

**GENDER-AWARE POLICY APPRAISAL**  
**HEALTH SECTOR**

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2006

Prepared for the Gender Responsive Budget Initiative (GRBI) Project

## FOREWORD

The Government of Pakistan is fully committed for introducing gender responsive budgeting and this has been reflected in the key policy documents which include Poverty Reductions Strategy Paper (PRSP), Medium Term Development Framework (MTDF) and Gender Reform Action Plan (GRAP) which all explicitly advocate for instituting gender responsive budgeting.

The Ministry of Finance, Government of Pakistan with the technical and financial support of UNDP and its cost sharing donors has initiated the 'Gender Responsive Budgeting Initiative' (GRBI) project to promote policy and resource allocation with a gender perspective.

Gender Aware Policy Appraisal is one of the tools of gender responsive budgeting which analyses policies and programmes funded through the budget from a gender perspective by asking whether policies and their associated resource allocations are likely to reduce or increase gender inequalities. The project commissioned three appraisal studies for the sectors of Education, Health and Population Welfare as part of its planned activities. The studies undertook a sector-specific situation analysis to understand the needs and identify gaps from a gender perspective. The draft reports were shared with the departmental focal persons as well as other stakeholders in a workshop and a focus group discussion for feedback and inputs received have been subsequently incorporated in the final report.

The reports were supervised, with valuable inputs, by Ms. Deborah Budlender, founding member of South African Women's Budget and a leading international adviser on gender responsive budgeting.

I would also like to take this opportunity to thank UNDP and its cost sharing donors, namely Swiss Agency for Development and Cooperation and Royal Norwegian Embassy, for their continued support as well as the departmental focal persons, both federal and provincial, for their contribution.

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## ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARIs	Acute Respiratory Infections
BHU	Basic Health Unit
BMI	Body Mass Index
CMR	Child Mortality Rate
DOTS	Directly Observed Treatment Strategy
CPR	Contraceptive Prevalence Rate
CRPRID	Center for Reduction in Poverty and Income Distribution
DPT	Diphtheria, Pertussis, Tetanus
GAVI	Global Alliance for Vaccines and Immunizations
GDI	Gender Development Index
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HDI	Human Development Index
HI	Health Index
ICPD	International Conference on Population and Development
LHWL	Lady Health Worker
MCH	Mother and Child Health
MMR	Maternal Mortality Rate
NCDs	No-Communicable Diseases
NWFP	North West Frontier Province
ORS	Oral Rehydration Therapy
PSDP	Public Sector Development Program
RHC	Rural Health Centre
TFR	Total Fertility Rate
USMR	Under Five-Mortality Rate
UN	United Nations
UNIFEM	United Nations Fund for Women
WHO	World Health Organization

## EXECUTIVE SUMMARY

### *Introduction*

Better health has welfare implications not only for the individual and the household they form part of, but also for the country as a whole. The government undertakes health interventions because peoples' health status plays a crucial role in determining the social and economic development of a country. The focus of the study is on health differences prevailing between males and females and differences in health losses and gains that make some groups of people worse off than others. The study covers the federal provincial and district level with sub-national analysis confined to the Punjab province and two districts namely Gujrat and Rajanpur.

### *Situation Analysis*

Overall, Pakistan performs poorly in terms of health indicators. Pakistanis have a lower expectation of life at birth than the average for South Asian countries. Further, UNDP's Human Development Report states that female life expectancy in Pakistan stands at 60.7, compared to 61.0 years for males. This, and the fact that the female:male ratio in Pakistan is 95:100, are unnatural patterns in that biologically one can expect females to outlive males by several years, and the female population to outnumber the male population. Probable causes for this unnatural pattern include a high maternal mortality rate and possible under-enumeration of females in some communities.

Other macro level indicators support the picture of overall poor health in Pakistan with an added gender bias. For example, the infant mortality rate per 1000 live births was 83 in 2002, compared to 66 for other countries in the region. Gender is an issue here to the extent that the infant mortality rate is closely related to the health of mothers. Mortality statistics show that female in the early reproductive age group are more likely to die than their male counterparts. At least some of this pattern is explained by Pakistan's high rate of maternal mortality and the young age at which many women start bearing children.

More generally, statistics suggest that women are more likely than men to die from communicable diseases such as typhoid, diarrhea, tuberculosis, jaundice and pneumonia. In absolute terms, more women in Pakistan die as a result of tuberculosis than die from maternal mortality.

Pakistan has a very high maternal mortality rate, at 500 per 100,000 live births. A contributory factor is that in the period 1995-2002, only 43% of pregnant women received antenatal care and only 58% received tetanus toxoid vaccinations. During this same period, skilled birth attendants attended only 20% of pregnancies. Another cause of the high maternal mortality rate is that 34% of pregnant women are malnourished. Similarly, 48% of lactating mothers had a calorie intake less than 70% of the recommended level.

### *Policy Analysis*

The National Health Policy of 2001 identifies ten key areas for achieving comprehensive progress in the health sector. The fourth of the ten areas is 'promoting greater gender equity in the health sector'. The major physical targets of the policy include reduction in the maternal mortality rate (MMR) to 250/100,000 live births by 2010.

In Pakistan, delivery of health services is primarily a provincial or district matter. Ordinary citizens' main interface with the public health system is through district-based first level care facilities (FLCFs). However, the federal Ministry designs and funds a range of vertical programmes which are implemented through the provinces and districts.

At the provincial level, there is a specific provincial unit responsible for maternal and child health (MCH). However, this is not the only unit in Pakistan that plays a role in promoting women's health. Women's issues are also addressed through several other programs such as LHWs, the national programme for family planning and primary health care (FP & PHC), and the Women's Health Project.

### *Budget Analysis*

The overall government budget allocation for the health sector increased from Rs 24.4 billion in 2001-02, to Rs 38.0 billion in 2004/05. The allocation nevertheless remains a small fraction of gross domestic product. More than 70% of the health allocation is through the recurrent budget.

Alongside Population Welfare, the Ministry of Health was one of the two pilot ministries for the federal level Medium Term Budgetary Framework (MTBF) initiative. The Ministry's first MTBF, for the period 2005/06 – 2007/08, provides for a significant allocation in respect of promoting gender equity in the health sector. For 2005/06, Rs 291 million of the total of Rs 12.4 billion was allocated for promoting greater gender equity. The amount increases to 306m in 2006/07 and then decreases to in 2007/08. For 2005/06 this area receives the third biggest allocation of the eight. In 2007/08 it is the fourth biggest.

Punjab accounts for about 45% of the total of all provincial expenditure on health and 18% of the federal allocation. Punjab's share of the federal allocation is based on its population share and the actual needs of people relative to those in other provinces. The provincial health budget shows that almost 93% of expenditure is on curative services. This contradicts the policy thrust in favour of preventive and PHC.

About 50% of total government health expenditure is accounted for in district budgets. At the district level, the overall responsibility lies with the District Health Officer (DHO). However, the DHO has limited control over national vertical programmes such as the LHW or FP & PHC programmes as the budget is allocated through the provinces.

The vertical programmes often receive significant support from donors. Reliance on donors raises issues of sustainability. In addition having vertical programmes in a devolved situation can hinder seamless service delivery to the women and men who need the services, as well as diminishing district ownership and commitment.

#### *Analysis of Service Delivery*

The Pakistan Integrated Household Survey of 2001/02 revealed that LHWs have better reach than all other types of health facility in Pakistan. In Punjab 80% of respondents said that there were LHWs in their village, and 64% nation-wide. A control study showed that for a range of selected health indicators such as use of antenatal care, tetanus injections for expecting mothers, and iron supplements, areas served by LHWs performed much better than those without this service. Similarly, the percentage of births attended by doctors or other healthcare professionals was far higher in areas served by the LHWs.

In Pakistan, population per hospital bed is 1,536, a figure that is in line with other developing countries. However, dispensaries and basic health units are usually not equipped with beds or labor rooms. Mother and child health clinics sometimes have one or two beds to handle non-complicated deliveries but are unable to handle obstetric emergencies. Punjab has a total of three beds in these facilities across the whole province. Yet provision of emergency obstetric care is recognized internationally as a crucial element if a country is to reduce the maternal mortality rate.

57% of people in Pakistan use private health centers as compared to 21% who use government facilities. Of the remainder, 14% used private dispensaries and 3% use private pharmacies. Factors promoting use of private health care facilities rather than public facilities include distance to the government facilities and unavailability of medicines at the outlets. Some of the other reported reasons are uncooperative staff (who probably are more uncooperative with women than men), lack of technical expertise to treat complications and unavailability of specialized doctors at the public health care centers.

Overall, the analysis reveals that while the reproductive needs of women are relatively well catered for, other gendered aspects of health are not adequately addressed in the health policies of the government.

## 1. INTRODUCTION

Better health has welfare implications not only for the individual and the household they form part of, but also for the country as a whole. The government undertakes health interventions because people's health status plays a crucial role in determining the social and economic development of a country. World Development Reports show that the past few decades witnessed an increase in health gains not only in the developed countries, but also in the developing countries. Yet, at the advent of 21st century, where many developing countries have achieved substantial improvements in health, the situation in Pakistan remains poor.

The focus of the study is on health differences prevailing between males and females and differences in health losses and gains that make some groups of people worse off than others.

### *Why Does Health Matter?*

According to the World Development Report (1993, pp.17) benefits of improved health are manifold. Broadly these can be summarized as follows:

1. Healthy people are better able to learn. In developing countries, where one of the major causes of low enrolment rates is child morbidity, better health can result in higher enrolment rates in schools. Low enrolment rates, especially those of females, associated with poor health reduce the gains from schooling and ability to learn. Studies by Jamison and Leslie (1990) and Psacharopoulos (1993) show education benefits of improved health and economic benefits of improved education. These studies show a strong link between schooling and income. Bliss and Stern (1978) show that better health and nutrition may increase labor productivity. Therefore, deficiencies that are developed in early childhood can have long term damaging effects on productivity in later life as well as on individual earning ability. Further, economic gains of improved health status are greater for poor people who can benefit from the use of resources otherwise inaccessible because of disease.
2. For the economy as whole, improved health can produce savings in treatment costs by reducing the incidence of disease. In developing countries, many illnesses can be prevented through strengthening the primary health care system, and resources can be saved that otherwise have to be spent on treatment costs. For the individual household as well, improved health results in better use of resources. For example, resources that otherwise have to be spent on treating illnesses can be freed and used in health promoting practices. However, costs and benefits of health may vary across individuals, especially males and females, because of differences in life situations they face and the strength of their preferences for health and their control over how household resources are used.

The World Development Report (1993, pp. 7) notes, "Advances in income and education have allowed households almost everywhere to improve their health. Of the economic policies, increasing the income of those in poverty is the most efficacious for improving health. The reason is that the poor are most likely to spend additional income in ways that enhance their health: improving their diet, obtaining safe water, and upgrading sanitation and housing." In Pakistan, the prevalence of high infant and child mortality rates and poor health are mainly the result of preventable conditions. Broadly, they include poor socio-economic conditions, malnutrition and high prevalence of infectious diseases. Improvements in health status therefore, ideally require that causes of ill health be tackled rather than their consequences. Promoting factors that directly influence the well being of vulnerable groups, such as women and children can assist in doing this. In Pakistan, there is a strong need to foster an environment that enables households to promote the health of their members. Within the household, it is mainly women who are responsible for the health of other household members. In this regard public policy can be helpful if it results in better health outcome. Better health means improved family welfare and a more productive nation. It also means more time for women to spend on other activities.

