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Epidemiological changes and Public Health: An Evidence from Pakistan

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Abstract

With the eight best mortality rates of the world just born ten years ago, five children died of that value in Pakistan. Also, women die of motherhood at 1 in 80 and opportunities have caused reproductive health in their lives. In order to back up in Pakistan, we continue the vaccination rate, infant mortality rate and contraception as compared with other South Asian countries. Compared to overall health expenditure, the proportion of payments between Pocket's positions in the pocket is the highest and the proportion of the cost of private medical costs in the region is about 98%. The data was collected from different secondary resource of Pakistan's official and non-governmental organizations (NGOs) which revealed that the area, Suffers from lack of health facilities. Pakistan also follows the double-borne, epidemiological changes of infections, maternal and parental conditions against time, and chronic infections. Beware of the poor condition of public service launched for the overall public health facilities in urban and rural areas differently because these parts are increasing significantly due to the provision of services to private business. Among the ruins 18 reforms to the constitution being undertaken in the public health sector the departments of the country, revenue creation services, and after rank uncertainty. Indicators of multi-faceted people working on policy Indicators of maternal health and mental health need a bottomless child, reducing the affliction of disease. It is also necessary to recover the care of the territories of the great arguments of the first and childbirth with powerful ones.

Keywords: *Public Health, Situation, Inequality, Pakistan.*

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1. Introduction:

The Millennium Development Goals (MDGs) provide timely targets for the eradication of poverty and pledge fundamental human rights for education, health, and security in the Universal Declaration of Human Rights and the Millennium Declaration of the United Nations (UN Millennium Project, 2006). A couple of years just before the 2015, it's beneficial to understand how Pakistan has reached health related objectives in the year 2000 health results, the health of a country in the past decades in measuring and performing comparisons between countries. Pakistan is not on the way to reach most of the MDGs for health. While it has been development in education

and health rests at the margin of the development setting. The 8 highest new born mortality rate into the world and born in 10 children expired in Pakistan throughout 2001-07 before the age of 5 years. According to World Bank report women have a 1 in 80 chance of dying of the health of mothers causes throughout their reproductive life by 2010. Pakistan has huge challenges to improve the health consequences for children and young.

In purpose to attain significant developments in the health sector, it is necessary to have a well organized health program not only in the short-term health effects, but also have to improve the long period of population health, when formulating more general. In view, the current level of public spending on health appears unlikely to progress in this segment. The superiority of public health care is a recession in recent decades and increasing population pressure on state institutes to increase. This allows the private agencies or organizations to link the gap between increasing demand and public facility of health related. And this way the role of the private sector in the stipulation of services has grown extremely. The weak state of public services contributed overall to the abridged role of public health. Out-of-pocket costs as a fraction of private health expenses are about 98 percent, putting Pakistan between the nations with the uppermost proportion of payments out of pocket for the as a whole health spending. (World Health Organization, 2009)

Pakistan's intervention of epidemiological changes in which a double affliction of infectious diseases associated with mothers and other genital diseases and also as well as chronic and infectious diseases. While the public health cares delivery landscape represents an unequal allocation of resources between pastoral and town areas. The poor in rural areas are at a clear drawback with regard to crucial and tertiary health care. They also flop fully to benefit from public plans such as the vaccination of youngsters. Subsequently, the 18th amendment in the constitution of Pakistan the health subdivision have been enthused in the provinces, but the division of tasks and means of income making within the strata still uncertain especially in rural areas.

2. Literature Review: -

It is very important for every researcher to go through relevant literature to get overview of the concerned topic. Relevant literature provides guiding steps to probe linking aspects of particular problem under study. The relevant literature to the problem of this study has been reviewed and is presented as under.

According to Franklin (2001:Abbas, 2020), The purpose of a Health Situation is to hub on what are the most important health and disease issues facing the health of a nation, or other defined population (e.g. province, region). The most persistent health burdens in Pakistan affect women and children and rural population in general. The following are the main causes of death in children: diarrhea, malnutrition, acute respiratory infections and vaccine preventable diseases. A large number of studies conducted internationally show that South Asians have a higher incidence and more unfavorable form disease than most other populations.

