HEALTH AND NUTRITION

"Ill being" and "ill health" is a multidimensional term covering not only disease but also other dimensions such as hunger, exclusion, isolation, insecurity and powerlessness. This ill health can consequently prevent individuals from realizing their full potential. Good health, in contrast, is identified as a vital component of a good quality of life. That is why access to good health is recognized as a basic human need and a fundamental human right. The WHO's definition of health as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity" applies to all human beings regardless of age gender, nationality and culture. Inequalities and deficiencies in health thus affect the well being of an individual and welfare of a society as a whole.

A healthy population is not only valued in its own right, but it also raises the human capital of a country thereby positively contributing to the economic and social development. Allowing people to lead a life they value and enabling them to realize their potential as human beings is first and foremost requirement of human development. In order to address the most enduring failures of human development, the international community has drafted the Millennium Development Goals-a broad vision with internationally agreed set of time bound goals for reducing extreme poverty, extending gender equality, and advancing opportunities for health and education. These goals serve as benchmark of progress toward the vision of Millennium Declaration-guided by basic values of freedom, equality, solidarity, tolerance, respect for nature and shared responsibilities. These values share the commonality of conception of human well being in the concept of human development and also reflect the fundamental motivation for human rights. In this way, Millennium Development Goals, human development and human rights share the same motivation.

Pakistan being a signatory to the UN Millennium Declaration is fully aware of its commitments regarding the MDGs. The Government's commitment to the MDGs is fully reflected in Pakistan's overall development strategy as embodied in the Medium-Term Development Framework (2005-10) and Poverty Reduction Strategy Paper (PRSP). Pakistan Millennium Development Goals Report 2006 (PMDGR) evaluates the progress regarding MDGs, both at the district as well as at the provincial/national level during 1998-2005. Three out of eight Millennium Development Goals are directly related to health sector such as: reducing child mortality, improving maternal Health and combating HIV/AIDS, TB, Malaria and other diseases.

Apart from socio economic significance of health, a right based approach has remained an integral part of Government's overall policies. In this context, Pakistan's National Health Policy 2001 has pledged for overall national vision based on "Health for All" approach. Besides National Health Policy, Pakistan Poverty Reduction Strategy Paper recognizes the need to substantially increase financing and to enhance efficiency of spending through organizational and management reforms. It goes beyond national health policy in the important areas of reproductive health and nutrition, outlining interventions like community midwifery, improvement of emergency obstetric

care, behavior change and communication and control of communicable diseases including HIV / AIDS.

About 9 percent of the total PRSP expenditure in FY06 was made on the health sector[1]. Between FY05 and FY06, health expenditure increased by 24.8 percent to Rs.39.2 billion. Largest increase in health expenditure was incurred in Sindh (43.1%), followed by Federal Government (40.4%), NWFP (17.4%), and Punjab (14.6%), whereas health expenditure declined by 6.6 % in Balochistan. One of the main mechanisms for monitoring the implementation of PRSP is through the Pakistan Social and Living Standard Measurement Survey (PSLM). The PSLM 2005-06 report is just been released. The results pertaining to health indicators exhibit further improvement over the last PSLM (2004-05) results. Some of the improvements are highlighted in the box item.

Box Item-1: PSLM (2005-06) – Health Indicators

In the category of at least 1 immunization (12-23 months), there has been an improvement from 88 percentage points to 94 percentage points. The highest achievement has been observed in Sindh where immunization coverage has increased from 77% to 97%. There has been a decrease in proportion of children suffering from diarrhea i.e., from 16 % to 12 %. Sindh has registered the most declines from 18% to 8%. Infant Mortality has also decreased from 82 (PIHS 2001-02) to 70 per thousand births in 2005-06. Pregnant women received Tetanus Toxoid injections are up from 51 percent in 2004-05 to 62 percent in 2005-06.

12.1: A Snapshot of the Health Status

At over 158 million, Pakistan is the sixth most populous country of the world with its current population growth rate at 1.8 % per annum. With respect to infectious diseases, data from the Pakistan Demographic Surveys (PDS) for the years 1992-2003 show that the percentage of deaths attributed to communicable diseases has decreased from 49.8% to 26.2%; in addition immunization coverage has also increased substantially. However, Pakistan's key health indicators still lag behind in relation to other regional countries. (See Table 12.1)

Table–12.1: Social Indicators

Country	Life Expectancy Year 2004**		Infant Mortality Rate per 1000** Year 2004	Mortality Rate under 5 per 1000 Year 2004**	Population Avg. Annual (%) Growth Year 2004**
	M	F			
Pakistan	**63.2**	**63.6**	**70^**	**101**	**1.8***
India	62.1	65.3	62	85	1.5
Sri Lanka	71.7	77.0	12	14	1.3
Bangladesh	62.5	64.2	56	77	1.7
Nepal	61.6	62.4	59	76	2.2
China	70.2	73.7	26	31	0.7
Thailand	66.7	74.0	18	21	0.7
Philippines	68.6	72.8	26	34	2.0
Malaysia	71.1	75.8	10	12	2.0
Indonesia	65.3	69.2	30	38	1.3

^ Pakistan Social and Living Standard Measurement Survey (PSLM) 2005-06
*Population growth for Pakistan is estimated at 1.8 percent (National Institute of Population Studies).
**Source: Human Development Report 2006

Non-communicable diseases and injuries are amongst the top ten causes of mortality and morbidity in Pakistan and accounts for almost 25 percent of the deaths within the country. One in three adults over the age of 45 years suffers from high blood pressure; the prevalence of diabetes is reported at 10 percent; whereas 40 percent men and 12.5 percent women use tobacco in one form

[1] Poverty Reduction Paper Annual Progress Report (2005-06)

or the other. Approximately one million people suffer from severe mental illness and over 10 million individuals from neurotic conditions. The National Survey of Blindness and Low vision 2002-04 has shown that there are an estimated 1.5 million blind people within the country. The large burden of infectious diseases in Pakistan is known to be closely related to the lack of sanitation facilities and safe sources of potable water. Water – borne diseases constitute nearly 12.5 percent of the diseases burden in Pakistan.

