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Pakistan Policy Note 10

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Expanding Quality Health, Population, and Nutrition Services

Pakistan's health and nutrition outcomes and service coverage lag behind those in most other South Asian countries, despite slowly improving over the past decade. Key issues include persistent inequities in health and nutrition outcomes and service use by economic status, gender, and region; poor governance and weak and centralized management; low public spending on health; and programmatic shortcomings in reducing fertility and improving nutrition—areas with cross-cutting impacts on human development and economic growth.

The adoption of the 18th Amendment to the constitution in 2010 and the subsequent devolution of most federal responsibilities for health and population welfare to the provinces provide opportunities for more responsive and accountable governance, but they also pose severe challenges. Special attention will be required to ensure appropriate institutional arrangements to house federal functions, a clear delineation of responsibilities, and the building of capacities and structures at all levels. Actions to improve health sector performance include improving health services targeting the poor; increasing health spending; strengthening health sector management and accountability with a greater focus on monitoring and information (in a context of devolution and contracting); and expanding family planning and nutrition services.

Health and population outcomes in Pakistan have improved over the last decade but at a slower rate than in most other South Asian countries. While the infant mortality rate and under-five mortality rate have fallen, the decline is far slower than in other South Asian countries, and both rates are the second highest in South Asia, as is the total fertility rate (Table 1). High fertility puts an enormous burden on women's health, as reflected in high maternal mortality ratios (260 deaths per 100,000 births).

Pakistani women and children also suffer from some of the highest rates of malnutrition in the world, and have seen little improvement in nutritional outcomes. The prevalence of nutritional stunting among children under age 5 (43.7 percent) has remained virtually unchanged since 1965.[1] The country has the second-highest rate of severely wasted children, after India: 15 percent of children under age 5 suffer from acute malnutrition and 6 percent suffer from severe acute malnutrition. Malnutrition is also a significant problem among women of reproductive age, as 14 percent have chronic energy deficiency. Micronutrient deficiencies are widespread with high rates of iron-deficiency anemia, with 62 percent of children under age 5 and 51 percent of pregnant women suffering from anemia and persisting high deficiencies of zinc, iodine, and vitamin A.

Coverage of most maternal care services has improved significantly over the last decade but is still far from adequate. During 2001–10, antenatal care attendance increased from 35 percent to 60 percent, postnatal care attendance from 9 percent to 28 percent, skilled birth attendance from 31 percent to 43 percent,

Table 1 Health, nutrition, and population outcomes in selected South Asian countries

Country	Under-five mortality rate (per 1,000 live births) 2011	Infant mortality rate (per 1,000 live births) 2011	Malnutrition prevalence, height for age (share of children under age 5) 2004–11	Maternal mortality ratio (per 100,000 live births) 2010	Total fertility rate (births per woman) 2010–11
Bangladesh	46	37	43	240	2.2
India	61	47	48	200	2.6
Nepal	48	39	41	170	2.7
Pakistan	72	59	43	260	3.4
Sri Lanka	12	11	19	35	2.3

Source: World Development Indicators database.

and tetanus toxoid 2 coverage in women from 46 percent to 69 percent. Immunization coverage improved modestly, increasing from 53 percent to 62 percent.[2] Contraceptive prevalence (using modern methods) remained stagnant at 22 percent (or less than half the rate of most South Asian countries). By province, health coverage remains better in Punjab and Sindh, while Balochistan stays the most underserved (Table 2).

The private sector is the main source of outpatient consultations and institutional deliveries. The public sector provides only a fifth of curative services, even for the poor and rural population. The use of the private sector for outpatient consultations has increased from 69 percent in the late 1990s to 78 percent in 2010/11. Nearly 70 percent of institutional deliveries took place in private facilities in 2011. The public sector remains the main source of preventive services, particularly in rural areas, and accounts for 90 percent of immunization coverage.

