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Women Health in Rural Pakistan in Millennium Development Goals Perspectives

Muhammad Israr[1] Dawood Jan[2] Nafees Ahmad[4] Muneeb-Ur- Rehman[3]
1.Assistant Professor and Head of Department, Department of Rural Development, Amir Muhammad Khan Campus, Mardan, The University of Agriculture-Peshawar, Khyber Pakhtunkhwa-Pakistan
2.Associate Professor, Department of Agriculture and Applied Economics, The University of Agriculture-Peshawar, Khyber Pakhtunkhwa-Pakistan
3.Graduate students, Department of Rural Development, Amir Muhammad Khan Campus, Mardan, The University of Agriculture-Peshawar, Khyber Pakhtunkhwa-Pakistan
4.Lecturer Department of Economics, University of Malakand, Chakdara (Dir Lower), KP-Pakistan

Abstract
This aim of this research was to study the situation of different Millennium Development Goals (MDGs) indicators at the gross root level in Mardan district of Khyber Pakhtunkhwa. For this primary data were collected with the help of pre-designed questionnaires through face to face interview from 60 randomly households head. The data was analysed by using descriptive statistics and non-parametric tests. Main finding revealed that majority and statistically significant respondents not using any contraceptive methods. Majority of the respondents have no deliveries in their homes ended in last 3 years and there was no significant difference in the percent distribution of the respondents in the selected villages regarding this. Maternal health care, births attendant status and immunization of children against EPI are not up to the mark. Knowledge about HIV/AIDS, malaria, TB, DM is at maximum. The study recommends for social campaign/awareness, births control at the household's level, training of more skillful persons having specialty in the maternal health care, immunization of children of less than 2 years about the different contagious diseases.
Keywords: Maternal health, HIV/AIDS preventions, MDGs

INTRODUCTION

The increasing concern with social aspects of development finds its roots in the realization that a unit of investment in education, health, social welfare or other branches of manpower planning is in the long run as productive as unit of investment in agriculture industry or trade. There is a close association between social expenditure and subsequent economic development. Investment in the manpower planning plays an important role towards social progress, political stability and economic development in most of the developing and under developed countries of the world (Israr et.al, 2010). To achieve these targets in the developing world the eight Millennium Development Goals (MDGs) were agreed upon at the United Nations (UN) Millennium summit in 2000, by 192 countries in order to improve the living conditions of the world's population. All 189 UN member states at the time and at least 23 international organizations committed to help in achieving the millennium goals. Each goal has specific targets and dates for achieving those targets. MDGs were meant as a major motivational contrivance to increase development efforts within and on behalf of poor countries. They can be seen as a fundamental promotion of human well -being from a multidimensional perspective and the principles enfolded in these goals share the concept of human well-being underlying the human development index. Although, the MDGs originated in the United Nations, country driven and nationally owned efforts are necessary for their achievement. Given that the goals are ambitious, reflecting urgent need for fast progress on development, every poor country has to prepare a national strategy that addresses these issues. They need to assess whether and how the goals can be achieved within the target period and may have to redefine policy priorities; every national development strategy should formulate national policies to attain these goals. Identification of new actions and resources may be necessary to reach the MDGs but this could also lead to attention being drawn away from certain areas or regions within a country (Chakravarty & Majumder, 2008). The MDGs originated from the UN millennium declaration. The declaration asserted that every individual has the right to dignity, freedom, equality, a basic standard of living that includes freedom from hunger and violence and encourages tolerance and solidarity. The MDGs set concrete targets and indicators for poverty reduction in order to achieve the rights set forth in the declaration.

The Human Development Index (HDI) is a well-known yardstick of wellbeing. Since its introduction 20 years ago, the index has attracted enormous interest in discussions of development, both in policy and academic circles as well as in the broader community interested in development issues. The simplicity of the index's characterization of development (as an average of achievements in health, education and income), linked to the basic message that development is about much more than growth has contributed to its popularity (Klugman et al., 2011). Human development is a process of enlarging people's choices. In principle, these choices can be infinite and change over time. But at all levels of development, the three essential ones are for

people to lead a long and healthy life, to acquire knowledge and to have access to resources needed for a decent standard of living. If these essential choices are not available, many other opportunities remain inaccessible (UNDP, 2010). With the continuing rapid evolution, adoption and relegation of ideas, policies and practices in development, words have continued to change. To achieve the diffident indicators of HDI in development of the developing world the UN set the goals to be achieved in the specified time. These are to reduce extreme poverty and hunger, achieve universal primary education, promote gender equality and empowerment of women, reduce child mortality, improve maternal health, including reducing maternal mortality by three–quarters, prevent the spread of HIV/AIDS, malaria and other diseases, ensure environmental sustainability and to develop a global partnership for development

