Draft

EVIDENCE BASED ASSESSMENT ON INTEGRATION OF HEALTH RELATED HUMAN RIGHTS IN PUBLIC HEALTH RESPONSE of PAKISTAN

November 2014

World Health Organization
COUNTRY OFFICE FOR Pakistan

Table of Contents

Acknowledgements

The publication is the product of contributions by several individuals. The publication was researched and developed by Dr. Farzana Bari. Technical contributions were also received from Ms. Masooma Butt and Dr. G.N.Kazi, WHO Pakistan and Dr. Hala Abou-Taleb, WHO Regional Office for the Eastern Mediterranean.

Abbreviations/Acronyms

AAAQ Availability Accessibility, Acceptability &Quality

ASRH Adolescent Sexual & Reproductive Health

ASRHR Adolescent Sexual & Reproductive Health Rights

BCC Behaviour Change Communication

BPFA Beijing Platform for Action

CEDAW Convention For Elimination Of All Form Of Discrimination Against Women

CCA Common Country Assessment

CSDH Commission on Social Determinants of Health

CSO/s Civil Society Organization/s

DHS Demographic Health Survey

EVAW/G Ending Violence Against Women/girls

HDI Human Development Index

GBV Gender Based Violence

GEP Gender Equity Program

GII Gender Inequality index

GoP Government of Pakistan

HRBA Human Rights Based Approach

ICPD International conference on Population & Development

INGO /s International Non Governmental Organization/s

ILO International Labour Organization

JICA Japan International Cooperation Agency

MDG Millennium Development Goals

NCSW National commission on the status of women

NNGO/s National Non Governmental Organization/s

PC Planning Commission

PRHN Pakistan Reproductive Health Network

RH Reproductive Health

RHR Reproductive Health Rights

SRH Sexual & Reproductive Health

SRHR Sexual & Reproductive Health Rights

UDHR Universal Declaration of Human Rights

UN United Nations

UNDAF United Nations Assistance Framework

UNICEF United Nations Children's' Fund

UNFPA United Nations Fund for Population

UNHCR United Nations high commissioner for Refugees

USAID United States Agency for International Development

VAWGC Violence Against Women Girls Children

VAW Violence Against Women

WB World Bank

WHO World Health Organization

Executive Summary

WHO Pakistan is fully committed to strengthen and deepen the HRBA in all its operations. The WHO country office in Pakistan in collaboration with WHO regional office for the Eastern Mediterranean (EMRO) has commissioned this evidence based assessment to gauge the integration of HRBA in public health response in Pakistan.

The main objective of the assignment was to conduct evidence based situation analysis on the integration of rights based approach in health policies, strategies and governance and to provide strategic guidance for the realization of right to health.

The WHO tool "Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence" is designed to support country assessments of the health sector from a human rights perspective. The assessment on the integration of human rights perspective, norms and principles in the design, implementation, monitoring, and evaluation of health-related policies and programs in Pakistan was conducted with the support of the tool developed by WHO.

The assessment was primarily based on desk and web review. The literature review includes the review of national data bases, health related laws, human rights instruments, national health policy; provincial health strategies, relevant reports of the government of Pakistan and health development partners in particular WHO, UNFPA and UNICEF. The research produced in the academic and in NGO sector is also included. The document contains selected text and information largely from the PDHS 2012-13 and PSLM 2012-13.

The information in this document is organized into three main chapters. First chapter sets the context of the assignment. Second chapter briefly describes the methodology, data sources and constraints. The third and final chapter discusses and analyzes legislations with direct and indirect impacts on health, human rights and health linkages in the health sector and programs. A very critical part of this chapter is the analysis of the existing four provincial strategies on health.

The most important and alarming outcome this entire exercise is the finding the national commitment on health as a human right has yet to be translated into practice. The situation analysis of the health sector from HRBA points out the multiple failures of the state and the market.

Apart from a slow progress made on some of the health indicators, the overall health scenario in the country remained dismal. Pakistan is lagging far behind on health indicators in the region and in all its likelihood going to miss MDG's targets.

The rights-based approach is about integrating human rights norms and principles in the design, implementation, monitoring, and evaluation of health and health-related policies and programmes.

In practice this means availability and accessibility of culturally sensitive, quality healthcare services to all without any discrimination on the basis gender, religion, ethnicity or other social division. The respect of human dignity, privacy and special focus on the socially excluded and

vulnerable groups is essential. The participation of people in decision-making processes and the provision of responsive and robust accountability mechanisms within the health system are central to the human rights based approach to health.

The need of the hour is to understand and accept Health as a human right is not only a legal but a political discourse as well. The global shift in the health paradigm from a medicinal phenomenon to a complex multidimensional social phenomenon is transformative in nature. It contends that inequity in health is a result of interplay of socio-cultural, economic and political structures and processes. A holistic approach that addresses structural as well functional issues in the health sector is the only way forward towards achieving the health as a multidimensional human right for all.

Based on this assessment of heath sector from the HR perspectives, the following steps are recommended that will lead to the realization of health that is structural, legal, institutional and functional in nature.

The first step that is needed is to establish the health as a constitutional right. The second step is allocating corresponding financial resources to the legal commitment to health as a right. The third main task is to reflect national commitment to health as a human right in the health policies and strategies. The health strategies should effectively address all aspects of human health and health system from the human rights perspective. The fourth prerequisite is the good governance to make the health and health related social sector more responsive, effective and efficient. Gender and ethnically balanced health workforce with the capacity of dealing with gender and human rights in health are critical for the health system to ensure equity in health conditions. The fifth milestone is the integration of HRBA in health sector should move beyond health sector into social policy at the national and provincial level to transform policy and practice. This can only be achieved through a top-down and bottom-up political actions. Thus the political will of both “duty bearer” and “right holders” together can help advance this political agenda of right to health. Lastly, the realization of health as a right is not only an issue of redistributive justice but also how the resources are produced in the society. Inequality and poverty are built into neo-liberal macro-economic framework and the structure of growth. Despite spectacular growth in global economy, rising poverty is become a global phenomenon.

Within this larger social, political and economic context in which health is instituted as a human right in Pakistan; certain specific structural, functional, legal and constitutional interventions are suggested as the most crucial steps on the long, medium and short-term basis. These will effectively address the structural, underlying and immediate barriers to the realization of health as a human right.

Chapter 1: Introduction

All human rights are indivisible with no hierarchy amongst them. However, the right to life is the most fundamental as all other human rights stem from it. Health being central to the right to life assumes special significance in the regime of human rights. Health has been progressively more recognized not only as an intrinsic right of an individual but also a public good. There is a direct linkage between the health of the population and the productivity, growth and the development of the country.

Health as a human right has become a part of global consciousness. This awareness is clearly reflected in the numerous international legal instruments and commitments.

The majority of countries in the world have ratified most of the Human Rights conventions and covenants that obligate state parties to promote, protect and fulfill the right to health for all citizens without any discrimination on the basis of sex, religion, caste, faith, social status and ethnicity

Health is a state influenced by myriad socio-cultural, economic and political factors. The right to health is tangled up with wide spectrum of human rights which are interdependent and mutually reinforcing. There is an increasing recognition of the nexus between social conditions in which people live, work and age and the health inequalities.

People's social positioning determines their differential access to determinants of health such as education, clean drinking water, sanitation, employment and housing. Consequently, certain groups and individuals suffer more due to multiple deprivations they face due to their position of class, gender, race, religion and ethnicity.

The conceptual understanding of connectivity between health and social determinant of health demands a holistic, integrated social development policy response. Most importantly health should be viewed as a social rather than a medicalized phenomenon. Illnesses and health is a matter of individual's physiology as well as socially produced and distributed.

To explore further the linkages between social determinants and health, the WHO established a Commission on Social Determinants of Health (CSDH) in March 2005.

The Commission supports health partners in addressing social factors that leads to ill health and health inequities. The regional office of WHO in the Mediterranean region has taken research initiatives to examine the social determinants of health and its impact on health inequities in several countries (WHO Regional Publications, Eastern Mediterranean Series 31, 32, 2008).The review of seven countries in Eastern Mediterranean Region clearly showed the interconnection of social determinants and health outcome. Based on this knowledge and evidence, the Commission's advocacy for an equitable health outcome encourage partner countries to take a holistic inter-sectoral approach to tackle social determinants that affects health outcome with special focus on socially marginalized sections of the society.

It has become clear that the right to health cannot be achieved in isolation without effectively linking it with the underlying social and cultural determinants that impact on health outcomes. Provision of safe drinking water and sanitation; safe food; adequate nutrition and housing; healthy working and environmental conditions; health-related education, information and gender equity have been identified as the key health related human rights that determine the health status of people.[1]

The realization of health and health related human rights are contingent upon the larger macro-economic framework, policy priorities, socio-cultural and institutional environment of the country. Political commitment alone is not sufficient for the realization of the right to health for all and the health related human rights. The corresponding human and financial resources, efficient service delivery systems and effective accountability mechanisms are imperatives for the realization of mental and physical health rights of citizens.

The state of Pakistan is characterized multidimensional poverty[2] (45.59% of population &Share of working poor, below $2 a day is 57%), militancy and terrorism and low priorities if any assigned to key human development areas namely health (2.51 % of GDP is the latest total expenditure), education (2.37 % of GDP is the latest total expenditure) and economy. The HDI rank of the country is 146 and GII[3] is 127 out of 187 countries.

According to the latest economic Survey[4] by the GoP the state of poverty, social safety nets and population is as follows:

The official poverty line adopted by Planning Commission from Pakistan's Millennium Development Goal Report 2013 in Pakistan is estimated by using consumption based methodology, and the report provisionally shows that poverty has declined from 22.3 percent in 2005-06 to 12.4 percent in 2010-11.

[1] The monitoring Committee on Economic, Social and Cultural Rights identified these as underlying determinants of health. The Human Rights Committee is the body of independent experts that monitors implementation of the International Covenant on Civil and Political Rights by its State parties. http://www.ohchr.org/en/hrbodies/ccpr/pages/ccprindex.aspx

[2] http://hdr.undp.org/en/countries/profiles/PAK. Human Development Report 2014, Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience. The proportion of the population living in multidimensional poverty is 58% in Bangladesh, 49% in Pakistan and 44% in Nepal, and the intensity of deprivation is 50% in Bangladesh, 53% in Pakistan and 49% in Nepal. When compared to Pakistan a larger proportion of the population lives in multidimensional poverty in Bangladesh. However the intensity of deprivation is higher in Pakistan.

[3] http://hdr.undp.org/en/content/table-4-gender-inequality-index.This is for 2013. India too ranks 127 Maldives with 49 ranking performed best in South Asia. Srilanka has 75 ranking, Nepal ranks 98, Bhutan 102, Bangladesh 115, while Afghanistan is positioned at 150.The gender inequality index is a composite measure reflecting inequality in achievements between women and men in three dimensions: reproductive health, empowerment and the labour market.

[4] http://finance.gov.pk/survey/chapters_14/Highlights_ES_201314.pdf

- `The decline in poverty can be attributed due to substantial allocations for social safety net programmes like tracking of pro-poor expenditures, BISP, PPAF, better support prices of agriculture/food products etc.
- During July-December, 2013-14, Rs.588.105 billion expenditures have been made on pro-poor sectors. ` BISP has been kept continued to eradicate extreme poverty through provision of cash transfers of Rs.1200/month to eligible families. Under the 18th constitutional Amendment, the subject of Zakat has been devolved to the Provinces/Federal Areas. Up to March, 2013 a total amount of Rs.4.05 billion has been distributed to the provinces and other administrative areas for onward distribution to the needy and deserving people.
- Pakistan Bait-ul-Mal (PBM) is also making efforts for eradication of poverty by providing assistance to destitute, widows, orphans, invalid, infirm and other needy persons through different initiatives.`
- Population growth rate has shown improvement and it decreased from 1.97 percent in 2013 to 1.95 percent in 2014.
- Total population is projected at 188.02 million during the year 2014.
- Fertility Rate (TFR) declined to 3.2 children per women in 2014 as compared to 3.3 in 2013.
- Contraceptive Prevalence Rate has improved from 30 percent in 2013 to 35 percent in 2014.
- Life expectancy has also increased from 66.5 (female) and 64.6 (male) in 2013 to 66.9 (female) and 64.9 (male) in 2014.
- Crude Birth Rate has improved from 26.8 per thousand in 2013 to 26.4 per thousand and Crude Death Rate has decreased from 7.0 per thousand in 2013 to 6.9 per thousand in 2014.
- `Infant Mortality Rate decreased to 66.1 per thousand in 2014 from 67.0 per thousand in 2013.
- Urban population has increased to 72.5 million in 2014 from 69.8 million in 2013, while rural population has increased to 115.5 million in 2014 from 114.4 million in 2013.
- Total labour force has increased from 57.2 million in 2010-11 to 59.7 million in 2012-13.
- Total number of people employed during 2012-13 was 56.0 million.
- Unemployment rate has increased to 6.2 percent in 2012-13 as compared to 6.0 percent in 2010-11.

`

The poor state of health and deteriorating socio-economic conditions shows that Pakistan will miss its targets in achieving the Millennium Development Goals (MDGs), especially the goal 4 to reduce child mortality, and 5 to improve maternal health.

The MDG Acceleration Framework (MAF) a methodological framework offering governments and their partners a systematic way to identify and address bottlenecks to progress on MDG targets that are off track, is formulated by the government in consultation with all relevant stakeholders. It comprises four systematic steps for each off-track MDG target: prioritization of country-specific interventions; identification and prioritization of bottlenecks to effective implementation; selection of feasible, multi-partner acceleration solutions; and planning and monitoring of implementation.

After consultation at the federal and sub-national level, Pakistan has selected MDG 2 (Net Enrolment Ratio) for acceleration. The MAF for education specifically aims to achieve: enrolment of a maximum number of out-of-school children in primary classes; in-school retention of all enrolled children and completion of their primary education; and improvement in the quality of primary education[5].

The World Health Organization (WHO) refers to the Health System Framework for an effective response to public health needs. The framework consists of six building blocks that include:

(i) sound health leadership and governance
(ii) (quality health service deliverance
(iii) (reliable health information system
(iv) access to latest medical products (including essential medicines) and technologies
(v) rational health system financing, and
(vi) an adequate and skilled human workforce for health.[6] The human rights based approach to health demands strengthening of all these six pillars of health system.

The human rights based approach (HRBA) has gained more currency lately after the adoption of a standard approach to HRBA in 2003 by the United Nations Agencies in programming and development assistance.

The UN "Common Understanding" of the HRBA have three elements:

(a) all programs, policies and technical assistance should further the realization of human rights

(b) human rights standards and principles guide programming in all sectors and (c) focus on capacity development of duty bearers to meet their obligations and of rights-holders to claim their rights.

[5] UNDP Pakistan MDGs Report 2013. http://www.un.org/en/development/desa/publications/mdgs-report-2013.html
[6] WHO, Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence. http://www.who.int/gender/documents/human_rights_tool/en/

The HRBA guides all UN common country programs, common country assessment (CCA) and United Nations Assistance Framework (UNDAF).

All core international human rights treaties uphold the right to health in general or in relation to a specific social group. All international relevant treaties recognizing the right to health are given in the annexe.

The conceptual and legal shift to health as a human right entails the establishment of entitlements. Availability, accessibility to non-discriminatory and culturally sensitive quality health care, health education and information are some of the key elements in the right based approach to health entitlements that every citizen must be able to claim.

Irrespective of the Government's claims and projections the fact remains that there is depleting ability of people to access the social determinants of health due to economic crisis, rising poverty, high employment and the patriarchal norms and traditions.

Chapter 2: Methodology and Literature Review

WHO Pakistan is fully committed to strengthen and deepen the HRBA in all its operations. The WHO country office in Pakistan in collaboration with WHO regional office for the Eastern Mediterranean (EMRO) has commissioned this evidence based assessment to gauge the integration of HRBA in public health response in Pakistan.

The main objective of the assignment was to conduct evidence based situation analysis on the integration of rights based approach in health policies, strategies and governance and to provide strategic guidance for the realization of right to health.

The WHO tool "Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence" is designed to support country assessments of the health sector from a human rights perspective. The assessment on the integration of human rights perspective, norms and principles in the design, implementation, monitoring, and evaluation of health-related policies and programs in Pakistan is conducted with the support of the tool developed by WHO.

A comprehensive review of domestic laws that guarantee the right to health was undertaken. Gaps are identified in the legal regime of the health sector and its coherence with international obligations and the commitment of the government of Pakistan.

While reviewing the national health policy/strategies and service delivery systems, special attention is paid to the needs and the rights of the most vulnerable/marginalized social groups. The review made a critical assessment of the health sector and recommends how the right to health is ensured in the health sector response.

The assessment of the performance of the health sector in Pakistan as to what extent HRBA is being integrated in the public health response wass conducted with the support of the tool developed by WHO.

The tool is based on three assessment levels.

The first assessment level appraises state's obligation and commitment to human rights and gender equality. The second level assesses how government translates its international commitments in domestic legislation, policy and institutional frameworks and the third level of assessment focuses on health system and delivery of services in line with the principles of human rights.

The integration of human rights based approach in public health response is assessed at three levels:

(i) consistency and compliance with International human rights laws, conventions, mechanisms and International consensus documents;

(ii) (ii review Constitution provisions and national legislations on health;
(iii) review of health sector policies, strategies, and programs.

The assessment was primarily based on desk and web review. The literature review includes the review of national data bases, health related laws, human rights instruments, national health policy; provincial health strategies, relevant reports of the government of Pakistan and health development partners in particular WHO, UNFPA and UNICEF. The research produced in the academic and in NGO sector is also included.

In-depth interviews also conducted with the key informants (identity not disclosed) who had the knowledge and insight on human rights issues in the health sector. The key health professionals from the public and private sector identified who were contacted for in-depth interviews during the course of the assessment. Also the research instruments (semi-structured questionnaires, guide questions for the roundtable) developed.

A relatively comprehensive review of the domestic laws also conducted in the light of international obligations and the commitment of the government of Pakistan. The gap from the human rights perspectives in the legal regime of the health sector identified and highlighted.

A roundtable was organized to consult and seek out views of the key health policy makers and professional on the status of integration of human rights perspectives in health sector, how that can be strengthened and to identify some key indicators and benchmarks to track progress on right to health. The multi-disciplinary actors from the provincial departments of health, representatives of medical professional bodies, provincial officers working for WHO, donor agencies and representatives of civil society organizations and human rights activists invited to participate in the round table. Their suggestions/recommendations have been included in this report.

The Framework of Analysis

The WHO tool "Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence" is designed to support country assessments of health sector from human rights perspective.

The rights-based response to health has three key dimensions (i) universality (ii) equity, and (iii) comprehensiveness. The health sector review was conducted through using these three key concepts of the HRBA.

Sub-Themes

Following were the thematic areas of the assessment based on the principle of human rights based approach.

- Universality and inalienability
- Indivisibility

- Interdependence and interrelatedness
- Equality and non-discrimination
- Participation and inclusion
- Accountability and the rule of law

The principles of human rights used as the basis to review the policies, strategies and in all aspects of service delivery - availability, accessibility, acceptability and the quality. This section will assess to what extent government is able to respect, protect and fulfil its obligation with regard to the Right to Health.

Checklist for the Review

The review of the health sector policy, strategies, institutions and the service delivery systems was guided by the following questions:

1. Is health as a human right explicitly stated in the national policy, provincial health sector strategies and whether adequate references are made to national and international commitments that recognize the right to health?
2. Do the strategies reflect on the connection between health and the underlying determinants of health and what multi-sectoral coordination mechanisms are proposed/placed/mentioned in the HSS?
3. Does the strategy clearly identify the poorest and the most vulnerable sections of the society? And what special provisions are made to address the specific health needs of marginalized groups.
4. Does the HSS uphold the principle of non-discrimination against all sections of society?
5. To what extent are women specific sexual/reproductive/maternal health and gender based violence issues/needs catered for in health service.
6. What administrative and judicial mechanisms are in place to redress the violation of rights to health?
7. Review health services within overlapping frameworks of Availability Accessibility, Acceptability and Quality (AAAQ) and six building blocks (leadership and governance; service delivery; health workforce; information; medical products, vaccines and technologies and financing) from HRBA.
8. How is the Human Rights Based Approach (HBRA) reflected in the Health sector budget?
9. What is the level of participation of local communities in the development of policies and strategies?

What human rights indicators are included in the monitoring and health management information system?

Broad Questions for In-depth Interviews

1. How would you assess the integration of HRBA in the health sector response in Pakistan?
2. What are the key issues/gap in terms of incorporating HRBA in health sector in Pakistan?
3. What type of discrimination exists in the health system?
4. Who are the most vulnerable groups, and how their health needs can be fulfilled?
5. Who participate in the development of health policies and programs?
6. What needs to be done for the realization of health as human rights?

Data Sources

This product draws information from various data sources (GoP, UN agencies, Newspapers, autonomous research institutes and independent studies) to eliminate any bias and provide diverse perspectives. Viewpoints from activists and representatives of the CSOs are also included though without verbatim.

Limitations and Constraints

By the time the first version of the report was ready for the public dissemination following the incorporation of the feedback from many stakeholders the findings of PDHS 2012-2013 were finalized and a few months later Pakistan Economic Survey 2014 and the PSLM (a Project that is designed to provide Social & Economic indicators in the alternate years at provincial and district levels.) were in place too. Hence, WHO commissioned a fast track review of the existing document in which certain statistics were up dated. Due to time and other resources constraint it was not possible to update each and every statistic, thus this limitation may appear as an information gap and or discrepancy to those readers who would look at the data and discussion in isolation with the timing/s of the production of this research product.

