



## District Swabi Human Development Report





# **District Swabi**

## **Human Development Report**

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

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## Acronyms

BHU	Basic Health Unit	NCHD	National Commission for Human Development
CPR	Contraceptive Prevalence Rate		
CDS	Comprehensive Development Strategy	NER	Net Enrolment Rate
DFID	Department for International Development	PPHI	People's Primary Healthcare Initiative
DHQH	District Headquarter Hospital	PSLM	Pakistan Social and Living Standards Measurement
EFA	Education for All	PTC	Parents Teachers Council
FGD	Focus Group Discussion	RHC	Rural Health Center
GDP	Gross Domestic Product	SAP	Structural Adjustment Programs
HDR	Human Development Report	SDGs	Sustainable Development Goals
IMR	Infant Mortality Rate	SPO	Strengthening Participatory Organisation
IDS	Integrated Development Strategy	THQH	Tehsil Headquarter Hospital
KPK	Khyber Pakhtunkhwa	UC	Union Council
LHV	Lady Health Visitor	WHO	World Health Organisation
LHW	Lady Health Worker		
MCH	Maternal and Child Health		
MDGs	Millennium Development Goals		
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 Swabi. 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 Swabi, though relatively better, is not very satisfactory. Enrolment, literacy, and school completion rates are low. Pupil-teacher ratio is high and many primary schools in rural areas lack basic facilities. Correspondingly, the number of out-of-school children in the district is not negligible. According to an estimate, 9.2% 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 Swabi, 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. 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 25% and 50% of household expenditure. The percentage for the poorest of the poor is much greater and adds to their vulnerabilities. Out-of-pocket costs are high due to a greater reliance on private health facilities. These facilities and services – including tests, treatment, medicines, and consultation fees – are largely unregulated and have considerably high values attached to them. Dramatically reducing out-of-pocket costs calls for developing a new policy regime,

prioritising universal healthcare, and allocation of resources for the health sector. Resources should be generated and directed towards creating and strengthening health facilities at the grassroots, tehsil, and district levels to provide a range of services and reduce the frequency of referrals to other cities. Reproductive health related services should be easily available to the population across the district if the wellbeing of the community is to be ensured. Investments in public infrastructure will shorten the distances and address the issue of access. Moreover, the private health sector should be regulated transparently and through citizen health committees to end malpractices like monopolisation, commissioning, profiteering, and producing and selling spurious drugs. Addressing vulnerabilities in health will eventually require prioritising health as a sector and an area of intervention, and offering policy prescriptions that duly respond to the community's health needs.

# Chapter 1

## Putting Human Development and Human Development Reports into Perspective

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

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

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

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

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

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

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



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

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

## 1.2: Human Development Reports: An Overview

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

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

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

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

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

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

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

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

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

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

### 1.3: Key Indicators

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

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

## Education

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

## Health

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

### 1.4: Key Themes

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

here discuss issues, barriers, opportunities, and data constraints surrounding these themes.

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

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

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

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).

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

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

The out-of-school-children phenomenon has a strong gender dimension as well, 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

<sup>10</sup> "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>

in life. Any exception to this outcome can only be treated as an anomaly and does not, and should not, condone the structural deprivations caused by being out of school.<sup>11</sup>

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

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

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

Among a plethora of problems that countries in the developing world have to battle with, is

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

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

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

Global commitments on the provision of health services, at least theoretically, are quite clear. The World Health Assembly resolution 58.33 from 2005 states that “everyone should be able to access health services and not be subject to financial hardship in doing so.”<sup>15</sup> However,

no substantial progress so far has been made towards realising this ideal.

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

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

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

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

constituted only 2.7% of the GDP.<sup>16</sup> A staggering 63.1% of total expenditure on health consisted of private expenditure.

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.

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

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<sup>16</sup> GHQ Data.

## Chapter 2

### Human Development in Swabi: What Key Indicators Tell Us

#### 2.1: Human Development in Khyber Pakhtunkhwa: A cursory Glance

Khyber Pakhtunkhwa (KPK) has received various setbacks in quick succession over the past few decades. It not only hosted a large population of Afghan refugees throughout the 1980s and 1990s but also suffered serious human and economic losses in the wake 9/11. In 2009, the province had to relocate and encamp 3.5 million internally displaced people from Malakand Division at the time of a military operation there. Many parts of the province were among the worst affected when the floods hit in 2010. Militancy in and around KPK intensified around that time, diverting the attention of the provincial government towards security. Recent military operations in North Waziristan have led to a mass exodus of local population out of the agency and into Bannu, a settled district of the province. All these factors come together to impinge on the efficiency of social service delivery and the state of human development in the province. It also makes it exceedingly difficult for the government and development agencies to redirect their focus towards collecting fresh and reliable data to analyse the situation and evolve policy responses. Data gathered through different sources are either too old or contradictory. Multiple Indicator Cluster Survey (MICS) 2007-08 is the last broad-scale province-sponsored effort undertaken to gather data on a range of important social

indicators.<sup>17</sup> We do have the Pakistan Social and Living Standards Measurement (PSLM) survey available to us but it is more helpful for education rather than for health indicators. However, an attempt has been made to put the latest datasets to optimum use.

KPK is the third most populated province in the country, and was estimated in 2010 to have a population of 24.7 million.<sup>18</sup> Development efforts in the province received a boost after the introduction of the MDGs. The provincial government devised a Comprehensive Development Strategy (CDS) to outline its development priorities between 2010 and 2017.<sup>19</sup> This strategy aligns itself with the key MDGs and seeks to make progress towards them. In 2014, it was subsumed in the Integrated Development Strategy (IDS)-2014-2018,<sup>20</sup> formulated by the new government. However, it is very clear by now that the province, despite some progress, is a long way off on the main targets. For example, its literacy rate is 52%, which is 5 percentage points less than a national average of 57%. Female literacy rate is 35%, whereas, the national average is 48% - a significant difference of 13 points. Though the overall literacy rate did go up from 50% in 2008-2009 to 52% in 2012-2013, it

17 "Multi Indicator Cluster Survey, 2008," NWFP.

18 "Millennium Development Goals: Report 2011," Khyber Pakhtunkhwa.

19 "Comprehensive Development Strategy 2010-2017," Khyber Pakhtunkhwa.

20 "Integrated Development Strategy 2014-2018," Khyber Pakhtunkhwa.



could not secure significant gains for education in the province. The primary Net Enrolment Rate (NER) of 54% is also not very encouraging and three percentage points below the national average. However, it was 51% in 2010-2011.<sup>21</sup> The incidence of poverty is also quite high in the province and suggests that the situation is very daunting. Where in 2005-2006, 29% of the population lived below the poverty line, this figure as reported in the CDS document in 2010, spiked to 39%.