## 2. OBJECTIVE AND SCOPE OF THE STUDY

This study intends to analyze gender differences in health outcomes/status and argues that these are perpetuated through resource allocations for health and health care policies in Pakistan. Generally, budget documents are claimed to be gender neutral, but the study will explore expenditure patterns of major health care programs to find out if they are gender biased, gender-neutral or gender-sensitive. The study will also analyze health care policies to find out the same. The major causal factors responsible for gender differences in health outcomes and status are social, economic and political.

In 2005, UNDP Pakistan, in partnership with the Government of Pakistan, initiated Gender Responsive Budgeting in order to mainstream gender in all stages of budget cycles for health, education and population welfare. This study is part of that exercise and will find out the extent of the problem for Pakistan. The following critical issues have been explored:

1. Pakistan's health indices are very low as compared to other developing countries or countries at a similar stage of development.
2. Biologically, females are expected to live longer but in Pakistan, females tend to die younger than males.
3. Females in Pakistan have higher mortality rates than males, especially in the rural areas of Pakistan where more than 70 percent of the population lives.
4. Incidence of a range of major diseases/illnesses is much higher for the females as compared to the males.

The study covers the federal, provincial and district level with sub-national analysis confined to the Punjab province and two districts namely Gujrat and Rajanpur, the pilot district of the GRBI project.

### 3. SITUATION ANALYSIS

This section explores the prevailing situation of health in Pakistan. The health situation is explored broadly at the macro level, and micro level health indicators are presented where data are available. The macro-level data have been obtained from the published sources of the Ministry of Health, and from the sources of international organizations such as the World Bank and the World Health Organization.

#### 3.1 Pakistan's Health Profile

To represent Pakistan's health profile, various macro-level indicators have been selected such as crude birth and death rates, life expectancy rate, infant mortality rate, maternal mortality rate. Pakistan's crude birth rate per 1000 live births in 2002 was 36, higher than the South Asian countries' weighted average of 26 and similarly, the crude death rate per 1000 live births in 2002 was 10 as compared to the South Asian weighted average of 9. As an indication of better health, expectation of life at birth has improved massively around the world since the 1950s. However, in Pakistan, overall life expectancy at birth was 61 years in 2002 as compared to the South Asian average of 63. Other macro level indicators such as infant mortality rate per 1000 live births in year 2002 is 83 compared to 66 prevailing in South Asian countries including, India, Bangladesh, Nepal, Sri Lanka, Bhutan, and Maldives.

In Pakistan, the Federal Bureau of Statistics conducts demographic surveys to provide information on births and deaths during intercensal periods. The following data have been obtained from Pakistan's Demographic Surveys (2001 & 2003) to highlight patterns of mortality across gender by area of residence in Pakistan. Distribution of deaths by age and gender highlights certain characteristics of the population that are important for health policy interventions and overall socio-economic developments. In Pakistan, however, the registration system of births and deaths is not efficient. Therefore, DHS data are used to inform on births and deaths.

**Table 3.1: Distribution of infant deaths by sex and region**

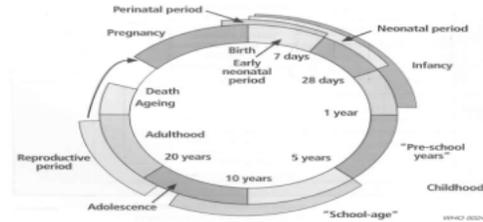
Region/Age	PDS 2001		PDS 2003	
	Males	Females	Males	Females
<b>All Areas</b>	<b>52.3%</b>	<b>47.7%</b>	<b>55.0%</b>	<b>45.0%</b>
Under 1 month	54.3%	45.7%	59.6%	40.4%
Rest of the year	49.2%	50.8%	49.1%	50.9%
<b>Urban Areas</b>	<b>50.9%</b>	<b>49.1%</b>	<b>53.9%</b>	<b>46.1%</b>
Under 1 month	51.5%	48.5%	57.3%	42.7%
Rest of the year	50.0%	50.0%	50.6%	49.4%
<b>Rural Areas</b>	<b>52.8%</b>	<b>47.2%</b>	<b>55.4%</b>	<b>44.6%</b>
Under 1 month	55.5%	44.5%	60.4%	39.6%
Rest of the year	48.9%	51.1%	48.3%	51.7%

Source: PDS 2001 & 2003

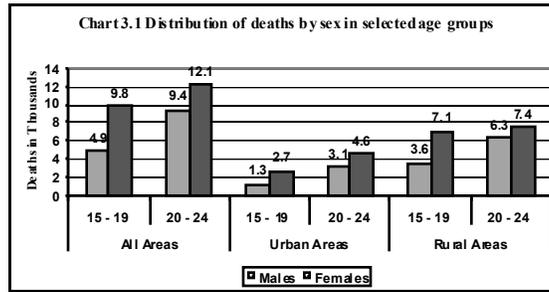
Table 3.1 depicts distribution of deaths for all areas, urban and rural, of Pakistan. It shows that almost half of infant deaths occur in the first month of their life. Moreover, the number of deaths of male infants is higher than that for female infants in both rural and urban areas. This finding is consistent with the expected biological differences between the sexes. However, after first month the number of deaths of female infants is slightly higher than that for male infants in rural areas.

The World Health Organization identifies the main stages for which health interventions can be implemented using a life cycle approach. The following diagram shows the key stages in the life cycle starting from infancy to late adulthood. In the life cycle approach, outcome indicators are linked to the risks of health at each stage of life.

**Figure-3.1 The Life Cycle Hypothesis**



The high infant mortality rate relates to one of the early stages of the life-cycles. Gender considerations in respect of the high infant mortality rate are two-fold. Firstly, as seen above, at the time of birth biologically females are stronger than males, and as a result more male infants are likely to die as compared to female infants. The fact that neonatal deaths form a significant portion of the overall infant deaths suggests that it should be prioritized for health intervention through policy or resource allocations. Secondly, maternal health has an important influence over neonatal chances of survival. Thus greater attention to maternal health would be one of the ways, in which the high rate of neonatal deaths could be addressed.



Source: PDS 2003

Chart 3.1 shows the distribution of deaths across areas for selected age groups. It highlights that overall, females in the early reproductive age tend to die more than males. This is true for both urban and rural areas. At least, some of this pattern is explained by Pakistan's high rate of maternal mortality and the young age at which many women start bearing children. In addition to early age child bearing during 1995-2002, only 43 percent pregnant women received antenatal care and 58 percent received tetanus toxoid vaccination. During this period, skilled birth attendants attended only 20 percent of pregnancies. These factors all together contributed to high maternal mortality rate.

The following table shows macro-level indicators of mortality, and life expectancy. Females have a noticeably higher expectation of lost healthy years at birth, of total life expectancy lost and probability of dying before reaching five years.

**Table-3.2: Gender disaggregated health indicators**

Health indicators	Male	Female
Life Expectancy	61.0	60.7
IMR (infant mortality rate)	78.0	74.3
IMR (Punjab)	85.5	73.3
Expectation of lost healthy years at birth 2002	6.9	9.3
Percentage of total life expectancy lost	11.3	15.0
Probability of dying under 5 years (per 1000)	105	115

Source: Human Condition Report (2003, pp 2-35); Pakistan Demographic Survey, 2003; UNDP, Human Development Report 2004

As shown in the table above, female child mortality is higher than male child mortality. According to the World Health Organization, in Pakistan, about 40% or 8 million children under five years of age are malnourished and about fifty

percent of deaths of children under five years of age are due to malnutrition. During the period 1995-2002, the percentage of under five underweight children was 38, with 37% children suffering from stunting and 13% suffering from wasting. The government of Pakistan has been promoting breastfeeding practices to overcome under nourishment of young children and during 1995-2002, exclusively breastfed children under 6 months of age were 16 percent. For children between 6-9 months of age, who are started on complementary food along with breastfeeding the percentage is 31 and still breastfeeding children were 56%. However, with 61% children living under absolute poverty, it seems harder for the government to overcome malnutrition and prevent premature child deaths. The gender patterns suggest that the relationship between malnutrition and child mortality is not straightforward. Thus while female child mortality is higher than male mortality, Table 3.3 suggests that girl children are slightly less likely than boy children to be malnourished.

**Table-3.3: Rate of malnutrition among Pakistani children**

Sex/Location	Underweight	Stunted	Wasted
Male	41.5	29.9	11.6
Female	40.4	27.5	11.8
Urban	38.7	24.5	12.1
Rural	42.3	32.5	11.2

Source: GOP and UNICEF (2004).

Breastfeeding is often promoted as a way of reducing infant mortality. However, while breastfeeding is good for babies and cheaper for the household, it can constrain women's opportunities to engage in income-earning. Effective breastfeeding also requires that the mother be adequately fed.

The following table shows the incidence of selected diseases that are much higher for females as compared to the males in respect of resulting in death.

**Table-3.4: Distribution of deaths by type of disease, location and sex**

Diseases	All areas		Urban areas		Rural areas	
	Male	Female	Male	Female	Male	Female
Typhoid fever	5.35	7.97	3.68	6.12	6.44	9.15
Diarrhea	2.79	5.59	2.76	5.76	2.82	5.49
Tuberculosis	3.65	5.59	3.68	5.04	3.62	5.95
Pneumonia	5.83	5.87	5.83	6.12	5.84	5.72
Jaundice	5.1	5.17	5.52	5.04	4.83	5.26
Malignant neoplasm (digestive organs)	2.67	4.34	1.84	5.76	3.22	3.43

Diseases of the nervous system (Paralysis)	3.89	<b>4.62</b>	4.91	<b>4.32</b>	3.22	<b>4.81</b>
Heart failure	13.37	8.25	16.56	12.59	11.27	5.49
Respiratory infections asthma	3.52	<b>4.76</b>	3.68	<b>4.68</b>	3.42	<b>4.81</b>
Kidney failure	2.31	<b>2.52</b>	2.76	<b>2.88</b>	2.01	<b>2.29</b>
Some other major disease	13.24	12.03	11.66	10.43	14.29	13.04

Source: Pakistan Demographic 2001

The evidence presented in this table shows that in all areas of Pakistan, females are more likely than males to die because of communicable diseases such as typhoid, diarrhea, TB, jaundice and pneumonia. The trend is similar for urban and rural areas. Meanwhile males are more prone to die from heart failure. Table 3.4 shows that among the significant causes of deaths, most originate in respiratory problems, such as lower respiratory infections, chronic obstructive pulmonary disease, TB and lung cancer. Susceptibility to most of these is increased by poor socio-economic and living conditions. The Federal Bureau of Statistics groups major diseases in 18 major categories and these include, intestinal infections, tuberculosis, bacterial diseases, viral diseases, rickettsiosis and other arthropod-bore diseases, venereal diseases, malignant neoplasm, endocrine diseases, blood diseases, diseases of the nervous system, diseases of the circulatory system, respiratory system, digestive system, urinary system, congenital anomalies and deformities, maternal deaths, sign symptoms and ill-defined conditions, and accidents, injuries and poisoning. Across all geographical areas, incidence of diarrhea, typhoid fever, food poisoning, TB, malignant neoplasm, disease of the nervous system, congenital diseases, is much higher for females as compared to the males.

