POVERTY AND ILL-HEALTH:

CHALLENGES, INITIATIVES AND ISSUES

IN PAKISTAN

INAYAT THAVER
Department for International Development (UK)

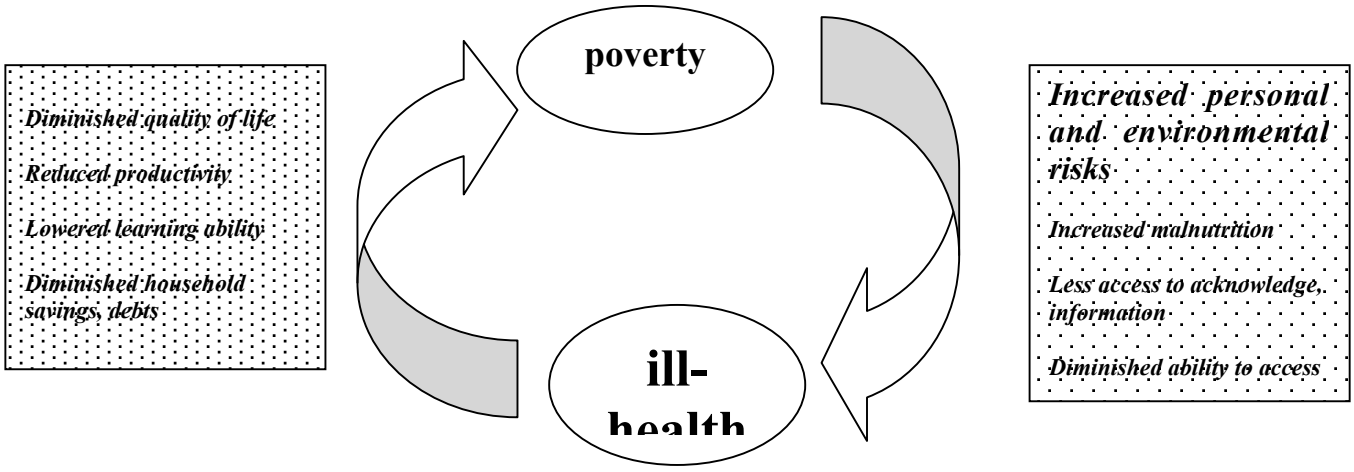
ZULFIQAR A. BHUTTA
Preofessor, Department of PAediatrics,
The Aga Khan University, Karachi

1. CURRENT STATUS

Poor people live without fundamental freedom of action and choice that the better off take for granted. They often lack adequate food and shelter, education and health, deprivations that keep them from leading the kind of life that everyone values. They also face extreme vulnerability to ill-health, economic dislocation, and natural disasters. And they are often exposed to ill treatment by institutions of the state and society and are powerless to influence key decisions affecting their lives. These are all dimensions of poverty.

Huge disparities exist in health between the rich and poor in the world, and between the rich and poor within developing countries. Poor health is closely associated with poverty. Across and within countries, differences in income can account for as much as 70% of variance in infant mortality. The poor are most vulnerable to ill-health and have the least means to combat it. The case for investing in health has been further strengthened by a growing body of evidence, which shows that better health contributes to greater economic security and growth. The complex relationship between poverty and ill-health is illustrated in Figure 1. Better health reduces poverty, and reduced poverty improves health. [1]

Figure 1.
Poverty and Ill-health: the Vicious Circle



Some of the serious deprivations noted and where the poor people live in developing countries are detailed in Figure 2. and Table 1.

Table 1. Serious Deprivations in Many Aspects of Life [2]

Developing countries:

Health:

- 968 million people without access to improved water source (1998).
- 2.4 billion people without access to basic sanitation (1998).
- 3.4 million people living with HIV/AIDS (end of 2000).
- 2.2 million people dying annually from indoor pollution (1996).

Education

- 854 million illiterate adults, 543 million of them women (2000).
- 325 million children out of school at primary and secondary levels, 183 million of them girls (2000).

Income poverty

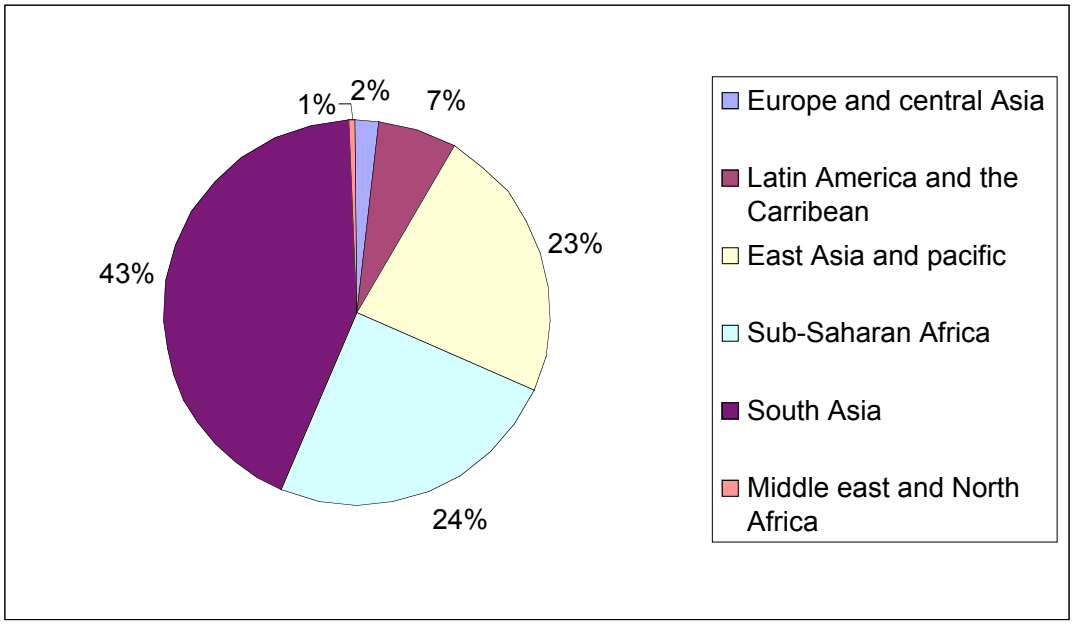
- 1.2 billion people living on less than $ 1 a day (1993 PPP US $), 2.8 billion on less than $2 a day (1998).