As written by Memon (2011), In Nawabshah four to five babies on an average are dying every day for want of baby warmers, incubators and nebulizers at Pediatrics Unit of the People's Medical College Hospital. Number of infants suffering from cold pneumonia and chest congestion and other diseases has jumped alarmingly with increase in cold and they require warmers to maintain body temperature and incubators to take intensive care of underweight premature babies. Sources in the hospital said that there were seven babies' warmers and many incubators in the unit but they had been out of order for a long time. Most infants who were dying cold have been saved if the devices had been working said the sources. The unit has a capacity of 250 admissions but it has only three nebulizers, which are insufficient for mobilizing so many children with chest and infections of respiratory tract. There are three to four children are losing life because of lack of

warmers and incubators and 15 to 20 children are dying due to lack of nebulizers. Doctors at the Pediatrics Unit said on request anonymity that it was most impossible for them for them to do without much needed facilities and essential medicines. There were no ventilators in the units (ICU and three of the four monitors were out of order. He said that unit also faces shortage of doctors and paramedic. Only three registrars were running affairs with the help of post-graduate students. Loft and Kletk (1989) demonstrated in his studies that most of the doctors have open their private clinic and hospitals because they found that in the private sector they get more money as compared to work in Government sector. But researcher has found that mostly doctors are moving into Government sectors of hospitals because of facilities they are getting from Government. Loft and Kletk (1989) found that physicians are slowly moving from private practices towards employment in hospitals and HMOs. However, in Pakistan, there is a mixed of both practices. Doctors do Government job in morning and private in evening.

According to Pakistan Demographic Health Survey (2006-07), the frequency of child mortality rate is 78% for each 1,000 live births annually. And 1 in every 11 births the state dies before the age of 5 and more than 3 deaths occur in the first month after the delivery. The mother mortality rate is 276 for every 100,000 live births of women between the ages of 25 to 29 years being specifically at danger. Dr. Batool said, “Many women in Pakistan prefer to go to mid-wives or untrained staff for their deliveries rather than trained doctors” (The Express Tribune, 2011).

3. Health:

In social science, health is a human condition deliberated by four different components; mental, social, physical and spiritual. Health is defined by the WHO as *“a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity”*.

3.1. The Public Health Situation in Pakistan:

According to NDMA, about 346 people were killed and 620 were injured as a result of sudden floods. The number of deaths may increase, as the lines of communication will be restored. According to NDMA, more than 55,200 houses were registered, and damaged or destroyed, and almost 2.4 million acres of sown area were affected by flooding. In order to provide immediate assistance to the affected families, 459 relief camps were established in the affected areas, emergency medical care, cooked food, non-food and temporary accommodation. The authorities expect about 3 million people affected by floods in the coming days. Currently, Punjab, Gilgit Baltistan, Kashmir and Jammu suffer the most. In the northern and central part of the Punjab, the water was seen to subside. Physical access is a problem, as many roads are destroyed and water covers access roads.

Although the rules of health care, life expectancy and even living standards have enhanced over the last few years, these growths have not been consistent across the nations, and even there is a clear difference in national health situation. Worldwide, the South Asia has the largest attention of underfed patients in the world, with 1 to 5 people suffering from malnutrition or micronutrient deficiency due to vitamin A and iron. Due to these deficiencies, the South Asian country is estimated to lose about 1% of its GDP (Pakistan Poverty Alleviation Fund, 2010).

a) ***Health Gauges of Pakistan with Neighbor Countries***

Pakistan has concluded a UN mission for the Millennium Development Goals (MDGs) to be achieved by 2015. In some areas, although some successful, the country has not achieved success in achieving health goals. He currently believes that death among South Asian children and women, given that he has not achieved child mortality, maternal health's Millennium Development Goals (MDGs) 4, 5&6 HIV / AIDS with speed, fight against malaria and other diseases, respectively). Millennium Development Goals to achieve Pakistan infant mortality rate to 1,000

births not to lose 1,000 births that should be less than 52 deaths or 40 deaths per mortality rate for children under 5 years of age It is expected. On the other hand, maternal mortality rate must be reduced by about 50% from its current level (140 100 000) in 2015 (Khan,2013)
Maternal mortality rates are alarming despite the fact that measurement is difficult. Many of these are due to low attendance of qualified women at birth and high ground forces. According to Pakistan Planning Commission, 2010 maternal mortality rate - in fact falls from 48% to 41% of the actual by 2008/09, and more surprising is the fact that there is a level of skilled health. The maternal mortality rate is almost double in urban areas an as well worse in rural areas. About 319 per 100000 women in rural areas and 175 per 100000 in urban areas are died during child delivery (Pakistan Planning Commission, 2010). These deaths despite the fact that it is difficult to measure, it is worrisome. Many of these are due to low attendance of qualified women at birth and high ground forces. Maternal mortality rate - in fact falls from 48% to 41% of the actual by 2008/09 and more surprising is the fact that there is a level of skilled health (Pakistan Planning Commission, 2010),

4. Material and Methods

The present research was purely based on qualitative research (Secondary data) where several qualitative tools was performed for the sake of data collection, interpretation and analysis. The data was analyzed through discourse and interpretivists' approaches.
Approximation shows that 38% of less than five years old children are skinny and other 12% are harshly scrawny (Khan, 2012). In Pakistan children are signify the weakest group of the state, and have not helped much from earlier growth periods and social development. The neighbor South Asian countries such as Nepal, Bangladesh, India and Sri Lanka have attained greater progress in their child mortality rates despite alike or worse economic presentation (see Table 1).

