

Perceptions of the Beneficiaries of Basic Health Units in Rural Areas

ZAHIRA BATOOL, AMNA AFZAL AND SHABBIR HUSSAIN
Department of Rural Sociology, University of Agriculture, Faisalabad–38040, Pakistan

ABSTRACT

Role of Perceptions of the beneficiaries of basic health units (BHU) in Rural Areas of Faisalabad (Pakistan) was studied to appraise the socio-economic characteristics to identify the problems faced by the respondents associated with functioning of the BHUs. Total number of respondents was 140 females. Data were collected from two villages of two union councils of Faisalabad Tehsil. Results revealed significant relationship between the availability of proper medicine and the attendance of medical staff at BHU.

Key Words: Perceptions; Beneficiaries; Health; Rural; Faisalabad

INTRODUCTION

Health is one of the basic essentials for normal existence. In Pakistan, the existing health system is not competent enough to provide adequate services for the growing population. Such a sorry state of affairs can be attributed to some key issues associated with health sector from the very beginning. Paucity of funds, limited access to health services and their inadequacy, extreme poverty, ignorance and lack of awareness among the masses and deficient health infrastructure have been identified as fundamental problems in the way of improving public health. These problems still stand and militate against the efforts of the government to make the health sector efficient.

Regarding inadequacy of the health services the government of Pakistan formulated a comprehensive health strategy based on short run and long run policy measures to rectify the over all situations with a significant increase in funds as well (Economic Survey, 1997-98, 2002-03). Among various steps taken to improve the health facilities, a network of BHUs and rural health centres (RHCs) has been constructed in the country (Economic Survey, 2000-01).

This study was planned to (i) study the socio-economic characteristics of the beneficiaries/respondents related with BHUs, (ii) identify the problems faced by the respondents associated with functioning of the BHU in the project areas, and (iii) suggest the measures to improve the role of BHU to reduce poverty in the rural areas.

MATERIALS AND METHODS

One hundred and forty female respondents, 70 each from two villages (Chak No. 133 and 134 RB) having the facility of BHU, one from each of the two union councils randomly selected from Faisalabad district.

Keeping in view the objectives of the study, interviewing schedule (Questionnaire) was prepared and

pre-tested. To test the significance of association between the independent variable and dependent variable, Chi-square test was used.

RESULTS AND DISCUSSION

There was no association between higher education of the respondents and use of rural health facilities (Table I). Illiterate respondents and those educated up to primary level were found to be the major users of rural health facilities as also described earlier (Awan, 1990). A vast majority (83.56%) of the respondents was found to have very low annual income (Rs. 20,000) followed by 14.99% having Rs. 20,000 to 50,000 and 1.43% having an annual income more than Rs. 50,000. The results indicate that level of the income of the respondents, in general, has not changed much in the light of results of Yasin (1990).

Table I. Association between respondent's education and use of rural health facilities

Education	Use of Health Facilities			Total
	Rarely	Often	Very Often	
No Schooling	24(48.9)	23(46.9)	2(4.1)	49(35.0)
Primary	27(55.1)	21(42.9)	1(2.04)	49(35.0)
Matric	11(29.7)	23(62.2)	3(8.1)	37(26.4)
F.A. and above	3(75.0)	1(25.0)	----	4(2.86)
Total	65(46.0)	69(48.7)	6(5.3)	140(100.0)

$\chi^2=8.25693$ NS $\alpha = 5\%$ or 0.05

Most of the respondents (41.43%) reported that the attitude of the staff was satisfactory (Table II). Attitude of medical personnel has bearing upon the use of rural health facilities. It means that good attitude of medical personal has positive effect on the use of rural health facilities especially for women. Availability of the doctor at BHU was confirmed by some (5.71%) of the respondents (Table II). Therefore, most of the patients were attended by the

Table II. Availability of the staff at the B.H.U.

