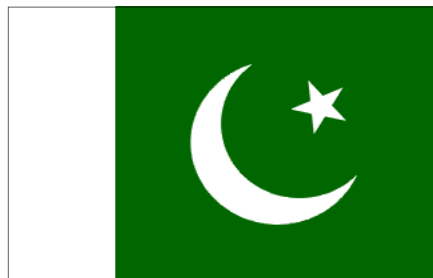


Draft

Social Determinants of Health



Pakistan



**World Health
Organization**

Regional Office for the Eastern Mediterranean

DRAFT

**Social Determinants of Health
in Pakistan:
The Glass is More than Half Empty**

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Section 1 Introduction

1.1 Health – the given understanding

Health has been defined as *a state of physical, mental and social well being , and not merely the absence of disease and infirmity.*¹ This was stated as part of the Primary Health Care Declaration in 1978 at Almaty, and which was endorsed at Riga in 1988. In 1978, at Almaty, while acknowledging the new challenges to the principles proposed in the said declaration, the Declaration was again accepted as relevant and to be pursued. Perhaps the most significant element of the Declaration was the emphasis on inter-sectoral collaboration and community participation, along with health services that were to be delivered.²

In 2000, at the first People’s Health Assembly in Bangladesh, a People’s Charter was developed and endorsed.³ The People’s Health Charter endorses the PHC Declaration and specially mentions the role of economic and social policies

*Illness and death every day anger us. Not because there are people who get sick or because there are people who die. We are angry because many illnesses and deaths have their roots in the economic and social policies that are imposed on us. (Quoted in the People’s Health Charter.)*⁴

In 2003, celebrating the 25th anniversary of the PHC Declaration, the Coordinator of the People’s Health Movement had the following to say:

- *The Declaration is particularly significant to the People’s Health Movement because the People’s Charter for Health which evolved at the first People’s Health Assembly at Gonoshasthya Kendra (GK) – Savar in Bangladesh on 8th December 2000, endorsed the principles and practice of universal, comprehensive Primary Health Care as outlined in the Alma Ata Declaration.*

Pakistan was a signatory to the Primary Health Care Declaration of 1978, and its health policy makers and planners visited China and other developing countries in the late ‘70s to apprise themselves of the global learning guiding health care.

Unfortunately, the framework provided by the Declaration is not reflected in the development of the Pakistani health sector. Intersectoral collaboration and community participation are conspicuous by their absence, and health as a right does not feature as a central concern especially when financial allocations are concerned.

Any discussion on the social determinants of health can derive its legitimacy from the Primary Health Care Declaration of 1978, and from the People’s Health Charter of 2000.

Health as a right is a significant dimension of principles guiding the health sector reform. Financial allocation is one of the significant parameters for commitment to health as a right. In Pakistan this commitment has been generally missing.

1.2 The social determinants (SD) of health.

Literacy levels, income levels, availability of potable water, housing, family size, are some of the well known determinants of health. These are also relatively easier to capture through quantitative measures. The most commonly used SD-indicators in Pakistan are literacy/education, gender (specially since the '90s) and poverty. Differences in IMR, MMR, diarrhea, to name a few health concerns, on the basis of urban-rural areas, and gender differences, are often highlighted⁵. Recently (last 5 years or so) relationship between poverty levels and some health outcomes has also started to emerge. Data is available on life expectancy by sex; IMR by locality (urban and rural); trends in birth control by location (urban and rural); immunization by location; and immunization by income quintiles.⁶ Data is also available on the urban and rural difference in several causes of death – namely, infectious and parasitic diseases; malaria; congenital anomalies, birth injuries, and peri-natal mortality; tuberculosis; dysentery and diarrhea; accidents, poison, or violence; cardiac and circulatory system diseases.⁷

Similarly, given the great significance of availability of water for health outcomes, this SD indicator is also monitored for urban-rural differences. For example, difference in the access to drinking water and sanitation for the poor and non-poor is also available.⁸ Within the urban centres of Pakistan, difference in the availability and consumption of water between the poor residential areas, and better off areas is well known but never a matter of policy analysis for overcoming the differences. Moreover, within the poorer localities (for example, nearly 50 % of Karachi's population lives in squatter settlements) differences in the availability and consumption of waters is seldom a public discourse. However, shortage of water, and people's right to water, is part of the public debate which frequently surfaces in the media.

Identifying and monitoring inequities in Pakistan is yet to become rigorous and to become part of the formal discourse. The media is more in touch with such injustices than the policy makers.

1.3 Expanding the domains of social determinants.

Discussion on the social determinants of health is an entry into the context within which health outcomes can be located. Sectors that affect health outcomes are many, though many of them are not considered in discussions on the determinants of health.⁹ Ideally, the domains that need to be reviewed and analysed, and linked to health outcomes, should include: transport; livelihood; labour; agriculture (food security); politics; environment; law; and gender in terms of power relations and not merely sex disaggregation.

Social determinants draw attention to the conditions in which people live, and the risks they carry because of the conditions. In Pakistan, for example, living in the rural areas would lend itself to a greater risk for mortality and morbidity than living in an urban area; being a woman places women at a higher risk than being a man. Similarly being poor makes you more vulnerable. While monitoring the differences between these sets of SDs needs to be sharpened, for example by looking at inequities within the rural areas, and also within the urban areas, it is also important to expand the SDs to get a clearer picture

of the determinants that perpetuate the commonly known SDs. Similarly, in Pakistan, which has a large rural base, poverty needs to be monitored not only through income measurements but also by examining the vulnerability of the livelihood of the poor.¹⁰

New domains need to be added to the list of determinants. These would need to be reviewed with the equity and gender lenses. Research and interventions in Pakistan too need to be assessed with the help of the equity lens. This would then help in the understanding of what should and should not guide the policies of those domains.

1.4 *Social determinants, inequities; and Health systems' enigma*

There are mortality and morbidity rates in every country, but in terms of lived realities, death and illness is really one per person. While rates help articulate policy directions, ground realities pose challenges. It is the lived experiences of people, specially the most vulnerable, that constitutes the reality which needs to change if health is to improve, and inequities in health outcomes are to be reduced. It is thus not only that average outcomes are to improve, but the underlying disparities too have to be targeted. The underlying disparities or inequities may not be easy to determine through a formal exercise, but are well known. *Everybody knows the inequities that prevail, but nobody is doing anything about them*, said a young faculty member at a meeting where community level work on equity was introduced.¹¹

When change is desired, it is well to remember that there is invariably a resistance to change. What information is available to highlight and monitor the resistance to changes is a great task which must be faced by any country, for information does not necessarily provide specific entry points that would make a difference to the lives of the most vulnerable

The enigma facing health systems is not only what ails the individuals, as what impedes the individual's agency to combat the ailment. For example, the link between women's *position and condition*¹² explains why there is high mortality and morbidity in women in Pakistan. Women's poor position in their society is linked to their health outcomes, and also on the well being of their families and communities. Gender abuse can be found in different forms -- in the form of delay in access to health services, restrictions on women's mobility, domestic violence, mental stress emanating from male unemployment and armed conflicts, and deaths due to armed conflicts, and women's workload.

A poorly functioning health system is itself a determinant of health. When a society is so structured that it resists amelioration of conditions leading to poor health outcomes, the challenge to any government, and civil society is phenomenal. Strategies for advocacy for policy change would need to be carefully chalked out. Whether the health professionals are geared to meet the challenge is itself a critical determinant of health.