Over the last decade, Pakistan has aimed to improve service delivery through management reforms and a stronger programmatic focus on strengthening maternal and child health services. Fundamental institutional changes enacted through the 18th Amendment have implications for health sector management. Key reforms include:

- *Expanding access to maternal neonatal and child health services.* The government made substantial investment over 2001–10 in expanding community-based programs, including the Lady Health Workers (LHW) Program and the National Maternal Neonatal and Child Health Program. This expansion supports the provision of family planning, basic primary health care, community midwifery, and emergency obstetrical services.
- *The Devolution Plan of 2001 envisaged a shift of responsibility for basic health services from the provincial governments to the newly created district governments, to improve service delivery by bringing government closer to the people.* The provincial and district departments were restructured, and efforts were made to build

Table 2 Health service coverage, federal and by province

(percent)

Province	Treatment of diarrhea in children with oral rehydration salts		Proportion of pregnant women who visited health facility for antenatal care		Proportion of pregnant women receiving at least one tetanus toxoid injection during pregnancy		Skilled birth attendance[a]		Postnatal care by skilled provider	
	2001	2010	2001	2010	2001	2010	2004	2010	2001	2010
Pakistan	54	74	35	60	46	69	31	43	9	28
Punjab	44	64	40	63	53	77	33	44	10	28
Sindh	70	89	38	61	43	60	38	49	10	34
Khyber Pakhtunkhwa	58	83	22	50	35	61	26	37	4	23
Balochistan	70	90	21	40	17	31	14	23	7	18

a. Includes assistance from doctor, nurse, lady health worker, or midwife.
Source: Pakistan Bureau of Statistics 2001, 2011.

capacity of district health systems. Yet the initiative stopped far short of full devolution of administrative and fiscal powers. District governments have limited administrative authority to hire and fire staff or make senior appointments, which are within the purview of the provincial government. The share of district governments in public expenditure increased, but the bulk of spending comprised salaries that could not be altered. The impact on service delivery was limited.

- *The 18th Amendment enhances provincial autonomy through devolving federal powers and responsibilities to the provinces of subjects in the concurrent legislative list, which includes health and population welfare.* The federal ministries of health and population welfare have been abolished. All vertical health programs that accounted for about 60 percent of Ministry of Health spending have been transferred to the provinces but will continue to be financed by the federal government until the next National Finance Commission award, expected in 2015. Some health oversight functions have been retained at the federal level and assigned to various federal entities, including health financing, formulation of norms and standards, human resource planning, and information collection and analysis. The reform has the potential to make the government more responsive and accountable and to develop a more cohesive public health system, yet it faces significant challenges that will require attention, particularly during the transition phase. These include appropriate institutional arrangements to house federal functions, clear delineation of responsibilities within provincial departments, and capacity building at all levels. The provinces are developing their own health sector strategies outlining their reform programs.
- *Contracting out health services management.* More than half the districts adopted this approach, under the People's Primary Health Initiative (PPHI). The model was first adopted in 2002 when Rahim Yar Khan District in Punjab contracted the Punjab Rural Support Program to manage all 104 basic health units in the district. The intervention demonstrated that effective management could quickly increase use of public facilities without additional cost to the government, thus increasing efficiency. The program was scaled up in 2006. Findings of an external evaluation of PPHI in Balochistan, Khyber Pakhtunkhwa, and Sindh confirm the rise in utilization. Outpatient attendance increased (threefold in Khyber Pakhtunkhwa, twice in Balochistan, and by 25 percent in Sindh; TRF 2010). Staffing and physical conditions of facilities improved. And there were greater levels of satisfaction with PPHI managed services.
- *Health insurance for the poor.* The Benazir Income Support Programme (BISP) in 2012 launched a pilot health insurance scheme in the first government initiative aimed at protecting poor households from the costs of catastrophic illness that involves hospitalization. Coverage is limited to the beneficiaries of BISP, who are identified through a poverty score card. The State Life Insurance Company has been contracted for managing the inpatient package of services. The initiative is financed directly by the federal budget. Launched in Faisalabad District, BISP aims to expand the program to the entire country. The progress of the pilot will be carefully monitored and evaluated before scaling up.

Key Issues in the Health Sector

Health outcomes are influenced by several factors, some outside the health sector such as poverty, education (particularly for girls), and environmental (sanitation and water supply) factors. With challenges in most of these, the sector faces a range of key issues.

