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A Sociological Study of the Health Problems of the Rural Area of Dera Ghazi Khan

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Abstract

It takes on a more serious form in developing countries like Pakistan, where democratic and administrative institutions are weak and societies are politically unstable, and where public health is not one of the top priorities of governments. Scientific research and statistics indicate that the growing population is reducing the resources available for public health, especially during childbirth, which severely affects the infrastructure of women and children. The people of rural areas live very close to the nature but also confront important challenges. These problems include lack of human service medical professional and facilities. On the other side, rural areas are often poor and lack the basic services, employment opportunities. Rural areas often lack sufficient numbers of health care professionals, hospitals, and basic health centres. Problem is the long distances that ambulances and patients must travel. Because ambulances and other emergency vehicles must travel so far, rural residents with any emergencies receive medical attention more slowly than their urban counterparts. The long distance that people must travel makes it more difficult for patients with health problems to receive medical care. Any case of medical emergency that needs to be treated within 2-3 hours might have to travel equal or more hours in each direction to receive treatment. Travel distances in rural areas also mean that rural residents are less likely than urban residents to receive preventive services. It was concluded that availability of emergency services were associated with patients satisfied with provided Basic Health Unit services. Medical facilities were associated with patients satisfied with provided medical facilities in Basic Health Unit. Doctor check-up was linked with patient's satisfaction with doctor's availability. Doctor's availability was associated with beneficial for rural people during emergency. Patient's satisfaction with paramedical staff performance in rural area. The study focuses a small region Dera Ghazi Khan for its health issues especially in the rural areas where insufficent facilities are the real challenges for health.

Keywords: Dera Ghazi Khan, Facilities, Health, Problems, Poverty, Rural.

Discussion

Pakistan needs to control population to improve its public health system, but experts say it is a problem that also requires a better health system to control. Because controlling population requires awareness and measures of family planning, which are not possible without a better public health system. At this point, both population control and the health system appear to

be interdependent. Or circular dynamic emphasizes the urgent need for comprehensive health care policies, which require attention to maternal health, access to women's health care and widespread awareness campaigns. The problems facing the health system in Pakistan include the increasing rate of patients coming to hospitals, inadequate manpower and facilities, the lack of modern testing systems for the poor and middle class population, and expensive medicines. While in addition to mainstream cities, insufficient doctors in towns and villages are also a deep problem. There are only 14.5 doctors per 10,000 people in urban areas of the country, while the ratio is 3.6 in rural areas. Due to which patients from towns and villages have to go to big cities in any case, which is why the pressure on hospitals and medical centers in cities is increasing day by day.

Health is state of functional fitness that emphasizes on social and personal resources, as well as physical capacities. In human beings, the extent of an individual's physical, emotional, mental and social ability to cope with his/her environment is termed as health. The WHO defines health as a state of complete physical, mental, and social well-being, and not merely the absence of diseases or injury. Access to health services depends on the availability of service (i.e. the availability of physicians, health centers, and hospitals) to the actual as well as potential users. In Pakistan, health facilities in both public and private sector are distributed in an unjust way, which makes the services inaccessible to low income and rural people. Along with such unjustified distribution of services between urban and rural areas, delivery of services also varied depending on the level of income (rich and poor), which is evident in discriminatory access to services (Naz, 2012).

Rural families face a particular set of issues in accessing mental health care. Like the rest of the rural population, rural families' access to mental health services is limited by the severe mal-distribution of psychiatrists and psychologists. Poor roads and distance from providers are also commonly cited issues that limit access to care for rural populations. Due to the sometimes remote location of farms, these factors may present an even greater barrier for rural families compared with other rural dwellers. Additionally, stigma may play a role in reducing access to mental health care for rural families. Stigma has been found to be a barrier to help-seeking among rural communities (Fraser, 2006). Another serious aspect of access to health facilities in Pakistan is the plight of rural areas. People living in cities may not even imagine how poor the health facilities are in villages. The lack of basic health centers, absence of doctors and lack of facilities in these areas is a problem that cannot be ignored. People living in rural areas have to travel miles for their treatment and often die before they realize the seriousness of their illness. Here the question arises: where is the government? How far have the projects that the government had made in the name of health facilities reached? Although the government allocates a budget for the health sector every year, most of it either falls victim to corruption or is spent on projects that are not accessible to the common man.

