

AVAILABILITY AND UTILIZATION OF PRIMARY HEALTH CARE SERVICES IN THE RURAL AREAS OF DISTRICT PESHAWAR – A CASE STUDY

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ABSTRACT

The aim of the study was to know about the availability and utilization of the primary health services in the rural areas of district Peshawar. The study was conducted in the three villages namely, Sufaid Dheri, Sarband, and Masho Khel, during May - October, 2006. The selection of the villages was made by choice. However, in the selection of the villages, few points were considered such as the distance of these villages from the urban area and access to the facilities of the urban area. Looking to the aim of the study, it was enough to interview only fifteen individuals from each village. In this way, a total of forty-five subjects were randomly selected from the three villages. A questionnaire was used to get information about all the components of primary health care. The study revealed that the primary health services especially sanitation, water supply, sewerage system, performance of duty by the doctors and supply of medicines were very poor while immunization program was found excellent. The study suggested the availability of safe drinking water; effective health units, availability of medicine in time and their distribution at a reasonable price, presence of doctors in the respective units, and availability of family planning devices and medicines for control measures, which play an important role in the improvement of health status of the people in the project area.

Keywords: Care Services, Drinking water, Health, Rural, Sanitation

INTRODUCTION

Health is the basic element of success of a nation. The social, economic, biological and environmental factors affect the health of a society. To achieve better health, people participation individually, as a family, or as a whole community is must. This is also important that they should do something themselves such as good habit of health or to make a healthy environment.

Primary health care refers to an approach to health and a spectrum of services beyond the traditional health care system. It includes all services that play a part in health, such as income, housing, education, and environment. Primary health care was a new approach to health care that came into existence following an international conference in Alma Ata in 1978 organised by the World Health Organisation and the UNICEF. The Alma Ata conference (WHO, 1978) defined primary health care as follows:

"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination".

The approach has also been called as "Health by the people" and "placing people's health in people's hands." Primary health care was accepted by the member countries of WHO as the key to achieving the goal of Health for all. The Declaration of Alma Ata outlined the 8 essential components of primary

health care. These include provision of potable water, nutrition, basic sanitary needs, provision of MCH services (child survival and child spacing), control of communicable diseases, immunization, provision of drugs and first aid care, health education, mental health, and strengthening of supportive services.

To achieve the goal "health for all", the Government of Pakistan has provided many promotive, preventive, curative and rehabilitative services. The UN organizations such as WHO, UNICEF, World Bank and other international donor agencies have fully participated in the provision of these services. The Implementation of the National Programme for Family Planning and Primary Health Care was a timely and much-needed response to the health care needs of the rural communities in the country. Until now, National Programme for Family Planning and Primary Health Care has 70,000 lady health workers (LHWs) working in almost every part of Pakistan and providing primary health care facilities to the community. Yet, despite these positive aspects and government- and donor-financed interventions, health indicators have been improving very slowly. Communicable diseases such as diarrheal diseases, respiratory infections, tuberculosis, and immunizable childhood disease still account for the major portion of sickness and death in Pakistan. Maternal health problems are also widespread, complicated in part by frequent births. In fact, Pakistan lags far behind most developing countries in women's health and gender equity: of every 29 women who give birth, 1 dies.

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The infant mortality rate (77 per 1000) and the mortality rate for children under age five (101 per 1000 births) exceed the averages for low-income countries by 45 and 26 percent, respectively. Although use of contraceptives has increased, fertility remains high, at 4.1 births per woman, and population growth rates are much higher than elsewhere in South Asia. The underlying problems that affect health-poverty, illiteracy, women's low status, inadequate water supplies and sanitation persist (WHO, 2005, 2006).

It is quite clear that the health sector in Pakistan especially in NWFP is facing numerous problems, constraints and contradictions. In fact a large majority of the population has little or no access to adequate health facilities and is faced with a high incidence of disease. Since the population is increasing day by day, especially in the rural areas, it is desired to check out such ways and means to provide the primary health services to the people. The present study is an effort in this connection. The main objective of the study was, therefore, to analyze the actual position of primary health facilities and situation in the study area.

MATERIALS AND METHODS

Location of the Study

The study was conducted in three villages of district Peshawar, namely *Sufaid Dheri*, *Sarband* and *Masho Khel*, during May - October, 2006.