Inequities in health outcomes and access to services

Wide inequities persist in nearly all health outcomes and access to services between rich and poor (the most pronounced) and between rural and urban regions. Under-five mortality and fertility rates of the poor are twice as high as those for the wealthiest households, while malnutrition, particularly stunting, is more prevalent in rural areas:

46 percent of rural children are stunted compared with 37 percent in urban households. Health service use also varies markedly by economic status and region, with the rural poor having substantially lower use than the urban poor.[3] Immunization rates for children from the poorest urban households are comparable with those of rural children from the richest. Contraceptive prevalence among urban households in the lowest quintile is higher than for rural households in the top quintile. Significant interdistrict variations in coverage of health services are observed in Balochistan, Khyber Pakhtunkhwa, and Sindh (Pakistan Bureau of Statistics 2011), which to some extent reflect differences in socioeconomic development and communities' remoteness.

A few efforts have been made to target services to poorer communities and to more remote districts, although the potential of the LHW Program and contracting out to the nongovernmental organization (NGO) under the PPHI has not been fully exploited. With more LHWs, some progress is being made to cover less advantaged areas, but the program has been unable to reach the poorest areas due to difficulties in recruiting LHWs given the limited supply of women in these areas who meet the program's minimal educational requirements (OPM 2009). To ensure a focus on the poor would require explicit mention of the objective in the service package to be delivered by NGOs and in the monitoring and evaluation (M&E) component of the PPHI contract.

Gender disparities have diminished over time. Sex differentials in child mortality have narrowed but have not disappeared. The lower mortality of boys ages 1–5 is attributed to better health care (Table 3). Research on determinants of nutrition in Pakistan has not found any significant differences in nutritional outcomes among boys and girls (Arif and others 2012; World Bank 2005). Differences in immunization coverage have also narrowed, although girls are still less likely to be fully immunized than boys. Improvements in women (even in rural settings) seeking health care during pregnancy and in skilled birth attendance partly reflect efforts to address gender constraints through expansion of the LHW Program and more deployment of trained community midwives in rural communities (see Table 2).

Low public spending on health

Total health spending in Pakistan is extremely low relative to other countries in the region as well as to countries at similar levels of development. About $22 per person was spent on health in 2009 (against an average of $41 in Southeast Asian countries). About 70 percent comes from private sources, mainly out of pocket by households at the point of care. Few households have access to financial risk protection against catastrophic diseases and accidents, even though such health shocks, attendant income losses, and associated out-of-pocket payments greatly increase the risks of impoverishment.

Table 3 Differences in health status and service coverage

Indicators	Total fertility rate	Under-five mortality rate (per 1,000 live births)	Child mortality rate (ages 1–5)	Contraceptive prevalence rate (modern methods)	Births attended by skilled personnel (percent)	Prenatal care by skilled provider (percent)	Children ages 11–23 months immunized (percent)
By wealth quintile							
Poorest	5.8	121	30	12.4	15.0	36.9	25.9
Richest	3.0	60	8	31.6	77.3	91.9	63.7
By area of residence							
Urban	3.3	78	13	29.9	60.0	78.1	54.2
Rural	4.5	100	20	17.7	30.0	53.4	44.0
By gender							
Male		93	14				49.8
Female		93	22				44.3

Source: National Institute of Population Studies and Macro International 2008.

Public funding on health was less than 0.86 percent of GDP in 2010, compared with at least 3–4 percent in other low-income countries, even though in 2008/09–2010/11 total public health and population welfare expenditure increased 36 percent in nominal terms to more than PRs 122 billion ($1.34 billion).[4] The increase was largely attributable to higher current spending, which rose from 66 percent of the total to 72 percent—reflecting a 50 percent increase in salaries of provincial employees—while development expenditures fell, even in nominal terms, from 34 percent to 28 percent. Population welfare spending remained low, at 3.2 percent of the total, declining in real terms.

At a more disaggregated level, in provinces in 2008/09–10/11 district nonsalary expenditures stayed low (TRF 2011). District budgets cover primary and secondary care facilities, including basic health units, rural health centers, tehsils, and district headquarter hospitals. In Khyber Pakhtunkhwa and Punjab, the district share of overall expenditures remained at around 30 percent, comprising current expenditures only as the districts receive no allocation for development funds. Nonsalary expenditure accounted for only 14 percent of the total in Khyber Pakhtunkhwa and 25 percent in Punjab.

