



## District Dera Gazi Khan Human Development Report





# **District Dera Ghazi Khan Human Development Report**

Addressing Vulnerabilities in Education and Health:  
Responding to Out-of-School Children and Out-of-Pocket Costs

Faisal Buzdar

Copyrights AAWAZ Programme @2015

AAWAZ Programme is funded by the UKAid through the Department for International Development (DFID), AAWAZ was conceived initially as a five-year programme, from 2012 to 2017. Development Alternatives Inc. (DAI) is the Management Organisation (MO) for implementing the AAWAZ programme, while Pakistan's prime civil society organisations: Aurat Foundation (AF), South-Asia Partnership Pakistan (SAP-PK), Strengthening Participatory Organisation (SPO) and Sungi Development Foundation (SF) form the implementation consortium responsible for directly working with communities.

All publications by AAWAZ are copyrighted, however, can be cited with reference.

## **Table of Contents**

<b>Executive Summary .....</b>	<b>5</b>
<b>Chapter 1: Putting Human Development and Human Development Reports into Perspective .....</b>	<b>7</b>
1.1: Enlarging Choices: The Case for Human Development.....	7
1.2: Human Development Reports: An Overview.....	8
1.3: Key Indicators .....	9
1.4: Key Themes .....	10
1.5: Methodology.....	13
<b>Chapter 2: Human Development in District Dera Ghazi Khan: What Key Indicators Tell Us.....</b>	<b>14</b>
2.1: Human Development in Punjab: A cursory Glance .....	14
2.2: District Dera Ghazi Khan .....	14
2.3: Education in District Dera Ghazi Khan .....	15
2.4: Health in District Dera Ghazi Khan .....	18
<b>Chapter 3: Out-of-School Children and Out-of-Pocket Costs in District Dera Ghazi Khan: What Qualitative Data Tell Us .....</b>	<b>22</b>
3.1: Out-of-School Children in District Dera Ghazi Khan .....	22
3.2: Out-of-Pocket Health Costs .....	30
<b>Chapter 4: Conclusions and Recommendations.....</b>	<b>37</b>
4.1: Education .....	37
4.2: Health .....	41
<b>Annex A: FGD Guide for AAWAZ District Forum .....</b>	<b>46</b>
<b>Annex B: FGD Guide for AAWAZ Village Forum .....</b>	<b>48</b>

## Acronyms

BHU	Basic Health Unit	NER	Net Enrolment Rate
CPR	Contraceptive Prevalence Rate	PEF	Punjab Education Foundation
CDS	Comprehensive Development Strategy	PSLM	Pakistan Social and Living Standards Measurement
DFID	Department for International Development	PPP	Public Private Partnership
DHQH	District Headquarter Hospital	PRSP	Punjab Rural Support Programme
DMO	District Monitoring Officer	PTC	Parents Teachers Council
EFA	Education for All	RHC	Rural Health Center
FAS	Foundation Assisted Schools	SAP	Structural Adjustment Programs
FGD	Focus Group Discussion	SDGs	Sustainable Development Goals
GDP	Gross Domestic Product	SMC	School Management Committee
HDR	Human Development Report	SPO	Strengthening Participatory Organisation
IMR	Infant Mortality Rate	THQH	Tehsil Headquarter Hospital
LHV	Lady Health Visitor	UC	Union Council
LHW	Lady Health Worker	WHO	World Health Organisation
MCH	Maternal and Child Health		
MDGs	Millennium Development Goals		
MEA	Monitoring and Evaluation Assistants		
MICS	Multiple Indicator Cluster Survey		
MMR	Maternal Mortality Rate		

## Executive Summary

Human development emerged in the context of growing frustration with traditional models of development that were based on a belief in the annual growth of income per capita alone. It gave primacy to people's wellbeing and turned focus to enlarging their choices. At the heart of human development lies a pressing concern for providing equal life chances for all. This report draws on the basic elements of human development and presents a commentary on the state of key social indicators in District Dera Ghazi Khan. Concerned with addressing vulnerabilities in education and health, and relying on qualitative data, it further reflects on the themes of 'out-of-school children' and 'out-of-pocket health costs' in the context of the district and highlights issues characterising them. Despite numerous achievements globally in the domain of education since the inception of the Millennium Development Goals (MDGs), the problem of out-of-school children remains; fifty-eight million children of primary school age (normally between six and eleven years) are still out of school around the world. This phenomenon has a strong gender dimension as well, as thirty-one million of the fifty-eight million children are girls. The number of out-of-school children in Pakistan is estimated to be twenty-five million. This report seeks to build a holistic analysis of the issue and discusses a range of variables central to it, viz.: access, quality, poverty, gender, and disability. Low investments in health result in increased risks and enhanced out-of-pocket costs

for the people. According to the Health System Financing Profile released by the World Health Organisation (WHO) in 2013, Pakistan spent 6.8 billion dollars on health in one year, 55% of which was spent by households. The problem of health related private costs is intimately linked to the state's priorities, as public spending on health constituted only 2.7% of the GDP. The report at hand undertakes to discuss and highlight the scale of out-of-pocket costs and vulnerabilities associated with them. It does so by examining the key issues of public and private healthcare, access, poverty, and gender.

The state of key education indicators in Dera Ghazi Khan is far from being satisfactory. Enrolment, literacy, and school completion rates are quite low. Pupil-teacher ratio is high and a number of primary schools have only one or two rooms. The scale of missing facilities is also significant as only 41% schools in the district have toilets and 37% have electricity. The building condition of only 72% of schools is considered satisfactory. Correspondingly, the number of out-of-school children in the district is very high. According to an estimate, 29.8% children of school going age are out of school. This can be ascribed to a range of factors such as lack of quality and access, poor infrastructure, and misplaced priorities. Poverty, child labour, gender discrimination, and disability also serve as barriers to education. Getting children into school requires evolving

an integrated strategy taking into account both supply and demand factors. This may involve building schools, providing for missing facilities, upgrading teachers' skills base, eradicating political interference, and offering broad-based social protection programmes. In addition, special measures need to be undertaken to end gender discrimination in education and promote female literacy. Disability is exclusion at its worst. In Dera Ghazi Khan, children with special needs remain very much marginalised. Steps should be taken to fulfill their learning needs and bring them into the mainstream. What actually is required to give a boost to education is a sense of ownership on the part of all the stakeholders, including the government, civil society, political parties, donor organisations, and media. This will clarify the assumptions, synthesise efforts, and create the synergy required to bring children into school.

Indicators related to health also present a gloomy picture. With 96 deaths per 1000 live births, the infant mortality rate in the district is quite high. Contraceptive Prevalence Rate (CPR) in the district is fairly low and the incidence of reproductive health related problems is high. Public health facilities are sparsely situated and increasingly failing to respond to the health needs of locals. As a result, out-of-pocket costs for the community tend to be very high. According to a local estimate, health related expenses constitute between 20% and 40% of household expenditure. The percentage for the poorest of the poor is much greater and adds to their vulnerabilities. Out-of-pocket costs are high due to a greater reliance

on private health facilities. These facilities and services – including tests, treatment, medicines, and consultation fees – are largely unregulated and have considerably high values attached to them. Dramatically reducing out-of-pocket costs calls for developing a new policy regime, prioritising universal healthcare, and allocation of resources for the health sector. Resources should be generated and directed towards creating and strengthening health facilities at the grassroots, tehsil, and district levels to provide a range of services and reduce the frequency of referrals to other cities. Reproductive health related services should be easily available to the population across the district if the wellbeing of the community is to be ensured. Investments in public infrastructure will shorten the distances and address the issue of access. Moreover, the private health sector should be regulated transparently and through citizen health committees to end malpractices like monopolisation, commissioning, profiteering, and producing and selling spurious drugs. Addressing vulnerabilities in health will eventually require prioritising health as a sector and an area of intervention, and offering policy prescriptions that duly respond to the community's health needs.



# Chapter 1

## Putting Human Development and Human Development Reports into Perspective

### 1.1: Enlarging Choices: The Case for Human Development

Postwar development for over four decades remained primarily concerned with economic growth and placed a particular emphasis on the annual growth of income per capita. This focus intensified further with the arrival of neoliberal policies in the early 1980s, signaling the ascendancy of free market economy couched in the normative term of 'economic liberalization.'<sup>1</sup> However, this strictly market and enterprise-centred approach failed to develop a nuanced understanding of development and could not shine light on its different aspects. The main thrust of the policies and programmes conceived under this technocentric model remained on ensuring growth in underdeveloped and developing countries through broad-based structural reforms, aiming to promote free-market economy to create wealth for all in society. Not surprisingly, the effects of these reforms, formulated under the banner of Structural Adjustment Programs (SAPs) were disastrous. Though these policy prescriptions sought to address the fiscal imbalances of countries requiring economic assistance, they pushed them further into financial insolvency and indebtedness. International indebtedness of low-income countries increased from \$134 billion in 1980 to \$473 billion in 1992. Further, interest payments on this debt increased from

\$6.4 billion to \$18.3 billion.<sup>2</sup> This sorry situation called for redefining development and adopting measures sensitive to the historical contexts of aid recipient countries, as well as people's needs and aspirations.

In the 1990s, after the collapse of Soviet Union and the failure of traditional models of growth, intellectual debates about development shifted towards people's wellbeing, good governance, and human rights. Arguably, within development, the most vocal response came from those who advocated for a people-centred approach to development, one with a pro-choice orientation and based on an inclusive and multidimensional framework. This perspective came to be called Human Development. Human development was an outcome of the path-breaking work by a Pakistani economist, Dr. Mahbub ul Haq, who pioneered Human Development Reports (HDRs) and sought to go beyond income-based measures while defining development. Building further on Dr. Haq's contribution, the Nobel laureate in economics, Amartya Sen, a philosopher and an economist, enriched human development through his 'Capability Approach' that introduced his core ideas of capability and agency.<sup>3</sup> Essentially, the spirit of human development is summed up by the

1 John Rapley, *Understanding Development: Theory and Practice in the Third World* (Boulder: Lynne Rienner, 2007).

2 "Governance and Development," *World Bank* (1992). Available at: <http://documents.worldbank.org/curated/en/1992/04/440582/governance-development>

3 S. Deneulin and L. Shahani (eds), *An Introduction to the Human Development and Capability Approach: Freedom and Agency* (London: Earthscan, 2009).



notion that it is “about equal life chances for all”. At the heart of human development lies a pressing concern for enlarging people’s choices, a principle indispensable for ensuring human wellbeing. Wellbeing itself is a broad concept and requires a multidimensional frame of measurement and analysis for clear conceptualisation and effective operationalisation.

Operationally, human development is a composite index which measures progress in economic conditions, life expectancy, and literacy. Over the years, human development as a concept has evolved to a considerable extent and at present also focuses on measures of inequality, gender, and poverty. The current Millennium Development Goals (MDGs) are also based on this approach and undertake to make progress towards a broad range of capabilities. The upcoming Sustainable Development Goals (SDGs) too follow the same framework and turn to the freedoms of individuals and communities worldwide.

## 1.2: Human Development Reports: An Overview

Current Human Development Reports (HDRs) are being published to lend support to AAWAZ in achieving its overall objectives that focus on making Pakistan a ‘stable, tolerant, inclusive, prosperous and democratic place’. AAWAZ is a Department for International Development (DFID)-funded project aiming at strengthening the democratic process in the country through enhanced political participation and fostering a culture of accountability. It has a rights-

focused approach and all of its four national implementation partners are rights-based advocacy organisations. One of the core objectives of AAWAZ is to stimulate an effective demand for social services by enabling the citizens to voice their opinions.<sup>4</sup>

The Human Development Report at hand serves as a policy advocacy tool to influence outcomes and help AAWAZ and its partner organisations and forums to not only deliver on key promises of the programme but also to advance a pro-poor agenda by drawing on the basic elements of human development. It is important to mention here that the two approaches viz. human development and rights-based approach to development are not mutually exclusive; rather, they are mutually reinforcing and complement each other.

Since human development focuses chiefly on people’s freedoms – and not solely on their needs, as is the case with the needs-based approach – it resonates strongly with the rights-based approach that proposes a rights-focused framework for development that is about maximising people’s rights.<sup>5</sup> It is, indeed, safe to assert that the human development paradigm is attuned to the basic principles underlying the rights-based approach to development. It is the concept of agency, i.e. “a person’s ability to pursue and realise goals that she values and has reason to value,” that

4 AAWAZ: Voice and Accountability Programme. <http://www.aawaz.org.pk/>

5 S. Deneulin, “Ideas related to human development,” in Deneulin and Shahani ed. *An Introduction to the Human Development and Capability Approach: Freedom and Agency* (London: Earthscan, 2009).

serves as a common denominator between the two approaches. The connection between human rights and human development was cemented further when the 2000 Human Development Report on human rights affirmed: ‘Human rights and human development share a common vision and a common purpose – to secure the freedom, well-being and dignity of all people everywhere.’<sup>6</sup>

These reports undertake to capture the current state of a range of human development indicators in the selected districts to be able to provide local actors in governance such as government line departments, citizens’ forums, community-based organisations, and AAWAZ partner organisations with content for evidence-based advocacy. Where they analyse data against the basic indicators of human development, as discussed below, they also seek to develop a deeper understanding of the situation in these districts regarding the two selected themes of ‘out-of-school children’ and ‘out-of-pocket health care costs.’ It is expected that findings from these reports will enable civil society organisations and communities to put forward more robust and authoritative arguments about a wide range of social issues.