The disease burden in Pakistan can be divided between communicable and non-communicable diseases. Communicable diseases account for 49% and non-communicable diseases account for 41% of the burden of disease in the country (HCR 2004, pp. 180). Injuries account for the remaining 10% of the disease burden (GOP 2001b). An analysis of the burden of disease in Pakistan indicates that such burdens are mostly borne by the poor and the more vulnerable groups. In Pakistan, the major causes of morbidity are diarrhea, respiratory tract infections, and tuberculosis. Non-communicable diseases, in Pakistan are primarily cardiovascular, diabetes, cancer, and chronic respiratory diseases. For non-communicable diseases, the incidence is higher for females as compared to the males due to risk factors and vulnerability. Some of the risk factors for females include lack of decision-making power to access health services and other necessities (such as food) as and when needed, lack of mobility (most women are not allowed to travel on their own to seek health care) and lack of monetary resources. Due to the prevailing socio-economic culture in the country, there are

gaps in access and utilization of health care services in Pakistan along gender lines as well as along other lines such as rural/urban and rich/poor. The higher male rate for communicable diseases could be a reflection of the fact that they operate more in 'public' spaces while women are more confined to private spaces, such as the home.

Some other indicators that are used to assess the success of health policies being practiced in a country include immunization coverage and births attended by skilled attendants and access to primary health care. These basic indicators are used because people who lack access to even primary services, generally lack access to specialized or quality health services as well. Skilled birth attendants or lady health workers are an indicator of quality health care and reflect availability of health infrastructure that is accessible to expecting mothers. The following table shows child immunization rates for major diseases in Pakistan for males and females.

**Table-3.5: Children's full immunization rate, age 12-23 months (2001-02)**

Region/province	Boys	Girls	Both
Urban Punjab	72	80	76
Rural Punjab	57	50	51
Overall Punjab	57	58	57
<b>Pakistan (by income groups)</b>			
1 <sup>st</sup> quintile	19	21	20
2 <sup>nd</sup> quintile	24	23	24
3 <sup>rd</sup> quintile	27	26	26
4 <sup>th</sup> quintile	33	32	33
5 <sup>th</sup> quintile	33	31	42

Source: Pakistan Integrated Household Survey (2003)

In Pakistan, the Expanded Program on Immunizations (EPI) was launched in 1976 and was expanded in a phased manner to cover the entire country. The program is implemented at all levels, federal, provincial and district. However, the above table shows that there is not universal coverage of immunization for children against these major diseases. Overall, there is a negligible male/female difference in coverage. However, while in urban areas girls are noticeably more likely than boys to be fully immunized, in the more populous rural areas girls seem to be at a slight disadvantage. Similarly, while girls from the wealthiest quintile are well protected compared to boys, this is not the case for the middle quintiles.

Pakistan's composite health index shows the status of health in the country. According to the Human Development Report (2004), the health status index is calculated in two steps (i) Indices of maternal mortality index, under-five mortality index and under-nourishment index receive a value of 0-1, and then (ii) indices are combined to create health status index (see page, 214, Human Development in South Asia, 2004). The health status index's value for Pakistan is 0.701. The infrastructure index consists of public expenditure on health, skilled birth attendants, child immunization rate, number of physicians per 1000, access

to safe drinking water and access to sanitation. A value closer to zero reflects a poor health infrastructure index and close to one a fairly good one. For Pakistan the value of health infrastructure index is very low (0.282) as compared to certain other south Asian countries such as Sri Lanka (0.619) and Maldives (0.704). The limitations index is defined as the number of people living and earning less than US \$ one day, adult illiteracy rates, contraceptive prevalence rate, and prevalence of smoking. The value of this index for Pakistan is relatively high (0.565). It is important to note that inclusion of indicators such as maternal mortality rate, skilled birth attendants, access to water and sanitation pull the value of the index up or down. Therefore, improving the status of women on these indicators will result in a better profile of the country's health and vice versa.

**Box-1 Pakistan's Health Indices**

	Status index	Infrastructure index	Limitations index	Health index value	HDI value	HDI rank	Health index rank
<b>Pakistan</b>	0.701	0.282	0.565	0.458	0.497	142	147

The total female population in Pakistan is 73.13 million in 2002 and the female to male population ratio is 95:100. This ratio is unusual internationally and contradicts biology, which would usually see females tending to live longer than males and outnumber them. This reversed picture in Pakistan is partly explained by the high maternal mortality rate. As noted above, during 1995-2002, only 43 percent pregnant women received antenatal care and 58 percent received tetanus toxoid vaccination. During this period, skilled birth attendants attended only 20 percent of pregnancies.

In Pakistan more than 30 million women are in the reproductive age group of 15-49 and the country is going through a slow demographic transition from a previously high to lower population growth rate. However, the process is not complete because of the large share of youth in the population and slow rate of decline in the population growth rate, which currently stands at 2.5. The crude birth rates in Pakistan has been steadily but slowly declining due to factors of rising incomes, slow increase in literacy rates, especially those of women increasing use of effective birth control mechanisms and declines in child mortality rates.

**Table-3.6: Macro-level indicators for women health**

Indicators	Values
Total fertility rate	5.1
Maternal mortality rate/100,000 live births	500
Anemia (all women) year 2000-01	20.3
Births attended by skilled staff	20
Gender related development index 2002	0.471
% Pregnant women receiving antenatal care 1995-2002	43
Illiterate adult females	72%

Source: Human Development Report (2004), Pakistan's Human Conditions Report (2003).

The table shows that Pakistan has a very high prevailing maternal mortality rate (500/100,000 live births). One of the significant factors contributing to this high maternal mortality rate is child delivery at home that is not assisted by any trained medical attendant to prevent complications arising mostly due to female malnutrition and lack of awareness. MMR is much higher in Pakistan's rural areas than in urban areas (HDR, 2004, pp. 176); for example, MMR in Karachi is 281 as compared to 673 in rural Balochistan. This is largely due to the fact that the proportion of births attended by skilled medical staff in the rural areas of Pakistan is fairly low. Another cause of the high maternal mortality rate is in Pakistan is malnutrition that affects 34 percent of pregnant women. This figure shows that in Pakistan, a significant proportion of women is severely undernourished. Similarly 48 percent of the lactating mothers had a calorie intake less than 70 percent of the recommended level (Pakistan Human Conditions Report: pp. 20). This is bad for the health of the mother as well the baby. A related problem is iron deficiency in women (45 percent of women suffer from iron deficiency in Pakistan) that results in stillbirths, birth defects, mental retardation, and infant deaths, in addition to the effect on the women's lives and well-being. Among other significant factors that result in maternal deaths are hemorrhage, hypertensive diseases, unsafe abortion, infections and prolonged labour. Women's health in Pakistan is linked to their socio-economic status. Thus, public sector health policy needs to focus on interventions that empower poor women.

This profile of Pakistan's health, suggests that the health status of Pakistani people, especially that of females and children, is poor. Health indicators for women are poorer than for males for life expectancy, and there is greater probability of deaths for female children as compared to their male counterparts. Pakistan's health indicators lag behind other developing countries, and might be linked to resource allocation for health that is inadequate and does not adequately take gender related issues into account. Within the country, many socio-economic, demographic and health care variables contribute to poor health.

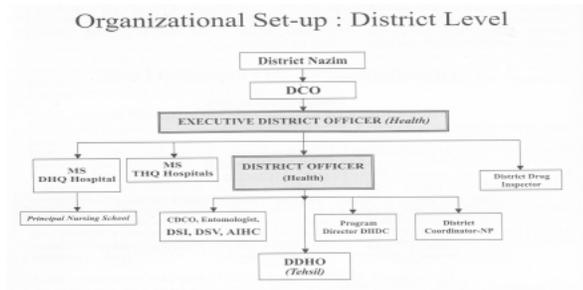
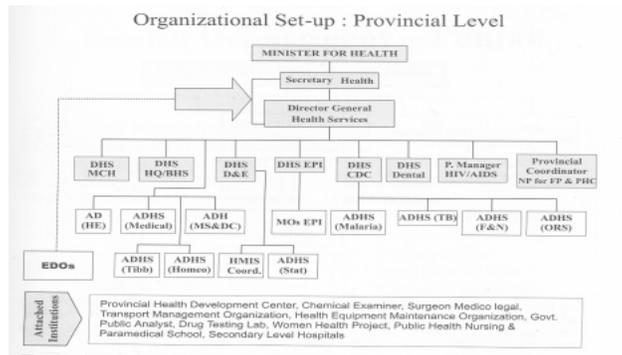
#### 4. POLICY ANALYSIS

##### 4.1 Pakistan's Health System

Pakistan's health system has three tiers (i) federal (ii) provincial and (iii) district. In Pakistan, health services delivery is primarily a provincial matter, while, the federal government plays a supportive and coordinating role. The functions of the Federal Ministry of Health include the following:

1. National planning and coordination
2. Agreements with other countries and international organizations
3. International aspects of medical facilities, issues of public health and international health
4. Trainings in the health sector through fellowships/ training in collaboration with the WHO and UNICEF.
5. Education/training in medicine, nursing, pharmaceutical and other allied subjects.
6. Standardization of pharmaceutical products and drugs.
7. Vital health statistics
8. Medical and health services for federal government employees.

The federal Ministry of Health runs a number of public health programs. Although, the federal government funds these programs, their implementation is carried out at the provincial and the district levels. In Pakistan, the private sector also plays a major role and both for-profit and not-for-profit private providers play a significant role in health service delivery. The following diagrams show the provincial and district government health setups. The first diagram reveals that there is a specific provincial unit responsible for maternal and child health (MCH). However, this is not the only unit in Pakistan that plays a role in promoting women's health. Women issues are addressed through several other programs such as lady health workers (LHWs), Twana Pakistan (that address the issue of lack of nutrition in females but funding for the program was stopped by the end of 2005), the national program for family planning and primary health care, and the women's health project.



Source: Inventory of Health and Population, Ministry of Health

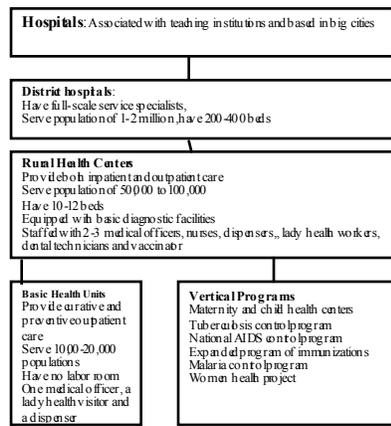
For implementing health care programs, the following box shows levels of responsibility and tasks at different levels of government. It suggests that the district and first level care facility (FLCF) are the main implementing agencies with which women, men and children will come into contact. However, budgeting takes place primarily at the federal and provincial levels.

