

# **Health-Related Millennium Development Goals: Policy Challenges for Pakistan**

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## **Abstract**

### **Objectives:**

There are two objectives: (a) to clearly articulate the Millennium Development Goals (MDGs) adopted by the United Nations in 2000 and their implications for developing countries like Pakistan; and (b) to critically review the challenges faced by Pakistan in achieving the health-related MDGs.

### **Methods:**

A critical review of secondary data and information generated primarily by multilateral agencies and United Nations organizations.

### **Results:**

The MDGs represent a global consensus on the broad goals of development to be achieved by 2015. Of the eight Millennium Development Goals, three are specifically health related - reducing infant (under-5) and maternal mortality; and combating HIV/AIDS, tuberculosis, malaria and other significant communicable diseases. According to various studies, many developing countries will not achieve the MDGs without concerted efforts and commitment of additional resources. Like many other developing countries, Pakistan is also faced with an enormous challenge in reaching the Millennium Development Goals and targets set by the United Nations. For Pakistan, perhaps the most challenging MDG is that of reducing "by three-quarters the maternal mortality ratio." Maternal mortality is so intertwined with other "social" factors - including the status of women - that a comprehensive holistic approach is required.

### **Conclusion:**

In order to achieve the MDGs, Pakistan would require a fundamental shift in its policy and strategic directions. Along with allocation of significant additional resources for health, it needs to review and reprioritize the use of existing resources, focusing more on primary health care. Pakistan must also adopt a holistic integrated approach that views health, education, and other social sector development as intrinsically interrelated and interwoven. Without such an integrated approach, achieving the health-related MDGs is likely to remain illusive for Pakistan. There is a critical need to foster a healthy debate on the health-related Millennium Development Goals in Pakistan so as to inform and, hopefully influence, public policy (JPMA 54:175;2004).

## **Purpose of the Study**

In September 2000, the United Nations General Assembly adopted a number of resolutions aimed at alleviating poverty and promoting equitable and sustainable development in developing countries. One of these resolutions identified eight areas for concrete action with measurable results to be achieved by the year 2015 (Table 1). All 189 member-states of the United Nations endorsed these Millennium Development Goals (MDGs) and vowed to make concerted efforts in achieving them.<sup>1</sup> In subsequent summit-level meetings in Monterrey, Mexico (2001), Doha, Qatar (2002), and Kananaskis, Canada (2002), the Development Assistance Committee (DAC) of the industrialized world adopted a number of complementary measures to help developing countries achieve the MDGs. Increasing development assistance, gradual untying of aid, and providing greater access for the developing country goods to the markets of the industrialized world, constitute some of these complementary measures.

Three of the eight MDGs are explicitly health related - goal numbers 4 (reduce under-5 child mortality), 5 (improve maternal health), and 6 (combat HIV/AIDS, malaria, and other diseases). Goals 4 and 5 call for the reduction of under-five child mortality rate by two-thirds and the maternal mortality ratio by three-quarters within the next fifteen years (taking 1990 as the base year). Similarly, by 2015, the goal (six) is to "halt and begin to reverse the spread of HIV/AIDS and the incidence of malaria and other major diseases." Another three Millennium Development Goals are intricately related to health - eradication of extreme poverty and hunger (goal 1), achieving universal primary education (goal 2), and promoting gender equality and empowerment of women (goal 3). The relevance and importance of these three goals in achieving the directly health-related ones can hardly be overemphasized.

Since their adoption, the MDGs received wide endorsement from civil society organizations in both the developed and developing countries. Various development agencies expressed their commitment to work with the developing countries in achieving the MDGs. Following the Johannesburg World Summit for Sustainable Development (WSSD) in September 2002, the United Nations has urged the member states to redouble their efforts to achieve the MDGs. It has been stressed that "meeting these goals is feasible but far from automatic. Indeed, on our current trajectory, those goals will not be met for a significant proportion of the world's poor. Success in achieving the MDGs will require a seriousness of purpose, a political resolve and an adequate flow of resources from high-income to low-income countries on a sustained and well-targeted basis".<sup>2</sup>

Where is Pakistan in achieving the health-related MDGs? What are the challenges faced by Pakistan in reducing child mortality and in improving maternal health? Can Pakistan reach the targets set for 2015? The purpose of this paper is to answer these questions using a holistic perspective.