The Government is fully aware of the extra-ordinary burden of preventable deaths and morbidity among women and children and is fully committed to improve their health status. Pakistan stands in the list of those few developing countries which have mainstreamed non-communicable diseases and injuries in their public health agenda and justifiably so, given that these are amongst the top ten causes of mortality and morbidity in the country. Indeed, Pakistan's public health interventions have a wider scope than the MDGs. In addition, Khushal Pakistan Program, a recently launched pro-poor intervention, has provision of safe drinking water as one of its priority program objectives. This is an important step in eradicating diseases related to lack of sanitation facilities and safe sources of potable water. Pakistan also recognizes a number of emerging challenges, in particular the threat of emerging and re-emerging infections in the aftermath of SARS, Avian influenza and Dengue fever. The need for an emphasis on disaster preparedness as part of the overall public health policy and planning has been heightened in the aftermath of the October 8, 2005 earthquake.

Pakistan Millennium Development Goals Report 2006 (PMDGR) provides district level information including top and bottom ten districts in terms of immunization coverage during 2005.This district level information is depicted in Table 12.2.

Table-12.2: Immunization Coverage

Top Ten Districts				Bottom Ten Districts			
Rank	**Districts**	**Province**	**Rate**	**Rank**	**Districts**	**Province**	**Rate**
1	Chitral	N	100	89	Sibbi	B	50.2
2	Jhelum	P	99.2	90	Chaghi	B	48.8
3	Sialkot	P	97.7	91	Musakhel	B	48.3
4	Gwadar	B	96.5	92	Kohistan	N	48.2
5	Khushab	P	96.5	93	Sanghar	S	45.8
6	Attiock	P	95.4	94	Barkhan	B	44.8
7	Chakwal	P	94.3	95	Qilla Abdullah	B	41.3
8	Gujrat	P	93.7	96	Jscobabad	S	35.2
9	Mianwali	P	93.4	97	Jaffarabad	B	32.5
10	Bahawalnagar	P	93.1	98	Qilla Saifullah	B	27.9

Source: Pakistan Millennium Development Goals Report 2006
Note: N=NWFP; P= Punjab; S=Sindh; B= Balochistan

The districts in Punjab occupied most of the positions in top ten performers. None of the districts from Sindh are among the top ten during the period under study. Among the bottom ten districts, seven out of ten districts belong to the province of Balochistan.

During 1998-2005, on average there was an improvement of 10 percentage points in the immunization coverage. In absolute coverage districts of Punjab has dominated the top ten ranking with more than 90 percent coverage. Districts in Balochistan with roughly 40 percent coverage were among the bottom ten in the country. However, coverage in many of the districts in Balochistan and NWFP grew rapidly during the period. In relation to the national MDG target of greater than 90 percent set for 2015, nearly 16 districts have already achieved it and going along with recent performance it is safe to suggest that another 50 districts are likely to achieve it around 2015. *(Pakistan Millennium Development Goals Report, 2006).*

12.2- Health Expenditures:

Fiscal year 2006-07 has witnessed an impressive increase in health sector allocation, rising from Rs.40 billion to Rs.50 billion (0.57%of GDP), thus registering a growth of 25 percent over the last year. Health expenditures have doubled during the last seven years; from Rs.24 billion in 2000-01 to Rs.50 billion in 2005-06(see Table 12.3).

Table 12.3: Health & Nutrition Expenditures (1999-00-2006-07) (Rs.billions)

Fiscal Years	Public Sector Expenditure (Federal and Provincial)			Percentage Change	Health Expenditure as % of GDP
	Total Health Expenditures	Development Expenditure	Current Expenditure		
1999-00	22.08	5.89	16.19	6.1	0.58
2000-01	24.28	5.94	18.34	9.9	0.58
2001-02	25.41	6.69	18.72	4.7	0.57
2002-03	28.81	6.61	22.21	13.4	0.59
2003-04	32.81	8.50	24.31	13.8	0.58
2004-05	38.00	11.00	27.00	15.8	0.57
2005-06	40.00	16.00	24.00	5.3	0.51
2006-07	50.00	20.00	30.00	25	0.57

Source: Planning and Development Division

12.3 - Service Delivery

Service delivery is being organized through preventive, promotive, curative and rehabilitative services. The curative and rehabilitative services are being provided mainly at the secondary and tertiary care facilities. Preventive and promotive services, on the other hand, are mainly provided through various national programs; and community health workers' interfacing with the communities through primary healthcare facilities and outreach activities. Pakistan has one of the largest public sector owned service delivery infrastructures in the world. Due to differences in incentives in the public vis-à-vis the private sector, it is not uncommon for public health workers to hold jobs both in public and private sectors to augment their earnings. Accordingly the role of privates sector is gradually increasing in the provision of heath service delivery.

Efforts are underway to address the currently prevailing service delivery challenges by developing alternative service delivery and financing options at the basic healthcare and hospital levels. Provincial governments have focused on restructuring the mode of primary healthcare delivery by revitalizing Basic Health Units (BHUs) and Rural Health Centers (RHCs). The Governments of Punjab has taken a lead in this area by developing models of contracting out service delivery to private sector and other models where service delivery has been incentivised within the existing system. The government of NWFP is also following on similar model. In Punjab, models are also being tested to transfer management to lower levels of government – an option, which is complementary to the administrative arrangements within decentralization.

Efforts are also underway to enhance regulatory capacity within the country. The permission to establish Drug Regulatory Authority was given in 2006, the work for which is currently underway. The Ministry of Health is also working to develop a framework for the regulation of the private sector healthcare.

12.4- CONFIGURATION OF PAKISTAN'S HEALTH SYSTEM

Constitutionally, health is a provincial subject in Pakistan with clearly demarcated roles, responsibilities and prerogatives at each level of the government. The Federal Government is mandated with policy-making, coordination, technical support, research, training and seeking foreign assistance. The provincial and district departments of health are responsible for the delivery and management of health services. The devolution of administrative powers under the Local Government Ordinance 2001 has devolved service delivery to the district level.

12.4.1- Health Infrastructure:

The state attempts to provide healthcare through a three-tiered healthcare delivery system and a range of public health interventions. The former includes *Basic Health Units* (BHUs) and *Rural Health Centers* (RHCs) forming the core of the primary healthcare structure. Secondary care including first and second referral facilities providing acute, ambulatory and inpatient care is provided through *Tehsil Headquarter Hospitals* (THQs), and *District Headquarter Hospitals* (DHQs) which are supported by tertiary care from *teaching hospitals.*

There are seven hospitals under the control of Federal Government located in Islamabad, Rawalpindi and Karachi. There are tertiary care hospitals in all the provinces including those with the status of teaching hospitals, which are under the administrative jurisdiction of provinces. However, recently four hospitals in NWFP and three in Sindh have been granted autonomous status. Throughout the country, the vast network of health care facilities include 924 hospitals, 5336 BHUs and Sub- Health Centers , 560 RHCs, 4712 Dispensaries, 906 MCH Centers and 288 TB Centers. These healthcare facilities show an improvement over the previous year as the total number of healthcare facilities during 2005-06 was 12,637. During 2006-07, these healthcare facilities have increased to a total of 12,726. The detail about the human resource available within the country up till 2006 is provided in Table12.4. There has been a gradual improvement in the number of doctors, dentists and nurses over the years. A cursory look at the Table 12.4 is sufficient to see that doctors, dentists, nurses and LHVs have doubled in the last one decade and accordingly population per doctor, per dentist, per nurse etc. have all registered a significant improvement.