1.5 *Determinants of health – conventional and non- conventional*

For a country like Pakistan, the conventional determinants of health are not enough. Given the inequities that prevail, determinants on inequities need to be brought into

focus. These can be called the non-conventional determinants of health. They are part of the larger family of social determinants, but for the sake of clarity should be distinguished from the conventional social determinants on which data is repeatedly gathered to track overall progress of the country. These determinants are the sub-text of the social determinants. For example, when it is said that illiterate women are more likely to be ill, and have ill children, then by raising the question *why is she illiterate ?* one can see the various layers underlying illiteracy.¹³ Similarly, an analysis of a maternal death, or any illness, using the same method of *But why?*, a chain of causation and a web of causation can be developed. This chain and/or web presents the sub-text of a maternal death or illness. This sub-text of determinants can also be called the determinants of inequities, or structural determinants.¹⁴

The second layer of determinants, the determinants of inequities or structural determinants, are the causes which need to be brought to the centre stage of policies and programmes. These realities are not captured by most surveys. Pakistan Participatory poverty Assessment, however, does capture the complex and dynamic local realities of the poor.¹⁵

*Poverty is the name of despondency and wishing for death due to persistent illness and hunger (A poor female analyst.)*¹⁶

To take a more concrete example, net primary enrolment ration (%) increased from 46 – 52 from 1990-91 to 2004-05 (though it had fallen to 42 in 2000-01)¹⁷. Similarly, enrolment rates and literacy rates for women are reported to have improved, but data does not show whether there is a decrease in the rates for the poorest and thereby the most vulnerable population groups. Anecdotal harsh realities pose considerable challenge to the averages that are often cited, for averages hide inequities.

In a meeting in a village in a rural district of Sindh, older men (over 50 years) were found to have at least primary school education, whereas the younger generation (15–25 years old) were found to be illiterate. When reason for this difference was probed, an older man said: *In our times the Mirs (the local rulers of area before the creation of Pakistan) were very strict... we had to go to school.*¹⁸

Section 2

Overall Profile of Pakistan and its People

2.1 Overview

Pakistan is part of South Asia with a long boundary with India on the east. It also has neighbours that are outside the South Asia sub-continent. These are: Iran on the west, and Afghanistan on its west and north west. Pakistan also shares a small segment of its border with China.

Pakistan's geographical location is critical and its relations with its two neighbours (India and Afghanistan) have been a cause of great tension and turmoil within Pakistan. This has a bearing on the militarization of Pakistan, and a very heavy expenditure on the defense budget of Pakistan. Relationship with Afghanistan has contributed to great instability within Pakistan during the Afghan upheaval against the Soviet Occupation of Afghanistan, and with Pakistan becoming the buffer state for the political agenda of the western countries.

Pakistan is the seventh most populous country in the world. Its annual growth rate is said to be 2.13%,¹⁹ This has led to an increase in population from 32.5 million in 1947 to 148 million in 2003. The rapid growth rate has resulted from a decline in death rates, and high fertility rates. The rural - urban distribution of Pakistan is now becoming a contentious issue because of the steady migration of the rural population to urban centres.²⁰

Pakistan is classified as a low-income country (World Bank 2006). Now in its 59th year of independence, the country's political history has not been very stable. For most of its years of independence, the country had been under the rule of military leadership. Even the years that it was ruled by democratically-elected governments, they sometimes proved more autocratic than their military counterparts. At the time of its independence, Pakistan inherited a rather narrow resource base. The breakup of the country in 1971 also contributed to this overall bleak picture. Despite this tumultuous political history, Pakistan has managed to achieve an average Gross Domestic Product (GDP) growth rate of around 6 (Zaidi. A.S 2005). However, development in the social sectors has remained dismally low.

Pakistan's geopolitical position and its tensions with two of its neighbours has a direct bearing on the low status accorded to health and other social sectors in Pakistan. When defense becomes the priority, military expenditures are legitimized, and the first to suffer are the poor and marginalized.

2.2 Sense of deprivation

Pakistan spans an area of more than 796,000 square kilometers. The River Indus flows through Pakistan, and its water distribution has been a contentious issue between two of its provinces. A sense of deprivation felt by the people at the tail end of the water distribution network, and great damage to the mangroves in the delta region has adversely affected the livelihood of the population dependent on the river water.²¹ If the armed

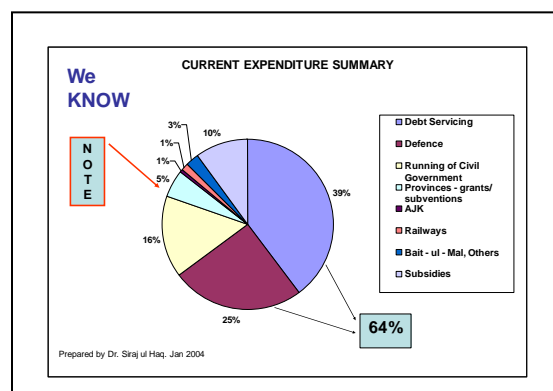
conflicts between the government and local groups in two of the four provinces is any indication of deprivation, then it is definitely there. Similarly, in the most populous province there is a peasant movement against the farm owners who are trying to deny the peasants their tenancy right. This too reflects a deep sense of deprivation.

The more vocal and visible expression of discontent as reflected in the indigenous movements (as opposed to the agitation by the political parties) ²² but the less volatile and near silent discontent is expressed in various forms in the media. The plight of the landless, the plight of those living in remote rural areas, the gross neglect of the disabled population are well known phenomenon. Whereas poverty is flagged continuously as an issue that Pakistan strives to address, there is a conspicuous silence on the state of the disabled. The National Health Policy (1997, and 2001) do not mention the disabled. From the 49 initiatives taken from 1950 to 2005, ²³ there is not a single one for the disabled. There is, however, a programme for prevention of night blindness.

When a sense of deprivation is expressed through armed insurgency, or through peaceful movements, and when large groups suffer their deprivation silently, and when political instability persists, issues of social determinants and equity would be hard pressed to find and create space for their voices to be heard.

2.3 Rationale for military expenditure

There are four provinces in Pakistan -- Punjab, Sindh, North West Frontier Province (NWFP) and Baluchistan. There are some federal units which include District Islamabad, Federally Administered Tribal Area (FATA) and Northern Areas (FANA=Federally Administered Northern Areas); and Azad Jammu and Kashmir (AJK) This last mentioned region of Pakistan is the political quagmire which has kept India and Pakistan embroiled since their respective independence in 1947. The situation provides reason for both countries to build arms, and develop nuclear capabilities.



2.4 Data is available

Data is available to compare health outcomes in the different regions of Pakistan. For example, immunization coverage, nutritional status by region, IMR, MMR, and other health indicators by region are available. ²⁴

Malnutrition is rampant in the country with 30-40% of the children being stunted and 14% being wasted. Malnutrition accounts for nearly half child deaths every year. Malnutrition not only causes physical impairments but also impacts cognitive development of the child, and thereby not only the future generation of the girl child but also the future of Pakistan. 25

The overall indicators, however, are quite misleading as they reveal little in terms of how different groups fare on various development indicators. In education, for example, there is considerable gender and rural/urban disparity. The ratio of female to male enrolment is 0.6 which is the lowest in South Asia. The dropout rates within public primary schools are alarmingly high and generally higher among girls and are increasing at a higher pace relative to boys. Similar gaps also exist between urban and rural areas with an urban literacy rate of 63% while that for rural area at just 34% (Social Policy and Development Centre 2002). Similarly health indicators highlight the urban bias as well.

