Responsiveness and Accountability in the Health Sector, Pakistan

Annexes

September 2010

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ANNEX 1: LIST OF INTERVIEWEES

Name	Organisation
Federal Authorities	
Dr. Nadeem Ahsan	Chairman National Standing Committee for Health
Mr Javed Malik	Federal Ombudsman
Dr. Rashid Jooma	Director General (Health)
Sheikh Ghazanfar Hussain	Secretary, Local Government
Dr Assad Hafeez, Ms Saadiya Razzaq	Health Systems Strengthening and Policy Unit
Dr Haroon Khan	Pakistan Institute of Medical Sciences
National Assembly	
Dr Nadeem Ahsan	National Assembly Standing Committee, Health
Dr Donya Azizi	National Assembly Standing Committee, Health
Province of Punjab	
Mr Fawad Hassan Fawad	Secretary Health
Mr Anwar Ahmed Khan	Secretary Local Government
Mr Abdullah Khan Sumbal	Special Secretary Health
Dr M. Aslam Chaudhery	Director General Health
Dr A. Janjua	District Health Information System
Dr Zaffar	EDO (Rawalpindi)
Dr Talat	EDO (Sialkot)
Dr Junaid Qureshi	EDO (Sheikhupura)
Dr Arshad Ali Sabir	EDO (Chakwal)
Faneem Ahmad Khan	DSM, PRSP (Chakwal)
Province of Khyber Paktunkhwa	
Dr Fazle Mehmood	DGHS-Khyber Pakhtunkhwa
Dr Shabina Raza	Chief HSRU
Dr Ali Ahmad	Project Director DHIS
Dr Salar khan	Provincial Coordinator MNCH
Dr Ihsan Ullah Turabi	Provincial Coordinator LHW Program
Dr Mujahid Hussain	Deputy Director EPI-DGHS

Dr Sabz Ali Khan	EDO Nowsehra
Dr. Gul Akbar	EDO Charsadda
Dr.Shad Ali Khattak	EDO Kohat
Dr Haider Ali	Chairman Standing Committee on Health
Dr Muhammad Irshad	SMO – RHC ,Badaber District Peshawar.
Dr Hameedullah	MO- BHU, Sufaid Dheri District Peshawar.
Shakil Ahmed	People's Primary Health Care Initiative, PPHI
Dr Rubina Gilani	Fred Hollows Foundation for Prevention of Blindness

Province of Baluchistan

Mr Jalal Mandokhel	Secretary Health
Dr. Mohammad Tariq Jaffar	CPO Health
Dr. Mir Yousaf Bizinjo	MNCH Programme Manager
Dr. Shoaib Magsi	EDO (H) Lorali District
Dr Wahib Baloch	EDO (H) Lasbela
Mr Sharfaddin Zehri	CEO, Poverty Alleviation Organisation
Mr Anwar Panezai	Manager, Social Sector and Relief Operations, BRSP

Donors

Mr Sohail Ahmed	JICA
Ms Janet Pancastillo	USAID
Dr Inam-ul-Haque	World Bank
Mr Imran	GTZ
Blaine Marchand etc. Carrie Lee Chung, Sadia Ahmed	CIDA
Dr Mubashir	UNFPA

Special projects

Mr Farasat Iqbal	Health Sector Reform Programme & PMDGP Asian Development Bank (ADB)
Mr Mansoor Saqib	HSRP and PMDGP Asian Development Bank
Mr Atif Dar	District Monitoring Officer (Chakwal)

	Education Sector Reform Programme World Bank
Dr Simon Azariah	Systems Oriented Health Investment Programme (SOHIP), Agriteam Canada Consulting
Dr Nabeela Ali	Pakistan Initiative for Mothers and Newborn (PAIMAN)

NGOs

Dr Sania Nishtar	Heartfile
Mr Daniyal Aziz	Governance Institutes Network International
Mr Abid Saeed	Punjab Rural Support Programme
Ms Saadiya Yunus	National Commission for Human Development
Ms Fatima Naqvi	Oxfam GB
Mr Naseer Memmon, Dr Noreen Kalid	Strengthening Participatory Organisations (SPO)
Dr Abid Qaiyum Suleri	Sustainable Development Policy Institute (SDPI)
Dr Arif Azad	The Network for Consumer Protection
Dr Saman Yazdani,	Shirkat Gah

Media

D Shireen Mazari	The Nation
Nasim Zehra	Dunya TV
Quatrina Hosain	The Tribune
Mohammed Malick	GEO News

ANNEX 2: PROVINCIAL CONSULTATIONS

Name	Organisation
Province of Punjab	
Saadiya Razzaq	HSSPU
Dr Saman Yazdani,	Shirkat Gah
Dr Khalid Maseed	EDO (H) Muzzafargarh
Dr Tariq Jamsheed Shah	Public Health Specialist, MNCH programme
Muhammid Zul Qarnain	DSM, PRSP
Faneem Ahmad Khan	DSM, PRSP Chakwal
Atif Dar	DMO, PRSP Chakwal
Dr Khaleeq A. Qureshi	DG Health Office
Mansoor Ahmad	Punjab Health Sector Reform Programme
Province of Khyber Paktunkhwa	
Dr Assad Hafeez	HSSPU
Saadiya Razzaq	HSSPU
Dr Ahmad Ali	Special Secretary, Health Regulatory Authority
Ivan G Somlai	Project Field Manager, CESSDI
Dr Ali Ahmad	Project Director DHIS
Dr Salar Khan	Provincial Coordinator MNCH
Dr Aminhulhaq	Deputy Provincial Coordinator LHW Programme
Mr Adil Saeed Safi	Senior Planning Officer, Dept of Health
Dr Qasim	EDO Abottabad
Dr Shahid Yumis	Coordinator, HSRU
Dr Emel Khan	Frontier Primary Health Care
Dr. Jehan Zel Uhau	Deputy EDO Charsadda
Dr Qazi Afsar	Assistant Director, EDI programme
Himayat Ullah Mayyar	Ex-Nazim Distict Mardan
Tauseef Ahmad	The News newspaper
Ashfaq Yousaf Zia	DAWN newspaper

ANNEX 3: DRAFT LOGFRAME

<table>
<tr><td>PROJECT NAME</td><td colspan="8">Responsiveness and accountability strategy for health sector, Pakistan</td></tr>
<tr><td>GOAL</td><td>Indicator</td><td>Baseline</td><td>M Y1</td><td>M Y2</td><td>M Y3</td><td>M Y4</td><td>Target Y5</td><td>Assumptions</td></tr>
<tr><td rowspan="4">To improve the health and wellbeing of all Pakistanis, particularly women and children, through access to essential health services.</td><td rowspan="4">Selected MDG health indicators disaggregated by gender e.g. maternal mortality ratio, neonatal mortality rate</td><td></td><td></td><td></td><td></td><td></td><td></td><td rowspan="4">Achieving MDG health targets in Pakistan remains a priority for federal and provincial governments.

International support adequate to enable federal and provincial governments to respond adequately to impact of 2010 floods.
Security situation is conducive to health service delivery for the poor and marginalised.</td></tr>
<tr><td colspan="3">Source(s) of Verification</td><td colspan="4">Collected by</td></tr>
<tr><td colspan="3">Pakistan Demographic & Health Survey 2012</td><td colspan="4">National Institute of Pakistan Studies(NIPS) under Ministry of Population Welfare</td></tr>
<tr><td colspan="3"></td><td colspan="4"></td></tr>
<tr><td>PURPOSE</td><td>Indicator</td><td>Baseline</td><td>M Y1</td><td>M Y2</td><td>M Y3</td><td>M Y4</td><td>Target Y5</td><td>Assumptions</td></tr>
<tr><td rowspan="3">To promote an accountable health service responsive to the needs of the its citizens, in particular the poor and marginalised, in line with the MDGs.</td><td rowspan="3">Documented positive changes in the responsiveness and accountability of public health services relevant to MDGs, at all levels.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="3">Source(s) of Verification</td><td colspan="4">Collected by</td><td rowspan="2">Commitments to greater accountability in health sector in NHP 2010 are ‘toughened up’, adequately resourced, implemented and monitored.</td></tr>
<tr><td colspan="3">Proposed annual health sector assessments</td><td colspan="4">HSSPU/NHIRC</td></tr>
</table>

<table>
<tr><td rowspan="6">IMPACT WEIGHTING

Increased demand in the media and in public fora for improved, accountable health services that meet the needs of the poor and marginalised</td><td>OUTPUT 1</td><td>Indicator</td><td>Baseline</td><td>M Y1</td><td>M Y2</td><td>M Y3</td><td>M Y4</td><td>Target Y5</td><td>Risks</td></tr>
<tr><td rowspan="2">Number of media reports on need for health services more responsive to the needs of the poor and marginalised.</td><td></td><td></td><td></td><td></td><td></td><td></td><td rowspan="2">Deteriorating security or economic situation diverts public attention and budgets from health sector.</td></tr>
<tr><td colspan="2">Source(s) of Verification</td><td colspan="4">Collected by</td></tr>
<tr><td colspan="2">Proposed annual health sector assessments</td><td colspan="4">HSSPU/NHIRC</td></tr>
<tr><td>Indicator</td><td>Baseline</td><td>M Y1</td><td>M Y2</td><td>M Y3</td><td>M Y4</td><td>Target Y5</td><td>Risks</td></tr>
<tr><td rowspan="3">Number of meetings of the public with decision and policy makers on the on need for health services more responsive to the needs of the poor and marginalised.</td><td></td><td></td><td></td><td></td><td></td><td></td><td rowspan="3">Deteriorating security or economic situation diverts public attention and budgets from health sector.</td></tr>
<tr><td colspan="2">Source(s) of Verification</td><td colspan="4">Collected by</td></tr>
<tr><td colspan="2">Proposed annual health sector assessments</td><td colspan="4">HSSPU/NHIRC</td></tr>
</table>

<table>
<tr><td>OUTPUT 2</td><td>Indicator</td><td>Baseline</td><td>M Y1</td><td>M Y2</td><td>M Y3</td><td>M Y4</td><td>Target Y5</td><td>Risks</td></tr>
<tr><td rowspan="5">IMPACT WEIGHTING | %

Evidence of increased responsiveness of public health system to public review and citizen engagement, especially by the poor and marginalised.</td><td rowspan="3">Number of policy/practice changes in MOH in response to open review by NHPC of progress to national health commitments</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Source(s) of Verification</td><td colspan="5">Collected by</td><td rowspan="2">NHPC is not revived or inadequately resourced to fulfil its anticipated monitoring role.</td></tr>
<tr><td colspan="2">Proposed annual health sector assessments</td><td colspan="5">HSSPU/NHIRC</td></tr>
<tr><td></td><td>Baseline</td><td>M Y1</td><td>M Y2</td><td>M Y3</td><td>M Y4</td><td>Target Y5</td><td>Risks</td></tr>
<tr><td rowspan="3">Number of policy/practice changes in provincial health services in response to public scrutiny of health strategic plans in KP & Punjab</td><td></td><td></td><td></td><td></td><td></td><td></td><td>Lack of political commitment or resources to use the strategic plan for health in KP as a framework for transparency and accountability</td></tr>
<tr><td colspan="2">Source(s) of Verification</td><td colspan="5">Collected by</td><td rowspan="2">Strategic plan for health in Punjab not developed.</td></tr>
<tr><td colspan="2">Proposed annual health sector assessments</td><td colspan="5">HSSPU/NHIRC</td></tr>
<tr><td></td><td>Indicator</td><td>Baseline</td><td>M Y1</td><td>M Y2</td><td>M Y3</td><td>M Y4</td><td>Target Y5</td><td>Risks</td></tr>
<tr><td rowspan="3"></td><td rowspan="3">Documented use of monitoring and reporting system in public health system for performance</td><td></td><td></td><td></td><td></td><td></td><td></td><td>Failure to develop a ‘fit for purpose’ M&E system</td></tr>
<tr><td colspan="2">Source(s) of Verification</td><td colspan="5">Collected by</td><td>Inadequate use of M&E system by health managers e.g. through a</td></tr>
</table>

	management and public accountability.	Health sector reports at district, provincial and federal level		HSSPU/NHIRC				lack of an appropriate culture and/or incentives.
	Indicator	**Baseline**	**M Y1**	**M Y2**	**M Y3**	**M Y4**	**Target Y5**	**Risks**
	Number of suggestions made by CSGs taken up by NSP health managers							Lack of ownership and commitment by NSP staff to a culture of accountability to the community.
		Source(s) of Verification		**Collected by**				
		NSP annual reports		NSPs				
	Indicator	**Baseline**	**M Y1**	**M Y2**	**M Y3**	**M Y4**	**Target Y5**	**Risks**
	Increased utilization of & satisfaction with health services in pilot districts with increased EDO(H) operational flexibility							
		Source(s) of Verification		**Collected by**				EDO(H) ability to manage performance effectively undermined by political and other pressures
		Client satisfaction surveys Independent evaluation		EDO(H)				
INPUTS	**DFID (FTEs)**	**DFID (£)**	**Govt (£)**	**Other (£)**			**Total (£)**	

OUTPUT 3	**Indicator**	**Baseline**	**M Y1**	**M Y2**	**M Y3**	**M Y4**	**Target Y5**	**Risks**
Increased, more effective parliamentary oversight of health sector by national and provincial standing health committees.	Number of committee research reports, policy recommendations acted upon by MOH or provincial health departments.							
		Source(s) of Verification		**Collected by**				Political agendas/motives distort the priorities/activities of the committees
		Parliamentary reports		Implementing agency e.g. PIPS or PILDAT				
								Risks
	Number of health manifestos of and public references to health issues by main political parties.							
		Source(s) of Verification		**Collected by**				Health commitments/statements by political parties are rhetorical rather than have serious intent.
		Party manifestos Media reports		Implementing agency e.g. NDI or PILDAT				
INPUTS	**DFID (FTEs)**	**DFID (£)**	**Govt (£)**	**Other (£)**			**Total (£)**	

OUTPUT 4	**Indicator**	**Baseline**	**M Y1**	**M Y2**	**M Y3**	**M Y4**	**Target Y5**	**Risks**
Increased, more effective regulation of private and alternative health services by provincial regulatory authorities.	Number of monitoring, regulation, accreditation & reporting activities of provincial authorities							
		Source(s) of Verification		**Collected by**				Effective functioning of authorities resisted by vested interests
		Annual reports of provincial authorities		HRA, PHCC				
								Risks
	Establishment and frequency of use of complaints mechanism & system of redress							
		Source(s) of Verification		**Collected by**				Availability of complaints mechanism inadequately publicised and followed through
		Annual reports of provincial authorities		HRA, PHCC				
INPUTS	**DFID (FTEs)**	**DFID (£)**	**Govt (£)**	**Other (£)**			**Total (£)**	