Chapter 3: Findings and Analysis of the Review

Legal Context: International

The international discourse on health as a fundamental human right is first articulated in the preamble of WHO Constitution of 1948.

The definition of health as physical well being is being expanded to encompass mental and social well-being. It establishes the principle of equity in health. It states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition; and governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures".

The rights perspective on health repeatedly surfaced later in the International Human Rights Bill. The 1948 Universal Declaration of Human Rights (UDHR) (Article 25) recognises that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including... medical care and necessary social services."

The International Covenant on Economic, Social and Cultural Rights, 1966in Article 12 clearly recognize the right of every individual to attain the highest standards of physical and mental health. To further elaborate this article 12, General Comments 14 of the Committee on Economic, Social and Cultural Rights is the most significant in terms of creating conceptual clarity on health as a right and assisting State parties to achieve it.

According to this General Comment, the right to health encompasses "a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment."

The General Comment specifies that availability, accessibility (including non-discrimination, physical accessibility, affordability and information accessibility), acceptability and quality are all inherent to the right to health.

Similarly, there are several international conferences, UN declarations, resolutions and General Comments adopted by various UN bodies that establish and further elaborate the right to health.

The international consensus documents that affirm health as a fundamental human right include the Declaration of Alma-Ata, 1978; the United Nations Millennium Declaration and Millennium Development Goals; Ottawa charter-healthy public policy,1986;Sundsvall conference- supportive socio-political environment; 1991;Jakarta/MexicoCity:globalization and inequalities 1997; Bangkokconference:sixth global health promotion, 2005; Adelaidedeclaration of Health in All Policies

2006;RioDeclarationreiteratingHiAP, 2011;Helsinki Declaration on HiAP, 2013; Declaration of Commitment on HIV/AIDs; Beijing Platform/Declaration of Action, International Conference on Population Development.

The international legal context is sufficiently aligned with the international commitments to health as a fundamental human right. The right to health is placed under the categories of social and economic rights.

Monitoring committees of international human rights treaties keep track of the progress made by the state parties on the promotion, protection and fulfilment of these rights. Nevertheless, there are gross health inequities between and within countries. The international treaties and declarations have not resulted in achieving better health status for the world populations.

The enforcement mechanisms at the UN level to push state parties to fulfil their obligation towards the realization of health as right needs to be improved. The state parties appear to be far more diligent in fulfilling their obligations in bilateral agreements than in multilateral agreements.

The Office of the High Commissioner for Human Rights (OHCHR) works to offer the best expertise and support to the different human rights monitoring mechanisms in the United Nations system: UN Charter-based bodies, including the Human Rights Council, and bodies created under the international human rights treaties and made up of independent experts mandated to monitor State parties' compliance with their treaty obligations. Most of these bodies receive secretariat support from the Human Rights Council and Treaties Division of the Office of the High Commissioner for Human Rights (OHCHR).[7]

There are nine core international human rights treaties, the most recent one -- on enforced disappearance -- entered into force on 23 December 2010. Since the adoption of the Universal Declaration of Human Rights in 1948, all UN Member States have ratified at least one core international human rights treaty, and 80 percent have ratified four or more.

There are currently ten human rights treaty bodies, which are committees of independent experts. Nine of these treaty bodies monitor implementation of the core international human rights treaties while the tenth treaty body, the Subcommittee on Prevention of Torture, established under the Optional Protocol to the Convention against Torture, monitors places of detention in States parties to the Optional Protocol.

Many countries treat the international human rights treaties as standard setting instruments on rights rather than mandatory mechanisms to establish equality and justice in the community of nations.

The treaty bodies are created in accordance with the provisions of the treaty that they monitor. OHCHR supports the work of treaty bodies and assists them in harmonizing their working methods and reporting requirements through their secretariats.

[7] http://www.ohchr.org/en/hrbodies/Pages/HumanRightsBodies.aspx

There are other United Nations bodies and entities involved in the promotion and protection of human rights

The UN organizations coordinate their efforts in line with human rights with regard to health enshrined in international treaties and laws. In the domestic arena the realization of health as a right is subject to socio-cultural, economic and political conditions that impact on health conditions. Therefore, the development assistance and programming interventions of UN agencies need to focus more in supporting actions that may fall outside the sector to affectively address health inequities.

The 1948 Constitution of WHO recognizes health as an inclusive right and its causal linkages with social and political conditions and circumstances. The glaring reality of health inequities in global health as a failure of health policies has lately given a push in favour of a social perspective on health.

In 2005, WHO established the Commission on Social Determinants of Health (CSDH) to provide support in tackling the social causes of poor health and health inequalities? The Commission developed a comprehensive conceptual framework to inform an understanding of country specific health disparities in any particular country.

The framework identifies structural, underlying and immediate determinants of health and establishes the causal linkages in them.

The CSDH framework identifies social, economic and political processes that create social divisions and power hierarchies along the lines of class, gender, race, religion, and ethnicity as structural determinants.

The underlying determinants are material provisions (water, sanitation, food, housing etc), psychosocial, (stress, lack of social support etc.), behavioural and biological factors (nutrition, tobacco consumption, genetic factors etc.) The immediate determinants of heath relate to availability and accessibility of health services[8].

The CSDH Framework has added another layer of structural determinants to the normative analytical framework of social determinants of health that focused on intermediary determinants alone. The holistic framework of CSDH widens the scope by linking health policy with wider social and economic policies and an inter-sectoral response to health.

WHO's assistance practically in country program often remained technical, rooted in clinical health care systems and supporting vertical disease control programs implying that a visible focus on treatment of health issues as human rights concern is conspicuously absent.

[8] Commission on Social Determinants of Health (2007), A Conceptual Framework of Action on the Social Determinants of Health. 2010.

The collaborative efforts of the WHO in Pakistan are primarily focused on polio eradication; improvement in routine immunization, supporting maternal, neonatal and child health (MNCH), family planning, primary health care, nutrition, tuberculosis; malaria control; prevention and control of hepatitis, etc[9]. All these health issues are human rights/women rights and child rights issues as well but policies and programming do not spell the same spirit.

The multi-sectoral coordination at the policy and practice level as recommended by the CSDH seems to be lacking in the working of UN agencies. There are several similar health initiatives of WHO, UNFPA and UNICEF that are parallel without multi-agency coherence and coordination. Health concerns are not synergized with other development programs of UN agencies that work in the area of social determinants of health.

Similarly, the debate on underlying determinants of health remained focused on social determinants at the expense of ignoring the cultural and political determinants.

Cultural determinants in particular negatively impact on women's rights. There is relatively less attention paid to cultural factors as opposed to social ones in WHO country assistance and that of related UN agencies.

[9] WHO Country Cooperation Strategy for Pakistan 2011-2017

Legal Context: National

Pakistan has ratified seven (7) out of nine (9) core international human rights treaties namely:

(i) International Convention on the Elimination of All Forms of Racial Discrimination
(ii) International Covenant on Civil and Political Rights
(iii) International Covenant on Economic, Social and Cultural Rights
(iv) Convention on the Elimination of All Forms of Discrimination against Women
(v) Convention on the Rights of the Child
(vi) Conventions on the Rights of Persons with Disabilities
(vii) Convention against Torture (CAT)

The country acceded to ILO conventions, and been party to several international declarations and commitments such as Alma Ata Declaration (1978) Health for All, MDGs, ICPD 1994, and Beijing Platform of Action 1995. All these have elements on health rights in them.

However, Pakistan is faltering on translating these commitments into practice. There are several areas where Pakistan still has to bring its domestic laws at par with international laws. There are certain discriminatory legislations such as *Hadood* Ordinance, Law of Evidence, ***Qisas*** and ***Diyat***, Blasphemy Law, Citizenship Act etc[10].

These are the legislation which determines the status of women and religious minorities as second class citizen. The discriminatory law mentioned above shows that the state of Pakistan does not treat all citizens equally. These laws create the social basis of discrimination against women and non-Muslim Pakistanis. Therefore, it is important to repeal these discriminatory laws to bring domestic legal framework in aligned with international laws and commitments.

Moreover, there are number of areas where protective legislation should be introduced to protect citizen's rights such as domestic violence law as well as laws to provide protection to women and children working in the informal sector of the economy etc.

Despite the sluggish pace of execution of these international commitments to the health and health related rights, international human rights instruments serve as a tool in the hands of citizens and empower them to hold their governments as duty bearers accountable and to claim their rights.

---

[10] The ***Hudood*** **Ordinance** is a law in Pakistan that was enacted in 1979 as part of Islamization project of military ruler Muhammad Zia-ul-Haq. The Hudood Law prescribe maximum Islamic punishments mentioned in the Quran and ***Sunnah*** for ***Zina*** (extramarital sex),*Qazf* (false accusation of zina), Offence Against Property (theft), and Prohibition (of alcohol consumption). Hudood Ordinance equate adultery rape. As for the rape, a woman alleging rape is required to provide four adult male eyewitnesses. In case of failure, she faced charges of adultery, if she is married, or for fornication, if she is not married. Law of Evidence makes two women witness equal to one man in financial matters
Qisas and Diyat (law of Retribution) The worth of women's life is considered half of man's life
Citizenship Act does not allow the citizenship to the non-Pakistani husband of Pakistani women whereas non-Pakistani wife of the Pakistani man is entitled for citizenship

The European Union (EU) granted Generalised System of Preferences (GSP) plus status to Pakistan in December 2013 that is effective from January 2014, granting Pakistani products a duty free access to the European market.

The GSP Plus status granted to Pakistan is conditional on the ratification and implementation of 27 international conventions in the areas of human rights, labour standards, environment and good governance.

Adoption of these conventions will assist Pakistan in integrating into the cross-border supply chain which will strengthen manufacturing activity and further promote its exports. Pakistan has ratified almost all the conventions. The most critical aspect of these conventions is that their compliance will be strictly monitored by the EU through the unnamed third parties from civil society or NGOs.

Another critical challenge pertaining to the compliance would emanate from the 18th Amendment to the constitution. As a result of the 18th Amendment, there has been a shift of power relevant to the conditions of GSP Plus – from the federal to the provincial governments. While the federal government has worked hard to get the GSP Plus status and is responsible for monitoring and reporting of the 27 conventions, implementation of the corresponding domestic legislation is largely the responsibility of provincial governments, perhaps not yet ready for compliance. The federal government must establish a supervisory body to coordinate with provincial governments in this respect[11].

The Constitution of Pakistan does not recognize health as a fundamental human right; however there are several constitutional guarantees, policy principles and provisions that obligate the state to ensure health for the citizens without any discrimination.

Article 38 (a) and (b) states, " The state shall secure the well-being of the people, irrespective of sex, caste, creed and race……provide basic necessities of life , such as …medical relief, for all such citizens, irrespective of sex, caste, creed or race, as are permanently or temporarily unable to earn their livelihood on account of infirmity, sickness or unemployment…."

The principle of gender equality is further established under article 25 (2).It clearly states, "There shall be no discrimination on the basis of sex alone."

Article 9 of the constitution guarantees the right to life by stating, "No person shall be deprived of life or liberty…." Similarly, there is a case law that sets the precedent that health is critical for right to life. The case of Shehla Zia versus Water and Power Development Authority (WAPDA) (Human Rights Case No. 15)in which residents in Islamabad protested to WAPDA against planned construction of a grid station, with major concerns that electromagnetic effects produced by high voltage transmission lines of the grid station might cause serious health hazards for the residents of the area. Scientists and experts remained unable to draw definite conclusions on adverse effects of electromagnetic fields on human health. However, the Court has expanded the ambit of article 9 of the Constitution of Pakistan to include the right to health services and quality of life.

[11] Source; various news reports(consultant)

There are constitutional provisions that guarantee health related human rights and social determinants of health. Article 25(a) of the constitution states that **"The state shall provide free and compulsory education to all children of age of five to sixteen years in such manner as may be determined by law".**

Similarly there is an impressive number of laws on health and health related issues in Pakistan and these provide an adequate legal cover for the protection of health and health related rights in Pakistan[12].However, there is a need for an exclusive public health law that explicitly recognizes health as a constitutional right of people as it has been done in the case of education.

Some of the important laws that provide protection and promotion of health are mentioned below:

- The Public Health Ordinance, 1944 obligates the government to ensure the provision of medical services, prevention of diseases, and the establishment of public health services that includes water supply, sanitation, vaccination etc.
- The Epidemic Diseases Act 1958, the Mental Health Ordinance, 2001,
- Disabled Persons' (Employment and Rehabilitation) Ordinance (XL of 1981), the HIV and AIDS Protection and Treatment Act, 2006, Transfer of Safe Blood Ordinance, 2002,
- The Transplantation of Human Organs and Tissue Act, 2004 .These cover fairly broad ground in the area of public health care and response.

Further legislative actions have been taken in support of health. There are preventive laws that protect people from harmful health behaviour such as the Prohibition Order in Hudood Ordinance 1979 that prohibits use of alcohol and intoxicants. The Prohibition of Smoking and Protection of Non-Smoker's Health Ordinance 2002 was introduced to discourage people from smoking. Human Organs and Tissues Ordinance 2007.

To protect health of citizens the Essential Commodities Act, 1957 ensures the quality of foodstuff. Similarly to protect infant and child health, the Protection of Breastfeeding and Young Child Nutrition Ordinance, 2002 has been passed. Legislative actions were taken for the fortification of ghee and oil with vitamin A, iodization of salt and safety of blood transfusion, etc.

There are several laws in the statute book that regulate drugs and medical practices. There are several Drug Acts covering different aspects of drugs e.g.

- The Pharmacy Act, 1967,
- The Medical and Dental Council Ordinance 1962,
- Unani, Ayurvedic and Homoeopathic Practitioners Act, 1965,

[12] WHO, An Inventory of Pakistan laws on Heath and Health Related Issues. http://www.heartfile.org/pdf/phpf-GWP.pdf

- Allopathic System Ordinance, 1962 and Pharmaceutical Industry Order, 1995 There. are some of legal provisions that regulate the health industry to improve access to essential medicines and protect people's right to health.

Health inequities are found in the poor sections of the society who face serious challenges to enjoy physical and mental health due to lack of access to underlying determinants of health as well as health care services.

Amongst the most marginalized and the poor strata of the society includes women, elderly, children, disable[13], mentally challenged and religious minorities. These categories of people are disproportionately suffered from ill heath due to their subordinated social and economic status in the society.

[14]Gender appears to be one of the determining social factors that are shaping disparities in health outcomes. There is a widening gender gap in health indicators.

The root cause of gender discrimination is the patriarchal beliefs that creates and recreates gender hierarchy in society. Women's inferior socio-cultural position vis-à-vis men compounded by their subordinate political and economic status, because of low investment in their human capital by the family and the state, detrimentally impact women's health status.

Women's health further suffers due to discriminatory attitudes and behavior at the family, state and the societal levels. Gender discrimination in intra-household food distribution, early marriages, multiple pregnancies, lack of education, cultural restriction on mobility, lack of control over their

[13] The National Assembly's Standing Committee on Law and Justice in 2012, approved the MQM's Constitution amendment bill giving representation to the "disabled persons" in the parliament and deferred the party's bill on new provinces due to lack of quorum. The private member bill seeking amendments to Articles 50 and 59 of the Constitution for giving representation to the "disabled persons" in the National Assembly and the Senate had been moved by MNA Kishwar Zehra of the Muttahida Qaumi Movement (MQM) earlier this month. The bill suggests that there should be four reserved seats for the "disabled persons" — one from each province — both in the National Assembly and the Senate.Source: http://defence.pk/threads/na-approves-mqms-bill-for-representation-of-disabled-people-in-national-assembly-and-senate.291778/#ixzz3GKzEewPh.Globally, and in Pakistan, policy approaches to disability have largely been focused on rehabilitation, welfare handouts and related charity. This has been changing since the UN Convention on the Rights of Persons with Disability (CRPD), which became operational in 2008. The CRPD offers a blueprint for a rights-based approach to mainstreaming persons with disabilities. Pakistan ratified the treaty in 2011, but progress around building an inclusive society has been slow. Source: Moving from the margins-Mainstreaming persons with disabilities in Pakistan-A custom research report produced for the British Council.August 2014.

[14] In the review it was observed that many health issues are still neglected and a legislation and or improvement in the existing legislation is/are required. For instance RHR bill is still pending in the parliament & the law on abortion is largely misunderstood in the community of health care providers and legal experts. This very law also needs to be reviewed through gender lens as it does not permit abortion due to fetal defects and pregnancy resulting from rape /incest. (Consultant).

own bodies and sexuality, lack of gender awareness and sensitivity in health system are some of the factors that result in diminished health status of women.

It is imperative that the legal framework for health of the country takes into consideration the gendered cultural context that significantly impacts on health gains in particular for women who constitute nearly half of the population (49%)[15]. Gender equality is a fundamental condition for the better health status of children, families and the nation.

Regrettably, the Constitution of Pakistan has contradictory provisions with regard to gender equality. There are constitutional provisions which establish that there shall be no discrimination on the basis of sex (Article 25); however, there are several laws that clearly discriminate against women and religious minorities such as Hudood Ordinance, Qisas and Diyat, Law of Evidence, Citizenship Act, Blasphemy Law, etc.

There are nineteen major laws related to women's issues in the statute book.

The current parliament has passed significant laws for the promotion and protection of women's rights. The most significant law, The Prevention of Anti-Women Practices (Criminal Law Amendment) Act 2011, has criminalized some of the customary practices such as forced marriages, child marriage, marriage to Quran, depriving women from inheriting property, etc.

The law on Sexual Harassment at Workplace has made sexual harassment punishable with imprisonment for up to 3 years. Acid Control and Acid Crime Prevention Act has also been passed.

However, there are several protective laws that need to be introduced to protect women from social injustices and to establish gender equality in society. In view of high incidence of family violence against women, a law on domestic violence[16], something that hugely impacts on women's physical and psychological health, should be passed to protect women from violence and to establish social justice in society.

[15] The World Bank.2011. http://web.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTRESEARCH/EXTWDRS/0,,contentMDK:23252415~pagePK:478093~piPK:477627~theSitePK:477624,00.html

[16] The Balochistan Assembly passed the Domestic Violence (Prevention and Protection) Bill, 2014. The legislation appears to generally follow the pattern of the landmark bill passed on the same issue by the Sindh Assembly in March 2013, the only other province to have passed such legislation. individually responsible for legislation on devolved subjects, including women's rights. (Legislation for the ICT is passed by the Senate and the National Assembly. The ICT's domestic violence bill was only passed by the Senate which means it has not yet become law.)-an observation by the consultant.

Major Laws Relating to Women in Pakistan

Sr.No.	Particulars
1	Guardian and Ward Act, 1890
2	Foreign Marriage Act, 1903
3	The Child Marriage Restraint Act, 1929
4	Dissolution of Muslim Marriage Act, 1939
5	Muslim Family Laws Ordinance, 1961
6	The West Pakistan Rules Under Muslim Family Laws Ordinance, 1961
7	West Pakistan Family Courts Act, 1964
8	West Pakistan Family Court Rules, 1965
9	The Dowry and Bridal Gifts (Restriction) Act, 1976
10	The Dowry and Bridal Gifts (Restriction) Rules, 1976
11	Hadood Ordinance, 1979
12	Family Courts (Amendment) Ordinance, 2002
13	Criminal Law Amend Act, 2004
14	Protection of Women Criminal Law Amendment Act, 2004
15	Amendment to the Pakistan Penal Code
16	Protection Against Harassment of Women at the Workplace, 2010
17	Acid Control and Acid Crime Prevention Act, 2010
18	Prevention of Anti Women Practices Criminal Law Amendment Act, 2011
19	Women in Distress and Detention Fund (Amendment) Act, 2011
20	Child Marriage Restraint act 1929
21	The Sindh Child Marriage restraint act 2013[17]

Key Source: Blue Veins , Major laws relating to women in Pakistan. http://www.blueveins.org/

[17] http://www.actionaid.org/pakistan/what-we-do/womens-rights/child-marriage-restraint-act-2013

Gap and Issues in Legal Framework of Health Sector

The major gap in the legal framework from the rights perspective is that health is not being recognized explicitly as a human right in the Constitution of Pakistan. The right to education is being defined now as a constitutional right under the 18thconstitutional amendment, making education free and compulsory for all children under sixteen[18].A similar constitutional amendment is needed to make health a constitutional right too.

The need for an overarching legislation in health is even more now due to abolition of Ministry of Health under the 18th Amendment. Health is being devolved to provinces. By making health a constitutional right the state will be required to deliver at least a minimum essential health care package or standards to all citizens and take necessary actions to redress underlying and structural constraints to health. The provincial health policies and strategies would have to develop within the overall national legislative framework of health.

The majority of people in Pakistan are seeking health services from the private sector. The private sector accounts for providing 70% of health care and two third of total health expenditure[19].The private health sector is expanding fast with mushrooming of private clinics, hospitals, and homeopaths all over the country.

The sector is essentially profit driven without any equality or equity considerations. It hardly follows the minimum quality standards for establishing health facilities and quality of care. In the absence of monitoring mechanisms, private facilities do not comply with quality of care standards.

The current regulatory mechanisms for the private health sector in the country are fairly weak. In view of the large private health care sector in the country, it is imperative for government to register and regulate the sector for quality control and patient's safety through appropriate legislation and regulation. The laws that regulate public-private partnership do not exist in Pakistan[20].