The Infant Mortality Rate (IMR) in KPK, according to the MICS 2007-08 survey, is 76 per 1000 live births, which is considerably high and falls behind MDG 4. Under-five mortality rate of 76 per 1000 live births in 2006-07 went up to a startling 100 per 1000 live births in 2007-08. Immunisation coverage in KPK appeared to be making strides up until 2011 but suffered a severe jolt after the Abbottabad incident. According to an estimate in 2011, 73% of children in the province aged between 12 and 23 months had been fully immunised. Contraceptive Prevalence Rate (CPR) again is an abysmal 38.6%. Similarly, though recent data on maternal mortality is not available, according to one estimate it was 275 per 100,000 live births in 2006.<sup>22</sup>

## 2.2: District Swabi

### *Geography, Location and History*

Swabi is situated in Khyber Pakhtunkhwa and surrounded by Buner District to the north,

Haripur District to the east, Attock District of the Punjab to the south, and Nowshera and Mardan Districts to the West. The district lies between the Indus and Kabul Rivers. Its distance from the provincial capital Peshawar is about 100 km. The total area of the district is 1,543 sq km. According to the 1998 census of Pakistan, the district had a population of 1,026,804, which, according to an estimate, had risen to 1,654,000 in 2014. Swabi consists of four tehsils, namely Swabi, Lahor, Topi, and Razzar. Swabi city is the district headquarter.<sup>23</sup>

Swabi is a relatively new administrative district, having been declared one in 1988. In the past, it remained a part of Peshawar and Mardan districts. Pashto is the main language spoken in the district; however, Hindko is also spoken in some villages. Agriculture thrives in the district and wheat, barley, oilseed, maize, rice, and sugarcane are among its major crops.

## 2.3: Education in District Swabi

Education indicators for Swabi 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 50%, i.e. two percentage points less than the provincial average. Stark differences can be observed between female and male literacy rates, which are 34% and 68%, respectively.<sup>24</sup> The situation in rural and urban areas, however, is almost even and represented by literacy rates of 50% and 51% respectively. This phenomenon is rarely seen in districts with a similar level of

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

22 "Millennium Development Goals Report 2011."

23 "District Profile: Swabi," Government of Khyber Pakhtunkhwa, Finance and Planning Department.

24 PSLM 2012/13.



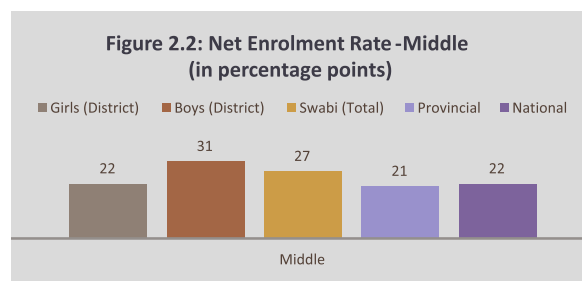
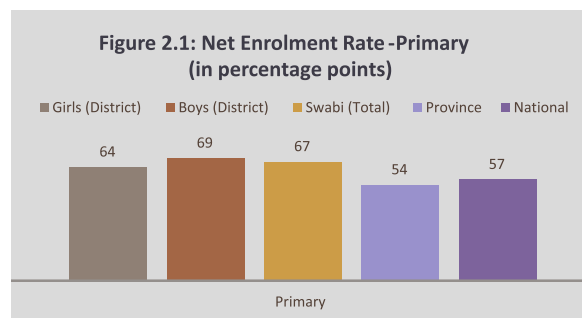
human development. Similarly, where Swabi comes across as battling against education indicators in an absolute sense, its performance in the province, on the other hand, is relatively much better. According to the Pakistan District Education Rankings issued by Alif Ailaan in 2014, Swabi is ranked 7th out of 25 districts in KPK. This means that many districts in the province have far worse rates and ratios in education. Its national ranking is 54 out of 146 districts nationwide. This brings about a modest score of 65.68 for the district.<sup>25</sup>

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

District Swabi has an enrolment rate of 67%, which is above both the national and provincial averages of 57% and 54%, respectively. Even in NER there do not exist sharp gender gaps at the primary level. The enrolment rate for primary school age girls is 64%, while for boys it is 69%.<sup>26</sup> Though the urban and rural divide is not too stark, figures are tilted in favour of the latter. Primary enrolment rates of 70% and 66% for urban and rural areas respectively point towards service gaps across different regions in the district (see figure 2.1).

Enrolment rates for the district suffer a steep drop at the middle level and come down to 27% (see figure 2.2). Even though this figure is above the national and provincial averages of 22% and 21%, it is not an encouraging one in an absolute

sense. The enrolment rate for girls at this level is 22% and for boys 31%. Rural and urban gap – very surprisingly – puts urban areas at a disadvantage with an enrolment rate of 18%, whereas that of rural areas is 29%. It would be instructive to further explore this gap and look into supply and demand factors.



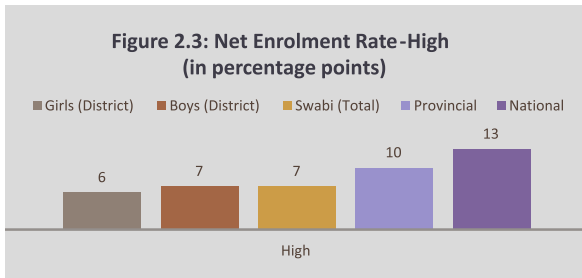
At the high school level, the enrolment rate plummets to a shocking 7%, with serious repercussions for a range of human development indicators, particularly those around income and economic wellbeing. This is below both the national and provincial averages of 13% and 10% (see figure 2.3). It undergoes a precipitous decline for both girls (at 6%) and boys (at 7%). It would be an imperative to investigate this sharp decline at the high school level for it appears to betray trends at the primary school level.<sup>27</sup> Both rural and urban localities, at this level, turn out to

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

26 PSLM 2012/13.

27 Ibid.

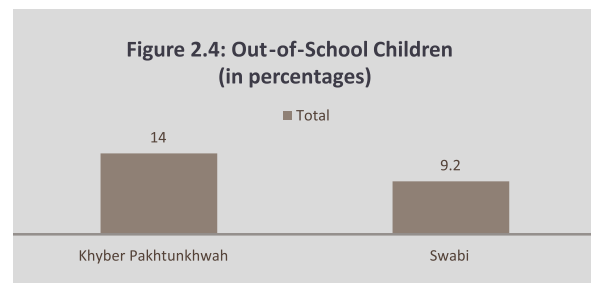
perform poorly and have enrolment rates of 7% and 6% respectively.



