



District Pakpattan Human Development Report





District Pakpattan

Human Development Report

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

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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 Pakpattan. 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 Pakpattan 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 considerable as 18% of the schools in the district do not have electricity and 16% are without toilets. Correspondingly, the number of out-of-school children in the district is high. According to an estimate, 18.9% 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 Pakpattan, 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 130 deaths per 1000 live births, the infant mortality rate in the district is the highest in the province. 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.’¹ 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.² 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.³ 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.⁴

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.⁵ 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.’⁶

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.”⁷

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.⁸ 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.⁹ 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.¹⁰ 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

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>

the structural deprivations caused by being out of school.¹¹

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.¹²

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

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.¹³

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.”¹⁴ 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.”¹⁵ 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/

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/

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.¹⁶ 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.¹⁷ 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.¹⁸ 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.¹⁹

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 66.4.²⁰

2.2: District Pakpattan

Geography, Location and History

Pakpattan, a largely rural district, is situated in central Punjab and surrounded by Sahiwal District to the northwest, Okara District to the north, Sutlej River and Bahawalnagar District to the southeast, and Vehari District to the southwest. Its distance from the provincial capital Lahore is 207 km. According to the 1998 census of Pakistan, the district had a population of 1,286,680, which as per an informal estimate, appears to have risen to 1,563,000.²¹ Pakpattan consists of two tehsils, namely Pakpattan and Arifwala, which together have 63 union councils. Pakpattan city is the district headquarter. Administratively, it falls under the Sahiwal Division and shares this status with Okara District.

¹⁷ "Punjab," *World Gazetteer*.

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

¹⁹ Ibid.

²⁰ "Punjab Health Profile". Available at http://health.punjab.gov.pk/?q=Punjab_Health_Profile

²¹ "Population of Pakpattan," Punjab Police Official Website.

Pakpattan is named after the great Chishti saint, Baba Farid. The place assumed importance during British rule and its population increased considerably. In 1947, at the time of partition, its demography changed sharply as the Sikh and Hindu population migrated to India and in came Muslim migrants from across the border, making the district more linguistically diverse.

Pakpattan has fertile soil and is a beneficiary of the rich irrigation system of Punjab. Therefore, agriculture is a mainstay of its economy and offer the district wider social and political significance. The main crops of the district are wheat, rice, cotton, maize, and sugar cane. The primary fruits and vegetables harvested from Pakpattan are mango, guava, carrots, potatoes, oranges and okra. According to data from the MICS, 37.2% of households have their own agriculture land whereas 56.1% own livestock.

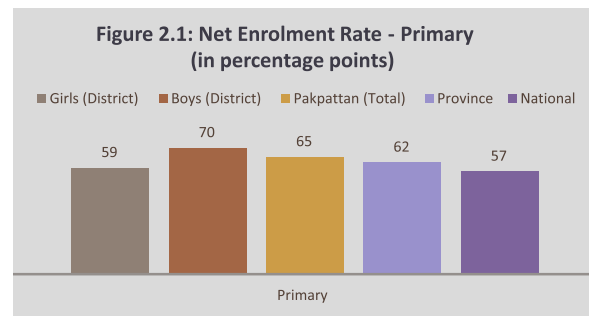
2.3: Education in District Pakpattan

Education indicators for Pakpattan on the whole are less than satisfactory. Low rates appear to characterise a variety of components in education. Total literacy rate in the area is 53%. Female literacy rate is 41% and that of males 64%.²² Rural and urban gap also appears to be quite sharp and is represented by literacy rates of 49% and 75% respectively. According to the Pakistan District Education Rankings issued by Alif Ailaan in 2014, Pakpattan is ranked 27th out of 36 districts in Punjab. Its national ranking is 51 out of 146 districts nationwide. This brings about

a modest score of 66.14 for the district.²³

2.3.1: Net Enrolment and Primary School Completion Rates

District Pakpattan has a relatively low enrolment rate of 65%; however, in relative terms, it is above both the national and provincial averages of 57% and 62% respectively. However, girls in the district suffer disproportionately. The enrolment rate for primary school age girls is 59%, which for boys from the same age group is 70%.²⁴ Disparate primary enrolment rates of 80% and 62% for urban and rural areas respectively point towards inequalities across other dimensions as well (see figure 2.1).