Another important area that needs better regulations and legal cover relates to the drug price and quality control. Pakistan has a sizeable pharmaceutical industry of Rs. 88 billion with 411 local manufacturing units and 30 multinational corporations[21]. This is largely a private industry.

Drug prices used to be regulated under Section 12 of the Drug Act 1976 by the Ministry of Health till June1993. In 1993, partial deregulation in favour of free market was approved that led to

[18] The 18th Amendment of the Constitution
[19] Planning Commission Government of Pakistan, Framework for Economic Growth Pakistan, May 2011. Pp. 50
[20]Nishtar, Sania (2010) Choked Pipes, Oxford University Press, pp. 237
[21] Ministry of Health, National Health Policy 2009 (zero draft)

unprecedented rise in drug prices and certain drugs increased to over 400% of the original price.[22] In the post-18th amendment period, Pakistan is lacking a central regularity authority.

In order to ensure the quality, availability and affordability of essential drugs, a pro-people legislation is required to establish a central drug regularity authority with effective implementation and monitoring mechanisms in place.

The issue of spurious drugs or counterfeit of the branded drugs is extremely serious one. Pakistan is one of thirteen countries in the world where manufacturing of spurious medicines has been reported[23].

Many human lives have been lost through the use of the substandard and spurious drugs that are being marketed with impunity in the country. The most recent example is the deaths occurring in the Punjab Institute of Cardiology.

Moreover, the Drug Act does not applicable to traditional and herbal medicine. Thus 130,000 registered practitioners of traditional medicine are outside of any regulatory framework.[24]

In view of the weak implementation of Drug Act 1976, the need for a stronger institutional mechanism to regulate drug market was felt. The gap is now filled by the Drug Regulatory Authority Bill 2012 passed by the parliament which provides legal framework for the establishment of Drug Regulatory Authority of Pakistan.

The authority has thirteen directorates dealing with different subjects from licensing to quality control and post-marketing surveillance. Another directorate is dealing with the allocation and regulation of quota of controlled substances for the manufacture of drugs. This will help to prevent the recurrence of scandals like Ephedrine Case being heard by the Supreme Court recently.

The Drug Regulatory Authority of Pakistan (DRAP) launched new D-Drug software to control counterfeiting and spurious drugs entering the market. With the help of this software, information about expired drugs could be obtained and patients could be saved as expired medicines would be taken out of the shelf before time.

According to some mainstream activists who were interviewed for this research, in Pakistan another gap that exists in the legal framework of the country is that there is no comprehensive social protection policy in the country. Numerous constitutional provisions can be interpreted and extended to cover health related human right such as gender equality, right to employment, access to clean drinking water, food, sanitation and housing - fundamental conditions for the attainment of health. However, none of these are explicitly given the status of a constitutional right of citizens.

[22] Sania Nishtar, The Gateway Paper Health Systems in Pakistan-a Way Forward, Heart file, 2006
[23] ibid, pg158
[24] ibid, pg 158

Implementation issues

The legal framework that governs the health sector in Pakistan is by no means comprehensive. Some of the key areas as identified above need legal cover to protect people's rights to health. However, the major issue the sector faces is the non-implementation of the laws and regulations that are already in place. Poor governance, corruption, inefficiency, weak monitoring, lack of transparency and accountability are some of the endemic institutional challenges that debilitate the effective implementation of legal and regulatory frameworks in the health sector.

In addition to regulatory bodies in the health sector, there is a human rights mechanism in the country that should take stock of the violation of health related human rights. The Ministry of Law ,Justice & Human Rights, the National Commission on the Status of Women (NCSW), the National Commission for Child Welfare and Development (NCCWD), the Parliamentary Standing Committees on Health and Human Rights, the National Commission of Minorities (NCM), the National Commission on Human Rights,25 all have the mandate to promote and protect health rights. However, the role of human rights machinery has not been very effective to promote and protect health related human rights so far.

A number of CSOs, NGOs and INGOs are working through advocacy initiatives on different health issues including the very challenging issues in Sexual Reproductive Health /Sexual Reproductive Health Rights/Adolescent Sexual& Reproductive Health Rights etc. However, the weak appearance and of status of health movement if any in the is country is due to the very fact that understanding of health as human rights issue has yet to be internalized by mainstream rights based activists, their affiliated organizations in public, private and voluntary sectors. The role of donors and technical aid agencies in the given context merits a separate research and review

[25] Established under the National Commission of Human Rights Act, 2008. The commission n is not functional to date.

The State of Health in Pakistan

The health indicators in Pakistan present a dismal picture. Also Pakistan is performing badly on the socio-cultural determinants of health such as literacy employment, gender equality, access to safe drinking water, sanitation, and the environment.

On Global Gender Gap Index, Pakistan lags behind the global average on all the four sub-indexes — economic participation and opportunity, educational attainment, health and survival, and political empowerment. It now occupies the last spot in the region.

This sixth most populous country(182.14million) with the largest cohort of young people (e.g 21.76% are under 5 years of age) has lowest literacy rate (e.g Adult literacy rate for 15 years of age and older is 7% and Population with at least some secondary education -aged 25 and above is 54.9 %) in South Asia, very [26]high maternal **(276/100000 live births)**and Infant (66.57/1000 live births) mortality rates and incredibly high gender gapi (135 out of 136 countries[27]).

Some other important statistics having a direct as well as an indirect impact on the state of health and human rights in Pakistan are summed up in annexe 2:

The health status in not even and stark health disparities exist across class gender, ethnicity, religion, rural/urban divide and other social divisions.

This section gives a broad overview of the state of health in the country.

Pakistan health sector is facing the challenge of double burden of Communicable and non-communicable diseases. There has been an increase in non-communicable diseases (NCD). The study on Global Burden of Disease (GBD) (2010) shows there are more death in Pakistan from non-communicable diseases that includes cardiovascular diseases, diabetes, respiratory diseases, cancers and injuries[28]. The proportion of NCDs is likely to continue to increase in the coming years. For example, 11% of the total burden of disease is a result of accidents and injuries, something that is likely to increase in coming years. Pakistan is also among the top 10 countries in the world with the highest diabetes prevalence, showing at 7.1%[29].One in four persons over the age of 40 years

[26] National Institute of Population Studies [Pakistan] and ICF International. 2013. Pakistan Demographic and Health Survey 2012-13. Calverton, Maryland, USA: National Institute of Statistics and ICF International.

[27] The global gender gap report-2013. It is published by the World Economic Forum in collaboration with faculty at Harvard University and the University of California, Berkeley, assesses 136 countries, representing more than 93 per cent of the world's population, on how well resources and opportunities are divided among male and female populations.

[28]Lozanor, NaghaviM, Foreman K, et al. Global and regional mortality from 235 causes of death from 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet 2013; 380:2095-128es AD, Mathers C, Ezati M, Jamison DT, Murray CJ. Global and regional

[29]Ministry of Health, National Health Policy 2009 (zero draft)

suffers from coronary artery diseases. The rise in militancy, political and sectarian violence, terrorist's attacks, natural disasters, deteriorating economic and security situation has a high social cost as it leads to mental health disorders in people.

Pakistan's health system is effectively unable to meet the challenge of communicable disease despite tremendous support from the global health partners. Expanded Programme on Immunization is failed to meet its benchmark. Pakistan is one of the countries (Nigeria, India and Afghanistan) who remained polio endemic. Pakistan rank fifth highest globally in burden of Tuberculosis[30]. The ratio of TB incidence is 231/100,00. 620000 people have TB and every year 59000people die from the disease.[31]About 8-9 million people are infected with hepatitis C virus. 500,000 cases of malaria rise every year[32].

The Pakistan Demographic and Health Survey (PDHS) 2012-13 findings reveal that at the federal level only 74 per cent children of aged 12 to 23 months were vaccinated last year against the 80 per cent immunization coverage recommended by the World Health Organisation (WHO). At present, health departments of both the Islamabad Capital Territory (ICT) and the Capital Development Authority (CDA) are short of vaccinators and those who are available remain busy in anti-polio drives throughout the year. After the devolution of the health ministry, provinces are responsible to look after their own EPI cells. However, they do not seem serious about improving the routine immunisation. "Majority of districts in Balochistan, interior Sindh and Punjab lack proper infrastructure to vaccinate their children against nine vaccine preventable diseases and in FATA they do not have proper system to even make ice packs to maintain the cold chain[33].

The latest measles outbreak in the country has taken the lives of hundreds of children. The official DPT3 coverage for 2010 was 88%.

Findings of the survey have shown 16 percent decrease in under-five mortality since 2006-07, but neonatal mortality has remained unchanged for the past 20 years. The neonatal mortality rate in the past five years is 55 deaths per 1,000 live births. Currently under-five mortality is 89 deaths per 1,000 live births.

At these mortality levels, one in every 14 Pakistani children dies before reaching age one and one in every 11 does not survive to his or her fifth birthday resulting in over 1,100 deaths per day.

The immunisation coverage rate has increased from 47 percent in 2006-07 to 54 percent in 2012-13 still 46 percent of the children below 2 years are not fully immunised. And regional data highlights areas of concern with only 16 percent of children fully immunized in Balochistan

[30]WHO, Country Office for Pakistan: Fact Sheet
[31] Pakistan: health is an opportunity to be seized. Comment www.thelancet.com
[32]ibid
[33] http://www.awaztoday.com/News_Change-of-guard-EPI-gets-new-head_1_42427_Political-News.aspx. 15 February 2014.A public official's statement.

compared to 74 percent of those in Islamabad. In Sindh immunization rate has decreased from 35 percent in 2006-07 to 29 percent in 2012-13. According to the survey, 45 percent of children under-five are stunted, or too short for their age that indicates chronic malnutrition.

Stunting is most common among children of less-educated mothers (50 percent) and those from the poorest households (62 percent). In addition, 30 percent of Pakistani children are underweight or too thin for their age.

Whereas more work is required in the area of mother and child health, and fresh strategies have to be developed to cope with the double burden of disease, there are emerging challenges that need attention. For example, with reference to HIV&AIDS, the current population prevalence is estimated to be 0.1%. However, certain practice and sexual behaviour exposes certain groups of people more vulnerable to the transmission of HIV-AID infection. Poverty, gender inequality and social stigma attached to HIV-AID aggravate the problem of addressing it effectively.

Pakistan presents one of the most complex polio eradication environments in the world. The country has reported 206 cases so far this year compared to 58 this time in2013.

90% of these cases are from FATA and Khyber Pakhtunkhwa; of which 98% are from North and South Waziristan Agencies where no polio campaigns have been conducted and an estimated 290, 000 children under the age of five have not been vaccinated for two years leading to the ongoing explosive polio outbreak in the region. The numbers of infected districts are also on the rise, from 26 in 2013 to 18 in 2014. Environmental sampling results further confirm that since January 2014, the virus is circulating across the country.

"In a world which has been largely free of polio for many years, Pakistan is a country where 206 children so far in 2014 have been left crippled for life by a disease that is easily preventable through the oral polio vaccine.

More than 70 per cent of the polio cases in Pakistan hail from the tribal area of North Waziristan where polio vaccination was banned in 2012 by local leaders causing severe damage to the national and global effort for polio eradication."

Challenges

The challenge is huge. As long as the virus exists in some reservoirs like North and South Waziristan, the whole world will always be at great risk of an outbreak. In addition migration from a location where a single polio campaign has not taken place in two years makes it easy for the virus to travel as well.

Dr. Bilal Ahmed, the Polio team Lead for UNICEF, KP/FATA highlights the fact that Bannu is playing host to a large number of IDP's and already 9 cases have been reported from there. He says that *"the virus moves along with the people, it has gone from Fata into Bannu and to Lucky Marwat, and obviously if people travel from there to Karachi, then Karachi too will be at risk"*[34].

[34] http://www.endpolio.com.pk/12-field-stories/147-crisis-offers-an-opportunity-for-polio-eradication-in-pakistan news report by Abid Hasan &http://www.endpolio.com.pk/media-room/media-releases/128-pakistan-polio-update-briefer

"The dengue cases continue to be reported this year as well. According to the weekly Epidemiological Bulletin, compiled by WHO in collaboration with the Pakistani government, this year so far a total of 173 laboratory confirmed cases have been reported from across the country. Of these, 171 cases have been reported from Sindh and two from Punjab.

The Flu factor

According to a comparative analysis of Influenza A (H1N1) cases in 2013 and 2014, 2013 had a total of nine reported cases; however in 2014 from January to March a total of 23 positive cases have been reported. Of these 21 are from Punjab from which nine died. Three reported cases were from K-P.

On the other hand at the Federal level, the Ministry of National Health Services, Regulations and Coordination (NHSRC) suffers from a lack of professional staff and funds. "I do not have the professionals to fulfill the key vacant posts and there is a lack of funds to carry out awareness campaigns against infectious diseases," a state minister said."[35]

1 According to the index, Iceland tops the list with the most equitable sharing of resources among the sexes, followed closely by north European countries such as Finland, Norway and Sweden.

Pakistan comes down at 135, followed only by Yemen, and its score has fallen three spots since the study was conducted last year. The comprehensive annual report measures the size of the gender inequality gap in four areas, including economic participation and opportunity (salaries, participation and highly skilled employment), educational attainment (access to basic and higher levels of education), political empowerment (representation in decision-making structures), health and survival (life expectancy and sex ratio).According to the index, Pakistan ranks second-worst in economic participation and opportunity, eighth-worst in terms of equal access to education, 13th from the bottom in terms of health and survival. The magnitude of disparities is much smaller in Pakistan when it comes to political empowerment and representation in decision-making structures among the two sexes, with a rank of 64 among 136 countries.

Among neighboring countries, China ranked at 69, Bangladesh at 75, India at 101 and Iran at 130.

Afghanistan was not included in the study.

[35] *Published in The Express Tribune, April 7th, 2014.* http://vustudents.ning.com/forum/topics/world-health-day-april-7-2014?commentId=3783342%3AComment%3A4119008

Vulnerability Analysis & Mapping

In South Asia economic performance of Pakistan is improving quantitatively and qualitatively as growth is broad based and touched all sectors of the economy and is the highest achievement since 2008-09. Despite these very and other claims in the latest economic survey the economy of this country (as may be interpreted from its HDI rank) is not performing well due to a number of exogenous and endogenous factors. The economy suffered external shocks from the global economic recession coupled with sharp rise in fuel and food prices.

The population is suffering under inflationary economic conditions and with a severe energy crisis which has also affected the capital, Islamabad. In reaction to gas and power shortages, citizens have rioted against government institutions in many cities. A lack of economic reforms, for instance the government's failure to broaden the tax base, rising energy import bills and dwindling foreign direct investment, has caused an increase in Pakistan's total debt to more than PKR 15 trillion, accounting for more than 68% of GDP in 2012. One positive economic development was that Pakistan granted India most-favoured nation (MFN) status in January 2013. This change should increase trade between both countries and should help to increase societal and political interaction[36].

More than 40,000 civilian and security forces lost their lives to terrorist attacks and the economy suffered a loss of US $ 67 billion due to damage to social and physical infrastructure. There is a flight of local and foreign investment, closure of industrial units and slowdown of economic activities as a result of security situation and the energy crisis in the country.

This has resulted in an increase in poverty. Presently, no official poverty figures are available. The previous government did not accept the poverty figure of 17.2% of the Integrated Household Economic Survey, 2007-08. This showed a 5.7% decline in the incidence of poverty that was estimated at 22.9% in 2005-06. A study conducted by Akmal Husain claims that nearly 43.1% (79 million) people in Pakistan are living in abject poverty[37].

The poor and marginalized are vulnerable to health risks due to their powerlessness in the social and economic structure of power that impact on their ability to access social determinants of health. Inadequate diet and lack of access to safe drinking water and sanitation facilities makes poor more vulnerable to illnesses that further adds to their vulnerability.

The incidence of poverty is higher in rural Pakistan. However, the urban poor living in slums are the high risk group. Pakistan has the highest level of urbanization in South Asia and it is expected that by 2025 Pakistan will have a total population of over 210 million by 2025 of which 50% will be living in urban areas. In aggregate the health outcomes are better in urban areas, however poor households living in squatter settlements have poor health outcomes equal to or worse than rural communities. Urban centres are growing fast due to internal migration. Most of these migrants live in squatter settlements.

[36] http://www.bti-project.de/uploads/tx_itao_download/BTI_2014_Pakistan.pdf
[37]Husain, Akmal, Institutional Imperative of Poverty Reduction, 2008

In Pakistan 30 percent of the households are using tap water as main source of drinking water. Among provinces regarding tap water as main source of drinking water **KP with 44 percent** has the highest while **Punjab with 22 percent** has the lowest percentage. In Islamabad (Federal Capital) 54 percent of households are using tap water as main source of drinking water.

While observing the district level position, Karachi(Sindh) with 86 percent is at the top, while in district Washuk of Balochistan no household is using tap water as their main source of drinking water is dug well with 49 percent followed by motorized pump with 36 percent.

Overall in **Pakistan 71 percent of households use flush toilet**, 15 percent households have no toilet facility while 14 percent are using non-flush. By comparing provinces **Punjab with 77 percent** is at the top where the highest numbers of households are using flush toilet and **Balochistan with 30 percent** is at the bottom. In Islamabad (Federal Capital) 99 percent households are using flush toilet. While observing the district level pattern Lahore (Punjab) with 98 percent is at the top while Washuk (Balochistan) with 1 percent is at the bottom.

The comparison of housing units by number of rooms shows that there is slight increase in housing units with one room, 26 percent in 2012-13 as compared to 25 percent in 2010-11 and there is marginal decline in housing units with 2-4 rooms, 68 percent in 2012-13 as compared to 69 percent in 2010-11.However, houses with more than five rooms remain stable at 6 percent during 2012-13and 2010-11.

The housing units using electricity as source for lighting have increased to 93 percent in 2012-13 from 91 percent in 2010-11. **Punjab** with 95 percent has the highest percentage of household using electricity as a main source for lighting while Balochistan with 79 percent has the lowest percentage. In **Islamabad** (Federal Capital), 98 percent households using electricity as source of lighting. Among Districts, **Bannu** (KP) with 100 percent have the highest percentage of households using electricity as source of lighting while **Aware** (Balochistan) with 29 percent has the lowest percentage.

Use of gas/kerosene oil as fuel for cooking has increased to 38 percent in 2012-13 from 34 percent in 2010-11. **Sindh** is at the top with 53 percent and Balochistan with 23 percent is at the bottom. In Islamabad (Federal Capital), 80 percent households are using gas/kerosene oil for cooking.

While observing districts, Karachi with 98 percent has the highest number of households using gas/kerosene oil for cooking, on the other hand some districts like Shangla (KP),Awaran,Washuk, JhalMagsi(Balochistan) are predominantly using wood/charcoal as fuel for cooking[38].

[39]Following table summarizes some key indicators on sanitation (an important determinant of health) with regional breakdown.

[38] http://www.pbs.gov.pk/sites/default/files/pslm/publications/pslm_prov_dist_2012-13/6-Exeutive%20Summary%2010-02-2014.pdf

A study conducted by Life with the support of UNDP estimated that 35% of urban population and nearly 40% in metropolitan cities of Karachi, Lahore, Hyderabad, Peshawar and Quetta live in these settlements and underserved areas[40].The health status of slum dwellers is worst due to limited access to social determinants of health and health services.

In terms of vulnerability mapping in health, it is generally the poor who are the most vulnerable to health risks. However, within poor, its women, children, elderly and disabled who have the worst health outcomes.

The incidence of illness is higher among women across all income quintiles[41].Malnutrition among women and children are high in Pakistan. Nearly 12% burden of disease in the country is due to reproductive health problems.[42]

[43]Following table summarizes some key indicators with regional breakdown.