Table 12.4 Human Resource Available from 1995 till 2006

Years*	1995	2000	2002	2003	2004	2005	2006
MBBS Doctors	70,670	92,804	102,611	108,130	113,273	118,062	122,798
Dentists	2,747	4,165	5,058	5,531	6,128	6,734	7,388
Nurses	22,299	37,528	44,520	46,331	48,446	51,270	57,646
Midwives	20,910	22,525	23,084	23,318	23,559	23,897	24,692
Lady Health Visitors(LHVs)	4,185	5,443	6,397	6,599	6,741	7,073	8,405
Population per doctor	1719	1473	1392	1350	1316	1274	1254
Population per dentist	44223	32819	28244	26389	24320	22345	20839
Population per Nurse	5448	3642	3209	3150	3076	2935	2671
Population per midwife	5810	6068	6189	6260	6326	6297	6235
Population per LHVs	29027	25113	22332	22119	22108	21274	18318

* Year as on Ist January

Sources: Pakistan Medical and Dental Council (PMDC) and Pakistan Nursing Council(PNC), Islamabad

12.4.2- Physical Targets and Achievements during 2006-07:

The targets for the health sector during 2006-07 included the establishment of 30 Rural Health Centers (RHCs), 70 Basic health Units (BHUs) and up gradating of 25 existing RHCs and 50 BHUs. The manpower target included the addition of 5050 new doctors, 460 dentists, 2600 Nurses and 5500 paramedics. The plan called for training 500 traditional birth attendants and 500 Lady Health Workers during 2006-07. Under the preventive program, about 8 million children were targeted to be immunized and 24 million packets of Oral Rehydration Salt (ORS) were to be distributed during 2006-07 by the EPI Program.

The health program during the current fiscal year has realized, on average, 80 percent of its physical targets (up to March 2007). The highest achievement of 99 percent has been obtained in the health human resource development especially doctors, followed by the provision of ORS (96 percent) and immunization coverage (94 percent). The sub- sector wise achievement has been recorded as 80 percent for RHCs and 90 percent for BHUs. It is encouraging to note that the achievements obtained so far are in the close vicinity of the targets.

Table–12.5: Physical Targets and Achievements During 2006-07

Sub-Sector	Targets (Numbers)	Estimated Achievements (Numbers)	Achievements (%)
A. Rural Health Programme			
i. New Basic Health Units (BHUs)	70	63	90
ii. New Rural Health Centres (RHCs)	30	24	80
iii. Upgradation of existing RHCs	50	45	90
iv. Upgradation of existing BHUs	25	20	80
B. Beds in Hospitals/RHCs/BHUs	3000	2500	76
C. Health Manpower Development			
i. Doctors	5050	5000	99
ii. Dentists	460	450	97
iii. Nurses	2600	2300	88
iv. Paramedics	5500	4800	87
v. Training of TBAs	500	400	80
vi. Training of LHWs	15000	14000	80
D. Preventive Programme			
i. Immunization (Million Nos)	8	7.5	93
ii. Oral Rehyderation Salt (ORS) (Million Packets)	24	22	96

Source: Planning and Development Division

12.4.3- National Programs

The relationship between health and economic development of a country can not be over-emphasized. Government is aware of the fact that economic growth and development of the country require sound and sustained health programs / policies. Public health interventions include a number of public health programs, which are federally led with provincial implementation arms and counterpart institutional mechanisms. These include the national programs for the prevention and control of tuberculosis, malaria, HIV / AIDS, hepatitis, blindness and more recently a program on maternal, neonatal and child health etc.(Table 12.6).

Table 12.6: Various Public Health Programs

Federally-led national program	The National Program for Family Planning and Primary Health Care
	The Expanded Program for Immunization
	The National HIV / AIDS Control Program
	The National Tuberculosis Control Program
	The National Malaria Control Program
	The National Nutrition Program
	The Women Health Project
Newly launched program in the public sector (2005-07)	The National Program for Prevention and Control of Blindness
	National Program for the Prevention and Control of Hepatitis
	National Neonatal, Maternal and Child Health Program

The details about the various national programs regarding health sector are as under:

a- National Program on Family Planning & Primary Health Care

The program was initiated in 1994 with the objective to provide basic health care package to the community, specifically rural community at its doorstep and bridge the gap between communities and static health units. The program envisaged the deployment of Lady Health Workers. The Lady Health Workers (LHWs) program is recognized as one of the success stories in the health sector. Currently, 95,355 LHWs have been recruited and deployed to conduct outreach activities. A bulk of LHWs is deployed through national program which is 93,208 during the year 2006-07. While during the same period, 2147 LHWs have been appointed by Reproductive Health Program. Women Health Project (WHP) has provided 8000 LHWs during the years 2002 to 2005.

b- Expanded Program on Immunization

The Expanded Program on Immunization (EPI) focused on TT vaccination of pregnant women; routine immunization and immunization against Hepatitis among children in the age of 0-11 months during January to December 2006. The targeted population of pregnant women was approximately 6.75 million which is about 4.1 percent of total population. The country-wide coverage remained 48 percent for TT-1 and 50 percent for TT-2+. The immunization coverage of infants in the age group 0-11 months was undertaken during the same period. The target population for the vaccination was 5.8 million infants and 5.0 million infants have been administered HBV-I, 0.47 million have been given HBV-II and 0.5 million have been administered HBV-III. The percentage achievement range from 78% to 86%. The immunization against tuberculosis, diphtheria, polio, and measles was carried out. The coverage against measles was recorded as 78%.

c- National AIDS Control Program (NACP)

