

HEALTH

3.1 Introduction

The Government health strategy under PRSP and MDGs focuses on young children and their mothers, particularly in rural areas. One of the most pressing needs addressed by Government is to improve women's access to government health care. There are six indicators i.e. Infant mortality rate, Proportion of fully immunised against measles, Proportion of children under five who suffered from diarrhoea in last 30 days and receive ORT, Pre and Post Natal consultation, Lady Health workers coverage of target population, Proportion of births attended by skilled birth attendants for monitoring MDG's health indicators. The Government's strategy for health includes:

- Improving the efficiency and utilisation of basic health care services, both preventive and curative;
- Improving programme design by paying more attention to quality;
- Increasing access to health care by constructing more facilities;
- Increasing women's access by recruiting more female staff; and,
- Promoting community participation in the design and management of health care services.

In this chapter, information is presented on a number of key indicators of progress in the health sector. These include immunisation; diarrhoea; infant mortality; access to health facilities; pre-and post-natal care; and health facility characteristics.

3.2 Immunisation

Expanding the coverage of immunisation in Pakistan is a primary objective of Government. Measuring immunisation coverage in household surveys is not easy. Parents often do not have the children's immunisation/health cards with full information on vaccinations received. Immunisation rates based only on the information given on immunisation cards ('record') may therefore underestimate coverage. However, it has the benefit of using written information recorded by health workers.¹ The alternative is to ask parents about their child's vaccination history, and calculate coverage rates using this information ('recall'). This runs the risk that parents will not remember vaccinations will confuse different types of vaccine or will confuse other injections with vaccination.

¹ Note that even the record-based measure cannot be based exclusively on vaccinations recorded on the health card, since it is not possible to identify the source of the information on each antigen. Instead, it is calculated for all children who had a health card, using all immunizations reported, whether or not these were recorded on the card. It is likely that most will have been recorded on the card.

Neither measure is ideal; both are presented in this report to help make an informed judgement on trends. In this report, both of these measures use all children of the appropriate age range in the denominator.

According to the WHO guidelines, a child should receive a BCG vaccination to protect against tuberculosis, three doses of DPT to protect against diphtheria, pertussis, and tetanus, three doses of polio vaccine, and a measles vaccination. Table 3.1 presents immunisation rates for children aged 12-23 months, who have been immunised during the period 12 to 24 months prior to the survey. At least one immunisation based on recall has shown significant increase which is 94 in 2005-06 compared to 83 percent for 2004-05. The values reported for at least one immunisations for 2001-02 have been recalculated for comparison as this report and PIHS also includes vaccination of Polio by campaign where as 2004-05 includes only routine vaccination that completes in nine months. Overall, when recall measures are included, full immunisation rates (all the 8 recommended vaccines) showed decrease from 77 percent in 2004-05² to 71 percent in 2005-06. The reduction in full immunization based on recall and record basis may be due to mixing up of polio campaign with the routine immunization in 2004-05 which was taken care off in 2005-06 survey through intensive training and this is evident from the fact that record based immunization remains at 49 percent in 2005-06 as well as in 2004-05

When considering the record based measure immunisation rates have increased in rural areas. By and large, all provinces have shown significant improvement except Sindh.

Coverage by antigen is given in Tables 3.2 and 3.3. The former is based on record, the latter on record plus recall. For record-based measure, there is a general improvement in the coverage of all antigens in 2005-06 compared to 2004-05, but coverage of all antigens based on record shows decline in Sindh, which follow the similar pattern of immunization reported in table 3.1. For measures that include recall, the trend for all antigens is positive.

Table 3.4 shows the relationship between quintile and full immunisation. The relationship is strong in urban areas, where 37 percent of children in the first quintile (families with lowest consumption level) are fully immunised compared to 64 percent in the fifth quintile (families with highest consumption level) in overall Pakistan. The similar increasing trend is also observed in the provinces of Punjab, Sindh and NWFP.

3.3 Diarrhoea

Dehydration caused by diarrhoea is a major cause of mortality among children. Childhood diarrhoea has been a serious health problem in Pakistan. Both its prevention, through improved water and sanitation and the treatment of dehydration through oral re-hydration salts (ORS) are goals of government. Home management of diarrhoea through

² Full immunization means that the child has received: BCG, DPT1, DPT2, DPT3, Polio1, Polio2, Polio3 and measles.

oral re-hydration salts (ORS) or a recommended home fluid (RHF) - can prevent many of these deaths. Preventing dehydration by increasing fluid intake is important strategy for managing diarrhoea.

It was asked to report whether a child had diarrhoea in the 30 days prior to the survey. If so, a series of questions were asked whether they have consulted someone for it or not and about whether ORS has been given to child or not.