Sample Size and Criteria for Selection

Before sample selection, district census report, revenue records and other relevant information were consulted to have an idea of the socio-economic and socio-cultural conditions of the villages. The selection of villages was done by choice. However, few points were kept in mind in their selection such as the distance of these villages from the urban area. Since the urban area has more health care facilities as compared to the rural areas. Similarly, beside the existing health facilities in the villages, the villagers near the urban area have more access to the health facilities of the urban area. Therefore, the villages selected were at varying distances from the urban area. Moreover, it was assumed that these villages would cover the socioeconomic and environmental variations as well. The unit of study was individual irrespective of age and sex of the respondent. Looking to the aim of the study and available resources, only fifteen individuals were randomly selected from each village. In this way, a total of 45 subjects were selected from the three villages. Though the sample size may or may not be enough to represent the whole district, but it can indicate the actual position of the available primary health care services and their utilization by the dwellers.

Data Collection

A simple questionnaire form was used to collect information regarding all the essential components of the primary health care. Before interviewing, the individuals were briefed about each question in the form. Then they were asked to simply reply in Yes or No. Keeping in view the education level of the respondents, the questions, originally framed in English, were asked in local language i.e. Pushto.

The questionnaire also had space for gathering other relevant information that were obtained from respondents, by personal investigations, or from the available data about the rural areas of district Peshawar.

The males were either contacted at their houses or at village commons i.e. hujra, mosque etc, while, females were interviewed in the health centers. Emphasis was laid to get information in friendly atmosphere and in privacy, so that the respondent may not feel embarrassed and hesitate answering in the presence of others.

Data Analysis

The collected data was analyzed using computer software (Ms Excel). The percentages of Yes or No of each question were determined and presented in tables.

RESULTS AND DISCUSSION

In this study, the primary health care services available in the sample villages and their utilization by the respondents were evaluated and described as under:

Availability of Clean Water

The availability of clean water for drinking and other purposes is presented in Table I. In village Sufaid Dheri, 20% of the respondents reported that they have adequate and regular supply of clean water. The respondents reported that the main source of water in their village is tube wells, which is run by the Public Health Engineering Department. But due to the negligence of the concerned department sometimes the water distribution pipes break and some impurities enter into these pipes, which causes great damage to the public health in the area. It means our water sources still do not get the credibility of clean water supply. In the village Sarband the availability of clean water was 33.33%. However, different water sources reported were tube wells, canal and river locally known as (Khwar). In the village Mashokhel 70.33% respondents complained about non-availability of adequate clean water for drinking and other purposes, while the rest of 29.67% were using clean water. Different water sources used were reported to be tube wells, land and river water. As a whole in the project area

26.66% of the respondents had got the facility of adequate clean water, while 73.34% respondents complained about the non-availability of clean water. When compared with the reported data (WHO, 2005; World Bank, 2006) for Pakistan, the figures of availability of clean water are much less in the study area. However, our results are in relation with that of the Guissé (2004) who reported 20% access to a sufficient water supply of the rural population.

Sanitation Conditions of the Houses

The results of the sanitation conditions of the houses in the selected villages are shown in Table II. The sanitary conditions inside and outside of the houses of the sample respondents were very poor in the project area. In the village Sufaid Dheri only one respondent was satisfied with the sanitary conditions of his house and area, while 14 (93.44%) replied that sanitary conditions of their houses and area are not satisfactory. The sanitary conditions of the village Sarband was same as that of the village Sufaid Dheri. In village Mashokhel, 2 (13.33%) subjects responded positively to the satisfaction of sanitary conditions, while 13 (86.67%) respondents were not satisfied with the sanitary conditions of their houses and the area. On average, 8.88% of the subjects were satisfied and 91.22% were not satisfied with the sanitary conditions of the project area. The values for the Pakistani population (WHO, 2005) with access to improved sanitation (54%) are much higher than our results for the sampled villages. The main reasons behind the unsatisfactory sanitary conditions in the project areas were: no drainage system, open septic tanks in the streets, no proper sewerage system and no sanitation services available in the area.

Availability and Utilization of Health Centers

In all the three villages different types of health care centers, including basic health units (BHU's), private clinics, family planning services, were available to the residents. For major treatment, these villagers also avail the services of the three general hospitals i.e Lady Reading Hospital, Hayat Shaheed Teaching Hospital and Hayatabad Medical Complex, Peshawar. Besides, a lot of patients also visit the private clinics and hospitals, where they pay more but the service are quick, efficient and more reliable for the patients. It is evident from Table III that the people in the selected villages were greatly utilizing these health centers. In village Sufaid Dheri 15 respondents (100%), Sarband 14 respondents (93.34%) and Mashokhel 13 respondents (86.67%) had utilized the medical facilities of the available health centers. As a whole 42 respondents (93.34) in the project area had utilized these health services.