It is also rather strongly hoped that these reports will provide a perspective from below on progress towards the MDGs. The realisation of the MDGs, as is quite evident now, has been fraught with a myriad of policy, implementation, and resource challenges, and seems unlikely by the end of

2015. The current reports should serve to bridge data gaps and help revisit our policy commitments at the national level. It would be a valuable opportunity to contextualise debates about the MDGs at the district level. Similarly, these reports are coming out at a time when the international community is on the cusp of finalising the agenda for the upcoming SDGs. They can be utilised to draw lessons for future interventions proposed under the rubric of the SDGs. Making the most of these reports will require vigorously framing specific policy proposals by taking note of the findings.

### 1.3: Key Indicators

These reports comply with the basic elements of human development and focus mainly on key health and education related indicators. Income measures are also a part of human development, but since in Pakistan we do not have sufficient knowledge about the economic activity output produced in each district, we cannot proxy the measure of GDP at that level and generate data on economic indicators. Some of the indicators discussed in these reports are the same as those featuring in the MDGs. The framework for these indicators was developed in the pioneer human development reports published by Strengthening Participatory Organisation (SPO). They are further used in these reports because they adequately capture the multidimensional nature of development and wellbeing. They are as follows:

6 “Human Development Report 2000: Human Rights and Human Development,” *United Nations Development Programme* (2000). Available at: <http://hdr.undp.org/en/content/human-development-report-2000>

## Education

- Net enrolment rate
- Primary school completion rate
- Adult Literacy rate
- Teacher to Student ratio
- Number of Schools (Primary Schools)
- Missing facilities (boundary wall, drinking water, toilet, etc.)

## Health

- Infant Mortality Rate (IMR)
- Maternal Mortality Rate (MMR)
- Doctor to Patient ratio
- Number of BHUs, RHCs, FWW, LHWs
- Contraceptive prevalence rate (CPR) and availability
- Missing facilities in hospitals (Doctors, LHV, Skilled Birth Attendants, etc.)

### 1.4: Key Themes

In addition to the aforementioned indicators, these reports seek to explore in detail two key themes characterising current debates about wellbeing: out-of-school children and out-of-pocket healthcare costs. The exercise at hand draws heavily on qualitative data to capture and understand the state of these two important issue areas in the selected districts. The reports here discuss issues, barriers, opportunities, and

data constraints surrounding these themes.

#### 1.4.1: Out-of-school children

Since 2000, expansion of primary education globally has received a remarkable boost and by 2012 the number of out-of-school children of primary school age had fallen by 42%. This has been mainly attributable to the initiatives undertaken under the umbrella of the MDGs and the Education for All (EFA) goals. However, according to a recent estimate, 58 million children of primary school age (normally between six and eleven years) around the world are still out of school. The situation is even worse in the realm of lower secondary education where, as of 2012, “63 million young adolescents (between twelve and fifteen years) were out of school worldwide.”<sup>7</sup>

Unfortunately, Pakistan is home to one of the largest out-of-school children populations. Although since 2000 it has sharpened focus on increasing enrolment rates and managed to reduce the number of out-of-school children by 3.4 million, it still has a long way to go, with 25.02 million children out of school.<sup>8</sup> This accounts for more than one-half of out of school children in South Asia. Moreover, girls account for more than half of this number.<sup>9</sup> It is fairly unrealistic to expect considerable improvement in social indicators in the remote regions and districts of the country.

7 “Teaching and Learning: Achieving equality for all: Education for All Global Monitoring Report, 2014,” *UNESCO* (2014). Available at: <https://en.unesco.org/gem-report/report/2014/teaching-and-learning-achieving-quality-all#sthash.fx5cAmxH.dpbs>

8 “NEMIS (2012-13): National Education Management Information system,” *AEPAM, Ministry of Federal Education and Professional Training, Government of Pakistan*.

9 “25 Million Broken Promises: The crisis of Pakistan’s out-of-school children,” *Alif Ailaan* (Islamabad, 2014).

South Asia already has the highest inequality in education, and it is these far-flung places that are the pivot of this inequality.<sup>10</sup> Additionally, Pakistan has the distinction of having the largest urban-rural gap in education in the region.

Poverty exacerbates inequalities in education, with poor households finding it exceedingly difficult to send their children to school in times of crisis. Though data suggests that inequality in education has remained constant, it cannot make us complacent or turn a blind eye to the scale and enormity of the stagnant inequality. If anything, rigorous efforts should be directed towards significantly reducing inequalities and expanding education to the most vulnerable and marginalised groups in the developing world.

The out-of-school-children phenomenon has a strong gender dimension, as 31 million of the 58 million out-of-school children globally are girls. The importance of girls' education can be gauged from the fact that about one-half of the reductions in maternal and infant mortality over the past four decades have been ascribed to increased female education. Effective advocacy campaigns can play a big role in eroding cultural practices limiting girls' participation in the public sphere. If children of school going age are out of school, they are less likely to fully enjoy a broad range of freedoms and exercise their agency later in life. Any exception can only be treated as an anomaly and does not, and should not, condone

the structural deprivations caused by being out of school.<sup>11</sup>

The issue of out-of-school children is complex and multifaceted and hence must be scrutinised using a broad-based framework. While delving into low enrolment and high dropout rates, we need to look across a range of variables intersecting with the problem at hand. Globally, the following five barriers to education are considered crucial and central to understanding the situation holistically: conflict, gender discrimination, child labour, language challenges, and disability.<sup>12</sup>

The HDRs sufficiently shine light on these barriers as they apply to the selected districts. Relying on qualitative data and inputs received from civil society activists and community members, they also suggest ways to tackle these pressing issues, such as getting children into school and increasing enrolment rates through non-formal literacy programs and facilities. Social protection programmes can serve as effective means to dissuade poor parents from taking their children out of school. They can further incentivise sending school-age children to school. A detailed discussion on the issue of out-of-school children appears later in this report.

#### 1.4.2: Out-of-Pocket Health Costs

Among a plethora of problems that countries in the developing world have to battle with, is the problem of providing healthcare facilities to their citizens. Owing to struggling economies

10 "Fixing the Broken Promise of Education for All: Findings from the Global Initiative on Out-of-School Children," *UNESCO Institute for Statistics (UIS) and UNICEF* (Montreal: UIS, 2015). Available at: <http://dx.doi.org/10.15220/978-92-9189-161-0-en>

11 Ibid.

12 Ibid.

and lack of sound governance mechanisms, they find it increasingly difficult to provide basic and advanced medical treatment to their citizens. As a result, many countries in the global south fall behind on key health indicators. The responsibility of responding to healthcare needs then falls upon citizens themselves, who have to pay a large bulk of their health expenses out of their own pockets. According to an estimate by WHO, 44.5% of private expenditure on health in 2012 was out-of-pocket.<sup>13</sup>

The issue of out-of-pocket costs is complex and its scope and scale varies from individual to individual, group to group, and region to region. At the end of the day, in addition to social policy, it falls under the purview of development, since “education, housing, food and employment all impact on health.”<sup>14</sup> Grappling with the problem requires systemic reforms in our policy responses to a variety of development problems.

Global commitments on the provision of health services, at least theoretically, are quite clear. The World Health Assembly resolution 58.33 from 2005 states that “everyone should be able to access health services and not be subject to financial hardship in doing so.”<sup>15</sup> However, no substantial progress so far has been made towards realising this ideal.

13 Global Health Observatory (GHO) Data, accessed on April 26, 2015. Available at: [http://www.who.int/gho/health\\_financing/out\\_pocket\\_expenditure/en/](http://www.who.int/gho/health_financing/out_pocket_expenditure/en/)

14 “Health system financing: the path to universal coverage: The World Health Report,” *World Health Organisation* (2010).

15 “World Health Assembly Resolution 58.33 (2005): Sustainable health financing, universal coverage and social health insurance.” Available at: [http://www.who.int/health\\_financing/documents/cov-wharesolution5833/en/](http://www.who.int/health_financing/documents/cov-wharesolution5833/en/)

Out-of-pocket costs affect low-income households more, as added to the basic healthcare costs are transport expenses. Vouchers, refunds, and microcredit schemes are some of the measures through which these additional costs can be covered. Moreover, a robust social policy, aiming to provide universal healthcare, can also endeavour to provide services at the doorstep by spanning a network of basic health units and mobile dispensaries.

Efficient use of resources is another problem that plagues the health sector globally. According to an estimate by WHO, 20-40% of resources spent on health are wasted. Given this considerable waste, it can be argued that if these resources were to be utilised efficiently they would go a long way in delivering the promise of universal health coverage. One way to dramatically reduce out-of-pocket expenses, particularly for the poor, is to ensure universal health coverage, centering on all types of health services such as promotion, prevention, treatment, and rehabilitation.

Pakistan in particular has a very high incidence of out-of-pocket costs. According to the Health System Financing Profile released by WHO in 2013, Pakistan spent \$6.8 billion on health in one year, 55% of which was spent by households. The state does not appear to have done much to prioritise health care as a key sector for intervention. In 2012, public spending on health constituted only 2.7% of the GDP.<sup>16</sup> A staggering 63.1% of total expenditure on health consisted of private expenditure.

16 GHO Data.

The situation is much worse in rural areas where, in many places, the state of health infrastructure is abysmal. This is compounded by rampant poverty that hardly allows the rural poor to save something for a proverbial rainy day. Our district reports, among other things, undertake to delve deep into the issue of out-of-pocket health costs at the district level. Based particularly on primary data, they approach the theme at hand from all possible dimensions. Interviews and Focus Group Discussions (FGDs) with communities and duty-bearers enable us to rigorously analyse the problem and subsequently suggest ways to solve it while mobilising both local and national resources.

findings will foster more research on similar issues in different settings nationwide.

### **1.5: Methodology**

These reports draw on both quantitative and qualitative data to generate and analyse findings. A considerable bulk of quantitative data on our key indicators comes from secondary sources. These include annual, monitoring, and issue-specific reports, as well as household surveys and data sets released by provincial and federal agencies. Qualitative data in these reports comes from primary sources. Qualitative fieldwork was conducted in the four selected districts viz. Dera Ghazi Khan, Pakpattan, Swabi, and Dera Ismail Khan. The data mainly focuses on the aforementioned two key themes and covers community responses to them. Since serious data gaps exist across the country on all levels, this qualitative data is invaluable in informing us about the prevailing situation in these districts vis-à-vis the key indicators. It is hoped that these

## Chapter 2

### Human Development in District Dera Ghazi Khan: What Key Indicators Tell Us

#### 2.1: Human Development in Punjab: A cursory Glance

Punjab has a population of 93,963,240, constituting approximately 56% of Pakistan's total population.<sup>17</sup> In Punjab as well, efforts around promoting human development were bolstered after the MDGs were announced. Though the province is quite far from achieving many of the targets the MDG strategy sets out to achieve, it has performed better than the national average against the 18 MDGs-specific human development indicators.<sup>18</sup> For example, it has a net enrolment rate of 64%, which is 7% above the national average.

In Punjab, the survival rate for grade 1 to 5 is 52%, whereas the national level at 50% is two percent lower. The overall literacy rate in the province has shown fair improvement and has risen from 47% in 2000 to 60% in 2012. Punjab's figures for Gender Parity Index (primary education), however, do not indicate progress as it went from 0.92 in 2001/2002 to 0.90 in 2011/2012. Similarly, its parity for secondary education slipped from 0.86 to 0.85 over the same period.<sup>19</sup>

Punjab also appears to have made gains in key health indicators, but they are not so significant and do not enable the achievement of MDG targets. The province was able to decrease under

5 mortality rate from 112 in 2003/2004 to 104 in 2010/2011. Infant mortality rate, on the other hand, shot up from 77 to 82 over three years in 2010/2011. This sounds a little staggering against the national average of 74 in 2012. Surprisingly, fresh data on Maternal Mortality Rate for Punjab was not available. In 2006, was at 227, which is way above the MDG target of 140. Life expectancy rate in the province is 64, which is somewhat lower than the national average of 66.4.<sup>20</sup>

#### 2.2: District Dera Ghazi Khan

##### *Geography, Location and History*

Dera Ghazi Khan is situated on the southern fringe of the Punjab province and lies at the intersection of Punjab, Khyber Pakhtunkhwa (KPK) and Balochistan. It is considered one of the most centrally located districts of the country and shares borders with six other districts, three in Punjab, two in Balochistan, and one in KPK. It is located at 30'03" N and 70'38" E. The district has four tehsils, Dera Ghazi Khan, Taunsa Sharif, De-Excluded Area, and Kot Chutta. Dera Ghazi Khan city is the headquarter of the district. The district has a population of 2,043,118.

Dera Ghazi Khan enjoys unique geographical features as it is a 198 km long narrow strip covering an area of 5,306 squared metres, wedged in between the Sulaiman Mountain to its

<sup>17</sup> "Punjab," *World Gazetteer*.