Provincial revenues have recently increased. Changes in the National Finance Commission award have considerably enhanced the provinces' fiscal space by sharply raising their share in the divisible tax pool, and the 18th Amendment devolved sales tax on services, a buoyant source of revenue for the provinces. These decisions raised transfers to the provinces by 23–28 percent, with greater benefits to Balochistan and Khyber Pakhtunkhwa. In addition, the federal government is committed to financing the devolved vertical health programs until the next award in 2015. The amounts involved are substantial. In 2010/11, the federal government share of total expenditure was 19 percent, nearly two-thirds for development programs (including vertical national health and population welfare programs).

A major concern since the 18th Amendment is whether the additional provincial resources will be used for national priorities. Such resources include preventive and primary health care services and nonsalary spending, all grossly underfunded and essential for facilities to function effectively. Past trends in provincial spending raise some concerns about lack of prioritization and political will to invest in these areas. Today, there is no instrument to incentivize provinces to focus on priority services.

Weak management and governance

Poor health performance is due mainly to weak management and governance, including widespread staff absenteeism, centralized management, and weak stewardship.

Staff absenteeism is the most serious manifestation of weak management and governance, including lack of accountability in public health services. According to facility-based surveys in Balochistan and Sindh, most doctors were absent from their assigned posts. The absentee rate was 58 percent in Balochistan while in Sindh 45 percent of doctors were absent from basic health units and 56 percent from rural health centers (World Bank 2010). They can get away with this because of political patronage and managers' weak administrative authority, who are not in a position to fire public sector staff. Political interference is also prevalent in appointments and postings, resulting in lack of merit-based recruitment and frequent transfer of managers.

Poor staff performance reflects systemic problems of weak motivation due to rigidity of civil service rules, which provide few performance incentives or flexibility for managers to innovate. Contracting out management has worked in Pakistan and elsewhere largely because it can circumvent civil service regulations and provide the necessary economic incentives and autonomy to managers (Loevinsohn and Harding 2004). The success of the PPHI and similar contracting-out experience after the earthquake in Battagram District in 2005 is thanks to capable managers who were motivated, well paid, and granted wide autonomy. Such autonomy included flexibility in fund management through a single line budget, full administrative authority for hiring and firing staff, and scope for providing financial incentives to attract staff,

particularly female providers who were in short supply.

Overly centralized management further erodes accountability and efficiency. Efforts to decentralize service delivery under the Devolution Plan of 2001 were unsuccessful as increased responsibility for basic health services was not associated with the requisite authority at the district level to allocate resources or manage human resources, both of which remained largely with provincial governments. Thus provincial governments remained occupied with service provision, with little time for oversight. Centralized management of vertical programs and other service delivery institutions left little time for the Ministry of Health to focus on its stewardship role, causing neglect of key public health functions including policy formulation, oversight, M&E, surveillance, and regulation. Capacity for stewardship functions was lacking at provincial and federal levels.

But the 18th Amendment provides an opportunity to delineate clear channels of accountability, effectively integrate services, and focus on stewardship roles, but also raises major challenges (WHO and others 2012; Nishtar 2010). The most pressing issue concerns inadequate federal institutional arrangements. After the Ministry of Health was dissolved, federal functions were assigned to federal entities with little experience or motivation for taking them on. The fragmented setup led to problems of coordination between these entities, between federal and provincial governments, and with donors. The lack of a central authority left the provinces with little technical support or guidance for their new responsibilities.

Programmatic issues—unmet need for family planning and the burden of malnutrition

Programmatic achievements have been few in reducing fertility and tackling malnutrition, with barely any change in outcomes or intermediate indicators. Family planning, in addition to reducing the mortality of mothers, infants, and children, also greatly boosts primary schooling rates and women's empowerment. Fertility decline also contributes to growth by increasing the relative size of the workforce and reducing the dependency burden. The long-term benefits of early childhood interventions in nutrition on adult health, economic productivity, and lifetime earnings are well documented.

Unmet need for family planning. Pakistan is the world's sixth most populous country, whose population of 180 million is likely to double in about 39 years if current growth rates persist. It will face a huge challenge in meeting the basic needs of this rising population, which will undermine its ability to sustain solid economic growth. Some of the indicators are worrying. The fertility decline from 5.6 children per woman in 1990/91 to 4.1 in 2006/07 was much slower (and later) than that in any of its neighbors. The contraceptive prevalence rate has stagnated over the last decade at half the rate of other South Asian countries. And the unmet need for family planning is rising—as is unwanted fertility. The increased demand without any changes in contraceptive use can partly be explained by access constraints and poor quality of service provision. One in four women who want to avoid pregnancy is not using any form of contraception, while two-fifths of pregnancies are unwanted (National Institute of Population Studies and Macro International 2008). Women from poorest households have the highest unmet need.