Category	No. of respondents	Percentage
Availability of staff		
Doctor	8	5.71
Dispenser	48	34.29
L.H.V.	4	2.86
Mid Wife	17	12.14
No response	63	45.00
Total	140	100.00
Attitude of staff		
No response	58	41.43
Satisfactory	58	41.43
Good	16	11.43
Bad	8	5.71
Total	140	100

Table III. Association between availability of proper medicine and use of rural health facilities

Responses	Availability of medicine		Total
	Yes	No	
Really	23(35.4)	42(64.6)	65(44.4)
Often	71(94.3)	4(5.7)	70(50.0)
Total	94(67.1)	46(5.7)	140(100.0)

$\chi^2 = 24.34620$ $\alpha = 5\%$ or 0.05 Highly Significant

dispenser and midwife. It was interestingly noted that 45% of the respondents did not respond to the question of availability of hospital staff. Results revealed significant relationship between the availability of proper medicine and use of rural health facilities (Table III).

CONCLUSIONS AND SUGGESTIONS

Along with education improvement in health status directly address the worst aspect of poverty. Access of the poor to health services are important both for increasing their income (illness reduces people's capacity to work) and for raising living standard even if income remains at poverty level. Following are the summary and suggestions establish on the basis of data analyzed and some for policy maker. These both suggestions will be helpful to enhance health level which will ultimately reduce poverty.

1 Higher the education of the people more will be the use of rural health facilities. This statement is not significant according to the current study. But, if the people are equipped with health education through different media more people will visit the hospital. Only 15% patients were attended by the doctor where as approximately 95% of the cases are attended by the Dispenser and L.H.V. This state of affair is very discouraging.

2. In case of emergency, patients have to go D.H.Q. hospital and many patients expired without taking any medical aid. Syringe used in the hospital are disposable but these are not disposed off after use and these are sources of infection for healthy (male and female) people. It is suggested that doctor

should be available at BHU 24 h. It will help to reduce mortality.

3. It is also recommended that mobile clinic vans should be attached with BHU so that emergency cases may be treated at the door step in time.

4. Moreover, facilities of diagnostic laboratory should be established at BHU, which should be controlled by the Health Department with active participation of local community.

5. Proper availability of medicine is associated with the use of rural health facilities. So, it is suggested that necessary medicine which are used for emergency cases (blood pressure, sugar and heart attack and labor cases) along with general medicine used for general case should be available at BHU. It is also suggested that availability of vaccine (hepatitis, diarrhea and small pox) should be ensured at BHU.

6. It is further suggested that a revolving fund may be generated at BHU and it should be managed with the participation of local council at village level or union council level as the case may be.

7. Medical staff reported by the respondent particularly doctor both (male & female) and other staff in general, were not present at BHU. They prefer to attend the patient at their private clinics. Therefore, this practice should be checked through good governance.

8. Health care is a fundamental right of the people and it must be the prime responsibility of the state. So health budget should be increased from 1% to at least 6% of G.N.P in order to proper furnishing the BHU with medicine, medical personnel and facilities for staff.

9. The role of hospitals, R.H.Cs and B.H.U.s should be redefined. Beside service to the patients, teaching training and research must be mandatory. Their financial and manpower needs should be met on priority basis. D.H.O (District Health Officer) should make frequent visits to the B.H.U (Scheduled and unscheduled).

10. Private hospitals and clinics should be encouraged and invited to play a more effective role in the national rural health activities. Those operating in the preventive field also and offering expertise, should be given incentives. Moreover, the existing private clinics and hospitals in rural areas should keep low their fees. So, rural people can maximum utilize them.

REFERENCES

- Awan, K.A., 1990. *Socio-economic and Demographic Profile*, Pakistan Institute of Development Economics (PIDE), Islamabad
 Government of Pakistan, 2000-2001. *Economic Survey of Pakistan*. Finance Division Islamabad
 Yasin, G., 1990. Demographic impact of Basic Health Units in rural areas of Toba Tek Singh district Faisalabad *M. Sc. Thesis*, Department of Rural Sociology University of Agriculture, Faisalabad-Pakistan

(Received 10 October 2004; Accepted 20 December 2004)