available in the BHU is absolutely not sufficient for the population. 75 % of people prefer to visit BHU beside all these problems just to save the private doctors fees; otherwise they have to purchase the medicine in any mean. Rest of 25 % people bypasses the BHU and prefers to go in private clinic just due to the poor behavior of the health center staff and lacking of quality care. Like other developing countries in rural health centers of Pakistan, the problems of qualified health worker is also there. Very harsh arguments have been given by all people that a large quantity of medicine is taken by indigenous chiefs and political notables with the help of health workers, thus leading an inequality in health care provisioning to rural people. No any safety nets are present for those who cannot afford the treatment. 70 % of the people said that even after imposition of users fees (which they cannot afford) the quality of health care services never been improved. It was also seen that the user's fees is a big problem for them in accessing quality health care services because many people could not afford it and therefore people try to stick in the homes even they are sick until their illness becomes very grave (Lucas & Nuwagaba :1999, Gassanah: 2001).

The community is suffering from reproductive, respiratory and pediatric problems with 50 % of the people said that they have almost two regular visits to the BHU while rest 50% have said that they have single visit to the health center in a month. This shows how serious is the health condition of the rural population. The disease condition is a major threat to the household livelihoods which lead to many people into poverty by illness,

having to sell their productive assets including livestock and land. This condition could further be deteriorated into debt to meet the health care costs. Rural people are in real suffering in term of their health issues which are quite evident from their burden of diseases, monthly hospital visits, putting an emphasis on state to reformulate its rural BHU policy and give maximum facilities to them according to their demands and needs. The demand for health care services in rural areas is also lacking, calling for a collective action by the community too. Due to un awareness and lack of education people do not know what are their health rights; what they should ask for emphasis according to the constitution its their right not a privilege. The important factor is the income of the people which is directly effecting their health care utilization. Rural politics and tribal influence is also a cause of inequality in rural people health care services. The politicization in rural developmental scheme's provisioning according to the political choice also lead poor health care services in rural areas.

4.3.3 Para medical staff's vision

The importance of paramedical staff cannot be ignored giving helping hands to the medical doctors during health service provisioning. Out of 96 paramedical staff in the district 31 are working in RHC and BHUs. 20 different BHU staff has been contacted in the district. No doubt all agreed that the BHUs are not in a good condition. Their rehabilitation, medicine shortage, equipment deficiency all effect on quality of health service provisioning to the people. Extra work load on paramedical staff, deficiency of female staff, accommodation problems, local notables interferences in health center matters, working coordination in between health officials, paramedics and behavior of the patient all resulting a pressure on the poor people in terms of burden of disease, getting low quality health care and economical burden on their households. Even 70 % of the PM staff is in their home district but still they are not happily serving in the BHU. The economical burden on their households involving them in doing private practice indirectly effecting on the quality of services they are providing in BHUs. All agreed that they need additional human resource supply because of extra work load on them due to heavy rush of outpatients. The health workers complaint that the local political authority and higher health officials are not taking any serious step to solve the BHU problems in

terms of human resource, medicine supply and equipment availability in health center in general.

4.3.4 Others: Politicians and health officials

The politicians are the true representatives of the people. The grievances of the people can be guided towards the authorities for better solutions through their voices. Ten of the local politicians have been asked on different health issues. All agreed that in their district health problems are existed related with doctors and paramedical staff's availability, their deficiency, medicine availability problem, mother and child diseases and deficiency of equipments and health care technology. The local administration knows that the local people are vulnerable. Their health condition is devastating, needs a serious intervention by the state. All agreed that people cannot afford health problems and their treatment which is expensive. The care in public hospital is difficult so people prefer to go private clinics unwillingly. Poor referral facilities for higher health center without any free transport services but all needs money which poor people cannot afford. All emphasized that the state should improve the BHU status adding other facilities for population's first level health care on equity basis.

