

Review

# The state of affairs at primary health care facilities in Pakistan: where is the State's stewardship?

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الحالة العامة في مرافق الرعاية الصحية في باكستان: أين هو دور «الحسبة» الذي تضطلع به الدولة؟

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الخلاصة: إن خدمات الرعاية الصحية الأولية في باكستان ولاسيما في المناطق الريفية هي في حالة بعيدة عن الوضع الأمثل. فقد أدت قصور الرعاية الصحية الأساسية التي تقدمها هذه المرافق، والتخيز، والجهل بأهميتها إلى نظام صحي مفكك وضعيف الأداء. وتستعرض هذه الورقة البحثية الوضع في بعض مرافق الرعاية الصحية الأولية في مقاطعة السند. وقد تبين أن عدم كفاية الأدوية والإمدادات، وضعف الاستفادة من خدمات تنظيم الأسرة، ونقص الموارد البشرية، وقصور المعدات، وغياب آلية مناسبة للإحالة، هي بعض المظاهر الأساسية لهذا النظام. ومن ثم فإن هنالك حاجة ملحة إلى إجراء تحسينات جذرية في نظام الرعاية الصحية الأولية من أجل تعظيم الاستفادة من مرافق الرعاية الصحية الأولية استفادة مناسبة. وفي سبيل تحقيق ذلك، تتناول هذه الورقة البحثية ضرورة تعزيز وظيفة «الحسبة» التي ينبغي أن تضطلع بها الدولة.

ABSTRACT Primary health care (PHC) services in Pakistan, particularly in rural areas, are in a dismal state. Inadequacies, unfairness and ignorance about the importance of the basic health care provided by these facilities have led to a disorganized and poorly performing system. This paper reviews the situation in certain PHC facilities in Sindh province. Inadequate medicines and supplies, underutilized family planning services, lack of human resources, faulty equipment, and absence of a proper referral mechanism were some of the key findings. There is therefore an urgent need for radical improvement in the PHC system in order to maximize the appropriate use of PHC facilities. In order to do this, the paper argues that the stewardship role of the State must be strengthened.

## Situation des établissements de soins de santé primaires et administration étatique au Pakistan

RÉSUMÉ Les services de soins de santé primaires au Pakistan, en particulier dans les zones rurales, sont dans un état désastreux. Les insuffisances, l'injustice et l'ignorance de l'importance des soins de santé de base fournis par ces établissements sont responsables de la désorganisation du système et de ses performances médiocres. Le présent article évalue la situation de certains établissements de soins de santé primaires de la province de Sindh. Des approvisionnements en fournitures et médicaments insuffisants, des services de planification familiale sous-utilisés, un manque de ressources humaines, des équipements défectueux et l'absence de dispositif d'orientation-recours approprié comptaient parmi les principaux résultats. Par conséquent, il est urgent d'apporter des améliorations radicales au système de soins de santé primaires afin d'optimiser l'utilisation des établissements. À cette fin, l'article fait valoir que la gestion étatique doit être renforcée.

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## Background

It is becoming recognized on the part of health professionals and policy-makers in Pakistan that health at the first level care facilities is in jeopardy and this situation has gradually become worse because of certain inadequacies, unfairness and sheer ignorance [1,2]. Despite this grim state of affairs, the public outcry to address basic health issues does not seem to reach those in power. At the same time, a huge proportion of the rural, illiterate and poor population is not even aware of their right to health; as a result they do not raise their voice against exploitation and inaction.

This review attempts to draw attention to the gaps, flaws and inadequacies in the health care delivery and functioning of the basic health units (BHUs) and the rural health centres (RHCs) in Pakistan. The other objective is to draw conclusions, based on lessons learnt, about how to revitalize the PHC system in the spirit of Alma Ata Declaration, 1978.

The sources used for the synthesis of evidence include observational field visits to primary health care (PHC) facilities in 3 rural districts of Sindh province. The basis for developing the recommendations was a thorough review of papers extracted from Medline, Google scholar and through Endnote®, using the key words: primary health care; developing countries; Pakistan; governance; stewardship in health systems. Documents, reports and national health surveys of the government of Pakistan are referred to wherever necessary. Moreover, the World Health Organization's (WHO) World Health Reports of 2000 and 2008 are used as primary documents to build the argument around the role of the State in institutionalizing PHC as well as the soundness of Alma Ata approach to strengthen PHC in developing countries.