While rural health is both diverse and complex, and the socio-economic and cultural factors at play in rural communities reflect this. These characteristics are entwined and inseparable. Characteristics that might have a substantial impact on the health of residents in one community might have little impact in another because of the influence of other locally distinctive factors. However, overall, socio-economic factors are major drivers of health in rural areas. The loss of younger families is also likely to weaken social cohesion and the ability of rural communities to provide resources and informally enforce acceptable behaviour. As

community groups and organizations become more and more dependent on an older generation for continued existence, the services they can provide and resources they offer are likely to decrease. Of course, these patterns are highly community-specific (Beard, 2009). The influence of changing social, economic, and political issues, particular health culture will get framed and re-framed continuously over a period of time. The psycho- sociological compliant of health culture we first need to take into account the overall culture of the community. It is a known fact that certain health culture practices lead to certain health disorders too. Hence, it is very vital to study rural health issues because certain cultural practices by the community will get either by diffusion or through any new local innovations. Social particular, plays a vital role in understanding both qualitative and quantitative changes in various domains of health culture of the rural people (Nanjunda, 2019).

Rural residents often encounter barriers to healthcare that limit their ability to obtain the care they need. In order for rural residents to have sufficient access, necessary and appropriate healthcare services must be available and obtainable in a timely manner. Even when an adequate supply of healthcare services exists in the community, there are other factors to consider in terms of healthcare access. For instance, to have good healthcare access, a rural resident must also have: financial means to pay for services, such as health or dental insurance that is accepted by the provider. Means to reach and use services, such as transportation to services that may be located at a distance, and the ability to take paid time off of work to use such services. Confidence in their ability to communicate with healthcare providers, particularly if the patient is not fluent in English or has poor health literacy. Trust that they can use services without compromising privacy and belief that they will receive quality care (RPHA, 2021).

Health systems need to account for the specific needs of the rural poor: financing e.g., ensuring equity in financial protection (can the rural poor access financial protection and is the depth of coverage and services included appropriate for their needs. Service delivery e.g., ensuring coverage by the rural poor with services of the type and intensity that are proportionate to need, using equity-oriented service delivery models that account for multidimensional poverty in rural areas. Enabling the availability of adequately skilled health personnel in rural areas, and providing gender-responsive and culturally appropriate care for the rural poor. Medicines e.g., facilitating the accessibility and availability of essential medicines, technologies and health products for all not only the urban affluent (Koller, 2019). The main problem is getting from the village to the HP/clinic as the Rescue 1122 ambulances based at the clinics generally do not provide this service. Since charges for medical care have now been removed it seems likely that the Rescue 1122 will not collect patients from villages at all because limited funds for fuel will make this unaffordable. The main means of transport from the villages are walking, bicycles and ox-carts. Bicycles are the fastest but are not suited to carrying maternity patients because of the discomfort. Walking and ox-carts are very slow and because women often leave the decision to travel until the first labour pains they may give birth by the road-side, increasing the risk of complications. The condition of the roads, particularly in the rainy season, is a significant barrier to access, making trips more uncomfortable and longer. Longer trips increase the risk of giving birth by the road-side. Streams and rivers may be particular barriers in the rainy season because of the lack of bridges for vehicles (Orcutt, 2013).