The sample respondents also complained of some problems in the utilization of the existing health facilities as shown in Table IV. These problems include expensive treatments, unnecessary long waiting and poor manners of the health staff. It is worth mentioning that most of the villagers in the project area are poor and can't afford high expenses for medical treatment.

Availability of Free Medicine

The provision of twenty-two essential drugs in the health centers is the key component of primary health care programme. The situation in the project area was very different as only 12 respondents (26.67%) stated that they had received free medicine in the health centers (table V).

In the village Sufaid Dheri only 2 respondents (13.33%) and in village Sarband and Mashokhel 5 respondents (33.33%) each reported that they received free medicine from the health centers. The respondents further disclosed that the medicine given was of low quality and the good quality medicine was either used or sold by the hospital staff. Purchasing medicine from market was an extra burden on their household budget.

Health Care Services at Home

The response of the sample respondents about the health care services at home is given in Table VI. Three respondents (13.33%) in village Sufaid Dheri, 4 (29.67%) respondents in village Sarband and 5 (33.33%) respondents in village Mashokhel stated that they had received the home health care. Collectively, 11 (24.45%) respondents in the sampled villages had received health care services at home. The remaining respondents contacted the private practitioners for home health care services at high fees. It is, again, an extra economic burden on these poor villagers. The reason for a relatively large number of respondents receiving home health care from private practitioners was the unavailability of the health staff in the health centers of these villages.

Use of Family Planning Services

As can be seen in Table VII, as a whole 28 (62.22%) respondents in the project area reported to have practiced family planning methods and have visited the family planning centers as against 17 (37.78%) respondents who did not practice family planning methods. The different contraceptive methods found to use by the respondents in the sample villages were injections, condoms, surgery and oral pills.

The information contained in table VII is very impressive indeed. It implies the fact that the public in general is using the family planning services and has a positive attitude towards it. It is a testimony of the clear-cut break through made by the family

planning programme in the socio-cultural milieu of the people. The family planning programme has succeeded in disseminating knowledge/awareness, which has tremendous influence on the attitude and behavioral pattern of the people. The only problem faced by the dwellers was the shortage of Family Planning devices in the village health centers.

Antenatal Care Services

The dwellers of the selected villages were well aware of the fact that antenatal care service is vital for mother and child health during pregnancy as shown in Table VIII. In the project area, 41 (91.22%) respondents reported to have positive attitude towards antenatal care as against 4 (8.88%) who do not take antenatal care during pregnancy.

According to the sample respondents, improvement is still needed due to the stark fact that in these villages antenatal care is mostly performed by unqualified village women (working in health centers), called as *Dais*, instead of qualified personnel. This situation can be witnessed in Table IX. In the project area only 18 (43.90%) respondents reported that qualified people did antenatal care while 23 (56.10%) reported that antenatal care services were provided in the village by the village Dai who was not qualified. In the village Sufaid Dheri the situation is satisfactory where 10 (76.92%) respondents reported antenatal care through qualified people as against 4 (28.57%) reported antenatal care by qualified people in village Sarband and Mashokhel.

Attitude towards Expanded Programme on Immunization (EPI)

EPI is working against six communicable diseases namely Tuberculosis, Poliomyelitis, Diphtheria, Whooping cough, Neonatal Tetanus and Measles. The services of EPI is available free of cost in almost every health centers of the country. The response and attitude of the villagers reported by the sample respondents was very encouraging, which can be seen in Table X.

In the project area as a whole 42 respondents (93.34%) reported that the EPI authorities have visited our homes in the villages and we have vaccinated our children against the six deadly diseases. In Sufaid Dheri 15 respondents (100%) have positive response towards EPI, in village Sarband 14 (93.34%) have positive response while, in village Mashokhel 13 (86.67%) respondents

reported to have vaccinated their children against the communicable diseases.

Extent of Satisfaction/Dissatisfaction with Existing Health Facilities

The subjects were also asked about their satisfaction on the overall health facilities as presented in Table XI.

Out of 45 respondents in the project area, 29 (64.45%) expressed their dissatisfaction on the health services. They complained about the shortage of good quality medicines in the health centers of their villages. Moreover, they complained about the unavailability of the qualified doctors in these health centers. Since there is also scarcity of transport service in the night time, so in case of emergency it becomes very difficult for them to reach the general hospitals of the city on time. Therefore, the respondents need 24 hours service in B.H.U's, or at least 24 hours emergency service that will meet the requirements of the villagers in case of emergency.