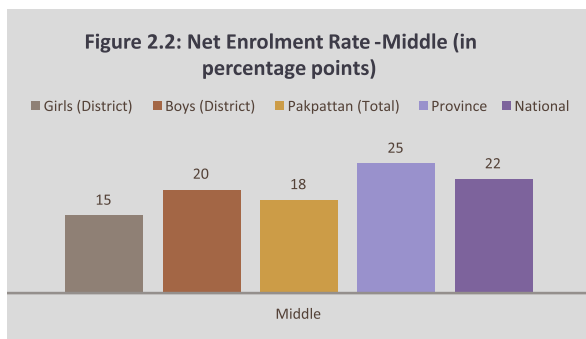


Enrolment rates for the district go down drastically at the middle level as they fall to 18% (see figure 2.2). This figure is below the national and provincial averages of 22% and 25%. The enrolment rate for girls at this level is a diminutive 15% and for boys 20%. Rural and urban disconnect is visible here as well. For rural areas the enrolment rate for this level is 15% and for urban 34%.

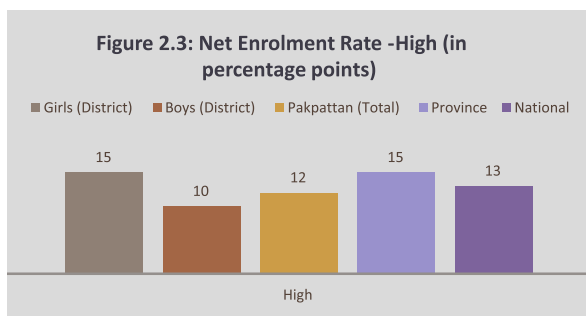
²² Pakistan Social and Living Standards Measurement Survey (PSLM) 2012/13.

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

²⁴ PSLM 2012/13.



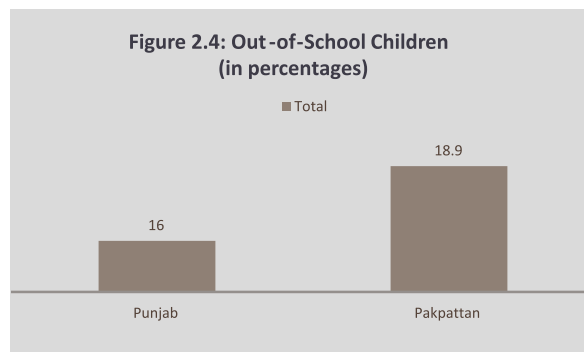
At the high school level, it plummets to 12%, below both the national and provincial averages of 13% and 15% (see figure 2.3). It remains constant for girls but undergoes a precipitous decline for boys and stands at 10%. There needs to be further research to study this sharp fall for boys at higher school level.²⁵ Urban areas have a slightly better average of 25%, compared to 10% for rural ones.



In a sorry situation like this, higher primary school survival rates cannot be ensured. Therefore, it is not surprising to find that only 37% of enrolled girls complete primary education. The figure for boys against the same category is 40%, a difference of mere three percent. Primary education is considered the bedrock of life-long learning and statistics like this only point towards its worrisome state in Pakpattan.

²⁵ Ibid.

According to the statistics released by the Annual Status of Education Report 2013, 18.9% children in Pakpattan were out of school. This figure is higher than the provincial average of 16% and makes the district lag behind this key education indicator (see figure 2.4). A detailed discussion on out-of-school children in Pakpattan features later in this report.