**Box-2: Organizational Responsibilities**

<b>Federal Ministry of Health</b>	<ul style="list-style-type: none"> <li>➤ Policy Formulation</li> <li>➤ National Reporting</li> <li>➤ Monitoring and evaluation</li> <li>➤ Operational planning and budgeting</li> <li>➤ Distribution</li> <li>➤ Health Management Information System</li> </ul>
<b>Provincial Ministry</b>	<ul style="list-style-type: none"> <li>➤ Internal monitoring</li> <li>➤ Program reporting</li> <li>➤ Accounting and budgeting</li> <li>➤ Organization of training and distribution</li> <li>➤ Data collection</li> <li>➤ Health Management Information System</li> </ul>
<b>District Health Offices</b>	<ul style="list-style-type: none"> <li>➤ Allocation, supervision and training of personnel</li> <li>➤ Plan implementation</li> <li>➤ Accounting and distribution</li> <li>➤ Program reporting</li> <li>➤ Health Management Information System</li> </ul>
<b>First level care facility (FLCF)</b>	<ul style="list-style-type: none"> <li>➤ Selection of workers, Training of workers, HMIS</li> </ul>

In Pakistan, health sector reforms have been proposed through three national health policies in 1990, 1997 and 2001. These reforms aimed to improve health services delivery through good governance, self-reliance and improving management to control communicable diseases. The policies proposed new strategies to control the spread of communicable and non-communicable diseases. The implementation of policies took place partly through improved health infrastructure. At present Pakistan has a fairly well established network of health facilities with trained health personnel that include 906 hospitals, 4,554 dispensaries, 289 TB clinics, 907 MCH centres, 552 rural health centers, 704 sub health centers/ first aid posts and 4586 basic health units beds in the country. In health services delivery, the nationwide network of health facilities with trained health personnel include

**Box-3 Health Service Delivery in Pakistan**



Source: The Centre for Reproductive Rights 2004

The box on the lower right above shows a range of vertical programs for which funding comes directly from federal government, very often assisted by the donors. For example, the National Program for Family Planning and Primary Health Care (FP& PHC) was launched in 1994 to extend outreach services to the communities through selection and training of lady health workers. An estimated Rs. 9.104 billion was allocated with UNICEF, UNFPA, WHO, DFID and JICA providing financial and technical assistance. Although, significant achievements have been made, provision of necessary support and strengthening of health facilities, and the need for improved warehousing, storage and transportation of supplies remain important issues. EPI was launched in 1978 with the aim of achieving targets of reductions in mortality and morbidity. This program also received financial and technical assistance from the WHO, UNICEF, JICA and the World Bank. In the PC-1 for year 2003-04, an amount of Rs. 110 million was allocated and under the national health facility (NHF) of the Department for International Development (DFID), Rs. 800 million were allocated in 2004-05. Although in this program, significant achievements have been made, the federal government requires an additional Rs. 300 million to launch sub-national immunization days for measles reduction. More recently, the federal EPI cell has included Hepatitis B vaccine in the National EPI program schedule, and an

additional Rs. 325 millions are required for vaccines and syringes after the end of Global Alliance for Vaccination Initiative or (GAVI) support in the year 2001. The Women Health Project has been developed in collaboration with Save the Children USA, to develop a behavior change communication strategy that includes health education, social mobilization and advocacy strategies that place emphasis on identification and targeting of negative behavior that hinder maternal health interventions. This is done through the recruitment of thousands of LHWs who are distinct from those employed by the FP & PHC. In 2002-03 an estimated Rs. 237,000 was allocated for federal government and 62% was utilized. The objectives of the program include expanding women's health interventions to the under-served population, and the strengthening of the institutional capacity to improve women health. However, 2005-06 is the last year of the program.

The sustainability of these vertical programs in absence of donor's support is a question and needs to be addressed while formulating national health policies. There is also a question as to how well vertical programs are integrated into other programs. In many countries, the existence of vertical programs in a context of decentralization has hindered integration and seamless service delivery to the women and men who need the services. Vertical programs also tend to lessen district ownership and commitment to the particular issues on which they focus.

#### 4.2 National Health Policy (2000-01)

The national health policy (2001) aims to protect people from communicable and non-communicable diseases, and promote public health and better preventive and curative health services. The policy document identifies ten key areas for achieving comprehensive progress in the health sector, as follows:

1. To reduce widespread prevalence of communicable disease, Expanded Program of Immunizations (EPI), TB malaria, Hepatitis B, and HIV/AIDS.
2. To address the inadequacies in primary and secondary health care services
3. To remove professional and managerial deficiencies in the district health system
4. To promote greater gender equity in the health sector
5. To bridge the basic nutrition gap in the target population, children, women and vulnerable groups
6. To correct urban bias in the health sector urban modalities.
7. To introduce required regulation in the private medical sector with a view to ensuring proper standards of equipment and services in hospitals, clinics and laboratories as well as private medical colleges and tribal homeopathic teaching institutions.
8. To create mass awareness in public health matters.
9. To effect improvements in the drug sector with a view to ensuring the availability, affordability, and quality of drugs in the country.
10. Capacity building for health policy monitoring in the ministry of health.

Since the inception of the National Health Policy, progress has been made on all ten identified areas. For example, in 1999, Pakistan won the Global Alliance for Vaccines and Immunizations (GAVI) award of US \$ 72 million on a competitive basis as a grant for new vaccines, infrastructure support and injection safety. For eradication of polio, Pakistan reported 62 cases in 2002 as compared to 200 in year 2000. The number of districts reporting polio has also decreased (from 76 to 32) in 2002. Similarly, vaccination for maternal and neonatal tetanus intensified in high-risk areas. The focus on gender-related interventions resulted in reductions of MMR per 100,000 live births and the contraceptive prevalence rate increased significantly, although the indicators are still not at the desired levels.

Through this National Health Policy, it is expected that the overall health scenario will be improved. The National Health Policy identifies physical targets in the health sector in line with both the MDGs and the PRSP. The major targets include reduction of IMR from 77 to 60/1000 live births and reduction in MMR to 250/100,000 live births by 2010. Similarly, immunization rates for children are expected to increase to 85% during 2005-2010. The National Health Policy (2001) is, therefore, taken as the guiding development framework in the health sector for the next five years, with roles defined for all the levels of the government, federal, provincial and districts.

The key area number 4 of the National Health Policy (2001, pp. 18-21) aims at promoting greater gender equity in the health sector and provides various modalities to achieve this objective. The document records the following achievements and planned activities for gender equity in the health sector:

1. Focus on gender related interventions resulted in reduction in maternal mortality rate, total fertility rate, and increase in contraceptive prevalence rate.
2. Senior level management positions have been given to female officers e.g., the Director General Health Services Punjab, Nursing Advisor, Executive Director Pakistan Medical Research Council, Head of Biological Controls Authority and Project managers of Women Health Project and HIV/AIDS program.
3. The concept of women friendly districts has been launched under the Women Health Project. Under this project, 20 districts were to be made women friendly by year 2006. Under the reproductive health project, a further 34 districts would be made women friendly. In these villages there will be well-organized network of health infrastructure whereby, more Lady Health Workers will take care of the basic health needs of women.
4. By the year 2005-06, it is planned that the recruitment of LHWs will reach a number of 100,000.
5. In NWFP, the Women Medical Officer (WMO) and Medical Officer (MO) cadres have been merged so as to provide equal opportunities for lady doctors. This will not only reduce the gender gap in high posts but will provide equal remuneration to females hired for these posts.

6. Training of midwives is being initiated in collaboration with the National Commission on Human Development, JICA, UNFPA, and the World Bank. The target is to train 25,000 midwives within five years. A memorandum of understanding between the Ministry of Health and National Human Development Commission was signed in 2002.

The Women Health Project was launched in 2000 with an outlay of Rs 3750 million with assistance from the Asian Development Bank. The federal component of the Women Health Project costs US\$ 15.8 million for

- Support to the national program for family planning and primary health care
- Strengthening of the nursing sector including building for Pakistan Nursing Council and grading of schools and colleges of nursing.
- Maternal and neonatal tetanus special immunization activities.
- Human resource development
- Strengthening of emergency obstetric care services in Islamabad

The provincial component of the project cost US\$ 59.2 million for

- Development of 20 women friendly districts that will deliver comprehensive reproductive health care services (8 in Punjab, 4 in Sindh, 4 in NWFP, and 4 in Balochistan)
- Basic and comprehensive emergency obstetric care services will be strengthened in these districts.

#### 4.3 Poverty Reduction Strategy Paper

Pakistan's Poverty Reduction Strategy Paper (PRSP) of 2003 was prepared after a comprehensive consultative process involving all the relevant ministries, provincial and district level governments, civil society organizations and other interest groups. The paper outlines a broad framework and poverty reduction strategy through accelerating growth, good governance, investment in human capital and targeting the poor for poverty reduction. The paper notes that Pakistan's overall health profile is poor. More than 60% of the burden of disease is borne by the poor population due mainly to lack of emphasis on preventive health care. The PRSP highlights facts relating to poor maternal and child health and quality of care in light of the widely prevailing poverty in Pakistan. In the health sector, improving the quality of services is expected to bring major improvements in the health outcome. Therefore, increased investment in health is seen as a means of poverty reduction and bringing improvements in primary and secondary health services. The PRSP notes that poverty plays a significant role in spreading communicable diseases and urban biases mean that provision of quality care mainly remains inaccessible to the majority of the population. The PRSP intends to link strategies of poverty reduction to improvement in health outcomes so as to be able to achieve the targets of the millennium development goals. For

this purpose a medium term strategy is also proposed that focuses on raising public sector health expenditures through a focus on prevention and control of communicable and non-communicable diseases, reproductive and child health and nutrient deficiencies. The PRSP also recommends shifting the focus from curative to preventive health care and in this way, focusing on providing access to adequate health care to the poor sections of the society.

The PRSP specifically recommends promoting gender equity through targeted health interventions. For this purpose, there has been a massive increase in health doorstep health services delivery by the trained lady health workers. The LHW programme is a community based initiative of the ministry of Health through which basic health promotive, preventive and some curative services are provided to the rural population of Pakistan on a house-to-house basis. This program was launched in 1994 and covers almost all 110-119 districts of Pakistan. The program has recruited 84,000 LHWs and the number is expected to rise to 100,000. This program is expected to meet the health care needs of about 100 million people. Besides the LHWs program, other programs in which significant investments are intended, include Roll Back Malaria (RBM), Directly Observed Treatment Strategy (DOTS) against TB, measures for preventing the spread of Hepatitis B, neonatal tetanus and polio, and HIV/AIDS control programs.