ANNEX 4: OPTIONS MATRIX

					Short-term				Medium-term				Long-term	
	Output		Option	Scope	Yr1	Budget	Yr2	Budget	Yr3	Budget	Yr4	Budget	Yr5	Budget
4.2	Increased public awareness and demand for responsive, accountable health services	4.2.1	Strengthen public communications and advocacy on health	National Punjab KP		300,000		300,000						
		4.2.2	Scale up and embed community approaches	KP Punjab		170,000		170,000						
		4.2.3.	Increase local scrutiny of health allocations and expenditures	KP Punjab		115,000		115,000						
4.3	Increased responsiveness and accountability of public health system.	4.3.1.	Support provincial governments to develop and implement strategic frameworks for the sector	KP Punjab		145,000								

		4.3.2.	Support a reconstituted NHPC, with a broader mandate and wider representation, to monitor and oversee the implementation of national health policy	National		150,000		150,000		150,000				
		4.3.3.	Strengthen the capacity of HSRU and HSSPU to develop a monitoring model for public health system	National		250,000		250,000						
		4.3.4.	Introduce performance-based contracts for NSPs with special emphasis on the role of local communities	Punjab		175,000		150,000						
		4.3.5.	Pilot test an	Punjab		82,000		157,000		187,000				122,000

			autonomous district model of health management by giving EDO(H) enhanced powers:											
4.4	Effective parliamentary oversight of health sector.	4.4.1.	Strengthen the capacity of national and provincial parliamentary committees of health	Punjab KP Balochistan		400,000		400,000		320,000				
		4.4.2.	Strengthen the Health Manifestos of main political parties	National		195,000		205,000						
4.5	Regulation of private and alternative health services	4.5.1.	Strengthen the regulation and accountability of private and alternative health services through provincial health authorities	Punjab KP Balochistan		560,000		260,000						
Total						**2,542,000**		**2,157,000**		**657,000**				**122,000**

ANNEX 5: LITERATURE REVIEW

Responsiveness and Accountability in the Health Sector in Pakistan: A Literature Review

May 2010

Cowan Coventry and Maliha Hussein

Contents

EXECUTIVE SUMMARY

1. There is a growing body of literature on 'voice and accountability' initiatives specifically, in relation to provision of services. The core proposition behind such initiatives is that making public agencies accountable to the citizens they serve is a key part of building effective states that work towards poverty reduction.

2. A responsiveness and accountability strategy must address both 'vertical' systems of accountability i.e. when citizens hold institutions accountable and 'horizontal' systems of accountability i.e. when state institutions engage in mutual scrutiny to correct abuses of office. Most likely, as a reflection of donor patterns of funding, research evidence on 'vertical' accountability in particular, on attempts to mobilise the voice of communities in holding service providers to account predominates over research on the inter-institutional arrangements associated with a 'horizontal' system of accountability. There is a view that horizontal channels of accountability e.g. public oversight bodies, have failed to adequately oversee the work of service providers and that forms of social accountability that introduce the 'voice' of poor people directly to service providers are more effective.

3. While much of the literature confirms the importance of an enabling environment to support the development of responsive services, new laws or regulations will be ineffective if not supported by capacity building and information provision. Public access to relevant information is frequently referenced as an important pre-condition to responsive and accountable public institutions. Once again, access to information needs to be complemented with support to interested actors and watchdog institutions to enable them to use the information. There has been a rich vein of research on the use of community monitoring mechanisms as the basis for community advocacy for improved services. These include citizen report cards, community scorecards and social audits, and the literature on these contains a number of positive case studies. However, all such mechanisms are sensitive to local contexts and cannot be replicated automatically. There is also an emerging consensus that they work best when aligned to formal planning and information systems rather than when operating independently.

4. Aligned to this, a review of donor support for voice and accountability interventions concluded that support for demand-led initiatives is more likely to generate responsive services if they are combined with initiatives to build capacity on the supply side. This might involve a range of support from training and skills development to support on information and monitoring systems.

5. It is widely accepted that civil society has an important role to play in responsive and accountable public services. The state frequently retains responsibility for the provision of health services while delegating the responsibility for the delivery of the services to non-state providers (NSPs). There is evidence that non-state health provision can work well where performance-linked contracts are in place. Civil society organisations (CSOs) also play an important role in advocating or supporting advocacy for improved services - for example, by analysing and presenting data to service providers or decision-makers. However, the literature warns that the capacity of CSOs in this regard is easily over-estimated.

6. Poor women are particularly affected by unresponsive health services. Even when mechanisms exist for giving feedback on the quality of services, women's voices can be eclipsed. Poor women's participation in community-based initiatives to generate responsive health services is vitally important but presents considerable challenges and requires specific, pro-active approaches.

7. South Asia has provided a large body of research on demand-side approaches to responsive service provision and contains a rich body of experience of, for example, experiments in citizen mobilisation and social audits. Specific problems with the health sector e.g. staff absenteeism and corruption, are well documented. Studies recommend the timely availability of funds, delegated responsibilities for hiring and deploying staff and improved performance management systems as some of the preconditions for improved accountability in this regard. However, most research concludes that such abuses cannot be eliminated without systemic reforms not only to the health sector but more broadly to systems of governance.

8. There are a number of syntheses of learning to date on responsiveness and accountability in service provision and an emerging consensus on some key lessons. These include the need to build a strategy on the basis of a good understanding of the 'political economy' of the sector, to align accountability interventions with other governance developments rather than stand-alone initiatives, to promote the access to and effective use of information' to promote voice initiatives that are pro-poor and avoid elite capture, to build capacity on both the demand and supply sides of the equation, to build political support through quick wins and to build on existing impetus for change.

9. A responsiveness and accountability strategy for the health sector in Pakistan will need to navigate a difficult, confusing accountability landscape. While a review of the literature illustrates some positive learning to date, particularly on initiatives to support the voice of the poor and marginalised in holding health service providers to account, a responsiveness and accountability strategy for the health sector will need to be 'politically astute' i.e. test the applicability of such positive examples against the complexity of prevailing conditions.

1. INTRODUCTION

This internal 'guidance note' was prepared in preparation for the development of a Responsiveness and Accountability strategy for the health sector in Pakistan, commissioned by DFID and AusAID. It does not aim to be a comprehensive review of the relevant literature but rather seeks to clarify key concepts, identify key issues and summarise key learning that might be relevant to the development of a responsiveness and accountability strategy for the health sector in Pakistan.

2. KEY CONCEPTS

The concept of accountability has featured increasingly prominently in the discourse of international development in the last decade, particularly in relation to the emergence of 'new' democracies. The World Bank, for example, highlighted the concept in relation to pro-poor service provision (World Bank 2004) and DFID more generally in relation to good governance (DFID July 2006). The key proposition associated with the concept is that making public agencies accountable to the citizens they serve is a key part of building effective states that deliver poverty reduction (DFID Feb2008).

Although there are a number of donor approaches to promoting accountability as part of good governance the DFID 'CAR' framework (DFID July 2006) has widespread currency. The CAR framework - which is reinforced in its latest DFID White Paper (DFID July 2009 pp97-100) in a separate section on *'Building capable, accountable, responsive states'* - centres on the key concepts of capability, accountability and responsiveness. These are defined as follows:

Capability: refers to the *"the extent to which leaders and governments are able to get things done"* (DFID July 2009). It includes, for example, the existence of well-staffed, funded, informed, independent oversight institutions that are impervious to political interference.

Accountability: in relation to governance refers to *'the ability of citizens, civil society and the private sector to scrutinise public institutions and governments and hold them to account'* (DFID July 2009). More generally, it describes the rights and responsibilities between people and the institutions that affect their lives which can

include private or non-governmental agencies (IDS Policy Briefing Issue 33, November 2006).

Given the centrality of the concept of accountability, it is worth looking at it in a little more detail. Accountability is seen as having two key characteristics (DFID December 2007):

- *Answerability* i.e. the right to receive a response and the obligation to provide one. This is seen as a weak form of accountability.
- *Enforceability* i.e. the capacity to enforce action and seek redress when accountability fails. This is seen as a stronger form of accountability.

A distinction is also often made between vertical and horizontal systems of accountability.

- *Vertical accountability* i.e. where citizens hold institutions to account through formal processes e.g. elections, or through lobbying or mass mobilization.
- *Horizontal accountability* i.e. when state institutions engage in mutual scrutiny to correct for abuses of office. For example, judicial institutions review the constitutionality of executive decisions, the public audit function reviews probity in public spending, and ombudspersons or human rights commissions investigate citizens' complaints.

In addition, reference is sometimes made to *diagonal* systems of accountability e.g. when citizens can engage directly in budgeting, auditing or oversight processes formally reserved for state entities.

The World Bank accountability triangle (World Bank, 2004) introduces the concepts of short and long routes of accountability:

- A *short route of accountability* when citizens hold service providers to account directly through client power. Direct forms of accountability that bypass formal accountability systems frequently encounter resistance from those powerful interests that feel threatened.
- A *long route of accountability* when citizens influence policymakers who in turn hold service providers to account.

Finally, it is important to distinguish *formal and informal accountability*. Formal accountability institutions refer to clearly defined laws, (written) rules and regulations. Systems of formal accountability, however, can bear little relationship to actual

accountability relationships. Therefore, it is important to ask the questions: 'accountability to whom?'; 'accountability by whom?'; and 'accountability for what?', as skewed patterns of accountability to privileged groups over excluded groups deepen inequality. Informal accountability, for example, refers to unwritten rules, norms expectations and processes including social and cultural norms such as clientalism or corruption. These informal relations and processes can fundamentally shape how formal institutions operate.

Responsiveness: is defined as *"whether public polities and institutions respond to the needs of citizens and uphold their rights"* (DFID December 2007). This refers to the degree to which, for example, health providers or policy makers respond to the suggestions and concerns of clients and communities through changes in attitude, organisational culture, systems, procedures or policies (Goetz A.M. and Gaventa J. 2001)

These three, sometimes overlapping but reinforcing, concepts are seen as forming a virtuous cycle of good governance. This might be expressed in a simple equation R = C + A. In other words, responsive governments are governments that have the capability to meet the needs of their citizens and who are held accountable to their performance by their citizens.

The concept of accountability is frequently paired with that of **Voice** in the literature - 'voice' and 'accountability' being seen as levers for good governance. For example, in relation to basic services, 'voice' refers to the ways in which citizens - individually or collectively - *'place pressure on service providers and policy makers to demand an advocate for better services' (DFID December 2007).* Another way of looking at this is that 'voice' refers to the demand side of the concept of accountability while capability, for example, refers to the supply side. As we shall see in the following review of the literature, a key lesson in voice and accountability interventions is that both the demand and supply sides of service provision need to be addressed in order to increase responsiveness and accountability.

3. RESPONSIVENESS AND ACCOUNTABILITY IN SERVICE DELIVERY: KEY LEARNING

There is a growing body of research and literature on responsiveness and accountability, particularly as it relates to the public provision of services. This in part may relate to an on-going discussion in the literature about the role service delivery in state-building. It is sometimes asserted that service delivery in conflict-affected or difficult environments enhances state legitimacy and promotes state building. The delivery of services, it is argued, can address social exclusion and offer tangible benefit - such as the reliable availability of medical personnel and medicines - that can contribute to an improved perception of government. Indeed, the term 'health' or 'medical' diplomacy is sometimes used to describe health interventions as a means of achieving strategic objectives in stabilisation contexts such as Afghanistan.

However, the relationship between service delivery and state-building is not straightforward (Eldon, J and Gunby, D 2009) and a number of contextual factors e.g. levels of stability, patronage and corruption, can influence the evolution of a state's responsiveness. More conclusively a recent research report reviewing the literature on the matter concludes that there is little evidence that improvements in health service delivery have proved a singularly important factor in the successful passage to stable government (GSDRC 2009).

Perhaps as reflection of the pattern of donor support, much of the literature on responsiveness and accountability refers to vertical rather than horizontal systems of accountability. Some researchers (Joshi, A. 2008) are of a view that horizontal channels of accountability e.g. public oversight mechanisms, legislatures, institutional checks and balances, have largely failed to oversee the work of service providers and place greater emphasis on 'social accountability' and, in particular, attempts to introduce the 'voice' of poor and marginalised communities to health service delivery.

In this section, we will review the literature to identify some key lessons in relation to work on responsiveness and accountability with regard to the importance of an enabling environment; access to the right kind of information; the role of civil society an d social accountability; the challenges of working in conflict-related environments; and of the importance of maintaining a gender perspective. Finally, we will review

briefly what evidence there is of the effectiveness of work to date on voice and accountability.

3.1 An enabling environment

It is important to state the obvious at the outset i.e. that donors cannot work directly on voice and accountability (O'Neil et al 2007). An important role for development partners, however, can be to strengthen the overall enabling environment and develop the capacity of organisations to express and respond to citizens/clients voices.

An enabling environment encompasses the formal legal, regulatory and policy frameworks and the structures of government. However, it is important to bear in mind the distinction between formal and informal accountability and also the concept of 'enforceability'. Formal mechanisms of accountability can be undermined by informal socio-political realities. A review of legal frameworks for citizen participation, for example, concluded that an effective legal framework is an important but not sufficient condition to promote effective citizen participation (McGee, R. 2003). New laws or regulations may be passed but make little difference in practice if gatekeepers do not have the political will or capacity to implement them. Legal frameworks are insufficient if governments do not have the capacity to fulfil their commitments. Support for legal frameworks, therefore, needs to be accompanied by other supportive measures such as capacity-building, transparency and information provision.

3.2 Access to information

Public access to information is frequently referred to as an important precondition to responsive and accountable public institutions. Legislative measures such as Freedom of Information Acts can strengthen the enabling environment for responsiveness and accountability by reinforcing the rights of citizens to access information and the duties of government to provide it. However, for these rights to be claimed civil servants must be aware of their obligations; information management systems in place; and effective redress machinery such as an ombudsman must also be place for citizens to stake claims on information (The IDL Group, 2008).

For citizens to stake a claim on information they need to be aware of their rights and entitlements. Public awareness campaigns can increase citizens' knowledge of their

rights and entitlements and increase their willingness to make claims on providers. A free, independent print, electronic and broadcast can play a key role in raising public awareness. So also can working through customary leaders and social networks.

Supporting the legal right to access information is not enough. Access to information should also be supported by improving the capacity of interested actors and watchdog organisations to understand and utilise the information correctly (Menochal, A.R. and Sharma, B. 2009).

Of course, poor and marginalised people in particular often lack information vital to their lives and the voice to access resources or influence policy. A UNDP practice note (UNDP, 2003) identifies four ways to strengthen communication mechanisms available to poor people:

- Strengthen the legal and regulatory environment for freedom and pluralism in information;
- Building the capacity of the national and local media to promote the exchange of information;
- Raising awareness on rights to official information and strengthening mechanisms to provide information;
- Strengthening communication mechanisms to vulnerable groups.