Rural residents have shorter life spans, less healthy lifestyles and overall, live in worse health states due to a higher incidence of chronic disease. They also face a wide range of threats to health status and health performance challenges including increased poverty and joblessness. The provision of quality health services in rural areas is not only challenged by a larger share of ageing populations but also by poor social determinants of health, barriers to system access and issues finding and retaining qualified medical personnel. Rural healthcare facilities also face financial pressure from low economies of scope and scale, making the balance between access and efficiency particularly difficult for Poor people with disabilities who live in poor rural societies experience unique problems in accessing health services. Their situation is influenced by multiple factors which unfold and interplay throughout the person's life course. The difficulties do not only affect the person with a disability and his or her family, but also impact on the relevant care unit. The barriers are rooted in a life in poverty, upheld and maintained by poverty-reinforcing social forces of the past and the present, and reinforced by the lack of the person's perspective of the health services. Various difficulties may interact and influence access to and utilization of health services, and how this may render health services out of reach even when they are available (Grut, 2012).

In rural areas, the facility does not have a stock of medicines available. Patients have to buy their prescriptions from general stores at higher rates. Staff and patients visiting the facility are forced to drink polluted water while the person hired to operate the project is being paid for rendering zero services. Perhaps the biggest issue faced by the rural health centre is the fact that the wall surrounding the premises has crumbled to the ground. At the back, the boundary wall is non-existent making it easier for thieves in the night to steal blankets and equipment (Zafar, 2019).

The government has allocated only a small share for health care in the budget. It is neglected just like education and basic health facilities are not within the reach of the poor man who cannot afford a normal doctor's fees and the price of medicines. Government hospitals lack resources as well as proper doctors. The hospitals where doctors are present are helpless due to the absence of proper resources to treat their patients. Those who can't afford private doctors wait for death to ease their suffering. Most of the health care facilities in such areas are provided by NGO run hospitals and clinics. Pakistan is ranked lowest in education and health among the nuclear powers. The birth rate and death rate are higher than usual as well. The government has clearly no interest in the welfare of its people, which is why they are deprived of basic facilities that the state is required to provide them. So it is time the government should take serious measures to improve health care facilities in rural areas as well as in cities (Shah, 2018).

Major rural health issues a chronic shortage of doctors, dentists, pharmacists, and non-physician providers; a wave of hospital closures; and a widening gap in life expectancy that favors the urban populace over rural residents continue to test the fragile system of rural care. Rural hospitals are prized assets in their communities, but as closures have increased and more facilities face financial troubles, there is greater recognition by stakeholders who advocate for rural providers that delivery alternatives may be necessary. While it is critically important to sustain rural safety-net providers, it is equally important to outline a meaningful, phased, and nondestructive transition strategy that successfully links today's payment and patient care structures to the health systems of the future (Iglehart, 2018).

The rural individuals, belonging to all age groups and backgrounds pay adequate attention towards their health conditions. The elderly individuals are required to make visits to health care centres on a regular basis to get their check-ups done. But in the case of severe health problems and illnesses, individuals are even required to make visits to urban areas. When the individuals spend their savings on medical treatment, then they do experience financial constraints in meeting other requirements. Hence, taking care of health care needs may use financial resources, thus giving rise to poverty. The individuals are required to maintain their good health and well-being to get engaged in any task or activity. Due to the prevalence of the conditions of poverty, individuals experience malnutrition and health problems and illnesses. In case of health problems and illnesses,4the individuals are unable to get engaged in any tasks or activities, or look for employment opportunities. The rate of unemployment is mostly high among the individuals, who experience permanent disabilities or health problems (Kapur, 2019). The main means of transport from the villages are walking, bicycles and ox-carts. Bicycles are the fastest but are not suited to carrying maternity patients because of the discomfort. Walking and ox-carts are very slow and because women often leave the decision to travel until the first labour pains they may give birth by the road-side, increasing the risk of complications. The condition of the roads, particularly in the rainy season, is a significant barrier to access, making trips more uncomfortable and longer. Longer trips increase the risk of giving birth by the road-side. Streams and rivers may be particular barriers in the rainy season because of the lack of bridges for vehicles (Orcutt, 2013).