BACKGROUND OF THE STUDY

The empirical literature on the effects of health capital on growth is relatively thin. Conceptually, a healthy person can not only work more effectively and efficiently but also devote more time to productive activities. Based on microeconomic evidences, Strauss and Thomas (1998) argue that health explains the variations in wages at least as much as education. Research at the macro level can better capture the potential externalities of health sector interventions and the existing studies are supportive of the positive contribution of health capital to growth. Bloom and Canning (2003), Bloom and Savilla (2004), and Gyimah and Wilson (2004) find that health capital indicators positively influence aggregate output. They find that about 22-30 percent of the growth rate is attributed to health capital and improvements in health conditions equivalent to one more year of life expectancy are associated with higher GDP growth of up to 4 percentage points per year.

Studies examining the impact of social spending on social indicators have produced mixed results. Based on cross-sectional data for developing countries, Baldacci et al., (2003) and Gupta et al. (2002) find that social spending is an important determinant of education and health outcomes. They also find that education spending has a greater effect on social indicators than health outlays. The positive effect of social spending on social indicators is also supported by Bidani and Ravallion (1997) and Psacharopoulos and Patrinos (2002). Similarly, a number of studies of Musgrove (1996), Pritchett (1996), Filmer and Pritchett (1997), and Filmer et al. (1998) find that the contribution of health spending to health status as measured by infant mortality or child mortality is either small or statistically insignificant. In contrast, Gupta, et al. (2003) finds a positive relationship between public spending on health care and the health status of the poor.

Also Schultz, (1999) pointed that education and health are interlinked in their contribution to growth. Higher levels of education increase public awareness and the capacity of families to address their own health needs. At the same time, better health enhances the effective and sustained use of the knowledge and skills that individuals acquire through education. Barro (1996) further argues that better health can reduce the depreciation of education capital and thus increases the favorable effect of education on growth. Few studies, however, have examined social spending, social indicators, and growth in an integrated system. Arjona et al. (2001) find that although there is no clear impact of social spending on growth at the aggregate level, there exists a positive association between certain types of social spending and growth. Recent study by Gyimah and Wilson (2004) finds a positive and robust link between investment in health and growth in both Sub-Saharan African and OECD countries. Research of Mauro (1998), Abed and Gupta (2002), Gupta et al. (2002) and Rajkumar and Swaroop (2002) has also highlighted the important role of institutions and governance in mediating the nexus between social spending, indicators and growth. Poor governance has been identified as a key cause of ineffective social spending.

MDGs are a global agenda of actions for human development. Inter-countries comparison of progress on MDGs targets from different South Asian countries confirms that there seems little possibility of meeting the MDGs. This is probably due to resource constraints and diversion of resources away from health to meet the pressing expenditures of energy, floods, food and security over the last few years which had a significant impact on the delivery of health services. Though Pakistan has registered a significant decline in its child and maternal mortality rates since, 1990 through a coverage of essential intervention to combat the major diseases malaria, measles and HIV etc. However, slow progress in the indicators of maternal health and child mortality are major concerns in the progress towards MDGs. Special efforts would be required to meet MDGs deadline of reducing the infant mortality rate to 40 ,under 5 years mortality rate to 52 and maternal mortality to 140 by 2015.

Prevention and treatment of HIV/AIDS remain among the most important condition for resumption of human development activities across much of the regions. The objectives of the HIV/AIDS prevention program are to prevent HIV/AIDS transmission and to promote safe blood transfusion. The number of injecting drug users has posed a threat of increasing numbers of total cases of HIV/AIDS in Pakistan. Still the prevalence of HIV/AIDS is considered to be as low as 1%, hence not considered a high risk country. The focus of the program is on behavior change communication (BCC), services to high-risk population groups, treatment of sexually transmitted infections (STIs) and supply of safe blood and capacity building of various stakeholders. Till date 4,500 HIV positive cases have been reported to the AIDS control programs at federal and provincial levels. The

program is technically supported by the UN agencies and global fund against AIDS, TB and Malaria.