The Program aims to control HIV/AIDS cases by creating awareness for safe behavior; increased availability of services related to "Sexually Transmitted Infections"; safe blood transfusion services; enhancing capacity in public and private sectors; and establishing treatment centers for HIV/AIDS patients. By end- December 2006, the total number of HIV cases tested positive was 3381. The number of full blown AIDS cases was 372. The total number of deaths caused by HIV/AIDS is 165 up till December 2006. It is estimated that the over all prevalence rate of HIV/AIDS is <1% among general population while it is 50% in some of the high risk groups like injecting drug users (IDUs). Keeping in view the potential threat of HIV/AIDS, the Government has been implementing a 5 years National AIDS Control Program since 2003. The National Program was approved at the cost of Rs.2858 million which also includes allocations for the provinces. The component of NACP is Rs.1137 million for the five years. The allocations for the fiscal year 2006-07 were Rs.229 million but the amount released during the period amounted to Rs.350 million.

d- National Tuberculosis Control Program

Pakistan is ranked 7th among 22 high disease burden countries in the world and contributes 43% of the disease burden towards the Eastern-Mediterranean region of the WHO. The estimated annual incidence of all types of TB cases is 177/100,000 population, hence, 250,000 are added to the toll of TB patients in the country. The WHO's recommended Directly Observed Treatment Short Course (DOTS) protocol is being implemented since 2000. By the year 2006 the absolute number of all TB cases was 76,668 as compared to 97,245 in the year 2004. The percentage of case detection rate is 50%, treatment success rate is 84% while cure rate is 71%.The TB Control Program was revived in the year 2000. A medium- term (2006-2010) TB Control Program has been approved at the cost of 1.18 billion. The major components of the program include trainings of district managers and staff; strengthening of lab network; strengthen and support availability of drugs; surveillance monitoring and evaluation; inter-sectoral collaboration; program-based research and development and public-private partnership. During 2006-07 an amount of Rs.198 million has been allocated.

Main achievement of the program during 2006-07 is the development of National Reference Laboratory. QA system for sputum smear microscopy has been developed and implemented

in 41 districts all over Pakistan covering 48 million population. Research activities are also being undertaken to provide baseline information on the socio economic status of the target population and the status of healthcare delivery system in the country.

e- Malaria Control Program (MCP)

In Pakistan, malaria has been a major public health problem threatening the health of the people due to prevailing socio-economic conditions and epidemiological situation. The transmission has been described as combination of stable and unstable malaria with low to moderate endemicity. It has a tendency for epidemic break outs over larger area, particularly Punjab and Sindh. The disease is now emerging as a prominent health problem in Balochistan, FATA particularly along the international border. Malaria is the disease that inevitably affects the poor sections of the population living in hot humid and arid far flung areas which also lack good health care facilities and functioning diseases surveillance system, so morbidity and mortality in most of the instances go unreported. Each year about half a million people suffer from malaria.

Pakistan has been actively engaged in malaria control activities since 1950. A malaria eradication campaign was launched in 1961 through out the country. Pakistan became the member of a global partnership on Roll Back Malaria (RBM) in 1999 and the project of RBM was launched in Pakistan in 2001. Malaria Control Program in the Ministry of Health has a Malaria Information Resource Center, receiving monthly districts' morbidity data from provinces. The confirmed malaria cases microscopically diagnosed are reported to the Directorate of Malaria Control, Islamabad. Private sector data is not being reported. Clinically diagnosed cases in public health facilities are reported to HMIS. According to estimates in 2003 a total of 3.9 million fever cases were treated as suspected malaria in public sector hospitals. While the total number of confirmed malaria cases reported from all the provinces were 126,719. About one third of the malaria cases are estimated to be due to falciparum and considered to be potentially dangerous.

According to figures of July to December 2006, the total positive cases through Active Case Detection (ACD) and Passive Case Detection (PCD) were 83, 570, out of this Falciparum cases are around 35%. The parasite incidence (PI) by the end 2006 was 0.5/1000 population while Falciparum incidence (FI) is reported to be 0.18/1000 population.

f - Women Health Project

During the current fiscal year, the Women Health Project focused upon capacity building in management, skill development, knowledge building; promotion of safe delivery kits; awareness raising and; development of data base. The Nursing Instructors are being provided training for modern teaching methods. As its continuous activity the project is distributing free of cost 'Safe Delivery Kits'.

g - National Program for Prevention & Control of Blindness

Blindness is one of the health problems that hamper the productivity and hence economic growth. A National Survey of Blindness and Low Vision 2002-04 conducted by the Ministry of Health have revealed prevalence of blindness with 1.4 million (or 0.9%) people blind. The province-wise prevalence of blind is reported to be 0.9 million in Punjab; 0.3 million in Sindh; 0.18 million in NWFP; 0.08 million in Balochistan and 0.05 million in Federal areas. The causes and burden of each cause of blindness include Cataract 53%; Corneal Opacity 14%; Glaucoma 7%; Refractive Error 3%; and Macular Degeneration 2%.

Pakistan is signatory to "Vision 2020 – Right to Sight" – a global initiative. Under this commitment a 5 year National Program for Prevention and Control of Blindness (2005-2010) has been launched at a total cost of Rs.2.77 billion. The program was approved in August 2005. The program has the following aims and objectives:

- to prevent blindness in more than 2 million adults and 15000 children by strengthening and up-gradation of 63 District Eye Units, 147 Tehsil Eye Units; 20 Tertiary/Teaching Eye Departments and development of 7 Centers of Excellence at PIMS, JPMC, PIPO Lahore, Nishter Hospital Multan, PICO Peshawar,

Civil Hospital Karachi and Helpers Eye Hospital Quetta.

- Development of sub-specialties particularly Pediatric Ophthalmology, Vitreoretinal, Glaucoma and Corneal Blindness

The National Program envisages achieving these objectives by developing human resource at service delivery levels; effective management and advocacy; research and public private partnership. In this regard, Boards and Committees for control of blindness have been formulated at federal and provincial levels. The achievements of the program so far include up-gradation of eye departments by provision of the ophthalmic equipments at PIMS, Islamabad and 22 District Headquarter Hospitals in the four provinces, AJK and Northern Areas.

h - National Program for Prevention and Control of Hepatitis

This program was launched in 2005 with the aim to substantially decrease the prevalence, morbidity and mortality due to hepatitis in the country, presently the program is in full pace of implementation. For the fiscal year 2006-07, Rs.450 million has been allocated for the program. Vaccine has been procured to vaccinate 399,600 health workers and prison inmates during 2005-06. Furthermore, screening and vaccination of healthcare personnel is underway in all provinces and areas, while vaccination of prison inmates has been completed in all prisons of Sindh, NWFP and Balochistan and 50 percent prisons in Punjab. Whereas, during fiscal year 2006-07 vaccination of 120,000 high risk segments of population have been planned with the cost of Rs.30 million. The program is in process of developing national guidelines on Hepatitis.