## **Study Design**

This is an analytical study based on a review of secondary data. Most of the data are available in reports produced by the United Nations agencies and other multilateral organizations like the World Bank, and the OECD. Scholarly articles on various aspects of the health sector in Pakistan have also been used.

The World Bank, World Health Organization (WHO), United Nation's Children's Fund (UNICEF), the United Nations Development Program (UNDP) regularly publish data on

social, economic and health indicators in all countries. These annual reports contain valuable information that can be used to identify and analyze trends in socio-economic and health-related changes occurring in different countries. Since the announcement of the Millennium Development Goals, some of these U. N. agencies are engaged in monitoring the progress towards achieving them. Special studies are, therefore, being conducted by these and other agencies. The Report of the Commission on Macroeconomics and Health, led by Harvard University Professor Jeffrey Sachs, published in December 2001, is a case in point. The Organization for Economic Cooperation and Development (OECD) also published a number of reports related to MDGs issues. The paper has used these study reports extensively. However, it should be noted that in most instances these studies provided the data, while the interpretation was that of the author's. So is the case with published and unpublished research studies and papers on health-related issues in Pakistan.

## **Results**

### **(a) Pakistan and the Health MDGs: The Targets**

For Pakistan two health-related Millennium Development Goals - 4 and 5 - are of particular relevance. One calls for the reduction by two-thirds the under-5 mortality rate, while the other demands a reduction of the maternal mortality ratio by three-quarters by the year 2015. The goal number 6 is also relevant insofar as malaria and other major communicable diseases (such as tuberculosis) are concerned. The base-year for these targets is 1990. In other words, countries are committed to reduce their under-5 mortality rate by two-thirds and their maternal mortality ratio by three-quarters between 1990 and 2015 - a span of twenty-five years.

Over the years, Pakistan has made considerable progress in reducing its Under-5 mortality and maternal mortality rates. The Under-5 mortality rate went down from 227 per 1,000 live births during 1960s to 128 per 1,000 live births by the 1990s.<sup>3</sup> Currently, the Under-5 mortality rate in Pakistan stands at 109 per 1,000 live births.<sup>4</sup> Infant mortality - children dying within the first 28 days of life - constitute a significant proportion of this Under-5 mortality rate. The infant mortality rate (IMR) in Pakistan was 145 per 1,000 live births during the 1970s and declined to 95 per 1,000 live births by 1990s. Since then, according to some scholars, the IMR in Pakistan seems to have increased somewhat to 101 per 1,000 live births.<sup>5</sup> In other words, IMR constitutes a large proportion of the Under-5 mortality rate in Pakistan. Consequently, without seriously addressing factors affecting the infant mortality rate, it would be impossible to achieve the required target in reducing the Under-5 mortality rate in Pakistan. While diarrhea, pneumonia, measles, malaria, and malnutrition (along with HIV/AIDS in sub-Saharan Africa) are the major causes of Under-5 mortality globally, asphyxia, pre-term delivery, sepsis, and tetanus are the primary contributors to infant mortality.<sup>6</sup> It is apparent that mother's health status in general and the care she receives during pregnancy and at childbirth in particular has significant relevance for infant mortality.

Over the last three decades, the maternal mortality ratio in Pakistan also declined considerably - from over 600 per 100,000 live births in the 1960s to 340 per 100,000 live birth by the turn of the new millennium.<sup>7,8</sup> These national level figures, it should be noted, hide the wide variation in Under-5 or infant mortality rate and maternal mortality ratios prevalent in Pakistan. For example, recent statistics tend to suggest that the

maternal mortality ratio varies from a low of 281 per 100,000 live births in urban Karachi to a high of 673 per 100,000 live births in rural Balochistan.<sup>9</sup> These intra-country differences must receive serious attention in relation to MDGs.

For Pakistan, the two most important MDG targets are as follows:

(a) Reducing the Under-5 mortality rate from 138 per 1,000 live births in 1990-91 to 46 per 1,000 live birth by the year 2015. The under-5 mortality rate currently stands at around 109.4

(b) Reducing the maternal mortality ratio from 410 per 100,000 live births (in 1991) to 104 per 100,000 live births by the year 2015. As noted earlier the maternal mortality ratio currently stands at around 340.

What is the prognosis for Pakistan? Will it be able to achieve these MDGs? More importantly, what measures are needed to realize these Millennium Development Goals?