Strengthening people's access to information and participation in service delivery processes is an important aspect of enforcing accountability of state or non-state service providers. Community or participatory monitoring systems play an important role in gathering the kind of information useful to local communities in advocating for improved services. Information on service provision can be gathered in a variety of ways e.g. public hearings, focus groups, household surveys, etc. but the use of the following has been well-documented:

- *Citizen report cards* i.e. survey-based quantitative assessments of services.
- *Community scorecards* i.e. quantitative surveys combined with qualitative meetings.
- *Social audits* i.e. a combination of both the above.
- *Public expenditure tracking* i.e. when the community can check the flow of resources to a particular service.

Community monitoring activities can take place inside or outside official monitoring systems, independently or in partnership with the state, but there is an emerging consensus that they work best when closely aligned to formal planning and information gathering processes. (GSDRC, 2008)

3.3 Voice and accountability at community level

Many voice and accountability initiatives in relation to service delivery have focused, quite sensibly, at the point of delivery of the service itself e.g. in the community. A shared premise of nearly all of these initiatives is that a collective voice is more influential than an individual voice i.e. when citizens, in particular the poor and marginalised, channel their concerns collectively to service providers they create a stronger basis for holding service-providers to account.

This is not to be confused with the assertion of individual consumer rights vis-à-vis a service provider. Institutionalising direct user participation through individual consumers is problematic since there is little evidence of individual citizens in poor communities being able to hold providers to account (Joshi, A. 2008). Social accountability, on the other hand, refers to collective actors exercising 'voice' through a variety of methods. Mechanisms of social accountability in the health sector might include:

- *Local health committees*: providing oversight of local health facilities and services.
- *Report cards:* providing feedback on the quality and performance of service provision. These can then be used as a benchmark to track progress or to compare provision across providers or municipalities.
- *Participatory budgeting:* participating in the formation of the budget and in tracking and monitoring expenditure, linking local needs to budget and planning processes. The increased transparency of decision-making processes can reduce the scope for corruption and clientalistic practices.

The Partnership in Transforming Health Systems Programme (PATHS) in Nigeria offers one of the best documented case studies of strengthening voice and accountability mechanisms at community level. Prior to 2002 the situation in Nigeria was not unlike Pakistan i.e. there were few mechanisms to enable clients to challenge poor quality health services and health providers and policy-makers lacked

incentives to respond appropriately to client needs. The result was a very low take up of public health facilities and a breakdown in the relationship between health facilities and communities. PATHS were designed to create opportunities to strengthen citizen voices on health and to address accountability failures.

PATHS involved seven voice and accountability initiatives which it categorised as:

Initiatives to establish the pre-conditions for voice i.e. awareness-raising or community mobilisation initiatives aimed to increase community understanding of rights and entitlements to health services;

Provider-led initiatives i.e. facility-based initiatives aimed to introduce a strong client focus for service delivery. These were formal, government-sanctioned efforts to improve internal accountability;

Government initiatives i.e. interventions to strengthen the governments stewardship of the health sector e.g. by introducing service standards or patient charters;

Joint government-civil society initiatives i.e. government-sponsored mechanisms that involved a high level of community participation, for example, the strengthening of facility health committees.

Some of the lessons from the PATHS experience have now been documented (Green, C. 2008). A key lesson was that, although PATHS initiatives to strengthen voice and accountability resulted in improved accountability of health providers to local communities, efforts to strengthen accountability between policy-makers and communities proved more challenging, and were prone to failure in the absence of parallel efforts to strengthen public accountability at local government level. More specifically the following lessons were identified:

- Clients and communities need to be supported if their participation is to be more than token involvement.
- Formal mechanisms to channel citizen voices to health providers and policy makers proved more effective than informal routes for improving voice and accountability since they placed an obligation public authorities to listen, and incentives to respond, to the voice of the people.
- Such initiatives need to be widely publicised so that service users and communities are better informed and able to claim their entitlements.

- Civil society organisations, such as NGOs and CBOs, have a potentially important role to play in creating space for voice and catalysing changes in accountability between providers, policy-makers and communities.

One of the key conclusions from a recent review of donor support for voice and accountability interventions is that support for demand-led initiatives are more likely to generate more responsive services if they are combined with initiatives to build capacity on the supply side (Menochal, A.R. and Sharma, B. 2009). Capacity development on the supply side might include improving the ability to generate, analyse and disseminate information; reinforce performance management systems; and strengthen technical and fiscal management systems. On the demand side it might include strengthening the ability of NGOs/CSOs to conduct research and advocacy and to improve their internal governance and transparency.

In 2006 DFID (DFID January 2006) reviewed current international research on health workers' role in responding to the needs of the poor. After identifying the main obstacles to their responding to the needs of poor end-users, it identified from the literature four categories of support that can incentivise health workers' responsiveness i.e.

- At the *client* level: Successful interventions are those which empower the client as a service user e.g. by increasing poor people's knowledge of entitlements, increasing their access to information, tackling gender constraints and voicing their demands. Civil society organisations have important role to play in this regard. Patients charters are reported to have had mixed success and should focus on both patients rights and responsibilities so as not to threaten service providers.
- At the *health worker* level: Increasing wages or improving related benefits was reported as having some impact. However, evidence shows that the performance of health workers has more to do with what they know and do rather than salaries, thus the importance of appropriate training and skills development.
- At the *health system* level: Key incentives were decentralised decision-making authority over facilities and budgets, good information and monitoring systems (in particular the use of disaggregated data to improve responsiveness to marginalised communities) and the availability of mechanisms of redress.

At an *institutional* level an inclusive approach to management and decision-making with health workers, empowering them to change their environment was cited as a proven incentive.

3.4 The role of civil society

It is widely accepted that civil society has an important role to play in responsive and accountable government and, indeed, in service provision. Civil society organisations can play an important role both as a health service provider and as an advocate for improved services.

A direct form of accountability is when civil society participates directly in state functions e.g. through participatory budgeting. This is sometimes referred to as 'co-governance' (Ackerman, J. 2003). Community-driven development (CDD) i.e. when communities are given control over decision-making, management and the use of development funds can be seen as a variant of direct accountability. A World Bank survey of CDD programmes in Indonesia, Cambodia and the Philippines (Wong, S. and Guggenheim, S. 2006) concludes that the approach presents great opportunities for enhancing state responsiveness, civic participation and cost-effective-service provision.

There is quite a body of literature on whether non-state providers (NSPs) offer a cost-effective method of delivering health services - for example, in difficult or conflict-affected environments. The state can retain responsibility for the provision of health services without necessarily being involved in direct provision by regulating and/or entering into contractual agreements with NSPs to deliver health services. This is not unlike the situation in Pakistan between, for example, the government and PPHI. However, the government's ability to perform this role can be constrained by a lack of organisational capacity to performance manage such agreements. Indeed a direct controlling role for the state which imposes contractual obligations on NSPs can be a risky strategy as it requires a level of capacity on both sides (Batley, R and Mcloughlin, C 2009).

Nonetheless, a recent GSDRC research report on non-state providers of health services in fragile states (GSDRC 2009) concluded that there is some evidence that NGOs and CSOs tend to be able to deliver services more efficiently and cost-effectively than governments to the poorest in difficult environments. More

specifically, it highlighted that 'performance-based contracting' can increase service utilisation and quality. A separate study (Antonio, L. et al 2006) reported that non-state health provision has worked well in Afghanistan, Nepal and Bangladesh. Giving NGOs a fair degree of autonomy while holding them accountable to achieving national health priorities was shown to address human resource related, infrastructural and logistic challenges.

On the other hand, other observers **(source)** have voiced concern that contracting health service provision to non-state providers may make trying to address the more 'hard to reach' populations more challenging and may fragment the health system as contracts may be difficult to specify and monitor.

In the context of responsiveness and accountability civil society organisations are more frequently referenced in their role in advocating or supporting advocacy for improved services. CSOs, for example, can have an important role to play in analysing and presenting data and engaging in dialogue with providers to advocate reforms in service delivery.

However, the capacity of CSOs to undertake advocacy at local or national level is easily overestimated. In many cases civil society organisations have their own limitations with regard to policy formulation and influence. For example, CSOs often produce 'soft' anecdotal evidence which is less persuasive to politicians; their communications strategies can fail to present data accessibly; and often suffer technical and financial limitations. (Court,J. 2006)

An analysis of 15 case studies from the Indian experience (Tandon, R. 2003) indicated three ways in which CSOs engage in public policy making i.e. by:

- Resisting policy reform once policy has actually been made and presented in the public domain.
- Including certain constituencies or perspectives in the policy making process e.g. slum-dwellers.
- Ensuring the implementation of existing, progressive public policies.

Tandon points out that much of civil society has little idea how policy is formulated and suggests that CSOs could achieve more concrete results for the poor and marginalised if they focused on ensuring the implementation of the *"many public policy commitments that gather dust in the bureaucratic labyrinth of district offices"*

(Tandon,R. 2003 p3) - in other words if the focused on ensuring the implementation of official policy commitments rather than protesting against policy commitments or advocating new policies.

Finally, the issue of sustainability is frequently alluded to in the literature. Many CSOs supported by donors to channel citizens' 'voice' are highly aid dependent. No obvious solution to this dependency emerges (**source).**

Interventions that target both state and non-state actors may prove more fruitful in terms of strengthening the quality of the relationship between state and society than interventions that target one or the other side (Menochal, A.R. and Sharma, B. 2009).

3.5 The need for a gender perspective

There has been a considerable amount of research in recent years on the reasons why services fail poor people and women in particular. While the obstacles to poor women's access to health services are numerous they can be summarised as being that the costs of travel and time, and fear and insecurity around travel, often outweigh the benefits of the services provided.

Deficiencies in the delivery of public services do not affect women only but they are affected differently and more acutely than men, particularly if they are poor. Poor women rely more than men on public services because they often do not have any other options. Given the critical role that public services play in women's well-being a major focus of women's collective action has often been the quality of public services (UNIFEM 2008 Chapter 3).

Women, for example, are particularly affected by corruption - a symptom of weak accountability in the delivery of services - and in specific ways. There is evidence that resources intended for poor women are particularly vulnerable to corrupt practices because poor women may be seen as less aware of their entitlements and less likely to challenge corrupt officials.

Even when mechanisms for registering complaints or giving feedback on the quality of services exist, it is likely to be men rather than women who communicate and negotiate with service-providers. User groups linked to service provision are often dominated by men and powerful community members. Women may also be unwilling

or unable to express their own needs, particularly when this runs counter to the perceived interests of male community leaders.

Accountability from a gender perspective requires that the decisions and actions of public actors can be assessed by women and men equally. Women's disadvantage in accountability systems is based upon their subordinate status in relation to men at home and as decision-makers. There is broad consensus therefore that the needs of poor and marginalised women must be specifically addressed if they are to play an effective part in holding service providers to account. Service delivery reforms, for example, must recognise the specific needs of women and counter power relations in the household and community that limit women's involvement. UNIFEM concludes that *"voice-based initiatives that enable women to interact with service providers, improve delivery methods, provide feedback about service quality and monitor and review performance can create the conditions to get services tight for women."* (UNIFEM 2008, p51) However, this must be accompanied with institutional change in service providers including new mandates, incentives and gender-sensitive performance indicators that can be measured and monitored.

3.6 Evidence of impact

A recent study (Menochal, A.R. and Sharma, B. 2009) concluded that the effects of voice and accountability interventions have remained limited and isolated. Some interventions have generated positive outcomes in terms of changes in behaviour and practice e.g. in raising citizen awareness and encouraging state officials to be more responsive, especially at a sub-national level. Interventions that have been targeted explicitly at marginalised or socially excluded groups have been useful in empowering such groups. However, the evaluation found few instances in which voice and accountability work contributed to policy impact e.g. changes in legislation.

A recent GSDRC research report (GSDRC 2010) reviewed evaluations of various forms of social accountability including access to information; community scorecards, citizen report cards, participatory budgeting/monitoring and social audits. A number of other 'voice' mechanisms - such as user committee's community radio, citizen's charters and juries - though cited as important instruments of social accountability were not reviewed as they appear to feature less prominently in recent evaluations.

The GSDRC cites a number of positive impacts such voice mechanisms. For example:

- Citizens Report Cards were reported to have shown results in reducing staff absenteeism and improvement in the quality of services in Uganda (Bjorkman, 2007)) and improved customer service in Bangalore (Ravindra 2004).
- The use of a Community Score Cards in Maharashtra (Murty, 2007) had a positive impact in terms of reviving several village level committees that had been semi-defunct and making villagers aware of their entitlements. In Andhra Pradesh (Murty, 2007) community scorecards in health led to a number of positive impacts such as community-managed nutrition centres, a health risk fund and a community-managed ambulance service. These in turn contributed to improving the number of pregnant women undergoing health checkups and delivering in hospitals in intervention areas.

However, while the literature contains a number of positive case studies of this nature any review of the impact of 'voice' initiatives of this nature is subject to a number of caveats. The first is to avoid an assumption that an effective 'voice' initiative in itself will lead to increased responsiveness of a service provider. There is evidence that the same types of interventions have worked in some areas but not in others, highlighting the oft-repeated caution that voice and accountability initiatives need to be sensitive to local context. Among the features of an enabling environment for such initiatives are an active civil society; evidence of readiness for change; quality and accessibility of information; a combination of bottom-up and top-down initiatives; and constructive partnerships between stakeholders. Critically the level of support and capacity building offered to local communities can be a critical factor in determining its success (Agarwal, S. et al 2009).

4. RESPONSIVENESS AND ACCOUNTABILITY IN SOUTH ASIA

4.1 A regional perspective

The growing interest in South Asia in voice and accountability in service provision - and in particular the health services - is a result of several factors such as donor support to the social sectors, the growth of the civil society sector and the increasing interest of independent researchers on issues of public sector performance. The investment in social sector programmes across South Asia by the World Bank, Asian

Development Bank and several bilateral agencies has led to a deeper examination of how these sectors are performing. The realisation that public delivery systems were not performing well led to a search for reasons why the performance was so poor and how to make the systems more accountable and responsive. The increased use of budgetary support to governments by donors; a growing interest in good governance and the use of government budgets; and an increased focus on corruption e.g. in the health sector, have also contributed to increased interest in how to make public services more responsive and accountable.