Although Pakistan was one of the first countries to establish a family planning program in 1965, the decline in fertility that started in the early 1990s was much later than in most of South Asia. A comparison with Bangladesh is illustrative, as the two counties started with identical levels of fertility and similar sociocultural contexts. Between 1971 and 2011, fertility in Bangladesh declined steeply from 6.3 children per woman to 2.3. Bangladesh virtually stabilized population growth as it made its program a top development priority with a broad coalition of support. In contrast, Pakistan's program has suffered from wavering political commitment and has not been central to the development agenda. Having two separate ministries (of population welfare and of health), with vertical structures going down to service outlets, was not only inefficient but also marginalized population issues at the Ministry of Health, which failed

to fully own the program. Government spending on population, which increased during the 1990s, also shows a declining trend in more recent years—for example, no new initiatives have been launched to increase contraceptive use since social marketing was introduced and expanded in the late 1990s and the LHW Program was expanded in the first half of the 2000s.

Nutritional outcomes have not improved over the last two decades—worse, they have deteriorated for some indicators. Pakistan has made little attempt to systematically address the causes of malnutrition—it has not made them a priority, as reflected in the lack of an institutional home or a clear strategy. It has carried out a few fragmented interventions, mainly to address micronutrient deficiencies (primarily vitamin A supplementation and salt iodization). More recently, Pakistan has started to develop a broader nutrition strategy and program in line with the international consensus on an action framework for scaling up nutrition. The strategy needs to be based on a two-pronged approach: addressing the determinants of nutrition through a multisectoral approach, and implementing and scaling up well-proven direct nutrition interventions through the health sector.

Policy Recommendations

Improve targeting of health services to the poor

Interventions and resources need to be better targeted to the poor as well as to lagging districts and regions. Further expansion of the LHW Program is necessary because those regions not yet covered by it are the most disadvantaged. Yet a constraint to further expansion is the difficulty in recruiting workers with the minimum educational requirements as well as the lack of functional health facilities in the underserved areas. To increase coverage, condensed-education courses to motivate girls to become LHWs and mobilization of disadvantaged communities to support the LHWs should be implemented. Another promising option to expand coverage is to contract NGOs, as they have greater flexibility to reach out to populations in difficult areas (see below).

Increase expenditure on health

Efficiency of resource use can be greatly increased, but provincial governments also need to boost spending, given the very low public health expenditures. In particular, district budget spending on the nonsalary component is grossly inadequate and needs to be raised substantially. Stronger funding is also needed if the reforms and policy options in this note are to be carried out.

Federal government support to vertical programs would be more effective and would inculcate greater ownership if it were financed through development grants and were incorporated in the provincial annual development program. In the medium term, provincial allocations need to expand considerably to finance the vertical programs, particularly the LHW Program and other devolved institutions now supported by the federal government. The federal government may also need to provide conditional grants to ensure that provincial policies are aligned to national priorities in areas such as fertility reduction and nutrition, as otherwise they may not receive the required attention and resources. This support could be in the form of results-based financing or tied grants.

Strengthen health sector management and accountability

The 18th Amendment will require a medium- to long-term implementation plan to fully realize its potential for responsive and accountable governance. Supportive measures to manage the transition should include:

- Establishing a federal institution, possibly under the Ministry of Inter-provincial Coordination, responsible for national functions in health that are currently dispersed across different ministries.
- Delineating and clarifying roles and responsibilities for structures within provincial departments.
- Expanding merit-based recruitment of staff and building capacity in key areas at federal and provincial levels.

- Undertaking an assessment of staff capacity requirements to prioritize needs.
- Finalizing and approving provincial health strategies.

Service delivery should ideally be devolved to district governments along with the necessary administrative and spending powers. The 18th Amendment recognizes the third tier of local government, but the district government's role and responsibilities are defined by the provinces in the Provincial Local Government Ordinance Act. As all provinces have opted for greater provincial control, the best option would be a deconcentrated system, with administrative powers at the district level.