(b) Achieving MDGs: The Challenge for Pakistan

At the very outset it must be emphasized that the two health related MDGs are interrelated; one cannot be achieved without the other. Infant mortality - a significant component of the Under-5 mortality rate - can hardly be reduced without reducing maternal mortality. This is especially so in case of neonatal or perinatal mortality that depends more heavily on the health and nutritional status of the mother during pregnancy.

On the other hand, maternal mortality and infant mortality are closely related to the educational and social status of women.<sup>11</sup> Educated women are more likely to use contraceptives, and have fewer numbers of children thereby reducing the risks of either infant mortality or maternal mortality. Table 2 clearly shows the strong inverse relationship between IMR and women's illiteracy. In other words, all the MDGs must be addressed simultaneously in order to achieve success. However, it is also important to note that achieving success in one Millennium Development Goal is likely to be accompanied by success in achieving other MDGs.

Pakistan's illiteracy rate, particularly among women, is much higher than its neighbors (Table 2). Moreover, illiteracy among women varies greatly within the country; in rural Balochistan, for example, women's illiteracy rate is estimated to be 98 per cent. The population program in Pakistan, historically, suffered from inconsistent political support and, as a result, it has one of the highest population growth rates in the world. The total fertility rate in Pakistan declined at a much lower rate than even in other Muslim countries like Bangladesh, Iran, or Indonesia. Consequently, Pakistan's population is expected to double within a span of 25 years (Table 3). Not surprisingly, the contraceptive prevalence rate (CPR) in Pakistan is one of the lowest in the world.<sup>12</sup> Although the CPR is estimated at about 24 percent (compared to 60 percent in Bangladesh, for example), it varies widely within the country. Contraceptive use is primarily limited to urban centers.

The health care system in Pakistan also suffers from various ailments. Pakistan spends only about 0.7 percent of its Gross Domestic Product (GDP) on health, a lower percentage than that of Bangladesh or India.<sup>13</sup> The publicly funded health care system lacks adequate financial and human resources; facilities and equipment, and appropriate organizational structure. Women health professionals are especially scarce in much of Pakistan.<sup>14</sup> Few managers or health policy makers are women; and women have little participation in the decision making process involving the health care system. The low socio-economic status of women and the overall conservative feudal character of the

broader society reinforce the gender bias of the health care system.

Although 38 of every 1000 women die prematurely during pregnancy or childbirth, the system hardly reacts to this challenge. The quality of services is poor and consequently, the health care system remains underutilized.<sup>15</sup> Health care services for women are particularly inadequate with little obstetric facilities in much of the Basic Health Units or Rural Health Clinics.<sup>14,15</sup> Not surprisingly, only about 19 percent of births in Pakistan are attended by a trained/skilled health care personnel, compared to 34 percent in India and 94 percent in Sri Lanka.<sup>16</sup> The private sector is playing an increasing role in the provision of health care services, although its impact on equity or poverty is yet to be fully examined.

Perhaps the most disturbing element is the weakness of Pakistan's economy. Over the last two decades, the economic growth rate hardly kept pace with population growth resulting in increasing poverty particularly in rural areas where 65 percent of the population live and in urban slums. On the other hand, debt servicing in recent years consumed more than 40 percent of the budget. Consequently, there is little room for other expenditures especially in the social sector.<sup>13</sup> It is encouraging to note that following the Afghan war and rapprochement with the United States, Pakistan's economy has started to show some signs of modest growth over the last two years. This is particularly a result of infusion of substantial foreign currency and greater flow of U.S. aid/or debt relief measures. It remains to be seen what would be the extent of this economic growth and how much it would contribute to poverty reduction and to greater investment in the social sector.

Long-term sustainability of such foreign currency infusion is also suspect.

Perhaps the biggest challenge facing Pakistan is improving the social status of women. It is universally recognized that this is a prerequisite for bringing about any positive change in the under-5 mortality rate and, in the long run, to significantly lower the maternal mortality ratio. Nutritional deficit in women, especially during pregnancy, so prevalent in Pakistan<sup>10,17</sup> is also a reflection of the low status of women in the country. Obviously the most ominous sign of women's low social status in Pakistan is the all pervasive violence against them in the country that are mostly justified on the basis of either religion or culture. "Women in Pakistan face the threat of multiple forms of violence, including sexual violence by family members, strangers, and state agents; domestic abuse including spousal murder and being burned, disfigured with acid, beaten, and threatened; ritual honor killings; and custodial abuse and torture".<sup>18</sup> According to the Human Rights Commission of Pakistan, Amnesty International and other non-government organizations active in the field, more than 70 percent of women in Pakistan experience domestic violence.