<sup>18</sup> "Pakistan Millennium Development Goals Report, 2013," *Planning Commission, Govt. of Pakistan* (2013).

<sup>19</sup> Ibid.

<sup>20</sup> "Punjab Health Profile". Available at [http://health.punjab.gov.pk/?q=Punjab\\_Health\\_Profile](http://health.punjab.gov.pk/?q=Punjab_Health_Profile)



west and the River Indus to its East. The overall climate of the district is relatively dry with only the western mountainous fringe receiving a little more rain than the rest of the region. As the district's website notes: 'The winter is relatively cold and the climate is hot during the remaining part of the year, but it is very hot in summer. The temperature during summer is usually about 115 °F (46 °C), while during winter season the temperature is as low as 40 °F (4 °C). The prevailing wind direction is North-South.'<sup>21</sup>

Together Dera Ghazi Khan and Dera Ismail Khan (a district in KPK), up until the middle of the nineteenth century, were known as the Derajats. After their accession to the British Raj in the aftermath of the Sikh War in 1849, they were divided into two districts. The old city of Dera Ghazi Khan was situated by the River Indus and was inundated following floods in 1908. In 1910, the present-day city was established around 10 miles (16 km) away from the old town near Drahma.

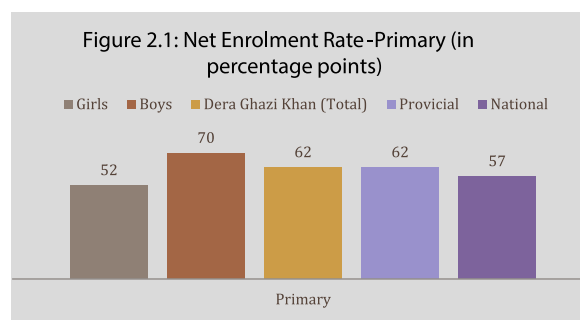
### 2.3: Education in District Dera Ghazi Khan

A whole host of factors – social, political and economic – have led to the abysmal state of education in the district. The total literacy rate of 45% is one of the lowest in the province. Female and male literacy rates are 32% and 58% respectively.<sup>22</sup> Rural and urban gap also appears to be sharp, with 41% literacy rate in the former

compared to 70% in the latter. According to the Pakistan District Education Rankings issued by Alif Ailaan in 2014, Dera Ghazi Khan is ranked 33<sup>rd</sup> out of 36 districts in Punjab. Its national ranking is 69 out of 146 districts nationwide. This means a low education score of 60.64 for the district.<sup>23</sup>

#### 2.3.1: Net Enrolment and Primary School Completion Rates

Even the net enrolment rate in the district is not very promising and stands at 62%. This is at par with the provincial average, and a little above the national average of 57%. It further reflects wide gender disparities as well (see figure 2.1), being 52% for the primary school age girls, compared to 70% for boys of the same age group.<sup>24</sup> Disparate primary enrolment rates of 81% and 60% for urban and rural areas respectively point towards inequalities across other dimensions as well.



The situation worsens at the middle school level where the net enrolment rate is 20% (see figure 2.2). This figure is below the national and provincial averages of 22% and 25% respectively. For girls in the district it is a paltry 15% and for

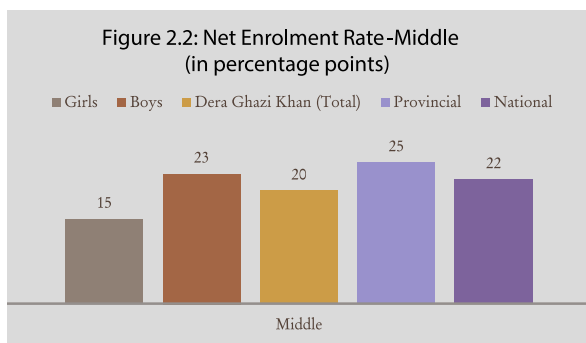
21 "District Government Dera Ghazi Khan," See <http://www.dgkhan.gop.pk/>

22 Pakistan Social and Living Standards Measurement Survey (PSLM) 2012/13

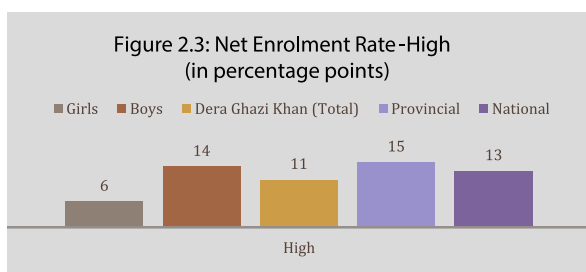
23 "Alif Ailaan Pakistan District Education Rankings 2014," Alif Ailaan (Islamabad, 2014).

24 PSLM 2012/13.

boys 23%. Rural and urban disconnect is visible here as well. For rural areas the enrolment rate for this level is 17% and for urban, it is 40%.

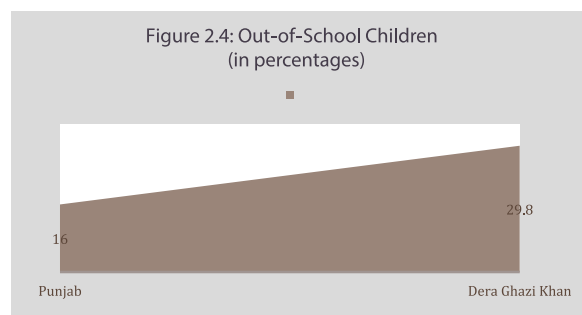


At the high school level, it plunges further down to a shocking 11% - below both the national and provincial averages of 13% and 15% (see figure 2.3). Again, it is 6% for girls, compared to 14% for boys. Urban areas have a slightly better average of 24%, compared to 9% for rural areas. And females in rural areas are the most disadvantaged group with an incredibly low average of 3%. These figures render the whole picture for primary education quite bleak. No wonder both girls and boys in the district have a primary school survival rate of 26%, a percentage pointing towards a massive swath of out of school children.



Punjab's average for out-of-school children is 16%; however, this does not reflect regional disparities within the province. According to

statistics released by the Annual Status of Education Report 2013, 29.8% children in Dera Ghazi Khan were out of school (see figure 2.4). But again, given the situation on the ground, this estimate comes across as conservative. A detailed discussion on out-of-school children in Dera Ghazi Khan features later in this report.<sup>25</sup>



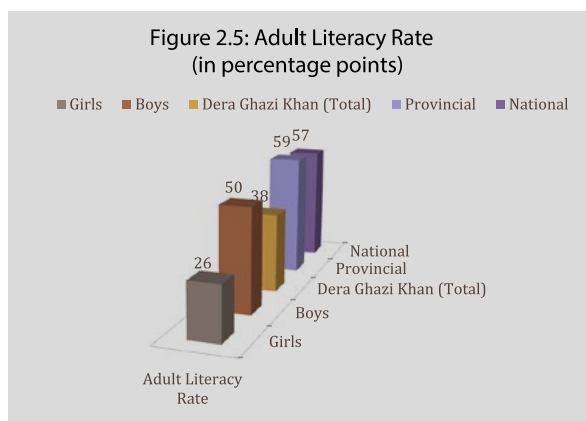
### 2.3.2: Adult Literacy Rate

The importance of adult literacy and life-long learning cannot be overstated. Adults with skills and knowledge enjoy enhanced sets of capabilities and functionings. They are less likely to experience unemployment and are more financially productive.<sup>26</sup> District Dera Ghazi Khan, however, does not have a significant literacy rate. Latest data suggest that only 38% adults in the district can be considered literate (see figure 2.5). This is much lower than the national and provincial adult literacy rates of 57% and 59% respectively. Within this category, across the district, gender disparities are very alarming. Where male adults in Dera Ghazi Khan have

<sup>25</sup> Ibid.

<sup>26</sup> "Adult Literacy: A Brief to the Select Standing Committee on Education," *British Columbia Teacher's Federation* (2006). Available at <https://bctf.ca/uploadedFiles/Public/Publications/Briefs/AdultLiteracyBrief.pdf>

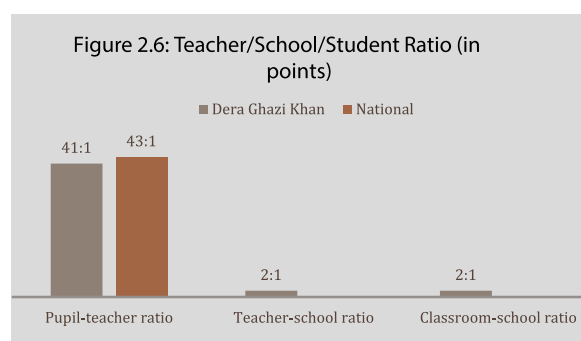
a literacy rate of 50%, females have an adult literacy rate of just 26%.<sup>27</sup> This figure implies that most adult women in the area are largely illiterate – a fact with serious consequences for a range of other health, education, and economic indicators. Adult literacy rates in the district vary across rural and urban areas as well. On average, they are 34% for rural areas and 65% for urban areas. Moreover, 22% of adult females in rural areas are literate, compared to 46% males. In urban areas, 54% of adult females can be considered literate, compared to 77% adult males.



### 2.3.3: Teacher/School/Student Ratio

Primary education is considered crucial to laying the foundation for knowledge acquisition and skills enhancement at later stages. Therefore, teacher-student interaction at this level has to be meaningful and of high quality. In places where the pupil-teacher ratio is high, quality in education cannot be ensured. Figures suggest that pupil-teacher ratio for primary schools in Dera Ghazi Khan is 41:1 (see figure 2.6), which is quite high,

considering the demand of a desired low ratio at this stage.<sup>28</sup> However, it is still 2 notches below the national average of 43:1.<sup>29</sup> Teacher-school ratio in primary schools is also unsettling at of 2:1. The same figures are found for classroom-school ratio, raising questions over the variables of access, attainment and achievement in education. Owing to this, the district earned a school score of 50.53 in the district education rankings released by Alif Ailaan in 2014.<sup>30</sup>



### 2.3.4: Number of Schools (Primary Schools)

Gender disparities are clearly reflected in the number of primary schools for boys and girls (see figure 2.7). There are 651 primary schools for girls in the district, while those for boys are almost double at 1095. We do not know how many primary school age girls and boys there are in the district, but it can be safely assumed that boys do not far outweigh girls. Correspondingly, stark imbalances also exist in the number of female and male teachers. According to latest figures available, there are 1,664 female and 2,407 male primary school teachers.<sup>31</sup>

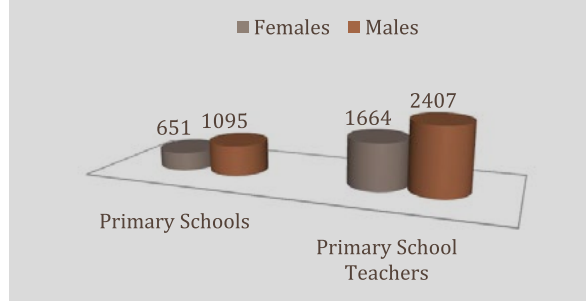
<sup>28</sup> Pakistan District Education Rankings 2014.

<sup>29</sup> "Pupil-teacher ratio, primary," *World Development Indicators*, UNESCO Institute for Statistics.

<sup>30</sup> Pakistan District Education Rankings 2014.

<sup>31</sup> NEMIS (2012-13)

Figure 2.7: Primary Schools and Teachers in Dera Ghazi Khan

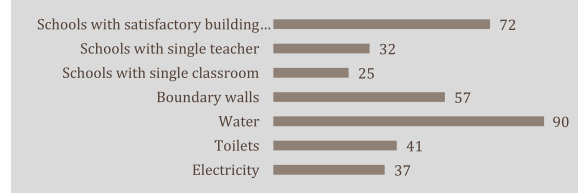


### 2.3.5: Missing facilities (boundary wall, drinking water, toilet etc.)

Requisite infrastructure and facilities go a long way in delivering on the promise of universal primary education. Building conditions have been shown to play an important role in parents' decisions regarding sending their children to school.<sup>32</sup> This becomes even more crucial in the case of girls, as parents are reluctant to send daughters to school with missing facilities.<sup>33</sup> When it comes to the state of infrastructure and facilities in Dera Ghazi Khan, the facts again present a grim picture (see figure 2.8). Electricity is available in only 37% of schools, and its non-availability leaves a question mark over the state of education governance in the district. Concerns regarding hygiene also take center stage as only 41% schools have toilets. Water seems to be the only basic facility that is available in 90% of schools. However, no data are available regarding the quality of water, which is important to consider many schools in the district are situated in rural and far-flung areas. In the wake of the December 16, 2014 attack on Army Public

School in Peshawar, safety of school children has become a pressing concern. Increasingly calls are being made to undertake adequate measures to ensure the security of schools. It is alarming to note that only 57% schools in the district have boundary walls. Indeed, it is not just a matter of boundary walls, since some schools can hardly qualify for the definition of a school. At least 25% of primary schools in Dera Ghazi Khan have a single classroom. In a similar vein, a sizeable 32% of primary schools have just one teacher. Overall, 72% percent schools buildings have been deemed to have satisfactory conditions.<sup>34</sup>

Figure 2.8: Missing Facilities in Schools in Dera Ghazi Khan (in percentage points)



## 2.4: Health in District Dera Ghazi Khan

### 2.4.1: Infant Mortality Rate (IMR)

District Dera Ghazi Khan has a high mortality rate. According to the latest Multi Indicator Cluster Survey (MICS) published in 2011, the district had an infant mortality rate of 96, which is higher than both divisional and provincial averages (see figure 2.9).<sup>35</sup> Dera Ghazi Khan is the divisional headquarter of Dera Ghazi Khan Division which consists, in addition to Dera Ghazi Khan itself, of Muzaffargarh, Layyah, and Rajanpur Districts.