Table No. 1: Health gauges for South Asia

Health indicators	Pakistan		Bangladesh		India		Sri Lanka		Nepal	
	1990	2010	1990	2010	1990	2010	1990	2010	1990	2010
Infant mortality rate (per 1,000 live births)	95	60	97	39	81	49	24	11	94	41
Maternal mortality rate (per 100,000 live births)	490	260	800	240	600	200	85	35	770	170
Under-five mortality rate (per 1,000 live births)	122	74	139	49	114	63	29	13	135	50
Immunization (DPT)* among 1-Year-olds (%)	54	86	69	95	70	72	86	99	43	82
Immunization (measles) among 1-year-olds (%)	50	82	65	94	56	74	88	99	57	86
Total fertility rate (births per woman)	-	3.4	-	2.2	-	2.6	-	2.3	-	2.7

Life expectancy at birth (years)	- 65.2 - 68.6	- 65.1 - 74.7 - 68.4

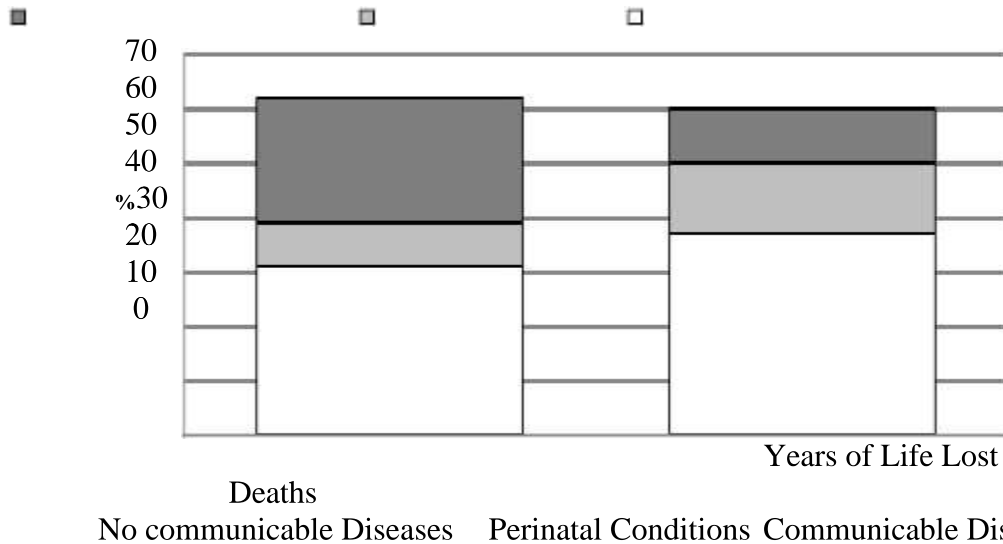
Source: World Health Organization (2013).

a. Affliction of Disease

Pakistan is experiencing a public epidemiological transition, it have double burden of illness which is combined with maternal and parental conditions, infections constitute over 50% of the burden. Diseases such as lower respiratory tract infections, diarrheal diseases, measles and whooping cough constitute about a third of their life, but such vaccination, simple procedures and hand washing. It can be controlled by the cost of low cost intervention. They have the majority burden is current poor condition of illness. While second burden related to chronic non-communicable diseases (World Bank, 2010).

Following Figure No. 1 highlights the total affliction of disease in Pakistan.

Figure No. 1: Affliction of disease in Pakistan



Source: World Health Statistics, 2006.

Hyder and Morrow (2000) look for absence of infection catch that hypertension, heart diseases and chronic liver are from the top 10 roots of loss of healthy periods of life. It is also prevalent in coronary artery disease and diabetes mellitus: about 30% of the young population suffers from the first and 7.1% from the latter. Pakistan is one of that states with a propensity to occurrence of diabetes. It is extremely important to acknowledge the existence of a large burden like a chronic disease in a medical system that can actively respond to these conditions. Unfortunately, there were a few methodological measures to mitigate the risk of infectious disease shortage. For example, despite the great level of cardiac disease in Pakistan, it is not a public or a private sector, but does not have an active anti-drug campaign.