While the health officials of ministry of health, Balochistan are working on various issues of health services focusing mainly on curative services in addition to preventive. For the fiscal year 2005-06, Rs. 1.9 billion has been allocated for health sector in Balochistan. The district health system has been introduced which is still in the way. The district health financial matters have been transferred to Executive District Officer Health(EDOH) (who is heading the district health system in the district) and District Coordinating Officer(DCO). Transfer / postings are still in the hands of provincial administration but can be altered by the advice of district government. The government of Balochistan is trying its maximum to post the health staff in their home districts to avoid any discomfort if to be posted other than their home districts. Although the promotions of the health staff is very slow but health department with the

collaboration of Services and General Administration Department (S&GAD) is trying to work on promotions.

To attract the civil servants to work in rural areas government is paying 40 % additional salary incentives for their services. Other federal programs are also running in the province with the help of international agencies. Currently government is giving special attention to eradicate polio in addition to work on HIV/AIDS, TB and malaria control. With the help of UNICEF government is focusing on BHUs to provide access and quality care health services to its rural population.

The interesting outcomes of this study indicating three aspects of the story. One is clear that the rural people are in real suffering in terms of their health.

Secondly BHUs are not providing sufficient health services to the community lacking quality of services on equal grounds.

Thirdly human resource as key element in health service provisioning in rural atmosphere continuously being neglected.

All needing serious efforts by the state to modify its Basic Health Units (BHU) policy.

Chapter 5

Conclusions and recommendations

5.1 Conclusions

While analyzing the policy of state on BHU level in provisioning of primary health care facilities to the rural population, an important outcome is that the needs of the rural people are not satisfactorily provided. The utilization of the BHU is likely to be unequal and insufficient for rural people. The rich in Pakistan do seek the medical services with most of them go to private hospitals due to perception of poor quality of services in public hospitals.

This study shows that the existing situation of the BHU policy is worse, with many problems associated with human resource, medicine and equipment deficiency, quality care provisioning and local political influence on health centers. This study also explored that the health workers are willing to serve in rural parts but needs financial civic amenities like their urban counterparts, they want to maintain their knowledge update and well aware communication and social life. There irregularity in the BHU affecting the quality of services they are providing to the people. For day to day health services in rural areas the government is still stick on the decades old policy for BHUs without real involvement of the needs of community as clients and upbringing of the BHU for quality care and development which is reflecting through the rural health indicators in Pakistan. The alarming figures indicating the health problems as serious matter needing urgent for interventions at BHU level. The health workers less willingness to serve in rural areas, the medicine and equipment deficiency, the rehabilitation of the health centers, local influence of political lords; all these problems directly effecting on health of poor with lacking quality of services.

This study is also showing that state's focus is only on curative services leaving the preventive aspect neglected with continuous burden of diseases on population. The local politicians even know that the health problems are their in BHUs but they have not shown any interest to solve these problems. This all manifests that state's BHU policy is not fully conferring the health need of the rural population which seeks more

modification for uplift of rural health development of Pakistan. In general the states BHU policy has not matched the improved quality of services and prevention of diseases which is the biggest factor in repelling the people from utilization of primary health centers.

5.2 Recommendations

The Basic Health Unit as the means of improving the first level primary health care services, decreasing the burden of diseases with promotion and well being of the rural population on equality basis in Pakistan, but this policy has not been succeeded since many years' experiences. Therefore it needs to study reasons why, and correct the policy that where it is wrong. The most important are the clients whose voices should be considered in making any policy formulation. Access to the quality health care to the vulnerable and very poor is their right which they do not know. State should make an effort to provide the best health services to the rural population not on the privilege basis but on their right basis.

The community participation is also very important in district health system when the state has very limited resources. Very basic needs of primary health care can be the priority like the enough quantity of medicine, the equipments, availability of human resources, rehabilitation of the health centers, health workers financial problems, these all can lead quality health care services and decreasing the burden of diseases on rural population. The distribution of modern health facilities and qualified health workers could be in the continuous process of the BHU policy. There should be a well coordination in between local politicians and district health management officials under the district health system which will reduce the local people's influence in the BHU.

In view of all this I will recommend that for quality care and health development of rural population the status of BHU should be upgraded with enough medicines and modern health equipments, well trained staff in a well organized and good conditioned health center. There should be indigenous people's health committees to see and solve the health problems at local level.

