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| **PAKISTAN BUREAU OF STATISTICS** **Ministry of National Health services, Regulation and coordination LG & RD complex, G-5, Islamabad****REPORT ON WOMEN AND HEALTH**  |

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**REPORT ON BEIJING PLATFORM OF ACTION**

Ministry of National Health services, Regulation and coordination

LG & RD complex, G-5, Islamabad

# WOMEN AND HEALTH

## Introduction

Traditionally girls and women are treated differently or unfairly because of being a girl or a woman, even though they have the same rights as boys and men. As a result of this discrimination, girls and women may not get a proper education and health care. Girls and women may also face various kinds of violence. Girls and women who live with disabilities, living in rural areas, are poor, or belong to different culture may face lot more discrimination.

Government of Pakistan is fully committed to ensure that Women enjoy highest attainable standard of physical and mental health. Pakistan believes that the enjoyment of this right is vital to their life and well-being, their ability to participate in all areas of public and private life. To turn words into action, the defunct Ministry of Health was working through following programs to achieve MDGs and women health

* National Maternal Neonatal and Child health Program
* National Program Family Planning and Primary Health (LHW program)
* National Nutrition Program
* Expanded Program on Immunization

## Current Status

Ministry of National Services and Regulation was restructured and Ministry of National Health Services, Regulation & Coordination was established on 4th May 2013. Ministry was also designated as federal entity to deal with health issues like immunization, MNCH, Nutrition, LHW program and any other ancillary subject.

# OVERVIEW OF ANALYSIS OF ACHIEVEMENTS AND CHALLENGES SINCE 2009 TO DATE

The current provincial Health Sector Strategies focus on a health system that is efficient, equitable & effective to ensure acceptable, accessible & affordable health services especially to vulnerable segment of the society i.e. women and children.. It will support people and communities to improve their health status so that the health system is fair, responsive and pro-poor while focusing on addressing social inequities and inequities in health.

## Gender and Health

Gender mainstreaming into policies, development plans and programs is the key strategy of the Government to promote gender equality in Pakistan. In the longer term, the government will support the use of gender sensitive budgeting (GSB) in analyzing the federal and provincial government budgets to determine the extent to which resources are allocated to address gender inequality. This will not only improve women’s status but will also contribute to national, social and economic development of the country. However there is need for sex disaggregated data collection, evidence based research and analysis on gender and health issues for the development of informed policies and programs concerning the needs of men, women, boys and girls. In this regard evidence-based assessment reports and research studies has been done including “Gender analysis of health care access and utilization” (2007); Organizational Mapping Assessment on Gender Based Violence Health Response in Pakistan (2010); Rapid Assessment on Health Sector Capacity and Response to Gender based Violence in Pakistan (2011); Rapid Assessment on Gender and Health Impacts of Agrochemicals (2011),Assessment on Integration of Health Related Human Rights in Public Health Response of Pakistan- Draft (2013) .

## Nutrition

Pakistan has taken a life-cycle approach and recognizes the importance of optimal nutrition for women before they become pregnant in order to minimize the risks associated with malnutrition. Securing the good nutritional status of women across the life course will in the long term reduce intrauterine growth restriction, child underweight and stunting. Effective interventions to reduce low birth weight should focus on adequate nutrition of girls throughout their reproductive life, but start with appropriate infant and young child feeding and continue with adequate nutrition in later childhood and adolescence.

After devolution, provincial health departments are focusing on this approach though nutritional interventions addressing anemia and iron deficiency anemia through de-worming and Iron Folic Acid supplementation. The micronutrient deficiency will be addressed through administering multi-micronutrient supplements.