Honor killings (termed karo-kari in the province of Sindh) take the lives of more than 300 women in Pakistan every year.<sup>19,20</sup> It is ironic that despite a signatory to the 1996 U.N. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Pakistan has made little formal attempt to halt and/or reverse these multiple forms of violence against women.<sup>20</sup> On the other hand, violence against women in Pakistan is so deep-rooted in culture that without explicit commitment and strenuous efforts from the state, it is impossible to address this social menace effectively. Sadly, the feudal structure of the society (and, by extension, the polity), makes such an explicit commitment from the state apparatus unlikely to materialize without encouragement from outside - from the wider international community.

The relationship between women's social status, contraceptive use, fertility decline, and child and maternal mortality is well established.<sup>21-23</sup> The Report of the Commission on Macroeconomics and Health, for example, points out: "one of the most powerful contributors to reduced child mortality is the literacy of mothers, which is itself the product of an education system that ensures widespread access to education for the poor, including girls as well as boys".<sup>2</sup> The Nobel Laureate Amartya Sen, in his seminal book *Development as Freedom*, emphatically stressed this relationship between women's education, social status and overall child and maternal health when he made education and health as the two basic capabilities that makes life meaningful and the enjoyment of freedom possible.<sup>11</sup> Enhancing women's social status through education and the provision of economic opportunities is, thus, an essential precondition for achieving the MDGs and securing sustained development. It is evident that Pakistan is painfully lagging behind in this respect.

In short, Pakistan is faced with multiple, and interconnected, challenges in its quest to achieve the millennium development goals. Some of these challenges relate specifically to the health care system, while others relate to the economy and the society (and culture) generally. However, the macro political environment is also a source of worry. Pakistan has had a dubious history of democracy. The country had been under actual or de facto military rule for most of its history that denied its people fundamental freedoms.<sup>23</sup> The true nature of the recent "transition" to democracy following the latest military coup in 1999 is questionable. The long-term viability of this transition is also suspect. Without meaningful democracy that promotes a strong sense of citizenship, human rights, and freedom, it would be difficult, if not impossible, for Pakistan to achieve the MDGs.

(c) Achieving MDGs: What Needs to be Done?

In short, Pakistan has to initiate some radical changes if it wants to make meaningful strides in achieving the health-related millennium development goals. Following the recommendations of the Commission on Macroeconomics and Health and that of other studies, the challenges faced by Pakistan include:

- (a) Increased resource allocation for health and education;
- (b) To re-double efforts to significantly (and quickly) reduce female illiteracy;
- (c) To ensure the availability of female health professionals in Basic Health Units and Rural Health Clinics;
- (d) To ensure the availability and accessibility of emergency obstetric services in secondary-level hospitals and clinics;
- (e) To improve the social status of women. In this regard, the first priority would be to address, with full commitment, the complex issue of violence against women;
- (f) Strengthening primary health care services with special focus on child survival; and
- (g) To initiate meaningful reform of the health care system to make it more sustainable and responsive to the needs of women and children.

These factors can be divided into two groups: those that are within the purview of the health care system, and those that are outside the health sector (e.g. education for women, improving the status of women, and water and sanitation as part of an integrated PHC). Improving the status of women (and their empowerment) is also one of the MDGs. In the context of Pakistan, this is the most complex issue as it encompasses dominant social values, the societal power structure, the legal system, and the role of the state. Empowerment of women would require not only the elimination of all laws that are

explicitly discriminatory in nature; but also strict enforcement by the state of laws that are meant to prevent such discrimination including violence against women. Given the long history of honor killings, and the very nature of the feudal social structure, the social status of women in Pakistan cannot be improved without a comprehensive program and unequivocal political commitment. Expanding education and eliminating female illiteracy can go a long way in this respect.