High dropout rates across different grades and levels do not augur well for the literacy rate in the district. Therefore, the percentage of those who have completed primary level or higher is not very high and stands at 43%. This is one percentage point less than the provincial average. Though up until now we did not see staggering differences between girls and boys in enrolment rates across different levels, the differentials in this category are huge. As of 2012-13, only 29% of females in the district had completed primary or a higher level.<sup>28</sup> The percentage of their male counterparts in the same category was 58%. This suggests that even though both boys and girls face almost similar barriers in accessing education, it is increasingly difficult for the latter to continue their education once enrolled. Finally, according to statistics released by the Annual Status of Education Report 2013, 9.2% children in Swabi were out of school.<sup>29</sup> This figure is much lower than the provincial average of 14% and once again testifies to the district's relatively better performance in terms of enrolment (see figure 2.4). A detailed discussion on out-of-school children in Swabi features later in this report.

<sup>28</sup> Ibid.

<sup>29</sup> "Annual Status of Education Report 2014," ITA.



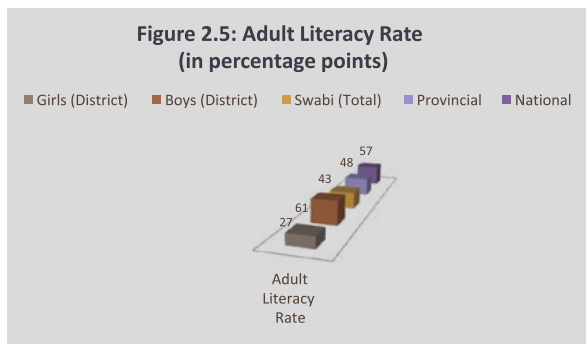
### 2.3.2: Adult Literacy Rate

The importance of adult literacy and life-long learning cannot be overstated. Adults with skills and knowledge enjoy enhanced sets of capabilities and functionings. They are less likely to experience unemployment and are more financially productive.<sup>30</sup> District Swabi, however, does not have a favourable adult literacy rate. There are only 43% of adults in the district who can be considered literate (see figure 2.5). This rate falls behind both the national and provincial adult literacy rates of 57% and 48% respectively. The scale of gender inequality in this category is no less shocking. There are only 27% of literate adult females compared to 61% males.<sup>31</sup> Such an abysmally low literacy rate for females is likely to have a serious bearing on multiple human development indicators. Unlike many other districts in the province and indeed country, we do not find a glaring urban and rural gap in adult literacy in Swabi. The adult literacy rate for rural areas is 42% and for urban areas it is 46%. Moreover, 27% adult females and 60% adult males in rural areas are considered literate,

<sup>30</sup> "Adult Literacy: A Brief to the Select Standing Committee on Education," *British Columbia Teacher's Federation* (2006). Available at: <https://bctf.ca/uploadedFiles/Public/Publications/Briefs/AdultLiteracyBrief.pdf>

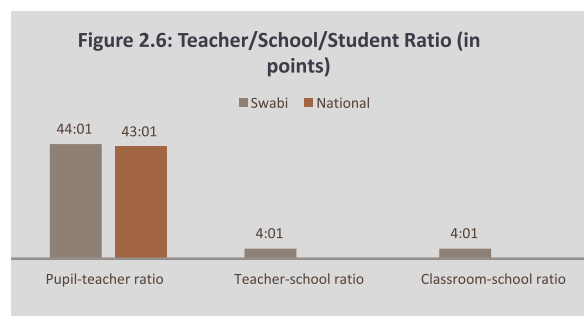
<sup>31</sup> PSLM 2012/13.

compared to 29% adult females and 63% adult males in urban areas.



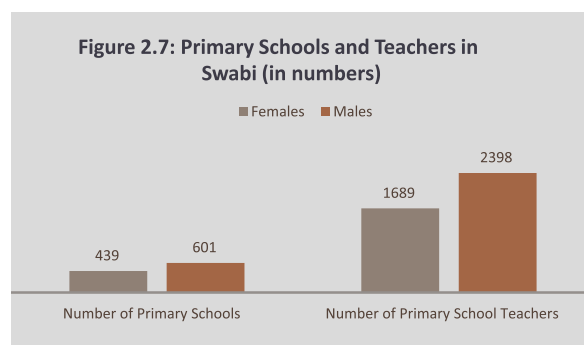
### 2.3.3: Teacher and Student Ratio

Primary education is considered crucial to laying the foundation for knowledge acquisition and skills enhancement at a later stage. Therefore, teacher-student interaction at this level has to be meaningful and of high quality. In places where pupil-teacher ratio is high, quality in education cannot be ensured. Data reveal that in Swabi pupil-teacher ratio is 44:1, which certainly cannot be considered low (see figure 2.6).<sup>32</sup> It is even one point higher than the national average of 43:1.<sup>33</sup> Teacher-school ratio in Swabi, on the other hand, is 4:1, which is slightly better in relative terms. This implies that primary schools though not so well resourced are nearly not as understaffed as many other districts. The classroom school ratio is 4:1, which suggests that availability of classrooms across different grades is certainly an issue requiring immediate attention.



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

Keeping up with trends in education in general, the number of primary schools for boys outweighs those for girls in Swabi. There are only 439 primary schools for girls while there are 601 such schools for boys – a noticeable difference of 162 schools. Similarly, differentials are also observable in the number of female and male teachers. According to the latest figures available, there are 1,689 female primary school teachers in the district, compared to 2,398 male teachers.<sup>34</sup>



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

Availability of requisite infrastructure and facilities goes a long way in delivering on the promise of universal primary education. Schools and other educational buildings have been shown

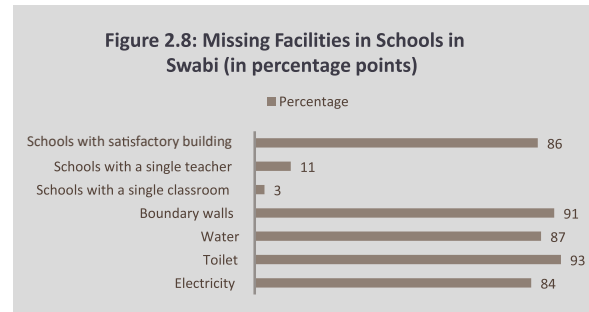
<sup>32</sup> "Pakistan District Education Rankings 2014"

<sup>33</sup> "Pupil-teacher ratio, primary," *Catalogue source: World Development Indicators, UNESCO Institute for Statistics.*

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

to play an important role in parents' decisions regarding sending their children to school.<sup>35</sup> This factor becomes even more crucial in the case of girls, for parents are certainly reluctant to send their daughters to school with missing facilities.<sup>36</sup> Provision of drinking water is ensured in about 87% of the schools, though the quality of water is not known (see figure 2.8). Similarly, this percentage also suggests that at least 13% of schools in the district have no access to a facility as basic and important as water. 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. The fact that Swabi is a district in militancy and terrorism-affected KPK, having a secured premises assumes more importance. Subsequently, 91% of schools in Swabi have a boundary wall and do not operate out in the open.