Children

- 163 million underweight children under age five (1998).
- 11 million children under five dying annually from preventable causes (1998).

Figure 2. Where the Developing World's Poor Live [3]

Distribution of Population Living on less than $1 a Day, 1998 (1.2 billion)



2. GLOBAL MOVEMENTS TO ADDRESS POVERTY

2.1. Development Paradigms:

1950-1960s:
The approach to reducing poverty has evolved over the past 50 years in response to deepening understanding of the complexity of development. In the 1950s and 1960s many viewed large investments in physical capital and infrastructure as the primary means of development.

1970s:
In the 70s awareness grew that physical capital was not enough, and that health and education were at least as important. *World Development Report 1980* articulated this understanding and argued that improvements in health and education were important not only in their own right but also to promote growth in the incomes of poor people.

1980s:
The 1980s saw another shift in emphasis following the debt crisis and global recession and the contrasting experiences of East Asia and Latin America, South Asia and Sub-Saharan Africa. Emphasis was placed on improving economic management and allowing greater play for market forces. *World Development Report 1990: Poverty* proposed a two-part strategy: promoting labor intensive growth through economic openness and investment in infrastructure and providing basic services to poor people in health and education.

1990s:
In the 1990s governance and institutions moved toward center stage – as did issues of vulnerability at the local and national levels. *World Development Report 2000/2001: Attacking Poverty* builds on earlier strategies in the light of cumulative evidence and experience of the past decade – and in light of the changed global context. It proposes a strategy for attacking poverty in three ways: promoting opportunity, facilitating empowerment and enhancing security to economic shocks, natural disasters and ill-health.

2.2. Development Goals:

The International Development Goals (IDGs):
The IDGS have been agreed upon by the United Nations membership, following a series of summit meetings held by the UN and its specialized agencies over the past ten years or so. The meeting discussed progress in poverty reduction and sustainable development and set targets for measuring the progress.

Millennium Declaration Goals (MDGs):
As the world entered the new millennium, heads of state and government gathered at the United Nations General Assembly to lay out their vision of the world. The leaders of the summit adopted the United Nations Millennium Declaration, recognizing their "collective responsibility to uphold the principles of human dignity, equality and equity at the global level". Among the many objectives set out by the declaration are

specific, quantified and monitorable goals for development and poverty eradication by 2015. These goals build on the international development goals, which include three more targets: namely, to reduce infant mortality rates by two thirds, to provide access for all who want reproductive health services, and to implement national strategies for sustainable development by 2005 to reverse the loss of environmental resources by 2015. (Box 1 illustrates the MDGs) [4]

Box 1:

Sustainable Development

I- PRSP:

MILLENNIUM DECLARATION GOALS:

The targets for 2015 are to:

- Halve the proportion of the world's people living on less than $ a day.
- Halve the proportion of the world's people suffering from hunger.
- Halve the proportion of the world's people without access to safe drinking water.
- Achieve gender equality in access to education.
- Reduce maternal mortality ratios by three quarters.
- Reduce under-five mortality rates by two thirds.
- Halt and begin to reverse the spread of HIV/AIDS, malaria and other major diseases.

A closer look on the status of how people are doing for MDGs reveals that among all the goals, most of the people are either *lagging, far behind or slipping* for the ones related to ill-health (see Table 2.). This in itself is evidence of the need to target ill-health as part of achieving the MDGs.

Table 2. Millennium Declaration Goals: How are People Doing?

Goal for 2015 (percentage of world population)	Achieved or on track	Lagging, far behind or slipping	No data
Gender equality:			
Eliminate disparity in primary education	58	5	22
Eliminate disparity in secondary education	42	22	21
Infant and child mortality:			
Reduce infant mortality by two-thirds (IDG)	23	62	(.)
Reduce under five mortality rates by two-thirds	23	62	(.)
Maternal mortality:			
Reduce maternal mortality ratios by three-quarters	37	48	(.)
Basic amenities:			
Halve the proportion of people without access to safe Water	12	70	3
Hunger:			
Halve the proportion of people suffering from hunger	62	11	12
Universal education:			
Enroll all children in primary school	34	5	46
Achieve universal completion of primary schooling	26	13	46
Extreme income poverty:			
Halve the proportion of people living in extreme poverty	43	34	8
Business as-usual growth pattern	54	23	8
Pro-poor growth pattern			

Note: Population shares do not sum to 100% because the analysis excludes high-income OECD countries.