In order to provide the facilities of diagnosis and treatment of viral Hepatitis, 61 Sentinal sites in teaching and DHQ hospitals have been made operational where services of viral hepatitis diagnosis and its management are being provided. During 2006-07 another 40 hospitals have been identified for provision of requisite facilities with a cost of 150 million. The laboratory refrigerators and dot matrix printers have been installed in sentinal sites at the cost of Rs.5.3 million. The disposable syringes, gloves, needle cutters etc have been supplied to the Provincial Departments of Health. Hospital waste management is another innovative approach of the program. The program is installing incinerators in 48 selected hospitals in the country with a cost of Rs.72 million. The need assessment been completed for strengthening of Water Quality Control Laboratory at the NIH. The installation of Water purification system at 50 selected hospitals is under way with the cost of Rs.15 million. The program is providing treatment, free of charge, to deserving patient of hepatitis B and C. The program has provided treatment to 1815 patients of Hepatitis B and 17227 patients of Hepatitis C during fiscal year 2005-06.

i- National Maternal Newborn and Child Health (MNCH) Program

Maternal and child health is very crucial component of National Health Policy and Millennium Development Goals. In this background, the Ministry of Health has planned a major Maternal and Child Health Program. In this regard, a Strategic Plan on maternal and child health amounting Rs.19.5 billion was announced in the year 2005. The program has been launched with following objectives:

- To reduce the Under Five Mortality Rate to less than 65 per 1000 live births by the year 2011 (MDG target for 2015:45 / 1000)
- To reduce the Newborn Mortality Rate to less than 40 per 1000 live births by the year 2011 (Target for 2015: 25 / 1000)
- To reduce the Infant Mortality Rate to less than 55 per 1000 live births by the year 2011 (Target is 2015:40 / 1000)
- To reduce Maternal Mortality Ratio to 200 per 100,000 live births by the year 2011 (Target 2015: 140 / 100,000)
- To increase the proportion of deliveries attended by skilled birth attendants at home or in health facilities to 90% (Target 2015 :> 90%)
- Increase in Contraceptive Prevalence Rate from 36 (2005) to 51 in 2010 and 55 in 2015

g- Health Information and Surveillance Systems

i) Health Management Information System:

The Ministry of Health has been implementing a Health Management

Information System (HMIS) for first care level facilities (HMIS/FCLF) since 1992. The objectives of the HMIS are to improve coverage and quality of care for priority health interventions, disease surveillance and epidemic control, and monitor availability of essential PHC commodities. In last seven years, the HMIS has been extended to 116 districts for which approximately 20,000 health workers were trained in data collection procedures. Most districts are now sending monthly reports with regularity around 86%. A number of organizations, both government and international are now using this data for looking at disease trends, resource allocations and planning.

ii) Disease Surveillance System

Communicable diseases remain the most important health problem in Pakistan. The common causes of death and illness in the country are acute respiratory tract infections, diarrhoeal diseases, malaria, tuberculosis, and vaccine preventable infections. Epidemic-prone diseases such as meningococcal meningitis, cholera, hepatitis and viral hemorrhagic fevers are also prominent health threats in the country. A functional disease surveillance system is thus needed for priority setting, planning, resource mobilization and allocation, prediction and early detection of epidemics and monitoring and evaluation of intervention programs.

With a view to respond to the need, the government has conducted an assessment study in 2004 to explore the existing situation of data collection, analysis, processing, its use and response for supporting both the communicable and non-communicable Disease Surveillance. The study has revealed a number of deficiencies in Public Health Surveillance in the country. Therefore, an inter-provincial process was initiated to develop a Disease Surveillance System. A ten year National Plan has been developed. It covers both communicable and non communicable diseases and is response/action oriented, which will integrate all existing surveillance activities of the disease control programs. Together, the state's healthcare infrastructure and the programs are helping the government to meet Pakistan's health sector goals – those that are part of the Millennium Development Goals (MDGs) and others articulated in the Poverty Reduction Strategy Paper and the Medium Term Development Framework 2005-10 (MTDF).

12.5- Strategic Policy Direction: Establishment of National Health Policy Unit

Over the period it has been recognized that although, there is a strong network of pubic sector health facilities and that service delivery is being supported by national preventive program the health outputs and outcomes are not in line with financial resources and infrastructure. Therefore, the government has recognized the need for strategic vision and policy coherence in the sector. In this regard the National Health Policy 2001 envisaged the creation of a policy unit which would analyze policies from time to time and would provide policy advice to the Ministry. Subsequently, a National Health Policy Unit (NHPU) was established in end 2005 under National Health Facility (NHF). The mandate of NHPU is to enable the government to respond to evolving health policy challenges. The task of the Policy Unit is to provide policy advice on strategy and resource allocation, monitoring and evaluation of health strategies across the health sector and ensuring that the national policies and strategies are responsive to the emerging needs.

12.6- Cancer Diagnosis and Treatment:

The Pakistan Atomic Energy commission (PAEC) is playing a vital role in the health sector. The Commission is pioneer in using the nuclear and other advance techniques for diagnosis and treatment of cancerous and allied diseases and is actively involved in the national cancer awareness prevention, diagnosis and treatment program. The PAEC is putting a lot of emphasis on its cancer program and has so far established 13 cancer hospitals throughout the country whereas 6 new cancer hospitals are in different phases of construction at Gilgit, Swat, Bannu, D.I. Khan,

Gujranwala and Nawabshah. These institutes are equipped with excellent facilities and the contribution of PAEC through its integrated program in diagnosis of different kind of cancer and allied diseases and their treatment has received considerable acclaim in the public. During the year 2006-07, utilizing the maximum capacity of the latest and state of art equipments available at the PAEC cancer hospitals, more than 400,000 patients were attended. A total of 219,718 patients benefited from the nuclear medicine facilities while 182,575 patients were provided cancer treatment as well as follow up managements in the field of Clinical Oncology during the same fiscal year.

Throughout the country, major disciplines available and operative in different PAEC nuclear medical centers include the discipline of Nuclear medicine; Clinical Oncology; Surgical Oncology; Clinical Laboratories; Radiology; Medical Physics; Bio Engineering; Research and Development; Teaching and Training ; Cancer Awareness and prevention; Cancer Registry& NCRC and Human Resource Development. A recent development at the PAEC Headquarters is the establishment of Separate Director General Medical Sciences along with an office of National Cancer Research Centre (NCRC).The aim is to supervise and harmonize the work of all cancer hospitals under the PAEC throughout the country under this Directorate. It will also be collaborating with the non-PAEC cancer hospitals in Pakistan, international agencies and hospitals in all over the world for research and development programs. It will also collaborate with all cancer hospitals in Pakistan to establish the Cancer Registry Program.