The number of schools with a single classroom is very low in the district, as only 3% schools are considered to be falling under this category. However, the percentage of schools with only one teacher is relatively high at 11%. Surely, this does affect a considerable swathe of the population and calls for urgent action. Overall, the proportion of schools where building condition is deemed satisfactory is 86%.<sup>37</sup>



## 2.4: Health in District Swabi

### 2.4.1: Infant Mortality Rate (IMR)

Recent and reliable district-level data on child mortality (whether IMR or under-five mortality rate) is not available in Khyber Pakhtunkhwa. Neither the last MICS report nor PSLM datasets report on this indicator at this level. However, certain inferences can be drawn and analysis built from current and previous provincial averages. MICS-KPK 2008 reveals that the Infant Mortality Rate (IMR) in the province was 76 per 1000 live births.<sup>38</sup> A gender comparison suggests that females have had higher mortality rate of 79 compared to 73 per 1000 live births for males (see figure 2.9). Rural-urban differences in child mortality also come to the fore. The figure for urban areas was 62, compared to 78 for rural areas. The province does not seem to have made significant progress in child mortality as in 2001 IMR stood at 79.<sup>39</sup>

The under-five mortality rate is even higher in the province and represented by the figure of 100 per 1000 live births. Gender-related mortality differences again emerge, and indeed

<sup>35</sup> "Fixing the Broken Promise of Education for All"

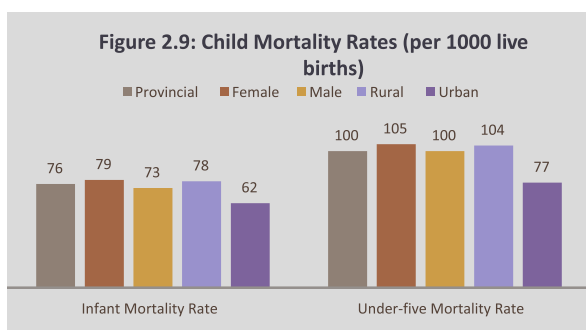
<sup>36</sup> "25 Million Broken Promises"

<sup>37</sup> "NEMIS (2012-13)"

<sup>38</sup> MICS-KPK (2008)

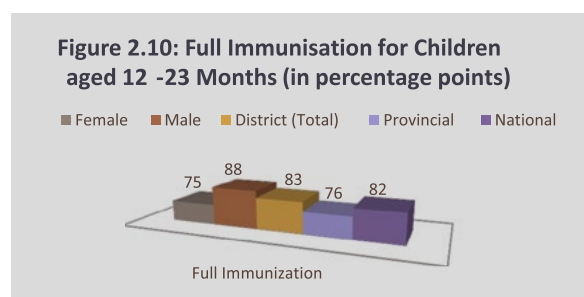
<sup>39</sup> MICS-NWFP (2001)

become starker. The mortality rate for males in this category is 95, compared to 105 for females. Rural-urban differences also persist. The under-five mortality rates for rural and urban areas are 104 and 77, respectively. This disconnect can partly be attributable to the fact that 17% of the population of the province is not covered by Lady Health Workers (LHWs), and a bulk of that population lives in rural areas.<sup>40</sup>



Child mortality is intimately linked to a range of services provided to make the overall conditions safe for children. Immunisation is an invaluable step in order to reduce child mortality and ensure the safety of children. Fortunately, district-level data on full immunisation in KPK is available. However, it is not very recent and does not take cognizance of the incalculable damage done to immunisation campaigns in recent years by militants. Still, through what is available we can gauge the scale of immunisation and what it might suggest for child mortality or lack thereof in the district. According to data released through the PSLM 2012-13, the percentage of children aged 12-23 months that have been fully immunised was 83% (see figure 2.10). This is

lower than both provincial and national averages of 76% and 82% respectively. Gender differences, however, cannot be overlooked, as the average for females is 75%, compared to 89% for males. Similarly, rural-urban gap is also manifest. In rural areas, the immunisation rate is 80%, whereas in urban areas this is 96%, a plain difference of 16 percentage points.<sup>41</sup>



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

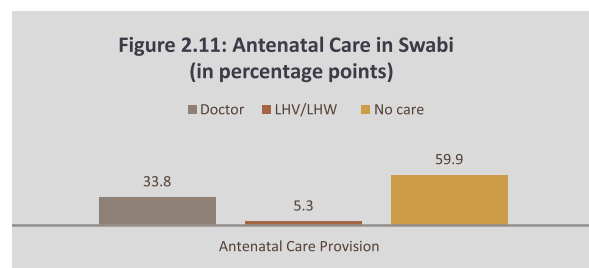
Maternal Mortality Rate (MMR) is an indicator for which data is hard to find. No data on district averages for KPK is available. Even though the provincial average is known, it is not very recent and is subject to doubts considering the indirect nature of data collection techniques for this indicator. The last available provincial average for MMR comes from MICS 2006-07.<sup>42</sup> Figures indicate that the mortality rate at the time was 275 per 100,000 live births. There are other indicators, however, crucial to understanding MMR in the absence of direct data. Reproductive health indicators can be assessed to speculate on the state of maternal health or lack thereof. In this regard, three measures, namely antenatal and postnatal care provision and during-delivery

40 "Khyber Pakhtunkhwa Millennium Development Goals 2011."

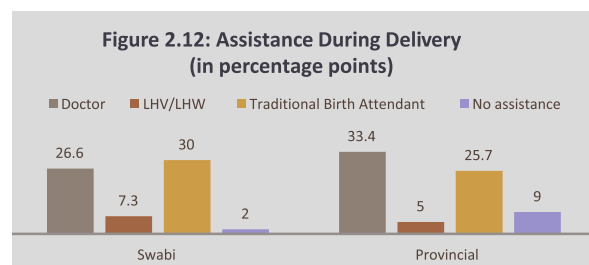
41 "PSLM 2012/13"

42 MICS-KPK 2006-07

assistance, are of considerable importance. In District Swabi, 33.8% of married women aged 15-49 saw a doctor for antenatal care, 5.3% of women turned to LHVs or LHWs, while a significant 59.9% were reported to have had no antenatal care.