2.3. Poverty and Ill-Health and the Way Organizations Work:

It has been argued that the horrific diseases burden of the poorest countries is a fundamental barrier to economic improvements of the world's poorest people. Consequently, although health is a valid end in itself, the main reason for seeking to improve the health of poor people is as an investment to facilitate economic growth. Clearly, many look to the World Health Organization (WHO) for leadership in this area. WHO advocates a broad response to poverty and health that includes focus on specific diseases, efforts to promote pro-poor health systems and measures that address broader determinants of health and initiatives, which promote cross-sectoral actions, e.g. in education, social protection etc.

Like WHO, other organizations include broad responses to issues of health and poverty in their policy statements. For example, the World Summit for Social Development [5] recognized the need for social development if economic policies were to succeed. The World Bank [6] sees health primarily as an essential asset for economic growth but includes a focus on a pro-poor health care system and a health environment as a means to promote health [7]. The Asian Development Bank (ADB) [8] sees health as the key to

human capital and goes beyond responses to specific diseases including emphasis on pro-poor health systems, environmental health and the broader determinants of health. Similarly, the African Development Bank (AfDB) [9] sees health in terms of human capital. The European Commission [10] sees work on strengthening health as increasing human capital. Strategies to achieve this include health system reform, extending primary health care, health promotion and disease prevention, investment in water, sanitation and housing, safety at work, gender equity etc. The UK Department for International Development (DFID) [11] also sees health as a mediator of economic growth and advocates for a broad social sector response. The Bill and Melinda Gates Foundation focuses its Global Health program on targeting the diseases that impose the greatest burden on poorest countries and those conditions which are associated with poverty [12].

Lush and Walt [13] argue that any focus on the diseases of the poor (major infectious diseases) must also consider social factors, e.g. insecurity and inequalities as "better health does not depend simply on medicines, doctors and health services". This view has been adopted by a number of international agencies. For example, the Rockefeller Foundation [14] argues that measures promoting public health are unlikely to be effective in promoting the health of poor people if they restrict them from participating in decisions that affect their health. For interventions to be successful, they argue, people must be able to negotiate their own inclusion into health systems and demand adequate health care. Other writers argue for a broad approach to public health, which focuses on reducing social and economic deprivation. Such a view challenges the recent 'neo-liberal' trend, which has increasingly seen health as the responsibility of the individual, as "the determinants of health are increasingly located at the global level".[15] The broader view on poverty and health were also discussed in People's Health assembly (PHA).[16] However, it relies not simply on seeking to address the diseases which affect the world's poor but seeks to ask a series of 'but why' questions relating to why these problems disproportionately affect the world's poor.[17]

2.4. PRSP: Opportunity and Conditionality:

While the limited progress in reducing poverty has many causes, it is clear that action is needed to strengthen domestic policies and institutions and to enhance external assistance. In September 1999, the World Bank Group and IMF approved an approach that recognized that nationally owned participatory reduction strategies were the most promising means of securing more effective policymaking and partnership between countries and donors. To ensure that assistance is well used for poverty reduction, Poverty Reduction Strategy Papers (PRSPs) would henceforth be the basis of all their concessional lending, and for debt relief under the enhanced Heavily Indebted Poor Country (HIPC) Initiative. [18]

Poverty reduction strategy papers (PRSP) will follow the Interim-PRSP (I-PRSP), which are an innovative initiative of the government to reduce poverty within the nation. It is an attempt to provide an integrated focus to a diverse set of factors that impact poverty. With reforms as its primary goal, PRSP not only assesses the factors contributing to poverty, but also suggests changes necessary to alleviate it. Thus PRSPs describe a country's macroeconomic, structural and social policies and programs over a three-year or longer horizon to promote broad based growth and

reduce poverty, as well as associated external financing needs and major sources of financing.

This initiative is a shift in the government's existing efforts to alleviate poverty. Without the active and relentless participation of the stakeholders, proper implementation of this strategy may not be possible. Among these stakeholders are the government and policy makers, NGOs, masses and opinion leaders.

As the IMF and World Bank are the two prime donors to this cause, they have asked the grantees for a formal strategic analysis, communication plan and implementation of the I-PRSP; this becomes a condition for the developing nations. In addition to that the issue of reduction of poverty and the strategic document is often used as an opportunity to leverage both political benefits in the country and to attract other donors for supporting the programs addressing poverty reduction.

3. CHALLENGES FOR PAKISTAN IN THE FACE OF POVERTY

3.1. Challenges:

The poor in Pakistan are not only deprived of financial resources, they also lack access to basic needs such as education, health, clean drinking water and proper sanitation (see Table 3.).