The main focus of the PRSP is on the strengthening of primary health care services that are expected to bring improvements in health outcomes. For this purpose, re-training of medical staff and provision of obstetric care facilities are considered important for improving the quality of health care services. Provision of obstetric care is especially important in addressing the issue of high maternal mortality rate in Pakistan. A national program for primary health care is expected to provide preventive, promotive and curative health services at the doorstep of the poor community. In the long term, it is expected that by redefining the roles of the federal and provincial governments, more emphasis will be placed on the empowerment of the district health systems. Through more active district health system, cost recovery of the health care services can be possible that will help generate more resources for the health sector development. One method to achieve this can be introduction of user fees in large hospitals and private wards so that funds can be generated from the ones who can afford to pay. In Pakistan there is not yet a national system of cost recovery through user fees. In some hospitals, nominal charges are levied for consultations, with fee waivers for the very poor. As hospitals have not been successful in cost recovery, introduction of user fees is one option based on the ability to pay. However, if user fees are introduced a strict exemption policy for poor and the needy (including many females) should be ensured (Shehzad, 2005). In order to improve the efficiency of the district health systems adequate financial powers need to be given to the district health offices under the devolution plan.

The government is giving priority to reproductive health services by increasing the number of distribution outlets. However, the numbers of these outlets vary

across provinces and districts. The aim is to institutionalize quality health care at the community level. For nutritional deficiencies in children and women, a nutrition program has been launched to overcome problems of low birth weight babies, deficiency of micronutrients and promotion of breastfeeding. A Tawana Pakistan program is a nutrition package for school going girls of age 5-9 years, introduced in 2000-01 in 26 high poverty districts of Pakistan. This project is implemented through Bait ul- Mal (Zakat Fund). Recently, the funding for the program has been stopped.

#### 4.4 Medium Term Development Framework (MTDF)

According to a decision of the National Economic Council, the Planning Commission of Pakistan was authorized to prepare a five-year plan 2005-10 for presentation at the time of budget of 2005-06. This assignment was called the Medium Term Development Framework (MTDF, 2005-10). MTDF was based on a consultative process of working groups in different sectors including health and involved experts from the federal and provincial governments under the facilitatory role of the Planning Commission. For the health sector, MTDF values health primarily as a determinant of economic growth and aims to reduce infant, child and maternal mortality rates and improve the nutritional status of women and children. MTDF envisions shifting public priority towards preventive and primary health care. Another priority area is combating non-communicable diseases such as malaria in line with the commitments of the MDGs. MTDF identifies major health care issues as the following:

- Widespread prevalence of communicable diseases
- Inadequacies in health care services
- Urban/rural divide
- Professional and managerial deficiencies in the district health system
- Basic nutrition gaps
- Addiction and mental health
- Improper health education system
- Unregulated private sector

The above listing of issues shows that in the MTDF, gender equity and women's empowerment do not appear explicitly as an issue beyond the issue of nutrition. Based on evidence, MTDF suggests that by improving outreach and community based activities (that focus on immunization, sanitation, malaria control, and family planning), primary care facilities, specialized care facilities it is possible to reduce 30% of under five deaths and home based services can further reduce another third of all deaths. During the period 2001-2004, an estimated Rs. 87 billion was spent on health in the public sector. Out of this amount 21.8 billion was development expenditure and 65 billion for non-development expenditure. In the same period, 2,800 hospital beds were added and about 35,000 health care personnel (doctors, dentists, nurses, and paramedics) were added. MTDF recommends bringing the district health system

in the loop through better coordination, monitoring and evaluation and pooling of health care resources. The health sector is envisioned to promote healthy population through encouraging them to practice healthy life style, and a health system that is responsive to the health care needs of the poor or more vulnerable groups. A few of the strategies that have been identified are the following:

- Strengthening of primary health care in the rural areas where all outlets will function as focal points for primary health and family planning services. This is often referred to as 'integrated' services, which makes it easier, for example, for women to avail reproductive services and at the same time get vaccination for their children. It also allows health budgets to be shared among services, users and expenditures.
- Provision of health care facilities in the underserved areas of the urban population. This needs to be emphasized in light of limited resources and shortage of medical personnel. Usually, efforts to improve health care facilities in underserved areas remain unsuccessful. There is therefore a need to increase the number of nurses, paramedics and community health workers, introduce service contacts of specialized staff, and funding of recurrent costs.
- Further training of the medical staff at all levels. Since community health workers can advocate preventive measures, for treatments of complications and surgeries, there is need for more specialized personnel.
- A better system of cost recovery through a mix of health care financing strategies and better subsidization for the poor.

#### 4.5 Millennium Development Goals (MDGs).

In the year 2000, the United Nations, through the MDG initiative, provided an opportunity for concrete efforts to improve global health. MDGs place health among other things, at the centre of economic and human development by linking developing and developed countries through commitments towards better health. However, achieving MDGs is not easy for many of the developing countries. Among major factors that weaken the link between the developed and developing country's health status are unfair international trade policies, inadequacy of official development assistance, debt relief and technology transfer. The World Health Report (2003, pp 25) recognizes the fact that without commitments from both developing and developed countries, the MDGs will not be met and outcomes will remain poor or far below the ones hoped for. Health-related millennium development goals targets and indicators are presented in the following table:

**Box-4: Millennium Development Goals**

Goals	Target	Indicators
Eradicate extreme poverty and hunger	Halve the proportion of people suffering from hunger	Prevalence of underweight children Population below minimum level of dietary energy consumption
Reduce child mortality	Reduce by two-thirds of under five mortality rates	Under five mortality, infant mortality, and proportion of 1-year children immunized against measles.
Improve maternal health	Reduce maternal mortality ratio by three quarters	Maternal mortality ratio, proportion of births attended by skilled health personnel
Combat HIV/AIDS, malaria and other diseases	Halve halted by 2015 and reverse the spread of HIV/AIDS, malaria and other diseases	HIV prevalence among 15-24 years, contraceptive prevalence rate, number of children orphaned by HIV/AIDS Prevalence and death rate associated with malaria, proportion of population in malaria risk areas, prevalence and death rates associated with TB, proportion of TB detected and cured under DOTS.
Global partnership for development	Provide access to affordable essential drugs in developing countries	Proportion of population with access to affordable essential drugs on a sustainable basis.

Source: Human Development Report (2005).

In Pakistan, progress towards achieving MDGs is very slow and not guaranteed to attain the objectives by the year 2015. The World Health Organization is supporting national efforts to achieve MDGs through extensive technical support in areas of maternal and child health, HIV/AIDS, TB, malaria, and access to medicine. However, some targets are questioned in respect of equity issues, such as the national averages versus gains for the poor and the disadvantaged. Gwatkin (2002) finds that significant progress in non-poor groups can result in achievement of goals, but with only minor improvement in the health status of the poor. MDGs should therefore, be achieved by creating a balance across groups, (focusing on the disadvantaged who need it most), and regions to ensure equality and flexibility in approach with a focus on those who are worse off. Similarly, crosscutting issues that are not directly connected to health may also be important for attaining the targets, such as access to water, sanitation and addressing gender inequities in health. To overcome inequity issues, more emphasis should be placed on safeguarding the interests of the most vulnerable groups, such as women, children and the elderly. The following table shows current status in Pakistan and highlights how unlikely the country is to reach the desired objectives by the year 2015.

**Table-4.1: Comparative situation of health targets and achievements**

Goals	Indicators	Current Status	PRSP	MDGs
			2004-05	(2015)
Eradicate extreme poverty and hunger	Prevalence of under weight children (<5 years)	37%	35%	<10%
	Proportion of population below minimum level of dietary energy consumption	32.6%	31%	16.3%
Reduce child mortality	Under 5 mortality per 1,000 live births	105	95	47
	IMR	77.1-82.0	65	40
	Proportion of 1 year old immunized against measles	57%		>90%
Improve maternal health	MMR per 100,000 live births	340-400	300-350	140
	Births attended by skilled labor	24%	28%	>80%
	Contraceptive prevalence rate	28%	35%	55%

Source: Health Sector Review (2005)

## 5. BUDGET ANALYSIS

The budget for health is a policy statement, and reflects government's priorities for the sector, and the fulfillment of its political commitment, in terms of funds and allocations for specific programs and policies. Although the budgets for health may appear to be gender-neutral, government expenditures can have different impacts on women and men. This section intends to highlight the importance of gender-responsive budget analysis to see the extent to which the government is committed to improvements in health outcomes and suggest ways through which commitments to gender equality can be achieved through allocation, distribution, and expenditure on different health care programs.

Federal and provincial budgets for health are summary statistics and reflect the way the health sector will operate in a given year. The (federal or central) budget of Pakistan reflects the country's federal structure as defined in 1973 Constitution in that Pakistan is a federation consisting of Federal Government and four provinces of Punjab, North West Frontier Province (NWFP), Sindh, and Balochistan. According to the Constitution, fiscal responsibilities are earmarked between the federal and the provincial governments with various tasks defined for the local governments as well in view of recently proposed decentralization of budgets. The Ministry of Health budget is divided into development or recurrent. The Ministry includes in the recurrent budget establishment (staff), traveling, fixed allowances and contingent expenditures. The development budget provides for development projects coordinated by the Planning Commission of Pakistan.

### 5.1 Budget Analysis (Federal and Provincial)

Total expenditure on health at both the federal and provincial levels is presented in table 5.1. It shows expenditure on health (development and non-development) since 2001-2002. The table shows a significant increase in health expenditure since 2001-02.

**Table-5.1: Total Expenditure on Health (Federal and Provincial) (Rs M)**

Year	Development	Non-Development	Total
2001-2002	6688	18717	25405
2002-2003	6609	22205	28814
2003-2004	8500	24305	32805
2004-2005	8500	33000	41500

Source: Inventory of health and population investment in Pakistan, Planning Commission (2005, pp.5), Economic Survey of Pakistan, Various issues

The following table shows the breakdown of expenditure into development and non-development expenditures. Over the years, more than 70 percent of the health expenditure is for non-development expenditure and the rest is for development purposes.

**Table-5.2: Development and non-development as percentage of total expenditure on Health (Rs.M)**

Year	Development	No-n-Development	Total
2002-2003	6609	22205	28814
% of total health	22.9%	77.1%	100%
2003-2004	8500	24305	32805
% of total health	25.9%	74.0%	100%
2004-2005	8500	33000	41500
% of total health	20.5%	79.5%	100%

Source: Inventory of health and population investment in Pakistan, Planning Commission (2005, pp.5), Economic Survey of Pakistan, Various issues

Although, for a developing country like Pakistan where health infrastructure is being expanded such a high component of non-development budget is not unjustified to make health projects and programs more sustainable, the development budget needs to be increased in line with the non-development budget.

The Poverty Reduction Strategy Paper (PRSP-I and 2003) provided for increased health allocations through the Public Sector Development Program (PSDP) that is published annually by the Planning Commission of Pakistan. The allocations and breakdown of spending is presented below. Table 5.3 shows that these expenditures were expected to increase by a significant amount by the year 2005-06, and also as a percentage of GDP.

**Table-5.3 Budgetary Expenditures for Health (Rs.M)**

Year	Health Expenditures	As % of GDP	Total PRSP	As % of TPRSP
2001-2002	19,211*	0.52%	133496	4.48%
2002-2003	22,368**	0.56%	208840	5.20%
2003-2004	29,172**	0.66%	238795	5.40%
2004-2005	38,075**	0.74%	278023	5.70%
2005-2006	44,313**	0.82%	323878	6.00%

Source: Poverty Reduction Strategy Paper (PRSP) \* Baseline (Actual) \*\* Projected values  
TPRSP covers figures of all programs of which health is one.