In the last few decades, there has been considerable analysis of the dismal performance in South Asia with respect to social sector indicators. This has been brought into sharper focus by the commitment to achieve the Millennium Development Goals. Many reports have been published on this issue in South Asia by independent researchers and policy think tanks such as the Mahbul Haq Human Development Centre in Pakistan which dedicated its 2004 report to the Health Challenge in South Asia. This report underlines the imperative of focusing on health in the region, pointing out that economic growth can neither be sustainable nor equitable without improving the health of the majority of the population. Within the health sector a major area of focus has been maternal and child health which presents a sorry picture in South Asia. The region has had persistently high rates of maternal and infant mortality that have remained largely resistant to change despite unprecedented economic growth in several countries in recent years. It is uncertain whether economic growth has led to improvements in health, especially that of women and children, and whether the underlying determinants of ill health have changed.

There have been a series of papers on the subject of governance and health in the region. The Transparency and Accountability Program (TAP), a program of The Results for Development Institute based in Washington DC, has published a number of reports on the subject, including a study of staff absenteeism in the health sector in Karnatka in India, Pakistan, Bangladesh and other countries in the region.

Resources have also been directed at building the capacity of civil society organisations to conduct research and evidence-based advocacy on issues of corruption and inefficiency in social sector public spending. Considerable reliance has been placed in South Asia on community organisations and NGOs in organizing local communities to play a role in monitoring and oversight of public services. These

social mobilization strategies seemed to fit well with traditional systems of organisation and self-help in the region.

This focus on demand-side approaches is reflected in the literature and many of the studies have tried to assess and show how social mobilization can lead to enhanced accountability and improved performance in the delivery of social sector services by the State. A plethora of case studies examine the mechanisms which have worked well, or not so well, in enhancing responsiveness and accountability of state institutions. Some of the mechanisms examined include the role of informal pressure mechanisms; citizen mobilisation; the role of both horizontal and vertical systems of accountability; and the comparison of both formal and informal mechanisms. Some of these are discussed below in more detail.

Informal Pressure Mechanisms

The use of informal pressure is sometimes the only recourse available to poor citizens to change the behaviour of state institutions. The literature acknowledges this and examines informal pressures that poor citizens exert on officials to provide services in Bangladesh. A paper from the Institute of Development Studies (Hossain, N. 2009) examined how poor people exert informal pressure e.g. through shame and the threat of violence to increase the responsiveness of service providers. Poor people have good reasons to use these methods in preference to formal accountability mechanisms. However, the study notes that *"the gains from 'rude' accountability are often short-lived, and may backfire."* It is important, therefore, to bridge the informal and official mechanisms of accountability. "Rude accountability" matters because it highlights how relationships of accountability in service delivery are *"embedded in social relations and political pressures that are unofficial, informal, and personalised."* When accountability systems fail, it is important to understand which particular informal pressures are operating and to learn how poor citizens attempt to claim their entitlements. However, the study concludes that prevalence of 'rude' forms of accountability cannot be celebrated as the spontaneous flowering of rights in poor countries.

Citizen Mobilisation

A recent paper (Jha, C. et al 2009) examines how citizen mobilisation can be supported to make local governance more inclusive and accountable. The study focuses on Nepal which has a long tradition of social mobilisation, and on the experience of the Local Governance and Community Development Programme

(LGCDP). The study argues that *"transformational mobilisation processes are needed to build peoples' capacity to actively participate in their own governance."* The report focuses on empowering citizens and communities to actively engage with local government bodies and hold them accountable.

The paper argues that social mobilisation refers to the type of group-based action that has supported community-led development over the past 25 years in Nepal. More specifically, social mobilisation denotes the process by which the critical link between citizen demand and state response is developed. The report also draws on the Gender and Social Exclusion Assessment framework of three domains of change, which include improved access to assets and services; changes in voice and agency; and changes in the rules of the game. The report highlights that there are two main forms of social mobilisation: transactional and transformational. Most social mobilisation programmes rely on transactional approaches by focusing solely on the first domain of change i.e. improved access to assets and services. However, real transformation and structural change requires action in all three domains of change.

An analysis of a range of social mobilisation processes reveals the following key findings:

- Transformational approaches to citizen mobilisation are more sustainable than transactional processes and help to build individual and collective capabilities,
- There are significant challenges in identifying disadvantaged households,
- Community-based processes help to ensure buy-in and reduce resentment over the selection of targeted households; however, they are not sufficient for the identification of those in need of formal social protection,
- The extreme poor are left out or self-excluded from most group-based processes,
- There is a lack of graduation mechanisms to help the extreme poor and excluded access mainstream development opportunities,
- Most programmes do not link citizens/groups with local body processes. Group processes are generally isolated and parallel to local structures, and fail to strengthen state-citizen relationships.

Social Audits

Community Information, Empowerment and Transparency (CIET), an international NGO, has conducted social audits across South Asia and elsewhere as a means of

introducing greater accountability in health systems. The audits gather data from households, communities and local public servants about how well public services serve the public. They focus on system flaws and create a wealth of locally identified solutions for regional and national reform.

The use of social audits in Pakistan and Bangladesh detected a number of irregularities in the costs of care. More than a fifth of those who visited government health facilities in Bangladesh made an extra payment to the health worker, and nearly a third paid an unofficial registration fee. Extra payments for nominally free services served as a disincentive for many to use government health care. In Pakistan nearly all women said they had paid for delivery even though government hospitals and primary health care centres claimed the service was free of charge. Medicines that disappear from, or never reach, the health clinic are another common form of system leakage reported through the audits. Asked what communities could do to counter corruption themselves, many mentioned "refuse to pay bribes." "There is no receiver if there is no giver," said one man in a focus group discussion. Extensive media coverage of audit results helped to reinforce this message. Similar suggestions to support public sector reform were put forward in workshops in the other countries. CIET social audits provide a baseline for targeting reform measures and subsequently measuring their effect.

Attitudes, Empowerment and Accountability

A case study from Nepal (Gibson, L. 2007) highlights the role that attitudes and perceptions play in enhancing accountability and, in particular, how a sense of disempowerment, when the individual feels no responsibility to work hard or change things, is an important barrier to organisational and managerial change. An earlier Nepalese study outlines the parallel universes that can exist within health systems. The official system emphasises the improvement of population health, the quality and number of services delivered and the role of the staff as providers of these services. However, staff do not perceive the services as very important and see service improvements as a way of generating additional income. Training is neither understood nor used as a tool for service improvements.

Another study notes the impact of training on the attitudes of health workers (Manongi, R 2009). The impact of a training workshop package was evaluated across seven countries using a common protocol. It judged that it had a *'positive impact on the relationship between providers and clients, creating teamwork within a*

facility, creating a supportive environment for health facility staff to take more initiative and to some extent, demand more responsiveness from the system.' The subsequent application of the package in Pakistan showed that it generated among participants a renewed commitment to work and a greater willingness to examine their own practices and improve quality of care.

However, a multiple country evaluation (Gibson, L. 2007), as well as the Pakistan study, noted that although application of the workshop package can be a step towards initiating behavioural change, it is vital to establish an enabling environment that supports the changes initiated at local level. The paper argues that additional funds or the decentralisation of responsibilities are ultimately unlikely to be enough by themselves to sustain better managerial practice. Such 'hard' interventions must be complemented by initiatives that strengthen 'softer' managerial skills and prompt wider cultural change in public sector organisations. Such innovative interventions are required to address health inequity and cannot be taken 'off the shelf'. Rather, the paper argues that:

- Managerial action cannot be separated from the context in which it occurs;
- Strengthening public sector management will require efforts to generate organisational cultures that support and enable relevant managerial actions;
- Changing organisational culture involves multi-level actions focussed on individuals within organisations, the organisation and the wider system in which the organisation is embedded;
- Leadership training for senior and middle level public sector managers is an essential element of strengthening health system management.

Staff Absenteeism

There has been considerable research undertaken on staff absenteeism in the health sector in South Asia. A study from Bangladesh (Hammer, J.S. and Chaudhery, N. 2003) represents the first attempt to quantify the extent of this problem on a nationally representative scale. Unannounced visits were made to health clinics to discover how many medical professionals were present at their assigned posts. The average number of vacancies over all types of providers in rural health centres was 26% nationwide. Regionally, vacancy rates (unfilled posts) were generally higher in the poorer parts of the country. Absentee rates of over 40% were particularly high for doctors. The absentee rate for doctors at the larger clinics was 40% but at the smaller sub-centres with a single doctor, the rate was 74%. The study also explored

the determinants of staff absenteeism, citing the location of the residence of the medical provider, access to a road, and rural electrification as important factors.

A case study form India (Government of India, 2005) revealed large scale dissatisfaction about absenteeism among doctors and support staff. The study looked at 30 primary health care centres in three districts of Karnataka and reported rates of absenteeism among doctors of more than 50%. The study found systemic failures in governance and accountability; inherent weaknesses in the centralised supervision and monitoring system; and an attitudinal problem among staff who did not perceive themselves accountable for their performance. The study concluded that absenteeism was an issue which needed serious consideration and suggests ways and means to reduce absenteeism.

Expenditure Tracking as a Tool for Accountability

Expenditure tracking has become a byword in development circles as a means of looking into whether the money gets to where it is supposed to be going (Sundet,G. 2008). The best known 'follow the money' initiative is the Public Expenditure Tracking Survey (PETS) methodology, developed in Uganda in the 1990s, that found that 80% of the funds intended for primary schools were diverted on the way. This 'leakage' was subsequently cut to 20%, an improvement attributed to a public information campaign initiated after the first PETS. The paper reviewed the evidence concerning the efficacy of expenditure tracking as a means of realising a *change* for the better in accountability systems and concluded there is a need to pay much closer attention to the political context of the various methods of expenditure tracking and budget monitoring.

The Role of the Media

The media can play an important role in responsiveness and accountability strategies in the health sector as a "critical check on state abuse of power or corruption." (DFID 2008). This is particularly relevant in Pakistan where the media has grown exponentially in the last few years and is relatively free, independent and increasingly diverse. The media can provide the opportunity for informed and inclusive public debate on issues of concern to people living in poverty and give greater public recognition to the perspectives of marginalised citizens. *"Engaged citizens need information that allows them to exercise democratic choices."* (DFID 2008). However, the DFID practice paper points out that transforming the way that the media relates to both governments and audiences is extremely challenging. It can best be

accomplished through interventions that address four levels - populations, practitioners, organisations and systems. Key lessons and principles for donors to increase the effectiveness of media development initiatives in support of capable, accountable and responsive states include:

- Identifying how and why media matter in the lives of people living in poverty;
- Understanding what can and cannot be supported;
- Directing support to media sectors that explicitly focus on the poor and marginalised – such as community media;
- Treating information, communication and the media as public goods and invest accordingly;
- Analysing the political implications of support to the media.

Corruption in the Health Sector

The prevalence of corruption in South Asian countries is recognised as hindering economic growth; reducing efficiency; acting as a disincentive to potential investors; and, above all, diverting resources meant for poverty alleviation. A key report (Transparency International, 2002) dealing with corruption in South Asia found that a major factor contributing to the poor impact of huge public investments in, for example, the health and education sectors was the lack of effective monitoring systems. The report found that, although there has been a growing awareness of the need to address the spread of corruption, most reform agendas are top-down; often donor-driven; and offer little or no space for civil society to play a meaningful role. This has led to a 'demand deficit' in the good governance agenda. Designing and strengthening 'voice' mechanisms in some cases may be the only available strategy to raise the demand for good governance and anti-corruption reforms, and the experiences from the five countries in the study point to the growing potency of citizen feedback surveys as highly effective voice mechanisms.

Transparency International has designed a database on corruption in public services in five countries in South Asia. It is the first regional survey of its kind in South Asia, measuring the extent, spread and intensity of corruption in seven key sectors from a user's perspective. Apart from highlighting and quantifying patterns of corrupt practices, the survey provides useful benchmarks to measure progress and track changes over time. The survey finds petty corruption to be endemic in all key public sectors in the five countries, with users reporting moderate to high levels of corruption in their regular interaction with public services. Middle and lower level functionaries are identified as the key facilitators of corruption in all sectors probed. A

lack of accountability and monopoly of power are quoted as the major factors contributing to corruption in public services.

Irregular admission processes was cited as a major impediment to accessing healthcare institutions in Pakistan and Bangladesh. Corruption in the use of hospital facilities e.g. paying bribes to get prescribed medicines or to get a bed was found to be extremely common in Pakistan and Sri Lanka. Doctors and hospital staff were identified as the main facilitators of corruption. Extortion was found to be rampant in the public health care system in all five countries, victims reporting large payments given as bribes to access and use services.

In corruption surveys in 23 countries (Mamdani, B. and Lewis M. 2006) health ranked amongst the top four in half the countries surveyed. The paper identifies specific areas where corruption impacts performance in the health sector. Important areas identified by them are availability of drugs, staff absenteeism, flow of funds, informal payments, performance incentives, etc.

A variety of systemic and management factors can influence the level of corruption in the health system. Health systems, hospitals and clinics are frequently managed by physicians, few of whom have management training. The centralised hiring, promotion and deployment of public health workers neutralises the role of local supervision. If local oversight bodies are unable to take action with centrally managed staff - for example, on cases of absenteeism, taking bribes and stealing drugs - they will have little impact on the quality and responsiveness of services.

Rigid civil service rules that limit promotion and pay differentials act as a disincentive to good performance. Low wages may encourage health workers to seek additional jobs; demand payments from patients, and engage in pilfering drugs and supplies. Delays in salary payments have been linked to the likelihood of health workers selling medicines and/or seeking other employment. There is evidence that linking the salaries of healthcare staff to productivity enhances performance. Studies show that physicians who receive a fixed salary -rather than fee-for-service, bonus payments or capitation - have lower productivity, offer lower levels of care and higher complication rates.

However, employment security, clear recruitment and promotion criteria, and effective management are more important than improved salaries in addressing

corruption. Ensuring timely availability of funds, hiring and deploying staff, maintaining basic record systems, and tracking facility performance are basic ingredients for improving management and overall healthcare delivery. Contracting out services often improves performance if it is accompanied by effective oversight.

Corruption in the flow of funds is identified as another key area of concern. The lack of public funds at the point of service is attributed to bureaucratic problems, corruption and mismanagement. Evidence showed that, for example, 87 per cent of funds never reached the schools in Uganda.

Informal payments for health services are widespread in South Asia and almost universally reported in Pakistan. A study in Bangladesh, India, Nepal, Pakistan and Sri Lanka showed that bribes are required for admission to the hospital, to obtain a bed, and to receive subsidised medications.

Corruption in the health sector is unlikely to be an isolated public service failure and must be addressed throughout the public sector. This requires an integrated, mutually reinforcing anti-corruption strategy with strong political backing.

Drug procurement poses multiple challenges given the ease and lucrative nature of drug corruption. Nigeria has strictly ensured that drugs meet a basic standard of potency, labels are clear and correct, and distribution is achieved through legal channels. This requires systematic oversight and regulation of provision, storing and handling.