By 2004, the Ministry of Health Government of Pakistan, WHO, and Heart-File (NGO) jointly enrolled the National Action Plan for non-communicable disease prevention, control, and health promotion in Pakistan. The process of this observation and implementation was started in October 2007, and the action plan's first round had attained a number of bulls. Such measures have brought issues of disease and their thinkable prevention hooked on the attention for donors, policy makers,

and the private sector to take operative stages for thorough operation. This plan was combined the control and deterrence of cardiac disease in case of basic evidence of an inclusive non-communicable disease deterrence endeavor.

5. Urban and Rural Health Inequality in Pakistan: -

Healthy and inequitable among urban and rural group of residents are the indices of residence, race, ethnicity, culture, occupation, gender, religion, age, education, income and other socio-economic position (SEP) It is determined based on. Reducing health inequality is an important issue for governments around the world. However, there is limited evidence for a strategy to reduce health and inequality, and in a systematic review, basic analysis could not be done. Healthy inequality - Population groups considered to be unacceptable with this inequality and unfairness, or differences in health among groups. Inequality in health can be implemented at all stages of implementation of measures that affect planning and health. If this inequality is composed according to socioeconomic variables, you can rely on interventions of voluntary change of behavior from other restrictions in the design of the intervention. As a result of such inequality, for policy-makers in all fields, practitioners and researchers they were made by interference with broad nature making them important (Barbones.J, 2009).

Health, job seekers' behavior and beliefs form a social structure of society. Changes in medical facilities for people in various societies around the world created by structural differences in social class are varied by urban and rural. People's working environment, resource ubiquity, and insufficient attention to the sensitive problems of people in specific areas artificially regardless of the density and gravity of public health problems, high-end and powerful people of society It is created with the favor of. Influenced people are not considered dangerous to the health of the social and physical environment for people living in disadvantaged areas and remote island areas, with influential social classes to think for themselves. The social and physical structure of a specific area was created to create a concept of people who intentionally can use medical facilities and treat people. We display very clear images of inequality in urban and rural medical facilities (Germov, 2002).

Compared to the urban community, in rural areas, we are lagging behind the items related to health. Especially in the villages of developing countries, due to health promotion, illness and health usually lack of medical facilities, lack of sufficient food, funds. Rarely in hospitals, nursing homes, does maternity home, pharmacies, clinics, clinical laboratories and other modern medical facilities in the village. In many places, especially in rural areas, people still follow the traditional way of treating diseases. There may be two reasons leading to adequate fund shortage in rural areas health nature, rural environment, from the city. Strong major groups in rural areas can take care of them, especially if they are sick, if necessary. As a result, villages affected (Shankar, 1990)

6. Health Budgetary:

Dogmatic assurance to develop health care can be determined by the budgetary funds allocation for social sectors. The present level of expenditure of Pakistan is about Rs 62 billion or 0.35% of gross domestic products (GDP) by 2012-13 which is clearly infer that basic and public health possessions such as medicines, health facilities, supplies and even universal vaccination are in little stock. Additionally, the portion of health spending as a proportion of gross domestic products (GDP) has dropped in the last period from 0.72% by 2000-01 to 0.27% by 2011-12 (Khan, 2012). World Health Organization (WHO) recommends allocating six percent of GDP to reduce the condition of deterioration of state health. By the National-Health-Account (NHA) for 2005/06, Pakistan said that the costs of other low-income countries (approximately $ 32 per person) legislative development and transparency (much smaller health care than the Pakistan Institute,

about US I spent $ 20 2013). Total health care accounts, about 2.4% of private expenditure GDP for 83.6% (WHO, 2009). Healthy private expenditure such as Pakistan's total medical expenses ratio is much higher than other South Asian countries. In addition, as a proportion of medical private spending, cash expenditure is about 98%, and Pakistan is between countries as the percentage of cash payments is the highest, compared to total health expenditure (WHO, 2009).