The breakdown of information indicating a strong urban bias in both the health and education sectors also depicts a deeper and more fundamental class bias. Although most of the resources in the social sectors go towards urban areas, yet not all urban inhabitants have equal access to health facilities, nor is there an equal discrimination against the rural dwellers. Facts reveal that access to good healthcare for a landlord may be much easier as compared to residents of a slum in a city. And besides access, the discrepancy in the quality of services between those who can and cannot afford to pay may be an equally important determinant of care. In rural areas it was also found that those in the low economic bracket (men as well as women) access government doctors less frequently than the better off class; they prefer to access the private doctor (the quality of the private doctor is not mentioned, as often quacks pass off as physicians). Women in poor households also visit government doctors more frequently than the private doctors. 43% of all visits by women from low income households were to para-medics. ²⁶

2.5 Politicization in Pakistan

Pakistan is primarily a rural country, and its rural economy is controlled by the landlords (feudal lords) and tribal heads. The industrial sector of Pakistan is gradually developing, but the trade union movement has been in a slump for the last decade. Politicization of the trade unions is such that it reflects all the ills of the political system of the country. This same can be said of the students' movement which too has suffered from the penetration of the political parties into the fora of the students, thereby using them as means for their political gains. This has led to the decline in the education standards in the public sector colleges and universities. The private sector, in health and education, is providing an alternative to the public sector, but is also contributing to the inequities that already prevail in the country.

2.6 Poverty in Pakistan

Pakistan experienced a return to poverty during the 1990s. The incidence of poverty increased from 26.1 per cent in 1990-91 to 32.1 percent in 2000-01, reversing the declining poverty trend in the 1970s and the 1980s (GoP, 2003)²⁷.

Estimates by the Federal Bureau of Statistics show that poverty levelled off in the 1990s and started to rise towards the end of the decade (GoP, 2001). The World Bank's Poverty Assessment covering the 1990s (World Bank, 2002) indicated a slightly different picture (i.e., that poverty levels fell during the middle of the decade before rising to near the previous levels by the end of the decade) ²⁸

As with any debate on the accuracy of data, this debate needs to be seen from the perspective of those who suffer poverty. Whether poverty has increased or decreased, the health of the poor is that which matters. The consensus is significant that poverty levels remained essentially unchanged throughout the 1990s. The Participatory Poverty Assessment (PPA) in Pakistan (commissioned by the Planning Commission) highlighted the exclusion of the poor, both men and women, from essential services like health, education, credit, and justice. PPA also described the vulnerability of the livelihood of the poor.

The policies of our governments are blind and deaf. Most of these policies are wrong. Nobody listens to the poor. The policies that are developed without our participation make the situation worse.

(An analyst, Pakistan Participatory Poverty Assessment, 2003)

2.7 *The average Pakistani woman*

She is Illiterate . Has 5 children. Lives with 4 persons per room. Works 15 hours a day.

Her children under 3 are malnourished.

Has had 6 pregnancies -- but with the maximum being 12 or more.

Lives in a 2 room, mud house. Undertakes in a day 12 - 13 major and minor activities (compared to 6/7 by men) Is Anemic. Gives birth to low-birth weight babies.

Does not have access to safe abortions.

The personal security of women in Pakistan is at high risk. There is fear of sexual harassment at work and public places and she carries the double burden of productive and reproductive work. Economic returns from her productive work are often collected by the male members of her family. She lives in fear of being killed in the name of honour, where there is no law to protect her from domestic violence. She lives in a society where public transport is grossly inadequate; and where the judiciary is weak.

The position of women in Pakistan can be easily gauged by the reports in the daily newspapers. For example,

Call for steps to help *swara* victims

Peshawar, Feb 19: Representatives of a civil society organizations have called for a proper interpretation of the law concerning custom of *swara* (marrying a girl to a rival to settle a dispute) as the present legislation does not give relief to the victims....They argued that under the prevailing law, if a *swara* victim made a

complaint, her father would be arrested. ‘This stops the victim from speaking up to get relief’ (DAWN Monday, Feb 20, 2006)

Only 18% births are attended by trained health personnel. Pakistan has a sex ratio of 905 to 1000 men; and there are over 5 million missing women, which constitute 12.9% of women in the reproductive group.

Man, pregnant woman axed to death.

Hyderabad, March 13: A pregnant woman and man were axed to death by the woman’s cousin on the pretext of karo kari²⁹

Two of the assailants surrendered to the police and confessed to have committed the crime

Police officials said that four people carrying hatchet intercepted ... and axed him to death.

Soon after, they murdered their cousin.... 19, in her house in the same village.

(DAWN Tuesday, March 14, 2006. Page 21)

There are two issues here – cultural legitimacy of a crime against women though men also get killed (there are more cases of women’s murder); and the weakness of the law and the judiciary to curtail this customary practice. The following account illustrates the most enigmatic aspect of the problem:

The great lawgiver ... threw another public tantrum a couple of days ago.

Readers will recall stories in this very space of the Lawgivers earlier fits of anger, including physical violence. This time he was on a Lahore to Islamabad flight and the Lawgiver was in occupation of a young businessman’s seat. The young man showed the Lawgiver his boarding card and asked him, ever so politely, to vacate his seat. The Lawgiver did not budge. The young man summoned the steward who asked the Lawgiver to vacate the seat and take another one. At this, the Lawgiver lost it, as is his wont, and shouted the usual obscenities at the poor steward. “Do you know who I am? I’ll sort you out!” etc. The steward backed down in the face of this tirade and the young man, in deference to the steward’s discomfort, went and sat at the back of the cabin. Lucky are the people of Pakistan for whom their public representatives set such wonderful precedents of good behaviour! (Friday Times. March 10-16, 2006. page32)

When customary practices place tremendous restriction on women, and women live in a near perpetual state of insecurity, when lawgivers have no sense of people’s rights, then the challenge is to capture these deeply entrenched realities as determinants of the inequalities that prevail. These determinants go well beyond the conventional determinants of health.

2.8 Gender

Gender-based disparities are very prominent in Pakistan. The South Asian region is known for its gender inequities. Even within this group, Pakistan does much worse ranking lowest on most gender-related development indicators. The indicator ‘missing women’ represents women who are not alive as a result of social and economic discrimination. The total number of women missing, as estimated by Amartya Sen, by applying global norms of female to male ratio, in South Asia is close to 74 million. Pakistan has the highest percentage of missing women at 13% of the total population (Dreze, J. Sen, A 1998). To corroborate this analysis the Social Watch estimates gender inequities using the Gender Inequities Index (GEI), which is calculated by combining dimensions of empowerment, education, and economic activity. On a score of 3 (the lowest score given to a country) to 12 (the highest) Pakistan is ranked at 4 (Social Watch 2005).

Gender disparities, although very important in Pakistan, represent only one dimension of disparities that plague the Pakistani society. Highlighting gender for this analysis by no means underestimates disparities based on rural and urban areas or those based on class. Disparities in health outcomes reflect power differentials that exist in the society; and gender relations as power relations is but one aspect of power relations. In the case of class-based power differentials, for example, relationship between the landless and the landlord; the cattle herder in a tribal set-up and the tribal chief, reflect power-relations in which the poor are dependent on landlords, moneylenders, and local state officials. This is the classis relationship of domination and subordination.