Table 3. Social Indicators of Pakistan

	Latest single year			**Same region/ Income Group**	
	1970-75	1980-85	1994-00	South Asia	Low - Income
Population					
Total population, mid-year (millions)	71.0	94.8	138.1	1,354.7	2,458.7
Growth rate (% annual average for period)	3.2	2.7	2.4	1.9	1.9
Urban population (% of population)	26.4	29.8	37.0	28.4	31.9
Total fertility rate (births per women)	7.0	6.5	4.8	3.4	3.7
Poverty					
(% of population)					
National headcount index			32.6		
Urban headcount index					
Rural headcount index					
Income					
GNI per capita (US$)	150	330	440	460	420
Consumer price index (1995=100)	20	42	148	138	142
Food price index (1995=100)		39	134		
Income/Consumption					

Distribution					
Gini Index			31.2		
Lowest quintile (% of income or consumption)	8.0		9.5		
Highest quintile (% income or consumption)	41.8		41.1		
Social Indicators					
Public expenditure					
Health (% of GDP)			0.9	0.9	1.2
Education (% of GNI)	2.2	2.9	2.7	3.1	3.3
Social Security and welfare (% of GDP)	0.3	0.9			
Gross Primary school enrolment rate					
(% of age group)					
Total			89	100	96
Male			77	110	102
Female			60	90	86
Access to an improved water source					
(% of population)					
Total		38	88	87	76
Urban		77	96	92	88
Rural		22	84	85	70
Immunization rate					
(% under 12 months)					
Measles		38	81	63	64
DPT		77	80	75	70
Child malnutrition (% under 5 years)		22	38	47	
Life expectancy at birth					
(years)					
Total	52	57	63	63	59
Male	52	57	62	62	58
Female	52	58	84	63	60
Mortality					
Infant (per thousand live births)	134	122	90	74	77
Under 5 (per thousand live births)	183	161	128	99	116
Adult (15-59)					
Male (per 1,000 population)	339	283	186	223	288
Female (per 1,000 population)	381	291	153	212	258
Maternal (per 100,000 live births)			340		
Births attended by skilled health staff (%)				49	

Note: 0 or 0.0 means zero or less than half the unit shown. Net enrollment ratios exceeding 100 indicate discrepancies between the estimates of school-age population and reported enrollment data.

Limited access to education, health and nutrition undermines their capabilities, limits their ability to secure gainful employment, and results in income poverty and social exclusion, while also making them vulnerable to exogenous shocks. This cycle is further exacerbated when institutions of governance tend to exclude the most vulnerable from the decision-making process and thus feeds into poverty and human deprivation. Some of the selective characteristics of poverty in Pakistan are highlighted below [19]:

Box 2.

Selective Characteristics of Poverty in Pakistan:

- Poverty in Pakistan has remained fairly stable during the 1990s, from 29.3% in 1993-94 to 32.2% in 1989-99.
- The poor have a high dependency ratio, as households with a large number of children and single earning member are more likely to be poor.
- Average number of births by a poor woman (married and of age 15-49) is almost five, compared to four for a non-poor woman.
- The poor are characterized by relatively low access to health related infrastructure, like sanitation. While 76% of the poor live in the households with no toilet with flush, compared to 53% of the non-poor.
- Relatively poor communities also seem to have less access to health facilities and immunization coverage; 45% of the children in poor households aged 1-5 years have been fully immunized as against 58% in non-poor households.

Economic performance:

Over recent decades, economic growth in Pakistan has followed a downward trend with real GDP growth falling from over 6% per annum in the 1980s to around 4% during the late 1990s. A sharp rise in interest payments on public debt and a commensurate fall in development expenditures over the same period, lie behind this sluggish performance. In addition, during the 1990s, Pakistan witnessed a gradual worsening in its governance profile, which impaired the government's ability to deliver essential good and services to the poor.

The conundrum of structural adjustments, the debt trap and poverty in Pakistan:

The long-standing World Bank/IMF sponsored Structural adjustment programs (SAPs) refer to a set of measures that countries need to implement in order to qualify for loans from these agencies. In 1987 these SAPs were expanded to create an enhanced structural adjustment facility, with the facility for developing countries to borrow from it subject to their agreement to accept the IMF conditions. These include all or most of the following measures:

- Privatization of government-owned enterprises and government-provided services
- Reduction in government spending
- Orientation of economies for the promotion of exports

- Liberalization of trade and reduction of tariffs for imports
- Increase in interest rates
- Elimination of state subsidies on consumer items such as foods, fuel and medications
- Taxation increase
- Currency devaluation and control of monetary supply

In contrast to other bank policies, the SAPs are primarily geared to achievement of fiscal and balance-of-payment stability, rather than stimulation of economic growth. The ostensible purpose of these economic measures is to improve debt repayments, reduce fiscal deficits, encourage private sector investment and move towards an export-oriented economy. The measures are targeted to allow the governments to undertake better long-term planning. It is thus anticipated that the consequent improvement in national economic efficiency will lead to stimulation of growth with subsequent "trickle-down" benefits to the poor and vulnerable groups of the population.

Many of the premises and underlying arguments for SAPs make intuitive sense and are overtly geared towards improving the general socio-economic conditions and indirectly, the health of the population[20]. These arguments are especially relevant in dysfunctional and noncompetitive economies. While there may be little that is inherently wrong in the principles that underlie SAPs, and that in an ideal and equitable world the "trickle-down" benefits of fiscal discipline and growth would be shared by the masses[21]; in reality, however, we hardly live in an ideal world and most of the countries targeted by the World Bank and the IMF are either under autocratic rule or boast fragile democracies. Thus several prerequisites of ensuring that the burdens of structural adjustment and austerity measures are equitably distributed do not exist. These prerequisites include social justice, good governance, true democracy (as opposed to the sham-democracy of the privileged elite or feudal class) and gender equity. Other factors determining a just sharing of the benefits and burdens of socio-economic change in many countries include the level of corruption, the monitoring of social welfare programs and systems for redressing grievances. A major problem with the way SAPs work is that while the IMF and World Bank make the requisite loans and agreements, there is little stomach for monitoring and oversight of the associated social safety nets and safeguards. This failure of the proponents of SAPs to adequately assess and monitor social safety nets and evaluate the grass roots impact of such programs is one of the major reasons for the disquiet surrounding them.