Good Governance

The quality of governance plays an important role in responsive and accountable services. There is a tendency for the private sector to increase at the expense of the public sector in lower income countries as incomes rise - for example, in India - and poor people opt to pay significant amounts of disposable income to obtain private care instead of low quality public services. The improved governance of the health sector would involve greater professionalism among health staff; effective training and supervision of staff at all levels; routine audits of all aspects of fiduciary transactions; improved records and recordkeeping to provide systematic data to managers; and an organisational culture and systems to facilitate user-friendly service delivery. One option is to run hospitals and clinics as businesses to provide the incentives to improve productivity, patient satisfaction and performance.

4.2 The experience of Pakistan

Pakistan has tried a range of options in trying to improve its governance systems in recent years. It has attempted to reform its public health systems and system of local government, and to adopt community mobilization approaches through the growing number of NGOs to emerge in recent years. These initiatives have been documented in detail. The literature has also been influenced by the donor agenda as many of the studies are donor financed or have been undertaken by donor supported and established organisations such as the Sustainable Development Policy Institute and the Devolution Trust for Community Empowerment.

Many self-styled think tanks have also begun to emerge in Pakistan and some have taken it upon themselves to promote the good governance and accountability agenda. These include the Mahbub-ul Haq Human Development Centre, Social Policy Development Centre, Heartfile and the Governance Institutes Network International (GINI). Even some of the more traditional mainstream research institutions like the Pakistan Institute of Development Economics have begun to focus on the themes of performance and governance. Partnerships of international organisations such as Community Information, Empowerment and Transparency (CIET), Transparency International and others with local institutions have also contributed to a closer examination of these issues.

There is, therefore, a large body of literature on the sector focusing on key areas of concern such as governance, corruption, levels of expenditure on the health system, perceptions about performance and the experiments undertaken in the public health system in recent years.

Governance in the Health System in Pakistan

A case study on Governance and health sector development in Pakistan (Pappas, G. et al 2009) presents the volatile political history of Pakistan as leading to problems with governance generally and in the health sector in particular. The paper defines six domains of concern - voice and accountability; political stability and absence of violence; government effectiveness; regulatory quality; rule of law; and control of corruption - and reviews the literature on the health sector using this conceptual framework. Two case studies, the President's Primary Health Care Initiative and the Tawana Pakistan Program, are used to understand how poor governance can

undermine important, positive political initiatives. The paper concludes that governance issues are a major barrier to improving health in Pakistan.

Sustainable Management Approach (SMA) in Health Systems Reform

The Family Health Project (FHP), funded by the World Bank, which operated in Pakistan from 1992-1999 was been used as a case study (Israr, S. and Islam, A. 2006) to argue that good governance, characterized by transparency, accountability and meaningful community participation, plays a critical role in the sustainability of donor-funded projects in the public health sector. The analysis revealed that the existing health care system could not absorb and sustain the "socio-political" thrusts of the project e.g. meaningful community participation and "democratic" decision-making processes. Hierarchical structures and management processes made it difficult to produce a sense of ownership of the project among all managers and the rank and file staff. The Provincial Health Development Centre (PHDC) and District Health Development Centres (DHDCs) established by the FHP did not receive adequate financial and political support from Department of Health. As a result the Centres largely failed to institutionalize a continuing training program for district level health officials/professionals; the District Health Management Teams (DHMTs) could not be institutionalized; and community participation in the DHMTs was symbolic rather than forceful.

The experience of the Systems Oriented Health Investment Programme (SOHIP), a Canadian funded initiative, in Pakistan has been similar. SOHIP concludes that improved coordination among all stakeholders, more stable and competent leadership, more meaningful community participation, greater devolution of project management to the district level, and better management of resources would have resulted in a more effective, efficient implementation of the project. Based on these findings, SOHIP introduced a Sustainable Management Approach (SMA) as a tool that can be used to ensure the sustainability of health systems projects, particularly those funded by international organisations in developing countries. Good governance and a conducive organisational culture are important prerequisites for incorporating any new project within an existing system. This includes prior consensus building among all stakeholders, a meaningful and inclusive participatory planning, implementation and evaluation process involving communities, political commitment, and the identification and use of appropriate leadership for project management.

Staff Absenteeism

A study from Pakistan (Agboatwalla, M. and Niazi T.) assessed the rate of absenteeism among doctors from their place of work, the impact of absenteeism on the quality of health services and the amount of money lost to it. Absenteeism among male doctors was reported as 38% and among female doctors as 44%. Nurses had a lower absentee rate of 28% and technicians of 24%. Absenteeism was higher in remote rural areas where a lack of basic facilities discouraged doctors from serving. Absenteeism rates are higher in those health facilities which lacked basic infrastructure and facilities (medicines, equipment) and where accessibility was an issue. Female doctors preferred to work in urban areas but doctors tend to concentrate on private practice in urban areas. The study also found unofficial arrangements between health personnel to exchange duties e.g. technicians substituting for doctors. The study concluded that pay increases or incentives unaccompanied by monitoring does not ensure regular attendance. New initiatives, like the People Primary Health Initiative (PPHI) programme should have an in-built monitoring systems to make them work effectively.

Gender Issues

Another study from Pakistan (Mumtaz, Z., et al. 2003) shows how gender discrimination in the workplace has an impact on the behaviour of service providers to patients. Hierarchical management practices within the public sector are infused with gender biases and undermine and oppress lower status women health workers, with negative consequences for the availability and manner of treatment they provide to poor rural women and men. Socio-cultural norms are embedded in the public sector (Shaikh, B.T. et al 2006). Reflecting wider experience (Woodford-Berger, P. 1998) a health provider study shows how societal gender norms underpin weak managerial practices (Standing, H., 1997). Hiring new staff that better reflect the diversity of the community has been identified as having the potential to strengthen the cultural relevance of health organisations and their acceptability (Gibson, L. 2007). However, as the Pakistan study of female health workers (Mumtaz, Z. et al 2003) clearly shows, such staff will perform well only if leaders support new employees and manage the workplace tensions that may result.

Corruption in the Health Sector

Corruption has attracted strong research interest in Pakistan since health outcomes are so critically influenced by it. A paper by Dr Sania Nishtar (Nishtar, S. 2007) on the health sector outlines the areas of poor governance, mismanagement and

corruption in the health sector. The paper is a preamble for the first chapter of a publication for the Partnership for Transparency Fund, NWFP Health Reform Unit and Heartfile on 'Assessing governance for eliminating corruption in the health sector in Pakistan'. The preamble sets out the context of corruption in the health sector in Pakistan and outlines a detailed qualitative observational analysis planned for a health facility in the North West Frontier Province. It is envisaged that the assessment will lead to the development of an agreed action plan for an anti-corruption strategy for the NWFP Government's Department of Health.

The paper concludes that corruption is not something that can be addressed in isolation in or by the health sector. Corruption in the health system is a manifestation of broader systems failures which require broader mandates to address. A mutually reinforcing, inter-sectoral anti-corruption agenda, driven by a forceful political will, is necessary to tackle the issue. This would entail strengthening anti-corruption agencies and mandated institutional mechanisms; creating operational linkages with the health sector and health systems strengthening; strengthening the role of the media; and priming politicians and bureaucrats in the administrative hierarchy through training and skill building to anti-corruption measures.

The paper highlights the need for civil and public service reforms to strengthen the performance-accountability-reward nexus in the health sector, for example developing:

- a system for national health accounts using electronic public expenditure tracking procedures and supply inventories to track leakages in the system,
- a nation-wide database for matching staff and wage payments that can maintain up-to-date personal records so as to eliminate abuses such as paying ghost workers.

It also identifies a number of necessary reforms in drug manufacture and procurement. Electronic bidding should be introduced and phased-in for enhancing transparency. Greater transparency in the process of drug registration, pricing and quality control will need to be institutionalized to improve the quality of drugs. Local regulations will have to be strengthened in line with the international code of marketing practises and should be strictly enforced with the industry and the medical community. Other measures should be promoted to check the growth of spurious drugs. Strict penalties should be implemented for violations of the law e.g. fake licenses to sell; duplicate documents; absence of warranty of purchase and gaps in

the sale purchase record of all products; and the inadequate storage practices - which make it possible for spurious drugs to gain access to the market.

Finally, the study suggests how corruption can be countered at a service delivery level. Alternative modes of service delivery and financing could be mainstreamed. In autonomous hospitals governance should be strengthened and efficient management with real administrative and fiscal controls introduced. Service delivery reforms at the basic health care level can increase accountability and audits through management devolution/contracting out and by giving greater fiscal and administrative autonomy. Institutional incentives such as the ability to hire and fire the staff and authority to reward performance and discipline, transfer or fire employees who engage in abuses and the ability to audit can also help counter corruption, albeit with safeguards. Performance reward incentives should be built through user fees but an anti-corruption agenda at a health systems level is a complex endeavour. It goes beyond incentives and requires broader health system reforms.

Ethics and Health

This study (Hyder, A. A. et al, 2008) presents a conceptual framework for the ethical analysis of health system events, noting how this approach might enhance the power of existing frameworks; and demonstrates the interplay of these frameworks through the analysis of an initiative to establish a national ethics committee in Pakistan. The paper concludes that, while ethics are gradually being integrated into public-health policy decisions in many developing health systems, ethical analysis is often implicit and undervalued.

This paper highlights the need to analyse public-health decision-making from an ethical perspective. The case presented refers to the Pakistan Medical Research Council (PMRC) which was formed in 1962 to spearhead the promotion and development of health research in the country and link it to national development. PMRC participated in the health research that helped to bring the "10/90 gap" to world attention i.e. that approximately only 10% of the world's expenditure on health research and development is devoted to problems relevant to the poorest 90% of the world's population. It was also instrumental in the creation of a National Bioethics Committee (NBC) in Pakistan in 2002. The two salient concerns of public health ethics in the case of Pakistan were social justice as a background motivation and accountability as the primary operational objective. The NBC's terms of reference include establishing a framework of accountability by preparing national ethics

guidelines for health research in Pakistan, reviewing research proposals for studies to be undertaken at the national level, and accrediting, monitoring and coordinating other research ethics committees. This offers the NBC an opportunity to be at the leading edge of research ethics.

Health Expenditures

An ongoing concern in Pakistan has been its low level of expenditure in the health sector. Several studies examine this issue, the most recent a study by the Pakistan Institute of Development Economics (Akram, M. and Jehangir F. 2007). The study was carried out to measure government spending on health in Pakistan at provincial level looking in both the rural and urban sectors. The study explores the inequalities in resource distribution and service provision against the government health expenditures. The conclusion was that public health expenditures are pro-rich in Pakistan. Rural areas are the most disadvantaged in the provision of health care facilities. Health expenditure is regressive in rural Pakistan as well as at provincial and regional levels. Expenditure on mother and child health is regressive in Punjab and on general hospitals and clinics it is regressive in all provinces. Only expenditure on preventive measures and health facilities is progressive in Pakistan.

5. CONCLUSIONS

There have been a number of attempts to synthesize some of the learning that has emerged from the growing body of research on responsiveness and accountability in service provision. There is quite a bit of overlap in what has emerged.

DFID (DFID Dec. 2007) has synthesised the implications for policy and practice of learning to date in voice and accountability in service provision as follows;

1. Map the political economy of sector and understand the context i.e. base recommendations on a good analysis of power and political relationships.

2. Ensure that specific accountability initiatives are aligned with broader governance developments i.e. avoid undermining local governance arrangements and ensure coherence and synergy with broader governance agenda.

3. Promote access to and effective use of information i.e. opening public access to information e.g. access to information laws, promoting better information flows etc. is a necessary condition to accountability.

4. Strengthen institutional capacity to respond to demands i.e. support relevant internal, institutional reforms to the state.

5. Promote V&A that is inclusive and pro-poor i.e. ensure 'voice' mechanisms are inclusive and avoid 'elite capture'.

6. Identify appropriate combination of aid instruments to promote domestic accountability i.e. donors should employ a mix of aid instruments to build citizen and state capacity.

7. Build the evidence base through on-going documentation of country experience and impact evaluations i.e. strategies need to be tailored to context and should be documented and evaluated cases in order to continue to build a growing evidence base.

A recent evaluation commissioned by seven bilateral donors reviewed 90 donor interventions in voice and accountability and highlighted six core principles to guide donor support (Menochal, A.R. and Sharma, B. 2009). These were:

- *Build or sharpen 'political intelligence in developing V&A initiatives* i.e. entry points are conditioned by context. Donors interventions should be conditioned by an understanding of the interaction between formal and informal institutions and of the incentives framework within which different actors operate.

- *Work with institutions you have and not the ones you wish you had* i.e. engage with rather than ignore the informal institutions and practices that predominate. Focus on what is already in-country rather than on transplanting institutional frameworks from the outside.

- *Focus capacity building on political skills not just technical skills* i.e. while it is important to continue building the technical capacity of both civil society and

state actors, it is important also to address their political capacity e.g. to forge alliances, provide evidence, influence others to make change happen.

- *Focus on mechanisms that address both sides of the equation at the same time* i.e. donor support tends to focus more on 'voice' interventions than on accountability. This can be problematic without a parallel effort to build the effectiveness and capacity of state institutions. Donors should seek to strengthen institutions at local and national level e.g. parliaments or local development councils, that bring the state and citizens together.

- *Diversify mechanisms of engagement and be prepared to work outside 'comfort zone'* e.g. work with non-traditional CSOs such as religious organisations, trade unions and social movements that often have close links and legitimacy with sections of the population that otherwise would be hard to reach.

- *Improve design and implementation features of Voice and Accountability interventions* e.g. provide longer term and more flexible support. Voice and accountability efforts can take a long time to bring about since they aim to change entrenched attitudes and alter power dynamics.

What emerges is that there are no universal prescriptions of what will be appropriate in any specific context. All responsiveness and accountability strategies have to be sensitive to local context and adjust to political realities. A guidance paper for UNDP on this subject (IDL Group 2008) concludes that a technically sound - but politically astute - voice and accountability strategy is one that:

- Is opportunistic and responsive i.e. looks for windows of opportunity and is responsive to changes on the ground including changes in leadership and emerging issues around which coalitions of change can be supported;
- Builds political support for capacity development in voice and accountability in the longer term by providing the sorts of capacities and 'quick wins' that governments want in the short term;
- Bridges accountability and voice i.e. helps create space for government/ civil society collaboration on specific issues that can lead to greater accountability in the long run;
- Builds on existing impetus for change.

A responsiveness and accountability strategy for the health sector in Pakistan will need to navigate a difficult landscape. The greatest depth of need is where operating conditions are most difficult. Health service provision is fragmented; a public health system operates alongside sub-contracted non-governmental providers in the provinces and several centrally managed major federal health programmes targeting national health priorities. Different health service providers are responsible to different federal ministries. The private sector is meeting a growing proportion of need in response to the low quality of public health service provision. Corruption is perceived to be endemic in the sector.