Government of Pakistan in collaboration with UNICEF has

1. Development of breastfeeding rules and regulations with the infant feeding board established at federal and provincial levels
2. National IDD legislation formulated and endorsed already in Gilgit Balistan
3. Elaboration of Pakistan integrated nutrition strategy (PINS) at federal level and being adapted at provincial level building capacity for operationalization with the collaboration of donors and technical partners.
4. Addressing anemia and iron deficiency anemia through de-worming and Iron Folic Acid supplementation. The micronutrient deficiency will be addressed through administering multi-micronutrient supplements.
5. The micronutrient deficiency will be addressed through administering multi-micronutrient supplements.

Pakistan has joined **Scaling Up Nutrition** (SUN) Movement in early 2013. Since then there have been substantial increase in support- political, partners integrative approach, donors, private and others.The SUN frame work promotes working with various actors and sectors, but tailored according to local conditions, SUN build on the principle that it is a government owned process with clear leadership at the Federal and provincial level.. It includes ensuring capabilities, strong monitoring and evaluation agreed by all, resource mobilization, allocation, utilization and capacity building of stake holders. Multi-sectoral stakeholder’s platforms are key to starting initiatives for ensured change. **The SUN key processes focus on;**

1. harmonization of approaches with the stakeholders, advocacy, mobilization of resources and organization,
2. focus on cost effectiveness of the approaches
3. organizing stakeholders platforms
4. contribute to the gaps
5. review update policy frames, like provincial policy guidelines,
6. formulation of common results frame work.

## Elimination of Iodine Deficiency Disorders

Iodine Deficiency Disorder (IDD) is a public health problem in Pakistan, a country with more than half of the population estimated to be at risk for Iodine Deficiency Disorders as reflected in various surveys. The Government of Pakistan is implementing a Universal Salt Iodization/ IDD Control Program that is functioning in 102 districts of the country to eliminate IDDs with the objective to improve the availability and accessibility of adequately iodized salt to the vulnerable sections of the population. Under USI/IDD program, salt processors were provided iodization equipment along with training on iodization technique and internal quality control. Government Health officials were also provided trainings on supervision, monitoring of USI Program, external quality control and compilation and analysis of iodization data.

As per findings of an assessment of salt iodization at production level carried out in 2010, the program achieved 99 percent of salt iodization in the country but there were issues regarding adequacy of salt iodization. Since then the Program has focused towards improvement in the level of adequate iodization of salt. For this purpose Quality Control Laboratories (QCLs) have been established in the salt producing districts to monitor the iodization levels.

The National Nutrition Survey conducted in 2011 has shown a significant increase in the consumption of iodized salt to 69 percent compared to 17 percent in 2001. The increased consumption of iodized salt led to a decrease in the percentage of children 6-12 years of age with iodine deficiency by 28 percent (i.e. NNS 2011-36 percent: NNS 2001- 64 percent). Prevalence of goiter amongst women of childbearing age also decreased to one third as per NNS of 2011 and now stands at only 3 percent

**Fig 1: Comparison of UIE among mothers and school aged children (SAC)**

## Family Planning & Primary Health Care

Program for Family Planning & Primary Health Care has a substantial impact on the uptake of important primary health services which include a large and positive impact on Childhood vaccination rates, Reversible methods of contraception, an increased uptake of antenatal services and Lower rates of childhood diarrhoea. Lady Health workers coverage has improved from 33.6 to 80 percent

## Maternal, Neonatal and Child Health program

Maternal, Neonatal and Child Health program has improved access to high quality MCH and FP services, by  Provision of basic and comprehensive EmONC services, training of skilled birth attendants at community level, training of health facility staff on IMNCI guidelines, Provision of 24/7 child referral services in THQ and DHQ hospitals etc.

## Expanded program on Immunization

Pakistan has achieved 72% of Tetanus Toxide immunization coverage for a planned target of 90%. This would not have been possible to achieve in the presence of an overall coverage of 54% if the country would have not trained 15,000 community-based female health workers (Lady Health Workers) in 38 districts to work on immunization. This intervention has resulted in greater acceptance and accessibility of immunization. This intervention has led to increased access to and acceptance of immunization. According to a comprehensive review of the program, households in areas with Lady Health Workers were 15% more likely to have immunized children below three years. Given the success of the program, the Provincial Governments now plan to provide immunization training to the remaining 85,000 Lady Health Workers in the country.