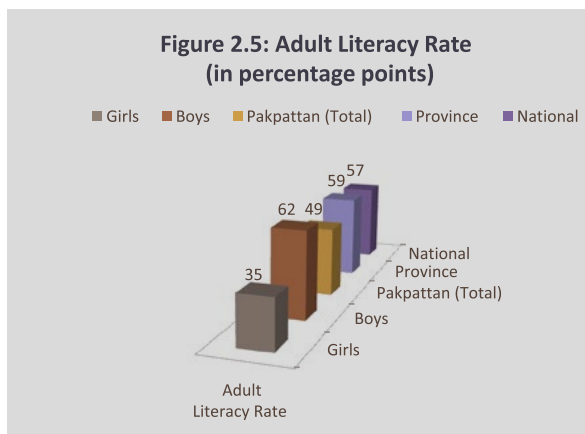


2.3.2: Adult Literacy Rate

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.²⁶ District Pakpattan, on the other hand, does not have a high literacy rate. Data available to us reveal that only 49% 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. Again, within the same category, gender inequality comes to the fore across the district. Where male adults in Pakpattan have a

²⁶ "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>

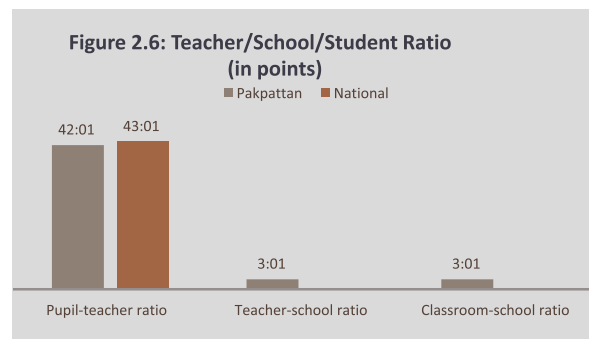
literacy rate of 62%, their female counterparts have an adult literacy rate of meager 35%.²⁷ This figure implies that a bulk of adult women in the area is largely illiterate – a fact with serious consequences for a range of other health, education, and economic indicators. Adult literacy rates in the district vary across rural and urban areas. On average, they are 44% for rural areas and 72% for urban areas. Moreover, 29% of adult females in rural areas are literate, compared to 60% of their male counterparts. In urban areas, 69% of adult females can be considered literate, compared to 76% of 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 Pakpattan is 42:1, which is quite high, considering

the demand of a desired low ratio at this stage (see figure 2.6).²⁸ However, it is still 1 notch lower than the national average of 43:1.²⁹ Teacher-school ratio in primary schools is also quite low and represented by the figure of 3:1. This means schools are understaffed and there are not enough teachers available to teach across different grades. The classroom-school ratio of 3:1 also raises a stream of questions over the variables of access, attainment, and achievement in education.



2.3.4: Number of Schools (Primary Schools)

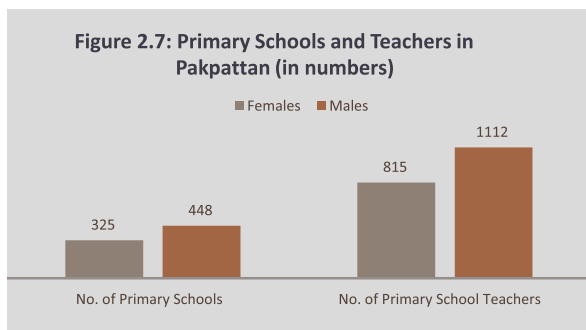
Though we do not know the population size of girls and boys of primary school age in Pakpattan, we cannot entertain the thought, based on the population data available, that gender imbalance would be significantly tilted in the favour of boys. But when we consider the number of educational facilities available to both gender groups, stark differences emerge. In Pakpattan, there are only 325 primary schools for girls in total, compared to 448 for boys – a noticeable difference of 123 schools. Similarly, differentials are also observable in the number of female and male teachers.

²⁸ "Pakistan District Education Rankings 2014."

²⁹ Pupil-teacher ratio, primary. Catalogue source: World Development Indicators. UNESCO Institute for Statistics.

²⁷ PSLM 2012/13.