12.7- Drug Abuse in Pakistan

Drug Abuse is wide spread in our society and has affected Pakistan in many ways. It contributes to crime, adds to the cost of our already over burdened health care system and to the financially strapped social welfare system. According to National Assessment study on Drug Abuse conducted in Pakistan 2000/2001, there were about 500,000 chronic heroine users including 60,000 drug injectors in the age group of 15-45 years. 40 percent of the total heroine users fall in the age bracket of 25-34 years, which is an alarmingly high rate according to the international standards. In order to update the assessment data about drug addicts population in Pakistan, a new project National Assessment Study -2006 is in the pipeline and will be completed at the end of June 2007. For the prevention of drug trafficking and drug abuse, effective and meaning full steps have been initiated. A Drug Abuse Control Master Plan (1998-2003) was launched with the assistance of UNODC at a total expenditure of Rs.2.800 billion out of which Rs.1920 million were for Law enforcement and Rs.912 million were for drug demand reduction. However, out of the total estimated budget only Rs.185.837 million was spent. Consequently in physical terms partial programs have been implemented but the objectives laid down in the plan could not be fully realized due to financial constraints. However, keeping in mind the present scenario a revised Drug Abuse Control Master Plan (2007-2011) is being prepared with the assistance of the United Nations Office on Drug and Crime (UNODC). The Master Plan has two components i.e., Law Enforcement and Drug Demand Reduction

12.7.1- Drug Demand Reduction

Under sections 52 & 53 of Control on Narcotics Substances Act, 1997, Provincial Governments have been directed to register drug addicts and establish treatment and rehabilitation centers at provincial levels.

However, at Federal level, two Model Addiction treatment and Rehabilitation Centers each at Islamabad and Quetta have been established by Anti narcotics Force. Since its establishment in 2005 ,1277 drug addicts have been admitted /treated and 96 ex-addicts were provided jobs. Both the Centre have started functioning and drug addicts are being provided free treatment, medicine, food and stay at the centre. In addition two more model Addiction Treatment and Rehabilitation Centers one each at Lahore and Karachi have been planned. The estimated cost of both the projects is Rs. 44.304 million. Beside these treatment and rehabilitation Centers ,two other projects i.e., NGO Support Program for Treatment and rehabilitation; Focused Drug abuse Prevention for High Risk and Marginalized Groups costing Rs. 55.7 million are being implemented in Pakistan. These Programs aim to create awareness amongst the masses particularly high risk group and

involve the civil society in prevention as well as treatment and rehabilitation of drug addicts.

The details about the seizure of narcotic drugs in Pakistan, cases affected and defendants arrested during the fiscal year 2006-07 are given in Table 12.7.

Table 12.7- Seizure of Drugs

No. of cases	27594 (Nos)
No. of defendants	27647 (Nos)
Opium	2461.543 (Kgs)
Heroine	5031.788(Kgs)
Hashish	53177.192(Kgs)
Cocaine	66.482(Kgs)
Injections all types	36,736(Nos)

Source: Ministry of Narcotics Control

12.7- FOOD & NUTRITION

Malnutrition is one of the major public health challenges in Pakistan. Malnutrition occurs throughout the lifecycle resulting in low birth weight, wasting and stunting. National Nutrition Survey 2001-2002 provides information on various nutritional aspects of the vulnerable group of population. Micronutrient deficiency in Pakistan is common and reflects a combination of dietary deficiency, poor maternal health and nutrition, high burden of morbidity and low micronutrient content of the soil especially for iodine and Zinc. However, the food availability in the country has been sufficient to meet the overall national requirements across regions. Availability of major food items during the fiscal year 2006- 07 depicts an increase in supply over the previous year. In terms of nutritional intake average caloric availability per day is likely to increase from 2423 to 2425 by the end of fiscal year 2006-07. Details of the food availability are given in Table 12.8.

Table -12.8 : Food Availability Per Capita

Items	Year/ Units	49-50	79-80	89-90	99-00	02-03	03-04	04-05	05-06 (E)	06-07 (T)
Cereals	Kg	139.3	147.1	160.7	165.0	147.3	150.7	142.0	155.2	153.5
Pulses	Kg	13.9	6.3	5.4	7.2	6.0	6.1	6.8	7.6	6.6
Sugar	Kg	17.1	28.7	27.0	26.4	31.5	33.6	27.0	29.8	30.0
Milk	Ltr	107.0	94.8	107.6	148.8	153.4	154.0	155.7	162.6	170.1
Meat	Kg	9.8	13.7	17.3	18.76	19.2	18.8	19.6	19.1	20.0
Eggs	Dozen	0.2	1.2	2.1	5.1	4.5	4.6	4.7	4.6	4.8
Edible Oil	Ltr	2.3	6.3	10.3	11.1	10.8	11.3	12.4	12.0	11.9
Caloric & Protein Availability (Per Capita)										
Calories per day (Number)		2078	2301	2324	2416	2333	2381	2271	2423	2425
Protein per day (Gms)		62.8	61.5	67.4	67.5	66.4	67.8	65.5	69.6	69.5

Source: Planning & Development Division

E:Estimates, T: Targets

The targets of nutrition are part of Pakistan's international commitment under Millennium Development Goals (MDGs). First goal under MDGs is to halve between 1990 and 2015, the proportion of people living below the poverty line. The targets for Pakistan are to reduce below 20 percent the prevalence of underweight children less than 5 years of age and reduce up to 13 percent the proportion of population below minimum level of dietary energy consumption.

To address these challenges major five targeted interventions have been proposed. These interventions include:

- Maternal Health and Nutrition (including new born)
- Infant and Child Health and Nutrition
- Adolescent Health and Nutrition
- Adult Health and Nutrition
- Nutrition and Health of the elderly

Following are the four cross cutting strategies which are envisaged with a view to address specific nutrition and health issues. The strategies include:

- Behavior change communication strategies
- Fortification strategies and programs (for vitamin A, iodine, iron/folate and other micronutrients)
- Food safety and regulatory issues
- Institutionalization of Nutrition and Management strategies

The Nutrition Program has five components i.e. Information and Educational Communication Activities (IEC); Protection of Breastfeeding and Child Nutrition Ordinance No. XCIII of 2002; training; printing and; research.