Differences in health outcomes cannot be seen only as a sectoral issue. There is a need to go deeper to the underlying processes that give rise to health inequities and to unravel the causes of such disparities at the societal and structural levels. Looking at power-relations that underlie the relationship of subordination and domination can be labeled as an imperative for addressing health inequities.

Section 3 Health Sector of Pakistan

3.1 What was inherited at independence

Pakistan gained independence on 14th August 1947, and inherited a health system that consisted of hospitals and dispensaries, even in some small town surrounded by rural areas.. The efforts of the government of British India are well captured in the review of the Bhore Committee Reports of 1946

The recommendations of this Commission created the foundation for sanitary reforms and public health in India, albeit on an enclave pattern. Sanitary Commissions were set up and from then on some organised data on health and disease particularly vital statistics and disease control, was available in the annual reports of the sanitary commissions. An investigative tradition became an integral part of the sanitary movement, especially after the first systematic enquiry into the 1861 cholera epidemic by the Government of India (ibid).

³⁰

The Bhore Committee, amongst several other recommendations, also prepared a National Health Services Scheme, which as described in its review ³¹ is still relevant for India.

its [sic Bhore Committee] relevance to the Indian people is even greater today. ³²

The extent to which Pakistan government followed the recommendations of the Bhore Committee is not clear. There is no evidence, to date, to establish what principles and goals guided the development of the health sector. However, it can be safely assumed that the health professionals in the early years of Pakistan were familiar with the recommendations of the Bhore Committee and tried to follow them. Furthermore, whatever infrastructure that the British Government had developed provided the foundation for later work. However, given the state of health of the poor in Pakistan, there is a need to understand why Pakistan could not build from the foundation it received (unlike the development of the health sector of Sri Lanka which too was under the British rule). Furthermore, it is also important to understand why Pakistan health services failed to take care of what the Bhore Committee specially singled out as the most important group – the *tiller of the soil*. ³³ The *tiller of the soil* today in Pakistan is probably worst off than before, or probably in greater stress given the deterioration of the natural environment, and rise of the non-communicable diseases.

The Bhore Committee of 1946 identified the ‘unsanitary conditions’ as the cause of death and diseases. A ‘sanitized’ village was meant to have a water supply ‘protected from surface contamination’; it should have ‘drains for removal of waste water’; and proper garbage disposal. It recognized malnutrition as a health issue’ along with having adequate medical and preventive health measures. . ³⁴

3.2 Initiatives by the Government of Pakistan 1947 -- 2005

From 1947 to 2005, the Government of Pakistan and its partner organizations (UNICEF, for example) took 49 initiatives.³⁵ The breakdown of the number of initiatives per decade is given below:

#	Decades	# Initiatives
1	1950 - 1959	04
2	1969 - 1975	10
3	1975 -- 1978	03
4	1981 - 1989	11
5	1990 – 1999	11
6	2000 -- 2005	10
	Total⇒	49

It is important to note that the 3rd and 4th decade of Pakistan's creation (1975 -- 78 and 1981 – 89) also saw the building of the elaborate health infrastructure³⁶ of Pakistan. (1975-85, part of the 6th five year plan of Pakistan) It is also important to note that in the 8th five year plan the Government of Pakistan committed 0.32 billion rupees for the up-gradation of 515 Rural Health Centres (RHCs), 3700 Basic Health Units (BHUs), and 600 Urban Health Centres.

The 49 initiatives taken by the government have been primarily disease focused. However, in 2005, safe water provision has been listed as part of a national development programme called *Khushaal Pakistan*.

Over fifty five years after gaining political independence, health indicators as well as the conventional social indicators are poor, specially when compared to the health indicators of Sri Lanka. The best indicator for assessing health outcomes of a country is to look at the status of women, and then link that to their health status.

3.3 National Health Policies

Pakistan, from 1947 to 2005, has produced three health policies. The first policy came in 1990, followed by polices in 1997, and 2001. In June 2004, the federal government published a report on Health Sector Reforms.³⁷ In May 2005, a Medium Term Development Framework for 2005-2010 was developed.³⁸

The 1990 policy focused on primary health care, with emphasis on universal immunization of children; drugs for 22 common diseases; training for health personnel, specially for maternal health; reduction in numbers of low birth weight babies; reduction in IMR 'for all identifiable subgroups'.³⁹ The language of equity should be noted here, as it disappears in the later policy documents.

The 1997 policy also focuses on reduction in IMR, but without any reference to the subgroups. It speaks of universal immunization; increase in trained personnel, and interestingly does not target improvement in the doctor-nurse ratio. The 2001 policy is

more comprehensive, as it strives for preventive and promotive measures in health, rather than relying entirely on curative care. It also proposes to overcome the urban bias in health care. The 2001 policy identified ten areas for attention, and they include: reducing communicable diseases; promoting preventive care; removing rural-urban bias, gender and income biases; improving the quality of primary health care; and regulating the private sector. A major shift to address inequities has been taken by setting a goal of removing three areas of inequities, namely: urban-rural; gender; and income differences. How this would be done, and what changes in the health management information system would be possible to capture and monitor inequities is yet to be seen.

3.4 Policies and concern with equity

Analysis of some key policy documents from the lens of *Benchmarks of fairness in health care* highlighted the absence of some key dimensions of equity and fairness.⁴⁰ The documents analyzed were: National Health Policy 2001; Health Sector Reform 2004; National Plan of Action 1996 (2002); Women Development Policy (2002); Poverty Reduction Strategy Paper 2003; and Pakistan Population Policy 2002. Besides these policy documents, other documents reviewed were: Pakistan Population Assessment 2003, UNFPA; Pakistan Reproductive Health and Family Planning Survey 20001, NIPS; Pakistan Population - Statistical profiles 2002, PAP; State of World Population 2002, UNFPA.; State of world newborns –Pakistan 2001, Save the Children; and Economic survey of Pakistan 2001. The findings were:

- a) Policies focus primarily on nutrition; education; health and health education; Health Information System, and drugs.
- b) Policies have less emphasis on: public safety and violence; health coverage; environmental and occupational health; gender (specially gender as a social construct, and as power-relations); efficiency; quality; intersectoral efforts.
- c) There are several gaps in the policies. These are: financial and non-financial barriers to equitable access; administrative efficiency and democratic accountability and empowerment.⁴¹

Section 4

Women, Gender and other related policies and reforms

4.1 Policies for women and gender reforms

Pakistan has had three Commissions on the Status of Women, and interestingly the second Commission was formed during the reign of General Zia-ul Haq (the longest serving military dictator). The third Commission strongly recommended the repeal of the laws that discriminate against women, but the government has so far not honored it. A permanent commission on the status of women was established after the report of the 3rd Commission, and met the long standing demand of the women's groups in Pakistan.

Pakistan has so far taken three critical steps for addressing women's need in view of the poor social status that the society has created for them. The three steps are: Formation of a National Plan for Action; National Policy for the Development and Empowerment of Women; and Gender Reforms.