At a macroeconomic level the basic thrust of SAPs in Pakistan has been to improve its balance of payment position through improving exports of cash crops, closure or privatization of public sector industries as well as removal of subsidies on food items and utilities. Although it is evident that the benefits of such a fundamental shift in policy must be closely intertwined with the prevalent system of land ownership and agriculture, in Pakistan's predominantly feudal system with large-scale land holdings by a privileged few, it is unlikely that the benefits of increasing agricultural support and subsidies will automatically translate into benefits for the largely poor and disenfranchised farmers. It has been argued that true liberty and democracy in many developing countries must be coupled with an egalitarian society and equitable distribution of income and assets[22]. This has hardly been the case in Pakistan. Until the stabilization of the economy, following the post-9/11 scenario, recent socio-economic

trends in Pakistan starkly illustrate the point. Pakistan has been a signatory to the structural adjustment program of the IMF for almost 10 years. Despite assurances to the contrary and the imposition of IMF conditions, the same period has seen a dramatic rise in the proportion of national budget devoted to debt servicing and a corresponding rise in the incidence of poverty. While there is a paucity of reliable information on whether this increase in poverty has led to an increase in rates of malnutrition, at the very least available data indicates that trends in critical nutrition factors such as childhood malnutrition and maternal anemia have hardly changed (see chapter on Nutrition trends in Pakistan). There is a clear link between household income and food intake and enough evidence exists that when purchasing power is limited, food quality and intake of the vulnerable suffers[23].

It can be argued that this economic downturn reflects a general deterioration in the economy of the country, and that in the absence of an IMF sponsored restructuring program, the rate of economic deterioration would have been much faster. It is this writer's considered opinion that this assumption is without a sound basis. There is usually an unholy nexus between rampant corruption, vested interests and economic mismanagement. Pakistan received approximately US$ 31 billion in external assistance and IMF loans between 1985-2000, yet the amounts actually spent on infrastructure and the social action program during this period have been miniscule in comparison. The bulk of the impact of recent structural adjustments in Pakistan has been largely felt by the common man because of an immediate significant increase in the cost of utilities, higher fuel costs and withdrawal of food subsidies. It is hardly surprising to see that the privileged traders and industrialists are able to cushion these by transferring the burden to the consumers through price hikes.

It is important to understand the consistent failure of successive versions of SAPs in Pakistan against the background of a climate of poor governance[24]. This combination of poor governance, lack of representation, institutionalized corruption and economic stagnation are potent ingredients for societal breakdown, disillusionment and the growth of militancy. The unemployed youth of Pakistan, who see little hope in traditional politics or way of governance, are attracted to the missionary zeal of the religious right wing. The rapid growth of Islamic militancy and obscurantism in Pakistan may be a consequence of poor governance and economic stagnation, and in no small measure due to the failure of the international financial institutions to provide firm and consistent support to Pakistan geared towards human development, rather than mere avoidance of loan defaults. There are no mechanisms in place to even remotely gauge these societal impacts of structural adjustments.

Table 4. Economic Indicators

	Annual Average for		
Indicator (%)	1980s	1990/91 - 1994/95	1995/96 - 1999/00
Compound growth rate of real GDP	6.5	4.9	3.3
Poverty incidence	46(1985/86)	34	33
Inflation (period average)	7.2	11.5	7.9
Fiscal deficit/GDP (excl.grants)	7.1	7.2	6.5
Fiscal deficit/GDP (incl.grants)	6.4	6.7	6.4
Public debt/GDP	66 (mid-1980)	94(mid-1990)	101 (mid-2000)

Source: Poverty incidence - Bank staff; public debt/GDP - Pakistan Debt Report; rest Economic Survey, GOP

The social gap:

Pakistan lags behind countries with comparable per capita income on most of the social indicators[25] (see Table 5). This is true of the effort expended (e.g. expenditure on public health) and outcomes (e.g. infant mortality), a phenomenon called "social gap". Thus Pakistan has grown much more than many other low-income developing countries, but has failed to achieve social progress commensurate with its economic growth. For example, while infant mortality rates and female illiteracy rates declined by 73 and 60% from 1960 to 1980 for countries that grew at about the same rate, in Pakistan the declines were of the order of 43% and 20% respectively[26]

Table 5. Pakistan's social Indicators in International Perspective

Indicators	**Actual Values for Pakistan**	**Predicted Values for Countries with Similar Incomes**	**Difference between Actual and Predicted**	**Percentage difference of Actual from Predicted**
Child (Under Age 5) Mortality Rate (1998)	120.0	101.0	19.0	18.8
Percent of childbirths with low birth-weight (1990s)	25.0	13.4	11.6	86.6
Public spending on health as percent of GDP (1996)			-1.6	
Gross primary enrolment (1990s) For females	67.3 42.7	88.1 83.2	-20.8 -40.5	23.6
Illiteracy rate (1990s)	59.5	35.1	24.4	69.5
For females	70.0	37.8	32.2	
Public spending on education as percent of GDP (1990s)	2.7	4.1	-1.4	
Fertility rate (1998)	4.9	4.3	0.6	14.0
Contraceptive prevalence rate early – (1990s)	15.0	36.0	-21.0	
Proportion of females in total population (1999)	48.2	50.3	-2.1	

Pakistan is faced with twin challenges of reviving growth and reducing poverty. This requires rapid economic growth, yet growth in itself is not sufficient for poverty reduction. The government realizes that additional income alone, either through jobs or financial assistance, would not eliminate poverty unless the causes of poverty are addressed and eliminated. Therefore, restoring economic growth and improving access to basic needs, such as primary education, preventive health care and population welfare services, are essential for winning the war against poverty.