CONCLUSION AND RECOMMENDATIONS

In all the three villages health facilities were available but due to the negligence of the medical staff majority of the respondents were not satisfied from their services. Moreover, these health centers were always short of essential drugs. The important finding of the study is that the attitude of the dwellers toward family planning was very positive. They were aware of the importance of the Family Planning services and they use different types of contraceptives. The main policy implications in the health sector of rural areas are to make sure the availability of clean drinking water and sanitation services to the remote rural areas so that these facilities can be readily available and also water borne diseases can be controlled effectively. The rural health centers were poorly equipped and therefore these should be well equipped with all the necessary instruments, as well as, with cheap medical care and medicines so that it is within the financial means of the rural poor. Furthermore, efficient use of medical care and medicines should be ensured in government sector monitoring and controlling the misuse of the available facilities in the rural health centers. In this regard, more incentives need to be given to doctors and paramedical staff working in the rural areas. Also there is great need for training and awareness to the rural population about health and hygiene through the health visitors.

Table I *Respondents reporting about the availability of clean drinking water*

Villages	Availability of Clean Water			
	Yes	%age	No	%age
Sufaid Dheri	3	20	12	80
Sarband	5	33.33	10	66.67
Mashokhel	4	29.67	11	70.33
Project area	12	26.66	33	73.34

Table II *Respondents reporting about the sanitation system in the sample villages*

Villages	Sanitation Conditions			
	Yes	%age	No	%age
Sufaid Dheri	1	6.66	14	93.44
Sarband	1	6.66	14	93.44
Mashokhel	2	13.33	13	86.67
Project area	4	8.88	41	91.22

Table III *Respondents reporting about the Utilization of Health Services*

Villages	Availed services			
	Yes	%age	No	%age
Sufaid Dheri	15	100	0	0
Sarband	14	93.34	1	6.66
Mashokhel	13	86.67	2	13.33
Project area	42	93.34	3	6.66

Table IV *Problems faced in the Utilization of Health Facilities*

Villages	Problems faced			
	Yes	%age	No	%age
Sufaid Dheri	9	60	6	40
Sarband	12	80	3	20
Mashokhel	12	80	3	20
Project area	33	73.34	12	26.66

Table V *Availability of Free Medicine in the Health Centers*

Villages	Free medicine			
	Yes	%age	No	%age
Sufaid Dheri	2	13.33	13	86.67
Sarband	5	33.33	10	66.67
Mashokhel	5	33.33	10	66.67
Project area	12	26.67	33	73.33

Table VI *Home Health Care Received by Sample Respondents*

Villages	Home health care			
	Yes	%age	No	%age
Sufaid Dheri	2	13.33	13	86.67
Sarband	4	29.67	11	70.33
Mashokhel	5	33.33	10	66.67
Project area	11	24.45	34	75.55

Table VII *Family planning services used by the dwellers in the health centers*

Villages	Services availed			
	Yes	%age	No	%age
Sufaid Dheri	11	73.33	4	26.67
Sarband	8	53.33	7	46.67
Mashokhel	9	60.00	6	40.00
Project area	28	62.22	17	37.78

Table VIII *Respondents Attitude towards Antenatal Care Services*

Villages	Respondents Attitude			
	Yes	%age	No	%age
Sufaid Dheri	13	86.67	2	13.33
Sarband	14	93.34	1	6.66
Mashokhel	14	93.34	1	6.66
Project area	41	91.22	4	8.88

Table IX *Antenatal Care received from Qualified/Unqualified Personnel*

Villages	Antenatal Care Received			
	From Qualified personnel	%age	From Unqualified personnel	%age
Sufaid Dheri	10	76.92	3	23.08
Sarband	4	28.57	10	71.43
Mashokhel	4	28.57	10	71.43
Project area	18	43.90	23	56.10

Table X *Utilization of EPI Services*

Villages	Utilization of EPI Services			
	Positive response	%age	Negative response	%age
Sufaid Dheri	15	100	0	0
Sarband	14	93.34	1	6.66
Mashokhel	13	86.67	2	13.33
Project area	42	93.34	3	6.66

Table XI *Response towards health facilities in the project area*

Villages	Satisfied			
	Yes	%age	No	%age
Sufaiddheri	9	60	6	40
Sarband	5	33.33	10	66.67
Mashokhel	2	13.33	13	86.67
Project area	16	35.35	29	64.45

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