The Pakistan Demographic and Health Survey (2012-13) shows some, but not significant, gender inequity in access to immunization services (M=56, F=51.5). The EPI has planned to introduce a column of gender in its data collection forms at all levels to assess the reported coverage (which will be assessed against similar data from other sources) for gender equity and wealth quintile.

## Civil society organizations

Recognizing that: (a) working alone the public services would not be able to deliver the MNCH plan and reach desired results/health outcomes; (b) any investment in improving quality and accessibility of health services will have an impact only if similar skills and resources are made available to other service providers; and (c) that the proposed strategies will not achieve desired objectives until substantial improvement is made at the level of community engagement and involvement in planning and monitoring. Thus brought together a Technical Working Group (TWG) with representation from the Ministry and UNICEF, to support the process of collaboration with civil society organizations. While the major role of CSOs is in provision of services where there are gaps, they have also established close linkages and trust in the remote and very poor communities where they work. CSOs have demonstrated strength in mobilizing and organizing village level health committees to plan for community health care and monitor services. CSOs have been playing key role in building communities confidence for vaccination and public health system. The supporting CSOs have been instrumental in arranging vaccination campaigns for missed, due and defaulters in rural villages, provision of maternal and child health services along with raising awareness on important health issues. Achievement includes:

1. Health Awareness on
	1. TT vaccination, immunization
	2. maternal health care, family planning
	3. nutrition, safe injection practices
2. Awareness and advocay for introduction of pneumococcal vaccine
3. Mass media campaigns and awareness raising on injection safety and minimize use of unnecessary injections
4. Total 14 centers are operational and are providing MNCH services in remote areas to provide skilled delivery services
5. Participation during national health days like world health day, global breastfeeding day, pneumonia day, etc

## HIV/AIDS

Pakistan is having concentrated HIV/AIDS epidemic with 27% prevalence among people who inject drugs (PWID), 5.2% in Hijra, 1.6% amongst male sex workers and 0.6% in female sex workers. Thus, having a high prevalence among vulnerable group. Gender norms and relations are a key factor in determining, who acquires HIV and AIDS in Pakistan, and in determining its treatment, care and support outcomes. NACP acknowledges this and all programs and services that are devised and implement strategies that address gender norms and relations. NACP focuses on ante-natal care services, on assisting pregnant women particularly wives of returning labor migrants, to assess their HIV risk, to access voluntary, confidential HIV counseling and testing, to access antiretroviral treatments for themselves, and to access Prevention of Mother-To-Child-Transmission(PMTCT) programs, if HIV-positive.

The National AIDS Control Programme is working to overcome the fear and misunderstanding associated with HIV and AIDS. The people living with HIV and AIDS and their families can receive the VCCT services, treatment, care and support. The women in Pakistan can participate fully in protecting their health and the health of their families by educating and involving in the HIV and AIDS response at all levels.

# DATA AND STATISTICS

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| **Health and related services** **Indicators** | **Year** | **Reference to the strategic objectives in the Beijing platform for action and MDGs** |
|  | 2008-09 | 2012-13 |  |
| Contraceptive prevalence rate (%) | 30 | 35\* | C.1, C.2; Goal 5 |
| Under-five mortality rate (per 1,000 live births) | 100 | 89\* | C.1,; Goal 4 |
| Maternal mortality ratio (per 100,000 births):  | 276 | 276\* | C.1, Goal 5 target A |
| Antenatal coverage | 61 | 73\* | C.1, Goal 5 target B |
| Proportion of births attended by skilled health personnel (%) | 39 | 52\* | C.1, Goal 5 target A |
| Smoking prevalence among person aged 15 and over by sex |  | M:45%\* F: 6% | C.2 |
| Proportion of adults who are obese by sex |  | F: 15%\* | C.1, C.2 |
| People living with HIV, 15-49 yrs old (%):  | <0.1 | <0.1\*\* | C.3, Goal 6 target A |
| Access to anti-reto viral drug by sex |  | M:2595\*\* F:955Transgender:8Children:153 | C.3, Goal 6 target B |
| Life expectancy at age 60 by sex |  | Both sexes: 18\*\*\* | C.1, C.2 |
| Adult mortality by cause and age group  | Data is not available | C.1, C.2 |
| **Sources:** \* PDHS 2012-13\*\*National AIDS Control Program: 100 % of the patients who are registered with HIV treatment centers and need ART have access to and are provided ART free of cost. Number given here is the number of registered patient who are required to be given ART\*\*\* WHO http://www.who.int/gho/countries/pak.pdf?ua=1 |