The health sector factors are relatively easier to address. Further expansion and strengthening of the Lady Health Workers (LHW) program and making it an integral part of primary health care services could be a good start. The need for more trained female health professionals, including midwives, nurses, and Lady Health Visitors in Basic Health Units and Rural Health Clinics and other secondary health care facilities is widely recognized. So is the need for emergency obstetric services in appropriate health facilities. Along with these almost universally recognized measures, health care system per se needs to be made more gender sensitive. There are training tools that can be effectively used in this respect. Two of such available tools are "the Health Workers for Change", and "the Healthy Women Counseling Guide" developed by UNDP, WHO, and the World Bank in mid-1990s.<sup>25</sup> All professionals, paramedic and frontline staff working within the health sector must undergo training using the tool "Health Workers for Change". This will make them and the healthcare system more sensitive to women's health issues, and improve the client-service provider relationship. This tool is geared towards making the service providers better understand the inherent gender bias of the system and in making them respect and appropriately respond to women's health needs. The "Healthy Women Counseling Guide", on the other hand, is an excellent tool that can be used to train underprivileged women better understand their health care needs and articulate them in order to demand better services from the healthcare system. Training in this tool raises the awareness of women and helps them participate in decisions affecting their lives. In other words, while the former tool makes the service providers better understand women's health needs, the latter makes women better articulate their demands and participate in the decision-making process. These two tools, in short, would engender the health care system in Pakistan. Massive training using these tools should be an essential part of any health sector reform effort.

#### (d) Achieving MDGs: Critical Choices

However, how to finance all these efforts is also a serious issue. Pakistan spends far less public money on health care than most other developing countries, including some of those in the region. It is imperative for Pakistan to significantly increase resource allocation for health - from the current 0.3 percent of the GDP to about 2 percent of the GDP (this refers to public expenses on health only, not including out-of-pocket expenses) within the next decade. At the same time, following the recommendations of the WHO Commission on Microeconomics and Health (CMH) Pakistan should redirect its public investments in health to primary health care. The CMH Report, published in December 2001, recommended that developing countries should concentrate on spending public funds for health to cover the cost of a basic package of essential health care interventions targeting the major causes of morbidity and mortality among, primarily, the poor and the disadvantaged.<sup>2</sup> While the nature and contents of this "essential package" will vary from country to country, it must remain focused on morbidity/mortality affecting the poor. For Pakistan that would mean major communicable diseases like tuberculosis and

malaria, basic maternal and child health and nutritional services, and water and sanitation. CMH estimated that such an essential package would cost around \$34 (in constant 2002 U.S. dollars) per capita per year. CMH contends that while the least developed countries would require significant external aid to meet this need, low-income countries like Pakistan should be able to mobilize additional resources largely from within for this purpose. Pakistan currently spends about US\$ 17 per capita per year on health, only \$6 being from the government.<sup>9</sup> It would be extremely difficult for Pakistan to increase the public expenditure on health from \$6 to \$34 per capita per year in the foreseeable future without substantial external aid. Perhaps the most challenging task for Pakistan is to redirect public expenditure on health to those issues that primarily affect the poor.

However, increased development assistance from industrialized countries could ease such a transition. The CMH recommended that the international donor community should increase its contribution to health from the current \$6 billion a year to \$27 billion by 2007 and to \$38 billion by 2015. "In addition, the World Bank and the regional development banks should offer increased non-concessional loans to middle-income countries aiming to upgrade their health systems".<sup>2</sup> Table 4 presents the CMH recommended donor commitments for health.

Despite the recommendation of the CMH, it is highly unlikely that official development assistance (ODA) for health will register a 6-fold increase between now and 2015. The total ODA (covering all sectors) currently stands at around \$52 billion annually. If the rate of increase suggested for health is applied to other sectors, the total ODA should reach almost \$350 billion by 2015. In reality, only a few countries increased their ODA in recent years. It is important to note that only a few Scandinavian countries so far achieved 0.7 percent of GDP ceiling for ODA set by the United Nations in mid-1970s.<sup>26</sup> The biggest donor countries (in terms of total ODA volume) like the United States and Japan are falling further behind in reaching this ODA ceiling. It is, therefore, rather unrealistic to expect a more than 6-fold increase in ODA for health over the next 12 years. In other words, low-income countries like Pakistan must rely on their own resources, with some modest increase in ODA, to strive towards reaching the health-related MDGs. Prudent reallocation of resources, therefore, will play a crucial role in this endeavor. In short, Pakistan is faced with crucial choices. The future of human development in Pakistan hinges on the choices that it makes.