3.2. Initiatives for Addressing Poverty:

Social and economic reforms:

Successive governments attempted to respond during the 1990s by announcing measures to free interest rates, privatise, reduce protection, reform the banks, spur the development of small and medium sized enterprises, and even (via the Social Action Programme, SAP) to address the large social and gender gap. SAP was launched in 1992-93 as a major initiative of the Government of Pakistan (GOP), with the aid of donor financing and technical assistance. The program explicitly aimed at increasing the physical availability and improving the quality and efficiency of services, especially for the poor and for women, in four distinct target areas: elementary education, basic health care, family planning and rural water supply and sanitation. The essential modalities were to support the provinces in expanding access to, and the quality of, each of these four areas.

However, the results were disappointing. The reforms were partial, while corruption and weak institutions did not provide a solid foundation for a market economy. The present government, which took office in October 1999, has sought to build upon the efforts of its predecessors by launching a comprehensive program that seeks to achieve sustained pro-poor growth by attacking the inter-linked problems of slow growth, the social gap and the heavy debt return.

Improving human development:

A weakened social profile is detrimental for growth, just as human development is essential for attracting investment and generating the capacity for future sustainable growth. The Human Development Strategy developed by GOP is articulated in I-PRSP, and attempts to embody lessons from the difficulties encountered by SAP. Ongoing reforms are seeking to address some of the critical constraints in service delivery, by focusing on the core institutional factors that limited the success of SAP. The core principles of the poverty reduction strategy include: a) engendering growth, b) implementing broad based governance reforms, c) creating income generating opportunities, d) reducing vulnerabilities to shocks (by programs such as Khushal Pakistan, food support program and Zakat grants) and e) improving social sector outcomes by improving human development.

The government of Pakistan has thus prepared comprehensive human development strategies aimed at the effective utilization of available resources through improved institutional mechanisms. The areas addressed include: Education; Health; Water Supply and Sanitation; Nutrition; Population Planning; Protecting the Vulnerable; and Environment. In devising these strategies, the government has given particular attention to three factors:

1) These policies have been developed through a comprehensive bottom up consultative dialogue, which ensures that they are demand driven and locally owned.
2) The development priorities are focused on what is already on the ground, instead of going for additions.
3) Cultivating public-private partnership for improving human development outcomes has been specially emphasized.

3.3. Commitments by Government of Pakistan:

Investing in people:

Narrowing the large social gap is the most pressing issue for Pakistan, not just because it stunts the lives of those who remain illiterate and exposed to ill-health, but also because no country can expect to progress in a global world economy without an educated and healthy workforce. The following commitments can be cited by GOP in health, nutrition and population planning.

Health:

Improvements in health outcomes are an important determinant of economic growth, as better human health leads to increased productivity, improved learning ability and reduced population growth rate. Although consolidated health expenditure rose from

Rs. 13 billion in 1995-96 to Rs. 17 billion in 2000-01, that still represents a reduction from 0.63% of GDP in 1995-96 to 0.5% of GDP in 200-01. Additionally, a major share of these expenditures is focused towards tertiary health care facilities, with the result that primary and secondary tiers especially in the rural areas have been neglected. Moreover, serious institutional/governance deficiencies also mar the health sector. Therefore, overall vision of the government's medium term health strategy is focused towards raising public sector health expenditure through a keen focus on preventive and control programs, especially in the areas of communicable and infectious diseases, reproductive health and nutritional deficiencies.

Nutrition:

Estimated total number of malnourished children in Pakistan was around 8 million, during 1990-00, with iron and anemia deficiency being most prevalent; in fact one third of pregnant women in Pakistan are malnourished, giving birth to low birth weight babies (25% of all live births). The National Nutrition program has been strengthened, especially its components of breast feeding, fortification and provision of Vitamin A, iron and iodine. A project for the improvement of nutrition through Primary Health Care and Nutrition Education/Public Awareness Program costing Rs. 302.00 million has been approved.

Population Planning:

Between 1991-01, population growth rates came down from 3% per annum to around 2.2%. The awareness of at least one method of family planning is around 97%, while contraceptive prevalence rate is 28%. However, the current total fertility rate (4.8) is still one of the highest in Asia. Antenatal care is used by only 27% of the women and about 76% deliveries take place at home. The Ten Years Population Perspective Plans for Population has been developed to address this situation. In addition, there is a renewed emphasis on utilizing the outlets of both health and population welfare ministries for distribution of various contraceptives. This is in addition to the outreach workers, who are now about 70,000 after the merger of LHWs and VBFPWs.