Overall the percentage of children who have suffered from diarrhoea in the 30 days decreased from 16 percent in 2004-05 to 12 percent in 2005-06. By province Punjab and NWFP have shown increase in diarrhoea cases while Sindh and Balochistan have shown decrease in both urban and rural (Table 3.5). In addition, the proportion of cases that lasted for between 8-14 days has shown noticeable decreased (Table 3.6). However, the severity of episodes measured in terms of number of motions per day has increased (Table 3.7). While surprisingly, there does not appear to be any consistent relationship between quintiles and the incidence of childhood diarrhoea (Table 3.8).

In 86 percent of diarrhoea cases a practitioner of some kind was consulted. This represents an improvement as compared with 83 percent in 2001-02, however it has decreased as compared to 91 percent in 2004-05. The use of ORS in diarrhoea cases in overall urban area has increased from 78 percent in 2004-05 to 80 percent in 2005-06. ORS is less used in Punjab as compare to other provinces. ORS is more or less equally used in NWFP urban and rural areas.

In cases of diarrhoea, the most likely practitioner to be consulted continues to be a private practitioner 65 per cent in 2005-06 (Table 3.9). Government facilities remain same as compared to 2004-05. Basic health units (BHU) and rural health centres (RHC) consulted only 4 percent of cases in rural Pakistan (Table 3.10), which gives some indication of the very limited use of the government primary health network for these kinds of curative services. Cases that consult a government practitioner first as a share of all cases that consult any other practitioner has decreased between 2001-02 to 2005-06.

The mothers were asked why they did not take their child to a government practitioner, in cases where another practitioner was used. The reasons most often cited concerned lack of access: 'no government facility' 19 percent or 'too far away' 27 percent (Table 3.12).

3.4 Infant mortality

There has been a decline in IMR from 82 per thousand live births in 2001-02 to 70 per thousand live births in 2005-06 (Table 3.14). The infant mortality rate for urban areas is 41 where as it is 82 in rural areas. This indicates that there is improvement in health care system more particularly in urban area. Table 3.15 shows the relationship between infant mortality and mother's education. As expected infant mortality rate is substantially higher for mothers with "education class 1-4" 84 per 1,000 live births and

declines as mother's education level increase. It is 26 per 1,000 live births when the mother completed class 10 or higher education.

3.5 Pre-and post-natal care

Quality prenatal care can contribute to the prevention of maternal mortality by detecting and managing potential complications and risk factors, including pre-eclampsia, anaemia, and sexually transmitted diseases. Pre-natal care also provides opportunities for women to learn the danger signs of pregnancy and delivery, to be immunised against tetanus, to learn about infant care, and be treated for existing conditions, such as malaria and anaemia.

Some 52 percent of mothers who had given birth in the last three years went for pre-natal consultations during their last pregnancy (Table 3.16). The attendance rate was much higher in urban 74 per cent than rural areas 42 percent for overall Pakistan. Attendance rates have increased in urban as well as rural areas from 66 in 2004-05 to 74 in 2005-06 and 40 in 2004-05 to 42 in 2005-06 respectively. In urban areas, Punjab has the highest attendance 82 percent whereas NWFP urban 53 percent has the lowest. In Pakistan, the three most commonly consulted sources were private hospital/clinic 48 percent, government hospital/clinic 37 percent.

Tetanus toxoid injections are given to women during pregnancy to protect infants from neonatal tetanus, a major cause of infant death that is due to primarily unsanitary conditions during childbirth. In addition these injections protect women from developing tetanus themselves or suffering from sepsis. Two doses of tetanus toxoid during pregnancy offer full protection. However, if a woman was vaccinated during a previous pregnancy, she may only need a booster to give full protection. Five doses are thought to provide lifetime protection. Some 62 percent of mothers had received a tetanus toxoid injection during their last pregnancy compared with 51 percent in 2004-05 (Table 3.17).

Some 50 percent of births takes place at home (Table 3.18). Where as in rural areas, 61 percent compared to 36 percent in urban areas. The most commonly cited source of assistance in rural areas was doctor 39 percent followed by trained dai, & traditional birth attendant 34 percent of cases.

Overall 22 percent of mothers received a post-natal check up within six weeks of delivery during their last pregnancy in 2005-06 (Table 3.19) which is almost at the level in 2004-05. Urban areas had higher rates than rural areas, though both were low. The three most commonly cited sources of post-natal care in rural areas were private hospital/clinic 43 per cent, government hospital/clinic 28 percent, and traditional birth attendant at home 10 percent.

The vast majority of mothers, some 96 percent, breast fed their last child (Table 3.20). There was very little difference between regions and provinces. By the age of 6 months, some 91 percent of mothers were giving the child semi-solid foods.