## Basic Health Units and Rural Health Centres

A Basic Health Unit (BHU) is intended to provide treatment and medication to rural people, give appropriate health education, vaccinate the children against 7 diseases, give essential maternal and child health care and implement national programmes related to diseases such as poliomyelitis and measles. The standard essential services at a BHU are shown in the Box 1.

A Rural Health Centre (RHC) is an administrative and supply centre run by professional and midlevel health-care workers.

The RHCs and BHUs were developed to extend basic health care to rural populations during 1975–85. The main push was to train paramedics and community health workers and prepare them for the greater task of curative and preventive services for the majority rural population [3]. After the devolution of district governments, all of these health facilities had come directly under the purview of the district governments by the year 2001 [4]. All PHC centres are supposed to provide curative, preventive and promotive health services. However, in spite of all the potential, this devolved system faced many challenges in achieving the desired results [5].

In addition to the BHU package of services, an RHC also provides the following services: treatment and prevention of common illnesses; dental services; an ophthalmologist; a facility for minor surgery; an equipped and maintained operation theatre; maternal; neonatal and child health services; family planning services, services for 10–20 inpatients; a dispensary; a laboratory; and an electrocardiograph and X-ray facility. Health education is also one of the core components of an RHC.

## State of affairs at PHC facilities: data from field visits

### Medicines and supplies

The BHUs lack essential medicines and supplies for the treatment of childhood acute respiratory infection and diarrhoea, 2 illnesses that are supposed to be treated at this level of care. There is a serious discrepancy in the record of illnesses treated and the medicines available on the shelf. The majority of the BHUs do not even have functioning apparatus for oxygen. The state of the first-aid facility can be imagined by the fact that the BHUs lacked a simple nebulizer, which is essential for the treatment of asthma and chronic obstructive pulmonary disease both of which are very prevalent among the rural populations.

### Immunization

Immunization coverage is relatively low in rural populations served by the PHC facilities. Insufficient facilities for vaccination render the situation even more fragile. The vaccines are kept in private refrigerators of the facility staff because of no or non-functioning cold storage at the BHUs themselves. Thus, hardly any BHUs follows the principles of cold chain. There is apparently a massive unmet need for the vaccination against hepatitis B but the level of awareness among the population of this disease is very superficial. Thus people often seek health care for *black fever* (as local people call hepatitis B in their dialect) from traditional healers and quacks; this also illustrates the lack of health education by the PHC staff.

### Maternal & child health care

Maternal and child health indicators are not being achieved in the face of the poor performance of the PHC system. Two of the main factors required to prevent maternal deaths are attendance of skilled birth attendants at births and the

**Box 1 Role and services of a Basic Health Unit**

- Comprehensive medical care and relief, curative and preventive
- Prevention and control of communicable and endemic diseases
- Maternity and child health services and immunization
- School health services
- Health education programme
- Family welfare programme
- Improvement of environmental sanitation and provision of safe water
- Improvement of nutritional status
- Collection of vital statistics records
- Train village health workers, birth attendants, etc.
- Serve as the first level of primary care for patients referred by Lady Health Worker or Family Health Workers and in turn refers the patients to Rural Health Centre as and when necessary
- Provision of static and out-reach services for the following:
  1. Maternal and child health, family planning, Expanded Programme on Immunization and advice on nutrition
  2. Sanitation and health education
  3. Control of diarrhoeal diseases (CDD), communicable diseases control (CDC), acute respiratory infections (ARI) and other special programmes
- Serve as a focal point, where community and the public sector health functionaries come together to resolve issues concerning health
- Provide support, logistics, and management to Lady Health Workers, trained birth attendants, dispensaries, maternal and child health centres, subhealth centres, etc. falling within its geographical limits.

availability of emergency obstetric care. Bearing in mind the 3rd delay responsible for maternal deaths (health services capable of 24/7 provision of emergency obstetric care), it is obvious that the rural health system does not have the capacity to provide the emergency obstetric services so crucial to reducing maternal mortality. There are neither sterile facilities for safe deliveries nor skilled birth attendants available round the clock at these health centres. The gender of the health provider is another issue; very few BHUs and RHCs have female health staff to cater to women clients.