[39] Selected indicators Reproduced from Pakistan Social And Living Standards Measurement Survey (PSLM) 2012-13 Provincial / District. Government of Pakistan,Statistics Division,Pakistan Bureau of Statistics,Islamabad April – 2014.http://www.pbs.gov.pk.http://www.pbs.gov.pk/content/pakistan-social-and-living-standards-measurement-survey-pslm-2012-13-provincial-district

[40]Life , UNDP, Climbing Out of Poverty: Viable Alternatives to Katchi Abadis in Islamabad.2003.
[41] Social Policy and Development Center, Public Spending on Education and Health in Pakistan, 2010. Pg 65
[42] Planning Commission, Medium-Term Development Framework 2005-10
[43] [43] Selected indicators Reproduced from Pakistan Social And Living Standards Measurement Survey (PSLM) 2012-13 Provincial / District. Government of Pakistan,Statistics Division,Pakistan Bureau of Statistics,Islamabad April – 2014.http://www.pbs.gov.pk.http://www.pbs.gov.pk/content/pakistan-social-and-living-standards-measurement-survey-pslm-2012-13-provincial-district

		2008-09 PSLM				2010-11 PSLM				2012-13 PSLM		
AT LEAST 1 IMMUNIZATION	**M**	**F**		**T**	**M**	**F**		**T**	**M**	**F**		**T**
(12-23 MONTHS)												
OVERALL	**97**	**96**		**97**	**97**	**97**		**97**	**98**	**98**		**98**
Punjab	97	97		97	97	96		97	98	98		98
Sindh	97	97		97	99	98		98	98	98		98
Khyber Pakhtunkhwa	95	95		95	98	98		98	98	98		98
Balochistan	94	92		93	94	94		94	93	92		92
Islamabad	94	96		95	98	98		98	98	100		99
Rajanpur	98	97		97	100	100		100	100	100		100
Jaccobabad	96	100		98	100	95		98	100	100		100
Lower Dir	91	93		92	100	100		100	100	100		100
Mastung	100	100		100	94	94		94	100	100		100
FULL IMMUNIZATION (12-23 MONTHS BASED ON RECALL AND RECORD)	**M**	**F**		**T**	**M**	**F**		**T**	**M**	**F**		**T**
OVERALL	**78**	**77**		**78**	**82**	**79**		**81**	**84**	**81**		**82**
Punjab	86	84		85	87	84		86	90	88		89
Sindh	69	68		69	75	74		75	75	73		74
Khyber Pakhtunkhwa	73	74		73	78	77		77	79	73		76
Balochistan	43	42		43	55	56		56	58	49		53
Islamabad	91	93		92	88	76		83	86	95		90
Attock	100	87		93	91	83		87	98	97		97
Karachi	87	88		87	91	91		91	90	87		89
Malakand	95	92		93	89	92		91	95	97		96
Barkhan	66	70		68	85	93		93	96	88		91
DIARRHOEA LAST 30 DAYS(UNDER 5 YEARS)	**M**	**F**		**T**	**M**	**F**		**T**	**M**	**F**		**T**
OVERALL	**11**	**10**		**10**	**12**	**11**		**11**	**10**	**10**		**10**
Punjab	11	9		10	11	11		11	10	10		10
Sindh	12	13		12	12	13		12	10	9		9
Khyber Pakhtunkhwa	10	10		10	11	10		10	11	11		11
Balochistan	7	6		6	14	13		13	14	13		14
Islamabad	9	10		9	12	15		14	6	4		5
Layyah	15	11		13	19	19		19	28	32		30
Jaccobabad	4	4		4	7	6		7	24	21		23
Nowsehra	9	8		9	4	4		4	17	18		17
Mastung	6	8		7	21	23		22	39	45		42

PRE NATAL CONSULTATION												
(percentage of Married	**U**	**R**		**T**	**U**	**R**		**T**	**U**	**R**		**T**
women aged 15-49 years)												
OVERALL	**77**	**50**		**58**	**79**	**57**		**64**	**83**	**63**		**69**
Punjab	75	55		61	79	63		68	83	69		73
Sindh	84	43		60	85	49		65	86	55		68
Khyber Pakhtunkhwa	67	46		49	69	49		52	76	56		59
Balochistan	57	30		36	55	41		44	65	45		50
Islamabad	98	96		97	95	92		93	98	93		96
Lahore	80	62		77	85	68		82	95	73		91
Karachi	98	72		96	94	69		93	95	79		94
Haripur	95	90		90	82	75		76	86	81		82
Harnai	0	0		0	0	76		76	80	80		80
TETANUS TOXOID												
(percentage of Married	**U**	**R**		**T**	**U**	**R**		**T**	**U**	**R**		**T**
Women aged 15-49years)												
OVERALL	**84**	**61**		**68**	**83**	**63**		**69**	**86**	**67**		**72**
Punjab	87	72		76	86	74		77	91	77		81
Sindh	81	39		57	84	42		60	83	48		63
Khyber Pakhtunkhwa	83	61		64	74	58		61	81	62		65
Balochistan	47	18		24	41	28		31	48	26		31
Islamabad	98	96		97	93	93		93	98	99		99
Sialkot	98	93		94	96	93		94	98	95		96
Karachi	92	59		91	95	61		94	92	56		91
Malakand	82	85		84	83	84		83	88	86		86
Kalat	49	6		11	42	63		60	49	85		77
POST NATAL												
CONSULTATION	**U**	**R**		**T**	**U**	**R**		**T**	**U**	**R**		**T**
(percentage of Married												
Women aged 15-49 years)												
OVERALL	**37**	**21**		**25**	**38**	**24**		**28**	**37**	**25**		**29**
Punjab	38	20		25	40	24		28	37	25		28

Sindh	38	23	29	40	29	34	40	31	35
Khyber Pakhtunkhwa	28	22	23	29	22	23	30	22	23
Balochistan	27	12	15	22	17	18	28	21	23
Islamabad	81	73	77	69	75	72	78	74	76
Rahim Yar Khan	47	47	47	43	50	49	55	44	46
Hyderabad	60	21	52	69	28	60	74	34	68
Lower Dir	22	43	41	28	48	47	25	43	42
Sibbi	28	5	13	30	16	22	36	47	41

Women's vulnerability to health failures is not only the result of supply side factors in terms of provision of health care but also due to the demand side factors, shaped by patriarchal culture.Maternal malnutrition is estimated at 26% and nearly 36% women in reproductive age are anaemic.

[44]Currently, women in Pakistan have an average of 3.8 children. This is comparable to Tajikistan, but higher than TFR in Kyrgyz Republic, Nepal, and Bangladesh. Fertility in Pakistan has decreased from 5.4 births per woman to 3.8 births per woman in the past 23 years.

Fertility varies by residence and region. Women in urban areas have 3.2 children on average, compared with 4.2 children per woman in rural areas. Fertility is highest in Balochistan, where women have an average of 4.2 children. Fertility is lowest in ICT Islamabad, where women have an average of 3.0 children. Fertility also varies with mother's education and economic status. Women who have higher education have an average of 2.5 children, while women with no education have 4.4 children. Fertility increases as the wealth of the respondent's household* decreases. The poorest women, in general, have 2.5 children more than women who live in the wealthiest households (5.2 versus 2.7 children per woman).

[45]Eight percent of adolescent women age 15-19 are already mothers or pregnant with their first child. Teenage fertility has decreased over time from 16% in 1990-91 to the current level of 8%. Young motherhood is highest in Khyber Pakhtunkhwa (10%) and lowest in Gilgit Baltistan and Balochistan (7% each). More than 10% of adolescent women with no education have begun childbearing compared with less than 5% of women with at least a middle school education. Teenagers from the poorest households (12%) are more likely to have begun childbearing than those from the wealthiest households (3%).

[46]Thirty-five percent of women age 25-49 were married by age 18 and more than half (54%) were married by age 20. There is evidence that age at first marriage among women in Pakistan is rising.

[44]National Institute of Population Studies [Pakistan] and ICF International. 2013. Pakistan Demographic and Health Survey 2012-13. Calverton, Maryland, USA: National Institute of Statistics and ICF International.

[45]ibid
[46]ibid

The median age at first marriage increased from 19.1 years in 2006-07 to 19.5 years in 2012-13. The median age at first marriage among Pakistani men age 30-49 is 24.7

[47]Knowledge of Family Planning methods in Pakistan is universal; 99% of ever-married women and 95% of ever-married men know at least one modern method of family planning. The most commonly known methods among ever-married women are injectables (95%), the pill (95%), and female sterilization (91%). Among ever-married men, the most commonly known methods are the condom (89%), the pill (85%), and injectables (82%).

More than one-quarter of married women currently use a modern method of family planning. Another 9% are using a traditional method. The condom and female sterilization (9% each) followed by injectables (3%) are the most commonly used modern methods. Use of modern family planning methods varies by residence and region. Nearly one-third of married women in urban areas use modern methods, compared to 23% of women in rural areas.

Modern contraceptive use ranges from a low of 16% among married women in Balochistan to a high of 44% in ICT Islamabad. Modern contraceptive use increases with education; 30% of married women with higher education use modern methods compared with 23% of married women with no education. Modern method use is highest among women from the wealthiest households (32%).

Trends in Family Planning Use of modern family planning methods has increased from 9% in 1990-91 to 26% in 2012-13. The use of female sterilization, condoms, and withdrawal increased slightly since 2006-07.

[48]Public sources, such as government hospitals and lady health workers, currently provide family planning to 46% of current users, while the private medical sector provides methods to 35% of users.

Two-thirds of female sterilizations are accessed at public facilities, while condoms are primarily accessed from the private sector. 26 35 9 Any method Any modern method30% of married women with higher education use modern methods compared with 23% of married women with no education. Modern method use is highest among women from the wealthiest households (32%).

[49]Use of modern family planning methods has increased from 9% in 1990-91 to 26% in 2012-13. The use of female sterilization, condoms, and withdrawal increased slightly since 2006-07.

[50]Unmet need for family planning is defined as the percentage of married women who want to space their next birth or stop childbearing entirely but are not using contraception. The 2012-13 PDHS reveals that one in five married women have an unmet need for family planning—9% of women have a need for spacing births and 11% for limiting births. Women living in Balochistan (31%) and women in the lowest wealth quintile (25%) are most likely to have an unmet need for

[47]ibid
[48]ibid
[49]ibid
[50]ibid

family planning. Unmet need is higher among women with no education (22%) than among women with higher education (15%).

Almost two-thirds of women report having at least one problem accessing health care for themselves. More than half of women were concerned about going alone. Four in ten women were concerned about management of transportation. More than one-third of women were concerned about distance to the

[51]Almost three-quarters of women receive antenatal care (ANC) from a skilled provider (doctor, nurse, midwife, or lady health visitor), most commonly from a doctor (67%). One in four women had no ANC at all. ANC coverage varies by region. About 30% of women in Balochistan received ANC from a skilled provider compared to 94% in ICT Islamabad.

The timing and quality of ANC are also important. Forty-two percent of women had an ANC visit before their fourth month of pregnancy, as recommended, and more than one-third (37%) of women made four or more ANC visits. Nearly half (45%) of women took iron supplements or syrup during pregnancy. Half of women were informed of signs of pregnancy complications during an ANC visit. Nearly two-thirds (64%) of women's most recent births were protected against neonatal tetanus.

Nearly half of births occur in health facilities, primarily in private sector facilities. Facility-based births are least common in Balochistan (16%). More than half of births occur at home. Home births are more common in rural areas (60%) than urban areas (32%).

Among children under the age of five 43.6% are stunted, 15.1% are wasted and 31.5% are underweight and 62.5% are anaemic.[52]More than 350,000 children die in Pakistan every year before the age of five and 35% of these deaths are due to malnutrition.[53]

The ideology of sexual division of labor that defines women's role in the reproductive arena of home is the determining factor in creating gender inequalities. This gender status quo is maintained through the institution of segregation/***purdha*** and gender based violence.

Women are denied equal access to education, health and employment opportunities. Women's low social and economic status makes them dependent on men for their survival. The institution of marriage establishes the patriarchal control of men over their bodies and lives.

The private patriarchy is strengthened and reinforce by public patriarchy through laws, religion, local customs, traditions and masculine institutions. Women's inferior socio-cultural status has implication for their life chances as they are unable to take decision about their own well being. However, it must be stated that there are variation in the health status of women because of their social position in terms of class, religion, ethnicity or other social identities. Women are poor class background are more vulnerable to health socks.

[51]ibid
[52] WHO, Country Office Pakistan. HPP Health Protection & Promotion Cluster
[53] The Express Tribune, July 9, 2013 pg 5.

Children from poor classes are also extremely vulnerable. Almost 3.3 million children are working in the country and a significant number in bonded labor. They are often employed in the informal sector of the labor market. The vast majority of informal jobs are characterized as low status, low paid, exploitative and hazardous. Children and women constitute 70% of labor force in the informal sector of the economy. About one out of thirty-three i.e. 2.8 per cent of the labor force reported some sort of occupational injury or disease in 2003-04. The majority of sufferers fall in the category of the self-employed[54].

In Pakistan, there are an estimated 500,000 "eunuchs"—a community of castrated men, hermaphrodites, transsexuals, transvestites, and homosexuals.[55]This is one the most vulnerable and extremely marginalized section of society. They were even denied the right to citizenship till 2011 when the Supreme Court recognized them as a "third gender," and ordered that they be issued separate identity cards and given the right to vote. They are normally live in the fringes of the society in isolation, cut off from the larger community. Their only profession is singing and dancing on wedding and child birth or begging.

They are often attacked, raped or forced to work as sex workers to support themselves. They are routinely denied public healthcare. Their special health needs are completely ignored by the health sector.

In recent years there are an increasing numbers of internally displaced people (IDPs) due to conflict and disasters. 1 [56]An estimated five million people have been displaced in the north-west of the country since 2004. IDP movements peaked n 2009 when three million people were forced to flee their homes. The loss of livelihood and homes, limited assistance from the state, lack of income opportunities have systematically eroded the ability of IDPs to access health services and increased their vulnerability.

[57]Pakistan currently hosts some 1.6 million registered Afghans, the largest protracted refugee situation globally. Since March 2002, UNHCR has facilitated the return of 3.8 million registered Afghans from Pakistan in the world's largest voluntary repatriation operation.

Moreover, Pakistan's economy has been constantly battered by natural disasters, such as earthquakes, floods and droughts since 2005.Natural disasters played havoc with human lives and adversely affected the economy of the country. Nearly 32.8 million people have been victims of these disasters. The massive earthquake of 2005 left over 83,000 dead, while the devastating flood of 2010 affected 20 million people.

Natural disasters directly affect people's physical and mental health. There is always a disproportionate impact of these catastrophes on poor because of their vulnerable social and

[54]Amjad, Rashid, Pakistan's Poverty Reduction Strategy: Why Employment Matters in The Lahore Journal of 52. AFPComment: We Won't Dance': Pakistan's Transgender Candidates Hit the Campaign Trail,, April 18

[56] http://www.internal-displacement.org/south-and-south-east-asia/pakistan/figures-analysis
[57] http://www.unhcr.org/pages/49e487016.html

economic position that undermines their capacity to recover. Natural disasters expose poor to all types of illnesses because of food insecurity, lack of access to safe drinking water that often results in water-borne infectious diseases such as diarrheal; malaria; dengue; cholera; and gastroenteritis.

The other socially excluded groups such as disabled and mentally sick, and HIV/AID are not only vulnerable because of their lack of access to health care that cater to their special needs, but also because of social stigma attached and discrimination they face socially as well as in the health care system.

The vulnerability analysis of the health sector should be central to the health sector reforms from Human Rights perspective. The social mapping of vulnerability and various forms of discriminations is essential for the integration of HRBA in health policy and strategies. Vulnerability and health are intimately inter-linked.

In this political and economic backdrop, the vulnerability analysis of those who have the worst health outcomes can be conducted from the poverty and disease perspective, although both are not mutually exclusive.

Poor and the socially marginalized are deprived in social and economic terms. They lack opportunities and access to resources that are critical for good health. Then there are vulnerable group of people who bear the burden of certain diseases such as HIV-AID, Hepatitis, TB, and Cancer etc.

The uneven socio-economic development of the country has created vast disparities amongst people. There are certain groups in the society who are systematically discriminated and excluded from opportunities and structures of power structures on the basis of their social class, gender, religion, language, caste, age, disability, or other social identities.

Such multidimensional disadvantage prevents these groups from accessing resources, having voice and claiming rights. There are significant disparities in terms of access to healthcare and health indicators between rich and poor, rural and urban as well as between and within provinces. The link between vulnerabilities and poor health indicators needs to be better understood for effective policy interventions

Issues in Health Sector from Human Rights Perspectives

The institutional analysis of the health sector from HRBA requires an analysis of the inequalities and discriminatory practices that exist in accessing health care and how to address them.

Resource constraints will determine how fast the progress is in achieving the full realization of the right to health, but what requires immediate effect is that the right should be exercised on the basis of equity and non-discrimination. The HRBA would therefore ensure the movement towards the realization of the right to health as laid down in national and international human rights legislation.

Biological or socio-economic factors or a combination of the two can result in certain groups or individuals being unable to enjoy their right to health. Similarly this can happen as a result of discrimination or stigma.

Examples of these people are children, women, persons with disabilities, and people living with HIV &AIDS, the poor, and ethnic or religious minorities. Very often the socio-economic context is such that it is usually a multiple of these situations that affect an individual's or a group's right to the highest attainable standard of physical and mental health.

Consideration of health as a right requires that the state pay specific attention to these socially marginalized groups and individuals. Seemingly neutral laws and policies do not address these needs, and benefit mainly the majority or the privileged. Therefore states need to adopt positive measures by tailoring health laws and policies to those that are otherwise marginalized.

The ability to access health care is one aspect of the right to health. The object of the right to the highest attainable standard of physical and mental health involves factors beyond access to health care. Therefore, there is an increasing attention on underlying determinants of health, which are diverse in nature, but all contribute towards a healthy life.

As mentioned earlier safe drinking water and sanitation, safe food, adequate nutrition and housing, healthy working and environmental conditions, health-related education and information, and gender equality are not only rights in themselves these are intimately connected to the right to health. Therefore the realization of the right to health will involve the realization of these rights as well.

The assessment of health sector from rights perspective demands a shift in focus from the six building blocks of the health system to the end goal that is a provision of available, accessible, acceptable and good quality health care without any discrimination.

This section gives an overview of the health sector using the framework of Availability, Accessibility, Acceptability and Quality (AAAQ) as these are four interrelated and essential elements in the right to health

Availability means that health care logistics and equipments, services and programmes have to be in sufficient quantity and delivered through functional facilities. Also this will include the underlying determinants of health, such as safe and potable drinking water, adequate sanitation facilities, housing, employment and gender equality.

Accessibility means health facilities; goods and services should be accessible to everyone without discrimination. Accessibility has fur overlapping dimensions:

"(i) Non-discrimination: accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds

(ii) Physical accessibility: within safe physical reach for all sections of the population especially vulnerable or marginalized groups such as ethnic minorities, indigenous population, women, children, adolescents, and older persons, persons with disabilities and persons with HIV-AID. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, are within safe physical reach, including in rural areas. This also includes adequate access to buildings for persons with disabilities.

(iii) Economic accessibility (affordability): must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principles of equity, ensuring that these services, whether privately or publically provided are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

(iv) Information accessibility: right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

Acceptability: Services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned. Acceptability

Quality: As well as being culturally acceptable, heath facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water and adequate sanitation"[58].

[58] Taket, Ann (2012) Health Equity, Social Justice and Human Rights, Routledge, London. (pg18)

Availability

The availability of health services is the most critical factor in promoting and protecting public health. This includes functional health care facilities as well as the availability of the underlying determinants of health.

In Pakistan, the health needs of people are met through a mix of public and private health care systems. The private health sector is catering for two-thirds of the people in need of medical care from all over the country with regional variations.

According to the official Pakistan economic survey,2013-14, in the whole country, there are 1,096 hospitals, 5,310 dispensaries, 5,527 basic health units and 687 maternity and child health centre's in Pakistan as compared to 1,092 hospital, 5,176 dispensaries, 5,478 basic health units and 628 maternity and child health centre's in the same period of last year. ` The number of doctors has increased to 167,759, dentists 13,716, nurses 86,183 and hospital beds 111,953 in the country during 2013-14 compared to 160,880 doctors, 12,692 dentists, 82,119 nurses and 111,726 hospital beds last year. The population and health facilities ratio worked out 1,099 persons per doctors, 13,441 persons per dentist and 1,647 persons per hospital bed. It was 1,123 persons per doctor, 14,238 per dentist and availability of one bed for 1617 person in 2012-13. ` During July-April, 2013-14, 32 basic health units and 7 rural health centre's have been constructed, while 10 rural health centre's and 37 basic health units have been upgraded. During nine months of 2013-14, 5,000 doctors, 500 dentists, 3,150 nurses and 4,500 paramedics have completed their academic courses and 3,600 new beds have been added in the hospitals compared to 4,400 doctors, 430 dentists, 3,300 nurses, 4,500 paramedics and 4,200 beds over last year. Moreover, some 6 million children have been immunized and 21 million packets of ORS have been distributed. A number of health program are implemented, which include Malaria, TB, AIDs and Food and Nutrition program.

For the current year a total outlay for health sector is budgeted at Rs.102.3 billion which included Rs.27.8 billion for development and Rs.74.5 billion for current expenditure which is equivalent to 0.40 percent of GDP during 2013-14 as compared to 0.35 percent in 2012-13.

Essential Drugs:

The availability of essential drugs of good quality at an affordable price is another imperative for public health. The liberalization policy of drug prices and quality control has led to an unchecked increase in the price of essential drugs in the market. Pakistan spends more than 80% of its total health expenditure on buying medicine and yet essential medicines are often not available in public sector health facilities due to corruption, pilferage, lack of monitoring and accountability[59].

There are certain areas in the health domain where the gap between needs and the availability of health care services is more pronounced, particularly in reproductive, sexual and mental health.

[59] Ibid

There is constitutional provision under article 37 that obligate the state to ensure the maternity benefits for women in employment. Four different laws relates to maternity and its related benefits:

- The Mines Maternity Benefits Act, 1941
- The West Pakistan Maternity Benefit Ordinance, 1958
- The Provincial Employees Social Security Ordinance, 1965
- The Civil Servants Act, 1973 (Revised Leave Rules, 1980)

Maternity Leave: The article 37 of the Constitution of Pakistan makes reference to maternity benefits for employed women, they are only provided to women employed in certain occupations. The Maternity Benefit Ordinance 1958 stipulates that upon the completion of four months employment or qualifying period, a worker has the right of up to six weeks pre-natal and post-natal leave during which she is paid salary drawn on the basis of her last pay. The ordinance is applicable to all industrial and commercial establishments in the country, excluding the tribal areas. It also places restrictions on the dismissal of women employees on maternity leave.