### **Conclusions**

The Millennium Development Goals endorsed by the UN General Assembly in September 2000 represent a broad international consensus on the human development targets that the developing countries must strive to achieve by 2015. Out of the eight MDGs, three are explicitly health related - reducing under-5 mortality rate by two-thirds, reducing maternal mortality ratio by three-quarters, and halving or reversing the onslaught of HIV/AIDS and other communicable diseases like TB and malaria. Another three MDGs are closely linked with these health-related ones - universal primary education, reducing extreme poverty and hunger and eliminating gender inequality and providing empowerment of women. Pakistan is a signatory to this declaration and must make every effort in achieving them.

For Pakistan the task is daunting indeed. It must reduce its Under-5 mortality rate from the current 109 per 1,000 live births to 46 per 1,000 live births by 2015. Similarly, the



maternal mortality ratio must come down from the present 340 per 100,000 live births to 104 per 100,000 live births by 2015. Moreover, female illiteracy must be eliminated by 2015 and real progress must be made in bringing in gender equality and empowering women.

In order to achieve the MDGs, Pakistan must adopt a pro-poor health policy, radically changing its health care system. Significantly more resources for health along with a fundamental shift in the structure and composition of the health care system will be required. Following the recommendations of the WHO Commission on Macroeconomics and Health, Pakistan must put more emphasis on primary health care and on diseases and health issues that affect the poor and the disadvantaged. While some additional ODA can be expected for the health sector, Pakistan must rely more on reallocation of its own resources to achieve the MDGs. Critical choices made by Pakistan in its resource reallocation exercise now will determine the future direction of human development in the country. Health and development professionals in Pakistan must engage in a healthy debate on the Millennium Development Goals and their implications for Pakistan. It is time to critically assess the challenges faced by the country in this regard. Such debate, hopefully, will inform and influence public policy leading to fundamental shifts in strategic directions that are essential to achieve the MDGs.

## **Results**

### **(a) Pakistan and the Health MDGs: The Targets**

For Pakistan two health-related Millennium Development Goals - 4 and 5 - are of particular relevance. One calls for the reduction by two-thirds the under-5 mortality rate, while the other demands a reduction of the maternal mortality ratio by three-quarters by the year 2015. The goal number 6 is also relevant insofar as malaria and other major communicable diseases (such as tuberculosis) are concerned. The base-year for these targets is 1990. In other words, countries are committed to reduce their under-5 mortality rate by two-thirds and their maternal mortality ratio by three-quarters between 1990 and 2015 - a span of twenty-five years.

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Although 38 of every 1000 women die prematurely during pregnancy or childbirth, the system hardly reacts to this challenge. The quality of services is poor and consequently, the health care system remains underutilized.<sup>15</sup> Health care services for women are particularly inadequate with little obstetric facilities in much of the Basic Health Units or Rural Health Clinics.<sup>14,15</sup> Not surprisingly, only about 19 percent of births in Pakistan are attended by a trained/skilled health care personnel, compared to 34 percent in India and 94 percent in Sri Lanka.<sup>16</sup> The private sector is playing an increasing role in the provision of health care services, although its impact on equity or poverty is yet to be fully examined.

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Honor killings (termed karo-kari in the province of Sindh) take the lives of more than 300 women in Pakistan every year.<sup>19,20</sup> It is ironic that despite a signatory to the 1996 U.N. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Pakistan has made little formal attempt to halt and/or reverse these multiple forms of violence against women.<sup>20</sup> On the other hand, violence against women in

Pakistan is so deep-rooted in culture that without explicit commitment and strenuous efforts from the state, it is impossible to address this social menace effectively. Sadly, the feudal structure of the society (and, by extension, the polity), makes such an explicit commitment from the state apparatus unlikely to materialize without encouragement from outside - from the wider international community.

The relationship between women's social status, contraceptive use, fertility decline, and child and maternal mortality is well established.<sup>21-23</sup> The Report of the Commission on Macroeconomics and Health, for example, points out: "one of the most powerful contributors to reduced child mortality is the literacy of mothers, which is itself the product of an education system that ensures widespread access to education for the poor, including girls as well as boys".<sup>2</sup> The Nobel Laureate Amartya Sen, in his seminal book *Development as Freedom*, emphatically stressed this relationship between women's education, social status and overall child and maternal health when he made education and health as the two basic capabilities that makes life meaningful and the enjoyment of freedom possible.<sup>11</sup> Enhancing women's social status through education and the provision of economic opportunities is, thus, an essential precondition for achieving the MDGs and securing sustained development. It is evident that Pakistan is painfully lagging behind in this respect.

