

## **3. HEALTH**

### **3.1 Introduction**

The Government health strategy 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. The Government's strategy for primary 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,

In this chapter, information is presented on a number of key indicators which include percentage of population who get sick or injured, type of health consultation, immunisation; diarrhoea; pre-and post-natal care.

### **3.2 Sick or injured**

7.1% of the population reported sick or injured during the reference period of two weeks prior to the date of interview. Sindh and NWFP with 8.11% and 8.79% respectively have comparatively higher prevalence of sick or injured population compared to Punjab and Balochistan. Prevalance of sickness / injuries is lower in most of the districts in the Punjab compared to other provinces, Bahawalpur with 12.12% prevalence is at the top. Bahawalpur (Punjab), Lakki Marwat (N.W.F.P), and Jhal Magsi ( Balochistan) districts with little over 12% have the highest prevalence rates among all the districts. Almost 93% of reported as sick or injured had some type of health consultation. Over 67% of sick or injured persons consulted private hospitals or doctors compared to 22.8% who visited public hospitals/ dispensaries/ RHCs /BHUs for their treatment (Table 3.3). The pattern of health consultation in districts for public and private hospitals / dispensaries is the same which has been observed at National/ Provincial level.

### **3.3 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.<sup>1</sup> 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. Neither measure is ideal; both are presented in this report to help make an informed judgment 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 3.4 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 is 83 per cent overall as compared to 74 percent for PIHS 2001-02. The values reported for at least one immunisations for PIHS 2001-02 have been recalculated for comparison as PIHS also includes vaccination of Polio by campaign where as PSLM includes only routine vaccination that completes in nine months. Overall, when recall and record measures are included, full immunisation rates (all the 8 recommended vaccines) showed a positive increase from 53 per cent in 2001-02 to 77 per cent in 2004-05.<sup>2</sup> . For fully immunised based on recall and record Jhelum with 99%, Hyderabad 88%, Chitral 100%, and Gwadar 97% are top ranked districts in the Punjab, Sindh, N.W.F.P, and Balochistan provinces respectively.

Using the measure that includes recall, there is an increase in full immunisation rates for both urban and rural areas, but in rural areas it is particularly impressive going from 46 per cent in PIHS 2001-02 to 72 per cent in PSLM 2004-05. When considering the record based measure immunisation rates improved in urban areas as well as rural areas. Considerable improvement is shown in rural Sindh from 6 per cent in PIHS 2001-02 to 32 per cent in PSLM 2004-05 where as NWFP has shown a slight decline for record based measurements for full immunisation (46 per cent in PIHS 2001-02 to 42 per cent in PSLM 2004-05).By and large, all provinces have shown significant improvement in measures that includes recall and also in record.

Coverage by antigen is given in Tables 3.5 and 3.6. The former is based on record, the latter on record plus recall. Both measures have shown general improvement in the coverage of all antigens as compared with 2001-02.

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<sup>1</sup> 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 immunisations reported, whether or not these were recorded on the card. It is likely that most will have been recorded on the card.

<sup>2</sup> Full immunisation means that the child has received: BCG, DPT1, DPT2, DPT3, Polio1, Polio2, Polio3 and measles.

### 3.4 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 rehydration salts (ORS) are goals of government. Home management of diarrhoea through oral rehydration 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 increased from 14 per cent in PIHS 2001-02 to 16 per cent in PSLM 2004-05. By province Punjab and Sindh have shown increase in diarrhoea cases while NWFP and Balochistan have shown decrease. Bahawalpur 28% in the Punjab province, Larkana 30% in Sindh, D.I Khan 29% in NWFP and Gwadar 34% in Balochistan province are the most affected districts within each province. (Table 3.7).

In 91 per cent of diarrhoea cases a practitioner of some kind was consulted. This represents an improvement as compared with 83 per cent in 2001-02 PIHS. The pattern of practitioner consultation in districts of Punjab(except Kasur 77%),Sindh (except Tharparker 77%) and N.W.F.P is the same. However, in Balochistan Province pattern is mix with the exception of Musa Khal district having 45% consultation rate (Table 3.8). The use of ORS in diarrhoea cases has increased to 78 per cent in 2004-05. ORS is most likely to be used in Sindh NWFP and Balochistan, whereas its use is lowest in Punjab. ORS is more or less equally used in NWFP urban and rural areas, except in rural Balochistan. The pattern within the districts is more or less the same, which has been observed at provincial levels.

In cases of diarrhoea, the most likely type of practitioner to be consulted continues to be a private practitioner 68 per cent in PSLM 2004-05 (Table 3.9) as observed in PIHS 2001-02. Government facilities shows decline as compared to PIHS 2001-02(20 to 15 per cent). Basic health units (BHU) and rural health centres (RHC) consulted only 5 per cent of cases in rural Pakistan, which gives some indication of the very limited use of the government primary health network for these kind of curative services. However , in Balochistan 52% diarrhea cases were consulted by government facilities and in most of the districts, government facilities such as hospitals, Dispenseries and BHUs were consulted.

### 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 50 per cent of mothers who had given birth in the last three years went for pre-natal consultations during their last pregnancy (Table 3.10). The attendance rate was much higher in urban (66 per cent) than rural areas (40 per cent). Attendance rates have increased in urban as well as rural areas. In rural areas, Punjab has the highest attendance and Balochistan the lowest. Attock & Sialkot 80% , Karachi 81%, Abbotabad 71% and Gwadar 72% are at the top ranks within the provinces. In rural Pakistan, the three most commonly consulted sources were private hospital/clinic (34 per cent), government hospital/clinic (25 per cent) and Home TBA (16 per cent).

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 51 per cent of mothers had received a tetanus toxoid injection during their last pregnancy compared with 46 per cent in the 2001-02 PIHS Sialkot (87%) in the Punjab, Karachi (72%) in Sindh, Peshawar (63%) in N.W.F.P and Panjgur(50%) in Balochistan are at top ranks within the provinces. (Table 3.11).

The vast majority of births, some 71 per cent, takes place at home (Table 3.12). In rural areas, some 81 per cent were at home compared with 56 per cent in urban areas. The most commonly cited source of assistance in rural areas was a trained dai,& traditional birth attendant (53 per cent of cases), followed by family member/relative (26 per cent). Bhakhar (92%) in the Punjab, Tharparker (88%) in Sindh, Kohistan (99%) in N.W.F.P and Awaran (99%) in Balochistan are the highest ranked districts ,where child was delivered at home.

Post-natal consultation rates even though improved in 2004-05 were much lower than the pre-natal rates cited above (Table 3.13). 23 per cent of mothers received a post-natal check up within six weeks of delivery during their last pregnancy in 2004-05 compared to 9% in 2001-02. Urban areas had higher rates than rural areas, though both were low. Islamabad (50%) followed by Karachi (45%) are the top two districts for post natal consultations.

The three most commonly cited sources of post-natal care in rural areas were private hospital/clinic (39 per cent), government hospital/clinic (24 per cent), and traditional birth attendant at home (15 per cent).