As per Section 3 of WPMBO, no employer shall knowingly employ a woman and no woman shall engage in employment in any [establishment] during the six weeks following the date she delivers a child. Section 4 of the WPMBO provides right to and liability for payment of maternity benefits."Subject to the provisions of this Ordinance, every woman employed in an establishment shall be entitled to, and her employer shall be liable for, the payment of maternity benefit at the rate of her wages last paid during the period of six weeks immediately preceding and including the days on which she delivers the child and for each day of six weeks succeeding that day.There is no legal provision of paid paternity leave for a father. **However, the Government of Punjab has amended the Revised Leave Rules, 1981 on 30th October, 2012 and now a male civil servant can take paternity leave of a maximum of seven (7) days outside his leave account immediately on or after the birth of a child[60].**

Breast-Feeding: There is no clear provision on breast-feeding (breaks) however Factories Rules (93 under section 33-Q) require employer to facilitate nursing mothers at the workplace. Every factory wherein more than 50 women are employed has to provide a room or rooms for the use of children, under the age of 6 years, belonging to these women workers. It also requires employers to hire a trained nurse and a female servant to attend to these children during working hours. Women workers can also use these rooms for breast-feeding during their rest/meal breaks. These rooms are restricted only to children, their attendants and children's mothers.

[60] Punjab Govt has already issued the notification No. FD.SR.II.9-107/2012 dated 30th October 2012 in connection with Paternity Leave as well as Maternity Leave for the Provincial Govt Employees.. http://www.glxspace.com/2012/12/10/download-copy-of-notification-of-paternity-leave-maternity-leave-punjab-govt-employees/

Post Abortion Care: [61]The number of unsafe abortions is increasing across South Asia, also in Pakistan, where abortion is only permitted under special circumstances. The law on abortion is vaguely interpreted by the legal community.

Mental health is another domain of health that has been badly neglected by the state and society. The deteriorating social and economic conditions in the country, increasing poverty, unemployment, conflicts, violence and the breakdown of law and order situation, increasingly exposes people to multiple stresses, leading to different kinds of mental illnesses.

Social attitudes toward mental illness are based on misperception, superstition, lack of knowledge and information. Mental illnesses are socially stigmatized. The social stigma related to mental illness is rather worst in the case of women and girls. These are associated with lunacy and institutionalized treatment in mental asylums. People are reluctant to seek professional help due to illiteracy, lack of awareness, knowledge and fear of disclosure. They prefer to go to local quacks, traditional or religious healers (pirs/fakirs) and visit shrines rather than seeking psychiatric treatment.

At the state level, the mental health legislation was enacted in 2001. The Ministry of Health developed a National Policy on Mental Health in 2003. A National Mental Health Authority also exists in Pakistan that provides advice to the government on mental health policies and legislation.

However, the state of mental health is abysmal. The burden of all forms of mental morbidity is about 10-16% in the country. The provision of mental health services is inadequate. There is no systematic epidemiological data available due to lack of awareness and stigma attached with mental health that leads to under reporting. In 1987, a working group report of the Planning Commission on mental health reported the figure of one million severely ill and 10 million mildly mentally ill people within the country[62]. Almost 30-35% of patients at PHC shows some symptoms of mental disorder but has never been investigated or diagnosed[63]. Women are more likely to suffer from mental disorders than men. In urban areas mental disorder reported at 10% among men and 25% amongst women while in rural areas, the prevalence rate is 15-25% among males and 46-66% among women[64].

Mental health is not integrated in public health response and facilities. Specialized services are few and far between. There are five mental hospitals and 3729 outpatient mental health facilities in the country. The total number of professionals working in mental health facilities or private practice per 100,000 populations is 87.023[65].

---

[61]A qualitative enquiry among the legal community of Pakistan.Syed Khurram Azmat , Mohsina Bilgrami , Babar T. Shaikh , Ghulam Mustafa & Waqas Hameed,Marie Stopes Society, Pakistan.2011.

[62] Planning Commission. A Report of the sub-working group on mental health care in Pakistan, 1987.

[63] Ministry of Health, Health for all by the year 2000

[64] Heart file, National Action Plan for Prevention and Control of Non-Communicable Diseases and Health Promotion in Pakistan.

[65]Ministry of Health, WHO-AIMS Report on Mental Health System in Pakistan, 2009

The public sector contributes only 23% of total expenditure on health. In contrast, private sector contributes 77% of health expenditure. It means that total 3to 4% of GNP is spend on health, with 2 to 3% of GNP is spend on private healthcare sectors (Sheikh, 2010). “Pakistan spends $17 per capita on health, and $13 of this amount comes from out-of-pocket expenses” .

The government of Pakistan and other developmental agencies like NGOs always strive for public private partnership but there is no well defined strategy to regulate both. However, the unregulated private healthcare facilities have some illegal and unethical issues such as mal practice of healthcare professionals, over charging patients, unnecessary prescriptions of medications and laboratory test without any indications and so on. Several studies has concluded that the overall utilization of private healthcare facility is 80% whereas 20% is from public healthcare facilities by the population[66].

[66] COMPARISON AND ANALYSIS OF HEALTH CARE DELIVERY SYSTEM:
PAKISTAN VERSUS CHINA- International Journal of Endorsing Health Science Research
www.aeirc-edu.com Volume 2 Issue 1, June 2014.Shaista Taufiq Meghani, Sana Sehar & Neelam Saleem PunjaniAga Khan University School of Nursing and Midwifery. Karachi, Pakistan.Corresponding

Health Education and information

Health Education and information is another important aspect of the right to health. This is one of the components of Health for All. The Health Education Cell that was working in the Ministry of health prior to Devolution and the Health Education Units at the provincial levels impart heath education and information to the public.

Health education is a part of the training curriculum in medical colleges, nursing schools and training programs of paramedical staff. School Health Programs are designed and community based health information programs are delivered through lady health workers. Health education campaigns on EPI, ORS, Family Planning, AIDS, Smoking, Breast Feeding, Drug Addiction and other health issues are designed to create public awareness. However, the communication strategies clearly have an urban and gender bias. Electronic and print media is the primary source of imparting health information. The way messages are delivered in the print and electronic media, reaches mostly only urban populations. The public health awareness campaigns are neither well designed nor properly communicated. The level of understanding on health issues is generally low in Pakistan.

Three-Tier Network of Physical Infrastructure for Health

Pakistan has a well-established three-tier network of physical infrastructure for health. The First Level Care Facilities (FCF), Basic Health Units (BHUs) and Rural Health Centers (RHUs) are at the grass roots level. At the Tehsil and district levels there is a network of Tehsil Headquarters Hospitals (THQHs) and District Head Quarters Hospitals (DHQHs). However the inoperativeness of public health facilities is the major issue that negates people right to health.

Absenteeism of medical personnel, lack of availability of specialist staff such as gynaecologist, anaesthetist and paediatrician and lack of medicines, vaccines supply and functional equipments in public health facilities seriously undermines people's right to seek medical assistance from public health facilities.

The opportunity cost in terms of low quality of care, travelling over long distances and long waiting times is high. That is why the First Level Care Facilities are largely underutilized in rural areas as compared to urban health where these are relatively functional and thus over crowded. Poor governance and dysfunctional facilities disproportionately affect the poor and women who are the end users of public sector health care.

The spread of public health facilities is fairly unequal around the country. There is clearly an urban bias in the availability of health services. The majority of people [67](68%) live in rural areas but the health workforce is concentrated in urban areas. Similarly, geographical spread of public health facilities is uneven and inappropriate. Some of the facilities are physically inaccessible to people

[67] http://www.pbs.gov.pk/sites/default/files/tables/DEMOGRAPHIC%20INDICATORS%20-%201998%20CENSUS.pdf

living in remote areas. Despite the national commitment for universal coverage of services, there are stark disparities in the health status of people across class, rural/urban and gender divide.

The availability of services on the face of growing population is shrinking. The physical infrastructure is not expanding to match the population growth rate. Pakistan is spending a meagre portion of 0.9% of its GDP on health[68]. In 2007, per capita health spending of Pakistan was US $ 64 whereas India was spending $ 109, Sri Lanka, $179.[69]

Similarly, the majority of people are unable to access social services that impact health. There is a clear urban bias in the availability of services. Only 65% people in Pakistan have access to safe drinking water. In rural areas, 55% population have access to safe drinking water as compared to 85% urban population.

A total of 42% population has sanitation facilities, 65% urban and 30% rural. With the exception of big cities, sanitation services are almost non-existent. 45% households have no access to latrines; only 51% households are connected to any form of drainage system. Similarly, half of the urban population is living in slums and katchi abadis.

According to the 1998 census there are 19.3 million households in Pakistan with an average size of 6.6 persons and occupancy at 3.3. Persons per room. 39% of houses are kucha, mostly without a proper water supply, 40% semi-pucca, mostly without planned sanitation or sewerage and 21% pucca houses. Incremental housing demands in the country is 570,000 units per annum while only 300,000 are constructed with a backlog estimated at 4.3 million in 2005.

The share of housing in public sector programmes has decreased from 10.9% in 1960s to 5.9% in 1990s. More than 80% of the population cannot afford the financing terms of HBFC and other institutions, so construction of low income housing has been much slower than the incremental needs.[70]

[68]Nishtar, Sania, Zulfiqar Bhutta and et.al, Health reform in Pakistan: a call to action. Lancet 2013. Published on line
[69]WHO, Country cooperation Strategy for Pakistan 2011-2017
[70]Planning Commission, Medium Term Development Framework 2005-10, May 2005

Accessibility

Availability of services is the precondition for accessibility of health care. However, the availability of services does not automatically ensure accessibility to health services for all. There is a relationship between accessibility and diversity. The social status of people in society influences access to health services and health determinants.

The concept of accessibility as defined in the General Comment 14 of CESCR has four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility and accessibility to information for all sections of the population.

The health profile of the population reflects health inequalities along the rural/urban, male/female and regional divide. The rural poor, population living in remote areas, conflict zones and disaster prone areas, and women as a social group are amongst those who have the least access to health and health related resources.

Women do not enjoy equitable health outcomes due to their weak social and economic position in society. The poor health status of women vis-à-vis men shows that gender plays as a determining factor in mediating women's access to health care. The patriarchal cultural context of the country that establishes male control over resources, women's bodies and lives, shapes women's ability to access health care services and other health related rights.

The cultural perception of women as lesser beings is the rational for investing fewer resources in building their human capital. The traditional practices of gender discrimination in intra-household food distribution, early marriages, high fertility, multiple pregnancies, marital rape, inability to negotiate safe sex and domestic violence makes women far more vulnerable to health failures. Thus women's inferior social and economic position combined with restrictions on their mobility limits their access to health care.

Gender and ethnic imbalance in health care professionals is another factor that impinges on the issue of accessibility for women, girls and ethnic groups. In the cultural context of Pakistan, women are often reluctant to see male doctors especially if they have genealogical problems

Physical distance to health facilities, especially secondary and tertiary level care is another impediment in accessing health services. People living in rural and mountainous areas especially find it hard to reach public health services due to poor road infrastructure.

Violence against women is a serious public health issue in Pakistan. According to a research study conducted by the Ministry of Women's Development, every third women in Pakistan is a victim of domestic violence[71]. Domestic violence has serious consequences not only for women but also on children who live in violent homes. Medical research has established a link between exposure to domestic violence as a child and health problems as an adults. It contends that men and women

[71]Ministry of Women's Development-undated

who experienced violence in the home as children are two to three times more likely to suffer from cancer, a stroke or cardiovascular problems, and five to ten times more likely to use alcohol or illegal drugs[72]. The capacity of service providers to identify or to treat cases of gender based violence is extremely limited.

The key findings from the PDHS 2012-13 are as follows:

- Thirty-two percent of ever-married women age 15-49 have experienced physical violence at least once since age 15, and 19 percent experienced physical violence within the 12 months prior to the survey.
- Overall, 39 percent of ever-married women age 15-49 report ever having experienced physical and/or emotional violence from their spouse, and 33 percent report having experienced it in the past 12 months.
- Among ever-married women who had experienced spousal physical violence in the past 12 months, 35 percent reported experiencing physical injuries.
- One in 10 women reported experiencing violence during pregnancy.
- Fifty-two percent of Pakistani women who experienced violence never sought help or never told anyone about the violence they had experienced

According to a report based on the findings of the Pakistan Demographic and Health Survey (PDHS) in which, among various other questions, respondents were asked to choose reasons for which it is justified for a husband to hit his wife.

The six circumstances were: if the wife burns the food, if she argues with him, if she goes out without telling him, if she neglects the children, if she refuses to have sexual intercourse with him and if she neglects her in-laws. Respondents were allowed to choose multiple reasons.[73]

The rapid assessment conducted by WHO to assess "Health Sector Capacity and Response to Gender-based Violence in Pakistan" (2011) concluded that the health sector does not have any policy for addressing gender based violence. There is no data management systems on GBVand health providers lack understanding and sensitivity to violence against women. The health system in the country is not geared to provide medical and psychosocial support to survivors of violence. It is also ill equipped for screening, DNA testing, medical treatment and in medico-legal services. There is lack of sensitivity, knowledge, commitment and capacity of the health delivery staff to effectively deal with women survivors of violence.

Similarly, there are other excluded and high risk groups such as transgender, transsexuals, male and female sex workers, drug addicts; People living with HIV/AIDs whose health needs are neglected due to the socio-cultural and personal biases among health service providers.

[72] The World Bank, World Development Report 2012, Gender Equality and Development (pg 5).
[73] tribune.com.pk/story/663321/34-of-women-believe-that-their-husbands-are-justified-to-hit-them-if-they-argue-with-him-survey/

Affordability

Another important aspect of accessibility relates to affordability of services. There is a reasonable network of health infrastructure in the public sector that provides free of cost health care. However, the majority of people in Pakistan are unable to access these services because of poor quality and non-functionality of health facilities. They are seeking services largely from the private health sector and pay out of pocket. Private health expenditure is 78.8% out of which private households spend 92%, while the government is spending only 25% of total health expenditure in the country[74].

Social Insurance System

With increasing poverty and high unemployment, people's economic power to purchase health care is diminishing fast. Although in Pakistan, a social insurance system exists in the form of social security since 1967, however its scope is limited. There are inadequate safety nets for the poor. Only 5% of the population is covered through social security provided by the government. Combined figures of population who have health cover fully or partially by government entities which include employees, social security institutions, military and cantonments, zakat and bait-ul-mal and Benazir Income Support Program, as well as private health insurance and autonomous bodies and firms providing health care to their employees is only 26.62 percent[75].

Increasing inflation (8.1%),high unemployment, lack of regulation of the private sector and drug price control makes health care unaffordable for the poor and marginalized sections of society in general and women in particular. Women often lack independent source of income. Their economic dependence makes them more vulnerable to health failure.

[76]South Asia is still home to the largest group of population left without any kind of protection against social risks. Countries like Pakistan still face today the daunting challenge of extending social security benefits to all workers operating in the informal economy which account for more than 70% of the total labour force. With a critical mass of poor people dependent upon informal activities there is obviously the need for efficient protection mechanisms that can reduce their particular vulnerability to various shocks and stresses. For a country like Pakistan still trying to bridge a huge social protection gap, the central policy challenge would probably be to design pluralistic, social security systems that combine a range of protective mechanisms in an effective way to provide adequate levels of protection to all groups of the society on the basis of universal access to at least some minimum level of protection for all.
"The ILO has been providing assistance to Pakistan in the areas of:

- Policy, legal and regulatory context for social security and social protection in Pakistan;

[74] Pakistan Bureau of Statistics, National Health Accounts Pakistan 2007-2008
[75] Sania Nishtar, Choked Pipes, Oxford University Press, 2010
[76] http://www.ilo.org/islamabad/areasofwork/social-security/lang--en/index.htm

- Institutional arrangements for social security and social protection, both governmental and non-governmental;
- Social security and social protection schemes and mechanisms that could be made available to the population;
- Social security extension plans presently being considered under the various development programmes adopted at the national level such as Pakistan Baitul Mal and Benazir Income Support Programme and at the provincial level such as Benazir Bhutoo Shaheed Youth Development Programme in Sindh."

[77]In a paper by PIDE it was noted that "An examination of the public pension and social security schemes in Pakistan reveals that the provision of regular pensions is limited to formal sector employees only. A number of social security schemes that are operational in the public and private sectors cover a small proportion of old-age population, whereas a significant proportion of the elderly population working in the informal sector remains largely unprotected by social security schemes. As such, the challenge of meeting the needs of the increasing elderly population demands an improvement of the support base and social security system in Pakistan that emphasises the need to implement reforms of public pensions and programmes of social protection. Efficient deployment of resources and improvement of the governance structure are needed for effective welfare of the eligible sub-group of the elderly and the economically disadvantaged population."

Acceptability

Pakistan is a pluralist society with diverse cultural, religious and ethnic backgrounds. Health service decision makers and provider's understanding and sensitivity to the diversity of culture, respect for individual dignity, patient privacy and confidentiality, sensitivity to gender, adherence to medical ethics are the core values that make health services culturally acceptable for all.

It is the fundamental right of the people to receive culturally and linguistically appropriate health care. This requires that the health sector recruit culturally competent staff with diverse background and representative of the diverse demographic population of the service area. There is hardly ethnic, religious or cultural parity in the workforce of health sector. Also the health sector staffs are not trained in cultural sensitivities.

There are no standards that are followed by health professionals to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner.

The gender imbalance in health workforce hampers women's access to health care services because of sex segregation in the society

[77] "Pension and Social Security Schemes in Pakistan: Some Policy Options".Nausheen Mahmud AND Zafar Moin Nasir.PIDE Working papers.2008.:42.

Quality of Care

Health services should provide scientifically and medically good quality of care. Quality of care remains a serious concern in Pakistan. One of the main reasons for the underutilization of public health facilities is the poor quality of health care. Even poor tend to bypass public health services because of the poor quality of care. They are forced to seek treatment in the private sector which put pressure on their meager economic resources.

The basic concept of quality of health care includes effectiveness, efficiency, accessibility, acceptability, equity and safety.[78] The health care system in Pakistan is foundering on all these accounts.

The provider-client relation is central to public health care. Pakistani society is highly status conscience. People get different treatment because of their personal characteristics of socio-economic status, gender, ethnicity etc. Poor are often not treated with respect and given equitable care and personal attention by health professionals.

Lack of regulation and monitoring of the private sector where unqualified people are practicing medicine often exposed patients to low quality treatment. In the absence of accountability mechanism, people are unable to register cases of discrimination or medical negligence. They are silenced though patterns of humiliation, exclusion and alienation.

[78] WHO, Quality of Care: A Process for Making Strategic Choices in Heath System, 2006

Issues in Health Programs from Human Right Perspective

The analysis of the health sector through the AAAQ framework highlights issues of exclusion, health inequities, lack of integration of a rights based approach in the health system and delivery of health services. By applying the lens of health as a human right, this section presents an analysis of some of the key health programs. Attention is focused on how they affect the large majority of the poor in general and women in particular.

Expanded Program on Immunization (see related text described earlier under issues in health sector)

The Expanded Program on Immunization (EPI) Pakistan aims at protecting children below 23 months of age against eight vaccine-preventable diseases - Childhood Tuberculosis, Poliomyelitis, Diphtheria, Pertussis, Measles, Tetanus and also immunizing mothers against Tetanus to reduce morbidity and mortality.

The government of Pakistan has the exclusive responsibility of providing immunization services to the entire population. The private sector only provides 3% of the immunization[79].

"The startling facts revealed by the Pakistan Demographic Health Survey (PDHS) 2012-13, paint a gloomy picture of the overall routine immunisation coverage across the country.

According to PDHS, currently only 54 per cent children in Pakistan aged 12-23 months are fully vaccinated against the nine vaccine preventable diseases against the 80 percent immunisation coverage recommended by the WHO.

Measles – another worry

Since 2011 Pakistan is unable to control the outbreak of measles due to delay in carrying out nationwide Supplementary Immunisation Activities (SIAs). This has put the life of 64.5 million children aged between nine months and 10 years at risk.

According to the data gathered from the federal Extended Programme on Immunization (EPI), so far this year from January to March a total of 327 positive cases of measles and nine deaths have been reported from across the country. Out of these, 131 confirmed cases were reported from Khyber-Pakhtunkhwa (K-P), 84 from Sindh which resulted in five deaths (four in Thatta and one from Tando Muhammad Khan), 54 from Azad Jammu and Kashmir which resulted in four deaths, 40 from Balochistan, eight from Islamabad Capital Territory (ICT) and three from the Federally Administrated Tribal Areas (FATA)."[80]

There were 19 cases of polio reported in the country in 2013. KP and FATA reported f15 cases and two cases each reported from Punjab and Sindh this year after Taliban leader hafiz gulbahadar

[79]Q.Hasan, A.H.Bosan and K.M.Bile, A review of EPI progress in Pakistan towards achieving coverage targets: present situation and the way forward in Eastern Mediterranean Health Journal EMHJ, Vol. 16 Supplement 2010.

[80] Published in The Express Tribune, April 7th, 2014. http://vustudents.ning.com/forum/topics/world-health-day-april-7-2014?commentId=3783342%3AComment%3A4119008

imposed ban on polio inoculation, around 260,000 children below age five have been missing the OPVs because vaccination teams cannot carry out door-to-door campaigns in the region.[81]

Tetanus Toxoid coverage of married women age 15-49 is 69 percent. There are significant disparities in rural and urban areas with 83% and 63% respectively. Punjab has the highest 77% followed by Khyber Pakhtunkhwa, 61% Sindh 60%, and Balochistan has the lowest 31% married women covered against the disease.

The underachievement of the EPI with stark disparities in coverage indicates that Pakistan will miss its target set in MDGs for 2015 and fail to integrate a human rights approach in the program.