As noted above, the Medium Term Development Framework was the result of a consultative process under the auspices of the Planning Commission to prepare the five year plan for years 2005-2010 for presentation and approval of the National Economic Council. The year 2005-06 is the first year of the MTDF 2005-2010. The MTDF in turn will inform the public sector development program, which is a yearly activity financed through the budget for all sectors including health. Table 5.4 shows actual PSDP allocations versus health care expenditures for the period 2001/02 through 2005/06, and thus includes the first year of the MTDF. The table shows that in all previous years, health allocations exceed expenditures, hence reflecting under-spending of available resources. If this pattern continues, allocation of larger amounts will have limited impact.

**Table-5.4: PSIP Health Allocations and Expenditures (Rs M)**

Year	Allocations	Expenditures	Expenditure as % of allocation
2001-2002	4190.40	2658.17	63.43%
2002-2003	3309.253	2814.504	85.04%
2003-2004	4372.525	3781.306	86.47%
2004-2005	6044.556	4820.990	79.82%
2005-2006	9439.107	--	--

Source: PSIP, Various Issues.

The government of Pakistan has been using the Ministry of Health as a pilot for the Medium Term Budgetary Framework (MTBF). MTBF is aimed at improving the quality of planning and budgetary process for effectiveness of public expenditure. MTBF is a multi year activity that aims to formulate, plan and implement health policies and focus on public service delivery or "outputs" rather than only on financial allocations. In the MTBF, three year budgetary ceilings have been issued to the Ministry under the MTBF Budget call circular as well as guidelines for determining (i) output indicators (ii) defining activities to match these outputs, and (iii) costing of these activities in a medium term perspective. In line with the objectives given in the National Health Policy (2001), the following table shows that for the next three years, the government has allocated a significant amount to promote greater gender equity in the health sector, although the amount for 2007/08 is smaller than for 2006/07. This allocation of funds shows that the government is paying attention to gender issues in the health sector. Such resource allocation is likely to reduce gender imbalance in Pakistan in the coming years as compared to previous years if the money is well-spent. The expenditure activities will focus on improved health services delivery for mothers and children.

**Table-5.5: Medium term budget allocation under National Policy Objectives (Rs. M)**

Policy objectives	Budget estimate 2005-06	Budget forecast 2006-07	Budget forecast 2007-08
Reduce the widespread prevalence of communicable diseases	2,042	2,680	2,706
Address imbalances in primary and secondary health care	9,408	12,024	12,940
Remove professional and managerial deficiencies in district health system	271	544	369
<b>Promote greater gender equity in the health sector</b>	<b>291</b>	<b>306</b>	<b>273</b>
Bridge the basic nutrition gap in the target population	73	-	-
To create mass awareness in public health matters	5	6	6
To effect improvement in the drug sector for availability, affordability and quality of drugs	65	71	78
Capacity building for health policy monitoring in the MoH	258	180	159
<b>Total</b>	<b>12,408</b>	<b>15,811</b>	<b>16,531</b>

Source: MTBF (2004).

In Pakistan health is a provincial matter. The following table shows budgetary allocations for health in Punjab versus other provinces and share of Punjab in total resources.

**Table-5.6: Federal and Provincial allocations - 2004-05 (Rs. M)**

Provinces/Districts	Development	Non-development	Total
<b>Federal Government</b>	6531.9	339.9	6871.8
<b>Share of Punjab in Federal Government allocation</b>	18.3%	58.1%	46.0%
<b>Total Provinces</b>	4468.1	26660.0	31128.1
<b>Punjab</b>	2016.4	15701.3	17717.7
<b>Share of Punjab in total provinces</b>	45.1%	58.9%	56.9%

Source: Inventory of health and population in Pakistan, Ministry of Health, Planning and Development Division, pp. 18, (2005).

Figures in table 5.6 reflect that of the total Federal and provincial expenditures on health the share of Punjab as percentage of all provinces is around 45 percent and of federal government's allocation is 18 percent. Punjab's share is based on its population and actual needs of people.

In Pakistan's health sector, bilateral agencies and various multi-lateral organizations such as the Department for International Development, the United States Agency for International Development (USAID), Canadian International Development Agency (CIDA), and Japan International Cooperation Agency (JICA) are providing major support to the Ministry of Health. The Department for International Development (DFID) is providing budget support and technical assistance to Pakistan's seven national health and population welfare programs. The National Health and Population Welfare Facility is a four year (2003-07) project to improve the utilization of health services by poor people. This project consists of £60 Mn in financial aid (2003-2007) and £4.5 Mn in technical assistance at federal, provincial and districts levels to help improve the quality of programs and support the devolution process in the health sector. The NHF aims to strengthen the link between policy objectives in national health and population programs and resource allocation and management. It is expected that the budget support will enable respective ministries (health and population) to receive allocations on the basis of their strategic plans to attain policy objectives. The Ministry of Finance and the Planning Commission are responsible for budget preparation and execution in respect of the NHF.

The following table shows resource allocation and spending on major health care programs under the national health facility. These amounts form part of the larger amounts reflected in the (federal and provincial) sectoral budgets.

**Table 5.7. National Health Facility: Program allocations (Rs M)**

	2001-2002	2002-2003
<b>FP &amp; PHC</b>		
Allocation	2256	1791
Releases	1796.386	1632.379
Expenditure	1770.415	1617.891
<b>EPI</b>	<b>2003-2004</b>	<b>2004-2005</b>
Allocation	40000	80000
Releases	40000	80000
Expenditure	39446	77100
<b>LHW</b>	<b>2003-2004</b>	<b>2004-2005</b>
Original budget	2100.00	3700.00
Revised budget	2600.00	3430.78
Expenditure	2427.012	2952.43
<b>Nutrition</b>	<b>2003-2004</b>	<b>2004-2005</b>
Allocation	60.713	64.772
Surrender	15.985	4.682
Expenditure	44.727	60.089
<b>Malaria</b>	<b>2003-2004</b>	<b>2004-2005</b>
Allocation	29.00	29.50
Expenditure	22.00	27.24

Source: Report of the Program Managers, Ministry of Health.

Table 5.7 shows that under the National Health Facility, major expenditure is incurred for Family Planning and Primary Health Care services. The primary purpose of this program is to address the reproductive health needs of females, to increase family planning services especially among lower and middle-income groups, to increase access to quality and cost effective contraceptive services. Similarly, the Lady Health Workers program created community health workers for delivering low cost primary health care services especially for the females. The program initially started in 1994 as a vertical program with funding from the Ministry of Health and aimed at improving access, especially of rural poor, to primary health care services. LHW are multi-purpose workers who provide basic health services to communities and receive three months training on preventive and basic curative care. Each LHW is expected to serve 1000 women and visit each household in a month. The services include provision of basic health education, health promotion, and informing females about family planning services and how to improve health and hygiene. The LHW program has been successful for increasing awareness about health issues and improving access to basic health care.

The following table shows federal and provincial allocations for the major programs.

(Rs.M)

Years 1999-2000 to 2003-04	Total cost	% Share
<b>EPI</b>		
Enhanced program	5335.275	100%
Federal Area	26.676	0.50%
Punjab	2777.011	52.05%
<b>HIV/AIDS</b>		
Federal area	1137.366	39.9%
Punjab	632.523	22.1%
<b>Malaria</b>		
Total cost of program	273.00	100%
Federal area	0.720	02.60%
Punjab	98.00	35.89%
<b>TB</b>		
Total cost of program	158.97	100%
Federal area	20.30	15.40%
Punjab	25.40	19.08%
<b>Women Health Project</b>		
Enhanced program	3675.332	100%
Federal area	788.020	21.44%
Punjab	1260.034	34.28%

Source: Inventory of Health and Population Investment in Pakistan, (2005), Pp.172-5

One indicator of gender sensitivity in the health budget is the amount allocated for programs that explicitly target gender issues. In this respect, the Government of Pakistan has, for example, given special emphasis to Primary Health Care and Family Planning Services. The following table shows total budget allocations for

the different programmes, including NHF as well as other funds, for the major health care programs in Pakistan. It reveals that PHC & FP gets a much larger share than all the other major health care programs. This table also shows that for all major health care programs, spending are less than budget

**Table 5.9: Budget vs spending of major health care programs (Rs.M)**

Year	2003-04			2004-05			2005-06
	Budget	Revised	Spending	Budget	Revised	Spending	Budget
HIV/AIDS	175	173	48	227	200	288	253
EPI	400	400	--	800	800	--	1117
FP& PHC	2100	2600	2427	3700	3431	2955	4080
Malaria	29	29	27	30	30	--	33
TB	19	9	--	15	13	--	39
Nutrition	61	61	45	67	65	60	73

Source: MTBF: Ministry of Finance

As noted above, the national health policy 2001 through its intervention points emphasizes the provision of primary health care. At the federal level, this is achieved through various national health care programs such as family planning and primary health care. However, the provincial breakdown for Punjab shows expenditures in favor of government tertiary health care facilities. Thus table 5.10 shows almost 93% of expenditure on curative services as compared to 7% on preventive care.

**Table-5.10: Punjab's Health care expenses on preventive and curative care (Rs.M)**

Year	Preventive	%	Curative	%	Total
2001-2002	1309.693	13%	8394.97	87%	9704.663
2002-2003	723951	7%	9564.506	93%	10288.457
2003-2004	4364.608	47%	4951.048	53%	9318.656

Source: inventory of investment in health and population

## 5.2 Districts Data

Table-5.11 shows the development and non-development health budgets for districts in Punjab

**Table-5.11: Districts Health Budgets for Punjab (2004-05) (Rs.M)**

	Districts of Punjab	Development	Non-development	Total
1	Attock	14.603	1171.25	1317.28
2	Rawalpindi	30.120	2369.01	2670.21
3	Jhelum	35.203	1580.81	1932.84
4	Chakwal	16.908	1939.95	2109.03
5	Sargodha	49.188	3668.67	4160.55
6	Mianwali	9.734	1525.21	1622.55
7	Bhakkar	33.917	1805.30	2144.47
8	Khushab	8.966	1362.23	1451.89
9	Gujranwala	46.752	2943.88	3411.20
10	Hafizabad	32.129	99.369	1314.98
11	<b>Gujrat</b>	<b>36.374</b>	<b>1903.19</b>	<b>2266.93</b>
12	Narowal	14.090	1308.61	1449.51
13	Mb. din	12.809	1167.16	1295.25

14	Laore	56,100	406,604	462,704
15	Kasur	20,414	189,867	210,281
16	Okara	36,708	205,990	242,698
17	Lodhar	11,528	101,136	112,664
18	Vehari	19,213	239,206	258,419
19	Sahwal	17,932	201,891	219,823
20	Pakpattan	18,208	106,535	124,743
21	Khanewal	20,404	252,782	273,186
22	Faisalabad	56,708	388,347	445,055
23	Toba Tek Singh	15,371	184,561	199,932
24	Jhang	23,056	330,000	353,056
25	DG Khan	12,809	203,603	216,412
26	<b>Rajanpur</b>	<b>54,812</b>	<b>1,309,997</b>	<b>1,858,009</b>
27	Muzaffargarh	7,932	272,246	280,178
28	Layyah	20,247	136,390	156,637
29	Bahawalpur	47,187	166,507	213,694
30	Bahawalnagar	23,000	230,752	253,752
31	RY Khan	25,618	305,653	331,271
32	Multan	44,002	338,636	382,638
33	Sheikhpura	27,000	181,631	208,631
34	Sialkot	26,879	295,417	322,296
	<b>Total</b>	<b>925,901</b>	<b>7,742,647</b>	<b>8,168,518</b>

Source: Inventory of health and population investment in Pakistan, pp. 20.

