Prospects of e-Health in Federally Administered Tribal Areas of Pakistan

Sir,

The Federally Administered Tribal Areas (FATA) of Pakistan are considered to be lagging behind the rest of the country in development with regard to economy, education, infrastructure and health. Health services are provided by the public sector and - to an unknown extent - by the private sector. The public sector provides health through primary care facilities staffed by medical technicians and Lady Health Visitors (midwives with a 2 years training in basic nursing care and midwifery) and through hospitals of which few can be considered to providing secondary level care including diagnostic facilities, major operations, blood transfusion and specialist medical services. This translates to one doctor for 6239 people and one Lady Health Visitor (LHV) for 6428 females.¹

It is assumed that most health workers in FATA do not have access to updated medical information. Health records are kept in paper form, referral information and reports to the health administration are also submitted in writing. An IT based District Health Information System (DHIS) is supposed to be made functional with external support (hardware, software and training of data entry personnel) and supposed to be producing reports soon. A similar system which was in place until 2007, was given up in favour of the new system.²

There is ample evidence that the current DHIS is not delivering reliable data and the communication between the health facilities and their supervisors at FATA Secretariat is not efficient and, therefore, management of the primary healthcare facilities is lagging behind. Mobile phones are now available in most areas of FATA, whereas computers and internet facilities might only be available in the offices of the agency surgeon (for Health Management Information System / District Health Information System purposes) and in the agency headquarter hospitals. Even if information technology is available, utilization might be limited because of unreliable power supply.

In Pakistan, m-health has been applied in other provinces such as Punjab, Sindh and Gilgit Baltistan. In Asia e-Health has been applied in countries like India, Malaysia, Thailand and Singapore for education / in-service training of health workers, electronic records, disease surveillance, transfer of diagnostic data (X-ray, ultrasound pictures, laboratory results) to a higher level of care, specialist consultations and generation of reports in the framework of a Health Management Information System (ESCAP report).³⁴ m-Health on the other hand has been applied in countries with a much lower level of infrastructure development and is being used for awareness raising campaigns (HIV), follow-up of patients (DOTs, ART, return visits), remote data collection, disease outbreak tracking among others in countries like Uganda, Kenya and South Africa.

FATA is currently not accessible in person to anyone not belonging to the tribal group in a particular area. This does not necessarily apply to health workers in the public sector who might or might not be residents of FATA and might or might not belong to the tribal group of the area where their work place is located. Movement of people living in FATA is restricted due to security threats. Both conditions limit access of health workers to information and limit exchange of information among health professionals. On the other hand, the same condition may aggravate medical conditions which require referral of patients to a higher level of care (from primary care level to the agency headquarter hospital) and cause delays in accessing curative treatment.

E-Health / m-Health have the potential to overcome the physical distance and the communication barriers between health workers, health facilities and health authorities in FATA, and between the healthcare delivery system in FATA and the outside world.

In future, it is envisaged that health workers in FATA could be in close contact by mobile phones with colleagues, superiors, the health administration, training centers and specialist doctors at medical teaching institutions for consultancy service. Referral services could be improved, ambulance services for emergencies managed, and logistics of supplies could be improved by using mobile phones.

Disclaimer: This publication reflects the personal opinion of the authors and not of their organizations.

REFERENCES


Shafa Haider Sawal1, Hassan Mehmood Khan1, Mehran Qayum1 and Nadia Pervaiz2

2 Department of Obstetrics and Gynaecology, Lady Reading Hospital, Peshawar.

Correspondence: Dr. Mehran Qayum.
E-mail: mehranqayum@hotmail.com

Received: August 28, 2014; Accepted: September 29, 2014.