**Family planning services**

Most of the BHUs visited had no female doctor or staff members; female staff would be considered essential by the

local communities for counselling on contraceptives and family planning. Therefore, it becomes understandable why the prevalence of contraceptive use remains so low in rural areas despite government claims and resource-intensive programmes to promote their use. At the same time there was no shortage of supplies, especially oral contraceptives, yet the demand is negligible due to inadequate health education on family planning.

**Human resources**

Not all BHUs are fortunate to have a doctor posted there; instead we found a dispenser or a vaccinator to be the professional in charge of the facility. In certain BHUs, the doctors and other staff were working on temporary postings. Staff members reported their concerns

about their transfer to the place of their choice. Some of them mentioned that they would try to arrange this through political pressure. The security situation in certain areas makes many BHUs sites unsafe for work. Lady health workers, instrumental in community outreach health services, were also concentrated in one union council (smallest administrative unit/population concentration) alone for unknown reasons. The PHC staff mentioned the need for refresher training in order to adhere to the international standards; and also for incentives for motivation.

**Referral mechanisms**

Lack of essential medicine and other services, absent staff, questionable quality of care, limited hours of operation and many more factors leave

the patient in the middle of nowhere. On the other hand, staff of the PHC facilities feel compelled to refer patients to higher levels of care because of the lack of capacity to treat even some common ailments. At the same time, no formal mechanism of referral (ambulance, referral slips, code of practice) to *taluka* or the district level is in place. As a result, referred patients are very likely to end up in the hands of unskilled traditional healers and quacks.

## Discussion

Not more than 20% of people seek health care from the first level PHC centres in the public sector [6]. Despite all the government efforts, total fertility rate (4.1%) and contraception prevalence use rate (30%) have remained almost stagnant for the past several years, and unmet need for family planning was reported at 25% in 2006–07, which is considered high [7], suggesting low utilization of PHC services. Possible reasons for this include: non-availability of basic and essential medicines which has been an oft-observed fact; and supplies and logistics supposed to support basic maternal and child health care are either absent altogether or are in deplorable condition. However, it is very likely that this low utilization of PHC facilities is due to variety of other issues as well.

PHC as a service has long been neglected for appropriate human resources deployment and training, adequate financing and professional management, to form the base of the larger national health care system. The Millennium Development Goal 4, to reduce by two-thirds the under-5 mortality rate by 2015, and Goal 5, to reduce by three-quarters the maternal mortality ratio by 2015, and universal access to reproductive

health remain over-ambitious for a country like Pakistan. More than 65% of the rural population is still deprived of basic health facilities and quality services. The State seems uninterested in providing this very basic human and constitutional right to the majority of its citizens, reflected in its all-time low financial allocation to health for the last 10 years [8].

Strong political will is required to steward the health care system of the country to ensure the quality of services at the doorstep. Good governance, increased responsiveness, and equitable and effective service delivery will be possible if WHO's recommendation is followed in its spirit, allocating 5% of gross domestic product for health care [9]. Radical improvement of the state of the affairs at the BHUs and RHCs and updating of standards will help to maximize the appropriate use of PHC facilities. This will effectively reduce the burden of trivial and complicated cases brought to *taluka* (subdistrict) and district care hospitals. It will also benefit the entire health care system by reducing the costs incurred by these large hospitals.

It is also important to recognize that health-care staff at PHC level are poorly managed in most circumstances. Staff satisfaction is directly proportionate to user satisfaction. It is staff behaviour that determines the use of the health services at the first level care facility [10]. Unless the doctors and paramedics are given their due rights and incentives, they will continue to avoid providing their services with commitment at PHC level. Proper human resources management, administrative efficiency, monitoring and evaluation would help deliver the desired results.