According to the latest figures available, there are 815 female primary school teachers in the district, compared to 1,112 male teachers (see figure 2.7).³⁰



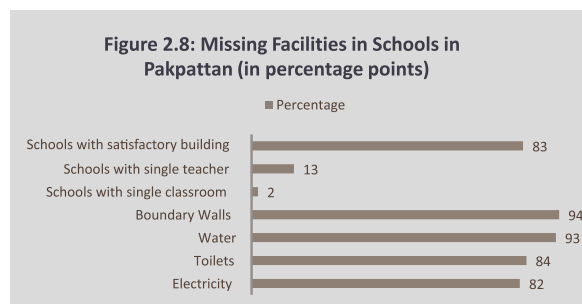
2.3.5: Missing facilities (boundary wall, drinking water, toilet etc.)

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.³¹ This becomes even more crucial in the case of girls, as parents are reluctant to send daughters to school with missing facilities.³² Interestingly, Pakpattan district appears to have done much better in the domain of facilities compared to many other districts with similar socio-economic characteristics. Electricity is available in 82% of the schools – an average higher than that of most of the districts in the southern part of the province. Toilets are installed in 84% of the schools, which shows that health and safety concerns are not

overlooked to a dramatic extent, as is the case in districts with low human development.

The provision of water too seems to be fairly even as 93% of the schools have access to water (see figure 2.8). However, data fall silent on the quality of water, and we do not know whether children in these schools drink clean water or not. Also, 7% schools still have no access to water. This is an issue that needs to be looked into further and addressed. Security of schools and school children is increasingly becoming a pressing concern, particularly in the wake of attack on the Army Public School in Peshawar on December 16, 2014. Therefore, having a boundary wall around the school is a must; 94% of schools in Pakpattan have a boundary wall and do not spread out in an open space.

Schools with single classroom are a rarity in the district, as only 2% are considered to be falling under this category. There are at least 13% schools that have only one teacher. This figure is a little high and requires immediate attention. Overall, the proportion of schools where building condition is deemed satisfactory is 83%.³³



30 "National Education Management Information system, NEMIS 2012-2013," AEPAM, Ministry of Federal Education and Professional Training, Government of Pakistan.

31 "Fixing the Broken Promise of Education for All."

32 "25 Million Broken Promises."

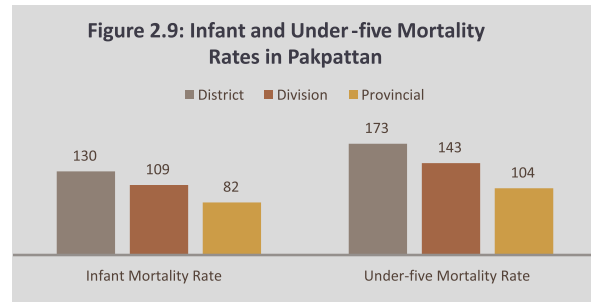
33 NEMIS (2012-13).

2.4: Health in District Pakpattan

2.4.1: Infant Mortality Rate (IMR)

Infant Mortality Rate in District Pakpattan is disturbingly high (see figure 2.9). According to the latest Multi Indicator Cluster Survey (MICS), published in 2011, the district had an infant mortality rate of 130, which is the highest in Punjab. Neither the divisional nor provincial average is a match for it.³⁴ Administratively, Pakpattan falls under Sahiwal Division and shares this status with Okara. The infant mortality rate for the entire division is 109, which is 21 points below the district average. In fact, it is the IMR for Pakpattan District that leads to a rather high divisional average; otherwise, the other two districts in the division, namely Sahiwal and Okara, have infant mortality rates of 93 and 108 respectively. The situation looks more startling when compared to the provincial average of 82 – a huge difference of 48.

There are indicators for the district that are even more discouraging. The Under-five Mortality Rate goes through the roof and touches a staggering figure of 173. Again, this is the highest in the province and vastly contributes towards soaring the divisional average of 143 as the other two districts – Sahiwal and Okara – have under-five mortality rates of 119 and 141 respectively.³⁵ The figure for the same indicator at the provincial level is 104.