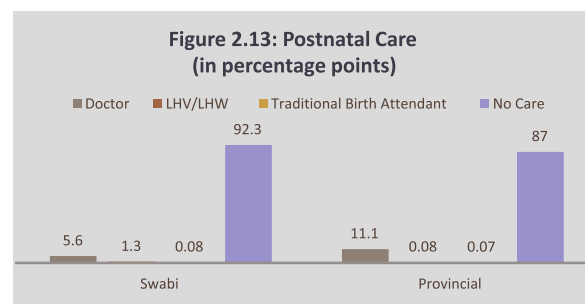


Figures around during-delivery assistance also point at serious service gaps (see figure 2.12). Only 26.6% of women received assistance from a doctor during delivery, 7.3% of women were helped by an LHV or LHW, 30% were reported to have hired the services of a traditional birth attendant, while 2% received no assistance whatsoever. The provincial averages, on the other hand, for the same are 33.4%, 5%, 25.7%, and 9% respectively.<sup>43</sup>



Figures for postnatal care are even more disturbing (see figure 2.13). Only 5.6% of women in Swabi said they received some kind of postnatal care from a doctor. Only 1.3% approached or were approached by an LHV or LHW. An incredibly

low 0.08% turned to a traditional birth attendant while 92.3% received no postnatal care at all. Provincial averages for the same were 11.1%, 0.08%, 0.07%, and 87% respectively.<sup>44</sup>



### 2.4.3: Number of Hospitals/Healthcare Facilities

District Swabi has a population of 1,654,000, which certainly cannot be considered small. This calls for a corresponding presence of health facilities. However, when we cast a glance at the number of facilities available in the district, it appears to be disproportionately small. There are only 4 hospitals in the entire district. The number of dispensaries is 13, while 4 Rural Health Centers (RHCs) are currently serving the community in rural areas and 40 Basic Health Units (BHUs) operate across the district. There are only 2 TB and 1 leprosy clinics available. The number of Maternal and Child Health (M.C.H) centers is 3.<sup>45</sup>

43 MICS-KPK 2008

44 Ibid.

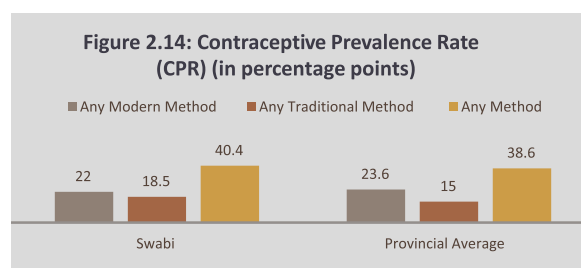
45 Department of Health. Government of Khyber Pakhtunkhwa. See <http://www.healthkp.gov.pk/>.

**Table 2.1: Number of Hospitals/Healthcare Facilities**

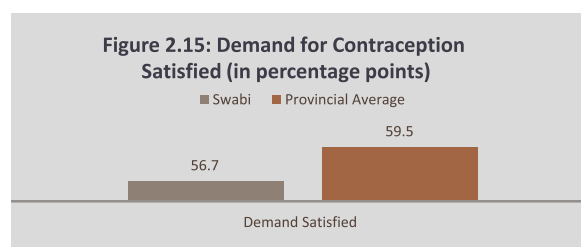
Type of Hospital	Total No.
Hospital	4
Dispensaries	13
Rural Health Centers (RHCs)	4
Basic Health Unit (BHU)	40
TB Clinic	2
Leprosy Clinic	1
Maternal and Child Health Centers (M.C.H)	3

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

Gaining access to data on contraceptive prevalence rate (CPR) is fraught with challenges. Most of the figures available are very old and do not reflect the current situation. MICS 2008 is the only document with figures on this indicator. Even subsequent provincial development and MDG reports rely on this source. In District Swabi, the number of women using contraceptives or showing inclination towards using them is quite low (see figure 2.14). Only 22% of women appear to be using any modern method. The number for any traditional method is 18.5%. Overall, 40.4% of women use at least some kind of contraceptive method. The provincial averages for the same are 23.6%, 15%, and 38.6% respectively. This means more or less Swabi can be placed slightly above the province average.



Percentage of demand for contraception satisfied is 56.7 (see figure 2.15). This can be contrasted with the provincial average of 59.5% - considerably higher than that for Swabi.



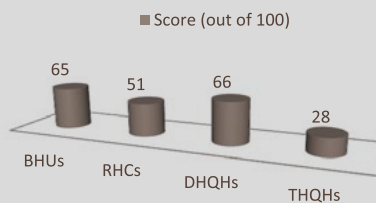
#### 2.4.5: Missing Facilities in Hospitals

Missing facilities in hospitals is another problem which impinges on various other health indicators. District Swabi, unfortunately, does not seem to be faring well in this area either. According to the KPK Health Facility Assessment 2012, the district struggles to maintain a competitive position on the Health Facility Index (see figure 2.16). In fact, some of the scores are very discouraging. The assessment shows that the Basic Health Units (BHUs) in the district are considerably lacking in various health facilities. Swabi scored 65 on a scale of 1 to 100 for average availability of inputs for BHUs. The assessment considered the components of infrastructure, human resources, equipment, drugs and supplies, and support services.

The district's performance against the category of missing facilities in Rural Health Centers (RHCs) drops to 51. The score goes up for the District Headquarter Hospitals (DHQs) and reaches 66. However, massive differences appear between the DHQs and the Tehsil Headquarter Hospitals (THQs). In the case of the latter, the score plummets to 28. This is a colossal difference and speaks volume about the situation regarding missing facilities in hospitals at the tehsil level. A 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.

Swabi's score for a range of health facilities are disparate and imply both improvement and neglect. Tehsil hospitals definitely need more resources and attention from the health department. Due to a large number of missing facilities at the tehsil level, one can see the potential to translate these into deterioration in various social indicators, particularly those pertaining to health.

**Figure 2.16: An Assessment of Missing Health Facilities in Swabi**





## Chapter 3

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

#### 3.1: Out-of-School Children in District Swabi

According to the Annual Status of Education Report 2013, 9.2% children in Swabi were out of school. This figure may seem small, compared to percentages from other districts in the province, but it actually means thousands of children out there, abandoned and left out by the system and society. 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 community, however, contests the figure mentioned above and contends that the actual number of out-of-school children is much bigger. For example, Haryan is a village situated in UC Anbar, which is about 25 km away from Swabi city. One expects the number of out-of-school children in a settlement close to the district headquarter would be considerably lower. However, according to estimates made by locals, there are at least 30% of children out of school.