Mother and Child health has been one of the priority areas of public health in Pakistan. This program has been launched by the government in order to improve maternal and neonatal health services for all, particularly the poor and the disadvantaged at all levels of health care delivery system. It aims to provide improved access to high quality mother and child health and family planning services, train 10,000 community midwives. Comprehensive emergency obstetric and neonatal care services in 275 hospitals/health facilities, basic services in 550 health facilities, and family planning services in all health outlets. Despite these modalities, Pakistan has shown a modest improvement in this segment and the Infant mortality rate and Child mortality rates are still very high as compared to the other countries in the region. It is envisaged that successful implementation of this project will bring these indicators in a respective range with improved health status of mothers and children. Resting on the importance of the topic in contribution to the existing literature this study was design with the following objectives:

OBJECIVES OF THE STUDY

1. To study the different indicators of the MDGs in the study area at the gross root level.
2. To study the situation of different contagious diseases which affect the human capital?
3. To forward policy recommendations on the basis of study findings for bringing improvement in the human development index in the area.

MATERIAL AND METHODS

District Mardan is comprised of two Tehsail, namely Mardan and Takhtbhai. For this study Tehsail Mardan was selected purposively because of the reasons of having urban, per-urban and rural characteristic. Further from this three union councils i.e. Khazana Dheri, Chamtar, Manga were randomly selected as a stratum and from this stratum three different sub-stratum of villages were selected randomly i.e. Gund Abad, Shah Kalay and Muslim Abad. The respondents of the study were the head of households having age between 25 -60 years. Primary data were collected by means of questionnaires about the different aspects of the MDGs and was confirmed from secondary data from different published and unpublished sources available through face to face interview from the respondents from 60 (20 from each village) respondents due to the time and money limitations. The sample size in the representative of the whole population as mentioned by Rescoe (1975) cites in Sakaran (2000), “sample sizes larger than 30 and less than 500 are appropriate for most research”. As mostly the data were qualitative in nature therefore, it was analyzed by using descriptive statistics coupled by non-parametric tests for checking the significant of the variable.

RESULTS AND DISCUSSION

The data on the indicators of maternal health, including reducing maternal mortality by three –quarters and prevent the spread of HIV/AIDS, malaria and other diseases. The discussion starts from the married women in the households.

Married women in the households

The MDGs and other global commitments have focused primarily on the entitlements and needs of women. Women play a significant role in the development of nation. Women are heavily engaged in domestic chores along with the socio-economic activities. They have major role in household management and they have to do of household works in spite of having low decision making power. After the marriage the women responsibilities in the household management increases. The data in table-I presents information regarding the number of married women in household. The numbers of married women were divided into a class interval of 1-2, 3-4 and 5-6. It is evident from the data in that in almost all villages an overwhelming majority (90%) of the household having 1-2 number of married women. This is attributed by the fact that in the sample area as like in Pakistan majority of the respondents having young people in the household. The chi-square value explained that there is a significant difference in the percent distribution of the respondents in the numbers of married women in households among the three selected villages.

Table-I: Respondents distribution on number of married women in the households

Village name	Number of married women in the households				
	No women married	1-2 married women	3-4 married women	5-6 married women	Total
Shah Kalay	0{0%}(0.33)[0.33]	18{90%}(18.00)[0.0]	1 {05%}(1.33)[0.08]	{05%}(0.33)[1.33]	20
Gund Abad	0{0%}(0.33)[0.33]	18{90%}(18.00)[0.0]	2{10%}(1.33) [0.33]	0{00%}(0.33) 0.33]	20
Muslim Abad	1{5%}(0.33)[1.33]	18{90%}(18.00)[0.0]	1{5%}(1.33)[0.08]	0 {0%}(0.33)[0.33]	20
Total	1{02%}	54{90%}	4{06%}	1{02%}	60

- figure without parenthesis is the frequency, {Percent distribution}, (expected cell totals), [Chi-square statistic for each cell].
- Chi-square statistic at 5% level of significance is 4.5 and P value is 0.609339.