2.4.2: Maternal Mortality Rate (MMR)

Recent data on MMR at the district level that take note of demographic changes caused by a boom in the population over the years, are not available. However, data on some of the other reproductive health indicators can be found and help us draw a picture of the state of maternal health. 20.9% mothers in Pakpattan are reported to have not received any antenatal care visit. Moreover, 17.7% of pregnant women had not had blood pressure measured, or urine specimen, blood test, and weight taken. The provincial average for the same is 31.9%. Place of delivery for 53.5% of women in the district was home, which is the highest in the division. Even postnatal care does not seem to be receiving adequate attention and mothers are largely left to resort to semi-skilled or traditional care providers. Only 29.1% of women in Pakpattan saw a doctor after giving birth to a child. It is a figure that comes close to the provincial average of 29.9% for the same category. Finally, 35.1% of women in the district turned to traditional attendants and, shockingly, 13.9% received no care at all.³⁶

³⁴ "MICS Punjab 2011," Bureau of Statistics Punjab, Government of Punjab. Available at: <http://www.bos.gop.pk/publicationreports?q=provincialreport>

³⁵ Ibid.

³⁶ Ibid.

2.4.3: Number of Hospitals/Healthcare Facilities

District Pakpattan's population is 1,563,000, which cannot be considered small. The number of existing health facilities, therefore, should be in line with this figure. However, this is certainly not the case (see table 2.1). There are 6 hospitals in all with a collective capacity of 290 beds. The number of dispensaries is 15 with 0 beds. 6 Rural Health Centers (RHCs) are currently serving the population with a total capacity of 120 beds. The proportion of Basic Health Units (BHUs) seems to be better with 70 BHUs comprising 152 beds in all delivering services. There is only 1 TB clinic in the district with no beds at all. There are 9 S.H and 3 Maternal and Child Health (M.C.H) centers, neither of which has a single bed.³⁷

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

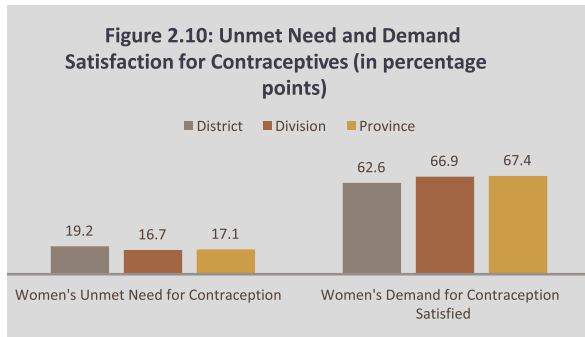
Type of Hospital	Total No.	No. of Beds
Hospital	6	290
Dispensaries	15	0
Rural Health Centers (RHCs)	6	120
Basic Health Unit (BHU)	79	152
TB Clinic	1	0
SH Centers	9	0
Maternal and Child Health Centers (M.C.H)	3	0

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), 19.2% of women aged 15-49 years had an unmet need for contraception (see figure 2.10). Only 62.6% of women had their demand for contraception satisfied. These figures are slightly below the provincial average. The provincial average for the unmet need for contraception is 17.1%, and for contraception demand satisfaction is 67.4%. Even the divisional averages are better than those for the district. They are, for the two categories at hand, 16.7% and 66.9% respectively. It should be borne in mind that according to the MICS Punjab 2007-08, the contraceptive prevalence rate in Pakpattan was 19%, one of the lowest in the province. The provincial average for the same, on the other hand, was 32%.

³⁷ "Punjab Development Statistics 2013," Bureau of Statistics, Government of the Punjab.



2.4.5: Missing Facilities in Hospitals

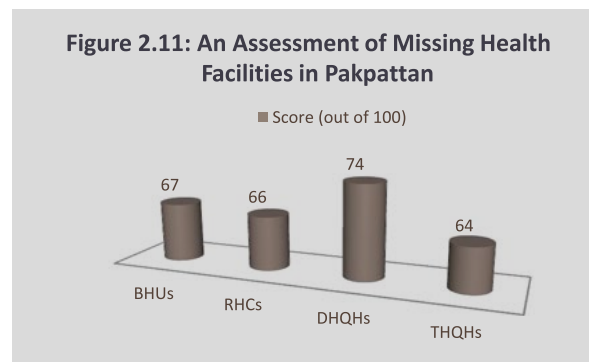
Missing facilities in hospitals is another problem that impinges on various other health indicators. Very surprisingly, despite having disturbingly high infant and under-five mortality rates, District Pakpattan turns out to be performing well against various indicators around missing facilities. According to the Punjab Health Facility Assessment 2012, Pakpattan ranks fairly high on the Health Facility Index (see figure 2.11).

