HEALTHCARE CHALLENGES IN GILGIT BALTISTAN: THE WAY FORWARD

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Abstract

Quality healthcare delivery is the bedrock to exponentially accelerate the development of a country. Unfortunately, in Pakistan healthcare has been neglected since a long time, with the common man bearing the brunt of this acute situation. There are critical challenges in health care, with paucity of trained human resource and deficit of regulated infrastructure and service delivery being the predominant dilemmas. Primary and secondary healthcare are in an unseemly state, to say the least. Maternal and child health care, accident, and emergency departments and mental health are among the most undermined and forsaken areas of healthcare, primarily in the far flung Gilgit Baltistian region of Pakistan. The only way forward is if the political regime, administration and the medical personnel work in concurrence to revise the health infrastructure of the country.

Introduction

The Northern Areas of Pakistan were re-designated as Gilgit Baltistan (GB) under the Gilgit Baltistan Empowerment and Self Governance Ordinance 2009. Gilgit Baltistan now holds the status of an autonomous territory of Pakistan. The people of GB are a pristine example of ensuring survival against challenges imposed by nature and worldly circumstances. They are an amalgam of various Islamic sects cohabiting in harmony, enduring harsh winters, enjoying pleasant summers and hosting throngs of tourists from all over the world. These people have homes amongst the three largest mountain ranges of the world; the Karakoram, Himalayas and Hindu Kush. With serpentine roads and in certain areas just rocky mountainous tracks being their only means of commute from far flung towns and villages to the main cities of Gilgit and Skardu. GB has an estimated population of 1.3 million and three administrative divisions; Gilgit, Baltistan, and Diamer, which are further ramified into ten districts. There are 5 District Head Quarter Hospitals (DHQ), 27 Civil Hospitals (CH), 15 Basic Health Units (BHU), and 2 Rural health Centers (RHC) in the region. (1).

A public health facility assessment was conducted in all the DHQs, CHs, RHCs and 20% BHUs to determine the availability and quality of maternal, child and newborn services by evaluating the following parameters; infrastructure, training of staff, availability of drugs and equipment, work coordination and supervision, service delivery protocols, management information systems, infection control and death reviews. The report revealed that all BHUs assessed were unable to provide 8/6 (8 hours a day, 6 days a week) preventive Maternal, Neonatal and Child Health (MNCH) services due to deficiency of one or more components of preventive MNCH services package. Similarly the RHCs and CHs were assessed for provision of 24/7 (24 hours a day, 7 days a week) Basic Emergency Obstetric and Newborn Care (EmONC) service package and for additional complementary services, none of them were fully functional and were unable to provide complete package of basic EmONC services. Likewise in all DHQ hospitals due to lack of one or more of the essential components, none of the DHQ hospitals were completely functional for provision of 24/7 Comprehensive EmONC services package. It is pertinent to mention here that GB has a maternal mortality rate of 600/100,000 live births (2).

With the national incidence of poverty at 29.5% and a literacy rate of GB at 43%, it is veracious to reason that health, education, and economic stability are all densely intertwined issues which cannot be untangled independently (3,4). Nonetheless it is the responsibility of the state to make quality healthcare accessible and available to the masses.

Another grave issue is that the doctor to population ratio in GB is alarmingly disproportionate i.e. 1:4100 whereas the national statistic is 1:1206 (5,6). This statistical evidence testifies to the stark reality that health care in Gilgit-Baltistan is in an appalling state. There is no trained medical specialist and neonatologist in Skardu city and no trained psychiatrist in public sector in the Gilgit Baltistan region. There is only one psychiatrist in Combined Military Hospital (CMH) Gilgit, who is accommodating psychiatry patients from the entire GB region.

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The Gilgit Baltistan Demographic and Health Survey 2008 also shows noteworthy statistics, revealing that women delivering in a health facility are only 39% and child mortality rate for both sexes is estimated at 92/1000 live births. Furthermore, contrary to World Health Organization (WHO) recommendations only a little more than one third (37%) of children are exclusively breast fed in GB, with high prevalence of micronutrient deficiencies such as Vitamin A deficiency in infants. The prevalence of all types of diarrhea among children under five years of age during the two-week survey preceding the study was found to be 22% (7).

The prevalence of mental health disorders is also an unchecked realm of health care in Pakistan in general but particularly in GB. Pakistan is a developing country, with GB largely constituting of a population with orthodox views and limited horizons of thinking. Hence seeking help for psychiatric and psychological disorders particularly, is associated with a social dogma of conservatism, which makes people resist, or decline help for mental illnesses. On the other hand in health care settings, psychiatric illnesses are commonly under diagnosed and under treated by health care providers. These hurdles are a few reasons as to why accurate national indicators of psychiatric morbidity are scarcely available and only a handful of studies are documented to have examined this facet.

A study conducted in district Ghizer shows age specific suicide rate in females of 61.07/100,000 per year, which is the one of the highest in the world (8). Another article published in Passu times has revealed statistics that show substantial increment in suicide rates throughout Pakistan, specifically in the Gilgit Baltistan region; 23 suicides were reported in Gilgit in 2012, with gender breakdown of 10 females and 13 males (9). A cross-sectional study conducted in Chitral and Khyber Pakhtunkhwa (KPK), which is a region ethnically and culturally similar to GB, uncovered that the suicide rate in females is almost double than that of men, of 168 suicide cases studied, 68% were women and 38% are men. The leading causes identified were family issues, lack of confidence, mental health problems, and academic failures (10).