The multiple challenges that Pakistan is facing today ranging from shrinking fiscal space due to unstable macroeconomic situation, displacement of millions caused by natural and human made disasters, deteriorating security situation due to political violence, terrorist attacks on polio health workers and human rights defenders.

Moreover, the devolution of health to the provinces as a result of the 18th Amendment to Constitution is posing a risk of stock-outs due to financial constraints and lack of capacity of the provinces to procure and maintain the quality of vaccines.

The poor performance of the EPI can be attributed to both supply side and demand side issues. Lack of financial resources, weak management and inter-provincial coordination, poor monitoring, evaluation, surveillance systems and lack of capacity and motivation of the EPI staff are issues that are endemic to the health system. Community health-seeking behaviors, lack of education especially amongst mothers and gender inequality are demand-side issues that negatively impact the performance of the program.

EPI needs to integrate two essential elements of equity and non-discrimination in its delivery system. There are substantial differences in EPI coverage across and within regions, social class and rural-urban divide. The program needs to undertake the mapping exercise to identify the areas and social groups that are at higher risk and also lagging behind in EPI coverage.

Targeted interventions to reach poor and socially excluded groups are imperative. This approach should be combined to integrate EPI in the primary health care programs and also in social policy. Women's empowerment through creating education and employment opportunities is a long-term strategy but clearly the most necessary intervention to achieve health targets in Pakistan.

[81] The Express Tribune, July 11th, 2013

Maternal Neonatal Child Health Program (MNCH)

The Maternal Neonatal Child Health Programme aims to reduce child and maternal mortality. Despite some improvement in maternal and child health indicators, Pakistan has the third highest burden of maternal, fetal, and child mortality[82].

The leading causes for maternal deaths include postpartum haemorrhage, sepsis and eclampsia. While obstetric bleeding is responsible for one-third of all maternal deaths[83]. Hypertension during pregnancy, and infections accounted for 56.8% of all maternal deaths.[84]Many women also suffer from obstetric fistulas.

The National Nutrition Survey (2011) shows that almost 43.7% of children under the age of 5 in urban areas, and 46.3% in rural areas are stunted. 15.1 % children are wasted and 31.5 % are underweight. 44 % of mothers in urban areas and 57% in rural areas are underweight.

Again, the wide differential in terms of access to healthcare across provinces, rural/urban and between the poorest and wealthiest quintiles shows that the program is faltering on the principle of equity.

The program has a sufficient focus on poverty, but is lacking in a gender and rights based approach. Gender inequality is the determining factor in poor health outcomes. Patriarchal control, restriction on mobility, lack of power to take decisions that affect well-being are mainly responsible for barring women's access to health services.

There is sufficient evidence to show that women's educational level and economic empowerment has a positive impact on fertility, child survival and maternal mortality. The program has little awareness of inequities and does not focus on targeting those areas and social groups where MNCH indicators are lagging behind.

The issue of women's equality and empowerment is closely connected with program objective. The fragmented approach to MNCH will not lead to holistic program outcomes. The social determinants affecting MNCH are closely linked with the issue of women's empowerment. Fragmented health approach to MNCH has not yielded any tangible results so far. The program should focus not only on promoting the quality of health care and strengthening of delivery systems but should also link itself up with social development policy that aims to improve women's status through providing them equal opportunities for education and employment.

[82]Bhutta, Zulfiqar Assad Hafeez and et.el, Reproductive, maternal, newborn,, and child health in Pakistan: challenges and opportunities. Lanset 2013

[83] ibid

[84]Bhutta, Zulfiqar Assad Hafeez and et.el, Reproductive, maternal, newborn,, and child health in Pakistan: challenges and opportunities. Lancet 2013

HIV-AIDS

The key findings from PDHS 2012-2013 are as follows:

- Four in 10 ever-married women and 7 in 10 ever-married men age 15-49 have heard of AIDS.
- Comprehensive knowledge of AIDS is not widespread among either women (7 percent) or men (12 percent).
- Only 12 percent of women and 18 percent of men know of ways to prevent mother-to-child transmission of HIV.
- Only 17 percent of women and 15 percent of men express accepting attitudes toward people living with AIDS.
- Thirty-six percent of men and 11 percent of women know of a place where they can go to get an HIV test.
- •Sixty-one percent of women and 53 percent of men reported receiving a medical injection from a health worker during the 12-month period preceding the survey.

Across regions, knowledge of AIDS ranges from a high of 83 percent among women in ICT Islamabad to a low of 12 percent among women in Gilgit Baltistan. There are large urban rural differentials within regions. The percentage of women who have heard of AIDS in urban areas of Punjab and Khyber Pakhtunkhwa is twice that of their counterparts living in rural areas of these regions. Likewise, women in urban Balochistan and Sindh are much more likely than their rural counterparts to have heard of AIDS. Similar patterns are observed among men within each region. Nearly all women with a higher education have heard of AIDS, as compared with only 18 percent of women with no education. The proportion of women who have heard of AIDS increases with increasing wealth. Men show similar patterns of knowledge of AIDS by education and wealth, although the differentials are not as marked as for women.

Knowledge of HIV prevention methods among men is greater than that among women. Thirtynine percent of men know that the risk of transmitting the AIDS virus can be reduced by using condoms, and 57 percent know that transmission risk can be reduced by limiting sexual intercourse to one uninfected partner. Over one-third of men (37 percent) know both means of reducing transmission. Women and men age 15-19 and 40-49 are less knowledgeable about methods of HIV prevention than respondents in other age groups. Female and male respondents living in urban areas are more knowledgeable about HIV prevention methods than those living in rural areas; 34 percent of urban women and 53 percent of urban men know that that the risk of transmitting the AIDS virus can be reduced by using condoms and limiting sexual intercourse to one uninfected partner, whereas only 12 percent of rural women and 28 percent of rural men know both means of prevention. A similar pattern is observed in urban-rural areas within regions. Among both women and men, knowledge of prevention methods is positively correlated with education and wealth. Overall, 17 percent of women and 15 percent of men express accepting attitudes regarding all four situations. Among both women and men, accepting attitudes toward those living with HIV/AIDS increase with increasing education and wealth. Except for women in Balochistan and men in Balochistan and Sindh, accepting attitudes toward people with HIV/AIDS are more or less similar in all regions.

Lady Health Workers Program

Pakistan launched a community based health workers program known as National Program for Family Planning and Primary Health Care in 1994. The program has currently employed more than 90,000 Lady Health Workers nationwide. Each LHW has a duty to serve around 1000individuals or 150 households. The Program acts as a catalyst for the change and link up local communities with health system. The main objective of the program is to provide promotive, protective, curative, rehabilitative and referral services that are appropriate and accessible to the target population. The scope of LHWs work includes:

- Mobilization of community;
- Liaison between formal health system and community;
- Health Education Massages;
- Registration of all families;
- Provision of family planning serviced;
- Contribution in improving skilled attendance cover;
- Support other vertical programs (nutrition, immunization, TB, Malaria and others);
- Prevention and treatment of minor ailments; and
- Initiate information sheet about her area

The majority of LHWs are recruited and deployed in rural areas and primarily serve rural population. Several evaluation of LHWs program show a positive link of the programme with the improvement in health indicators at the community level[85].Improvements in EPI coverage, reduction in IMR and MMR are attributed to the program[86].

Despite the obvious strengths of this community based programmed, LHWs who mostly belong to low income strata of society are not given due recognition and fair treatment by the health sector. Despite the strong recommendation by the Global Health Workforce Alliance, those community health workers should be included in the formal health system, provincial governments refused to absorb them in regular health workforce after the devolution of health in 18thamendment.

The situation led to a long drawn public protest by LHWs all over Pakistan. They demanded the regularization of their service. However, Federal and Provincial governments paid no heed and finally the Chief Justice Iftikhar Muhammad Chaudhry took suo motu notice of the issue and directed the government to regularize the service of the LHWs last year 2012.

LHWs work under unfavorable working conditions. They often do not receive their salaries in time. The supply of essential medicines, equipment, lack of support from health facilities, lack of

[85] External Evaluation of the National Programme of Family Planning and Primary Health Care: Lady Health Workers Study of Socio-Economic Benefits andExperiences. Oxford Policy Management, 2009
Mahmood, Arshad, Syeda Saman Naz, Assessment of Management Information of National Program for Family Planning and Primary Health Care, Population Council 2012

[86] Nishtar, Sania, Boerma et el. Pakistan health system: performance and prospects after 18th Constitutional Amendment , Lancet, 2013

operational cost for the supervision of the program and low capacity of the LHWs remains a problem. However, the program has huge potential to improve PHC through this well placed cadre of local women who enjoy confidence and trust of local communities.

Non-recognition and under-value work of LHWs by the health sector typically represent the patriarchal mindset of institutions where women workforce is not treatment equally and fairly with respect. The marginalization of LHWs in the system de-motivates them. Gender bias and lack of understanding of gender issue in health in the policy makers undermines the significant role LHWs are playing in the field. The performance of LHWs must be assessed in relation to sub-optimal level functioning primary and secondary level health facilities. Without the political will at the highest level of leadership to better focus on equity, community participation and inter-sectoral action on social determinants of health, as it is unlikely the LHW programme alone could achieve the goal of primary health care.

This year the Governments of Punjab and Sindh finally decided to regularize the job of LHWs.

Analysis of Provincial Health Strategies from the Perspectives of Heath as a Human Right

This section looks at the provincial health strategic documents that have been developed in the wake of the 18th Constitutional Amendment and the consequent devolution processes that resulted in the absence of a national ministry of health.

One of the stated objectives of the state is full realization of the right to health, policies and plans need to systematically and explicitly integrate and further these rights. These provincial frameworks are examined from four perspectives;

(i) references to and therefore focus of these documents relating to international and national commitments to the right to health,
(ii) references to specific marginalized and vulnerable groups and how their right to health is to be realized,
(iii) the importance given to the underlying determinants of health, and

The four elements essential to the enjoyment of the right to health i.e. Availability, Accessibility, Acceptability, Quality as well as the issue of equity and discrimination within.

Balochistan: Health Sector Strategy 2012-2017

The Provincial Health Strategic Plan of the Government of Balochistan (May 20120 is a five year plan, and sets itself three objectives;

(i) to increase access and availability of infant and young child feeding (IYCF) and community based management of acute malnutrition (CMAM) services for 70% of targeted populations (children 0-5 years, pregnant and lactating women),
(ii) to improve consumption of micro nutrients through fortification and supplementation by more than 70% among target groups, and
to promote behavior change among general public through various communication packages. The 'strategic objective' is "to reduce malnutrition among target groups (<5 children and PLWs) especially marginalized and the disadvantaged. Therefore critically speaking the document is not a provincial health strategy, but rather expresses a policy priority within health for nutrition as an issue, reflected in its subtitle, "Not one Child Should Die".

Shortcomings of the document

One shortcoming of the document is that expressions like target groups, marginalized, disadvantaged, etc., are not defined, and therefore the required focus is lost.

Similarly, inequalities are largely discussed in terms of differences is attainment or indicators between districts, and those between socio-economic groups, minorities, etc., are not mentioned.

They are only given a passing reference in the sense that "inequalities in child survival outcomes persist between rural and urban areas, across districts, and across socio-economic groups". Even the number of facilities is approached from a district point of view rather than a population perspective, which is unlikely to result in rational decision making in terms of investments.

The document carries statements for the vision and mission, and it is under values that the right to health is mentioned, "Right to health, equity focussing marginalized and the disadvantaged, community involvement and governance."

Other then this reference, there is no discussion of the right to health, what it comprises of and any steps or roadmap for its attainment. There is no reference to any international or national commitment, except to the Millennium Development Goals, acknowledging that reducing child malnutrition is one of the key MDGs.

Other than the MDGs, the absence of reference to international and national commitments to rights of women and children, respectively, means that the foundation of the rights based approach to health is absent from the document.

The strategy obliquely refers to groups that might need special treatment in order to enjoy the right to health in an equitable manner, and does not tackle in a direct manner. There are references to "focussing marginalized and disadvantaged", "create social conditions which ensure good health for the entire population of Balochistan", "achieve equity in health actions", "socio-economic disparities are tremendous", etc. However, since these are neither defined nor discussed, these remain acknowledgements. As a result, the strategy to be followed and the actions to be taken in order to cater to those who are marginalized and have no chance of treating health as a right have not been discussed.

The strategy gives passing recognition to the underlying determinants of health, "The very low levels of education especially female literacy further contribute to the poor health outcomes.

The lack of access to clean drinking water and poor sanitation facilities also contribute to poor health outcomes." This passing recognition is not elaborated upon, and neither is the other determinants discussed. Therefore, there is a gap in the document regarding a thorough analysis of the issue as well as any means of addressing the requirements of coordination, cooperation, coherence between the different development sectors and related provincial government departments.

The Balochistan strategy is a limited document since it is focused on nutrition and therefore does not look at the broad spectrum of health care, underlying determinants, and right to health issues. Its primary focus is the mother and child.

Given that it is therefore a limited framework, it would have been useful if it had looked at and discussed the AAAQ and capacity issues within the limitations. The human resource issues discussed are largely administrative in nature, and pertain to management and technical skills. Not surprisingly there is no reference to the capacities of "duty bearers" to meet their obligations and of individuals as citizens and "rights holders" to claim their rights, since the human rights based approach has not been used to formulate this strategy. The strategy is largely an attempt to increase availability of goods and services, and has tried to address some of the physical and informational accessibility issues. In terms of acceptability and quality, there is an absence of discussion in the document.

In terms of economic accessibility or affordability, the document has a section on health care financing, which partially refers to out of pocket expenses. The way forward on the issue is limited to "alternative financing mechanisms shall be explored through research and pilot projects in the province and different options shall be evaluated for the province. These policy options shall then be made available to the districts for implementation." Therefore the way forward on this front is limited and not clear, and therefore there is no discussion of how these alternative financing mechanisms will impact the marginalized like the poor, women, unemployed, etc.

What the strategy implies implicitly is that financing for publically funded and publically provided health care is not expected to increase to the levels that are required.

Khyber Pakhtunkhwa: Health Sector Strategy 2010-2017

Khyber Pakhtunkhwa Health Sector Strategy 2010-2017 (December 2010) is organized on the basis of five priority outcomes;

(i) enhancing coverage and access to essential health services especially for the poor and vulnerable,
(ii) a measureable reduction in morbidity and mortality due to common diseases especially among vulnerable segments of the population,
(iii) improved human resource management,
(iv) Improved governance and accountability, and (v) improved regulation and quality assurance. Each outcome is broken down into key objectives and strategies and associated actions.

Shortcomings of the document

In terms of national and international commitments, the strategy refers in passing to the draft National Health Policy (2010) and the Millennium Development Goals targets for 2015. Other than this, there is no reference, especially so to those international commitments that turn health into a human right to be enjoyed by all. The focus is completely that of physical health, and mental health gets no attention. The goal of the provincial health department is defined as "to improve the health

status of the population in the province through ensuring access to a high quality, responsive health care delivery system which provides acceptable and affordable services in an equitable manner." There are other references to equity; however in the absence of an elaboration of the approach and concept of equity it is difficult to decipher the implications in the strategy. Similarly, the basic concept of non-discrimination is not stated up-front, making it difficult to then have a potential discussion about marginalized individuals and groups that need special attention in order to enjoy the right to health.

The strategy does refer to some of the underlying determinants of health, but without stating that these are rights within themselves and nor does the strategy discuss how these human rights affect each other. The document states that "Planned investments in housing, education, transport, water and sanitation and the provision of social protection will contribute to improved health outcomes" and that "the CDS [Comprehensive Development Strategy] provides the impetus for strong coordination and collaboration between the various sectors with the role of the Planning and Development Department being essential."

The strategy document also tentatively and implicitly proposes a change in the paradigm in which the provincial health department had operated hitherto, by suggesting that "It is likely that the DoH will focus more in the future on stewardship, regulation of health service provision, managing potential innovations in financing mechanisms for healthcare provision, and developing policies and initiatives that support synergies and reduce duplication in service provision between the private sector and public sector." Thus the department will be moving away from its traditional responsibility of publically funded and publically provided health care services. It is unfortunate that this potential policy choice is not discussed more fully in the document.

The document acknowledges that "household out of pocket expenditure remains the main source for financing health care", and that "with the high percentage of people below the poverty line, the cost of health care can result in families becoming completely impoverished." Like the poor, it also acknowledges the low level of women and children's health status, as well as the fact that "a significant number of people, particularly in remote rural areas have difficulty accessing primary health care."

The desired outcome of enhancing coverage relates largely to physical access issues, with strategies such as implementing minimum health service package at primary and secondary level and related actions like conducting assessments and identifying gaps in service provision against the packages and developing comprehensive proposals for filling the gaps, and upgrading of health facilities. Information access is partly addressed too, with one of the actions being the development of "a communication strategy to ensure the community is aware of the services to be provided."

One of the strategies under the same desired outcome is to "define a mechanism to protect the poor and underprivileged population by reducing out of pocket expenditure." The actions under this head are tentative in nature, for example the document proposes that existing services should be analyzed in terms of social safety nets or free services to the community and on that basis to develop feasible proposals.

The second outcome relates to reduction in morbidity and mortality due to common diseases especially among vulnerable segments of society. The strategies and associated actions related to this desired outcome, however, are general in nature in the sense that they do not either define or focus on the vulnerable groups. Thus, there is the proposed integration of national health programmes into a package of services provided at primary, secondary and tertiary level, the development and implementation of a strategy for nutrition intervention under which one of the actions would be the capacity development of relevant staff to identify and manage malnourished children at an early stage, etc.

The underlying determinants of health are acknowledged implicitly under this desired outcome, since the document proposes to "develop institutional mechanisms to ensure inter-sectoral departmental collaboration to improve the health status of the population." This is proposed to be done by the creation of an inter-departmental committee on health, review of annual development programmes to promote synergies, etc. T

The third desired outcome, that relating to human resource management, unfortunately does not discuss either capacities or training of health care related personnel to approach health as a human rights issue either at the policy level or at the service delivery level. The strategy of strengthening of stewardship function of the Department of Health (under the outcome related to improved governance and accountability) would have been the appropriate place to locate the concept of the rights based approach to health, even if it was to be addressed in the future. Unfortunately, HRBA finds no place here. Similarly, the actions related to improved accountability and transparency does not cater to a grievance redress mechanism where an individual's right to health is concerned.

In terms of the outcome related to improved regulation and assurance, some actions are vague, for example, "institutionalize the quality process in the system by establishing a proper set up for the purpose", while others are related to health, drugs and food regulation. These actions are of the nature for example improving the quality of assurance and inspection system (drugs), facilitating the registration of providers and then monitor standards (health), and conducting a study to identify key issues regarding food safety.

Health as a human right does not find explicit expression in the strategy, and there is an absence of references to the national and international commitments that recognize or give rise to the treatment of health as a human right. The strategy does not overtly reflect on the connection between health and the underlying determinants of health, but implicitly acknowledges the connection and goes on to propose general mechanisms to address these in a holistic manner. The poorest and most vulnerable sections of society do find mention in the strategy, however the document would have benefited from a clear identification of such groups since it would have naturally led onto what special provisions would be required to address the special needs that these groups might have to enable them to enjoy the right to health. Maternal health issues find some focus in the strategy, but unfortunately other women specific issues like gender based violence, sexual and reproductive health rights as well as awareness on these rights are not discussed. Similarly, because the development of the strategy has not been grounded in the concept of health as a human right, there is the

vacuum related to any administrative or judicial measures that may have the potential to redress the violation of the right to health. It is therefore not surprising that there are no indicators or a discussion related to development of indicators that might be used to measure progress towards the establishment of health as a human right.

Main strength:

KP is the only province that has spelled out Gender as a cross sectoral strategy

Sindh: The Health Strategy 2012-2020

The Strategy 2012-2020: Sindh Health Sector (April 2012) is a "broad based five year strategic plan ..." that can be "used to mobilize funds from public sector, corporate sector, philanthropies and international agencies" and is meant to "reduce overlaps and redundancies, improving efficiency and coordination across the health sector while providing an overall strategic vision."

Furthermore, "the five year plan will be a basis for detailed annual plans with links to the Annual Development Planning and Operational Expenditure Forecasting for Department of Health, Sindh." Amongst the objectives, one is "to harmonize the strategy plan with national policies and international commitments while maintaining strong contextual relevance for Sindh."

Among the Guiding Principles is one that aims to "improve equity by maximizing benefits to disadvantaged population" and another that demands a "sectoral and inter sectoral vision encompassing both public and private sector." The process for strategy development used the WHO's Health Systems Framework, and was preceded by a situational analysis. However, an HRBA situation analysis would have responded to four main questions, identifying the groups that undergo a greater denial of right to health, pinpoint the causes of exclusion or discrimination, focus on institutional "duty bearers" and their obligations in this regard, and finally come to a capacity analysis regarding both the parties whose rights are affected adversely as well as parties whose obligation it is to fulfil those rights. Unfortunately, this was not the approach followed in the situation analysis, providing for the absence of a foundation for human rights based approach to development of a health strategy.

Shortcomings of the document

The Sindh strategy does not refer to any international commitments to the right to health, except for the one reference cited above. Health is not explicitly stated as a human right, and neither is any reference made to any specific commitment of any sort. This obviates the foundation on which a human rights based approach could be argued in the strategy. The reference to "sectoral and inter sectoral vision encompassing both public and private sector" under the title of Guiding Principles may initially be taken to be pointing to the underlying determinants, however, further reading of

the document reveals that unfortunately that is not the case. This reference is probably to the public versus private health sector.