# EMERGING PRIORITIES AND ACTION TAKEN

1. After the 18th amendment of the constitution, Health is devolved to the provinces. The provinces need capacity building and backup support until they are self dependent
2. Keeping the post devolution scenario of Pakistan and the role of Provinces, a meeting was held in November, 2013 to developed Accelerated Plan of Action for MDG 4&5 in consultation with provincial health and population departments, Health development partners, CSO, WHO and UNICEF. Pakistan has also introduced web based logistic modeling for forecasting and quantifying contraceptives and advance contraceptives supply chain interventions
3. Pakistan has in the past undertaken a number of initiatives to improve the status of women. However there have not been too many interventions targeted towards adolescent girls; something on which the provincial health departments are focusing through the soon to be launched Nutrition PC-1s. Baluchistan and Sindh has develp a separate PC- 1s while Punjab and KPK has developed integrated Pc-1 integrating MNCH, LHW, Nutrition and EPI program.
4. Scale Up Nutrition (SUN) as an essential element to achieve the targets of vision 2025 and 11th Five Year Plan;
	1. Committed to make nutrition a priority in all related sectors to alleviate malnutrition within a generation.
	2. Focusing on children and women with a priority to focus on the 1,000 days form conception to 24 months of age is the window of opportunity
	3. Stakeholder mobilization and organization Policy Framework
	4. Finalization of the policy/planning process:
		1. Formal approval of the Intersectoral Strategies
		2. Prioritisation/operational plan/action
		3. clarification of the roles and responsibilities of the key sectors
		4. Coordination and implementation mechanisms
	5. Common Results Framework:
		1. Translating Intersectoral Strategies into operational sector plans (budget time-frame)
		2. Monitoring and implementation tracking system
		3. Operational research priorities
		4. Comprehensive Communication Strategy
	6. Resource Mobilization
		1. Costing/ PC-1
5. The USI program will be expanded to 8 additional (remaining) salt producing districts of Sindh province that are not covered by the Program so far, thus bringing the total number of USI districts to 110. Efforts would be made towards the development of an open market system of procurement and availability of the potassium iodate (KIO3). In those provinces that do not have compulsory salt iodization legislation, advocacy will continue with concerned government departments and stake holders for promulgation of provincial legislation on mandatory salt iodization. Advocacy will also be carried out with the salt processor associations to motivate them to arrange for the replacement of equipment themselves on self help basis. Priority will be given to the component of quality control in program implementation to ensure adequacy of edible salt iodized and necessary steps taken in this respect.
6. EPI has developed comprehensive Multi Year Plan (cMYP) 2014-2018. cMYP aims at
	1. Streamline immunization program management at all levels in the light of the devolution and with focus on local ownership and sustainability,
	2. improve immunization service delivery through
		1. mobilization of additional skilled immunization staff and strengthening physical infrastructure,
		2. implementation of micro-planning in all UCs
		3. Upgrade of physical infrastructure and logistics system
	3. Increase sustainability of immunization through:
		1. Effective integration into MNCH services
		2. Improved planning and budgeting
	4. Increase political and public awareness of the importance of immunization through evidence based advocacy, communication and social mobilization activities