The BHUs and RHCs have to take on the role of institutions that can help the local communities have a healthy

life. These health facilities can bring great change to the lives of people through raising awareness about the risk factors for various communicable as well as noncommunicable diseases. Maternal and child health can also be improved by allocating optimal resources, i.e. material and manpower for these health facilities. Strengthening the PHC system will be instrumental in helping lift the poorest out of the vicious cycle of poverty and ill health.

## Conclusion

As we approach 2015 the date for achieving the Millennium Development Goals, efforts to strengthen immunization programmes and expand health services must be intensified, and quality maternal health services must be made widely accessible at the PHC level [11]. Pakistan, being one of the 134 signatories of the Alma Ata declaration, must realize that it is investment in PHC that will guarantee gains in health. The PHC system must therefore be improved to achieve universal coverage through better integration of various health system components, particularly working with the local stakeholders [12]. Capacity-building of subdistrict and district personnel in administration, financial and human resources management is imperative for efficient use of all available health resources for strengthening PHC in Pakistan [13].

Thirty years on from the Alma Ata declaration, PHC remains a valid strategy and the cornerstone of any national health care system [14]. With greater emphasis on stewardship role of the government and meaningful community participation, there is certainly potential to make the PHC facilities in Pakistan more responsive and accountable.

## References

1. Fikree FF, Mir AM, Haq IU. She may reach a facility but will still die! An analysis of quality of public sector maternal health services, District Multan, Pakistan. *Journal of Pakistan Medical Association*, 2006, 56(4):156-163.
2. Nishtar S. The Gateway Paper—public sector service delivery infrastructure and health reforms in Pakistan. *Journal of Pakistan Medical Association*, 2006, 56(12, Suppl. 4):S43-50.
3. Khattak FH. Rural health programme in Pakistan. In: *Health Economics and Planning in Pakistan*. Islamabad, Ad-Ray Publishers, 1996.
4. National Reconstruction Bureau. *Devolution Plan 2000*. Islamabad, Government of Pakistan, 2001.
5. Shaikh BT, Rabbani F. District health system: a challenge that still remains. *Eastern Mediterranean Health Journal*, 2004, 10(1/2):208-214.
6. *National Health Survey of Pakistan—Health profile of the people of Pakistan*. Islamabad, Pakistan Medical Research Council, 1998.
7. *Pakistan Demographic and Health Survey 2006-07*. Islamabad, Pakistan, National Institute of Population Studies and Macro International Inc., 2008
8. Ahmed J, Shaikh BT. An all time low budget for health care in Pakistan. *Journal of the College of Physicians and Surgeons of Pakistan*, 2008, 18(6):388-391.
9. *World Health Report 2000: Health systems-improving performance*. Geneva, World Health Organization, 2000.
10. Van Lerberghe W et al. When staff is underpaid: dealing with the individual coping strategies of health personnel. *Bulletin of the World Health Organization*, 2002, 80(7):581-584.
11. Shaikh BT. Marching toward the Millennium Development Goals: what about health system, health seeking behaviors and health service utilization in Pakistan? *World Health and Population*, 2008, 10(2):44-52.
12. Gillam S. Is the declaration of Alma Ata still relevant to primary health care? *British Medical Journal*, 2008, 336(7643):536-538.
13. Shaikh BT, Kadir MM, Pappas G. Thirty years of Alma Ata pledges: Is devolution in Pakistan an opportunity for rekindling primary health care? *Journal of Pakistan Medical Association*, 2007, 57(5):259-261.
14. *World Health Report 2008: Primary health care-now more than ever*. Geneva, World Health Organization, 2008.

### **Social determinants approaches to public health: from concept to practice**

The 13 case studies contained in the publication *Social determinants approaches to public health: from concept to practice* were commissioned by the Knowledge Network on Priority Public Health Conditions (PPHC-KN), a WHO-based interdepartmental working group associated with the WHO Commission on Social Determinants of Health. The case studies describe a wealth of experiences with implementing public health programmes that intend to address social determinants and to have a great impact on health equity. They also document the real-life challenges in implementing such programmes, including the challenges in scaling up, managing policy changes, managing intersectoral processes, adjusting design and ensuring sustainability.

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