Within this landscape public accountability institutions are seen as largely ineffectual, although there are early indications of the beginning of ad hoc parliamentary oversight on a federal level. Civil society organisations are, on the whole, in an early stage of evolution. They play a significant role in service provision in the health sector but lack experience in research and advocacy in the sector. The involvement of poor and marginalised people, and in particular women, in holding health service providers to account is inhibited by socio-cultural and other barriers. However, the media is growing in confidence, competence and diversity.

While a review of the literature illustrates some positive learning to date, particularly on initiatives to support the voice of the poor and marginalised in holding health service providers to account, a responsiveness and accountability strategy in Pakistan, if it is to be 'politically astute', will need to test the applicability of such positive examples against the complexity of the accountability landscape, nationally and locally.

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ANNEX 6: SITUATION ANALYSIS OF THE HEALTH SECTOR

Responsiveness and Accountability in the Health Sector in Pakistan

Situation Analysis of the Health Sector

June 2010

LIST OF ABBREVIATIONS

ADB	Asian Development Bank
BHU	Basic Health Unit
DCO	District Coordination Office
DFID	Department for International Development
DGHS	Director General Health Services
DHIS	District Health Information System
DHMT	District Health Management Team
DHQ	District Headquarters Hospital
DMO	District Monitoring Office
DOH	Department of Health
ECC	Economic Coordination Committee of the Cabinet
ECNEC	Executive Committee of the National Economic Council
EDOH	Executive District Officer (Health)
FIA	Federal Investigation Agency
GDP	Gross Domestic Produce
HMIS	Health Management Information System
LGO	Local Government Ordinance
LHV	Lady Health Visitor
LHW	Lady Health Worker
MS	Medical Superintendent
MDG	Millennium Development Goals
MEA	Monitoring and Evaluation Assistants
MOH	Ministry of Health
NCHD	National Commission for Human Development
NHRIC	National Health Resource Information Center
NHPU	National Health Policy Unit
NAB	National Accountability Bureau
NACS	National Anti-Corruption Strategy
NEC	National Economic Council
NWFP	North West Frontier Province
PNC	Pakistan Nursing Council
PRSP	Punjab Rural Support Programme
RHC	Rural Health Center;
THQ	Tehsil Headquarters Hospital

CONTENTS

A. OVERVIEW

1. Despite some improvements, the overall health status of the population remains poor. Life expectancy at birth, which was 34 years in 1951 has increased to 65 years in 2005 with no gender disparity. The 2008 report of the MDG Gap Taskforce showed that while there has been much progress in Pakistan during the last decade, the delivery on commitments has lagged behind schedule. It is recognised that the measures taken by the Ministry of Health have so far not made significant headway in reducing under five and infant mortality and have not reduced maternal mortality. Infant mortality has reduced to 78 per 1000 live births. Maternal mortality has also reduced to 276 per 100,000 live births but is still high.[1] Malnutrition remains widespread and unaddressed. In addition, persisting burden of infectious diseases is now compounded by increasing burden of non-communicable diseases. However, smallpox and Dracunculiasis (Guinea worm) which were wide spread at one stage have been eradicated. Pakistan is also very close to the eradication of Polio and the burden of deaths due to Diarrheal diseases is decreasing. However, it is proving difficult to provide services to a growing population. Commitment to the health sector is overshadowed by other priorities. Low expenditures on the health sector by the Government as a percentage of GDP have stagnated at 0.6%.[2] While Pakistan's population growth rate has declined from 3% in the late 1980's to the present estimated level of 1.9% per annum. High fertility translates into 4.2 million new births every year.[3] Pakistan was the sixth most populous country in 2010 with a population of over 170 million people. The population is projected to increase to 210 million by 2025.

2. The health infrastructure in the country has grown rapidly. In 1947, there were 292 hospitals in the country which have now increased to 920 hospitals in the public sector and about 800 in the private sector. There was hardly any health facility in rural areas at the time of independence. However, now there are more than 550 rural health centres and 5,300 basic health units, 4,600 dispensaries and 900 Maternal and Child Health (MCH) centres in urban areas. The information on private sector remains inadequate but a rough estimate is that there are about 20,000 private clinics in the country. About 525 pharmaceutical units produce more than 47,000 pharmaceutical products and medicines of which some are exported. Pakistan also

[1] National Health Policy. May 2010. Ministry of Health. Government of Pakistan.
[2] Economic Survey of Pakistan 2010. Government of Pakistan.
[3] Health Policy Document (2009). Ministry of Health. Government of Pakistan.

has 71 medical and dental colleges in the country, 32 are in public sector and 39 in the private sector. The number of registered doctors has increased exponentially from 78 in 1947 to more than 111,600 doctors and 8,400 dentists including 21,500 specialist doctors and 517 specialist dentists. Nursing profession has also seen growth with 109 schools of nursing (76 in public and 33 in private sector), 141 schools of midwifery, 26 public health schools and 7 colleges of nursing. More than 46,000 nurses and 4500 Lady Health Visitors (LHVs) are registered with Pakistan Nursing Council (PNC), backed up by a community based workforce of about 95,000 lady health workers. Pakistan has now initiated a Programme to deploy 12,000 community midwives (CMW) in the rural areas. .

3. The provision of essential health services remains the responsibility of government. In addition, the Government takes responsibility to provide free medical treatment to all citizens who cannot afford health care. National health care services provide medical care, including hospital care free of charge. However, at the primary level, the delivery of those services is increasingly being delegated to non-governmental organisations and private providers as a strategy to improve the effectiveness and efficiency of services. These delivery models piloted nationwide are straining integrated governance at local levels. The government has ceased to be the principal provider of health services. It is estimated that 70% of health services are provided by the private sector. The most recent Pakistan Living Standards Measurement Survey found that when people are sick, they are increasingly turning to the private sector for medical care. However, the market for health related services remains completely unregulated.

4. Despite improvements, Pakistan's health sector continues to face many challenges. The key issue remains slow progress in improving health outcomes. The poor are not benefiting from the health system whereas they bear the major burden of diseases. Expanded infrastructure is poorly located, inadequately equipped and maintained resulting in inadequate coverage and access to essential basic services. Private health sector continues to expand in an unregulated manner mainly in urban areas. Factors contributing to inadequate performance of health sector are deep rooted including weak management and governance, partially functional logistics and supply systems; poorly motivated and inadequately compensated staff, lack of adequate supportive supervision, lack of evidence based planning and decision making, low levels of public sector expenditures and its inequitable distribution. In

addition to factors internal to the sector, external factors also contribute to poor health outcomes including illiteracy, poverty, unemployment, gender inequality, social exclusion, lack of access to safe drinking water and inadequate sanitation.[4]

5. It is generally acknowledged that despite devolution of powers at the local level, the health system remains centralised and not able to respond to the organisational and governance challenges resulting in ineffective use of already scarce resources and its ability to deliver. The management challenges arise due to multiple supervisors, lack of clear roles and responsibilities in three level of government and multiple directions coming from different levels. Devolution remains incomplete with weak accountability mechanisms and management capacity at the district level. The public health system needs re-organisation based on management principles, with the federal and provincial governments focusing on its core stewardship functions of policy, regulation, monitoring and evaluation, standard setting and moving towards quality service delivery both by the public and private sector.[5]

6. The Ministry of Health is the first to recognise that political interference and patronage play a significant role in determining the agenda for health policy and administration, and influencing health services delivery down to the lowest level health facility. It appears necessary for federal and provincial health authorities to rebuild its stewardship of the health system through professional independent advice and technical governance of health services planning, provision and delivery. The reforms of the public health sector implemented under the National Health Policy of 2001, which focused almost entirely on the reform of publicly provided health services have not produced improved health outcomes. The increased deployment of stand-alone health interventions and vertical programs in the past decade have eroded the stewardship of federal and provincial health authorities and led to fragmented health services delivery and potential duplication of resources.

[4] Health Policy Document Ministry of Health. Government of Pakistan. 2009
[5] Zero Draft. National Health Policy 2009. Stepping Towards Better Health. Ministry of Health. Governmet of Pakistan. March 2009

B. THE HEALTH SYSTEM IN PAKISTAN

(i) Overview

1. Pakistan has a centralised health care system in which the various governments share responsibility.[6] The health system in Pakistan is organized on the basis of its federal structure. The essence of federalism is that two constitutionally established orders of government are autonomous and accountable to their own electorates.[7] Pakistan follows the system of concurrency in a broad set of areas including health. Concurrency means simultaneous authority of the two autonomous orders of government over subjects of mutual importance. This means that the parliament and provincial assemblies can make laws with respect to any matter on the concurrent legislative list.[8] The 1973 Constitution enshrined 47 subjects in the Concurrent Legislative List. Health is recognised as an area on which both federal and provincial governments have had the power to legislate. However, despite some apparent advantages of concurrency, the concurrent legislative list of 1973 constitution has been a subject of considerable tension between the centre and the provinces in Pakistan. The proponents of provincial autonomy in Pakistan have often demanded complete abolishment of the concurrent list. In the aftermath of the 18th Amendment which seeks to abolish the concurrent legislative list health legislation will no longer be the prerogative of the federal government. Whether abolishing the concurrent list will in fact enhance provincial autonomy appears to be beside the point.[9] The National Finance Commission Award of 2009 also gives greater fiscal autonomy to the federating units by reduction in the share of the federal government.[10] This is also likely to change the availability of funds that the government will have available for health expenditures at both the federal and provincial levels. These developments are likely to change the management of the health system in Pakistan. However, it is too early to identify the precise impact on the health systems and programmes in the country.

[6] Khan, Muhammad Mushtaq Khan , Jitse P. van Dijk and Wim Van den Heuvel. Health Policy Process and Health Outcome: The Case of Pakistan. Eastern Mediterranean Health Journal. 2006.

[7] Anderson, G. Fiscal Federalism: A Comparative Introduction (pp. 54). Forum of Federations. Ontario, Oxford University Press. 2010.

[8] Goraya, Amir Khan Concurrent List: 1973 Constitution and Recent Political Developments. 11th January 2010.

[9] Almeida, Cyril. The 18th amendment and the concurrent list. April 8th, 2010. http://criticalppp.org/lubp/archives/9285.

[10] Goraya, Amir Khan Concurrent List: 1973 Constitution and Recent Political Developments. 11th January 2010.

(ii) Federal Level

2. In the past the federal, provincial and district governments have clear roles and responsibilities, but there were overlapping functions. The role of the federal government relates to policy formulation, provision of technical backstopping, coordination with different partners, communicable disease control and financing for health care. Provincial departments of health are responsible for translating the national policy into planning and implementation, through generating the required human resource, providing specialized care through its tertiary care hospitals, besides overseeing primary and secondary health services provided by the district governments. The actual service delivery takes place at the district level where the two tiers of primary and secondary health outlets are managed. The districts also run the federally financed national health programmes that bring a dichotomy in the management due to its dual command mechanism. All the preventive services are implemented at the district level where government is more or less the sole provider, besides the provision of medico-legal services.

3. The Federal Ministry of Health (MOH) is responsible for national health policy, health legislation, quality of health care, health planning and coordination of health related activities. The Ministry is also responsible for educational standards in the field of medicine and nursing, dental, pharmaceutical, and paramedical professions. The MOH has a number of major preventive programmes being funded by the federal and provincial budget jointly. These programs are coordinated by the federal ministry through the national and provincial programme managers throughout the country. Every province and district has a focal person for each of these programmes who is responsible for smooth implementation of the project in their respective districts. The health partners and donors have been contributing to these projects in varying capacities. These include the Lady Health Worker Programme, Tuberculosis Control Programme, National Aids Control Programme, Expanded Programme of Immunisation, Malaria Control Programme, Nutrition Programme, National Maternal and Child Health Programme, the Population Welfare Programme, the Prime Minister's Programme for Prevention and Control of Hepatitis A & B. It is generally thought that an overemphasis of the Ministry of Health towards national programmes has diminished its stewardship roles of policy making, regulation, monitoring & evaluation including surveillance.

4. The Federal Ministry of Health consists of one division: the Health Division and eighteen departments. These departments are situated in different cities, however, working under the supervision of the Health Division in Islamabad. The important functions performed by these federal health departments include, hospital services, drug control, stimulation of medical research, child health care and care for the handicapped. There were about 462 employees working in the Federal Ministry of Health in Islamabad in 2006. Among these employees 78 were mid- and top level civil servants (Grade 17 and above) and 384 administrators as well as clerical staff (Grade 16 and below).[11]

5. Although the Federal Ministry of health is formally responsible for all tasks related to health it works in close coordination with other governmental bodies such as Planning and Development Division (P&D Division), the National Economic Council (NEC), the Executive Committee of the National Economic Council (ECNEC), the Economic Coordination Committee of the Cabinet (ECC), and Provincial Developmental Working Party (PDWP). The P&D Division plays an important role in health planning in collaboration with the Ministry of Health. The NEC, being the supreme policymaking body, has an overall control over planning and approves all plans and policies in the country including for the health sector. The ECNEC sanctions health projects and schemes costing more than Pak Rupees 100 million. It also supervises the implementation of health care policy. The ECC coordinates the health and other public policies, oversees the monetary situation, and extends approval to all major health projects. In some cases other federal bodies such as the Cabinet Division manage special initiatives in various sectors directly from the federal level. For instance the People's Primary Health Care Initiative is being directly managed by the Cabinet Division.

6. The policy framework within which the health sector establishes its goals and sets its targets is provided by a host of documents which include the health related Millennium Development Goals, the Medium Term Development Framework, the Poverty Reduction Strategy Papers, the National Health Policy (2010), and the Vision 2030. The new health policy is the result of an understanding that there was a need to reset the strategic direction in the health sector due to: a) slow progress in improving health outcomes; b) inadequate sector performance in improving coverage

[11] Khan, Muhammad Mushtaq Khan , Jitse P. van Dijk and Wim Van den Heuvel. Health Policy Process and Health Outcome: The Case of Pakistan. Eastern Mediterranean Health Journal. 2006.

and access to essential health care services especially for the poor; and; c) lack of synchronization of various policy documents and their linkages with Millennium Development Goals (MDGs).

7. A national health policy unit was established in the MOH in 2004 with technical assistance of WHO and financial support of DFID. Its role within MOH's organisational structure has not been fully institutionalized and its capacity both in terms of human and financial resources needs to be strengthened for it to deliver on its mandated role of furnishing evidence for the health policy and system reforms in the country. In addition, it relationship with provincial DOHs and their health planning and reforms unit needs to be strengthened.[12] Despite the many constraints, the NHPU was able to constitute a National Health Policy Council, contribute to the health sector reform agenda and is now playing a more proactive role in the formulation of the new national health policy. However, there are still issues of mandate with the MOH and the NHPU as is evidenced by the fact that the MOH and the NHPU were independently pursuing the formulation of the new health policy and it was not clear whose version was the official version.