<sup>32</sup> "Fixing the Broken Promise of Education for All."

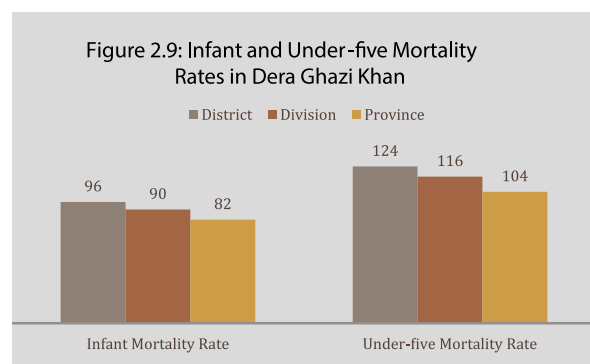
<sup>33</sup> "25 Million Broken Promises."

<sup>34</sup> NEMIS (2012-13).

<sup>35</sup> MICS Punjab 2011, Bureau of Statistics Punjab. Government of Punjab. Available at: <http://www.bos.gop.pk/publication-reports?q=provincialreport>

The infant mortality rate for the entire division is 90, six notches below the district average. Only Muzaffargarh District in the division with a score of 97 has a higher mortality rate than that of Dera Ghazi Khan. Even Rajanpur, a district otherwise characterised by low human development, has a rate of 82. The provincial rate of 82 too is much lower than the rate for Dera Ghazi Khan.

The Under-five Mortality Rate for the district is even more disturbing and stands at 124. Again, this is higher than both divisional and provincial averages, which are 116 and 104 respectively.<sup>36</sup>



#### 2.4.2: Maternal Mortality Rate (MMR)

Recent data on MMR at the district level that takes note of demographic changes caused by a boom in the population over the years are not available. However, other reproductive health indicators suggest that the facts are not likely to be reassuring. For instance, 42.6% mothers in Dera Ghazi Khan complained of not receiving any antenatal care visit, while 11.4% of pregnant women had not had blood pressure measured, and urine specimen, blood test and weight taken,

although the provincial average for this is 31.9%. Place of delivery for 75.1 % of women in the district was home, which is the second highest in Punjab after Rajanpur. Similar daunting patterns continue into postnatal care and the neglect is all too obvious. Only 17.2% of women saw a doctor after giving birth. The rest turned to LHVs, LHWs or traditional birth attendants or a friend.<sup>37</sup>

#### 2.4.3: Number of Hospitals/Healthcare Facilities

With a population of 2,043,118, one expects a fair number of healthcare facilities addressing vulnerabilities and providing treatment. However, in Dera Ghazi Khan District their number is not commensurate with the population size (see table 2.1). There are 8 hospitals in the district in all, with a collective capacity of 553 beds. There are 34 dispensaries and 11 Rural Health (RH) Centers. The number of Basic Health Units (BHUs) is 53 with a capacity of 114 beds in total. The district has 4 TB clinics and 30 SH Centers, while only 7 M.C.H Centers are available to the community.<sup>38</sup>

<sup>36</sup> Ibid.

<sup>37</sup> Ibid.

<sup>38</sup> "Punjab Development Statistics 2013," Bureau of Statistics, Government of the Punjab.

**Table 2.1: Number of Hospitals/Healthcare Facilities in the District**

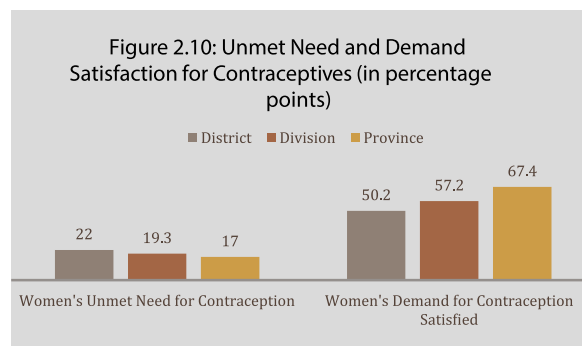
Type of Hospital	Total No.	No. of Beds
Hospital	8	553
Dispensaries	34	4
Rural Health Centers (RHCs)	11	180
Basic Health Unit (BHU)	53	114
TB Clinic	4	36
SH Centers	30	0
Maternal and Child Health Centers (M.C.H)	7	0

#### 2.4.4: Contraceptive Prevalence Rate (CPR)

Gaining access to data on contraceptive prevalence rate is fraught with challenges. Most of the figures available are very old and do not reflect the current situation. Even some of the reports published by the Punjab Government over the past two years are relying on old data, making assumptions based on outdated information. For instance, Punjab Development Report 2013 is still making projections based on MICS 2007-08. MICS Punjab 2011 report on reproductive health does present data on contraceptive prevalence but it is not very clearly categorised and illustrated.

According to figures released under MICS Punjab (2011), 22% of women aged 15-49 had an unmet need for contraception (see figure 2.10). Only 50.2% of women had their demand for contraception satisfied. This can be contrasted with the situation at the provincial level in Punjab where overall unmet need for contraception is

settled at 17.1%, whereas, the percentage of women whose demand for contraception was satisfied is 67.4%. Even the divisional average is more encouraging than the one for the district serving as the divisional headquarter. For the two categories at hand, the division rates are 19.3% and 57.2% respectively. It should be borne in mind that according to the MICS Punjab 2007-08 the contraceptive prevalence rate in Dera Ghazi Khan was 18%, one of the lowest in the province. The provincial average, on the other hand, was 32%.



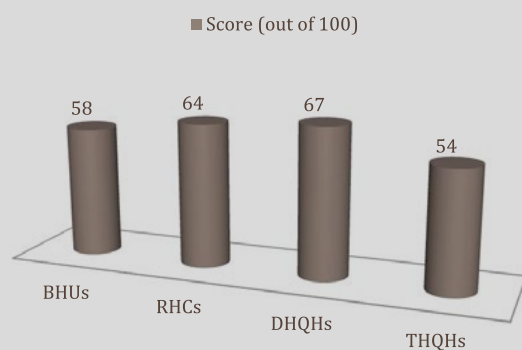
#### 2.4.5: Missing Facilities in Hospitals

Missing facilities in hospitals is another problem that impinges on various other health indicators. According to the Punjab Health Facility Assessment 2012, District Dera Ghazi Khan ranks low on the Health Facility Index (see figure 2.11).

The assessment shows that the BHUs in the district considerably lack various health facilities. Assessment by the Punjab Government reveals that Dera Ghazi Khan scored 58 out of 100 on average availability of inputs for BHUs. The assessment considered the components of infrastructure, human resources, equipment, drugs, and supplies and support services. The

district's performance against these criteria for RHCs is however slightly better and earned a score of 64. The ranking continues to go up for DHQs as well and enjoys a score of about 67. But in the case of THQs, it again plunges down to a disappointing 54. An abysmal score for the BHUs and THQs suggests that the state of health governance in far flung areas and at the tehsil level is quite unpromising and requires urgent attention.

Figure 2.11: An Assessment of Missing Health Facilities in Dera Ghazi Khan





## Chapter 3

### Out-of-School Children and Out-of-Pocket Costs in District Dera Ghazi Khan: What Qualitative Data Tell Us

#### 3.1: Out-of-School Children in District Dera Ghazi Khan

According to the Annual Status of Education Report 2013, 29.8% children in Dera Ghazi Khan were out of school. This figure implies that there are thousands of children out there, abandoned and left out by the system and society. Though the problem of out-of-school children is not peculiar to Dera Ghazi Khan, its scale there is disproportionately high. Across the district, in rural and hilly areas in particular, one finds children out of school, tilling the land by the sweat of their brows, grazing cattle, working in brick kilns and auto workshops and trapped in domestic drudgery and household chores.

The figure of 29.8% does not reflect regional disparities as percentages for different places and regions in the district vary. For example, in one village of Tehsil Kot Chutta, currently there are 20% out-of-school children. This contrasts sharply with the situation in the tribal region of the district, where according to an estimate 60% of children do not go to school. Things appear to be tough in the tribal and mountainous part of the district. Enrolment rates are chronically low and quality of education is seriously compromised. The trend continues in many other parts as well. Despite recent efforts of the government, both enrolment and student retention continue to pose challenges.

The problem of out-of-school children affects groups differently and has varied manifestations. The poor in the district seem to be hit worst. They cannot afford to send their children to school beyond a certain point and are not convinced of the potential dividends of education. People living in rural areas are already at a disadvantage owing to scarce educational facilities, and have to prioritise the education of children by spending extra money on transportation. This phenomenon further has a strong gender dimension and girls have to face acute structural and service deprivations. Understanding the problem of out-of-school children necessitates looking into a host of issues that characterise it.

##### 3.1.1: Public Educational Facilities

Schools as sites of learning play a big role in attracting students. Our interviews and discussions with the community revealed that many government schools in the district had only two rooms and two to three teachers. Some schools even had only one room and one teacher. This places serious constraints upon service delivery. The education department claims that the current government has shown serious commitment to education and stepped up efforts to address the issues of access, quality, and affordability. Schools for girls and boys across the district receive special attention and it is ensured through increased monitoring that teachers come to school regularly. The Punjab

Education Foundation (PEF) and Danish schools are evidence that educational facilities are functional and provide education to the poorest of the poor. The community while acknowledging government's increased interest in education, also calls it partial, inadequate, and selective. The state of education in the district, they argue, has yet to see a radical improvement. PEF schools and some public schools that have been declared model facilities have definitely improved service delivery, but their number is small and outreach limited. Around them, at a short distance, there are schools that present a picture of neglect and unresponsiveness. Enrolment rates are low and the number of out-of-school children markedly high. The government fails to take into account supply and demand factors that keep children out of school.

Shortage of schools is a huge problem. In many areas there are no functional schools at a reasonable distance. Not every UC in the district has a girls' high school. There are many rural UCs where there are no high schools for girls and parents have to make a choice whether to send their daughters to a school situated at a distance or to discontinue their studies. It is also quite difficult for teachers in rural areas to commute on a daily basis. Distances are great, road networks poor and the public transport is almost non-existent. There are schools in the rural areas where a number of teachers come from Dera Ghazi Khan on a daily basis. They normally come to school at 10:30 am and leave around 1:30 pm. Their teaching hours are limited and they

are more concerned with ensuring that their commute is safe and smooth. But some localities are worse off. The school for boys in Rakhi Munh, a settlement in the tribal area for example, has 45 students and only one teacher. The teacher is not a local and comes to school once a week. This makes it almost impossible for students to be regular, take interest in their studies and show results.

Many teachers refuse to go to schools in the far flung areas and file a case against their transfer. A primary school in a village about 10-15 kilometers from Dera Ghazi Khan City is currently said to have only one teacher for scores of students. There is more than one teacher appointed for that school but they have moved court against their transfer. Local reports also suggest that despite increased monitoring by the government, there are still ghost schools in the district, which deny children the opportunity to receive education.

Most of the schools cater to the needs of a big village or more than one village. When students come to schools in large numbers, they are met with fewer teachers and facilities. Sometimes there are schools where even some of the most basic facilities are missing, thus discouraging students from attending classes regularly. There is a primary school in Mamuri with only one teacher, no boundary walls, and students from which are found swimming in the nearby canal.

Many schools in rural areas have only one or two rooms with little going on in them. This state of public educational facilities in Dera Ghazi Khan

has encouraged private schools to mushroom, making it even more difficult for children from poor households. Children of most duty-bearers attend private schools, and it has also been reported that some public school teachers have opened up academies and private schools of their own and urge students to go there instead. Understandably, they would be little interested in increasing enrolment in the public schools they teach in. Private tuition is another factor that threatens to raise the cost of receiving education and keeps more children out of school.

School Management Committees (SMCs), ideally, are a viable way to improve service delivery and enhance accountability. But in Dera Ghazi Khan, overwhelmingly, they are not functional and exist only on paper. Committees for primary and middle schools receive Rs. 20,000 and Rs. 45,000 annually, but these funds are hardly spent on schools. Community representatives on these committees are approached only when their signatures are needed for transactions, and they are not provided with any idea of how and where that money will be spent.