Rural areas have by definition low population densities, often making rural medical infrastructure less economical in terms of number of individuals that can be served. Attracting and retaining well-qualified medical personnel is more challenging in rural environments. Some of the health problems like lung diseases and silicosis run with the primary occupation of the inhabitants, especially those working in stone mines. Reproductive health is often poorly managed and results in high pregnancy rate, high miscarriage rate, death at the time of labour, etc., due to both economic and cultural reasons. The biggest problem faced by authorities in this regard is lack of awareness. One of the major reasons for such a deplorable state of health in these areas is the lack of health facilities. Medical facilities such as clinics and hospitals are scarce. When advanced medical care is necessary, villagers must traverse long distances through the desert. Transportation in itself can be a prohibitive barrier or expense for many poor villagers (Naz, 2013).

Due to the lack of a consensus definition of rurality, researchers tend to develop their own measures that are appropriate for a particular study, but cannot then be compared with other areas or studies. Consequently the evidence base for rural health issues is limited. A similar exercise is planned for wales. If researchers and policy-makers were to use this categorization widely, the level of comparable evidence for rural areas could improve. Health staffs are also affected by distance: many practices in rural areas have larger areas to cover than their urban counterparts. More unproductive time and money are spent travelling to see patients, attending meetings and accessing continuing professional development for staff. The socio-cultural issues also affect staff. On the improving health services in poor communities might involve changing the incentive structure for public providers. Introducing incentives in the public sector is often difficult due to non-flexibility of civil service rules. Incentive methods like paying extra allowances for hardship posts have been implied in many countries. All

mechanisms of incentives have their own risks and none of them is problem free. A potential obstacle to the implementation of the strategy for quality service delivery is the understandable reluctance of health staff, often having a relatively urban background and social and family ties, to work in remote communities with poor utilities and social opportunities. Better selection process would be to link selection of candidates to districts where they already live, so that even before they are trained, they are allocated for particular districts and communities, and after training will not be accepted elsewhere (Farooq, 2004). Health service delivery in our country offers nothing much to write home about. People are suffering for want of proper health services even in urban centres. For those who can afford medical treatment, there are good healthcare facilities in private-sector hospitals. But most of the people those belonging to the poor and lower middle class have had to depend upon public-sector hospitals that are not just burdened way beyond their capacity, but are not properly equipped and adequately staffed either something that affects the quality of healthcare services. The situation in rural centres is even more pathetic. In particular, even a small healthcare facility is only available at a distance. A big number of people in small towns and villages lose their lives just because of lack of medical facilities and shortage of doctors, nurses and paramedical staff. Even for cases like dog bite, patients have to be rushed to cities. There are reports of women giving birth outside hospitals either for non-availability of bed or of medical staff something that often results in children dying during birth (Ahmed, 2021). Better management and oversight and an increase in the number of sanitary workers may improve the better hygienic conditions, the report suggested. One third of the monitored rural health center either did not have latrines or had latrines without running water. Most deficient in female staff, maternity and family planning facilities. During a day-long monitoring, female staff was not found on duty in half of the observed rural health center and family planning counseling staff was absent in three- fourths of the rural health center (Wasif, 2010).

A rural society, individuals in rural areas today can be characterized as a vulnerable population. Rural residents are more likely to live in poverty, lack health insurance, report poor health, have a chronic health condition, and be unemployed. As a population, rural inhabitants earn less income and include a higher proportion of the elderly. Additionally, rural areas lack the social and health services necessary to accommodate its inhabitants. Services that do exist have been described as fragmented and inconsistent. This is especially true of mental health care in rural areas. The problems with mental healthcare services in rural areas are an unimportant endeavor; identifying these problems is crucial to developing solutions. The energies of rural psychologists, both in academia and in practice, be directed toward collaborative work to implement strategies for change (Jameson and Blank, 2007).