"The solution in simple terms is to make the entire spectrum of rural practice attractive. Although numerous suggestions have been all that is needed is money and people"

(Hutton 1998:07)

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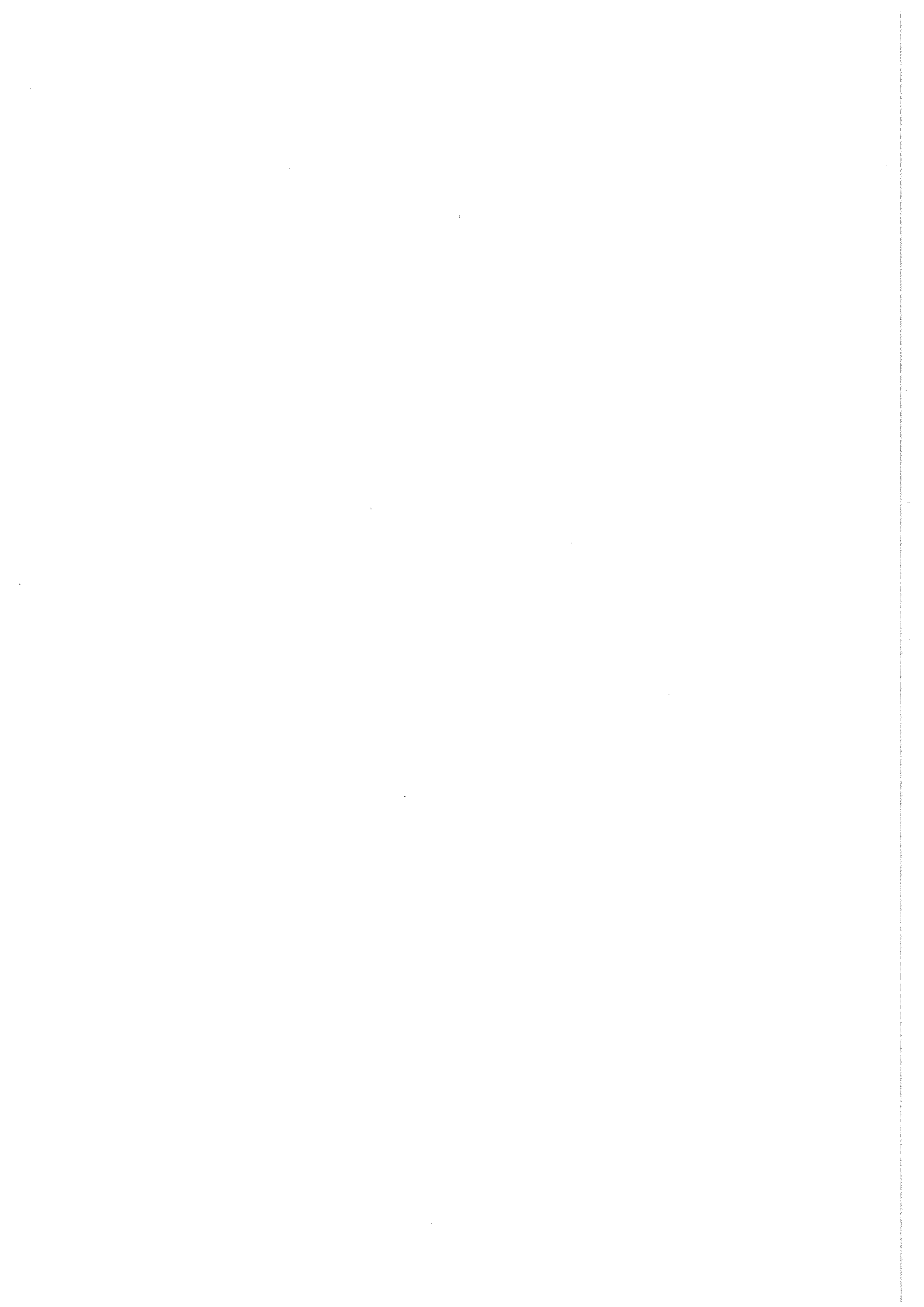
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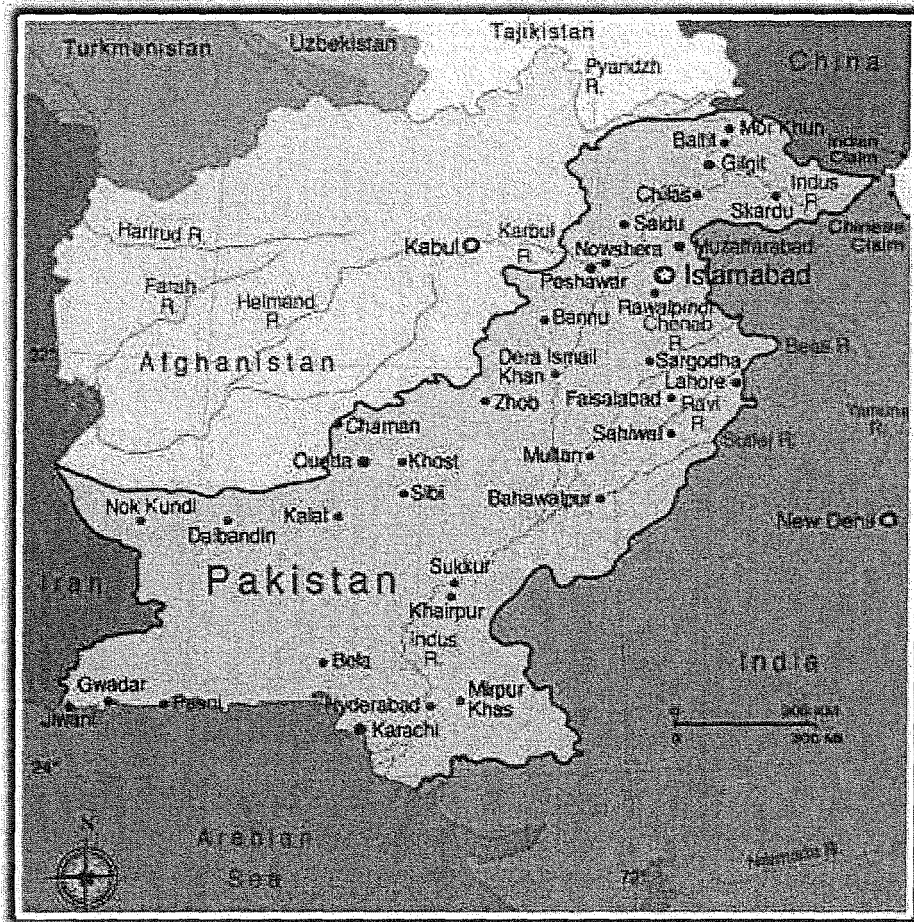
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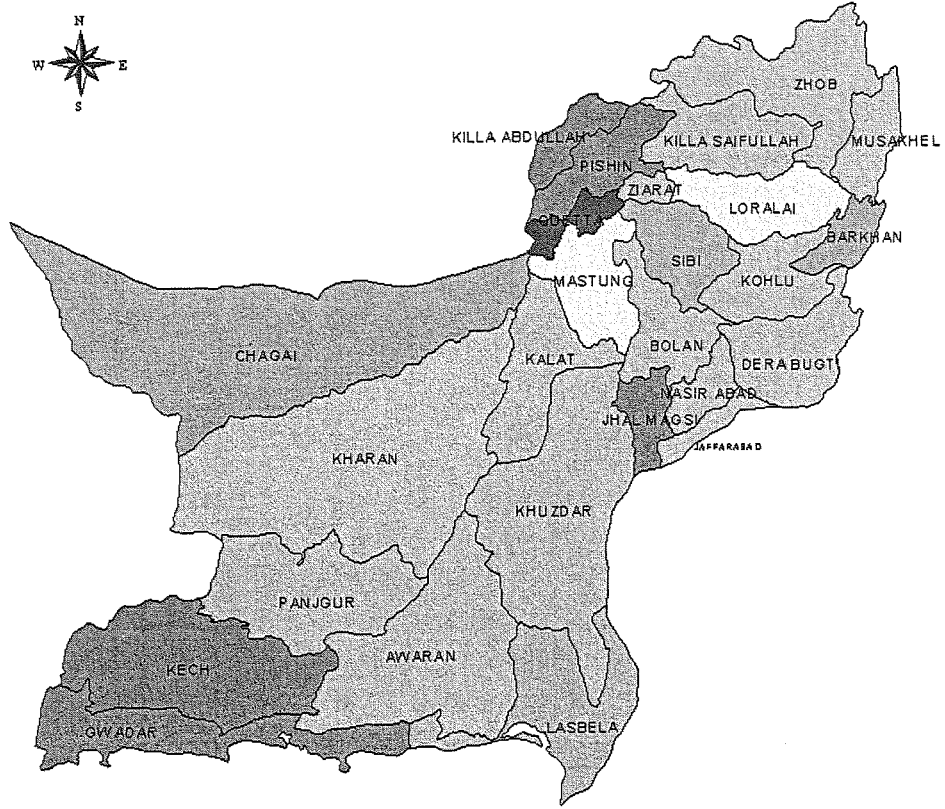