In short, Pakistan is faced with multiple, and interconnected, challenges in its quest to achieve the millennium development goals. Some of these challenges relate specifically to the health care system, while others relate to the economy and the society (and culture) generally. However, the macro political environment is also a source of worry. Pakistan has had a dubious history of democracy. The country had been under actual or de facto military rule for most of its history that denied its people fundamental freedoms.<sup>23</sup> The true nature of the recent "transition" to democracy following the latest military coup in 1999 is questionable. The long-term viability of this transition is also suspect. Without meaningful democracy that promotes a strong sense of citizenship, human rights, and freedom, it would be difficult, if not impossible, for Pakistan to achieve the MDGs.

(c) Achieving MDGs: What Needs to be Done?

In short, Pakistan has to initiate some radical changes if it wants to make meaningful strides in achieving the health-related millennium development goals. Following the recommendations of the Commission on Macroeconomics and Health and that of other studies, the challenges faced by Pakistan include:

- (a) Increased resource allocation for health and education;
- (b) To re-double efforts to significantly (and quickly) reduce female illiteracy;
- (c) To ensure the availability of female health professionals in Basic Health Units and Rural Health Clinics;
- (d) To ensure the availability and accessibility of emergency obstetric services in secondary-level hospitals and clinics;
- (e) To improve the social status of women. In this regard, the first priority would be to address, with full commitment, the complex issue of violence against women;
- (f) Strengthening primary health care services with special focus on child survival; and
- (g) To initiate meaningful reform of the health care system to make it more sustainable and responsive to the needs of women and children.

These factors can be divided into two groups: those that are within the purview of the health care system, and those that are outside the health sector (e.g. education for women,

improving the status of women, and water and sanitation as part of an integrated PHC). Improving the status of women (and their empowerment) is also one of the MDGs. In the context of Pakistan, this is the most complex issue as it encompasses dominant social values, the societal power structure, the legal system, and the role of the state. Empowerment of women would require not only the elimination of all laws that are explicitly discriminatory in nature; but also strict enforcement by the state of laws that are meant to prevent such discrimination including violence against women. Given the long history of honor killings, and the very nature of the feudal social structure, the social status of women in Pakistan cannot be improved without a comprehensive program and unequivocal political commitment. Expanding education and eliminating female illiteracy can go a long way in this respect.

The health sector factors are relatively easier to address. Further expansion and strengthening of the Lady Health Workers (LHW) program and making it an integral part of primary health care services could be a good start. The need for more trained female health professionals, including midwives, nurses, and Lady Health Visitors in Basic Health Units and Rural Health Clinics and other secondary health care facilities is widely recognized. So is the need for emergency obstetric services in appropriate health facilities. Along with these almost universally recognized measures, health care system per se needs to be made more gender sensitive. There are training tools that can be effectively used in this respect. Two of such available tools are "the Health Workers for Change", and "the Healthy Women Counseling Guide" developed by UNDP, WHO, and the World Bank in mid-1990s.<sup>25</sup> All professionals, paramedic and frontline staff working within the health sector must undergo training using the tool "Health Workers for Change". This will make them and the healthcare system more sensitive to women's health issues, and improve the client-service provider relationship. This tool is geared towards making the service providers better understand the inherent gender bias of the system and in making them respect and appropriately respond to women's health needs. The "Healthy Women Counseling Guide", on the other hand, is an excellent tool that can be used to train underprivileged women better understand their health care needs and articulate them in order to demand better services from the healthcare system. Training in this tool raises the awareness of women and helps them participate in decisions affecting their lives. In other words, while the former tool makes the service providers better understand women's health needs, the latter makes women better articulate their demands and participate in the decision-making process. These two tools, in short, would engender the health care system in Pakistan. Massive training using these tools should be an essential part of any health sector reform effort.