### *3.1.2: Quality of Teaching*

Quality of teaching also affects enrolment and retention of students. It is a common perception that teachers in public schools generally lack basic skills required to impart and foster learning and transfer knowledge. Their skills and competencies are either undeveloped or not harnessed to a point where they can effectively help young learners acquire basic literacy skills. This problem

is more acute in both public and private schools in rural areas. Even the education department understands that senior teachers in particular lack skills central to teaching new curricula and implementing policy reforms. In fact, many of these teachers were inducted through political patronage and lacked requisite skills and knowledge. The community also believed that a number of teachers were not keen on teaching at all and merely concerned with turning up at school in the morning. However, teachers also have their grievances and some claimed they did not regularly receive salaries and remained financially insecure.

Another factor that both the community and duty-bearers believed kept children out of school is teachers' behaviour. Though corporal punishment is officially prohibited, it is still practiced in quite a few schools in the district and serves to damage children psychologically. Making children run errands for their teachers and clean the school premises and different equipment and facilities therein, which demoralises students, hurts their dignity and distracts them from their studies.

### *3.1.3: Poverty and Child Labour*

Poverty is a huge and highly disempowering barrier that not only stops children from going to school but also drags them into the practice of child labour. Poor households in both rural and urban areas sometimes find it exceedingly difficult to afford to send their children to school, and when they are convinced that the dividends of education are far from certain, they tend to

### Box 3.1: Poverty and Child Labour in Dera Ghazi Khan

Zubaida Mai is a single parent and lives in a village of Union Council Mutfariq Chahan. She has four children: two daughters and two sons. Her eldest daughter never went to school and got married at the age of 15. Her other daughter, now 15 years old, went to school but dropped out very early and is almost illiterate. Her eldest son is 12 and never went to school. The younger one who just turned 7 is enrolled in school but is often seen cutting classes and loitering around with friends. Zubaida says she really wanted her children to study but being a single parent she could not afford their education and one by one saw them growing up without formally learning anything.

drive their children into labour. Child labour may take several exacting forms. In district Dera Ghazi Khan, children of school going age involved in child labour may be expected to work as brick kiln workers or participate in field cultivation and wheat harvesting. In urban areas, they can be found working at food outlets or auto workshops, work places with low entitlements and taxing conditions. For the past three to four decades, there has been a trend in Dera Ghazi Khan of sending labour to countries in the Gulf. Scores of people in their late teens and early 20s leave for the Middle East every year. Since normally they are supposed to take up low-skilled jobs requiring little or no education, parents in certain parts

of rural areas are not encouraged to invest in their children's education. In some cases, small land holding does not allow peasants to send their children to school, for they want them to lend a hand in agricultural activities. Then there are parents who work as labourers and owing to the hard nature of the work, tend to age early and look to retire or transfer some of their responsibilities to minors in the family. This results in the abandonment of their children's education.

Once a child productively becomes a labourer, it is tremendously difficult for him or her to break

### Box 3.2: Growing Incidence of Child Labour in Tehsil Taunsa Sharif

*Taunsa Sharif is a rural tehsil of the district, which traditionally relied on arid agriculture and had a subsistence economy. The tehsil in the past was known for its relatively high literacy rate and serving as a nursery of educators who rendered services across the country. The Chashma Right Bank Canal (CRBC), a water course irrigating a particular stretch of land in Tehsil Taunsa Sharif and District Dera Ismail Khan in Kyber Pakhtunkhwa, was brought in some 10-12 years ago. It is now being reported that even though the irrigation project has brought relative prosperity to a certain part of the tehsil, it has created incentives for the poor parents to send their children to work on the farms, instead of going to school. This seems to have increased the incidence of child labour in the tehsil.*

out of it at a later stage. Though there are more male children than female ones working in both informal and formal sectors as labourers, the latter too are expected to actively carry out domestic chores to contribute to household economy by getting involved in economic activities such as embroidery, sewing, crocheting, and knitting.

### *3.1.4: Gender Discrimination*

Girls' education faces numerous challenges in the district and in the rest of the country. Certain cultural attitudes stigmatise female education and seek to alienate them from the mainstream. Early marriages, mostly in rural areas, are encouraged and the prospects of a decent education are doomed forever. There are places in the district where girls are married off on average at the age of 15 or 16. Early marriage not only diminishes the chances of receiving further education, it also bars the girl from enjoying a number of freedoms and tends to increase the family size.

Girls' access to schools is a serious issue in rural areas and limits their prospects of receiving education. In UC Samina, which is a fairly big rural UC, there is only one middle school for girls, and this is the only proper and formal educational facility available to girls over there. In Village Bhattiwallah, there is one primary school for girls, which has no building. As a result girls in that area do not go to school. There are fewer schools for girls at every level and if they decide to go to a school situated at a fair distance then the odds are already against them. The situation is perhaps the worst in the tribal region where educational

facilities for girls are few. Thousands of girls of school going age are deprived of learning opportunities. Then there are girls in the district, again increasingly in the rural areas, who on account of having no school in their surroundings, study privately and then sit for exams elsewhere. This increases their reliance on tuition, but at the same time does not guarantee success. Creating opportunities for them requires setting up new schools and investing in infrastructure. In the meantime, they can be encouraged to attend the nearest school for boys. Even some of the education officials believe that by making such an arrangement we can ensure that no cohort misses going to school.

### *3.1.5: Disability*

Disability is a major barrier to attaining education for children with special needs. Currently, there are only four schools for special children in District Dera Ghazi Khan, each situated in different parts of the district, namely Dera Ghazi Khan, Taunsa Sharif, Kot Chutta, and Sakhi Sarwar. They are all functional and provide education to children with special needs. However, their outreach is quite limited and they do not respond to the needs of people living in remote areas. Even rural areas close to the tehsil and district headquarters cannot fully benefit from them, owing to lack of proper transport facilities. The school for deaf and mute in Dera Ghazi Khan is the largest of all and has a sizeable strength. Again, the community believes that the state's response to disability is not adequate, and there exist serious service gaps. People in Basti Birmani, about 40

minutes from Dera Ghazi Khan City, were of the view that the number of disabled in the UC was considerable, but no facility was available to them. Some of the education officials also admitted that children with special needs had been dropped off the radar and required immediate and special consideration.

They arguably constitute the most disadvantaged and excluded group. If someone is not physically handicapped to a dysfunctional extent, they might have a chance to go to school in the neighbourhood and exercise their agency, but anyone with a serious condition or impairment hardly finds any opportunity for learning, and remains largely at the mercy of people around him or her. In most areas, there are no estimates available for the disabled, which complicates the situation even more.

### *3.1.6: Dwindling Enrolment Rates over Different Levels*

Primary enrolment rates for the district are quite low. We saw in the last chapter that the NER for Dera Ghazi Khan is 62%, though this figure is disputed by civil society representatives who believe that the actual rate is quite low. Even this percentage continues to drop over different levels and reaches a staggering 11% at the high school level. The primary completion rates are extremely low too. This problem appears to affect girls the most, as there are fewer high schools available for them and the cost of access is quite high.

Precipitous drops in enrolment at the high school

level for both girls and boys are mainly attributable to fewer high schools in the district. High schools are normally situated at great distances from each other and cover a large swathe of villages and settlements. Though primary schools are generally present in localities, high schools are not, thus making it practically difficult for children to continue their studies beyond primary or middle levels. Sometimes high schools situated even at a few kilometers raise costs. People in Basti Birmani believed that only 10% of those who passed middle from the local school would go to high school in Choti Zareen, which is about 4 to 5 kilometers away. The rest would drop out. The reason primarily is increased costs. They would have to pay for transport, which on average would cost them about Rs. 1,500 a month. Private tuition, which seems to be at the heart of high school level studies, is another service they would require if they were to secure good grades in final exams or stand a fair chance to move up the grade ladder. It is also likely to incur them an amount of about Rs. 1,000 to 1,500 a month. Going to a high school would be even more difficult for girls. Owing to a range of factors, it is estimated that only 2% of girls from Basti Birmani end up in high school in Choti Zareen.

This problem affects poor households the most. It not only increases their costs but also makes the lure of child labour more attractive. Then among the poor – rural poor to be more specific – female children are most affected. Travelling to high school daily is an unthinkable proposition to parents of a considerable bulk of female children

of school going age. It raises transport costs and brings girls out into the public sphere.

Moreover, it is fairly challenging for women who are single parents to closely monitor the progress of their children in school. Cultural norms are such that the women do not feel encouraged to interact with male teachers. Thus, if the male child of a single parent is lacking interest in studies or facing some kind of difficulty continuing with his studies, the mother will have problems keeping track of his progress.

### *3.1.7: Policy Obstacles*

The Government of Punjab introduced primary school merger policy to “consolidate physical and human resources in a same village”. It is meant to introduce the principle of ‘rationalization’ in education by merging primary schools and transferring teachers to schools with considerable strengths. An education official was of the view that the rationalization policy is the way forward as it entailed benefits for the communities and helped deliver services efficiently, and that it also enhanced the quality of education. However, many of the teachers and community representatives believe that the merger policy has created problems for both teachers and students. Distances have sometimes increased and the costs of relocation are very high in terms of access, adjustment, and settling in. Instead of providing universal access to education, this step serves to minimise the role of the state and encourages privatisation. They argue that if enrolments in certain schools were low, it was

mainly because of missing facilities and absence of linkages between the community and the educators. The government would do well if it focused on missing facilities and undertook steps to make SMCs functional. Communities in both rural and urban areas require more, not less, schools.

### *3.1.8: Political Interference*

Education governance in the past was characterised by political interference and arbitrariness to a great extent. Sanctioning schools, recruiting staff, and buying equipment saw a lot of political meddling and were used to gain political mileage. Where to build a school and where not to build a school was decided by political considerations and not practical concerns. Therefore, there are places in the district where the nearest settlement is several kilometres away from the school.

Though over the years such practices have dwindled to some extent, owing to a changed policy environment in the country, their remnants continue to affect service delivery. Still there are schools built on land given by the local influential. Some of these schools are quite far from the village they were set up for. The transfers and postings of teachers and other education staff, however, are still politically determined to a great extent.

### *3.1.9: Responses to Out-of-School Children*

The government of Punjab over the past many years has taken a number of steps to increase



enrolment and promote literacy in the province. Some of these measures have started yielding results and provided a boost to education. Enrolment rates have gradually increased and teachers in most cases come to schools regularly. However, some policy initiatives appear to be struggling with achieving desirable outcomes. Questions are also being raised over the government's overall approach towards education. Some believe that the strategy has limited outreach and is failing to address issues of exclusion and deprivation. By introducing policies like primary school mergers, the government is encouraging privatisation in education. Though an exhaustive assessment of the government's education policy is outside the scope of this report, it is important to discuss some of the main steps taken by the government to promote education, in addition to giving text books to students for free.

The government runs its enrolment campaign every year between the April 1 and May 31. This involves going from door to door in the community and urging parents to send their children to school. Activities to raise community awareness about education are also undertaken. But the people in the district are generally skeptical about the effectiveness of this campaign and believe that it exists more on paper and no meaningful measures are undertaken to increase enrolment and achieve sustainable gains.

The Government of Punjab has developed an elaborate system of school monitoring. According to this initiative, each district in the province has

an office of the District Monitoring Officer (DMO). The DMOs supervise the work of Monitoring and Evaluation Assistants (MEAs), who go out into the field and inspect schools across the districts. Most of the MEAs are retired from the armed forces. Each MEA is supposed to monitor 30 schools. Monitoring involves assessing attendance, syllabus, and the state of facilities. Stakeholders in the district endorsed the usefulness of this initiative and believed that it had increased teachers' attendance. However, they further added, there was nothing these MEAs could do to ensure the quality of services. They neither have the mandate nor the skills to determine whether what is being taught to children enhances learning. As a result, a factor central to keeping children in schools goes unaddressed.

To promote female literacy, the government of Punjab has adopted a particular policy measure that seeks to incentivise education through cash transfers. According to this initiative, girls enrolled in grades 6 to 10 in public schools are entitled to receive a stipend worth of Rs. 200 per month. This incentive appears to have really encouraged the parents to send their daughters to school and support their education. However, it is too piecemeal a measure to offset structural barriers and restraining cultural norms. It does not even make up for lack of transport in rural areas.

Pakistan Education Foundation (PEF) in a bid to provide education to the poor through enhanced Public Private Partnership (PPP) has launched an initiative titled Foundation Assisted Schools (FAS). According to this policy, a private sector school is

owned by the government and the government pays fees to the school management. PEF pays Rs. 450 per student up to Grade 5. The fee for the senior section, i.e. up to Grade 10 is Rs. 750. In this way the government ensures that even the poorest of the poor can afford to go to school. The stakeholders in the district appreciate this effort and consider it important in providing services to the poor but they also think that the scope and outreach of this policy is very partial. Scores of areas and schools around the district do not fall under the purview of this initiative. A number of poverty-stricken children remain excluded and out of school. Without extending public support to all corners of the district, the situation cannot be significantly improved.

The divisional government in Dera Ghazi Khan recently undertook special measures to extend educational services to the children of fishermen and nomads. Two schools for the children of nomads and a boat school for fisher folk were set up in the district. These the steps in the right direction and need to be welcomed. However, considering the number of nomads and fisher folk in the district, they come across as partial. Nomadic and itinerant populations like the fishing community are found across the district and unless a full-scale policy is introduced to get their children into school, initiatives like these may not achieve optimum results and provide only an illusion of inclusion.