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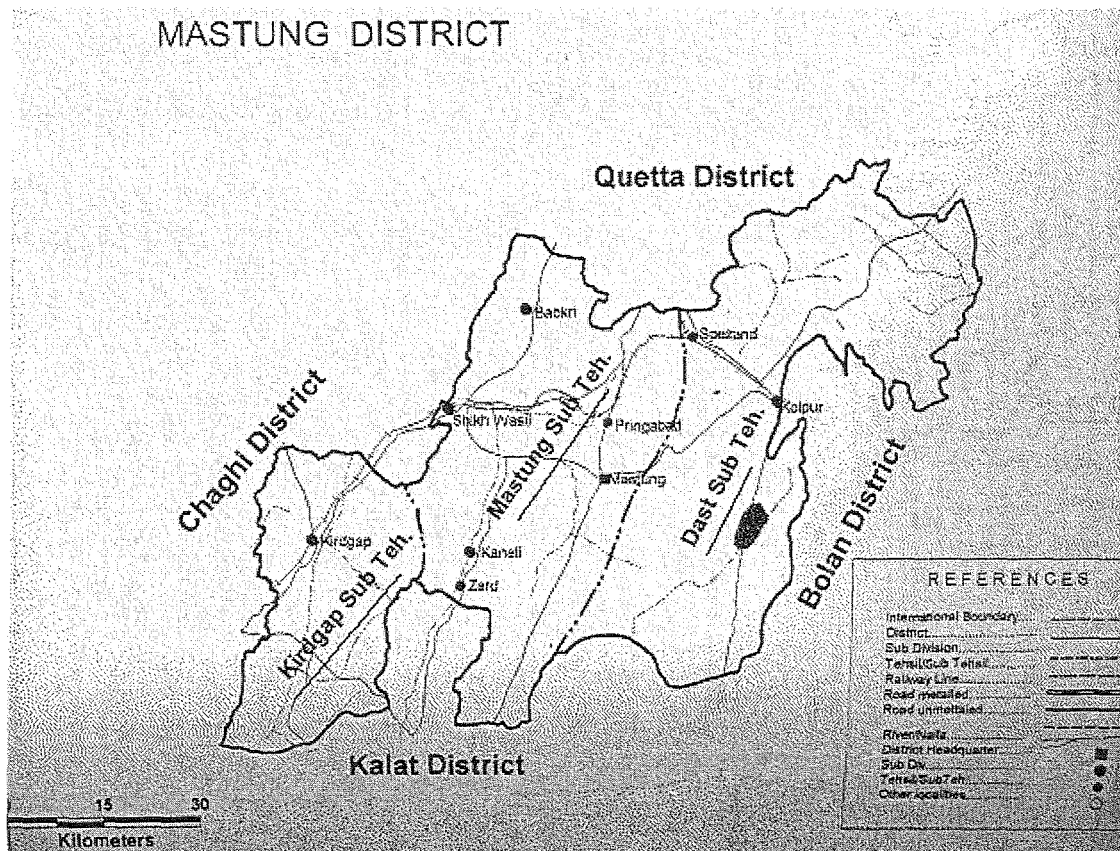


ANNEX-A (MAP OF PAKISTAN)



ANNEX-B (MAP OF BALOCHISTAN)

MASTUNG DISTRICT



ANNEX-C (MASTUNG DISTRICT)