Source: Field Survey, 2014

Eligible couples for marriage in the household

Women's health during the reproductive or fertile years is relevant not only to women themselves, but also has an impact on the health and development of the next generation. Many of the health challenges during this period are ones that only young girls and women face. Married adults have made greater economic gains than unmarried adults. Individuals who are legally married under the laws of the State where they have a permanent home, living together in the same household and holding themselves out as husband and wife to the community in which they live. The data in the table-II depicts the number of eligible couples in household for marriage. The number of eligible couples was divided into a class interval of 1-2 and 3-4. The data in the table shows that in almost all villages an overwhelming majority of the household having 1-2 number of eligible couples for marriage in the household. This implies that majority of the Pakistan population consist of the young group and are eligible to established the martial relationship in the society. Chi-square statistic explains that there is no difference in the percent distribution in the numbers of eligible couples among the selected villages in the area.

Table-II: Total numbers of eligible couples for marriage in the household

Village name	Number of eligible couples in HHs			
	No couple	1-2 couples	3-4 couples	Total
Shah Kalay	2 {10%}(2.33) [0.05]	17 {85%} (16.33) [0.03]	1 {05%} (1.33) [0.08]	20
Gund Abad	2 {10%} (2.33) [0.05]	16 {80%} 16.33) [0.01]	2 {10%} (1.33) [0.33]	20
Muslim Abad	3 {15%} (2.33) [0.19]	16 {80%} 16.33) [0.01]	1 {05%} (1.33) [0.08]	20
Total	7{12%}	49{82%}	4{06%}	60

- figure without parenthesis is the frequency, {Percent distribution}, (expected cell totals), [Chi-square statistic for each cell].
- Chi-square statistic at 5% level of significance is 0.8265 and P value is 0.934856.

Source: Field Survey, 2014

Couples using contraceptive methods

Reproductive intentions are important predictors of contraceptive behavior. Joint fertility intentions of the spouse will significantly determine whether the couple will use modern methods of family planning (Bankole, 1998). There is a positive relationship between income and knowledge of the respondents about the different methods of birth control (Shakeel, 2003). Future fertility is likely to be more important to married couples when choosing a birth control method. The data in the table-III pointed the number of couples using contraception methods. The number of couples using contraception was divided into not using any methods and using 1-2 methods. Findings of the data revealed that in village Gund Abad 80% of the couple not using any contraceptive methods, while only 20% of the sample respondents use it. Also in villages Shah Kalay and Muslim Abad more that 70% of the respondents reported for not using any contraceptive methods. In the whole study area 75% of the respondents mentioned for not using any methods of contraception while only 25% reported for it use. This implies that in sample area people often don't use contraceptive methods due to the strong cultural or religious backgrounds or not aware of any birth control mechanism. Chi-square value explains that there is not a significant difference among the percent distribution in the couple using contraceptive methods in the selected villages in the area.

Table-III: Total number of couples using contraceptive methods

Village name	Couples using contraception methods		
	Not using any methods	Using 1-2 methods	Total
Shah Kalay	15* {75%}(15.00) [0.00]	5{25%} (5.00) [0.00]	20
Gund Abad	16 {80%} (15.00) [0.07]	4 {20%} (5.00) [0.20]	20
Muslim Abad	14 {70%} (15.00) [0.07]	6 {30%} (5.00) [0.20]	20
Column Totals	45{75%}	15{25%}	60

- figure without parenthesis is the frequency, {Percent distribution}, expected cell totals), Chi-square statistic for each cell].
- Chi-square statistic at 5% level of significance is 0.5333 and P value is 0.765928.

Source: Field Survey, 2014

Deliveries ended in the last 3 years

Number of deliveries determined the women health status in the households. Continuous deliveries without any interval by a woman affect the neonatal health and also lead to the complication health problems for the mothers. Data in table-IV presents the number of deliveries ended in last 3 years. The number of deliveries in last 3 years was divided into no deliveries and 1-2 deliveries. The data in the table shows that in village Shah Kalay 70% of the population have no deliveries ended in last 3 years while only 30% have 1-2 deliveries ended. This shows that majority of the people are newly married and having no children yet and still have not opted for the child birth now. The chi-square value suggests that there is a significant difference in the number of deliveries ended in the last three years among the three selected villages of the area.