Some of the education officials believe that a dramatic increase in population over the past two decades has seriously undermined the ability

of the government to provide services to the people. However hard they try to carry out their responsibilities, they never cease to run out of resources, which eventually hampers their efforts to improve education indicators.

One education official admitted that the children of school going age were not being owned. They were not the center of attention and focus of policies. Whatever policy measures are undertaken in the future should keep children and their needs in mind, for this is how a difference can be made.

### **3.2: Out-of-Pocket Health Costs**

The issue of out-of-pocket costs is inextricably linked to the provision of universal healthcare or lack thereof. It is also about the state of health sector and responses to community's health needs. Out-of-pocket expenses rise when there are service gaps and policy prescriptions do not prioritise health as a sector and an area of intervention. These expenses are hard to bring down once they escalate, and thus compromise the ability of an individual to enjoy different sets of functionings and invest in their capabilities. Rising out-of-pocket costs in fact are indicative of a deeper malaise: a state failing to give primacy to the wellbeing of its citizens and letting them slide into an abyss sustained by profiteering and corporate greed.

Health-related private cost is an issue that manifests itself in both urban and rural areas. Wherever public service delivery does not match

people's needs, the specter of out-of-pocket costs is raised. Though all types of groups are affected by these costs, it is the marginalised and the poorest of the poor that suffer the most. Rural poor and women in particular bear the brunt of this problem and struggle with meeting their health needs.

### *3.2.1: Public Health Facilities*

As stated above, out-of-pocket costs are intimately linked to the state of public healthcare in the country. The effectiveness and functionality of basic health facilities determine how much the community members will have to pay from their own pockets. When we take a glance at the health facilities in District Dera Ghazi Khan, the situation does not look promising. In Chapter 2, we looked at a health department's assessment of health facilities in the district. The qualitative data collected through interviews, FGDs, and visits, seems to confirm our analysis. From BHU and THQ through to DHQ, the picture is one of unresponsiveness and indifference. Serious service gaps appear to characterise the health sector at the district level. Many of the facilities are functional, but not effective in an optimum manner. There are BHUs where doctors do not arrive regularly and medicines are not available. Doctors in general seem to prefer private practice over their jobs. Communities complain that when they go see a doctor in a public health facility, he or she asks them to come to their private clinic for treatment and check-up.

The management of BHUs across the district has

been outsourced to the Punjab Rural Support Programme (PRSP). But even this measure has largely failed to provide quality health services to the population. Medicines, as mentioned earlier, are difficult to find and doctors do not keep regular hours. In some areas there is even acute shortage of doctors. Labour rooms for deliveries in some places are not functional and reproductive health facilities non-existent. LHVs are also found running their own private clinics or the rest of the staff their own medical stores. Things are a little better in 13 of the BHUs that are open around the clock and serve as donor-funded Mother and Child Health Care Centers. But even these facilities have issues of their own and do not fully respond to local needs. A discussion on these centers will take place later in this report.

Considering all this, whenever someone suffers illness or ailment of mild or serious nature, they are taken to health facilities in the district headquarter. THQs in the district are not considered in a good shape and are bereft of various facilities. Shortage of doctors is another problem over there. Once in Dera Ghazi Khan City, people have two choices: either to go to the DHQ or a private facility. Overwhelmingly, they choose the latter. The DHQ is functional but not very effective and resourceful. It is commonly believed that you need to be 'well-connected' to be able to smoothly avail services there. There are fewer doctors available and consultation hours are limited. It is sometimes difficult getting hold of consultants. Common perception is that doctors care more about their private practice

than seeing patients in the hospital. Sometimes, they even ask the patients to see them in their private clinic. Testing services are either occupied at all times, creating a backlog, or non-existent or dysfunctional. X-ray machine and CT scanner are available but not functioning. The ultrasound machine is inconsistently functional and endoscopy unit inoperative. Technicians for some of the equipment and machines have yet to be hired. As a result, they are out of service.

Shortage or non-availability of medicines is another problem that plagues the DHQ. Patients and the community claim that they have to buy most of the medicines from outside the hospital. As a result, the DHQ has a very high rate of referrals. A large number of patients every day are referred to hospitals in Multan. This increases the costs for patients and their families.

### *3.2.2: Private Practice as an Unregulated Domain*

Private practice thrives across the district in the absence of universal healthcare. Be it a village, a town or a city, people are made to go to private clinics. Since it is largely an unfettered industry, the price of services tends to be inflated. One reason why the cost of different procedures and services such as testing and medicine is high is commissioning. Some practitioners specify the laboratories and medical stores the patient has to purchase the services and medicines from. Owners of these facilities then pay commission money to the practitioner for referring them. Pharmaceutical companies too create monetary incentives for practitioners for prescribing certain

medicines. Sometimes these medicines are not required by the patient at all, but he or she is led into purchasing them in order to increase the sale of the product. This practice is widespread and not only increases the treatment costs but also has the potential to create further health hazards.

Spurious drugs are another matter that associated with this unregulated sphere and offset what the patients spends on their health. Despite quality control measures being in place, counterfeit medications are available on the market. These medicines, even when not toxic, lead the money spent on health to go wasted. The patient sees little recovery and the amount spent on treatment is high.

### *3.2.3: Out-of-Pocket Costs and the Poor*

Out-of-pocket costs are a bar on the economy of a poor household. If someone in such a household falls ill or suffers from an ailment, it jolts the entire economic structure of the household. If illness is minor, it can be withstood by readjusting priorities, shuffling heads, or cutting back on overall expenditure. However, in case of major ailments, sustained injury, or serious illness, the price is exorbitant and fallouts crippling. Loans are secured and pledges made. Sometimes, they even have to sell jewelry or a plot of land to bear the expenses. Some, on the other hand, turn to the local moneylender who may provide loans with stringent conditions, which would be difficult to meet for a tenant or an extremely poor person. But not everyone manages to arrange the money or secure loans. With abject poverty comes

powerlessness, and those who are downright poor find it increasingly difficult to obtain loans. They are excluded from the mainstream and surrounded by the people who are nearly as destitute as they are. Even those who somehow end up borrowing money, spend the rest of their lives repaying the debt.

### **Box 3.3: Out-of-Pocket Costs and the Poor**

Sajida Khatoon, 40, is a mother of six, and lives in a village south of Dera Ghazi Khan. Her husband has a small landholding, which barely helps them stay afloat. A few months ago, she felt intense abdominal pain and was taken to a private clinic in Dera Ghazi Khan. She remained under treatment for a week, which cost her Rs. 25,000. It was quite a big amount for a household depending on subsistence economy, and made them redefine their priorities for the rest of the year.

Sometimes healthcare costs rise at the expense of other facets of individual wellbeing. Female household heads interviewed were of the opinion that at times health expenses barred them from making strategic investments, such as investing in girls' education or the learning needs of other members of their family. Nutrition is another area that appears to suffer from this. In poor households, if a large amount is spent on health, it is ensured that it is made up by taking up austere measures such as cutting back on one's daily food intake. This practice, when observed, entails serious consequences for one's health in the long term.

Population features also seem to play an important role in increasing or decreasing the health costs. Since maintaining a large family size is tied to ensuring financial security in rural and urban areas across the country, family size in the district on average tends to be quite big. A health worker was of the view that some people even had 15 to 16 children in rural parts of the district. Correspondingly, it results in escalated health expenses and cripples the household economy. Thus, a large pool of human resources that otherwise could have been harnessed to generate human capital, goes to waste.

### **3.2.4: Reproductive Health**

Reproductive health is an area that incurs huge costs. Antenatal care visits, as we saw in the previous chapter, are rare and delivery is overwhelmingly done privately. In some rural areas, according to an estimate, traditional birth attendants carry out 90% of deliveries locally. At times, women are pressured into going for private service by the LHV. Those who can afford to go to a gynecologist, look to spend between Rs. 20,000 to 40,000 depending on whether it is a normal delivery or a cesarean section (C-section). The rest, constituting the majority, turn to traditional birth attendants, which, on average, may cost Rs. 2,000 to 5,000. And there is no guarantee that the traditional birth attendant would be skilled. Sometimes they barely have any prior experience. One even hears of private delivery facilities in the district run by LHWs and not LHVs. It has been reported that there are union councils where there are no LHVs, and women are left to resort

to traditional reproductive health measures. Then there are places in the district where the LHV, instead of doing cases in BHUs, run their private clinics and extract fees from local people. Moreover, even where there are LHVs, they are assigned additional responsibilities such as running the polio campaign. In fact, at times the LHVs find themselves increasingly bogged down in making the polio campaign a success.

If one is socially resourceful and has connections in the health department, the THQs and the DHQ are also an option. Over there, according to an estimate, the entire process may cost up to Rs. 7,000 to Rs. 10,000. Relatively well-off households in rural areas prefer to take women to gynecologists in the tehsil or district headquarters. But it raises the cost for them. If someone does not own a vehicle and the delivery case is complicated, requiring expert assistance, they have to rent a car or a van to take the woman to the city. Depending on the distance between the origin and destination, private transport may cost a considerable amount of money. From the farthest corner of Dera Ghazi Khan, i.e. the western edge bordering Balochistan, to the district headquarter, the fare may range from Rs. 6,000 to Rs. 7,000. Therefore, under such circumstances, those who cannot afford to pay for transportation and other costs have to rely on local help, which may turn out to be fatal. 12 cases of MMR occurred in UC Mutfariq Chahan alone in one year. This figure is expected to be higher in the tribal region. IMR in the district, as we already know, is higher too. Deaths related to

delivery, therefore, are not an uncommon sight and maternal mortality, at times, is a concomitant of absolute poverty.

As mentioned earlier, 13 of the BHUs in the district are open around the clock and serve as donor-funded Mother and Child Health Care Centers. One civil hospital is also part of this initiative. These facilities provide antenatal and postnatal care and delivery related services. They have a range of staff at their disposal, including doctors, LHVs, dispensers, and technicians. However, in some cases there is a shortage of staff. There are even reports that some of the staff are not trained and made their way in through political patronage. Despite free reproductive health services, many around these centers do not come there. The rich or relatively well-off prefer to go to private clinics or hospitals in Dera Ghazi Khan or Multan. In case of the latter, there are even private facilities where a normal delivery costs about Rs. 70,000 to Rs. 80,000. The poor on the other hand turn to traditional birth attendants. A health official was of the view that a lack of turnout was attributable to both restraining cultural norms and absence of staff. However, things were not like that when this program started in 2010. The government took a lot of interest in it at the time and took steps to make it resource-efficient. Deliveries were incentivised and mothers would receive a newborn kit and oil among other assortments. The locals, therefore, preferred to come there. However, over time, the government lost interest in it and the quality of services suffered a decline. As a result, the community largely turned away

from these facilities. The staff associated with this initiative believe that increased ownership on the part of the government and revival of the old services can cause a turnaround and restore people's faith in public reproductive health services.

### 3.2.5: Out-of-Pocket Cost Estimates

Multiple contributing factors work together to raise out-of-pocket health costs. Even though the BHUs do not operate too efficiently, going there for a check-up or treatment may cost an average wage earner or a peasant a considerable amount. The consultation fee is only Rs. 5, but costs of tests and medicines tend to be high. If someone is suffering from high fever or a strep throat, total expenses could go up to anywhere between Rs. 500 and Rs. 1,000. In case of serious illnesses or health problems, the patient is necessarily initially taken to Dera Ghazi Khan. Tehsil headquarters are scantily preferred as sites of treatment. This certainly increases the toll. Over there, as we know, normally the patient has to settle on a private clinic. It might cost a lot. Someone coming from the far western fringe of the district, up in the hills, may expect to spend quite an amount. Room charges per night alone may cost between Rs. 1,000 and Rs. 1,500. However, even if he or she ends up in a government facility, an imminent referral or a delayed response threatens to elevate the cost. These expenses usually include, among others, transportation, laboratory tests, medicines, consultation fee, stay in the clinic or hospital, and food.

The cost of the entire treatment process soars when these additional costs associated with the travel, food, and stay of those who accompany the patient, are included. Sometimes, their number is one to two, and sometimes, in case of a female patient, three to four, depending on the distance from residence and the nature of ailment. If they are taken to Multan then the costs are much higher.

Estimates of out-of-pocket costs vary from household to household, group to group and locality to locality. A survey is required to establish monthly or annually health related expenses per household. Still, we have local estimates suggesting the scale of out-of-pocket costs. There were households in both rural and urban areas that maintained that health expenses constituted

#### Box 3.4: Out-of-Pocket Costs for the Rural Poor

Nasreen Mai is in her mid-30s and lives in a village of Union Council Mamuri. She has 7 children and her husband is a labourer. One day, she took an overdose of some over-the-counter medicine, which caused a serious reaction. She was instantly taken to a private facility in Dera Ghazi Khan and given treatment. She was an in-patient over there for four days. It cost her Rs. 15,000. They had to secure a loan to pay this amount and clear the dues. The entire incident badly shook their household budget and made them brave the outcomes.



at least 20% to 40% of their expenditure. This percentage was higher for poor, for the proportion of these expenses is much higher relative to their incomes. Receiving treatment is so difficult for some that they abstain from it altogether.