(iii) Provincial Level

8. At the provincial health departments are the cornerstone of health hierarchy in Pakistan; they work independently under the guidance of federal MoH and have their own budgets.[13] At the provincial level, the political head of the Department of Health (DOH) is the Health Minister. The provincial Health Secretary is the overall in-charge of the Department. The Director General Health Services is the technical head who reports to the Secretary. The role of provincial government is to coordinate between the federal and district government to ensure implementation of countrywide policy by evolving operational strategies. The department has regulatory, standard setting, technical support and resource mobilization functions. The Health Department

[12] Report of the Health System Review Mission – Pakistan World Health Organisation. United Nations Children Fund Department for International Development, United Kingdom. The World Bank. February 19-28, 2007.

[13]Khalif Bile Mohammad, Assad Hafeez, Sania Nishter. Public Sector health financing in Pakistan: A retrospective study. WHO country office1, Pakistan, Consultant Pediatrician and Epidemiologist , KRL Hospital2, Islamabad, Pakistan, Founder President,
Heartfile3, Pakistan

frames laws, rules and regulations to enforce policies of the Government in areas such as foodstuffs, blood safety, drugs, smoking etc. The Health Department lays down standards for quality control of drugs, electro-medical equipment and quality of health care services. It also prescribes standards for medical education and training of doctors, nurses and paramedics. It is also expected to provide technical support for capacity building of District Governments in administrative, financial and development areas. It provides necessary personnel and arranges for their appropriate training. The Health Department seeks to fill resource gaps through budgetary and extra-budgetary resources. It explores new avenues such as public-private partnerships and seeks diversification of resources. The provincial department is also responsible for all personnel management in the public health sector.[14]

9. The Provincial Health Secretary translates the provincial health policy, exercises control over the budget and has direct control over the teaching hospitals and other special institutions. The provincial Director General Health Services (DGHS) is the chief executing officer responsible to ensure delivery of policies and plans related to primary and secondary health care delivery. At the provincial level, a team of Directors supports DGHS, including Director MCH or Reproductive Health. The DGHS supervises the work of Divisional Director Health Services (DDHS) who are posted at the divisional level. The number of directors and deputy directors in the provincial health ministries vary due to different size of population and number of health facilities in every province. There are teaching hospitals providing specialized care and medical training for both medical students and newly graduated physicians in every province. The provincial health ministries exert direct control over these teaching hospitals. Tertiary care Hospitals are directly under the provincial Secretary of Health.

(iv) District Level

10. In the public health sector, districts are responsible for implementing routine health services and federally funded national programs through a network of BHUs, RHCs, maternal and child health centers, and secondary and tertiary hospitals. The Executive District Officer Health (EDO-H) is in charge of the district and is

[14] Health Systems Profile- Pakistan Regional Health Systems Observatory- EMRO. 2009.

responsible for delivering promotive, preventive and curative services through the outreach workers and primary care facilities in the district. There are 125 districts and 7 tribal agencies in the country and in every district several agencies and departments are engaged in the delivery of health care services. These agencies include teaching and district headquarter hospital headed by a medical superintendent, state-owned health care services under the administrative control of the district health officer, and municipal health services exclusively for urban areas under the administrative control of the municipal health officer. Managers of all Tehsil Hospitals, RHCs and BHUs report to him. On paper, EDOH have responsibility for all health matters in the district. Medical Superintendents are the chiefs at DHQ Hospitals, and they, as well as EDOHs, report to the Director General of Health through their respective Divisional Directors.

11. District governments lack capacity to deliver health and other social services. The medical staff is technically well qualified and experienced; however, the capacity of a health facility is also measured in terms of the availability of modern equipment and the experience of the medical staff in using this equipment. Unfortunately most of the health facilities lack proper medical equipment and funds for proper maintenance of the equipment they do have. Often health facilities have broken X-ray units or suffer from a shortage of X-ray film, ambulances out of order, shortage of laboratory chemicals, etc. In addition to the shortage of medical staff, equipment and medicine, the organisational and management aspect of service delivery also needs attention. The staff of the EDO-Health office spends more time trouble shooting problems and managing various aspects of health services than providing the actual services. Similarly, although the Medical Superintendent of any hospital or Senior Medical Officer of a Rural Health Center is a qualified and experienced doctor, most of his time is spent managing the technical and administrative matters of the hospital. There is a strong need for developing modern management skills in the medical and non-medical staff of the district health services; in particular the following aspects need more attention: EDO-Health office staff needs the technology and training to manage their assigned tasks; in particular, the enforcement of the drug and food and sanitation acts and the management of preventive health activities are very weak. The EDO-Health office needs training and tools to monitor the performance of the widely dispersed field staff. Bureaucratic procedures requiring multiple levels of approvals discourage officers from taking initiative to improve service levels. Such procedures need to be simplified.

12. The public sector in Pakistan does not provide performance-based incentives to its employees. It is assumed that incentives and rewards should not be given to employees for the completion of routine duties that are part of their job descriptions. There are no direct incentives for the medical staff to work harder or take initiative; rather bureaucratic procedures encourage people to accept the status quo. Generally, performance is driven by the moral values of individual workers rather than by an incentive mechanism: there are some doctors who do not report to their duties regularly without suffering adverse consequences and yet there are others who are devoted to their work. Although under the LGO, the district governments were allowed to give incentives and bonuses to their staff to improve performance, so far none of the district governments have developed any mechanism to measure and quantify the performance of its staff. Most districts lack or have a limited knowledge of performance management and are generally focused on day-to-day troubleshooting. Few district governments are collecting any formal data to measure the performance of its staff, and the few that are do not use this information in decision or policy-making. None to our knowledge are measuring the service quality through surveys or other data.

13. An assessment of key gaps in the health sector are identifies as lack of culture of evidence-based decision making in the public health sector, especially at the district level. The decision making, especially resource allocation, is based mainly on capacity and the historic structures, (number of hospital beds, health outlets, and staff strength) rather than performance (units of service provided) or need (size and health status of the population). A second major issue is the fragmentation of outreach and facility-based service delivery. The EDOH is responsible for ensuring implementation of national programs but overall resources and decision making is retained by federal program units. This situation has created management conflict and poor ownership of national programs by the district health department. The third major issue is the vertical HMIS owned by various national programs. The information systems are too vertical, centrally oriented, and poorly linked to program subsystems; in addition, they are overloaded with data that are of little relevance to the technical management of the health programs at the operational level. M&E processes are usually not built into the HMIS. Therefore, a holistic picture of a district's overall health performance is not available in one place – instead, information is fragmented, and so is the management of health programs and activities. The fourth major gap is no clear definition and provision of an essential health services package by various levels. Most of the health care providers at rural

health facilities are not aware of essential health services package for their respective levels.[15]

(a) Tertiary care facilities

14. There are 29 teaching hospitals in Pakistan. They also provide sub-specialty care. These hospitals mainly provide curative services and to a limited extent some preventive services. Majority of the communities have access to a primary care facility within a radius of 5 kms. While access to government health facilities is generally good, the utilization levels are low. Several surveys have consistently shown that about 80% of clients seek care from the private sector and only 20% visits the government managed facilities for ambulatory care, which is indicative of considerable unutilized capacity in the system.[16]

(b) Referral level care facilities

15. These include Tehsil Headquarters (THQ – sub district units) and District Headquarters (DHQ) Hospitals that are located at respective levels and offer first line referral services. Tehsil Headquarters Hospitals (THQH) serves a catchment population of about 100,000 to 300,000 people. They typically have 40-60 beds and appropriate support services including x-ray, laboratory and surgery facilities. The staff includes at least three specialists: an obstetrician & gynaecologist, a paediatrician and a general surgeon. District Headquarters Hospitals (DHQH) serve catchment population of about 1 to 2 million people and typically have about 100-150 beds. There are at least 8 specialist including obstetrician and anaesthetist. There were a total of 947 THQH and DHQH in Pakistan in 2009. There are few hospitals which provide Comprehensive EmOC.

(c) Primary care facilities

16. These include MCH Centers (MCHC), Basic Health Units (BHUs) and Rural Health Centers (RHCs). There is at least one primary health care center present in each of the Union Councils, which has a range of population from ten to twenty five

[15] Amjad, Dr. Sohail. Review and Assessment of Various Primary Health Care Models In Pakistan. Technical Assistance for Capacity Building in Midwifery, Information and Logistics (TACMIL). USAID. June 2009.
[15] Amjad, Dr. Sohail. Review and Assessment of Various Primary Health Care Models In Pakistan. Technical Assistance for Capacity Building in Midwifery, Information and Logistics (TACMIL). USAID. June 2009.
[16] Health Systems Profile- Pakistan Regional Health Systems Observatory- EMRO. WHO. 2007

thousand people. MCHCs and BHUs are expected to operate from 8 am to 3 pm, except Sundays, while RHCs are expected to provide 24-hour services. However, most of these facilities are operational for 3-5 hours on each working day. There are 1084 MCHCs in Pakistan,[17] which are managed by LHVs and provide basic antenatal care, normal delivery, post-natal and family planning services, and treatment of minor ailments to women and children. BHUs generally have a staff of 10 people consisting of a male doctor, a LHV or a FHT, a Male Medical Technician or/and a dispenser, a trained or unqualified midwife (dai), a sanitary inspector, a vaccinator, and 2-3 support staff (guard, sweeper, gardener, etc.). They are required to offer first level curative, MCH, family planning and preventive services through doctors and paramedics. There are 5798 BHUs/SHCs in Pakistan. RHCs provide more extensive outpatient services and some inpatient services, usually limited to short term observation and treatment of patients who are not expected to require transfer to a higher level facility. They serve catchment population of about 50,000 to 100,000 people, with about 30 staff including 2 male medical officers, female medical officer, 1 dental surgeon and a number of paramedics. They typically have 10-20 beds, x-ray, laboratory and minor surgery facilities. These do not include delivery and emergency obstetric services. The country was estimated to have 581 RHCs in 2007.[18]

(d) Community-based activities

17. The maternal health, child health and family planning services are provided by the outreach workers that include Lady Health Workers (LHWs), Female Health Technicians (FHTs) and TBAs. Each LHW has established a “Health House” in her home and is expected to reach each house to serve as the first level of health care for the rural and peri-urban women and children. LHWs maintain a record of all the households in their catchment areas. They are expected to actively follow up each family every month, especially those who have not availed of the immunization cover or dropouts from family planning services.

[17] Health Systems Profile- Pakistan Regional Health Systems Observatory- EMRO. WHO. 2007

[18] Health Systems Profile- Pakistan Regional Health Systems Observatory- EMRO. WHO. 2007.

C. REFORMING THE HEALTH SECTOR IN PAKISTAN

(i) Reforming health care through changes within the system

1. There have been several efforts to reform the health sector in Pakistan over the last few decades. These efforts have been initiated with the assistance of major bilateral and multilateral donors in the country, although some efforts such as the PPHI and PRSP models were initiated with Government's own resources. The reform effort has included various strategies (i) reform within the public health system, (ii) reform through devolution and (iii) public private partnerships. Each donor has picked a unique aspect of the health system or a geographic area and has tried to improve performance of some aspect of the public health system. Health system reforms have been undertaken mainly in Punjab and NWFP. The reforms range from financing of the health sector, contracting out and improving the quality of health services, and developing a policy on human resource. The reform process in NWFP was assisted by the World Bank with technical assistance from the German Agency for Technical Cooperation and DFID. The reform in Punjab has been financed mainly by the Asian Development Bank. In Punjab, the reform process is focusing on improving primary health care services by providing financial incentives and improving salaries of health professionals, creation of positions for midwives and lady health workers at BHU levels, provision of medicines and continuous professional development. Punjab has a network of 2748 primary healthcare (PHC) facilities spread over an area of 205,345 square kms. The Punjab government has initiated a two-year Health Sector Reforms Programme (HSRP) to make the primary healthcare network of 2456 basic health units and 292 rural health centres fully operational. Benefits of the programme for medical staff include a substantial salary and an incentive package combined with improved working and living conditions, a pre-service orientation programme and regular in-service training, a supportive monitoring and supervisory mechanism, and periodic third party inspections. There is however lack of harmonization among the provinces in the reform process and the federal government has so far not fulfilled its coordination function. In addition, various donor agencies have attempted to reform a particular aspect of the public health system. DFID has tried to improve the performance of the federally funded programmes and policy making capacity, USAID has worked on Maternal, Newborn and Child Health, JICA has attempted to improve the health information systems at the district level, CIDA has tried to adopt a systems oriented approach to health

investments in the Punjab. However, these reforms have had a limited impact on the health systems performance, responsiveness and accountability as they failed to address some core issues within the system.

(ii) Reforming Primary Health Care through Public-Private Partnerships

2. The past two decades have also seen increasing concern about access to and quality of Primary Health Care (PHC) services in Pakistan. The failure of the primary health care (PHC) system has been recognized by the government at the highest level land. The failure of the old PHC system can be summarized by low utilization rates caused by doctor absenteeism and poor management. Some initiatives are aimed at expanding service delivery through partnership with private providers and NGOs as part of contracting out arrangements. In order to address the inefficiencies and ineffectiveness of PHC service delivery in the public sector, various PHC models and initiatives are being tested.[19] Several studies have been undertaken to assess the three basic models. These models can be grouped into three key public sector PHC models:

- the Executive District Officer for Health (EDOH) model, managed by the district health department,
- the Punjab Rural Support Program (PRSP) or "public-private partnership" model, which
outsources BHUs, and
- the National Commission for Human Development (NCHD) model, which restructures and
strengthens BHUs through community participation.

3. The EDOH model receives a budget from the provincial government as a grant in aid through the respective district government. In the PRSP model the global budget for the PRSP-operated health facilities is transferred by the district government to respective district PRSP Program Implementation Units (PIUs) for target health facilities. The PRSP reform program was piloted in a limited number of BHUs in District Rahim Yar Khan. The new approach was administered by the Ministry of Industry and Special Initiatives (MOISI) which contracted the Punjab Rural

[19] Amjad, Dr. Sohail. Review and Assessment of Various Primary Health Care Models In Pakistan. Technical Assistance for Capacity Building in Midwifery, Information and Logistics (TACMIL). USAID. June 2009.