The different projects of the program have also achieved significant targets. The National Food Fortification project was implemented in 20 districts of the country with a target population of 37 million. As per review of the project it was estimated that achievement was more than 50% at the production level. The project will be further extended to 15 more districts in 2007. The Universal Salt Iodization (USI) project has completed a survey of the salt sector along with complete inventory in coordination with Micronutrient Initiative. Under this project 29 more districts have been taken up and a full fledged iodization at the production and utilization of household level is effective from early 2007.A next step regarding USI would be to undertake necessary legislation.

The National Wheat Flour Fortification Project (NWFFP) is being undertaken to reduce iron deficiency anemia and folic acid deficiency. For this purpose a ten year program for iron fortification of wheat flour has been agreed, which will be achieved by covering 45% of the population (those consuming flour from 600 roller mills) in the first five years, and covering the rest 55% of the population (consuming flour from the grinding mills i.e. chakkies) in the next five years. In this regard process of procurement of Micro-Feeders and Fortificant has been initiated; a draft communication strategy has been prepared.

The Vitamin A deficiency is another factor which has negatively influenced the health of children, mothers and other population segments in Pakistan. According to Pakistan National Nutrition Survey 2001-02, 13% of children have bio-chemical Vitamin A deficiency; 9.4% mothers and 1.2% children under five were reported to be night blind; 5.9% mothers and 12.5% had serum retinol levels deficiency (<0.7 umol/L). The Vitamin A Supplementation (VAS) Program is mainly linked to the routine immunization. A large scale distribution of Vitamin A supplementation was initiated for children 6-59 months old. The Expanded Program on Immunization (EPI) manages the distribution. It is estimated that around 64 million capsules are being distributed annually.

A pilot strategy was tested by the Ministry of Health in 14 districts of three provinces except for Sindh. In the piloted districts Vitamin A capsules 100, 000 i.u were given to the children aged 6-11 months and 200,000 i.u were given to the children aged 12-59 months. The Vitamin A supplementation was administered through LHWs; vaccinators outside LHWs catchment areas; Child Health Week celebrations in the areas with no LHWs and not reached by the vaccinators. Based on pilot strategy it has been decided to evaluate the pilot findings; to continue VAS through NIDs which will be continued up to 2009. It has also been decided to integrate VAS with routine immunization in 1-2 districts per province based on evaluation results of earlier pilot.

Besides these developments, the emphasis has been given to nutritional improvement in the MTDF and policy directly addresses nutritional adequacy through food security at household level and appropriate additional intervention. The government is ensuring food security at all levels, the specific food security measures have been taken to maintain desirable calories availability accessible to a common person. For improvement in overall nutritional status, the relevant sectors are undertaking appropriate nutritional interventions to improve individual well being for healthy and economically vibrant life.

The School Feeding program with three major objectives; improving nutritional status and educational performance of primary school girls,

reducing gender disparity in enrolment and drop out rates and creating awareness to adopt healthy life style has been started in four districts namely, Badin, Gwadar, D.G. Khan and Lakki Marwat. The special Nutrition package has been designed for the school girls which comprises nutritious biscuits (100 gm.) and milk (250 ml) enough to meet 1/3rd requirements of the school girls for calories, vitamins and trace elements.

Improvement of nutritional status of women, girls and infants is being addressed by providing public health Care (PHC) nutritional services. Lady health workers provide micronutrient supplementation and awareness across the country.

TABLE 11.1

NATIONAL MEDICAL AND HEALTH ESTABLISHMENT (YEAR-WISE)

(Progressive Numbers)

Year*	Hospi-tals	Dispen-saries	BHUs Sub Health Centres	Maternity & Child Health Centres	Rural Health Centres	TB Centres	Total Beds	Population per Bed
1990	756	3,795	4,213	1,050	459	220	72,997	1,444
1991	776	3,993	4,414	1,057	465	219	75,805	1,425
1992	778	4,095	4,526	1,055	470	228	76,938	1,464
1993	799	4,206	4,663	849	485	233	80,047	1,443
1994	822	4,280	4,902	853	496	242	84,883	1,396
1995	827	4,253	4,986	859	498	260	85,805	1,416
1996	858	4,513	5,143	853	505	262	88,454	1,407
1997	865	4,523	5,121	853	513	262	89,929	1,418
1998	872	4,551	5,155	852	514	263	90,659	1,440
1999	879	4,583	5,185	855	530	264	92,174	1,448
2000	876	4,635	5,171	856	531	274	93,907	1,456
2001	907	4,625	5,230	879	541	272	97,945	1,427
2002	906	4,590	5,308	862	550	285	98,264	1,454
2003	906	4,554	5,290	907	552	289	98,684	1,479
2004	916	4,582	5,301	906	552	289	99,908	1,492
2005	919	4,632	5,334	907	556	289	101,490	1,483
2006	924	4,712	5,336	906	560	288	102,073	1,508

* : Year as on 1st January

Source: Ministry of Health

TABLE 11.2

REGISTERED MEDICAL AND PARAMEDICAL PERSONNELS AND EXPENDITURE ON HEALTH

(Progressive Numbers)

Year*	Regis-tered Doctors **	Regis-tered Dentists **	Regis-tered Nurses **	Register-ed Mid-wives	Register-ed Lady Health Visitors	Population per			Expenditure(Mln. Rs)^	
						Doctor	Dentist	Nurse	Develop-ment*	Non-Deve-lopment
1990	52,862	2,068	16,948	15,009	3,106	1,994	50,967	6,219	2741.00	4997.00
1991	56,546	2,184	18,150	16,299	3,463	1,911	49,469	5,953	2402.00	6129.65
1992	61,017	2,269	19,389	17,678	3,796	1,846	49,630	5,808	2152.31	7452.31
1993	63,976	2,394	20,245	18,641	3,920	1,806	48,262	5,707	2875.00	7680.00
1994	67,167	2,584	21,419	19,759	4,107	1,764	45,859	5,532	3589.73	8501.00
1995	70,670	2,747	22,299	20,910	4,185	1,719	44,223	5,448	5741.07	10613.75
1996	75,201	2,933	24,776	21,662	4,407	1,655	42,445	5,025	6485.40	11857.43
1997	79,437	3,154	28,661	21,840	4,589	1,605	40,428	4,449	6076.60	13586.91
1998	83,661	3,434	32,938	22,103	4,959	1,561	38,020	3,964	5491.81	15315.86
1999	88,082	3,857	35,979	22,401	5,299	1,515	34,607	3,710	5887.00	16190.00
2000	92,804	4,165	37,528	22,525	5,443	1,473	32,819	3,642	5944.00	18337.00
2001	97,226	4,612	40,019	22,711	5,669	1,437	30,304	3,492	6688.00	18717.00
2002	102,611	5,058	44,520	23,084	6,397	1,392	28,244	3,209	6609.00	22205.00
2003	108,130	5,531	46,331	23,318	6,599	1,350	26,389	3,150	8500.00	24305.00
2004	113,273	6,128	48,446	23,559	6,741	1,316	24,320	3,076	11000.00	27000.00
2005	118,062	6,734	51,270	23,897	7,073	1,274	22,345	2,935	16000.00	24000.00
2006	122,798	7,388	57,646	24,692	8,405	1,254	20,839	2,671	20000.00	30000.00