The problem of out-of-school children affects various differently and has varied manifestations. The poor in the district seem to be worst hit segment of society. 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 face acute structural and service deprivation. There are more girls out of school than boys. Understanding the problem of out-of-school children necessitates looking into a host of issues that characterise it.

#### 3.1.1: Public Educational Facilities

Schools as a site of learning play a big role in attracting students. Our interviews and discussions with the community revealed that many a government school in the district had only two rooms and on average of two to three teachers. Some schools do not even have subject specialists and those subjects are taught by teachers trained in other disciplines. This places serious constraints upon service delivery.

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. For instance, there are quite a few schools in the hilly areas where electricity is not available. Learning and attending schools in harsh conditions become very challenging. Though the incumbent government has adopted a 'six rooms, six teachers' school policy, its implementation is yet to take place. These conditions have encouraged

private schools in Swabi to mushroom, making it even more difficult for the children from poor households to go to school. Even the children of most duty-bearers go to these private schools.

### *3.1.2: Quality of Teaching*

Quality of teaching is another area that reduces the prospects of getting children into school. It is a common perception that teachers generally lack basic skills required to impart and foster learning and transfer knowledge. Their skills and competencies are either undeveloped or not harnessed to a point where they can effectively help young learners acquire basic literacy skills. This problem is more acute in rural areas, in both public and private schools. Even the education department understands that senior teachers in particular lack skills central to teaching new curricula.

Another factor that both the community and duty-bearers thought kept children out of school is the behaviour of teachers. Though corporal punishment is officially prohibited, it is still practiced in quite a few schools in the district and serves to damage children psychologically. A sizeable number of parents interviewed were of the opinion that in public schools in particular the attitude of teachers was such that it discouraged learning and turned school into a place where a child dreads going. The effects of this could be serious. Making children run errands for their teachers or clean the school premises and different equipment and facilities therein, 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 child labour. Local estimates suggest that at least 35% of dropouts in the district are because of child labour. Child labour may take several exacting forms. In district Swabi, children of school going age involved in child labour may be expected to work as brick kiln workers or participate in tobacco or field cultivation. In urban areas, they can be found working at food outlets or auto workshops – workplaces with low entitlements and taxing conditions.

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.

### *3.1.4: Gender Discrimination*

Girls' education faces numerous challenges in the district and the rest of the country. Certain

cultural attitudes stigmatise female education and seek to alienate them from the mainstream. Early marriages, mostly in the rural areas, are encouraged and the prospects of a decent education are doomed forever. Girls' access to schools is also a serious issue in rural areas and limits their prospects 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. Creating opportunities for them requires setting up new schools and investing in infrastructure. In

the meantime, they can be encouraged to attend the nearest school for boys. Even some of the education officials believe that by making such an arrangement we can ensure that no cohort misses going to school.

### 3.1.5: Disability

Disability is a major barrier to attaining education for children with special needs. Currently, there is only one school in Swabi for children affected by blindness, which can accommodate only up to 25 children. However, even the present strength is far less than the actual capacity of the facility. Since blindness requires providing easy access to such educational facilities, there is a vehicle available for children. However, ironically, it does not function, for there has been no driver inducted so far. There is no school for the deaf and mute in the district and children suffering from hearing loss or impairment have nowhere to go.

In villages and distant vicinities on the outskirts of Swabi city, there is hardly any avenue for the education of children with special needs. For instance, it is estimated that there are about 360 disabled children in UC Anbar alone, but there is no formal or informal facility available to cater to their learning needs. In most of the areas, there are no estimates available for the disabled, which complicates the situation even more.

#### Box 3.1: Gender Discrimination in Education

How stifling the social environment can be for girls can be gauged from the story of Ayesha Bibi. Ayesha Bibi is aged 20 and lives in a village east of Swabi. She has three sisters and three brothers, one of whom is physically handicapped. Ayesha was a bright student and worked hard to earn a matriculation. She wanted to go to college to realize her true potential but was denied this and not allowed to continue her education. The reasons were poverty and disabling cultural attitudes towards female education. Kin and village folk taunted her and her parents about further studies and derided the very act of going to an educational institution. Her other sisters are unfortunate too, for they too could not complete their education. Ayesha Bibi has now confined herself to her house and has resolved to not think of pursuing further studies.

### 3.1.6: Dwindling Enrolment Rates over Different Levels

Primary enrolment rates for the district are not too low. We saw in the last chapter that the NER for Swabi is 67%. However, this percentage drops to a staggering 7% at the high school level. Most of the children actually drop out between the ages of 8 and 12.

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, it is the high schools that are few and far between, thus making it practically difficult for children to continue their studies beyond primary or middle levels. According to one education official, there are places in Gadoon and Topi in the district where there are no middle or high schools over 10 kilometers. This problem affects poor households the most. It not only increases costs but also makes the lure of child labour more attractive. Then among the poor – rural poor to be more specific – it is female children that are hit worst by it. Travelling to high school on a daily basis, which sometimes is as far as 5 to 7 kilometres, is an unthinkable proposition for parents of a considerable bulk of girls of school going age. It raises transport costs and brings girls out into the public.

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 such women do not feel encouraged to interact with male teachers. Thus, if the male child of a single parent is lacking interest in studies or facing some kind of difficulty continuing with his studies, the mother will have problems keeping track of his progress.

### 3.1.7: Policy Obstacles

Changes in the provincial educational policy in quick succession have further harmed the attainment of education. This is most palpable in the field of curricula. Successive governments changed the medium of instruction from Pashto to Urdu and then from Urdu to English over a few years. This made it increasingly difficult for children to switch to a new language and for teachers to develop competencies commensurate with the new policy.

During our interaction with the community, it frequently became apparent that many students, particularly the rural poor, dropped out because of the non-availability of textbooks. As per to government policy, all children in schools are provided with books for free, but once a student has lost a book or it is damaged, it is difficult to buy a new one, for they are hardly available on the market. This discourages some parents from sending their children to school to receive education without books. A 'book retrieval' policy does exist on paper but is not practiced at all. As per this policy, students being promoted to the next class return their books from the previous grade to the school staff. They then share those

books with students who have lost theirs or are in need of new ones. Implementing this policy also becomes harder in the face of change in curricula over a short period of time.

### *3.1.8: Political Interference*

Education governance in the past was characterised by political interference and arbitrariness to a great extent. Sanctioning schools, recruiting staff, and buying equipment saw a lot of political meddling and were used to gain political mileage. Where to build a school and where not to build a school was decided by political considerations and not practical concerns. Therefore, there are places in the district where the nearest settlement is several kilometres away from the school. For example, Qadra is a place where there are five schools clustered together with no settlement around at a short distance.