4.1.1 National Plan of Action for Women (NPA)

Pakistan is a signatory to all the major UN conventions, and has also signed the Declaration of the World Summits of the 1990s. Pakistan signed CEDAW in 1995, and also the Beijing Platform for Action.

The National Plan for Action was developed by the Ministry of Women's Development in September 1998. This was a follow up as per paragraph 297 of the Platform for Action adopted by Pakistan, at the Fourth World Conference for Women, Beijing '95. It thus follows the framework of the Beijing platform for Action, which has 12 themes.

The NPA was written following a series of consultative meetings and workshops at the provincial and national levels involving government and NGOs. The primary role for implementation of the plan lies with the Ministry of Social Welfare; which is also responsible for coordinating, monitoring, and evaluating progress of the advancement of women. Interestingly enough, this ministry is also the most neglected ministry of the government.

The importance of intersectoral action is stated within the NPA. Besides the ministry of Social Welfare, others who have a role in the implementation of NPA include: Women's Development Departments (the provincial arms of Ministry of Women and Development), Core Groups established at the national, provincial, divisional and district levels, Federal Line Ministries and Provincial Line Departments. Monitoring and evaluation of the NPA is to be done through the establishment of a Gender and Development Management Information System (GADMIS.)

Given the sorry state of the functioning of the government departments, implementation of NPA leaves much to be desired. These shortcomings are often reflected in the monitoring by various women's groups, and specially those striving for women's rights.

4.1.2 National Policy for the Development and Empowerment of Women

In March 2002, 50 years since the inception of Pakistan, a formal policy on Women's Development and Empowerment was developed by the Ministry of Women Development Social Welfare and Special Education.

The policy provides guidelines for ensuring a gender perspective in all national policies and plans, within the overall operating framework of the Government. This effort is aimed not only at raising the image of the country on fulfillment of international commitments but also in assisting in the attainment of goals of equity and gender equality.

The Ministry of Women Development is responsible for the implementation of the policy and is required to brief Cabinet on progress of implementation of policy and facilitate gender sensitization and training programs for all other Ministries. Women Development Departments (WDDs) at provincial & district levels are required to do the same. The Ministry has linkages with other line ministries and will coordinate implementation through its departments and through designated focal points of other line departments. The MOWD and the WDDs will be the primary monitoring, review and coordinating bodies, in consultation with the Bureau for Statistics.

Originally, in 2004-2005, Rs. 625 million was allocated under PSDP.⁴² In the Mid Year Review Meeting the allocation was revised to Rs. 169.6 million. Later on, out of Rs. 169.6 million, Rs. 54.9 million have been surrendered by the Ministry of Women Development. As such the net amount available with the Ministry was Rs. 114.7 million out of which Rs. 92.25 million have been utilized.⁴³

The goal of this plan is: "Empowerment of Pakistani women, irrespective of caste, creed, religion, or other consideration for the realization of their full potential in all spheres of life, especially social, economic, personal and political and in keeping with our Islamic way of life." Removal of inequities and imbalances is specifically mentioned, with a special focus on reducing gender gaps. Human rights and women's participation as equal partners is also stated, as well as girls access to quality health care services and all other pre-requisites to enjoying full health, including reproductive and mental health. Provision of equality of opportunity is also unequivocally stated.

The policy identifies three major areas of empowerment: Social Empowerment of Women (includes; education, health, law and access to justice, violence against women, women in the family and the community and the girl child); Economic Empowerment of Women (includes; poverty, access to credit, remunerated work, women in rural economy and informal sector and sustainable development).; and Political Empowerment of Women (includes; power and decision making).

The policy is guided by the principle of gender equity, and aims to give priority to the poorest of the poor, and to enhance the value of women's work.. It re-affirms the policies of each ministry (Health Policy for All, Housing Policy (2002), Education Policy for All

etc.). It reiterates/expands on each of these policies from a gender perspective. The document also aligns itself and confirms many of the international commitments made such as ICPD (4.2 c), ILO Convention 100⁴⁴ (5.3 b),

The fact that the policy reaffirms policies from other ministries and foresees its own implementation through other ministries and line departments is evidence of the fact that the NPDEW is rooted in a belief in intersectoral action. It aims at gender mainstreaming within all other ministries of the government and at playing the role of a catalyst in the implementation of the policy.

The section on health (4.2) in the policy focuses on the provision of primary as well as emergency obstetric care in order to reduce maternal mortality and morbidity rates. It also calls for ensuring quality health cover of women; and promotes family planning and a small family norm within a rights based approach.

The vision of the national policy for women's development and empowerment is bold and is an unequivocal articulation of the Government's commitment to women. However, the Ministry of Women's Development is not the most important ministry in the eyes of the government. Soon after the launch of the policy, the then Federal Minister left the said ministry, and for over two years now, the ministry has been headed by a male secretary. Furthermore, in 2003, the ministry was divided and its flagship project (Taawna Pakistan Project) was handed over to the Ministry of Social Welfare.

When the Ministry responsible for the implementation of the policy for women's development and empowerment is left without a Federal Minister to guide it, and is also split into two for political expediency, Government's commitment to women becomes suspect.

4.1.3 Gender Reform Action Plan

Gender Reform Action Plan (GRAP) was developed by: Ministry of Women Development, Social Welfare and Special Education and Provincial Women Development Departments in May 2004. It was developed through a 14 month consultative and review process, under an Asian Development Bank's technical assistance project, Gender Reform Program. Once approved by the Cabinets, GRAPs will be implemented under Decentralization Support Program of the Ministry of Finance. The GRAP proposes a coherent gender reform agenda to align policies, structures and procedures for enabling the government to implement its national and international commitments on gender equality.

GRAP attempts to bring about changes through policy, institutional and budgetary reforms in the public sector, and enhanced participation of women in the political domain, thereby contributing to the emancipation and empowerment of women.⁴⁵

The ambit of GRAP reforms does not allow for radical change, revolutionary reforms, or changes in the entrenched patriarchal, feudal and tribal structures nor do GRAPs engage

with discussions on religion and family institution, and concepts of drastic social change nor do they go into areas like land reforms or economic reforms.

4.2 *From Poverty Reduction Strategy Paper (PRSP) and Millennium Development Goals (MDGs) to Medium Term Development Framework (MTDF) 2005-2010.*

The MTDF is an attempt to synthesise PRSP and MDGs. Its stated objectives are to reduce poverty, and achieve the MDGs. Out of the seven objectives, objective six specifically mentions equity: *Ensure equitable development of regions.*⁴⁶ Minorities are mentioned in objective five, and speaks of fostering values of tolerance and democracy.

MTDF acknowledges the grim reality of little change in neonatal deaths in the last few decades, and that 50% of all infant deaths are neo-natal deaths. Having recognized this, the document is silent as to the possible stratifiers for further analyzing this phenomenon. Do these deaths occur in rural populations? Are they in households living in remote areas? Are the residents of urban slums also vulnerable?

Recognizing urban-rural imbalances, and gender inequities, this same concern is not reflected when targets are set for reduction in IMR, child mortality, maternal mortality, and the control of communicable diseases.⁴⁷

Unfortunately, nowhere does this large document (over 560 pages) talk of the socio-political problems that are a bane of Pakistan; social determinants of health are not mentioned. Cost recovery is also proposed, along with subsidies for the poor. This point is critical from the policy perspective. Is Pakistan going to have a pro-poor approach as opposed to an equity approach, then it would not be working for one fair system for the entire population. It would then, per force, struggle to have separate systems – one for the poor, and one for the better off.