Table-IV: Total numbers of deliveries ended in last 3 years

Village name	No. of deliveries ended in last 3 years		
	No deliveries	Having 1-2 numbers of deliveries	Total
Shah Kalay	14 {70%}(12.00) [0.33]	6 {30%} (8.00) [0.50]	20
Gund Abad	7 {35%} (12.00) [2.08]	13 {65%} (8.00) [3.12]	20
Muslim Abad	15 {75%} (12.00) [0.75]	5 {25%} (8.00) [1.12]	20
Total	36{60%}	24{40%}	60

- figure without parenthesis is the frequency, {Percent distribution}, (expected cell totals), Chi-square statistic for each cell].
- Chi-square statistic at 5% level of significance is 7.9167 and P value is 0.019095.

Source: Field Survey, 2014

HIV disease

For many women, the years between puberty and menopause offer multiple opportunities for personal fulfillment and development. However, this can also be a time of health risks specifically associated with sex and reproduction that may result in a significant burden of mortality and disability. Women are particularly vulnerable to HIV infection, due to a combination of biological factors, lack of access to information and services, and social norms and values that undermine their ability to protect themselves. Their vulnerability may increase during humanitarian crises and emergencies when economic hardship can lead to increased risk of exploitation, such as trafficking, and increased reproductive health risks related to the exchange of sex for money and other necessities (WHO, 2010). Globally, HIV is the leading cause of death and disease in women of reproductive age and women's particular vulnerability to HIV infection stems from a combination of biological factors and gender inequality (Ribeiro, et al., 2008). The data in tables-V and VI, presents information about HIV. The prevention methods of information about HIV is divided into different categories i.e. use of contraception method, careful relationship with partner, avoid use of untested blood and don't know. The value of the chi-square pointed that there is a significant variation in the knowledge of the percent distribution of the responders among the selected villages of the area about the HIV and AIDS diseases.

Table-V: Respondents distribution regarding information of major diseases

Village name	Knowledge about HIV/AIDS		
	Having knowledge	Having no knowledge	Total
Shah Kalay	17 {85%} (13.33) [1.01]	3 {15%} (6.67) [2.02]	20
Gund Abad	15 {75%} (13.33) [0.21]	5 {25%} (6.67) [0.42]	20
Muslim Abad	8{40%} (13.33) [2.13]	12 {60%} (6.67) [4.27]	20
Total	40{67%}	20{33%}	60

- figure without parenthesis is the frequency, {Percent distribution}, expected cell totals), Chi-square statistic for each cell].
- Chi-square statistic at 5% level of significance is 10.05 and P value is 0.006572.

Source: Field Survey, 2014

Table-VI: Respondents distribution on HIV/AIDS prevention methods

Village name	HIV/AIDS prevention methods							
	A (%)	**B** (%)	**C** (%)	**D** (%)	**E** (%)	**F** (%)	**G** (%)	**H** (%)
Shah Kalay	02 (12)	05(29)	10(50)	03(17)	05(29)	15(75)	03(17)	17(85)
Gund Abad	05(29)	02(12)	01(05)	12(30)	02(12)	18(90)	01(02)	19(95)
Muslim Abad	05(29)	02(12)	01(05)	12(30)	03(17)	17(85)	02(12)	18(90)
Total	**12(30)**	**09(22)**	**12(30)**	**27(67)**	**10(25)**	**50(83)**	**06(15)**	**54(90)**

A= use of contraception method, **B**=careful relationship with partner, **C**=Avoid use of untested blood, **D**=Avoid use of infected syringe, **E** = Don't know, **F**=HIV can spread through mosquito, **G**=HIV can spread through eating and talking with patient, **H**=healthy person can transmit HIV

Source: Field Survey, 2014

Malaria disease

Malaria eradication is one of the important points in MDGs. Malaria is one of the major diseases in Pakistan and all around the world. Women are the most vulnerable to malaria in Pakistan because in most rural areas livestock are reared by women and the dung cakes and dairy products are processed by women so they are vulnerable to mosquitoes which are the main reason of malaria. The data in tables-VII and VII explains that in all villages 13% of the people don't know about malaria and 87 % of people know about this disease. It is necessary for government and other social sectors to aware more and more people about this disease because if people don't know about a disease so then how one can prevent from it. The value of the chi-square explains that there is a significant difference in the percent distribution among the three selected villages of the area. The ways to

prevent the malaria disease, it was reported by 17% of the respondents for use of antimalarial medicines, 63% respondents adopted appropriate prevention measures from mosquitoes, 27% use mortein, while 15% don't know how to prevent malaria.