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

### *3.1.9: Security Concerns*

Though Swabi is not a district directly affected by militancy engulfing some parts of the province,

the uncertain security situation appears to be making its presence felt here as well. Children in the district go to school in an environment of fear and with a relative sense of insecurity. The Peshawar incident has not only made children more vulnerable, but has also disturbed them psychologically. Moreover, some of the measures taken in the wake of the incident have had negative effects on children and have made the environment more securitised. For example, the policy of allowing teachers to carry weapons to school turns out to be exerting a bad influence on students. We were informed by parents that their children now seemed fascinated with the idea of owning and carrying weapons and wanted to emulate their teachers. This trend certainly threatens to undo the gains students may have made over the grades.

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

The KPK government recently launched a campaign at the district level to increase enrolment. It is entitled ‘*Ghar Aaya Ustad*,’ meaning ‘the teacher comes to your doorstep’. The campaign sought to achieve its objectives by raising community awareness about education by holding seminars and talks. It also involved going from door to door and urging parents to send their children to school. Whereas the government has been able to project numbers signaling the success of this campaign, the community overall remains skeptical about it. The people we met and interviewed across the district were of the view that in this campaign the emphasis was more on campaign advertisement and publicity

and delivering talks instead of doing something meaningful and substantive to actually mobilise the community and promote literacy.

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

Civil society organisations such as the Sungi Foundation and National Commission for Human Development (NCHD) have been doing their bit to promote education and increase enrolment, but operating freely and maintaining a strong presence is fraught with security risks for them. Aid workers are of the opinion that they are afraid of being targeted if they too proactively pursue a socially progressive agenda. However, mobilisation at the grassroots is still possible and can give a boost to enrolment. Such a campaign was run by the AAWAZ Village Forum in one of its villages. It even included a female volunteer. The campaign bore results and parents who initially seemed reluctant agreed to send their children to school.

Some education officials believe that 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.

People seemed sanguine about the upcoming elections and the degree of decentralisation they would bring. They were of the opinion that local representatives could better deliver social services as they knew the community better and were responsive to its needs. However, some feared a resurgence of petty politics, which they thought would be inimical to transparent and effective service delivery.

### 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 Swabi, the situation does not look promising. We have already assessed the current state of health facilities in Chapter 2, and the insights derived through qualitative methods seem 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 hardly arrive or only cast their presence once a week. The facility for the rest of the week remains at the mercy of the medical technician, dispenser or other staff.

Deliveries hardly take place in the BHUs and antenatal care visits are a rare sight. The availability of medicines is also an issue and

generally patients are asked to buy them from medical stores. Sometimes the dispenser himself runs these stores or their owners have some kind of arrangement with the BHU staff that ensures the latter their commission. There are only 5 BHUs in the district that provide services around the clock under the special program entitled People's Primary Healthcare Initiative (PPHI). Still, they are fairly limited in their outreach.

Considering all this, whenever someone suffers illness or ailment of mild or serious nature, they are taken to health facilities in the district headquarter. Over there, they have two choices: either go to the DHQ or a private facility. Overwhelmingly, they opt for the latter. The DHQ is functional but again not very effective and resourceful. Recently, efforts were made to improve the facility, but the results did not appear to be sustainable. There are fewer doctors available and consultation hours small. It is difficult getting hold of consultants past 1 pm. The community generally believes that doctors in the hospital care more about their private practice. Testing services are either occupied at all times, creating a backlog, or are non-existent or dysfunctional. Even X-rays are mostly performed outside the hospital. No CT scan facility is available in the entire district.

Though health officials claim that 60% of medicines are available in the hospital, the community believes otherwise. Patients and respondents interviewed for this research claimed that whatever is prescribed to them in the DHQ, they buy it from the medical stores outside. It is



because of these reasons that the hospital has a very high rate of referrals. A large number of patients every day are referred to hospitals in Nowshera or Peshawar. This tends to increase the costs for the patients and his or her family. The referrals are so frequent that even minor cases are sometimes treated elsewhere. According to one respondent, a particular diarrhea case brought to the DHQ was not treated there and the patient was taken over to Nowshera, where it cost him Rs. 5,000.

### *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. In the absence of formal safety-nets, this happens through informal social networks and local money-lending mechanisms. But not everyone manages to access even these. With abject poverty comes powerlessness, and those who are downright poor find it increasingly difficult to obtain loans. They are excluded from the mainstream and surrounded by the people who are nearly as destitute as they are. Even those who somehow end up borrowing money, spend the rest of their lives repaying the debt.



### Box 3.2: Out-of-Pocket Costs and the Poor

Rehmat Khan, aged 50, is a Class-4 employee in a public school for girls in a rural union council of Swabi. About 3 years ago, he fell off the roof and sustained a serious spinal cord injury. He was first taken to Swabi and then to a private clinic in Peshawar. There he underwent surgery and remained admitted for three months. His treatment continued for another two and a half years even after he was discharged from the hospital. Though now he is back on his feet, he has to walk with a cane. The entire treatment and recovery process cost him Rs. 800,000 (0.8 million), an amount he borrowed over time from different people in the village. He has two children and is now left to pay off the loan from his meager salary of Rs. 10,000 a month. He now finds himself with his back against the wall, and the going is indeed very tough for him.

Sometimes healthcare costs rise at the expense of other facets of individual wellbeing. 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 large. 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. Those who can afford to go to a gynecologist, look to spend between Rs. 15,000 to Rs. 50,000 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. 5,000 to Rs. 6,000. And there is no guarantee that the traditional birth attendant would be skilled. Sometimes they barely have any prior experience. One even hears of private delivery facilities in the district run by veterinary physicians. It has been reported that there are union councils where there are no LHV's, and women are left to resort to traditional reproductive health measures. Then there are places in the district where the LHV's, instead of doing cases in BHUs, run their private clinics and extract fees from local people. Moreover, even where there are LHV's, they are assigned additional responsibilities such as running the polio campaign and providing security to the female staff at polling stations before and during the local government elections.

Relatively well-off households in rural areas prefer to take women to gynecologists in the tehsil or district headquarters. But it raises the cost for them. If someone does not own a vehicle and the delivery case is complicated, requiring expert assistance, they have to rent a car or a van to take the woman to the city. Depending on the distance between the origin and destination, private transport may cost a considerable amount of money. From the farthest corner of Swabi 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. Deaths related to delivery, consequently, are not an uncommon sight in the district and maternal mortality, at times, is a concomitant of absolute poverty.