If equity is reflected only as a vision, and does not cut across all sectors where the policies are to be operationalized, then inequities are likely to prevail and justice marginalized.

Section 5

Three examples of Mega initiatives

Pakistan has undertaken some very interesting initiatives for addressing the poor status of women, and the poor health outcomes of women. Some of these initiatives have been more successful than others, but their long term implications are significant. Whether they address the social determinants of health and equity can be the parameters for assessing these programmes.

5.1 Lady Health Workers (LHWs)

The Lady Health Worker's programme was conceived in 1993 and launched in April 1994 as a Federal Development Programme, funded by the Ministry of Health (MoH) and implemented by MoH and Provincial Department of Health. In 1994-95, 21,510 were employed all over Pakistan, and by 2004 the number increased to 70,000. There are 2,300 supervisors. An evaluation study showed the effectiveness of the programme as rates of immunization, use of contraception, and use of iron tablets by pregnant women increased. There is a plan to increase the LHWs to 100,000, and the supervisors to 4,000.

All LHWs are young women from the districts where they serve. They work out of their homes, and serve the households in the given villages. They are seen as role model for young women, especially in the rural areas.

The LHWs provide promotive, preventive, curative and rehabilitative services; are required to promote community participation; encourage the utilization of health facilities; and give family planning services and gradually integrate existing health care delivery programme like EPI, Malaria control, Nutrition, MCH within the programme.

Although the LHWs present a major achievement in a conservative country like Pakistan, the difficulties faced by this cadre of providers needs to be recognized. Some of the difficulties, which are generally faced by all female health workers in Pakistan in general and especially in rural areas, include; abuse of power, disrespect from male colleagues and sexual harassment, lack of sensitivity to women's gender-based cultural constraints, lack of support from communities and families, and the cultural unacceptability of working women

These impediments within the system not only increase the attrition rate, which is at present 4%, but also create an environment that is not conducive to improvements in the quality of services by female workers who decide to continue working despite cultural constraints.

5.2 Tawana Pakistan Project. Assertion of women's hidden potential

5.2.1 The Project—its scale and scope

This project was initiated by the Federal Ministry of Women and Development, Social Welfare and Special Education in 2000. In 2003, because of political expediency, it was

shifted to the Ministry of Social Welfare and Special Education. By the end of 2005, it was wrapped up so that it could take a new turn which was still unknown 1 March 2003. The major shift that was being propagated was to remove the strategy of women's empowerment, and replace it with a strategy of women's dis-empowerment.

Planning and managing the feeding programme was the central activity that became the source of women's development. To experience collective decision making, and to take responsibilities for the decisions is a very significant first step of women's empowerment

The Project engaged rural women through the School Tawana Committees (STC) having an average member of 12 women (including the teacher and 2 girls from the school). Thus nearly 50,000 rural women participated in the implementation of the Project with ongoing facilitation and mentoring by the Fieldworkers (mostly girls) from locally engaged NGOs. In addition to the ongoing efforts, a 2-3 day Continuing Education Program was organized for the STC members and community women from which nearly 100,000 women benefited. The CE-STC exposed these rural women to interactive session on issues of nutrition and education, and on the value of organized work. To train this large number 121 master trainers (all women) were trained, who in turn provided training to 680 STC-Mobilizers.

While the schools were the focus of Tawana, and women in the villages around the schools were being mobilized, a significant number of educated girls from the small towns of Pakistan were availing the opportunity to play a critical role for addressing the rogue of malnutrition in Pakistan. By Dec. 2003, 270 field teams had been recruited and trained. On an average, each team has two women, which means 540 young women have been trained, and for many it was their first job, and probably most were the first generation educated girls in their families; male assistants were also added to the team (where necessary) to facilitate women movement and access to the villages women.

When Tawana was directed to wrap up its activities (July 2005), 4,647 STCs had been formed, and 4383 Community Organizers (CO) had been trained. The number of teachers trained was 4336.

5.2.2 Success of Tawana

Tawana's success can be measured in its impact on the improvement in the nutritional status of girls in the age group of 5-12 years, and it also led to an increase in the enrolment of girls in the primary schools. Women's empowerment was demonstrated through the women's ability to plan and manage a feeding programme, and manage the funds for the development activities of the government primary schools which were the focus of the feeding programme. Their empowerment was also witnessed in the many actions the women took for the safety and protection of women, and for the continuation of the feeding programme. They interacted with the elected representatives of the district government, and also the officials of the district administration. Another aspect of the success of Tawana was its contribution to human resource development in the 29 districts where it was implemented; and it contributed to capacity development of local NGOs and

their staff. Tawana also showed how public private partnership can work, and the role of a university in such enterprises.

5.2.3 *Development is about making choices*

Development is about increasing choices, especially for the most vulnerable and marginalized. Monitoring development means monitoring who is making what choices. In Tawana, a space was created for the women to make choices. Against interesting odds, including the skepticism that *illiterate women cannot take decisions, and women in the remote areas cannot prepare meals*, women in some of the remotest parts of Pakistan dethroned the myths of women's incapacity, and male resistance to women's new roles. Women availed the opportunities to take collective decisions, and to make choices that benefited not only the schools girls but also the women in their respective villages. They thus entered a new leadership role. They proved that if given an opportunity and support to learn and reflect on their own practices, they can go a long way in bringing development to their villages.

5.2.4 *Resistance to Tawana*

This commendable human resource development through Tawana was perhaps difficult to comprehend by the senior bureaucrats who are furthest removed from the field where the local human resources were working. Accustomed to fraudulent representation of field work, and deeply skeptical that work with integrity is possible, the biggest resistance to Tawana came from the very ministry in which it was housed. Its most senior members, without attempts to grasp the multi-dimensional aspects of the Project, got entangled in procedural issues of their own ministry.⁴⁸

Perhaps resistance to Tawana is to be found in the interest of those who could not gain any benefit, in kind or in cash, from Tawana. Tawana benefited the thousands of women and girls for whom it was designed. It benefited the hundreds of young women and men from the districts that implemented the project. It benefited the eleven NGOs and the university as it gave them an opportunity to show how a mega project can be planned, and managed with transparency and in a participatory way. Importantly, Tawana demonstrated the possibility and importance of civil society in partnering the government in social development, as well as the strengths and benefits of the government's devolution policy.

Tawana has shown how community based projects can be monitored, and the monitoring data analysed; and how training and supervision can be empowering.

Section 6 Conclusion

6.1 Assessing commitment to health

Sixty four per cent of Pakistan's national budget goes into defense and debt servicing. Every year witnesses an increase in the defense budget and an increase in cost of living. The last five years have substantially increased the burden of poverty on the poor through increase in petrol prices. Pakistan total health budget is about 3.9 % of the gross domestic product (GDP), and government share is a mere 0.86%⁴⁹ If Pakistan is to comply with the recommendations, by the WHO Commission on Macroeconomics and Health, to increase spending on health by 1% of GDP by the year 2007, and 2% by 2015, Pakistan would need to increase its health budget by 143% and 285%.⁵⁰

Financial allocation to a national concern is a good indicator of the Government's commitment to that area of concern. The more adequate the resource allocation, the greater is the commitment to the life of the ordinary people

6.2 Lack of resources is not the issue

In Pakistan, inadequate budgetary allocation for health, and other social sectors, is not because of inadequate resources, but the iniquitous distribution of resources. In a country that commits resources to become a nuclear power, where its armed forces provide free medical care to all its employees and their families, and even those who have retired; where the elite indulge in a life-style comparable to the 'rich' in the developed world, there can be no excuse for the poor health care of the vulnerable groups.