### *3.2.6: Constraints*

A whole range of factors fundamentally raises out-of-pocket costs for the community and compromises public service delivery in health. Undoubtedly, health financing is a domain, which in Pakistan has not seen significant inflows. Spending on health constitutes a fraction of the entire GDP. A great bulk of this paltry allocation goes into staff salaries and recurrent costs. These resource constraints deal a blow to the ability of duty-bearers to efficiently execute their responsibilities and provide relief to the people. The government's treatment of health sector as a non-productive area not needing redistributive benefits, encourages private practice, which raises the costs for the community to an enormous extent. Private practice is largely unregulated and prone to all kinds of malpractices, ranging from profiteering and commissioning to substandard and, at times, fatal response to quackery.

Understandably, linked to financing is the area of human resources. Health departments in general suffer from shortage of staff and fail to ensure the presence of doctors in all of the public health facilities across the district. Doctor-patient ratio is fairly high and a number of positions for doctors are vacant. A robust response is required to fill this gap and extend the outreach of healthcare services.

## Chapter 4

### Conclusions and Recommendations

#### 4.1: Education

Low enrolment rates, missing facilities, poor quality of teaching, and a large number of out-of-school children are telling signs of misplaced priorities, missed opportunities, and deepening exclusion. It is mainly at the district level that the effects of policies and governance practices become visible. Responding to challenges in education requires holistically identifying and analysing the problem and creatively seeking viable solutions. The discussion in the previous chapters informs that following are the areas in which concerted efforts and systemic reforms are required to improve key indicators in education and effectively respond to the problem of out-of-school children at the district level.

##### 4.1.1: Enrolment rates

Low enrolment rates at the primary level are a matter of grave concern. It is at this level that the foundation for later learning is laid. The figure of 62% for Dera Ghazi Khan is quite low. It needs to be improved and consolidated subsequently. Efforts to increase the enrolment rate must take into account all the barriers to basic education. The government needs to ensure that the enrolment campaign is carried out with focus and diligence and that the most excluded groups and individuals are reached out without fail. It would help the education department if birth registration records were shared with them so that they had vital information. Particular attention should be

paid to enrolling girls. This may require mobilising the SMCs and other community forums to raise awareness about female literacy and engage the parents.

The tribal areas in the district have chronically low enrolment and literacy rates and have yet to receive preferential treatment from the government. A vast majority of children from these areas as a result remain out of school. Special measures should be undertaken in these areas to increase enrolment rates. The government needs to seriously widen the scope of its enrolment campaign and include all those areas that are far-flung and where access is a problem. Without redirecting attention towards excluded areas, positive results cannot be achieved.

Enrolment rates for the district suffer a steep drop at the middle and high school levels. High dropout rates across different grades and levels do not augur well for the literacy rate in the district. As suggested in Chapter 2, it would be imperative to take this sharp decline at the high school level seriously. This issue, in fact, is tied to the numbers of middle and high schools in the district. Schools at these levels are not present in all areas and children have to travel a considerable distance. This raises the cost, and children from low-income or poor households find it increasingly difficult to continue their education. It arguably affects girls the most as in a socially conservative environment it is fairly challenging for them to travel to a school

situated in a different neighbourhood or village. It was seen in many parts of the district that at times people have to prioritise the education of their children and move to the tehsil or district headquarter. It causes displacement, and relocation costs are sometimes very high. More resources should be directed towards building a network of schools at all levels to provide equal opportunity to all children.

It came to the fore that when children go to school, they find fewer teachers there. In places where pupil-teacher ratio is high, quality in education cannot be ensured. Data reveal that in Dera Ghazi Khan pupil-teacher ratio is 41:1, which certainly cannot be considered low. To tackle this, vacant posts for teachers should be filled on an urgent basis, and a policy should be evolved to ensure that adequate human resources are available in the education department.

#### *4.1.2: Quality of teaching*

Quality of teaching is central to achieving critical outcomes in education. Findings in this report suggest that teachers generally lack basic skills required to impart knowledge and learning. Their competencies are either undeveloped or not harnessed to a point where they can effectively help young learners acquire basic literacy skills. This calls for formulating a robust response to the training and capacity development needs of the teachers. Such a response should focus on both pre-service and in-service training needs. In addition to harnessing the skills of teachers and helping them acquire innovative pedagogies,

it is also very important to remind them about developing a non-judgmental approach towards learning and teaching, and abstaining from harmful practices like corporal punishment.

#### *4.1.3: Child labour*

Poverty and neglect on the part of the authorities come together to push children into child labour. This dehumanizing practice steals childhood from them and denies key functionings and capabilities essential for enjoying a balanced and fulfilling life. To combat this, bold measures are required. All the stakeholders, including community, parents, employers, and state authorities, will eventually have to come forward. Studies should be undertaken to assess the scale of child labour in the district and the causes behind it. Vigilance committees, consisting of government officials, school staff, parents, community activists, and employers such as brick kiln owners, should be set up to be able to dramatically reduce the incidence of child labour. Or if there are already such committees and forums in place, they need to be revived, reinforced, and strengthened through increased focus. Non-formal schools, learning centers and facilities should be established to engage with the out-of-school children involved in labour. Incentives should be provided to these children for attending school. Parents should be engaged to raise awareness about life-long risks associated with child labour and the need to send them to school. Moreover, whatever other mechanisms to curb child labour have been devised or proposed need to be enforced with a political will. Only then might we be able to

get these children into school and give them the opportunity to build a bright future.

#### *4.1.4: Girls' education*

Enrolment rates in Dera Ghazi Khan are far lower for girls than for boys and there are more girls out of school compared to their male counterparts. Both service and demand barriers collude to exclude a large bulk of girls from schooling and education. Stories heard from girls while writing this report are harrowing and speak volumes about opportunities being denied to them. This affects not only the girls but the wider society as well and involves serious consequences for a whole range of human development indicators. Broad-based and genuine efforts are needed to promote female literacy and allow girls to attend school. The implementation of Article 25-A would be a huge step in this regard. Moreover, the provincial government should take the lead in getting girls into school and ensuring high retention rates. This calls for investing in education and setting up more schools for girls. The government should also take seriously the issue of access and scale up efforts to reduce distances between communities and schools. This may involve allotting land for the school against criteria established by both the community and duty-bearers. Road networks should be built to link villages and settlements and improve students' access to places of learning. Female students in both rural and urban areas should be provided with transportation for free or on a highly subsidised basis. They are rights-holders and entitled to such facilities and services.

Giving stipends to school-going girls is a commendable step by the Punjab government. It needs to be consolidated and universalized and made more substantial by increasing the value of the assistance. These policy responses and practices will not yield results if the demand barriers are not taken into account. The data revealed that certain cultural norms and practices act to block girls' access to education. Female education is stigmatised and early marriages are encouraged. Effective advocacy campaigns can play a big role in eroding cultural practices limiting girls' participation in the public sphere. Therefore, all the stakeholders need to come up with a joint strategy to end gender discrimination in education. Sessions should be held with parents and communities to raise awareness about female literacy. An innovative approach, drawing on critical factors, is required to deal with the issue of gender disparities in education.

#### *4.1.5: Disability*

Disability is a serious barrier to education, affecting children with special needs. Sadly, the disabled are not part of the mainstream and their educational needs go unfulfilled. They are not only excluded but invisibilized too. Data on their number, nature of disability and literacy status is hard to get. Most of the children with special needs are forced to stay at home and eke out a forlorn existence. Though there are four schools in Dera Ghazi Khan for children with special needs, they are insufficient to respond to the learning needs of a great majority of students. Schools and learning centers for children with

disability should be set up in all parts of the district to widen the outreach of such services. There is a dire need to gather reliable data on the number of children in the district with disabilities. NADRA should make convenient the process of registration for the disabled. Then a coherent strategy needs to be formulated to identify the learning needs of the children and understanding how they can be met. The issues of transport, counseling and social support must be taken into account. Institutional development, resource mobilisation, and awareness raising need to be done simultaneously. Community organisations and concerned departments should collaborate with each other on finding ways to give a sense of inclusion to children with special needs by providing them quality education.

#### *4.1.6: Social protection in education*

Special safeguards are required for the economically underprivileged, socially excluded, and the structurally deprived. Exclusion and deprivation are so endemic that the duty-bearers will have to proactively undertake measures to offset their effects. PEF and Danish Schools though provide free education to the children of the poor, their scope is quite limited. Broad-based social protection programs can serve as an effective means to dissuade poor parents from taking their children out of school. Vouchers should be provided to parents if they find it difficult to finance the education of their children. Stipends and scholarships are also instrumental in increasing enrolment rates, retaining students and enhancing learning. These measures further

incentivise sending school-age children to school.

#### *4.1.7: Curbing political interference*

Electronic and social media have created a milieu in which issues are discussed and concerns raised. This has led to a changed policy environment, which is characterised by debate and relative openness. Education governance in the past was rife with political interference and arbitrariness. This has now changed to some extent. However, transfers and postings of teachers and other education staff are politically determined to a vast extent. Resource allocation, funds transfers, and need identification continue to see a great deal of political interference. This needs to change if efficiency, transparency and accountability in education are to be ensured. Participatory practices – taking on board parents, children, school staff and community representatives – should be introduced in the governance of education to achieve sustainable gains. For this, therefore, political interference must be completely eradicated.

#### *4.1.8: Local governance*

It is already fairly established that local governance in a devolved context has the potential to deliver a range of social services more efficiently and effectively. It is about time that the Punjab had its local governments and people as representatives at the grassroots. It would empower the communities, help them better identify their needs, and stimulate an effective demand for services. Forming local governments through

elections, therefore, should be the foremost priority of the government.

#### **4.1.9: Data gaps**

Recent and reliable data on social indicators at the district level are hard to find. Either there are no data on different themes or issues or they are outdated and conflicting. Different departments and agencies have different estimates of a range of indicators. The education department does collect data on a regular basis but it mostly revolves around figures for staff, students and facilities, and fails to grasp the bigger picture. It is also not cross-checked and, to some, is biased towards positive conclusions. Therefore, there is a dire need for fresh, broad-based and representative surveys and research exercises seeking to capture basic and important information. Such initiatives can be undertaken by both provincial and district governments. Data coming from these surveys can then be used to draw lessons, analyse the situation, and inform policy choices.

#### **4.1.10: Creating ownership**

Disparities in education are stark and wide. A complex web of barriers and causes keep thousands of children in the district out of school. This calls for creating a sense of ownership, not only at the district level, but at provincial and federal levels too. Government, civil society, political parties, donor organisations, and media need to own education as a sector and an area of intervention. This will clarify the assumptions, synthesise efforts and create the synergy

required to bring children into school. This kind of ownership is particularly important at the district level. A forum consisting of district government officials, teachers, parents, and civil society representatives should be established to uplift the state of education in the district and tackle the fundamental issues of literacy, enrolment, and out-of-school children. After deliberations, research, and consultation, a joint strategy should be formulated by the forum members to achieve the objectives. Resources, actors, and milestones need to be identified to hit the targets systematically and efficiently. What is basically required is political will, spearheading efforts to promote education and win the hearts of the children.

### **4.2: Health**

The state of health indicators in any country is emblematic of its policy concerns, normative framework for development and strategic choices in the social sector. Infant and maternal mortality rates, reproductive health indicators, life expectancy and immunisation against diseases, all reflect how the state views the wellbeing of its citizens. A lack of concern on the state's part results in the poor state of these indicators and raises the costs for the community. Out-of-pocket costs go up high in places where public service delivery is poor or non-existent. These costs, as the evidence suggests, create financial hardships and badly affect different facets of an individual's life. Chapter 3 provided us with an estimate of health-related expenses and different issues associated with them. Reducing out-of-

pocket costs at the district level requires having a sufficient understanding of these issues and evolving a coherent response to address them. Following are the domains an integrated strategy should focus on.

#### *4.2.1: Health financing*

A meager allocation of 2.7% of the GDP for health is set to decapitate the health sector from the beginning and raise personal costs for the citizenry. A great bulk of this goes into staff salaries and recurrent costs. These resource constraints deal a blow to the ability of duty-bearers to efficiently execute their responsibilities and provide relief to the people. Almost all the issues with regards to out-of-pocket costs we discussed above have a strong financing aspect. Resource constraints also abet all kinds of unethical and harmful practices in the domain of health, perpetrated by both public and private actors. The first serious step in the right direction calls for changing priorities and directing attention towards health. A robust social policy, affirming to provide universal healthcare, can endeavour to deliver services at the doorstep by spanning a network of basic health units and mobile dispensaries. But, to this end, public spending on health needs to be substantially increased and ensured that different sectoral components receive their due share. Though this measure pertains to the federal government, it is bound to have dividends at the district level as well. In the face of financial constraints, a mapping of different sources of funding should be carried out. This mapping will identify a range of sources that can be tapped to generate resources

for different service delivery components.

Additionally, at the district level, funds can be generated through innovative financing. All potential avenues of mobilising resources domestically should be explored. Funds raised locally and through innovative financing can be used to support services and interventions at the grassroots. It will further foster inventiveness in the health sector.