Table-VII: Respondents distribution about malaria knowledge

Village name	Knowledge about malaria		
	Having knowledge	Having no knowledge	Total
Shah Kalay	19 {95%} (17.33) [0.16]	1 {05%} (2.67) [1.04]	20
Gund Abad	20 {100%} (17.33) [0.41]	0 {00%} (2.67) [2.67]	20
Muslim Abad	13 {65%} (17.33) [1.08]	7 {35%} (2.67) [7.04]	20
Total	52{87%}	8{13%}	60

- figure without parenthesis is the frequency, {Percent distribution}, (expected cell totals), Chi-square statistic for each cell].
- Chi-square statistic at 5% level of significance is 12.4038 and P value is 0.002026.

Source: Field Survey, 2014

Table-VIII: Respondents distribution about malaria prevention methods

Village name	Methods of malaria preventions				
	Use of anti-malarial medicines	Prevention measures from mosquitoes	Mortein, mosquito repellent	Don't know	**Total**
Shah Kalay	3{16%}(3.63)[0.11]	13{68%}(12.12)[0.06]	4 {21%} (2.02) [1.94]	1{05%}(3.23)[1.54]	21
Gund Abad	5{25%}(1.90)[5.04]	5 {25%} (6.35) [0.29]	1{50%} (1.06) [0.00]	0 {00%}(1.69)[1.69]	11
Muslim Abad	1{08%}(3.46) [1.75]	12{92%}(11.54)[0.02]	0{29%} (1.92) [1.92]	7 {54%}(3.08)[5.00]	20
Total	9{17%}	30{63%}	5{27%}	8{15%}	**52**

- figure without parenthesis is the frequency, {Percent distribution}, (expected cell totals), Chi-square statistic for each cell].
- Chi-square statistic at 5% level of significance is 19.3688 and P value is 0.003584.

Source: Field Survey, 2014

Tuberculosis disease

Tuberculosis (TB) is one of the major diseases to combat against which is included in MDG. According to WHO (2005) 6 million people die every year due to HIV/AIDS, Malaria and TB and of those 2 million deaths are due to TB. TB is curable but kills 5000 people every day. Also it was reported that 98% of TB deaths are in developing world affecting mostly young age people. Global TB incidence is increasing by 1% a year. TB especially affects the most vulnerable such as the poorest and malnourished. The WHO also reported that 8.8 million new cases are reported in 2013 with 80% in less developed countries. The data in the table-IX pointed in all villages still 12% of people did not know about TB. The ways to prevent the TB disease, it was reported by 30% of the respondents for use well boiled milk/water, 70% of the respondents for adopting hygienic measures against TB, while 13% don't know how to prevent from TB.

Table-IX: Respondents distribution about T.B and its prevention

Village name	Respondents knowledge about T.B					
	Do you know about TB		If yes then how one can prevent T.B			
	Having knowledge (%)	Having no knowledge (%)	**A** (%)	**B** (%)	**C** (%)	**Total**
Shah Kalay	17(85)	03(15)	05(29)	12(71)	03(18)	17
Gund Abad	18(90)	02(10)	04(22)	14(78)	02(11)	18
Muslim Abad	18(90)	02(10)	07(39)	11(61)	02(11)	18
Total	**53(88)**	**07(12)**	**16(30)**	**37(70)**	**07(13)**	**53**

A=Use of well boiled milk/water, **B**= adopting hygienic measures against TB, **C**=don't know

Source: Field survey, 2014

CONCLUSION AND RECOMMENDATIONS

The empirical results of three selected villages pointed out that HIV/AIDS, knowledge about malaria, information regarding TB, DM is at maximum level and by looking the present progress, it will be stated that the desired result will be achieved in the specified time limit of the MDGs by the respective organization. The achievement at maternal health care, births attendant status and immunization of children against EPI is not satisfactory at all levels and hence cannot achieve the specified targets in the area. On the basis of the study findings the following recommendations are forwarded for future policy formulation about the targets of MDGs in specific to the rural areas of Mardan, other rural areas of the Province and Pakistan and the whole developing countries having similar socio-economic characteristic.

I. There is a need of social campaign/awareness among the respondents about the different contraceptive

methods for control of the population problem in the area

II. There is a need of births control at the household's level, and this can be achieved by taking in to confidence the household head/local elders about the different interventions made by the government and NGOs in the area.

III. Proper measures should be adopted for the prevention of DM, malaria and HIV/AIDS. They must be aware through awareness programs.

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