#### (d) Achieving MDGs: Critical Choices

However, how to finance all these efforts is also a serious issue. Pakistan spends far less public money on health care than most other developing countries, including some of those in the region. It is imperative for Pakistan to significantly increase resource allocation for health - from the current 0.3 percent of the GDP to about 2 percent of the GDP (this refers to public expenses on health only, not including out-of-pocket expenses) within the next decade. At the same time, following the recommendations of the WHO Commission on Microeconomics and Health (CMH) Pakistan should redirect its public investments in health to primary health care. The CMH Report, published in December 2001, recommended that developing countries should concentrate on spending public

funds for health to cover the cost of a basic package of essential health care interventions targeting the major causes of morbidity and mortality among, primarily, the poor and the disadvantaged.<sup>2</sup> While the nature and contents of this "essential package" will vary from country to country, it must remain focused on morbidity/mortality affecting the poor. For Pakistan that would mean major communicable diseases like tuberculosis and malaria, basic maternal and child health and nutritional services, and water and sanitation. CMH estimated that such an essential package would cost around \$34 (in constant 2002 U.S. dollars) per capita per year. CMH contends that while the least developed countries would require significant external aid to meet this need, low-income countries like Pakistan should be able to mobilize additional resources largely from within for this purpose. Pakistan currently spends about US\$ 17 per capita per year on health, only \$6 being from the government.<sup>9</sup> It would be extremely difficult for Pakistan to increase the public expenditure on health from \$6 to \$34 per capita per year in the foreseeable future without substantial external aid. Perhaps the most challenging task for Pakistan is to redirect public expenditure on health to those issues that primarily affect the poor.

However, increased development assistance from industrialized countries could ease such a transition. The CMH recommended that the international donor community should increase its contribution to health from the current \$6 billion a year to \$27 billion by 2007 and to \$38 billion by 2015. "In addition, the World Bank and the regional development banks should offer increased non-concessional loans to middle-income countries aiming to upgrade their health systems".<sup>2</sup> Table 4 presents the CMH recommended donor commitments for health.

Despite the recommendation of the CMH, it is highly unlikely that official development assistance (ODA) for health will register a 6-fold increase between now and 2015. The total ODA (covering all sectors) currently stands at around \$52 billion annually. If the rate of increase suggested for health is applied to other sectors, the total ODA should reach almost \$350 billion by 2015. In reality, only a few countries increased their ODA in recent years. It is important to note that only a few Scandinavian countries so far achieved 0.7 percent of GDP ceiling for ODA set by the United Nations in mid-1970s.<sup>26</sup> The biggest donor countries (in terms of total ODA volume) like the United States and Japan are falling further behind in reaching this ODA ceiling. It is, therefore, rather unrealistic to expect a more than 6-fold increase in ODA for health over the next 12 years. In other words, low-income countries like Pakistan must rely on their own resources, with some modest increase in ODA, to strive towards reaching the health-related MDGs. Prudent reallocation of resources, therefore, will play a crucial role in this endeavor. In short, Pakistan is faced with crucial choices. The future of human development in Pakistan hinges on the choices that it makes.

## **Conclusions**

The Millennium Development Goals endorsed by the UN General Assembly in September 2000 represent a broad international consensus on the human development targets that the developing countries must strive to achieve by 2015. Out of the eight MDGs, three are explicitly health related - reducing under-5 mortality rate by two-thirds, reducing maternal mortality ratio by three-quarters, and halving or reversing the onslaught of HIV/AIDS and other communicable diseases like TB and malaria. Another

three MDGs are closely linked with these health-related ones - universal primary education, reducing extreme poverty and hunger and eliminating gender inequality and providing empowerment of women. Pakistan is a signatory to this declaration and must make every effort in achieving them.

For Pakistan the task is daunting indeed. It must reduce its Under-5 mortality rate from the current 109 per 1,000 live births to 46 per 1,000 live births by 2015. Similarly, the maternal mortality ratio must come down from the present 340 per 100,000 live births to 104 per 100,000 live births by 2015. Moreover, female illiteracy must be eliminated by 2015 and real progress must be made in bringing in gender equality and empowering women.

In order to achieve the MDGs, Pakistan must adopt a pro-poor health policy, radically changing its health care system. Significantly more resources for health along with a fundamental shift in the structure and composition of the health care system will be required. Following the recommendations of the WHO Commission on Macroeconomics and Health, Pakistan must put more emphasis on primary health care and on diseases and health issues that affect the poor and the disadvantaged. While some additional ODA can be expected for the health sector, Pakistan must rely more on reallocation of its own resources to achieve the MDGs. Critical choices made by Pakistan in its resource reallocation exercise now will determine the future direction of human development in the country. Health and development professionals in Pakistan must engage in a healthy debate on the Millennium Development Goals and their implications for Pakistan. It is time to critically assess the challenges faced by the country in this regard. Such debate, hopefully, will inform and influence public policy leading to fundamental shifts in strategic directions that are essential to achieve the MDGs.

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