Table No. 2: Expenditures of Health in Pakistan

HEALTH	Quintiles					
	Total	**1st**	**2nd**	**3rd**	**4th**	**5th**
PAKISTAN						
Average Total. Expenditure Per Household (Rs.)	**2134.24**	**753.05**	**1035.31**	**1374.69**	**1944.60**	**4418.13**
Medical Care	**990.03**	**551.39**	**668.45**	**829.55**	**1031.38**	**1553.32**
Percentage of Expenditure						
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**
Medical Products, Appliance and Equipment	45.57	53.01	51.61	48.86	46.03	40.70
Outpatient Services	27.14	30.71	29.44	30.39	26.71	24.68
Indoor Patient Services	27.28	16.28	18.95	20.76	27.26	34.62
PAKISTAN URBAN						
Average Total. Expenditure Per Household (Rs.)	3067.15	829.73	1193.64	1549.91	2062.69	4977.56
Medical Care	985.25	509.08	609.74	717.14	837.88	1328.96
Percentage of Expenditure						
Total	100.00	100.00	100.00	100.00	100.00	100.00
Medical Products, Appliance and Equipment	46.71	53.68	52.87	51.14	48.51	44.09
Outpatient Services	28.43	33.63	29.85	29.46	29.10	27.55
Indoor Patient Services	24.86	12.69	17.28	19.39	22.39	28.36
PAKISTAN RURAL						
Average Total. Expenditure Per Household (Rs.)	1595.90	740.25	988.45	1297.28	1865.05	3559.18
Medical Care	992.79	558.45	685.82	879.20	1161.73	1897.80
Percentage of Expenditure						
Total	100.00	100.00	100.00	100.00	100.00	100.00
Medical Products, Appliance and Equipment	44.92	52.90	51.28	48.03	44.82	37.05
Outpatient Services	26.40	30.27	29.33	30.72	25.56	21.60
Indoor Patient Services	28.67	16.83	19.39	21.25	29.62	41.36

Source: Pakistan Bureau of Statistics (2011)

It is determined based on reducing health inequality is an important issue for governments around the world. However, there is limited evidence for a strategy to reduce health and inequality, and in a systematic review, basic analysis could not be done. Healthy inequality within social settings considered to be unacceptable with this inequality and unfairness, or differences in health among groups. Inequality in health can be implemented at all stages of implementation of measures that affect planning and health. If this inequality is composed according to socioeconomic variables, you can rely on interventions of voluntary change of behavior from other restrictions in the design of the intervention. As a result of such inequality, for policy-makers in all fields, practitioners and researchers they were made by interference with broad nature making them important.

No individual can create by his/her isolated actions a healthy environment or establish an education system or organize an industry to diminish economic insecurity yet these are the conditions which make the difference between happiness and misery, life and death. In so far as they exist they are a source of social income received not in the form of money but of increased wellbeing. More equivalent the world display lengthier life expectancy and then less equal population distribution of society within the country. This shows that societies could possibly convert better through diminutions in inequalities, but the small level mechanisms through which this can be proficient are not. However, it's declared that there are exists some type of associations between inequality and health the different provinces and sub divisional areas of Pakistan and that is both socially, economically and politically important (Barbones, 2009).

7. Conclusion:

The current study has unearthed the bare facts of poor healthcare system and the apathy of people in power towards the public health. The data was collected from secondary resource of Pakistan's official institutes and organizations which revealed that the area, Suffers from lack of health facilities. The study also depicted that majority of the poor people in the area cannot afford their treatment, even the purchase of very basic medicine. The local public hospitals do not have free treatment and medicine for common people. If it is available, only the elite class or vested interest group gets benefit of it. People in the area suffered from serious disease and a great number consult quacks which is very dismaying in contemporary healthcare system. People in the power position are least bothered about the dismaying condition of health in the area as they have access to better health both locally as well as in the big cities. The implementation of social model of healthcare is the need of the time to keep people safe from various fatal as well as ordinary diseases and health problems. It's authoritative for the government other policy makers to hold the country's terrible child and maternal health gauges. Female mortality prerequisites to be assume sensibly by increasing the numbers of professionally skilled and specialized persons such as doctors, lady doctors and Lady Health Workers (LHWs) in rural and less developing areas. These hands should also focus on distributing awareness of family planning, health care services and medical supplies as well.

In addition to low power consumption, there is also evidence that infectious diseases are also primarily responsible due to child malnutrition. In addition to such programs like EPI, we should be able to disseminate prevention data on healthy habits, like complete drinking water and hand washing such as sanitary cleaning. According to UN Children's Fund, 2008 reports, the incidence of diarrhea is mainly estimated in developing countries of the deaths, 90% are children less than age of 5 years annually. Approximately 88% of these deaths are related to unsanitary conditions, inadequate hygiene, and even dangerous water supplies.

However, this doesn't lean-to the public sector's accountability, which has the most to participation in relation of improving the country's sanitation sector and water management. In

this respect, the private sector and organizations could play a vital role to providing consciousness among educational institutions like Schools, Colleges and Universities. Governmental and private corporations also big prerequisite to be invigorate in undertaking health related complications.

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