The government of KPK has recently rolled out a scheme entitled '*Sehat Mand Maa, Sehat Mand Bache*' or 'healthy mothers, healthy kids' in order to provide financial support to pregnant women from low-income households. According to this scheme, each pregnant woman will be required to pay four visits to a public health facility to receive antenatal care. She will be given Rs. 300 on each visit. If the delivery takes place in a public facility or through midwife, the woman will be given Rs. 1,000. In case of paying a postnatal visit, she will be entitled to Rs. 500. The government has been actively disseminating information about this programme and expects an encouraging response. However, the communities we visited

hardly knew about this intervention; those who did, considered the financial assistance too insufficient.

### 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 Rs. 1,000. In case of serious illnesses or health problems, the patient is necessarily initially taken to Swabi. 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. 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. A woman in her mid-sixties fell terminally

ill and was admitted to hospital in Swabi. From there, she was referred to Mardan and then on to Peshawar. Four attendants accompanied her and she remained hospitalised for 7 to 8 days. Attendants' expenses and her own treatment and stay cost her family a fortune, but even this could not save her life. She died in the hospital without even ever finding out what ailed her.

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 25% to 30% of their expenditure, whereas in some cases this figure was 50%. The proportion of out-of-pocket costs relative to income and expenses was higher among the poor.

### 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 67% for Swabi, though above the provincial average, is not promising in absolute terms. 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 are shared with them

so that they had vital information. Particular attention should be paid to enrolling girls. This may require mobilising Parent Teacher Councils and other community forums to raise awareness about female literacy and engage the parents.

Enrolment rates for the district suffer a steep drop at the middle and high school levels. High dropout rates across different grades and levels do not augur well for the literacy rate in the district. As suggested in Chapter 2, it would be imperative to take this sharp decline at the high school level seriously. This issue, in fact, is tied to the numbers of middle and high schools in the district. Schools at these levels are not present in all areas and children have to travel a considerable distance. This raises the cost, and children from low-income or poor households find it increasingly difficult to continue their education. It arguably affects girls the most as in a socially conservative environment it is fairly challenging for them to travel to a school situated in a different neighbourhood or village. It was seen in many parts of the district that at times people have to prioritise the education of their children and move to the tehsil or district headquarter. It causes displacement and relocation costs are sometimes very high. More resources should be directed towards building a network of schools at all levels to provide equal opportunity to all children.

It came to the fore that when children go to school, they find fewer teachers there. In places

where pupil-teacher ratio is high, quality in education cannot be ensured. Data reveal that in Swabi pupil-teacher ratio is 44:1, which is certainly not low. To tackle this, vacant posts for teachers should be filled on an urgent basis, and a policy should be evolved to ensure that adequate human resources are available in the education department.

#### *4.1.2: Quality of teaching*

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

#### *4.1.3: Child labour*

Poverty and neglect on the part of the authorities come together to push children into child labour. This dehumanizing practice steals childhood from them and denies key functionings and capabilities essential for enjoying a balanced and fulfilling life. To combat this, bold measures are required.

All the stakeholders, including community, parents, employers, and state authorities, will eventually have to come forward. Studies should be undertaken to assess the scale of child labour in the district and the causes behind it. Vigilance committees, consisting of government officials, school staff, parents, community activists, and employers such as brick kiln owners, should be set up to be able to dramatically reduce the incidence of child labour. Or if there are already such committees and forums in place, they need to be revived, reinforced, and strengthened through increased focus. Non-formal schools, learning centers and facilities should be established to engage with the out-of-school children involved in labour. Incentives should be provided to these children for attending school. 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 Swabi are 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 KPK 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 is only one school in Swabi for the blind children but that too is not effective in responding to the learning needs of students owing to resource constraints and misplaced priorities. First of all, 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: Continuity in policy*

Policy continuity is an ingredient that ensures sustainable gains and a wider impact. However, in the case of KPK, what we have witnessed is quite the opposite. Sudden and continual changes in curricula create disruptions and serve to reverse progress made over the years. Since education is the cornerstone of a broad-based socio-economic development, a provincial consensus is required to develop a vision for the future. All the political parties should come together to discuss, debate, and assess the issues fundamental to education in the province. The outcome of such a process could be a strategy document outlining the future course of action jointly decided by all the stakeholders. Civil society, too, should be part of this initiative to seek expert advice and to elicit the point of view of activists working with the communities.

#### *4.1.7: 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. 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.

#### *4.1.8: Curbing political interference*

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

#### *4.1.9: Local governance*

People in Swabi in general appeared to be pinning hopes on the recently held elections for local governments. They were of the view that decentralised governance would be more responsive to their needs. However, it is yet to be seen what difference the new system will make. But 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. Therefore, it is important that steps are taken to make the most of this possibility and empower communities at the grassroots.

#### 4.1.10: 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.

#### 4.1.11: 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. Now that Swabi has a local government, it becomes easier to engage with the actors that may play crucial roles in resource generation. 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 Swabi, 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. 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 Swabi's indicators for reproductive health have not been very encouraging. Delivery related deaths and complications are not too uncommon. It is so because there are serious service gaps and traditional approaches to reproductive health hold sway. Antenatal care visits are rare and delivery is overwhelmingly done privately. The LHV's are either non-existent or unavailable owing to additional non-reproductive-health-related responsibilities. They are even found to be running their own private clinics. All these factors jeopardize the lives of women and significantly increase out-of-pocket costs for the community. It would help immensely if the presence of LHV's and LHW's was ensured in all the UCs and villages therein.

The government's scheme to provide financial assistance to pregnant women is a welcome sign, but it is not adequate or significantly supportive. By adding the value of assistance, reproductive health can be incentivised. In addition, it should be ensured that if there is provision of delivery facility in the BHUs, it is being properly used and functional in responding to cases. 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. 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. Investment in roads and transportation will produce long-term positive effects for the rural communities.

#### *4.2.7: Promotion and prevention*

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

## Annex A

### FGD Guide for AAWAZ District Forum

#### Guiding Questions

#### 1. Human development

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

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

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

- Monitoring

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

- Girls
- Exclusion

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

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

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

- What the government is doing?

- What the civil society organizations are doing?

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

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

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

3.2. What is the scope of private practice?

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

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

3.5. How does this issue affect different groups differently?

- Women
- Children
- Elderly
- Poor

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

3.7. Do you think that public health facilities in the district are sufficiently functional

and responding well to the health needs of the community in general?

- BHUs
- THQ
- DHQ (facilities and referrals)

3.8. How much do the following items cost?

- Test
- Medicine
- Surgery
- Delivery
- Transport

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

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

## Annex B

### 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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