In the absence of an appreciation of the underlying determinants of health, how these determinants are rights per se, and how they intimately affect and get affected by the right to health, it is not surprising that no discussion, argument, or proposal is presented with regard to inter-sector coordination in order to address the issues with the enjoyment of the right to health.

There is one reference under Provision of Innovative Outreach Measures to Support facility Based Services that calls for inter-sectoral pilots on nutrition and poverty alleviation that talks about food supplement programmes and micro-credit programmes, hardly a thorough approach to addressing inter-sector coordination needs in order to get to the underlying determinants.

An enunciation in the strategy in a clear manner and therefore identification of the poorest and the most vulnerable sections of society would have been welcome, and if that had been done it could have led onto a discussion how these shortcomings can be addressed, within the health sector as well as through inter-sector coordination in terms of addressing some or all of the underlying determinants.

As it stands, there is no specific provision for addressing any specific needs of marginalized groups. If the falls short in this regard, then at a minimum there was a need for vocalizing the principle of non-discrimination as far as different socio economic and other groups are concerned. This would be the minimum standard and could have been built upon at a later stage in a more sophisticated manner leading to positive actions to remove disadvantages that some groups face.

Unfortunately, there is no discussion around principles of non-discrimination, except isolated references to “equity”. For example, one of the eight challenges identified in the strategy is natural disasters and disaster preparedness, an important theme in view of the devastation caused by the recent floods. However, there is no recognition let alone discussion in the strategy of how (i) such events affect different groups in different ways, (ii) how specifically the vulnerable suffer more, and (iii) what actions need to be taken in order to redress this imbalance that affects the marginalized so intensely and so detrimentally.

While talking about inter district disparities and the need to redress them, the strategy suggests the formulation of a minimum health service delivery package (MSDP) addressing MNCH, family planning, and nutrition (for children, pregnant and lactating mothers, and the elderly). The strategy also specifies the formulation of a detailed essential package of health service (EPHS) for secondary care provision dealing with MNCH-nutrition, family planning, nutrition, communicable disease, etc. The way the strategy is done, each key challenge is responded to by a corresponding outcome defined in the document.

Thus, one outcome is an urban public health care system built on public private partnerships and addressing contextual needs of low income urban population; and one of the strategies to achieve this is to develop an integrated family health model of “one stop shop for health and population” in

low income urban localities. Here again the strategy talks about formulation of a basic health service package, essential health service package and outreach package with required resource[s] for needs of low income urban population, inclusive of MNCH-nutrition, etc., as well as "detection and referral of substance abuse, domestic violence, child sexual abuse." Another strategic action under this head is designing of alternative financing models for low income population. Whereas the strategy does not adequately define the target groups (poor, low income, disadvantaged, etc.) leading to a lack of clarity, it does on the other hand cater to pregnant and lactating mothers to some degree, as well as exhibiting some commitment to reaching out to them, if only in the geographic sense. Gender based violence and child sexual abuse finds a mention, but like other issues does not involve a real discussion.

One of the important outcomes that the strategy talks about is "streamline[ing] human resource production, retention and capacity to support priority health needs", and one of the strategies to be followed in this regard is to "strengthen development, deployment and retention of female health staff in the rural areas".

This would be an essential measure to enhance culturally appropriate availability of medical services for women and will lead to an increase in accessibility. Human resource development would have been an appropriate area to discuss trainings from the perspective of the rights based approach to health, and how to build the capacity of the state at all levels to respect, protect and fulfil the right to health. Similarly, right to health indicators in the context of health information systems would have been a useful section in the overall strategy. Proper accountability would result in the state having to explain how well it is working towards the realization of the right to health of all, and such systems of accountability need to be accessible, transparent and effective.

Administrative and political mechanisms play complimentary and parallel roles to judicial mechanisms of accountability. One of the essentials in this regard is a human rights based indicator for effective monitoring of key health outcomes.

When discussing governance, one of the strategy's objectives is to improve accountability in health service delivery by enhancing internal controls and establishing social accountability mechanisms. The strategy hopes to achieve this by introduction of transparency measures such as public expenditure tracking systems, citizen report card surveys, process reviews and appraisals, internal audits; constitution of health boards in tertiary hospitals with gradual expansion to district headquarter hospitals, with the boards' tasks being to oversee utilization of hospital budget particularly user charges, medical negligence cases, and service standards. In this sense, the strategy recognizes accountability as an important dimension of the health system, and ideally should have discussed how accountability would be measured, the utility of judicial accountability mechanisms and steps required to establish such systems, etc.

The focus of the strategy is on increasing the availability of public health and health care facilities, goods, services and programmes. In terms of accessibility, the focus is on physical and partially information accessibility, since the strategy is trying to address those areas (urban slums and rural underserved districts) where there is an imbalance of availability. By focusing on recruitment of

female personnel, providing them with medical skills, and ensuring their retention, the strategy is looking at culturally acceptable service delivery by catering to women. In terms of quality, the strategy is considering the regulation of private sector and some accountability systems.

These efforts are heading in the general direction of improving the health care system in the province. However, it lacks the essential framework that would allow the different aspects of the right to health to be addressed adequately and in an equitable manner. For example, the strategy does not address mental health aspect of the right based approach to health.

Punjab: Health Sector Strategy 2012-2020

The rationale of the Draft Strategy 2012-2020 (April 2012) acknowledges that "there are some important differences in the health of individuals and populations" in the province. "So whilst the overall health has been improving, the health of the least and less well-off has been getting worse." The Punjab strategy document states that there are differences between districts in the levels of deprivation, and therefore populations in these districts experience a greater burden of poor health.

The strategy states up front in the rationale that healthcare services is the focus of much of the strategy, but mentions that health is also affected by other social determinants such as "literacy, income, employment, housing, security", etc., and that it is worth addressing these so that "people with the least resources and opportunities are able to enjoy the standard of living and the opportunities that many take for granted." In the same vein, the strategy notes, "it is important to recognize that we have to engage other governmental departments, community groups, civil society organizations and above all the general public."

The consultations conducted in preparation of the strategy resulted in identification of themes, including that "emphasis should be placed on the social determinants of health within the strategy. These determinants should be linked with priorities and actions." The document admits that it is "unlikely that the province will achieve health related Millennium Development Goals by 2015" and that "maternal and child health services have been underemphasized within the health system, resulting in a high rate of maternal and child deaths". It goes on to say that the "nutritional status of the population is generally poor especially for the children, women of reproductive age and the elderly."

Discussing challenges in service delivery in the province, the strategy admits, "Access to healthcare is a major challenge in achieving health outcomes for the population. Limited access to essential health services is mainly affecting the population residing in rural areas due to persistent urban-rural bias exists in physical accessibility to health services", while there is a "glaring absence of urban primary health care in the public sector". The strategy acknowledges that serious gaps exist in the availability of emergency services at all levels, and furthermore quality of health care "both at

the public and private health facilities remain largely questionable" and that "currently there is no registration and licensing system for private health care facilities."

There are "frequent stock outs of essential drugs" in most public sector hospitals and health care facilities, and the "drug regulatory system in the province suffers from serious issues of quality". In terms of accountability, measuring performance is difficult because of the "absence of appropriately delineated processes and data". Talking further about data and information, the strategy states, "overall information system in the province is fragmented as existing systems for facility based and community based information suffer lack of integration at district level.""Similarly [the health information system] does not cover private sector hospitals and health care facilities, which deliver health care services to a larger proportion of population in Punjab."

"Health care in Punjab is underfunded (with low government funding); inequitable (overly dependent on out of pocket household expenditure); low in population coverage; and low in productivity", and per capita public expenditure is estimated to be between $6.50 and $7.5 per year. Amongst other things, the purpose of the strategy is to "remedy the disadvantages in health status across various population groups.

The strategy states "Punjab: Ensuring health and productive lives for the people" as the vision, followed by strategic principles of which from the HRBA perspective the important one is "equitable and universal health care service". Among the six stated directions of the strategy the relevant ones are (i) enhance access to achieve universal coverage (by increasing operations in multiple dimensions to remove barriers for meeting the specific needs of various population groups), (ii) focus on primary health care (will be rolled out through improving public expenditures aiming at delivery of essential package of health services for all members of society), and (iii) improve quality of care (through adoption of service standards and making investments in strategic health infrastructure as well as key areas of human resource development). Corresponding to these amongst the pillars of the strategy are (i) service delivery, (ii) governance and accountability, and (iii) health workforce. The goals the strategy sets for itself relate to (i) child health, (ii) maternal health, (iii) communicable diseases, (iv) non communicable diseases, and (v) nutrition. Another strategic direction is redefining the Role of Government – from provider of health care services to purchaser and regulator through taking up a facilitation position.

Shortcomings of the document

Except to admit that the MDG targets are unlikely to be met, and that there was a draft National Health Strategy before devolution removed health as a subject from the federal domain in Pakistan, there are no specific references to any national or international commitments regarding the right to health. Furthermore, the strategy looks at physical health, and mental health unfortunately finds no significant place in the discussion. The principle of non discrimination is implied, but is not explicitly discussed at any length.

The strategy refers to the poor and the marginalized in passing, but in the absence of definitions the document does no focus on such groups either in the sense of delineating them or that of defining

specific principles, strategies, programmes or activities that would provide them an equal opportunity to enjoyment of their right to health.

With reference to women, the strategy aims to "build an efficient, safe and effective health services delivery system which caters to the specific needs of all population groups with enhanced emphasis on MNCH, emergency care, family planning and nutrition services", and within that "focus and strengthen MNCH, family planning and nutrition services at all levels." Gender based violence issues with reference to women do not find mention, and other population groups are not mentioned.

The underlying determinants of health find mention in the strategy; however the details do not contain any strategy or mechanism that would allow addressing the right to health in a holistic manner in public policy.

The strategy does aim to "institutionalize inter-sectoral collaboration for better health" by emphasizing the role that the provincial Planning and Development Department should in any case be playing. There is an absence of detailed discussion to clearly argue the interplay between the underlying determinants and the right to health, and how the right to health affects the former. Similarly, it would have been useful to have coordinating mechanisms at the public policy level since most of these determinants are dealt with other, vertical provincial departments.

In the same vain, financial allocations and operational level coordination in order to address the underlying determinants of health would have been important areas of attention. The strategy does talk about "restructuring department of health for a stewardship and monitoring role", and one of the ways it suggests of doing this is by creating a Health Strategy Ministerial Board for "overall monitoring of achievement of health sector goals", but does not propose it as a an instrument to start addressing failing and shortcomings in addressing the underlying determinants of health.

The strategy essentially is looking to ensure availability of health care services in sufficient quantity, and therefore addressing questions of physical accessibility to some extent. Many of the specific strategic actions that the document specifies would take provincial health services in this direction. For example, one area is the development of an essential health package with reference to infrastructure, workforce, information systems, essential medicines, supplies and medicines, and the repositioning of primary and secondary health facilities on priority basis to deliver the EHS package; another is the upgrading of DHQ hospitals to district health complexes having teaching and training facilities for medical students, nurses and allied health professionals. Similar are the strategy actions like (i) integration of all MNCH, family planning and nutrition activities at community and primary health facilities, (ii) ensuring full package of 24-hours emergency obstetric neonatal care at all rural health centres and upgrading of rural health centres as hub of primary health care system, and (iii) providing family planning services through uninterrupted supply of family planning commodities to all primary and secondary level health facilities and outreach workers.

In terms of information access, the strategy aims to strengthen health communication with actions like (i) developing communication strategies to raise awareness about (a) communicable diseases

and (b) non communicable diseases, and (ii) raise community awareness through mass media campaigns to motivate household level action against malnutrition. If the context is to be the rights based approach to health, the information access will need to be much broader as well as deeper if all populations groups without any discrimination are to enjoy their right to health.

For health care financing, the outcome that the strategy aims for is "optimized health care financing through fiscal responses", with the objectives of enhancing public sector financing of health service delivery; protecting the disadvantaged and vulnerable from catastrophic health expenditures; enhancing the efficiency of public spending by improved budgetary utilization; and, increasing the use of private sector participation in provision of publically provided health services by outsourcing through transparent competitive process. In order to achieve these, the strategy uses a mix of policy options. On the one hand it proposes to gradually increase investments in health care to enhance coverage of primary health care facilities, while on the other it proposes the revision of the provincial finance commission awards and introduction of special health grants as alternatives to each other.

The strategy also heads the in the direction of a two tier system, on the one hand by "facilitating private sector in developing and maintaining health care facilities providing specialized care", and on the other introducing a health voucher scheme providing free health care to targeted, low income groups, the vulnerable and the disadvantaged. What the strategy does not do is go into any details of how all this is to be done, does not offer an analysis of how these policy options will impact different groups of population specially the disadvantaged, and does not offer the core argument against publically funded and publically provided health care for all. Similarly in the domain of "enhancement of contracting out mechanisms", the logical argument is noticeable by its absence in terms of explaining this policy option.

The Punjab provincial health strategy largely proposes to use the Punjab Health care Commission for improved regulation. This is to be done by, for example, developing a system of rule based regulatory regime, application of accountability to cases of service delivery failures and medical negligence, creating a system for licensing and registration of health facilities and medical laboratories. The strategy has two important aspects that address management systems and health workforce, and health information systems, respectively. In terms of human resource and its development, there are interesting ideas like the development and application of "codes of behaviour for health workers which should include gender sensitive standards for workplace behaviour with legal instruments for institutional accountability."

However, the transformative push required to change the attitude of the health care providers towards the concept of "duty bearers" in the context of the right to health is not discussed. Similarly, in the crucially important area of health information systems, there is no mention of any indicators, or even development of any such indicators that might be used to measure the progress towards the right to health for all. Another area where the strategy hopes to improve quality is that of drugs; it hopes to "improve quality of drugs by enforcement of drug regulation in Punjab at all levels of manufacturing, testing and sale.

Critique of Provincial Health Strategies from the Human Rights Perspective

This section pulls out some of the commonalities in terms of neglecting the human rights based approach in provincial health strategies. The human rights based approach has three aspects. The first one relates to its goal, that is "all programmes, policies and technical assistance should further the realization of human rights." The second relates to process, and needs "human rights standards and principles guide programming in all sectors." This relates to participation and inclusion, equality and non-discrimination, and accountability. The third aspect relates to outcome, whereby there is a "focus on capacity development of duty bearers to meet their obligations and empowerment of rights-holders to claim their rights."

Human Rights based Approach to Health is overlooked

A critical review of provincial health strategies reflects that HRBA to strategic health planning for the development of these strategies is overlooked at all level. Health is an inclusive right and highest attainable standard of health for all can only be achieved with the attainment of other health related rights.

Under discussion provincial health strategies do not even recognize health as fundamental human right at strategic level. The issue of realization and attaining of health related human rights for right holders i.e. population including excluded and vulnerable groups emphasize the importance of social determinants of health.

However the strategies do not provide any information and analysis on the impacts of social determinants of health on duty bearers and right holders in the context of Pakistan as well as strategic measures to address them in health service delivery.

The strategies are not exclusive even silent vis-à-vis response to key elements of HRBA to health that include empowerment of the right holders so that they could claim their health related rights; capacity building of the health sector duty bearers so that they could realize and opt their duty to respect, protect and fulfil health related rights of population in need of public health services; assessment/evidence on prioritization of the health related needs of marginalised, vulnerable and excluded population groups based on sex, age, class, ethnicity, social status, disabilities as well as different nature of social stigmas associated with diseases like HIV/AIDs, Hepatitis and TB. The strategies reflects different and limited focus to the extend like nutrition, MNCH, communicable and non-communicable diseases etc that may be due to different provincial political context and priorities however the evidence focusing equity dimension on prioritization of actual and different health needs of excluded population groups is not available.

Finally the key prevailing violations of health related human rights that cause ill health particularly Gender based Violence (GBV); sexual abuse/exploitation against women, girls and adolescents as well as response to sexual and reproductive health rights are unattended in the context of public health response at provincial level.

Absence of Health Policies

The provincial health strategies have been developed in the absence of a national or provincial health policies, albeit there might have been a reference to the national health policy that was drafted but never finalized or adopted because of the 18th Constitutional Amendment and related devolution from the federal government to the provincial governments.

The rights based approach has not been systematically employed in the development of these provincial strategies, although there might be passing references. There is no outright vocalization of health as a human right, and no proper planning is reflected about how progress is to be achieved towards this right.

Lack of Focus on Discrimination and Social Exclusion

The important concept that is not explored to any substantial degree in any of the strategies is that while the right to health may require progressive realization, there are some obligations that are of immediate effect, the primary one being that the state needs to guarantee that all health related rights are exercised on the basis of non-discrimination.

This effectively means that within the constraints of resources that may be available, there is an obligation to take steps towards the realization of right to health of the underprivileged and marginalized, and that these steps should be concrete, deliberate and targeted. Therefore the state must ensure that the right of access to quality health services, facilities and supplies happens on a non-discriminatory basis, especially for the vulnerable or marginalized groups.

Connected with the fact that there are groups that suffer from a greater denial of the right to health, is the idea of the social determinants of health. If the strategies were to address this marginalization, a clearer delineation of such groups, the reasons for this marginalization, and then ways to redress the situation would have been important. In order to identify the most vulnerable groups and the diverse needs, it is important to have the disaggregated data. Such groups can be children and adolescents, women across groups, persons with disabilities, ethnic, religious or linguistic minorities, displaced and undocumented people, and persons living with HIV/AIDS. The strategies do not adequately reflect these realities and these needs.

Absence of Mental Health

The second issue that has been neglected in these strategies is that the International Covenant on Economic, Social and Cultural Rights states recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” The Covenant therefore gives mental health the same importance as physical health. It is unfortunate that none of the strategies take this fact into account while not integrating mental health as part of public health response and focus on physical health aspects only.

Lack of focus on RHR/SRHR and ASRH is conspicuous in all strategies.

The determinants of health including gender issues mainly lying outside the health sector are not spelled out loud and clear.

Though the processes of strategies are claimed to be inclusive the convenience and male biases in consultations are quite obvious.

Last but not least all four strategies lack indigenous perspectives and the documents appear just another version of the existing technical literature

Conclusion and Recommendations

It is evident from the poor state of health of the country (kindly refer again to annexe 2 as well) that the national commitment on health as a human right has yet to be translated into practice. The situation analysis of the health sector from HRBA points out the multiple failures of the state and the market.

Apart from a slow progress made on some of the health indicators, the overall health scenario in the country remained dismal. Pakistan is lagging far behind on health indicators in the region and in all its likelihood going to miss MDG's targets.

The rights-based approach is about integrating human rights norms and principles in the design, implementation, monitoring, and evaluation of health and health-related policies and programmes.

In practice this means availability and accessibility of culturally sensitive, quality healthcare services to all without any discrimination on the basis gender, religion, ethnicity or other social division. The respect of human dignity, privacy and special focus on the socially excluded and vulnerable groups is essential. The participation of people in decision-making processes and the provision of responsive and robust accountability mechanisms within the health system are central to the human rights based approach to health.

The critical review of the health sector from Human Rights based Approach shows that the rights perspective is hardly integrated in the health policy, strategies and healthcare systems in Pakistan. There is a clear disconnect between the conceptual framework of health as a right and the planning and performance of the health sector. Health as a human right is still a more of rhetoric than reality in Pakistan.

Health as a human right is not only a legal but a political discourse as well. The global shift in the health paradigm from a medicinal phenomenon to a complex multidimensional social phenomenon is transformative in nature. It contends that inequity in health is a result of interplay of socio-cultural, economic and political structures and processes. A holistic approach that addresses structural as well functional issues in the health sector is the only way forward towards achieving the health as a multidimensional human right for all.

The HRBA to health have a strong political and social aspect to it. The political dimension of health as a right means that every citizen is entitled to universal right to health irrespective of his or her social standing in the society. It places a fundamental responsibility on the state to promote, protect and fulfil the right to health of its citizens.

The social dimensions of health as right highlights the interconnection of health with range of social, cultural, economic and political factors that influence, illness and disease. The perspectives of social determinants of health have a dual focus, on social services and cultural factors. But in practice, the approach focuses primarily on social services (water, sanitation, housing etc). The cultural determinants that adversely impact particularly on women's right to health because of patriarchal control over women's bodies, mobility, reproductive choices, mal-nutrition, early marriages etc. is to somewhat neglected. Also socio-cultural norms that affect health seeking behaviour are not dealt with.

The right to health is a structural issue that demands structural changes. The intersection of the health with other related rights demands a radical transformation in the nature of the state, development paradigms and the governance structures. Pakistan has emerged as a national security state over the last 65 years. It placed a low priority on the welfare and well-being of its people and remained focused on building territorial defence. The low investment in human capital now poses serious challenges to the growth, development and the national integrity of the country. The fast growing population, with a youth bulge largely illiterate, unskilled, unemployed and unable to protect themselves against health hazards.

Health as a human right is synonymous to the right to life. The immediate condition for good health such as availability of health services, safe drinking water, sanitation, housing, education, gender equality, healthy environment are dependent on underlying socio-cultural and economic factors that determine people's access to healthy living conditions.

The underlying determinants in turn are shaped by structural factors that positions people in the hierarchy of power relationships created through macro-economic and cultural frameworks. The immediate, the underlying and the structural factors are the interlocking links of the social process that creates inequalities in health outcomes. Therefore, the trajectory of change that will warrant health for all must be understood as a continuum requiring actions at all three levels.