The assessment shows that Basic Health Units (BHUs) in the district lack various considerable health facilities. It further reveals though that Pakpattan scored much better than many relatively affluent districts. It scored 67 out of 100 on average availability of inputs for Basic Health Units (BHUs). The assessment considered the components of infrastructure, human resources, equipment, drugs, and supplies and support services.

Being a largely rural district, its performance against the category of missing facilities in Rural Health Centers (RHCs) is above average and stands at 66. The curve goes up for the District Headquarter Hospitals (DHQs) as well and hits the figure of 74. However, the score for Tehsil

Headquarter Hospitals (THQs) slightly appears to buck the trend and drops to 64. A relatively high score for DHQs suggests that the district headquarter receives more attention in terms of resources and efforts than the peripheral areas in the district.

Overall, Pakpattan outperformed many districts in the province against the indicator at hand. However, it should not be forgotten that its a relative progress and aforementioned rates of 67, 66, 74, and 64 are still way off the mark and call for taking more steps to bridge this gap.



Chapter 3

Out-of-School Children and Out-of-Pocket Costs in District Pakpattan: What Qualitative Data Tell Us

3.1: Out-of-School Children in District Pakpattan

According to the Annual Status of Education Report 2013, 18.9% or 75,000 children in Pakpattan were out of school. Abandoned and left out by the system and society, out-of-school children are a ubiquitous sight in Pakpattan. Across the district, 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 18.9% does not reflect regional disparities as percentages for different places and regions in the district vary. In some places, the percentage of out of school children is around 20% to 25%, and in other areas, as high as 40%. There are settlements in the district that are remote, poorly connected, and characterised by rundown public infrastructure. The number of out of school children in such places tends to be higher.

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. There certainly are more girls out of school than boys. The plight of some of the socially excluded groups is even worse. It is estimated that the number of Pakhiwas, a nomadic community, in the district is about 20,000. There is no formal educational facility available to them and chances are slim that their children go to schools. Similarly, the shrine of Baba Farid in Pakpattan city has a small population of homeless children. There are 40 who are registered, and according to reports none goes to school. Thus, the problem of out-of-school children in Pakpattan is multi-faceted and has different manifestations. Understanding the problem 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. 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. While the community acknowledges the government's increased interest in education, it deems 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. High schools in particular are few and far between. This poses problems especially 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 in many places is almost non-existent. This certainly tends to have a bearing on the quality of education and affects retention rates.

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. Both the middle

schools in Chak 2EB, have scant access to clean drinking water. There are no women attendants in the girls' school, which creates a sense of discomfort among both teachers and students. Therefore, learning and attending schools in tough conditions become very challenging. This state of public educational facilities in Pakpattan has encouraged private schools to mushroom, making it even more difficult for the children from poor households to go to school. 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 Pakpattan, overwhelmingly, they are not functional and exist only on paper. Many community members have no idea that they are on the committee; they are approached only when their signatures are needed for transactions. No effort is made on the part of the school staff to update them on how the funds were 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. As a result, parents, particularly the poor ones, sometimes feel discouraged and think that investing in their children's education will not bear fruit. This problem of poor quality of teaching 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, in the past, 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. Teachers are also shown to be putting children through labour. Some time ago, a 5 year old student of a girls' primary school in Malik Pur was spotted watering a heap of bricks lying outside the school with a hose.

This fairly illustrates teachers' attitude towards students. 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 drive their children into labour. Child labour may take several exacting forms. In district Pakpattan, 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.