6.3 Emerging recognition of inequities

The policy makers and politicians in Pakistan have begun to recognize the disparities between the urban and rural sectors. Since the 1980s, when the language of gender began to appear in the discourse related to women and development, there has been an effort to note gender disparities. Similarly, there is now some data available on inequalities in health outcomes on the basis of income/poverty levels.

With Pakistan experimenting with out-sourcing of health facilities of the public sector, the issue whether such initiatives are likely to increase inequities is not being debated. The Rahim Yar Khan model, which has handed over the basic health units to an NGO that has expertise in rural development, shows increase in utilization rates of the health facility, but inequities are not even on the agenda of the NGO.⁵¹ The outreach services for immunization from the same facilities have not been given over to the NGO. This fragmentation of health services is not likely to address health inequities, as different agencies focus only on their tasks, and thereby overlook the interconnectedness of the social sector development and health outcomes..

6.4 *Gaps in the attention to health inequities in Pakistan*

The three inequities that Pakistan is now aware of and that are documented in the various reports and studies available are:

- a) Inequities on the basis of site – urban-rural
- b) Inequities on the basis of gender
- c) Inequities on the basis of poverty

Some of the inequities that need to be included are:

- a) Inequities on the basis of distance from the nearest secondary care hospital.
- b) Inequities on the basis of being a minority (religious or ethnic)
- c) Inequities on the basis of disabilities

Within the given recognition of inequities, focus is still very limited. For example, the latest compendium on gender statistics in Pakistan, data is available only on IMR, and urban-rural death rates, and age specific death rates of women and men.⁵² The same source also highlights the reduction in gaps in the gender health manpower gaps.

Focus on just urban-rural differences is not enough. It is important that inequities within the rural and urban sectors are also highlighted. Similarly, more work is needed for the classification of poverty level. It is not enough to take income measurement of poverty. Instead, livelihood framework for the assessment of vulnerability of livelihood can be used to determine the relationship between poverty and health outcomes.

Finally, Pakistan needs to decide whether it would take a poverty approach or an equity approach. The former will continue to see the poor as a marginal group which needs special attention. Hence two systems would emerge, whereby there will be talk of safety nets, and on mechanisms for reaching the poor. On the other hand, if an equity approach is taken, Pakistan would strive to build one system which would be fair, as it monitors inequities and strives to reduce them.

Footnotes

¹ The Conference strongly reaffirms that health which is a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is the most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. (Article 1. PHC Declaration)

² Dr Carl Taylor HEALTH BY ALL CHALLENGES FOR UNICEF. Paper presented at PHC21 – EVERYBODY’S BUSINESS Almaty, Kazakhstan, 27 – 28 November 1998

³ See : <http://www.phmovement.org>

⁴ See People’s Health Charter on the website of People’s Health Movement. <http://www.phmovement.org>

⁵ See for instance report : Social Sector Performance and Poverty Analysis Key Performance Indicators 1991-2001 (Commissioned by DFID) In the same report poverty analysis mentions poverty levels, and links number of poor households with urban and rural locations, but health indicators are not analysed from this perspective.

⁶ See : Human Development in South Asia 2004, The Health Challenge. Mahbub ul Haq Human Development Centre. Islamabad. (Oxford University Press.2005)

⁷ Akbar Zaidi, The poverty health relationship in Pakistan. Background Paper Series. Background paper: 6. Poverty Group; Country Policy Operations Unit; Asian Development Bank. Pakistan Resident Mission. 2006

⁸ See, Akbar Zaidi. The poverty health relationship in Pakistan. Background Paper Series. Background paper: 6. Page 20. Poverty Group; Country Policy Operations Unit; Asian Development Bank. Pakistan Resident Mission. 2006

⁹ Typically, social variables that are linked to health are education, potable water, housing, and income . Livelihood of the poor is seldom invoked to assess the difference in health outcomes.. Participatory Poverty Assessment in Pakistan used the sustainable livelihood framework, which assesses the livelihood of the poor with the help of five capitals/assets. This framework highlighted the diversity in the livelihood, something which income measurement fails to capture. It also showed how policies fail to respond to the fragile base of the poor.

¹⁰ See the Participatory Poverty Analysis (2002) of Pakistan. It highlights what the poor say about health and health care, and the factors that influence their health and issues of access to health services. There is a need to publish a health report on Pakistan on the basis of the PPA reports.

¹¹ Meeting with a group of faculty members in Shah Latif Unviersity, Khairpur, Pakistan. March 2006. this meeting was part of the equity related work initiated by the department of Community Health Sciences, Aga Khan University, Karachi. Pakistan. The project is funded by Global Equity Gauge Alliance. (GEGA).

¹² The terms 'condition' and 'position' refer to the distinction in gender analysis between the practical needs and strategic interests of women. Condition of women represents their practical needs, example, treatment of disease, literacy, income, etc. Position refers to women's strategic interest, whereby they can have control over their lives, and be part of the decisions that affect their lives and that of their family (and society) See also Kausar S Khan, *Trapped but Struggling*, in *Nursing in the Muslim Context*. Edited by Nancy Bryant. Oxford University Press. Pakistan.

¹³ The *But why ?* method developed by David Werner, and to be found in many training manuals of participatory methodoligies (example, Training for Transformation. VOI 1), takes an event and asks the question *Why?* The participants who are to do the analysis of the event start responding, and the question why is raised in connection with the responses to take the analysts to another dimension of the cause of the event. For a more detailed account of this method, see Kausar S Khan,... in a book edited by Fariha Zafar. [get the full reference]

¹⁴ A distinction is made between a functional analysis and structural analysis. Functional analysis focuses on the behaviour of an individual, and implicitly holds him/her responsible for his/her act. Structural analysis requires an analysis of why a person has behaved the way he/she has. This approach takes one to the underlying causes of human behaviour. For a more detailed discussion on the difference between the two forms of analysis see Kausar S Khan , *Public Health Priorities and the social determinants of ill health*. In *The Global Challenge of Health Care Rationing*. Edited by Angela Coulter and Chris Ham. Open University Press. Buckingham Philadelphia. 2000

¹⁵ *Between Hope & Despair, Pakistan Participatory Poverty Assessment. National Report 2003*

¹⁶ Between Hope & Despair, Pakistan Participatory Poverty Assessment. National Report 2003. Page 50

¹⁷ Pakistan MDG S Report 2005 Page19

¹⁸ Reported by Sadiq Bhanbhro, e field investigator of a community based project *Equity Analysis by Community*. Part of Global Equity Gauge Alliance initiative in Pakistan. This innovative work to understand community perspective on inequities, and their priorities, has been initiated by Kausar S Khan et al of the department of Community Health Sciences, Aga Khan University, Karachi. Information on this on-going work is available from kausar.skhan@aku.edu

¹⁹ The state of the worlds Children 2000. United Nations Children's Fund. UNICEF.

²⁰ While different reports provide different figures in terms of % of people living in rural areas, it is important to note that this debate needs to go beyond any quibbling over percentages. What is important is to compare the systems that prevail in the two sectors, and what opportunities exist for the poor, the vulnerable, specially women, to have better health and better life.