In Pakistan, health is a provincial matter. At the district level, the overall responsibility lies with District Health Officer (DHO) who is part of the provincial bureaucracy. However, the DHO has no control over national programs such as the LHWs program, as this is part of the overall federally administered Family Planning and Primary Health Care (FP& PHC), the budget is allocated through the province and the devolution process is not yet complete. In Pakistan there are 34 districts in Punjab, 21 in Sindh, 25 in NWFP and 26 in Balochistan. There are all together 116 districts in the four provinces of Pakistan.

**Rajanpur** is one of the four districts of Dera Ghazi Khan Division (consists of many districts). It consists of Jampur, Rajanpur, and Rojhan sub Divisions and De-excluded areas.<sup>1</sup> Rajanpur is the district headquarters that was created on 1st July, 1982. The following health profile of Rajanpur District is presented from the Census of Report of Rajanpur (1998, pp. 25). Rajanpur has one district headquarter hospital, 32 basic health units, 6 rural health centers, 2 dispensaries, 1 mother and child health centre and 42 health care facilities. The total population of Rajanpur was 1,103,618 as enumerated in March 1998 with an inter-census percentage increase of 172.7. In Rajanpur, the number of child bearing women in the age group 15-47 years was 180,166 and total number of children born was 819,127. In Rajanpur, 9,995 persons were disabled due to (among others) blindness, deafness, physical disability, insanity and mental retardation. Total population less than 10 years immunized is 397,762. Total vaccinated are 254,637 and not vaccinated are 89,064.

<sup>1</sup> De-excluded area of Dera Ghazi Khan is special area including Rajanpur where jirgas administered the districts. After 1950, these jirgas were presided over by Naib Tehsildars and in 1958, became part of the basic democratic system, Rajanpur Census Report, 1998, pp. 17.

**Budget:** In Rajanpur, health estimates were 190.977 million for 2004-05. Of this total budget for health, about half, Rs. 960,000 is for establishment charges (salaries).

**Gujrat District** takes its name from the headquarter town of Gujrat and is bounded on the north east by districts Mirpur and Bhimber of Jammu and Kashmir, and on the north west by the river Jehlum. The total population of Gujrat district was 2,048,008 as enumerated in March 1998 census with a 45.5 inter census increase. The average annual growth rate was 2.1 percent during this year. Gujrat's population density is 642 persons per square kilometer. The urban population is 27.7% of the total population and grew at an average rate of 2.8% during 1981-98. There are four town committees, three municipal committees and one cantonment in the district. The sex ratio in Gujrat is 100 - 96 in rural and 105 in urban areas. Of the total female population, 47% are in the reproductive age group of 15-49. Percentage of population under ten years of age that is immunized (both sexes) is 81.7, not vaccinated is 3.1%. Gender disparity prevails for immunization of male and female children, where the rates are 42.1 and 39.6 respectively. In Gujrat, there are 170 health care facilities. These include, 94 basic health units, 20 dispensaries, 9 hospitals, 13 mother and child health care centers, 9 rural health centers and 25 welfare centers. District Gujrat has income index of 0.113, health index (0.913), educational attainment (0.603), basic health facilities (156) and persons per household of 6.6.

**Budget for health:** For district Gujrat in the year 2004-05 total health expenditure is 190.319 million, of which Rs. 128.337 million is for salary and Rs. 61.982 million for non-salary.

## 6. SERVICE DELIVERY AND IMPACT ANALYSIS

### 6.1 Health Service Delivery

In Pakistan, the Federal ministry and provincial department of Health provide public health services through four major components. These include (i) outreach and community-based activities with a focus on immunization, sanitation, malaria control, maternal and child health, family planning and LHWs program; (ii) primary health care: e.g. out-patient facilities; (iii) tehsil and district head quarter hospital for basic inpatient and outpatient facilities; and (iv) tertiary care hospitals located in major cities. However, to explore what impact health services delivery has on the health of people, especially the ones that are vulnerable and neglected a specific question can be addressed “what changes in the health situation have been effected by health services delivery and related budgets?” Answering this question leads us to explore how health services delivery happens. This is done firstly through examining the distribution of facilities, and then through looking at utilization and examining performance of the major vertical programmes

The previous chapter documented that in Pakistan much of the government funding, especially at provincial level, goes into expensive tertiary care mostly located in the urban areas. Although Pakistan has a fairly good network of health infrastructure in the country, statistics reported in the health and population welfare facilities atlas show that the utilization in term of number of patients served per day in these facilities vary across districts. In Pakistan, the big hospitals are usually used for providing primary health care services, immunizations and outpatient services. People travel from long distances to big hospitals in the hope of getting quality services and availability of drugs. Other health care facilities such as basic health units located in rural areas are either not well equipped, or lack trained medical staff. Hence, their effectiveness in terms of quality health care is a question. The following tables show the distribution of health care facilities and beds in Pakistan

**Table-6.1: Distribution of health care facilities**

Health care facility	NWFP	Sindh	Balochistan	Punjab
Hospitals	183	328	88	302
Dispensaries	534	1945	650	1457
RHC	88	97	60	293
BHU	944	712	436	2402
MCH	118	152	88	516

**Table 6.2: Distribution of beds in healthcare facilities**

Beds in:	Sindh	Balochistan	NWFP	Punjab
Hospital	25672	4610	14225	34268
Dispensaries	569	77	130	2055
RHC	1454	718	1075	5545
BHU	1470	16	0	3944
MCH	60	0	16	3

Source: Health and population Welfare Facilities Atlas (2002)

These tables show that basic health units far outnumber other types of facilities in NWFP and Punjab, while dispensaries are the most common form of facility in Sindh and Balochistan. Both of these two types basically provide primary health services in the areas. Table 4.2 shows that the number of beds in rural health centres outnumbers those in BHUs in three of the four provinces in Pakistan, and is more or less equal in Sindh. In NWFP, there are no beds in basic health units. A point to note is that in Punjab, NWFP and Balochistan, there are either no beds or their number is very little. In face of very high maternal mortality rates, lack of adequate number of beds in MCH is very alarming. It highlights a lack of specialized or inpatient services that may be crucial in obstetric emergencies.

The following table shows district-wise utilization of health institutions in Punjab. The two selected districts for this study are Rajanpur and Gujrat. The table shows that in both these districts, the total number of new cases, total reports, and utilization is high as compared to other districts.

**Table-6.3: Districts wise utilization of health institutions: BHUs, RHCs, Dispensaries, MCH centers, Hospitals**

	Districts of Punjab	Population	Total New Cases	Total Reports	Utilization
1	Attock	1,274,935	42,1267	697	24
2	Rawalpindi	3,363,911	99,7980	1295	31
3	Jhelum	936,957	56,5482	719	31
4	Chakwal	1,083,725	74,3300	932	32
5	Sargodha	2,665,979	108,919	1691	26
6	Manwah	1,056,620	39,7741	523	30
7	Bhakar	1,051,456	43,8183	530	33
8	Khushab	905,711	35,5623	561	25
9	Gujranwala	3,400,940	67,4939	1247	22
10	Hafzabad	832,980	34,6297	462	30
11	<b>Gujrat</b>	<b>2,048,008</b>	<b>1120,378</b>	<b>1202</b>	<b>37</b>
12	Narawal	1,265,097	57,3258	824	28
13	MBdn	1,160,552	47,8430	739	26
14	Lahore	6,318,745	55,8862	683	33
15	Kasur	2,375,875	68,1158	1126	24
16	Okara	2,232,992	47,4574	1189	16
17	Lodhan	1,171,800	39,6190	674	24
18	Velhari	2,090,416	79,9775	1177	27
19	Sahawal	1,843,194	78,7552	1061	30
20	Pakpattan	1,286,680	41,0814	567	29

21	Khanewal	2,068,490	90,4276	1141	32
22	Faisalabad	5,429,547	1,661,538	2328	29
23	Tobateck singh	1,621,593	92,1933	917	40
24	Jhang	2,834,545	1,101,159	1,463	30
25	DG Khan	1,643,118	52,1348	656	32
26	<b>Rajapur</b>	<b>1,103,618</b>	<b>39,2938</b>	<b>488</b>	<b>32</b>
27	Muzaffargah	2,635,903	1,136,544	1,140	40
28	Layyah	1,120,951	57,5035	691	33
29	Bahawalpur	2,433,091	89,0868	1,173	30
30	Bahawalnagar	2,061,447	1,138,201	1,469	31
31	RY Khan	3,141,053	1,542,599	1,564	39
32	Multan	3,116,851	74,8370	1,001	30
33	Sheikhpura	3,321,029	1,148,443	1,777	26
34	Sialkot	2,793,481	71,4947	1,265	23

Source: Health Management Information System Data 1998-2000.

A look at Pakistan's health care facilities shows that the health care network is strong and present in different places in one form or another. However, the poor quality of health services, unavailability of drugs and medicines, staff absenteeism are some of the main issues that make health service delivery system not as effective as one would expect in the presence of physical infrastructure. In Pakistan, population per hospital beds is 1,536, a figure that is in line with other developing countries. However, in Pakistan, dispensaries and BHUs are not equipped with beds or labour rooms. Taking into account the fact that a very high maternal mortality rate prevails in Pakistan, due mainly to non-availability of skilled birth attendants and other medical facilities, it is recommended that more resources are allocated for upgrading these BHUs. On the other hand MCHCs that are providing mother child health care and midwifery services sometimes have one or two beds to handle non-complicated deliveries but are unable to handle obstetric emergencies. Provision of emergency obstetric care is recognized internationally as a crucial element if a country is to reduce the maternal mortality rate. Hence, to save maternal lives, it is important to equip these MCHCs with modern and advanced health care facilities and to provide emergency obstetric care either at these centres or through prompt referral to others.

The private sector in Pakistan has also been very active in health care service delivery, but mostly concentrates on the more lucrative tertiary level curative services. Many of these facilities are located in the urban areas. According to the Government of Pakistan, 57% of people in Pakistan use private health centres as compared to 21% who use government doctors (GoP, 1999b). The other 14% used private dispensaries and 3% use private pharmacies. One major factor for using private health care facilities rather than public facilities is distance to the government hospitals and unavailability of medicines at the outlets. Some of the other reported reasons are uncooperative staff (who probably are more uncooperative with women than men), lack of technical expertise to treat complications and unavailability of specialized doctors at the public health care centers. The following table shows the availability of health facilities in the rural areas of Pakistan as reported in the Pakistan Integrated Household Survey, 2001-02. The table illustrates impressive reach of the LHWs, but much poorer reach of

most other forms. The second most prevalent form is a non-government one, namely hakim and homeopath.