Source: (1) Ministry of Health. (2) Planning & Development Division.

* Year as on 1st January

^ Expenditure figures are on fiscal year basis

** Registered with Pakistan Medical & Dental Council and Pakistan Nursing Council.

TABLE 11.3

DATA ON EXPANDED PROGRAMME OF IMMUNIZATION VACCINATION PERFORMANCE, 0-4 YEARS
(Calendar Year Basis)

(000 Nos.)

Calendar Year/ Vaccine/doze.		1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
B.C.G.		4,387	4,092	3,448	4,841	4,804	4,804	5,582	4,995	5,070	4,778	5,115	4862	5203	5364
POLIO	0	945	1,151	1,007	1,372	1,522	1,522	2,031	1,788	1,735	1,842	2,132	2353	2626	2846
	I	4,386	4,233	3,675	4,797	4,739	4,739	5,254	4,581	4,584	4,543	4,820	4513	4859	5250
	II	2,952	3,730	3,141	4,282	4,221	4,221	4,559	4,027	4,079	4,015	4,282	4098	4387	4870
	III	3,686	3,466	2,845	3,994	3,947	3,947	4,131	3,812	4,024	3,780	4,035	3916	4160	4739
	IV	-	-	291	-	-	-	-	-	-	-	-	-	-	-
	BR	916	308	256	143	92	92	57	460	227	138	106	78	49	33
D.P.T	I	4,308	4,091	3,639	4,805	4,740	4,740	5,070	4,693	4,689	4,659	4,769	4428	4581	5275
	II	3,892	3,647	3,125	4,294	4,213	4,213	4,530	4,140	4,176	4,039	4,228	4025	4127	4886
	III	369	3,406	2,876	4,012	3,936	3,936	4,273	3,918	4,113	3,796	3,983	3840	3919	4756
	BR	717	265	225	137	89	89	169	45	47	22	6	2	0.1	0.2
H.B.V	I	-	-	-	-	-	-	-	-	-	1,772	4,483	4213	4458	5053
	II	-	-	-	-	-	-	-	-	-	1,290	3,892	3880	4065	4692
	III	-	-	-	-	-	-	-	-	-	966	3,576	3617	3841	4571
T.T	I	3,311	3,232	2,871	3,830	3,733	3,733	4,282	4,091	4,179	4,678	3,590	3391	4539	4069
	II	2,625	2,510	2,234	3,042	2,912	2,912	3,325	3,274	3,286	3,540	2,970	2650	2858	3133
	III	672	714	751	988	1,098	1,098	1,056	928	869	1,278	1,423	765	793	894
	IV	224	240	240	401	446	446	484	318	311	310	338	293	519	286
	V	86	97	100	166	251	251	308	152	164	159	164	132	157	176
MEASLES		3,819	3,690	2,991	4,428	4,242	4,242	4,794	4,277	4,547	4,106	4,163	4124	4387	5050

Source: Ministry of Health

- Nil.

B.C.G = Bacillus + Calamus + Guerin (0-4 Years).

D.P.T = Diptheria + Perussis + Tetanus (1-3 Years).

T.T = Tetanus Toxoid (1-5 Years).

B.R = Booster.

HBV = Hepatitis Vaccine

TABLE 11.4

DOCTOR CLINIC FEE IN VARIOUS CITIES

(In rupees)

Ending November	Faisal-abad	Gujran-wala	Hyder-abad	Islam-abad	Karachi	Lahore	Pesha-war	Quetta	Rawal-pindi	Sukkur	Average
1990	51.67	32.50	50.00	26.88	26.54	30.00	22.50	57.00	25.83	35.00	35.79
1991	42.00	32.50	50.00	27.50	27.09	24.64	22.50	60.00	26.67	40.00	35.29
1992	31.67	32.50	66.67	27.50	26.49	24.64	22.50	52.50	29.17	75.00	38.86
1993	32.54	43.75	80.00	27.50	28.85	27.14	27.50	52.50	29.17	75.00	42.40
1994	32.50	40.00	65.00	27.50	31.00	24.64	30.00	82.50	29.17	70.00	43.23
1995	37.50	40.00	65.71	27.50	32.24	30.00	30.00	90.00	30.00	75.00	45.79
1996	30.00	40.00	53.00	32.50	31.88	27.86	30.00	80.00	30.00	55.00	41.02
1997	35.00	40.00	46.25	32.50	31.88	27.86	30.00	80.00	30.83	60.00	41.43
1998	35.00	40.00	33.75	33.44	31.60	33.21	30.00	107.50	30.00	30.00	40.45
1999	35.00	40.00	33.75	33.44	32.17	33.93	30.00	107.50	31.25	30.00	40.75
2000	40.00	40.00	33.75	33.13	32.40	38.93	30.00	107.50	32.92	30.00	41.86
2001	40.00	40.00	33.75	33.13	33.00	41.96	43.33	107.50	33.75	30.00	43.64
2002	40.00	50.00	30.00	33.13	35.00	41.25	43.33	95.00	33.96	30.00	43.17
2003	40.00	50.00	31.25	45.00	36.35	41.96	50.60	100.00	38.75	30.00	46.33
2004	41.25	50.00	33.00	45.00	36.25	41.96	50.00	100.00	38.75	30.00	46.62
2005	41.25	50.00	33.75	46.25	38.08	44.29	50.00	100.00	42.08	30.00	47.57
2006	41.25	50.00	33.75	55.00	41.73	52.68	50.00	100.00	43.75	50.00	51.81

Source: Monthly Statistical Bulletins, Federal Bureau of Statistics.