The following table (6) illustrates I-PRSP budgetary expenditure (2001-04) and gives details of critical resources that would be realized for improving human development and implementing broad based governance reforms. These expenditures (inputs) have been developed with participation of provincial governments. The timely availability of these resources will be crucial for achieving the desired growth and poverty reduction strategy objectives.

Table 6. I-PRSP Budgetary Expenditures (2001-04) (Only Social Services)

	ACTUALS		Budget Estimates		PROJECTIONS (based on 2000-01 actual expenditures)					
IPRSP Expenditure	2000-01		2001-02		2001-02		2002-03		2003-04	
	Rs. Millions	As a % of GDP	Rs. Millions	As a % of GDP	Rs. Millions	As a % of GDP	Rs. Millions	As a % of GDP	Rs. Millions	As a % of GDP
Development	23,021	0.7	35,292	0.9	34,552	0.9	45,395	1.1	63,623	1.4
Current	96,284	2.8	115,391	3.0	101,816	2.7	113,407	2.7	120,799	2.6
TOTAL	119,305	3.4	150,683	4.0	136,368	3.6	158,802	3.8	184,422	4.0
B. Social Services										
Education	56,362	1.6	69,475	1.8	63,166	1.7	72,605	1.7	83,046	1.8
Health	17,494	0.5	22,728	0.6	19,275	0.5	21,098	0.5	22,960	0.5
Population Planning	1,552	0.0	1,837	0.0	2,116	0.1	25,210	0.1	2,983	0.1
Social security & other Welfare	1,568	0.0	3,864	0.1	1,681	0.0	1,816	0.0	1,949	0.0
Natural Calamities and other Disasters	912	0.0	185	0.0	964	0.0	1,035	0.0	1,103	0.0

Table 7: HEALTH AND POPULATION WELFARE TARGETS

HEALTH SECTOR TARGETS	Projections on 2000-01 Benchmark				
	1998-99 PIHS	2000-01PRHFPS	2001-02	2002-03	2003-04
Infant mortality rate (per 1,000 births)	89	85 (90)	80	72	65
Child mortality rate (per 1,000)	-	20			17
Births attended by trained personnel (%)	19	23 (20)	22	24	25
Immunization coverage of children (%)	49	67.5	77.5	82.5	85
Coverage of prenatal care (%)	31	43	45	47	50
Utilization rate of first level care facilities (BHU/RHC)	Source identified. Information will be made available in Full PRSP.				

Table 5.3:I-PRSP-Monitoring Targets (Cont.)

POPULATION WELFARE TARGETS	Projections on 2000-01 Benchmark				
	1998-99 PIHS	2000-01PRHFPS	2001-02	2002-03	2003-04
Population Growth Rate	-	2.2	2.1	1.9	1.8
Total Fertility Rate	4.5	4.8	4.5	4.3	4.1
Contraceptive Prevalence Rate (%)	17	28	32	35	39

Table 5.3:I-PRSP-Monitoring Targets (Cont.)

Source: PIHS 1998-99, FBS, Pakistan Reproductive Health and Family Planning Survey (PRHFPS), NIPS 2000-01; Ministry of Health (MOH)

Note 1: Overall National and Provincial Targets Consistent with Urban-Rural Disaggregation will be outlined in the full PRSP

Note 2: Figures in Parenthesis from MOH. (Where applicable) These have been used as Benchmarks.

4. ISSUES RELATED TO POVERTY REDUCTION STRATEGY BY ADDDRESSING HEALTH

4.1. Are the Health Programs Addressing the Poor:

The vicious cycle of poverty and ill-health necessitates that health services be addressed to the poor and needy, who are also the most vulnerable. The government of Pakistan is committed to providing the services to all of its citizen regardless of the class and creed and/or geographical variations. However, a closer look at health care utilization patterns indicates that only one third of all those who need or seek care utilize government health services. The remaining two-thirds end up seeking care from non-government, mostly private sector. Interestingly, both the government and private health seeker ends up by paying from his/her own pocket; more so by the poor as he/she starts with the government facility and to his/her disappointment does not get the quality services. Thus, at the end he/she is forced to seek private care, spending more money from his/her own pocket.

In addition, the data generated by HMIS, LHW-MIS and the FP-MIS does not distinctly identify the poor and the vulnerable. Though most of the health and population programs claim their focus is on the poor, there is no empirical evidence to support that claim. The GOP has also identified "safety nets" (such as health insurance, social security and food support program etc.) for the poor, but these have yet to materialize. Thus there is a need for concerted efforts to be put to not only improving the quality of services, but also focusing more on "pro-poor". This would require some strategic thinking and improved design of the health and population services.

4.2. How to Monitor Health Related Targets:

The monitoring mechanisms of I-PRSP focus on input (tracking budgetary expenditure) and outcome (the targets in individual areas, including health and population). Table 7. illustrates the targets related to health and population Welfare Targets.

However, there is a need to have output or intermediate targets, as measuring of the outcome targets may not demonstrate a significant and/or desirable change. The GOP, along with the assistance of DFID, has conducted a number of consultations and suggested some of the intermediate targets along with the source of information and the frequency (see Table 8)[27].