#### *4.2.2: Public health facilities*

BHUs, DHQs, and other health facilities in the district are the main sites of state's response to people's needs. It is the effectiveness and functionality of these basic health facilities that determines how much the community will have to pay from their own pocket. District Dera Ghazi Khan, as we have discussed earlier on, does not have fully functional and responsive health facilities. A number of measures are required to improve service delivery in this field. BHUs should receive primary attention. First, it should be ensured that all of the medical staff – doctors, nurses, medical technicians, LHVs – observe their full hours in the BHUs. And since rural areas serve as large pockets of poverty, by ensuring the presence of staff and equipment, much relief can be provided to people over there. Second, basic medicines should be easily available in the BHUs. This will decrease the community's reliance on medical stores and provide medicines locally. Third, all basic facilities should be present and functional. Steps should be taken to ensure that the requisite testing services are being provided



to the people. Fourth, whatever treatment is mandated for the BHUs should be available to the community.

The plight of the THQs presents a different story. They are arguably one of the most neglected health facilities in the district. They even fail to act as the buffers between the BHUs and the DHQ. Therefore, efforts should be undertaken to revive them and ensure effective service delivery there.

The DHQ is the largest public facility in the district and is supposed to accommodate people from all over the area. However, owing to a range of reasons, it has been struggling with performing that function. First, patients complain of not being able to see a consultant and receive proper treatment. Just like the BHUs, the staff in the DHQ too, should be asked to observe the full duty hours. Second, the plentiful availability of medicines is another target that the hospital staff finds hard to achieve. People complain that the medicines do come through, but are not available to the people. If these medicines are substantially provided, it will restore people's confidence in the system and reduce their expenses. Third, diagnostic and testing services should be functional in the hospital. Patients have to spend a large amount of money on these services should they avail them outside the hospital. Ensuring the provision of these services will further ease community's problems. Fourth, the referral system should be made more systematic. As of now, it is arbitrary and reduces the scope of locally available health solutions. If a broad range of cases is dealt with

at the district level it will decrease expenses dramatically.

#### *4.2.3: Reproductive health*

District Dera Ghazi Khan's indicators for reproductive health have not been very encouraging. Delivery related deaths and complications are not too uncommon. Insights generated through interviews and interactions with the community seem to confirm this. It is so because there are serious service gaps and traditional approaches to reproductive health hold sway. Antenatal care visits are rare and delivery is overwhelmingly done privately. The LHV's are either non-existent or unavailable owing to additional non-reproductive-health-related responsibilities. They are even found to be running their own private clinics. All these factors jeopardize the lives of women and significantly increase out-of-pocket costs for the community. It would help immensely if the presence of LHV's and LHW's was ensured in all the UCs and villages therein.

The government's initiative to provide maternal and child health care services to the community through selected BHUs is a welcome sign. It needs to be strengthened further. Evidence suggests that the quality of services there is declining. The government should take steps to improve its performance and extend this facility to the rest of the BHUs as well. Increased ownership on the part of the government can cause a turnaround and restore people's faith in public reproductive health services. Similarly, traditional birth

attendants can also be engaged in improving reproductive health by offering them specialised courses. This will create a local pool of skilled birth attendants. Moreover, special attention should be paid to reproductive health facilities in the tehsil and district headquarters. Arrangements should be made for the performance of C-Sections there without sending women to private practitioners or facilities outside the district.

#### *4.2.4: Providing relief to the poor*

The poor bear the brunt of health related costs. They have crippling financial constraints and, considering their quality of life, soaring health problems. Bigger family size adds further to their problems. In case of major ailment or a serious health problem, they have to resort to taking loans. Sometimes, these loans are so big that they spend the rest of their lives repaying them. Therefore, significantly reducing out-of-pocket costs should be the government's foremost priority. This chiefly requires universalising healthcare but, in the absence of that, special measures should be undertaken to provide relief to the poor. One way to do this is to improve service delivery at the BHU level, as we discussed above. Another is to provide financial assistance to the poor. This may take the form of a voucher, refund, or cash transfer. Partial health insurance and microcredit schemes are also viable ways to reach out to the most vulnerable groups.

#### *4.2.5: Removing monopolies and malpractices*

Private practice in health has grown to an extent where it has become a self-perpetuating industry.

Where there are doctors, vendors and laboratory owners who offer services in a responsible manner and pursue ethical means to earn profit, there are also those who do the opposite and employ unlawful means and harmful practices. Bold steps should be taken to come down tough on these malpractices. Arrangements such as commissioning between private practitioners and suppliers, retailers and laboratory owners increase costs for the patients. To protect consumer rights, a consumer rights protection committee, consisting of local authorities, health officials, community representatives, should be constituted in the district. This committee can raise awareness about ethical practices, develop a price regulatory mechanism and institute measures to ensure fairness and transparency in the private domain. The issue of spurious drugs, too, calls for attention. It should be ensured through mutual efforts that the inspection of medical stores takes place regularly and principally. The taskforce recently constituted to curb spurious drugs should develop linkages with civil society organizations and rights groups to enhance the efficiency of its operations and eradicate counterfeit medicines at the source. Existing quality control mechanisms also need to be enforced in true letter and spirit.

#### *4.2.6: Improving public infrastructure*

Out-of-pocket costs affect low-income households more as transport expenses are added to basic healthcare costs. Understandably, not all health services can be provided at the doorstep. There always will be health concerns for which one has

to travel a fair distance. But these distances can be made shorter or costs associated with them reduced by building road networks, connecting distant villages to the cities and creating better public transport facilities. Special road projects should be initiated to connect the hilly area with the rest of the district. Investment in roads and transportation will produce long-term positive effects for the tribal and rural communities.

#### *4.2.7: Promotion and prevention*

One way to markedly reduce out-of-pocket expenses, particularly for the poor, is to invest in health promotion and prevention. When the community is better aware of the importance of safer environments and healthy attitudes, they tend to value their wellbeing and take steps that, by default, curb many a disease at the source. For this, it is imperative that the health department extends its outreach and offers public health promotion programmes to communities. This would create safer conditions and reduce reliance on practitioners. Special programmes should be instituted to raise people's awareness about reproductive health issues and build their capacities. A sustained and intensive contact with the populace will help eliminate the context that gives birth to a number of health hazards.

## Annex A

### FGD Guide for AAWAZ District Forum

#### Guiding Questions

#### 1. Human development

- 1.1. What do you think is the importance of social indicators (health and education) for the overall wellbeing of your community?
- 1.2. Are you satisfied with the level of human development in your district? What do you think needs to be changed?

#### 2. Out-of-school children

- 2.1. What are your views on the percentage of out-of-school children in your district? (present the percentage/number from the report)
- 2.2. Why do you think they are out-of-school?
- 2.3. Service:
  - Why low enrolment and then gradual decrease?
  - No. of schools (primary, middle and high)
  - Teachers (number and quality)
  - Missing facilities
  - Financing (any fee? How much cost? How does government subsidies?)
  - Monitoring

- 2.4. What groups are more vulnerable to this problem and why? (probe into rural/urban disconnect and potential economic divide influencing the situation)

- Girls
- Exclusion

- 2.5. Which of the following barriers to enrolment do you think apply in your district and what is their scale and intensity?

- Conflict
- Child labour/Poverty
- Language challenges
- Disability
- Service quality (the state of facilities/buildings, corporal punishment etc.)
- Financing
- Cultural barriers

- 2.6. What is currently being done in the district to address this issue?

- What the government is doing?
- What the civil society organizations are doing?

- 2.7. What in your opinion can be done to get out-of-school children into school?

### 3. Out-of-Pocket Health Costs

3.1. To what extent is the state able to provide you universal healthcare?

3.2. What is the scope of private practice?

3.3. How much do people have to spend on health on average?

3.4. What percentage of household expenses on average consist of out-of-pocket costs?

3.5. How does this issue affect different groups differently?

- Women
- Children
- Elderly
- Poor

3.6. What possible factors do you think raise the out-of-pocket health costs? (discuss a range of potential factors such as access (transport), service gaps on the part of the service providers, quality of service in public health facilities)

3.7. Do you think that public health facilities in the district are sufficiently functional and responding well to the health needs of the community in general?

- BHUs
- THQ
- DHQ (facilities and referrals)

3.8. How much do the following items cost?

- Test
- Medicine
- Surgery
- Delivery
- Transport

3.9. How much do women normally spend on reproductive health? (antenatal, delivery etc.)

3.10. Are you aware of any initiatives currently being undertaken to reduce out-of-pocket costs?

## Annex B

### Guide for AAWAZ Village Forum

#### Guiding Questions

#### 4. Out-of-school children

4.1. How many educational facilities are there in your UC/village (primary/middle/high)?

4.2. What are their characteristics?

- Girls/boys
- Number of students
- Number of teachers
- Facilities (no. of rooms/toilet/electricity/provision of clean drinking water)
- Distance
- Cost (fee and other costs) (any government subsidies?)
- Is the School Management Committee there functional?

4.3. What is the scale of out-of-school children in your UC/Village?

4.4. Who does it affect the most (probe qualitatively into the following categories after hearing their responses)?

- Girls
- Poor
- Excluded
- Any other group/category

4.5. Why do you think they are out of school? (hear and jot down their responses and then proceed to the next question to explore the causes/barrier further)

4.6. Service:

- Why gradual decrease in enrolment over different levels?
- Teachers (skills quality & corporal punishment)
- Monitoring

4.7. Demand: What are the local attitudes towards education, particularly girls education?

4.8. Which of the following barriers to enrolment do you think apply in your village/UC and what is their scale and intensity?

- Conflict
- Child labour/Poverty
- Language challenges
- Disability

4.9. If there are any out-of-school girls in your UC/village, what do they do if they don't go to school?

4.10. What is currently being done in your locality by different service providers to address this issue?

4.11. What in your opinion can be done to get out-of-school children into school?

## 5. Out-of-Pocket Health Costs

5.1. What health facilities are available in your UC/Village?

5.2. What are their characteristics?

- Type of facility
- Number of staff
- Equipment/facilities
- Cost (receipt, test, medicine etc.)
- Distance/outreach

5.3. Do you think those health facilities are sufficiently functional and responding well to the health needs of the community in general?

5.4. Are there any LHV/LHWs in your community? If yes, how many and what duties do they perform or services they provide?

5.5. Where do you go if you or one of your members of family is sick (mildly or seriously)? (public or private?)

5.6. How much does it cost in case of a minor ailment? (include transport, consultation fee, treatment, medicine and any other expenses) (both public and private)

5.7. How much does a procedure or major ailment usually cost? (include transport,

consultation fee, treatment, medicine and any other expenses)

5.8. How do they manage those costs generally?

5.9 How do out-of-pocket costs affect different groups differently?

- Women
- Children
- Elderly
- Poor

5.10 How do out-of-pocket health costs affect reproductive health issues? (ask about antenatal care, delivery, postnatal care, visits by LHWs)

5.11 How do out-of-pocket health costs affect other areas of household economy and welfare?

5.12 What are the areas in which out-of-pocket costs incur more? (probe into different variables e.g, prevention, treatment and rehabilitation)

5.13 Are you aware of any initiatives currently being undertaken to reduce out-of-pocket costs?

5.14 What measures in your opinion can be taken to reduce out-of-pocket costs?





### AAWAZ Voice and Accountability Program

*AAWAZ voice and accountability is a governance and gender program jointly implemented by four rights base national organizations i.e. Strengthening Participatory Organization (SPO), Aurat Foundation (AF), South Asia Partnership (SAP)-PK, and Sungi Development Foundation (SDF) in 45 districts of KP and Punjab province. The program strives for inclusive, open and accountability democratic processes in Pakistan through increased participation of women and excluded groups. Program interventions aim that (a) violence against women will become less socially acceptable, incidences will drop and women and other excluded groups will be better able to participate safely in politics and public spaces (b) communities will be better able to resolve disputes peacefully and (c) citizens will work together for improved socially services through increased accountability of government functionaries.*



**SPO National Centre**  
House 9, Street 51,  
MPCHS, E-11/3  
Islamabad 44000  
UAN: +92-51-111-357-111  
Tel: +92-51-2228681-4  
(4 Lines)  
Fax: +92-51-2228691  
URL: [www.spopk.org](http://www.spopk.org)  
Email: [Info@spopk.org](mailto:Info@spopk.org)

**SAP-PK**  
Haseeb Memorial Trust  
Building, Nasirabad,  
2 K.M. Raiwind Road,  
P.O Thokar Niaz Baig,  
Lahore-53700  
Tel: +92-423-5311701-3  
(3 Lines)  
Fax: +92-423-5311710

**Head office**  
House 46, Street 15,  
F-11/2  
Islamabad  
Tel: +92-51-2111651-3  
(3 lines)  
Fax: +92-51-8433771  
URL: [www.sungi.org](http://www.sungi.org)

**Head Office**  
House 16,  
Attaturk Avenue  
(Old Embassy Road),  
G-6/4, Islamabad  
Tel: +92-51-2831350-52  
(3- lines)  
Fax: (051) 2831349  
URL: [www.af.org.pk](http://www.af.org.pk)  
Email: [headoffice@af.org.pk](mailto:headoffice@af.org.pk)