²¹ Pakistan's population 151.5 million; Annual population Growth Rate 2.13; Population doubling time 25 years; Fertility Rate 4.54; GNP per Capita US \$ 460; Urban Rural Ratio 34:66; Expenditure on health ; 0.7%of GNP; Literacy rate 38.9%

²² Here a distinction is maintained between agitation against the government by the mainstream political parties who vie for political power, and the movements at a more local level which are not linked to any particular political party. The disillusionment of people in general with those in the mainstream political arena is an issue that need not be discussed here. Suffice it to say that Pakistan has suffered political instability since 1947 when it gained independence from British rule. The biggest feature of its instability has been the four military take-overs.

²³ See Sania Nishtar, The Gateway paper. Page 17,18.

²⁴ Various Institutions conduct studies and monitor changes in these popular indicators of health. Some well known institutions are: PIDE (Pakistan Institute of Development Economics, Islamabad) SDPI (sustainable Development Policy Institute, Islamabad); SPDS (social Policy Development Studies ,Karachi); AERC (Applied Economics Research Centre. Karachi) , the Federal and Provincial Bureaus of Statistics Similarly, some information showing inequities within the region is also available. This is to be found in the comparison of districts within a given province.

²⁵ It is now a well established fact that malnutrition in the first three years of life has an adverse effect on the learning abilities of the child. In the last three years there has been a discourse on the importance of early childhood education. One of the first initiatives was taken by Aga Khan University when it organized an international conference on early childhood development in Karachi. (2003 ?)

²⁶ Akbar Zaidi, The Poverty-Health Relationship in Pakistan.

²⁷ Poverty Reduction Strategy Paper (2004 ?)

²⁸ Rashida Dohad. File note for a project being developed for Maternal and Neonatal Health initiative for Punjab and NWFP 2004

²⁹ *Karo kari* is translated as 'honour killing' or murder in the name of honour. In many parts of Pakistan there is a cultural practice whereby killing of young couples is justified if they marry against the wishes of their parents; or young women are killed if they are suspected to be involved with a man other than their husband. A motion in the upper house of the parliament in Pakistan, to condemn honour killing was defeated by the Senators. (Year : ---)

³⁰ Ravi Duggal, Review of the Bhore Committee 1946 and its relevance 1990 (1990) Duggal Ravi, Bhore Committee (1946) and its relevance today, Indian Journal of Pediatrics, 58:4, 395-406, 1991

³¹ Ravi Duggal Review of the Bhore Committee 146 and its relevance 1990.

³² Ravi Duggal Review of the Bhore Committee 146 and its relevance 1990. Page 2.

³³ Bhore Committee Volume II. Quoted in Ravi Duggal, Review of the Bhore Committee. 1946 and its relevance 1990. Page 1.

³⁴ The relevance of the recommendations of the Bhore Committee is established by a review of this 4 volume report in 1990, by Ravi Duggal. The review suggests the organization of health services of India on the basis of the analysis available in the report. In Pakistan, senior health planners do mention the report of the Bhore Committee, but there is little evidence to whether any attempt was made to guide the development of the health sector on the basis of the findings of the concerned report.)

³⁵ Sania Nishtar, The Gateway Paper –Healthy systems in Pakistan – a Way Forward. 2006 Page 16, 17. This is the first paper of the Pakistan’s Health Policy Forum established in 2005

³⁶ The health infrastructure of Pakistan has a four tiered healthy services in each district of Pakistan. The first level is called Basic Health Unit (BHU), the next level is called Rural Health Centre (RHU); the third level is a secondary level hospital; and the fourth level is the district hospital. A district, however, could also take its own initiative, and many established dispensaries where BHUs had not been established. the dispensaries were financed by the district.

³⁷ The fact that government of Pakistan took 43 years (1947 – 1990) to give the country its first health policy is indicative of the government’s lack of commitment to this sector.

³⁸ Medium Term Development Framework 2005-2010, Planning Commission Government of Pakistan. May 2005

³⁹ Sania Nishtar, the Gateway Paper. – Health Systems in Pakistan – a way forward. 2006 (sania@heartfile.org)

⁴⁰ *Benchmarks of Fairness in Health Care* is a policy analysis tool developed by Norman Daniels. The tool was adapted for developing countries in 2002 through a process involving four countries – Mexico, Columbia, Thailand and Pakistan. (See WHO Bulletin June 2002). The team from Aga Khan University in Karachi, Pakistan, that originally worked with the adaptation of the tool, then initiated a process of its use in Pakistan. Part of that work was the analysis of some key policy documents. The nine Benchmarks of fairness were used for this analysis.

⁴¹ *Policy and Data -- in relation to Fairness in Health Care* Presentation at the Dissemination Seminar : *Benchmarks of Fairness in Health Care*. 7 Dec. 2004 Islamabad.

⁴² Public Sector Development Plan

⁴³ <http://www.pakistan.gov.pk/divisions/planninganddevelopment-division/Data/AnnualPlan/WomenDev.pdf>

⁴⁴ Calls for equal pay for men and women for work of equal value.

⁴⁵ Prior to the development of GRAP the following studies were conducted:

- National gender situation analysis
- History of women’s movement in Pakistan and gender reforms
- History of political participation of women
- Women’s employment in public sector
- Policy review
- Institutional assessment
- Review of programs and projects of MoWD
- Public expenditure systems analysis

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- Gender training and capacity building assessment

⁴⁶ The MTFD 2005-2010. page xiii

⁴⁷ See MTFD 2005-2010 Pages 85 -- 103

⁴⁸ It is important to understand the mind-set of the bureaucrat if innovative projects for advancement of women's rights are to continue. Some telling statements made by some senior bureaucrats are revealing:

➤ *What drama are you enacting, this is what we do !*

(A DCO to the district supervisor)

➤ *Don't give the details of progress. These are all lies.. we fudge our data to fool the donors....*

(Federal Secretary at a meeting of the stakeholders.)

➤ *The Community Organizers are illiterate and kammi[sic low caste]... How can they do the work... you must change them. (Senior member of NIU)*

➤ *The Tawana schools are in very remote areas. There are difficulties of water... terrain is very harsh. Women can't do the cooking there.... I know it. Children should be given packed milk and cookies.*

(Federal Secretary at a meeting of the stakeholder)

I have been working in this office for over twenty years. I have never seen so much money go to the villages, and we cannot touch it !!

(Clerk at the education department in a district.)

⁴⁹ Akbar Zaidi, The Poverty-Health Relationship in Pakistan. Page xii; Pakistan Poverty Assessment update. Background Paper Series. Background Paper: 6. Poverty Group Country Policy Operation Unit Asian Development Bank. Pakistan Resident Mission. (Unpublished)

⁵⁰ Akbar Zaidi, The Poverty-Health Relationship in Pakistan. Page xiv; Pakistan Poverty Assessment update. Background Paper Series. Background Paper: 6. Poverty Group Country Policy Operation Unit Asian Development Bank. Pakistan Resident Mission. (Unpublished)

⁵¹ Discussion at a presentation on the concerned model. 2005

⁵² Compendium on gender statistics in Pakistan. Statistics compiled from 2004v data. Government of Pakistan. Federal Bureau of Statistics. Statistics Division. 2006 Pages 7-12