Table 8. Health Intermediate Indicators

Indicator for Immediate Inclusion	Recommended Source of Information	Frequency of Data Collection	Availability of Baseline Information
Utilisation Rates of First Level Care Facilities (Curative & Preventive) - BHUs and RHCs	HMIS/EPI Register Crosscheck with CWIQ *Disaggregated by province, district and gender*	Initially biannual, subsequently quarterly	Available
Proportion of the population covered by Lady Health Workers	DoH records to determine no. of LHWs multiplied by 813 Crosscheck with CWIQ/occasional surveys *Disaggregated by province and district*	Initially biannual, subsequently quarterly	Needs calculation from available data MIS to provide data to HMIS Cell
Immunisation coverage of children - completed courses of all six vaccinations (DPT1 – 3, measles, BCG, polio)	EPI MIS/CWIQ Cross check with PIHS, occasional surveys *Disaggregated by province, district and gender*	Initially biannual, subsequently quarterly	EPI MIS available but limited reliability, PIHS is biennial
Percentage of births attended by skilled birth attendants - doctors, LHVs, nurses & midwives	CWIQ cross-checked by PIHS *Disaggregated by province and district*	Annual	PIHS provides biennial data
Number of skilled female birth attendants - doctors, LHVs nurses and midwives but not TBAs	Initially DoH, later HMIS *Disaggregated by province and district*	Annual	Data can be compiled from DoH records
Number of skilled female health workers Lady doctors, LHWs, LHVs and nurses	DoH, LHW MIS, HMIS	Annual	Will need to be compiled.
Number of FLCFs meeting staffing norms Doctors & LHVs are the key staff to monitor			
Availability of all four contraceptive supplies from FLCFs	HMIS		

It is envisaged that GOP will take measures to ensure that these indicators are collected regularly to demonstrate the influence of commitments of Pakistan in social sector through PRSP.

5. DONORS' ROLE FOR REDUCING POVERTY THROUGH MPROVEMENTS IN HEALTH

A number of donors including both bilaterals and multilaterals are supporting the GOP for achieving the health and population related targets. However, many of the funding agencies are still focusing on 'project' approach and usually on a small scale in some isolated areas and/or at the district level. These projects can be good "role-models" or be a "demonstration" site for some innovative intervention or approach. However, when it comes to scaling up or duplication, they are doomed to be a failure, either because it was never designed to be scaled up or there aren't enough funds to scale up the "highly-concentrated" approach usually expected in the donor-driven approach.

In addition to the problem of being isolated projects, the whole issue of sustainability is hardly ever addressed in these pilot projects. Thus, the program managers of the health and population programs are busy implementing the donor-led interventions, which make some difference but seldom appear to get a mainstream approach. Thus there is a need that both the donors as well as GOP address this issue by first prioritizing the intervention areas, agree on implementation strategies, map out the shortfalls in the budget and then seek the donors' support for implementing the programs on a nationwide scale rather than doing piecemeal work at the behest of donors. Recently some of the donors such as DFID have taken an initiative for direct budgetary support to the GOP with an understanding that the extra support be utilized for the social sector. This can be further ensured by improving the budgetary processes and by strengthening the individual programmes to draw down more support from the budget[28]

In addition to the support offered by the donor to the GOP, it is necessary that civil society also be involved and encouraged to take forward the "pro-poor" agenda of the government. This can be ensured by either direct support to the nongovernment organizations and some of the social marketing organizations (especially in the field of family planning[29]), or by encouraging public-private partnerships.

6. DECENTRALIZATION AND DEVOLUTION AND ITS INFLUENCE ON HEALTH

The I-PRSP describes devolution as the major instrument to improve access to education, health and other public services. The success of the health strategy will crucially hinge on the extent to which devolution is able to improve incentives and accountability mechanisms of public service delivery. Accordingly, the I-PRSP recognizes the need to reorganize the district health offices to make them community based and locally managed establishments. Devolution will take time to become effective given the important

challenges of addressing capacity constraints especially at the district level and below. In addition, it is clear from both domestic and international experience that devolution is no panacea, and at best it takes time to implement the essential institutional reforms. This can further add to the confusion on reforms related to devolution with the recently held elections of the parliament (both national and provincial) and the distorted priorities of the elected Nazims (at the district level), which are not necessarily addressing the 'social gap'.

6.1. Linking Health Policy with Poverty Reduction:

The National Health policy, 2001[30] has following key features:

- Health sector investments are viewed as part of Government's Poverty Alleviation Plan.
- Priority attention is accorded to primary and secondary sectors of health to replace the earlier concentration on tertiary care.
- Good governance is seen as the basis of health sector reform to achieve quality health care.

Ten specific areas of reforms along with implementation modalities have also been identified. Interestingly, the issue of gender equity and capacity building in health policy monitoring is a welcome change among the specific targeted areas.

The Ten Years Perspective Plan of the Population, prepared by the Ministry of Population Welfare[31] addresses population stabilization, which is seen as a means to the attainment of goals and objectives of PRSP.

The need is for the time to ensure that sound strategies are planned, robust monitoring and evaluation mechanisms are in place and above all these programs are targeted to the needy and vulnerable. In addition, the whole issue of linking research to policy and putting emphasis on "international best practices" also needs to be addressed.

To conclude, Pakistan faces a number of critical challenges in developing its human resources as a basis for sustained growth and poverty reduction as well as to close the social and gender gaps. Earlier failures to develop human capital contributed to the recent malaise of the economy, and the slowdown in growth and poverty reduction during the last decade in turn led to further stagnation in human development indicators. In order to break this cycle of poverty, public policy must focus above all on measures to improve education and health outcomes.

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