The community believes that the incidence of child labour has increased in Pakpattan over the past few years. They ascribe it to growing rural poverty. Pakpattan is largely a rural district, with agriculture being the mainstay of its economy. The ongoing power crisis, coupled with increase in electricity power tariff, has shocked the farmers and the rural economy. It has resulted in increased expenses and reduced profits. As a consequence,

those belonging to support professions such as labour and vending – and dependent upon agricultural productivity – have suffered too. Their incomes have fallen and financial insecurity increased. The labourers, tenants, and the landless see little point in sending their children to school. They instead want them to become wage earners. Going to school thus does not seem to be a viable option for many poor parents.

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 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. In fact, surprisingly, girls are increasingly involved in the agricultural activity and work as labourers in Pakpattan.

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. There are households where it is considered against tradition to send girls to school. Sometimes, girls' education is narrowly interpreted and associated with lower economic returns. 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 4, educational facilities for girls are insufficient and they struggle to receive education. 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. It has been reported that there is no middle school for girls in Chak 14SP and some of the girls from there go to the one in Chak 15SP, which is situated at a distance of about 10-12 kilometers. 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. Those parents who could not send their daughters to school on account of poverty were of the view that vocational training centers should be opened for girls to provide them with skills and learning opportunities.

3.1.5: Disability

Disability is a major barrier to attaining education for children with special needs. Currently, there are only two schools – Institutes for Slow Learners – for special children in District Pakpattan, situated in Pakpattan and Arifwala. Though these facilities are functional, their outreach is quite limited and they do not respond to the needs of people living in remote areas of the district. Even rural areas close to the tehsil and district headquarters cannot fully benefit from them owing to issues of access. The community believes that the state's response to disability is neither adequate nor of quality, and there exist serious service gaps. Respondents in Union Council Chak Shafi were of the opinion that there were quite a few people with disability across the UC, but no facility was available to them.

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.

Box 3.1: Disability as a Barrier

Waheed is about 18 years old and lives in a village of Union Council Chak Shafi. He is mentally challenged and partially physically handicapped. He never went to a school and received formal learning. His parents are quite poor and could not afford to send him to one of the facilities in the district. His life is now confined to his house and the streets around him.

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 Pakpattan is 65%. Even this percentage continues to drop over different levels and reaches a staggering 12% at the high school level. The primary completion rates are extremely low too. This problem appears to affect girls the most, for whom fewer high schools are available and the cost of access is quite high. It becomes quite apparent to girls at an early stage that perhaps there would be no education past grade 5 or 8. In the middle school for girls in Chak 2EB, there are only 4 girls in grade 8, although the total strength of the school is about 100.

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. The number of students from Chak 2EB who go to high school in Chak Shafi, which is situated at a distance of about 4-5 kilometers, is quite small, compared to the number of students who passed their middle from there. Most of them, particularly girls, quit their studies. The reason primarily is increased costs associated with going to high school. They would have to pay for the transport. 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 grade in the final exams or stand a fair chance to move up the grade ladder. The situation is far worse in other areas of the district. Social workers and community activists point towards the area lying along Sutlej River, and claim that for 72 villages, situated in that expanse of land, there are only 45 primary and 3 middle schools available. There is no high school for the population there.

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.

Box 3.2: Decreased Enrolment over the Grades

Amna, aged 18, lives in a village of Tehsil Arifwala. She was a very bright student and studied up to Grade 8. She had plans to continue her education and go to high school, but her financial position did not allow her to do so. It was the transport cost that she could not afford. The high school was situated at a distance of only 4-5 kilometers, but the transport would have cost her between Rs. 1,200-1,500 a month, an expense her family could not bear. But Amna is not the only disadvantaged person in her house. She has five sisters, none of whom went to a high school. Two of them were a little fortunate and attended middle school, one up to Grade 6 and the other Grade 8, but the remaining three did not go to school at all. Amna lives with them and carries out domestic chores. She grows pensive whenever the matter of her incomplete education is raised. She wishes she had the opportunity to receive some kind of vocational training to be able to make up for lost time.

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: 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.