Health inequalities shows that although health and illnesses are suffered by individuals, these are socially produced and distributed depending on the living and working conditions in which people live. The causes of health and illnesses lie outside the health sector; therefore, it is important that decision makers now move away from a fragmented social sector policies approach to an integrated social policy with multi-sector coordination mechanisms in place

Based on this assessment of heath sector from the HR perspectives, the following steps are recommended that will lead to the realization of health that is structural, legal, institutional and functional in nature.

The first step that is needed is to establish the health as a constitutional right. This will establish that every citizen is entitled to universal health care. It will obligate the state to take steps towards fulfilling its constitutional obligation to provide health cover to all its citizens without any discrimination on the basis of sex, class, race, ethnicity, religion and other social divisions.

The second step is allocating corresponding financial resources to the legal commitment to health as a right. Currently, the development spending of the country is less than 10% of its total budget. The bigger share from the existing resource pie for the social sector is a matter of political struggle and reorientation of the national priorities. The higher financial allocation for the social sector will fundamentally change the nature of the state from the nation security to the welfare state.

The third main task is to reflect national commitment to health as a human right in the health policies and strategies. The health strategies should effectively address all aspects of human health and health system from the human rights perspective.

The fourth prerequisite is the good governance to make the health and health related social sector more responsive, effective and efficient. Governance institutions are not merely a set of neutral rules and regulations but are class based gendered structures that mediate people's access to resources, rights, opportunities and power. Institutions play a critical role in reproducing social division through its functioning. The larger social, political and economic frameworks that shape the masculine disposition of governance institutions also required to be changed. Gender and ethnically balanced health workforce with the capacity of dealing with gender and human rights in health are critical for the health system to ensure equity in health conditions.

The fifth milestone is the integration of HRBA in health sector should move beyond health sector into social policy at the national and provincial level to transform policy and practice. This can only be achieved through a top-down and bottom-up political actions. Thus the political will of both "duty bearer" and "right holders" together can help advance this political agenda of right to health. People who are poor and disadvantaged have the interest in bringing systemic changes that ends their marginalization. They need to mobilize and organize themselves in social movement of health for all. Through the agency of the marginalized community, the state can be pushed for corrective action to ensure right to health for all.

Lastly, the realization of health as a right is not only an issue of redistributive justice but also how the resources are produced in the society. Inequality and poverty are built into neo-liberal macro-economic framework and the structure of growth. Despite spectacular growth in global economy, rising poverty is become a global phenomenon.

Economic growth is not equal to human development. Growth although necessary, but is not sufficient enough to ensure improvement in the living conditions of poor. The neo-liberal macro-economic frameworks promote free markets and emphasize efficiency over equity as a systemic goal. Informal character and casualization of labour as the key features of neo-liberal economic framework has reduced ability of the poor to purchase health care services from the markets.

Similarly, the structural adjustment programmes (SAPs) by the international financial institutions that led to cuts in public sector spending on social sector have put enormous pressure on poor households in general and women in particular. Women from the poor households are forced to take care of sick members of their families in the absence of public healthcare provision.

Within this larger social, political and economic context in which health is instituted as a human right in Pakistan; following steps are recommended on the long, medium and short-term basis. These will effectively address the structural, underlying and immediate barriers to the realization of health as a human right

Structural Interventions.

- The restructuring of the growth process in favor of poor is imperative. The recommendation is in line with government of Pakistan policy commitment that is pronounced both in Frameworks for Economic Growth, 2011 and Medium Term Development Framework that a balance will be created between economic growth and human development. The emphasis is on 'software' by making growth pro-poor and investing in women empowerment, education, health, water supply and sanitation, rural development, livestock, SMEs and the social protection strategy for the poor and vulnerable. The government needs to translate this commitment into practice that will help remove inequalities in accessing health and the social determinants of health.
- The structural changes cannot be introduced without a proactive and empowered citizenry that can act and speak with a collective voice and could hold the government accountable on equitable health outcomes. The government, donor agencies and civil society must work together to promote, support and strengthen civil society organizations by bringing them in decision-making process that shape the lives and health at the national and local levels.

The state must take steps to uplift the most vulnerable and disadvantaged social groups by providing equal economic opportunities and ensuring equality of results. The removal of social and cultural biases through social, political and legal reform will help bring some balance in the hierarchy of power structures in the society.

Legal and Institutional Interventions

- Health should be made a constitutional right. The legal cover to health as a human right will necessitate the state to provide minimum universal health coverage to all.
- The government should take steps to create legal, regulatory and policy frameworks that promote social inclusion and right to health.
- To tackle gender biases and religious resistance towards gender equality pro-women legislations should be introduced and their effective implementation ensured.
- Gender and ethnic balance should be instituted for strengthening the workforce in health sector.
- The health workforce should be trained in gender and human rights issues. More

responsive capacity should be build through gender sensitization, training and human rights education.
- To bring change in people's attitudes and behavior towards health and health related issues, the health information should be incorporated in curricula and the public media.

Consumer protection mechanism should be in place. The Consumer Protection Act is promulgated only in Punjab and KP. Consumer courts are working only in few districts. The consumer protection act should be promulgated in all other provinces and the consumer courts should be made more effective in dealing with cases of medical negligence.

Functional Level Interventions

- The policy shift toward health as a human right requires allocation of significant additional resources for the health sector. The costing of minimum universal health package should be undertaken and health budgets rationalized accordingly.
- The office of the health ombudsperson for health rights should immediately be established at the federal and provincial levels so that people could have speedy justice on their complaint of health related human right violations.
- Re-orientating and re-prioritizing the existing resources in health towards primary health care and creating a balance in physical and mental health should be undertaken.
- The integrated approach to health as a human rights demand inter-sectoral coordination, which is currently non-existent at the federal and provincial level. The multi-sect oral strategy, formalized coordination and institutional arrangements with related ministries/departments need to be put in place. The ministry of Law, Human rights, departments of Women's Development and Social Welfare should also be taken on board in addition to water, sanitation and housing departments.
- Stronger linkages between health policies and poverty reduction policy as well as pro-poor policy initiatives taken by other relevant ministries/departments needs to be established
- Gender mainstreaming in the health sector should be prioritized to engender health policies, strategies, budgets and institutions. The capacity of the service providers should be built through training on gender sensitization and human rights.
- Social mapping of vulnerable population is a useful tool for targeting the excluded and marginalized within the principle of universalism. In addition to the universal entitlements of minimum health package, the vulnerable population should get extra benefits. Public policy and expenditure must ensure that socially excluded groups benefit from public expenditure as much as other groups.
- Functional integration of health and family planning services and vertical health programs in the health system is imperative for greater efficiency and cost effectiveness.
- Private sector needs to be regulated on urgent basis, as this will benefit the poor.
- Establishment of effective consumer groups can play an effective role in creating accountability of those responsible.
- Community and civil society organizations should be involved in the development of

health policy, strategies and monitoring of health services. This will enhance the accountability of the state towards citizens' right to health.

- Benchmarks for the quantitative and qualitative targets should set by each provincial government.
- Human rights indicators should be developed and integrated in the health system's performance framework.
- Health Information Management System (HIMS) needs to collect disaggregated data on vulnerable groups, discrimination to capture disparities in health and assess the progress make on human rights indicators.

Incentivized result based budgeting should be introduced and human rights principles should be fully integrated in the performance indicators of health sector.

ANNEXES

ANNEXE1

International relevant treaties recognizing the right to health

The 1965 International convention on the Elimination of all Forms of Racial Discrimination: (Article 5 (d) (iv)

"The right to public health, medical care, social security and social services"

The 1966 International Convention on Economic, Social and Cultural Rights (ICESCR) (Article 12)

". The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

The 1979 Convention on the Elimination of All Forms of Discrimination against Women (Article 11 (1) (f),

"The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction."

Article 12

"1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period,

granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

and 14 (2) (b)

(b) To have access to adequate health care facilities, including information, counselling and services in family planning.

The 1989 Convention on the Rights of the Child (Article 24)

"1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

The 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (Article 28, 43 (e) and 45 (c)

"Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.

Article 43 (e)

"Migrant workers shall enjoy equality of treatment with nationals of the State of employment in relation to:

e) Access to social and health services, provided that the requirements for participation in the respective schemes are met;

Article 45 © 1. Members of the families of migrant workers shall, in the State of employment, enjoy equality of treatment with nationals of that State in relation to:

c) Access to social and health services, provided that requirements for participation in the respective schemes are met

The 2006 Convention on the Rights of Persons with Disabilities (Article 25)

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

a. Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
b. Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
c. Provide these health services as close as possible to people's own communities, including in rural areas;
d. Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
e. Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;

Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

Annexes 2

Indicator	value	Indicator	value
Labour force participation rate, female (% of ages 15 and older)	24.4	Gender Inequality Index	0.563
Labour force participation rate, male (% of ages 15 and older)	82.9	Gender-related development index: female to male ratio of HDI	0.75
Gross national income (GNI) per capita (2011 PPP $)	4,651.64	Population in severe multidimensional poverty (%)	26.46
Adolescent birth rate (births per 1,000 women aged 15-19)	27.262	Population living below $1.25 a day (%)	21.04
Adolescent birth rate (births per 1,000 women aged 15-19)	27.262	Coefficient of human inequality	28.7
Youth unemployment (% of ages 15-24)	7.7	Inequality in life expectancy (%)	29.9
Unemployment rate (% aged 15 years and older)	5.5	Length of mandatory paid maternity leave (days)	84
Refugees by country of origin (thousands)	33.624	Inequality in education (%)	45.2
Homeless population (% of population)	6.197	Inequality-adjusted education index	0.204
Impact of natural disasters: number of deaths (per year per million people)	48.43	Inequality in income (%)	11
Internet users (% of population)	9.96	Inequality-adjusted income index	0.516

[87]INDICATORS		residence	
	Pakistan	Urban	Rural

[87]National Institute of Population Studies [Pakistan] and ICF International. 2013. Pakistan Demographic and Health Survey 2012-13. Calverton, Maryland, USA: National Institute of Statistics and ICF International.

Fertility			
Total fertility rate (number of children per woman)	3.8	3.2	4.2
Median age at first marriage for women age 25–49 (years)	19.5	20.7	18.8
Median age at first birth for women age 25–49 (years)	22.2	23.0	21.8
Women age 15–19 who are mothers or currently pregnant (%)	8	6	9
Currently married women age 15-49 who want no more children (%)	51	55	49
Family Planning (currently married women, age 15–49)			
Current use Any method (%)	35	45	31
Any modern method (%)	26	32	23
Currently married women with an unmet need for family planning1 (%)	20	17	22
Maternal and Child Health Maternity care			
Pregnant women who received antenatal care from a skilled provider2 (%)	73	88	67
Births assisted by a skilled provider2 (%) 52 71 44 Births delivered in a health facility (%)	48	68	40
Child vaccination			
Children 12–23 months fully vaccinated3 (%)	54	66	48
Nutrition Children under 5 years who are stunted (moderate or severe) (%)	45	37	48
Children under 5 years who are wasted (moderate or severe) (%)	11	10	11
Children under 5 years who are underweight (%)	30	24	33
Women 15-49 who are overweight or obese (%)	40	54	33

Childhood Mortality (deaths per 1,000 live births)			
Infant mortality	*74*	63	88
Under-five mortality	*89*	74	106
HIV/AIDS-related Knowledge Knows ways to avoid HIV (women and men age 15-49):			
Using condoms (women/men) (%)	22/39	38/55	14/30
Limiting sexual intercourse to one uninfected partner (women/men) (%)	32/57	55/75	20/48
Knows HIV can be transmitted by breastfeeding (women/men) (%)	27/40	43/48	18/36
Knows risk of MTCT can be reduced by mother taking special drugs during pregnancy (women/men) (%)	13/22	21/26	9/20
Knows where to get an HIV test (women/men) (%)	11/36	17/48	8/30
Domestic Violence			
Ever experienced physical violence since age 15 (%)	32	28	34
Ever experienced physical or emotional violence committed by husband (%)	39	32	42

International relevant treaties recognizing the right to health

The 1965 International convention on the Elimination of all Forms of Racial Discrimination: (Article 5 (d) (iv)

"The right to public health, medical care, social security and social services"

The 1966 International Convention on Economic, Social and Cultural Rights (ICESCR) (Article 12)

". The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

The 1979 Convention on the Elimination of All Forms of Discrimination against Women (Article 11 (1) (f),

"The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction."

Article 12

"1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period,

granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

and 14 (2) (b)

(b) To have access to adequate health care facilities, including information, counselling and services in family planning.

The 1989 Convention on the Rights of the Child (Article 24)

"1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

The 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (Article 28, 43 (e) and 45 (c)

"Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.

Article 43 (e)

"Migrant workers shall enjoy equality of treatment with nationals of the State of employment in relation to:

e) Access to social and health services, provided that the requirements for participation in the respective schemes are met;

Article 45 © 1. Members of the families of migrant workers shall, in the State of employment, enjoy equality of treatment with nationals of that State in relation to:

c) Access to social and health services, provided that requirements for participation in the respective schemes are met

The 2006 Convention on the Rights of Persons with Disabilities (Article 25)

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

f. Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
g. Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
h. Provide these health services as close as possible to people's own communities, including in rural areas;
i. Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
j. Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;

Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

Indicator	value	Indicator	value
Labour force participation rate, female (% of ages 15 and older)	24.4	Gender Inequality Index	0.563
Labour force participation rate, male (% of ages 15 and older)	82.9	Gender-related development index: female to male ratio of HDI	0.75
Gross national income (GNI) per capita (2011 PPP $)	4,651.64	Population in severe multidimensional poverty (%)	26.46
Adolescent birth rate (births per 1,000 women aged 15-19)	27.262	Population living below $1.25 a day (%)	21.04
Adolescent birth rate (births per 1,000 women aged 15-19)	27.262	Coefficient of human inequality	28.7
Youth unemployment (% of ages 15-24)	7.7	Inequality in life expectancy (%)	29.9
Unemployment rate (% aged 15 years and older)	5.5	Length of mandatory paid maternity leave (days)	84
Refugees by country of origin (thousands)	33.624	Inequality in education (%)	45.2
Homeless population (% of population)	6.197	Inequality-adjusted education index	0.204
Impact of natural disasters: number of deaths (per year per million people)	48.43	Inequality in income (%)	11

Internet users (% of population)	9.96	Inequality-adjusted income index	0.516

[88]INDICATORS		residence	
	Pakistan	Urban	Rural
Fertility			
Total fertility rate (number of children per woman)	3.8	3.2	4.2
Median age at first marriage for women age 25–49 (years)	19.5	20.7	18.8
Median age at first birth for women age 25–49 (years)	22.2	23.0	21.8
Women age 15–19 who are mothers or currently pregnant (%)	8	6	9
Currently married women age 15-49 who want no more children (%)	51	55	49
Family Planning (currently married women, age 15–49)			
Current use Any method (%)	35	45	31
Any modern method (%)	26	32	23
Currently married women with an unmet need for family planning1 (%)	20	17	22
Maternal and Child Health Maternity care			
Pregnant women who received antenatal care from a skilled	73	88	67

[88]National Institute of Population Studies [Pakistan] and ICF International. 2013. Pakistan Demographic and Health Survey 2012-13. Calverton, Maryland, USA: National Institute of Statistics and ICF International.

provider2 (%)			
Births assisted by a skilled provider2 (%) 52 71 44 Births delivered in a health facility (%)	48	68	40
Child vaccination			
Children 12–23 months fully vaccinated3 (%)	54	66	48
Nutrition Children under 5 years who are stunted (moderate or severe) (%)	45	37	48
Children under 5 years who are wasted (moderate or severe) (%)	11	10	11
Children under 5 years who are underweight (%)	30	24	33
Women 15-49 who are overweight or obese (%)	40	54	33
Childhood Mortality (deaths per 1,000 live births)			
Infant mortality	*74*	63	88
Under-five mortality	*89*	74	106
HIV/AIDS-related Knowledge Knows ways to avoid HIV (women and men age 15-49):			
Using condoms (women/men) (%)	22/39	38/55	14/30
Limiting sexual intercourse to one uninfected partner (women/men) (%)	32/57	55/75	20/48
Knows HIV can be transmitted by breastfeeding (women/men)	27/40	43/48	18/36

(%)			
Knows risk of MTCT can be reduced by mother taking special drugs during pregnancy (women/men) (%)	13/22	21/26	9/20
Knows where to get an HIV test (women/men) (%)	11/36	17/48	8/30
Domestic Violence			
Ever experienced physical violence since age 15 (%)	32	28	34
Ever experienced physical or emotional violence committed by husband (%)	39	32	42

References

1. WHO, Quality of Care: A Process for Making Strategic Choices in Heath System, 2006
2. WHO Regional Publications, Eastern Mediterranean Series 31, 32, 2008.
3. UNDP Pakistan MDGs Report 2013.
4. Taket, Ann .Health Equity, Social Justice and Human Rights, Routledge, London. 2012.
5. Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience. Human Development Report 2014.
6. Social Policy and Development Center, Public Spending on Education and Health in Pakistan, 2010.
7. Planning Commission, Medium-Term Development Framework 2005-10.
8. Pension and Social Security Schemes in Pakistan: Some Policy Options..Nausheen Mahmud and Zafar Moin Nasir.PIDE Working papers.2008.:42.
9. Pakistan: Pakistan's Health Policy Forum and Heartfile; 2006.
10. Pakistan Bureau of Statistics, National Health Accounts Pakistan 2007-2008 .
11. Nishtar, Sania. Choked Pipes, Oxford University Press, 2010.
12. Nishtar, Sania, Zulfiqar Bhutta and et.al, Health reform in Pakistan: a call to action.
13. Nishtar S. The Gateway Paper; Health System in Pakistan – a Way Forward. Islamabad, Lancet 2013.
14. Moving from the margins-Mainstreaming persons with disabilities in Pakistan-A custom research report produced for the British Council.August 2014.
15. Lozanor, NaghaviM, Foreman K, et al. Global and regional mortality from 235 causes of death from 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010.
16. Husain, Akmal, Institutional Imperative of Poverty Reduction, 2008.
17. Demographic and Health Survey 2012-13. Calverton, Maryland, USA: National Institute of Statistics and ICF International. National Institute of Population Studies [Pakistan] and ICF International. Pakistan. 2013.
18. Comparison And Analysis Of Health Care Delivery System: Pakistan Versus China" International Journal of Endorsing Health Science Research www.aeirc-edu.com Volume 2 Issue 1, June Shaista Taufiq Meghani, Sana Sehar & Neelam Saleem PunjaniAga Khan University School of Nursing and Midwifery. Karachi, Pakistan. 2014.
19. Commission on Social Determinants of Health (2007), A Conceptual Framework of Action on the Social Determinants of Health. 2010.Blue Veins , Major laws relating to women in Pakistan.undated.

20. A qualitative enquiry among the legal community of Pakistan.Syed Khurram Azmat , Mohsina Bilgrami , Babar T. Shaikh , Ghulam Mustafa & Waqas Hameed,Marie Stopes Society, Pakistan.2011.

Web sites[89]

1. http://finance.gov.pk/survey/chapters_14/Highlights_ES_201314.pdf
2. http://hdr.undp.org/en/content/table-4-gender-inequality-index
3. http://hdr.undp.org/en/countries/profiles/PAK
4. http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=9154457
5. http://lpp.org.pk/downloads/Case%20Studies%20and%20Reports/arif_hasan_on_low_cost_sanitation.pdf
6. http://vustudents.ning.com/forum/topics/world-health-day-april-7-2014?commentId=3783342%3AComment%3A4119008
7. http://web.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTRESEARCH/EXTWDRS/0,,contentMDK:23252415~pagePK:478093~piPK:477627~theSitePK:477624,00.html
8. http://www.awaztoday.com/News_Change-of-guard-EPI-gets-new-head_1_42427_Political-News.aspx.
9. http://www.blueveins.org/
10. http://www.bti-project.de/uploads/tx_itao_download/BTI_2014_Pakistan.pdf
11. http://www.endpolio.com.pk/12-field-stories/147-crisis-offers-an-opportunity-for-polio-eradication-in-pakistan
12. http://www.endpolio.com.pk/media-room/media-releases/128-pakistan-polio-update-briefer
13. http://www.glxspace.com/2012/12/10/download-copy-of-notification-of-paternity-leave-maternity-leave-punjab-govt-employees/
14. http://www.ilo.org/islamabad/areasofwork/social-security/lang--en/index.htm
15. http://www.internal-displacement.org/south-and-south-east-asia/pakistan/figures-analysis
16. http://www.ohchr.org/en/hrbodies/ccpr/pages/ccprindex.aspx
17. http://www.ohchr.org/en/hrbodies/Pages/HumanRightsBodies.aspx
18. http://www.pbs.gov.pk/sites/default/files/pslm/publications/pslm_prov_dist_2012-13/6-Exeutive%20Summary%2010-02-2014.pdf
19. http://www.pbs.gov.pk/sites/default/files/tables/DEMOGRAPHIC%20INDICATORS%20-%201998%20CENSUS.pdf
20. http://www.un.org/en/development/desa/publications/mdgs-report-2013.html

[89] Web sites mentioned here were visited between 10 to 17 October 2014.

21. http://www.unhcr.org/pages/49e487016.html
22. http://www.who.int/gender/documents/human_rights_tool/en/

23. http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

tribune.com.pk/story/663321/34-of-women-believe-that-their-husbands-are-justified-to-hit-them-if-they-argue-with-him-survey/