A stronger focus on results and M&E is a central element of the health sector management and accountability reforms. The federal government has an important role in M&E of provincial performance to track progress toward priority areas and to serve as the basis for advocacy with the provinces. A central role is also necessary for ensuring consistency in methods and instruments in data collection and indicators, for collating evidence, and for reporting progress at international forums. The provincial departments require data and analysis for feeding into the planning and policy-making process, to monitor implementation, and to improve service delivery. Given the wide variations in health sector performance, provincial governments should carefully track and then share information on district health performance (partly as an accountability mechanism but also to find out where special efforts are required). Poorly performing districts should receive special programmatic and technical support.

A basic prerequisite for these tasks is a well-functioning M&E system. This entails sound information systems and strengthened capabilities for data analysis, possibly through existing structures such as the National Health Information and Resource Centre or the Health Systems Strengthening Project at the federal level and the Health Sector Reform Units in provincial departments. Investment is required in improving quality, completeness, and timely availability of District Health Information System data to monitor performance of government health services. In addition, information from population-based surveys regularly conducted by the Federal Bureau of Statistics should be used.

The PPHI model is a viable option for improving performance of first-level care facilities through greater managerial autonomy, including flexibility in funding and full administrative powers to hire and fire. The approach should be further strengthened through the following measures at the provincial level:

- Adopting a package of primary health services covering preventive and promotive care.
- Granting managers control of all aspects of the primary health system, including basic health units, rural health centers, vaccinators, and LHWs.
- Selecting NGOs through a competitive process and bring in performance-based contracts with a greater focus on monitoring.
- Contracting NGOs to improve coverage of remote rural areas where provision of public services is constrained by staffing difficulties with an explicitly stated objective of the service package and of the M&E component of the contract.
- Building capacity of government counterparts in contract management and monitoring.

Expand provision of family planning and nutrition services

Pakistan needs to prioritize family planning and nutrition. It needs to invest in improving provision and quality of family planning services, focusing on rural areas where supply constraints are more severe, and should pursue the following measures:

- Ensuring coverage of family planning services through all public health outlets.
- Ensuring the provision of skilled staff and family planning products to make a broad range of contraceptive methods available.
- Broadening social marketing of family planning by expanding services to rural areas, where possible using performance-based contracts with the private sector.

- Promoting male involvement, including through information and services by trained male paramedics or doctors in health facilities.

Pakistan has to invest heavily and systematically in order to address malnutrition on a broad scale. It should do this by:

- Prioritizing nutrition in the national development agenda and assuring resources to carry out multisectoral provincial nutritional plans through interventions in education, agriculture, social protection, and water and sanitation.
- Ensuring implementation of provincial plans for scaling up nutrition interventions through the health sector for vulnerable women and children. The plans include promoting exclusive breast-feeding, promoting adequate complementary feeding, addressing micronutrient deficiencies, treating severely malnourished children through community-based approaches, and controlling childhood infections and increasing immunization.
- Building institutional capacity for nutrition in the health sector and in a coordinated multisectoral approach.

Notes

1. All data are from the Pakistan National Nutrition Survey 2011 unless otherwise indicated. The 2011 survey is the first to provide representative data for each province. By comparison, India is 48 percent, Nepal 45 percent, Bangladesh 43 percent, the Democratic Republic of Congo 43 percent, and Sri Lanka 17 percent.
2. Indicators are based on the Pakistan Social and Living Standard Measurement Survey (PSLM), except for immunization (Masud and Navaratne 2012). PSLM data were not used for immunization because of the large divergence between immunization rates based on PSLM and other data sources, including the Pakistan Demographic and Health Survey and Multiple Indicator Cluster Survey. The high rates of immunization reported in PSLM are also not in line with the continued outbreaks of vaccine-preventable diseases such as measles. In the case of other indicators for maternal care services, the figures are comparable across the different surveys.
3. A breakdown of data by expenditure quintile and by rural–urban status was available in PSLM only through 2005/06.
4. Data are from the Ministry of Finance's Poverty Reduction Strategy Progress Reports 2003–08 and TRF (2011). Expenditure data for Azad Jammu and Kashmir, Gilgit–Baltistan, Federally Administered Tribal Areas (FATA), and autonomous organizations were not included.

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