3.1.8: 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 district education department is trying to reduce service gaps by setting up non-formal basic education schools. So far 170 non-formal schools have been set up in places where there are no schools or where the distances are great. This is a positive step and seeks to extend services to the left-out communities, but in a district with a population of 75,000 out-of-school children, its scope needs to be enhanced.

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.

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 Pakpattan, 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 to see a doctor in a public health facility, he or she asks them to come to their private clinic for treatment and check-up.

Not all villages and communities have easy access to these facilities. Some of the BHUs are sparsely situated and people have to travel a fair distance to be able to avail services over there. For example, one of the BHUs in Chak Shafi of Tehsil Arifwala is situated at a distance of about 25 kilometers from the farthest point in the UC. Patients are brought over by personal or public transport – the latter is exceedingly rare – which takes time and also tends to raise the cost of the services. Medicines are also not fully available in these BHUs and at times patients are asked to buy them from the nearby medical store. The BHU in Chak Shafi, a special facility, is open around the

clock and has at its disposal one Medical Officer (MO). But even there, the full-scale availability of medicines is a problem and the community complains that more often than not they have to buy them from the outside. The locals even said that most of the times they did not trust the medicines given to them by the BHU staff, for they were of low potency and hence ineffective.

Considering all this, whenever someone in peripheral areas suffers illness or ailment of mild or serious nature, they are taken to the public or private health facilities in the tehsil or district headquarter. The former at the tehsil level are not considered in a good shape and are bereft of various facilities. Shortage of doctors is another problem over there. Therefore, most of the people go for the latter. Once in Pakpattan City, the 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. 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. The ultrasound machine is inoperative, as is the machine for eye examination. The emergency department lacks facilities and is not known for its response services.

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 everyday are referred to hospitals in Sahiwal or Lahore. In fact, many in Pakpattan City prefer to go to Sahiwal in the first place. This tends to increase the costs for the patients and his or her family.

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 spend 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.

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. 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. 10,000 to 35,000 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. 1,000 to 5,000. And there is no guarantee that the traditional birth attendant would be skilled. Sometimes they barely have any prior experience. 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 LHVs, instead of doing cases in BHUs, run their private clinics and extract fees from local people. Moreover, even where there are LHVs, they are made to carry out additional responsibilities.

If one is socially resourceful and has connections in the health department, the THQs and the DHQ are also an option. Relatively well-off households in rural areas prefer to take women to gynecologists in the tehsil or district headquarters or Sahiwal. 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 Pakpattan to the district headquarter, the fare may range from Rs. 4,000 to Rs. 5,000. 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. IMR in the district, as we already know, is higher too. In fact, with a figure of 130 per 1000 live births, it is the highest in the province. Deaths related to delivery, therefore, are not an uncommon sight and maternal mortality, at times, is a concomitant of absolute poverty.

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 Pakpattan or Sahiwal. 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. 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 Sahiwal or Lahore 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 at least 20% to 40% of their expenditure. This

Box 3.3: Out-of-Pocket Costs for the Rural Poor

Waheed Ahmed, in his late-30s, is a small vendor in a village of Tehsil Arifwala. A few years ago, his mother was taken seriously ill. He first took her to the DHQ in Pakpattan where the doctor could not find out what actually ailed her and prescribed medicines, which did not make any difference. Waheed's mother's condition turned critical and she was eventually taken over to Jinnah Hospital in Lahore. Over there, she was diagnosed with breast cancer but it was already too late, as the tumour had spread all over. She died there after being an in-patient for a few days. The treatment there, or illusion thereof, cost her family Rs. 150,000

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 65% for Pakpattan 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.

Some of the remote areas in the district have significantly low enrolment and literacy rates and have yet to receive preferential treatment from the government. A number 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. Therefore, 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 Pakpattan 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. There are only two schools in the district for children with special needs that 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 considerable 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 Pakpattan, 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 Pakpattan'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.

BHUs can play an instrumental role in providing reproductive health facilities to the community. Therefore, it should be ensured that if there is the provision of delivery facility in the BHUs, it is being properly used and functional in responding to the cases. Increased ownership on the part of the government can 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)
 - Issuing 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

FGD 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.



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