Health is a state of functional fitness that emphasizes on social and personal resources, as well as physical capacities. Enabling the availability of adequately skilled health personnel in rural areas, and providing gender-responsive and culturally appropriate care for the rural poor. Medicines e.g., facilitating the accessibility and availability of essential medicines, technologies and health products for all not only the urban affluent. In rural areas, the facility does not have a stock of medicines available. Patients have to buy their prescriptions from general stores at higher rates. Rural hospitals are prized assets in the communities, but as closures have stakeholders who advocate for rural providers that delivery alternatives may

be necessary. Due to the prevalence of the conditions of poverty, individuals experience malnutrition and health problems and illnesses. In case of health problems and illnesses, the individuals are unable to get engaged in any tasks or activities, or look for employment opportunities. The biggest problem faced by authorities in this regard is lack of awareness. One of the major reasons for such as deplorable state of health in these areas is the lack of health facilities. Medical facilities such as clinics and hospital are scarce. Transportation in itself can be a prohibitive barriers or expense for many poor villagers. A big number of people in small towns and villages lose their lives just because of lack of medical facilities and shortage of doctors, nurses and paramedical staff. Even for cases like dog bite, snake bites, patients have to be rushed to cities. Rural residences are more likely to live in poverty, lack health insurance, report poor health, have a chronic health condition and be unemployed. Additionally, rural areas lack the social and health services necessary to accommodate its inhabitants. The present study about emergency and health problems faced by rural people in rural area of Dera Ghazi Khan, because researcher belongs to tehsil Dera Ghazi Khan; and found the rural peoples faced various emergency health problems in rural areas. The focus was on the needs to massive investment, better planning, and special attention to rural areas for development in the health sector so that every citizen of the country can benefit from quality and accessible health facilities. It is the responsibility of the government to make the lives of the common man easier and provide them with better living facilities. The tragedy is that none of our governments has paid any attention to this.

Conclusion:

Another major problem in Pakistan's healthcare system is the unavailability of medicines. Free medicines are promised in government hospitals, but patients often have to buy expensive medicines from outside. The prices of medicines in pharmacies are skyrocketing and it is almost impossible for the common man to buy medicines. In this situation, people resort to the help of do-it-yourself doctors and fake doctors, who further worsen their illness. The government has made claims of reforms in the healthcare sector at different times. Programs like Sehat Insaf Card have been introduced, which were aimed at ensuring that everyone has access to quality healthcare facilities, but the reality is that the benefits of these programs are limited to only a few percent of the people, those who can benefit from these programs do not get information at all, and those who have the card do not get the required treatment. In all this, Pakistan's healthcare system looks like a hollow building, whose foundations are weak and which is in danger of collapsing at any time. Public trust in government hospitals has eroded, and only the elite can afford to go to private hospitals. The victim of this irony is the common citizen who cannot afford to get his illness treated.

The study was about "A sociological study about emergency and health problems faced by rural people in Dera Ghazi Khan.". Objectives of the study were: i) to investigate the health problems faced by rural people; to find out provision of medical facilities in rural health centres in case of emergency and health issues; to suggest some measures to overcome emergency and health problems in tehsil Kot Chutta. It was concluded that availability of emergency services were associated with patients satisfied with provided Basic Health Unit services. Medical facilities were associated with patients satisfied with provided medical facilities in Basic Health Unit. Doctor check-up was linked with patient's satisfaction with

doctor's availability. Doctor's availability was associated with beneficial for rural people during emergency. Patient's satisfaction with paramedical staff performance in rural area.

Recommendations

1. Emergency 1122 services should be provided 24/7 in rural area.
2. Availability of doctors should be ensured in rural area.
3. Laboratory/ lab test should be available in rural area.
4. Physicians should also be in rural area.
5. The medical superintendent should strictly check the duty of doctors.

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