**Table 6.4: Percentage of rural households with facilities present in their villages**

Type of Facility	Punjab	Pakistan
Government hospital	3	2
Govt. Dispensary	11	12
Basic Health Unit	18	18
Lady Health Workers	80	62
Private hospitals	5	4
Private dispensary	13	13
Private practitioner	21	22
Nurse/compounder	33	32
Hakim/Homeopath	41	33

Source: GP 2002c

The National Program for Family Planning and Primary Health Care is mostly implemented through the LHWs. The following table compares various health measures in areas served by LHWs and control areas

**Table 6.5: Health measures for LHW and control areas**

Measure	LHW areas	Control areas	National
Women who had birth since 1997 reporting on their last birth			
% who had at least one antenatal consultation at a health facility	58	1	31
% who had at least two tetanus toxoid injections in the last pregnancy	51	26	--
% who took iron tablets during last pregnancy	43	26	--
% of births attended by doctor, nurse or LHW	27	19	19
% using any method of contraception	33	26	28
% using any modern method of contraception	23	18	20
% who know at least one way to prevent diarrhea	66	52	--
% who know how to prepare ORS	73	61	--
% who know how malaria is caught	58	42	--
% of children aged under 4 months exclusively breast fed	39	20	--
% of children under 3 years ever weighed by health workers	38	13	--
% of children aged 12 to 35 months fully vaccinated (based on recall and record method)	57	40	49
% of children with diarrhea given ORS	47	35	54
% of children with respiratory infections given more liquids to drink	70	63	--

Source: Health Sector Review: An Aid to Budget Formulation

This table shows that the selected health indicators for mothers such as use of antenatal care, tetanus injections for expecting mothers, iron supplements are far

better in terms of percentage coverage for those areas that are served by the LHWs. Similarly, the percentage of births that are attended by doctors or any other healthcare professional is far higher in areas that are served by the LHWs. All such efforts to improve the health of women have a positive impact on their health outcome. Through the assistance of LHWs more women are using family planning techniques. The resultant longer birth intervals have a positive impact on both the mother and child health. Women who are assisted by the LHWs, especially in the rural/poor areas, are better able to overcome child illnesses such as diarrhea and respiratory infections than women in areas that are not served by LHWs. They also have improved awareness of disease causation and methods/ways to overcome them and treatment as and when needed.

According to the program managers of the FP& PHC, the following are the main weaknesses/ gaps in this program (i) most LHWs are under supplied with drugs and contraceptives (ii) limited services for patients after referrals (iii) lack of timely payments to LHWs (iv) lack of knowledge and expertise among the workers. However, the significant achievements include serving of the 60% of target population, a significant increase in the number for both LHWs and their supervisors. LHWs also played a significant role for increase in the number of child immunizations, where out of 30 million children, about 16 million are immunized by the LHWs. Similarly, out of 5 million target women, 4.5 were vaccinated against maternal and neonatal tetanus by the LHWs and they also ensure safe completion of the TB DOTS program. To gain significant improvements in health outcomes, the number of LHWs should be increased substantially, especially in areas that are under served by the mainstream health system. Lady health workers can advise on various health matters including safe and hygienic techniques for normal deliveries, and for more complicated ones, timely referral to clinics and hospitals. They can also help in identifying post partum hemorrhages, however, that may require training that is beyond the safe motherhood practices. For reproductive health care services, increase in access to contraception can significantly reduce maternal deaths by reducing the number of times women may become pregnant and may be exposed to risks related from complications. Lady health workers have been doing this job quite successfully but there is still scope of expansion and advancement in their skills. According to the Human Development Report (2003), if unmet need for contraception is met and women have only the number of pregnancies at the intervals they want, maternal mortality would drop by 20-35%.

The above figures show that in Pakistan, the government is focusing on primary/preventive health care services through use of an effective LHWs program. The selected health indicators reflect a success story, where relatively large numbers of women have access to basic and primary health care through doorstep health services delivery. The private sector may not be very willing to provide these basic services because of lack of opportunities for profit making. However, there is always a need to improve the skills and trainings of those workers that are providing care through proper monitoring and evaluation of their performance in

all areas. In this regard, attention should be focused on strengthening other supportive healthcare personnel, such as nurses and paramedics that can substitute the services of the doctors for primary health care provision. Special attention needs to be given to people living away from urban centers through special outreach and health care services.

Another important growing health problem in Pakistan is HIV/AIDS. The first officially announced case of HIV/AIDS was in 1987 in Lahore. To date, the majority of cases reported for HIV/AIDS are for males, with a male to female ratio of six to one, in 2003-04 (HDR, 2004). Part of this pattern could be related to socio-cultural norms that inhibit females to disclose their condition or access health care. Over time, it is expected that poor women will be especially vulnerable to HIV, because of poor nutritional status, low educational levels, their engagements in unregulated sector employments that do not provide any medical insurance and their inability because of the social norms to practice safe sex habits. As female autonomy is a major issue in Pakistan, it often men who decide when and how sex should happen and in case of illness, when they seek medical advice.

Although HIV/AIDS incidence is not yet high in Pakistan, the government has been proactive in creating awareness about the disease. In case of new cases detected of HIV/AIDS, the demand for health care services is increasing massively. This need is difficult to meet through existing structure and system and quality of services.

In Pakistan, expenditure for HIV/AIDS has increased over the past few years. However, it is also important to address social issues that are responsible for increase in the number of HIV/AIDS patients. Among these are stigma, gender discrimination and most importantly, unequal power relations between males and females in Pakistan. The expectation is that a lot more poor women, especially expecting mothers may be at an increased risk of the disease. Therefore, prevention and treatment programs must address the conditions that can make women more vulnerable to HIV infections as compared to males.

As Pakistan has now been identified as a high-risk country, the national AIDS control program has now been earmarked as a priority program with enhanced budgets for the next decade. The enhanced HIV/AIDS Control Program (2003-08) is being implemented with the assistance of the World Bank at a cost of Rs. 2.85 billion.

For the Expanded Program of Immunizations (EPI), Rs. 1117 million was allocated for the fiscal year 2005-06. The Federal EPI cell is responsible for overall planning, policymaking, technical guidance, co-ordination with international agencies, evaluation and reporting of the program. The requirements that were put up in 2001-02 were Rs. 911.058 and in the year 2002-03, Rs. 1019.571. As against actual requirements, Rs. 500 million was allocated and

released and slightly more than this amount utilized. The overall coverage (urban and rural) areas increased steadily but relatively low coverage was witnessed for the rural areas due mainly to absence of an effective rural health infrastructure, shortage of funding with the provincial health funding and administrative mismanagement. EPI is especially important from a gender perspective in terms of the provision of tetanus toxoid for pregnant women.

In the year 2004, 5.6 million children of 0-11 months and 6.2 million expecting mothers formed the target group for the EPI programme. In the same year, 69% of the target group of children and 48% of the target women were immunized, showing that women were less well reached than children.

In Pakistan's 5 year's project on Improvement of nutrition through primary health care and nutrition education/public awareness, Rs. 308.2 million was allocated for supplementation, fortification, growth monitoring, lactation management, weight gain during pregnancy and nutrition awareness. In this project, main activities include purchase and distribution of micronutrients to 40,000 TB patients receiving DOTS therapy, and nation wide training in lactation management. During 2004-05 Rs. 64,772,000 was allocated and Rs. 60,089,786 was spent.

## 6.2 Discussion

In Pakistan, there are gender differences in health and health care in respect of (i) access and (ii) utilization and (iii) health behaviors. Although the extent of differences remains less well documented at the micro or household level, the macro level indicators suggest that girls and young women face relatively more threats to their health and well-being than males. While reproductive needs are relatively well catered for, other issues are not adequately addressed in the health policies of the government. A detailed look at the budget allocated for health and expenditures incurred by the government also reveal that gender issues are not adequately addressed.

To find out the various socio-economic determinants of health, it is important that relevant data are gathered through household level surveys. In addition, there needs to be greater sex disaggregation in respect of data collected through the National Health Management Information System. More detailed sex-disaggregated data will better reveal the health care needs of all and help in holding government accountable for their commitment to promoting the nation's health. Similarly, the Ministry of Finance in conjunction with the Ministry of Health can carry out expenditure reviews of budgets. In this way the government can increase its capacity to address the gender impact of health budget, revenue collection and resource mobilization strategies for health.

The success and efficiency of ongoing vertical health care programs needs to be improved. Access can be improved by integrating these programs into the regular health care system and efficiency can be improved by extending effective coverage.

to the most vulnerable groups. For reduction in maternal mortality, better access to quality health services should be ensured, and provision of antenatal care that enables the family and the women to recognize danger signs of pregnancy, ensuring the availability of skilled birth attendants and provision of basic emergency obstetric care available at all primary health care outlets. Similarly, better health education is important for all women to attain better health outcomes and can be enhanced through community based health workers and media. Finally, the scope of the BHUs and dispensaries should be enhanced to accommodate inpatient services instead of only outpatient curative services.

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## Annex-1

### **Definitions**

**GDP:** Total market value of all final goods and services produced in a country in a given year.

**GNP:** GDP plus the income accruing to domestic residents from productive activities abroad, minus the income earned in domestic markets accruing to foreigners abroad.

**CBR:** Annual number of births per 1000 population

**Crude death rate (CDR):** Total number of deaths per 1000 population

**TFR:** Total fertility rate. Average number of births a woman could expect to have during her life time, if she followed observed levels of fertility for age group at every level.

**Immunization coverage:** The percent of children immunized under different programs.

**IMR:** The probability of dying between birth and exactly 1 year of age per thousand live births.

**Child mortality:** the probability of dying between 1-5 years of age expressed as per 1000 Live births.

**Life expectancy:** the number of years a newborn will live if subject to mortality risks prevailing for cross section of population at the time of their births.

**Under nourished people:** people whose intake is chronically insufficient to meet their minimum energy.

**Wasting** below 2 SD [standard deviations] from median weight for height of reference population

**Stunting:** below 2 SD from median height for age of reference population

**MMR** annual number of deaths of women from pregnancy related causes per 1000 live births

**Safe drinking water:** treated surface water and untreated but uncontaminated water such as that from protected boreholes, springs and sanitary wells.

**Status index:** relative status of health in a country, calculated in two steps: separate index that receives a value between 0-1 and uses other indicators such as MMR, U5MR and undernourishment index

**Infrastructure index:** the relative achievement of a country in building an appropriate infrastructure for health. Uses spending index, skilled attendance, immunization, physicians, access to sanitation indices.

**Limitations index:** Uses poverty, illiteracy, contraceptive prevalence and smoking indices

**Health index** is the weighted average of three indices = status, limitations and infrastructure index.

Sources: Human Development Report (2004) UNICEF (2001), The State of World's Children  
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