Depression is the most common mental health disorder, which has its origin in our society’s social and cultural dogmas. A pilot study conducted to determine socioeconomic factors of depression in females of district Ghizer, GB showed results that identified domestic abuse (verbal and physical) and poor relation with in laws as principal causes of depression. Non cordial relations with in laws were found to be a strong predictor of depression in females (11).

**Methodology**

This review article aims to analyze the healthcare crisis in the Gilgit Baltistan region in an attempt to find practical solutions to improve the healthcare delivery system and achieve health for all. The web links searched for research statistics and data on the northern region of Pakistan include Pub Med, Google Scholar, and Google Web search. The references include journal articles, government surveys, private sector and non-government organization (NGO) reports, information, and data from international development organizations websites.

**Problems in Healthcare Delivery**

There is a wide spectrum of issues in the heath sector in GB, some of which are the ubiquitous lack of doctors, trained paramedical staff, laboratory technicians, state-of-the-art equipment for diagnostic, and treatment purposes. People who have the means to reach the relatively big cities, Gilgit and Skardu, for treatment are seen swarming and choking the outpatient clinics and emergency rooms, where specialist doctors are sparse and the treatment options are limited. Patients then inevitably have to travel to major cities down south for better treatment options (12). As for the hefty population bracket that is unable to access and afford tertiary care hospitals in Gilgit, Skardu and the south of the country, are mostly residing in far flung towns and villages bordering areas as ranging as K2 and Siachen. They are left to wait for divine intervention or to quietly succumb to suffering and decadence.

The DHQs, THQs, BHUs, and dispensaries are of negligible benefit to the community since doctors are rarely available, a handful of laboratory investigations are being performed, there is a serious shortage of trained laboratory and operation theater technicians and trained nursing staff, and no basic medicines are procurable. Accident and Emergency departments are in dismal state with limited availability of lifesaving drugs (13).

Hospital set ups lack standard operating procedure for hospital laundry segregation, collection, and disposal. Additionally hospital waste management policy is almost nonexistent. Some hospitals also have serious issues of water supply shortage, making patient care, hospital cleanliness and maintaining even basic hygiene extremely difficult (14). Winter season is harsh, with patients trickling into hospitals and other facilities continuously nonetheless no well-regulated, round the clock heating system for pediatric and adult patients in wards and for attendants in waiting areas is being provided.

The silver lining in this crisis are the Lady Health Visitors (LHV), Lady Health Workers (LHW), and Dai (Traditional Birth Assistant, TBA), they are the caretakers of maternal and child health at the grass route level. They offer door to door antenatal checkups and assisted home deliveries. Despite of this there are many reported cases of complications during labor and delivery such as obstructed labor and postpartum hemorrhage, due to the unskilled management of patients by untrained health workers and TBAs.

Time and again donations by international non-government organizations (NGOs), donor
organizations, and public-private collaborative projects to health facilities have been made. With laboratory equipment, examination apparatus, dental chairs, examination couches and other hospital essentials being donated (15). But the scrupulous use of all these donations is crucial otherwise they have been wasted in the paste due to lack of use or improper use.

Conclusion
Resonating with a lack of accountability and professionalism, it is often claimed that there is a sheer lack of funds responsible for the unfortunate condition of health facilities; it will not be incorrect to assume that commensurate with the population load the funds available or allocated to the respective health departments are adequate, if utilized judiciously and honestly.

On the other hand it is also pertinent to highlight the essential role of doctors in improving the healthcare situation in this hard area. Doctors are mostly very reluctant to go and serve in a far flung, hard area which is difficult to access from the rest of the country and is lacking in very palatable facilities. These doctors should conscientiously realize their responsibility and duty to give back to the community that nurtured them (16). Although recently the government of Gilgit Baltistan has offered a pay incentive package to attract doctors but despite of this effort, unfortunately the shortage of doctors is persisting. To rectify this at a very nascent level, it is necessary that medical education be redesigned to substantially incorporate the facets of primary and secondary health care and their unparalleled significance in improving the health indicators, thus defining the fundamental role of social physicians and public health specialists for medical students. Furthermore, medicine supply chain should be very responsibly handled and maintained with the supply and delivery of life saving drugs ensured to each health care facility across GB.

In addition to this the LHVs, LHWs, dais and other paramedical staff need refresher trainings and knowledge of latest guidelines regarding maternal, neonatal and child health care to deliver health services in a more professional manner and therefore reduce the chance of complications during labor and delivery in both mother and baby (17).

Lastly an innovative health care model should be constructed and implemented where the infrastructure is revised, medical personnel is trained efficiently, health care facilities are equipped to handle at least basic medical emergencies. Surmounting all this should be good governance and an astute administration, whose pivotal role can’t be emphasized enough in the smooth execution, running and revamping of the current health program.

It is disheartening to see the common man being deprived of basic healthcare facilities, whereas advanced nations have championed affordable and quality healthcare delivery by instituting universal-healthcare coverage plans, such as in the United States, and have made state-of-the-art healthcare delivery the chief indicator of their burgeoning economy. On the other hand we have chosen to ignore the alarming state of our healthcare sector and the suffering of the underprivileged among us. Health constitutes 0.9% of Pakistan's gross domestic product (GDP), provincial and federal combined, making it one the smallest expenditure heads (18). This meager number is unequivocally depicting the apathy and lack of importance the government holds for healthcare. The state of government hospitals all over the country is dreadful, with the well-off relying mostly on private hospitals; it seems that the poor are left to suffer in silence and eventually wither into oblivion.

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