Support Program (PRSP) to manage the BHU service delivery. The provincial government also provides additional support to PIUs to cover the operating costs. To increase utilization of BHUs, the PRSP model has introduced clustering of BHUs to ensure the scheduled availability of a doctor; each cluster is visited by a doctor on scheduled days of each week. The model contracts with doctors at higher pay than they formerly received and provides nominal performance-based incentives to junior staff. The funding normally allocated to each BHU from the District Government's budget is transferred to the PRSP, which is then responsible for the disbursement of salaries and for the allocation of the remaining funds. In addition to being entrusted with the allocation of the BHU budgets, the PRSP was also granted the right to: Re-locate staff from one BHU to another in the interest of improved service delivery; Allocate and re-allocate functions and responsibilities of the staff at the BHUs; Offer additional benefits to the BHU staff based on assigned functions and performance; Hire additional staff to work at the BHU under a contract with PRSP and without financial claims on the District and Provincial Government; Propose to the District Government increases, adjustments, or re-arrangements of the budgetary provisions for medicines, maintenance, salaries, utilities, and equipment; Charge the actual cost (without making profit in the form of a fee) associated with the performance of management functions at the BHUs;

4. The results were striking; utilization rates in the PRSP run PHC facilities increased by over 200 percent in a few matter of months. The simple explanation for the success is that absenteeism was not tolerated by the PRSP management and that patients responded to the availability of a doctor and medicines in the PHC facilities. Patients come to clinics if doctors are available. PRSP also increased the salaries of the doctors three fold by allowing one doctor to work in as many as three PHC facilities. The most remarkable aspect of the pilot was that utilization increased at half the cost of the old system.

5. The NCHD model has been scaled up in selected districts of Punjab. It does not receive a budget from the district government; it pays for staff salaries and other operational costs through a provision in the Planning Commission Proforma-1 (PC-1). Like the PRSP model, the NCHD model works at the BHU level and does not get involved in facility management, but it has a greater role in the integration of facility outreach preventive services. It has a robust model of community participation in PHC service delivery and management. It focuses on strengthening the referral system from the community level up to secondary-level hospitals. The PRSP model

lacks such an arrangement, and this is one of the obstacles to its effective delivery of PHC services.

6. Introduction of an M&E system is one of the key changes introduced by the PSRP and NCHD models. The NCHD model enjoys superiority to PRSP model in establishing baseline data for its catchment population and therefore monitors progress toward targets against the baseline data. The PRSP intervention is limited to routine monitoring and supervision of implementation. While the PRSP model continues to enjoy strong political support and commitment from federal and provincial levels, the support for the NCHD model is waning somewhat. The PRSP model has been replicated at a rapid pace to other provinces through the President's Primary Health Care Initiative (PPHI). The PPHI was launched with the view that PHC centers could be better managed by contracting out services. This rapid scale-up is an indication of the readiness of policymakers and politicians to support initiatives aimed at improving health services for the citizens.[20] However, the PRSP model is bitterly opposed by the public health establishment at the district level due to the fact that it by-passes the health system and erodes the authority and credibility of the public health system.

7. The strengths of the PRSP model is that it gives the managing agency hire-and-fire authority, autonomy in allocating and reallocating service delivery functions, flexibility in financial management and budget utilization, performance-based incentives for staff and simple and result-oriented management with clear focus on OPD utilization for curative services. Its weaknesses are that it focuses on facility-based curative services, negligible linkages with national programs, no role in provision of preventive services, weak referral linkages and system, another vertical system within the district and lack of explicit QOC standards. Its threats are the opposition form the public sector district health managers, it entails additional resource burden, there is lack of clear exit strategy. The strengths of the NCHD model is that it has a performance-based M&E system with baseline surveys, there is provision for financial incentives for staff, there is focus on both curative and preventive services, community participation and mobilization is a strong component

[20] Amjad, Dr. Sohail. Review and Assessment of Various Primary Health Care Models In Pakistan. Technical Assistance for Capacity Building in Midwifery, Information and Logistics (TACMIL). USAID. June 2009.

in this PHC model and school health services are an integral part of this PHC model. The NCHD currently lacks political and administrative support, and therefore is struggling to reduce resistance from DHD in many districts, no financial incentives available for the junior staff (LHVs, dispensers, medical technicians) at the BHUs, QOC standards have not been spelled out and therefore no mechanism to access knowledge and skills of service providers and ensuring basic QOC standards.

8. Each of the PHC models studied has its strengths and weaknesses – essentially, each model focuses on strengthening of one of the pillars of PHC strategy through targeted interventions, and neglects other key pillars necessary for integrated delivery of PHC services. As a result, no model perfectly fulfils PHC needs of its community. The various contracting out models of service delivery need to be evaluated and compared, as is being done in NWFP, with parallel initiatives to improve existing public provision, for example, through empowering Executive District Officer in Health (EDO(H)) before a decision is made about their nation or province wide adoption. There is a concern about the premature scaling up of these initiatives without sufficient evidence of their effect on access, efficiency, equity and quality of health services and their impact on health outcomes. In addition, their being led under the New Initiatives scheme of the Ministry of Industries without the active engagement of the MOH and the provincial DOH raises additional concerns about their sustainability.

(iii) Reforming Heath Care through Devolution

9. The Local Government Ordinances (LGO) promulgated in 2001 also initiated some measures to reform the health sector. Accountability and citizen participation were identified as key elements of good governance at the onset of the devolution process.[16] The principal mechanism of reform envisaged under the devolution plan was allocation of resources through district councils, establishment of a district cadre, monitoring of government health facilities through monitoring committees and establishment of District Health Management Teams. However, the health profile has not risen in the majority of district development budgets. Many *Nazim's* have been primarily concerned with highly visible and short-term interventions that will ensure re-election. Road building and other physical infrastructure has therefore received higher priority than healthcare. However, in Punjab at least, health budgets have not suffered, and there is some evidence to suggest that drug budgets have increased if only by relatively small amounts.

10. Under devolution, the staff of the provincial Health Department working in the field (districts and tehsils) was transferred to the respective district governments. The June 2005 Amendment to the Local Government Ordinances establishes a separate district civil service cadre and provides stronger provincial powers to set aside the decisions of District, Unfortunately, transfers and postings of medical staff were still controlled by the provincial governments in most provinces, which has limited the impact of
devolution on the delivery of health services. The procurement process for obtaining medicines was also still carried out by the provincial government, which often delayed medicine procurement until after the end of the first quarter and sometimes as late as the end of the second quarter of the financial year. Thus, even though district governments had the legal and institutional authority to provide various health services, their ability to effectively manage these services was constrained by the provincial bureaucracy's administrative control over district staff. Most EDOs felt disempowered to make decisions and felt that they had not been given effective administrative authority over staffing issues, financial management or planning and budgeting.

11. Additional problems with the Local Government system were that key positions at the district level (such as the District Coordination Officer) were held by officers appointed by the province who, while performing their functions at the district level, remain primarily accountable to the provinces. Provincial control over the hiring, firing and transfers of senior district staff, senior teachers and health workers undermined the managerial powers of district government officials and impeded the effective and efficient delivery of services. This problem should have been solved with the adoption of the new district cadre. However, the deadline for its adoption, however, which was December 31, 2005, came and went. Members of the national and provincial assembly (MNAs and MPAs) interfere in the appointments and transfers of senior teachers and health professionals, often leading to excessive turnover of key personnel. This is especially true in Balochistan and SIndh. EDOs Health have faced problems in forging good working relationships with the District Nazims, District Coordination Officers (DCOs). Under the current institutional arrangements, many intergovernmental relations were left out of alignment and productive linkages between district departments and the corresponding units at the provincial level were lacking. The District Department of Community Development, for instance, did not even have a direct counterpart at the provincial level. As a result,

despite a very wide range of assigned responsibilities, the EDO-Community Development and his/her office represent a weak link in the district's management structure, which did not in practice perform "development" functions or connect constructively with community organisations, such as the CCBs.

12. The Local Government Ordinance (LGO) 2001, which later became Local government law in 2004, had been bold and innovative ideas to promote accountability and transparency at the grass root level. Monitoring Committees (MCs) were created under the LGO to provide monitoring and oversight of the functioning of various facilities and local government offices. Monitoring Committees were to be established for each function, such as finance, public safety, health, education, etc., at each tier of local
government i.e Unions, Tehsils/Towns, and Districts. Each MC was required to have at least three members elected for a term of three years. Unfortunately, the system suffered from some of the same endemic flaws which afflict service delivery in Pakistan more generally. The monitoring committees were provided with little or no operational budgets. Even where the committees were able to investigate and report on an issue of concern the failure was that the system to whom the report for redress was being submitted was the one against whom the report was being submitted albeit at a higher administrative level. The system generally preferred to protect its own. Evaluations of the system point to some of these weaknesses.

13. An evaluation by The Network for Consumer protection conclude the similar result with the explanation that the monitoring committees were nominally formed and their functioning, if at all, was mostly informal or inadequate[21]. The studies further sights that a general low level or complete lack of education of the monitoring committees members are one of the reason for their dismal performance and beside meetings and passing of the resolutions by councilors little changes on ground due to lack of systematic monitoring and evaluation. The forums also lack the capability of making distinction between individual and collective issues resulting in almost no change in the working of the government facilities they are suppose to monitor. In terms of generating specific monitoring data for effective decision making the local government committees has to be formed which need to submit regular monitoring reports. However field research[22] shows that the experience has not been

[21] Aziz Ehsan, Raja (2006) Local Government and Citizen Complaints: An analysis of Local Government System 2001 from Citizen-Consumer Perspective, The Network, Islamabad.
[22] Bilal Gulmina (2008) Devolution from Citizens Perspective Lead Pakistan.

encouraging. For instance in Faisalabad, twenty six committees have been formed but none of them have submitted monitoring reports. Devolution of the health sector, which was intended to increase accountability and voice, has paradoxically damaged the implementation of some public health programs. Districts do not have incentives to take up the low visibility preventive programs and have opted for high visibility projects like construction new hospitals, some of which sit empty due to lack of staff and equipment.

14. Aware that weak management can undo investments in health, the Government of Pakistan and many development partners have explored ways of improving management practices within the district health system. The concept of the District Health Management Team (DHMT) as a district health system strengthening intervention was introduced in 1999 in Pakistan under the Asian Development Bank (ADB) funded Women Health Project. Since then, various donor-funded projects have implemented DHMT. PAIMAN and SOHIP continue to propagate the concept of DHMT with the idea that DHMT promotes continuous performance improvement of the district health system via providing a forum for sharing and exchanging views, ideas, information and experiences for reaching consensus-based decisions to address district health problems, and to optimize resource utilization for improving the health care services; promoting inter-sectoral coordination and collaboration by bringing together district officials from various government departments in the district; promoting public-private partnerships; Promoting consultation with and participation in decision-making of the community through their elected representatives; Promoting ownership and prompt decision making on health-related issues that are sometimes beyond the scope of the District Health System.

15. An evaluation of the PAIMAN model of the DHMT found that the DHMTs had achieved a broad-based membership. In nine districts, the chairperson of the DHMT is the DCO and in one it is the District Nazim. In the nine districts where the Nazim is not the chair, he is represented by the Chairman of the District Health Committee or a member of the Zila Council. In most of the PAIMAN districts, the EDO (Finance & Planning), EDO (Community Development) and District Population Welfare Officer are also the members of DHMT. NGOs are represented in nine out of ten DHMTs and private practitioners/Pakistan Medical Association (PMA) in six DHMTs. A review of changes in the districts' health budgets in the ten districts shows an overall 16% increase in the 2007-2008 health budget as compared to the 2006-2007 health budget. It appears DHMT influenced this change by providing a forum where district

decision makers were sensitized on the health needs that the district governments had power to address.[23] Some other projects experimenting with the DHMT have not found it to be a very effective model and feel that the activation and sustenance of the DHMT requires constant support and follow-up. Furthermore, this is yet another mechanism which is outside the public health system and does not help address the fundamental problem of the lack of flexibility for the EDO-Health to take independent decisions regarding the financial and human resources at the district level.

16. Another key aspect which was ignored in the devolution plan was fiscal decentralisation. District governments remained dependent on provincial governments for fiscal transfers. Funding for health and education services continued to be provided by the provincial government in the form of grants to the district governments. District governments deposit all user fees collected in health facilities and schools (for children's school leaving certificates) into the provincial account. The funds were then distributed among the districts according to the Provincial Finance Commission (PFC) award formula, rather than in proportion to the actual amount collected in each. Discussions of district finance in Pakistan tend to focus on intergovernmental flows to the districts from the federal government and the provinces, while little attention is paid to the level or manner in which districts generate own-source revenues. Districts were not been assigned any broad-based taxes under the Local Government Ordinance, nor was their potential for own-tax generation explored. There was no medium or long-term budget planning taking place at the district level.[24]

[23] Annual Report Pakistan Initiative for Mothers and Newborns (PAIMAN). Cooperative Agreement No. 391-A-00-05-01037-00. USAID. October 2007 to September 2008.

[24] Stone, Ritu Nayyar, Robert Ebel, Sonia Ignatova, Khalid Rashid, Harry Hatry. Assessing the Impact of Devolution on Health Care and Education in Pakistan. Pakistan Devolution Support Project. United States Agency For International Development. Contract No. DFD-I-00-05-00129-00, Order No. 01. February 2006.

D. HEALTH INFORMATION SYSTEMS

(i) Health Management Information System

1. The Health Management Information System (HMIS) was established in the early 1990s with the support of USAID. It provides information on public sector first level care facilities. The Offices of EDO-Health used to receive HMIS forms from the province and distribute them to all first level care facilities (Basic Health Units and Rural Health Centers) in the district. The medical superintendents of each BHU/RHC used to complete the forms and give them back to their respective EDOs. The data is entered into computers at the district level and then sent to the province. Districts without computers send hard-copy reports instead. Ultimately, the compiled data reached the National HMIS Cell, where it is analysed using HMIS software and SPSS. This Cell generated feedback reports derived from the national data, which were sent to the EDO-Health. In addition, each vertical program has more or less its own information system. The LHW information system is community based and records births and deaths, covers well over 50% of the country's population and has the potential to provide reliable estimates of maternal and infant mortality. The major public sector hospitals of the country also provide information to the MOH on hospital mortality on an annual basis, with each hospital having its own information system.

2. Overall there is a problem of high error rates in reports as well as over reporting through many of these information systems. None of the health information systems cover the private health sector. Monitoring & evaluation and surveillance culture remains weak at all levels due to an absence of result based culture. Information systems are present in most First level care facilities (FLCFs) and in national programmes, so a culture of continuous data reporting exists. Currently, these systems are highly fragmented and often vertical leading to duplication of efforts. The significant issues with HMIS were data quality, its accuracy and completeness and limited use of information for decision making. The HMIS failed to evolve to develop other information sub systems initially envisioned e.g. human resource (HR) information system. The public hospital system in Pakistan also lacks a standardized information system and most maintain their own information system without a regular reporting mechanism. Federal and provincial governments now focus almost entirely on routine data coming from health management information systems. Pakistan has not undertaken a national health survey for more than

decade. The HMIS system has now been discontinued and the District Health Information System is expected to take its place. The DHIS has been piloted and work is in progress to initiate its implementation across Pakistan.

(ii) District Health Management Information System

3. The new DHIS is a district-centered information system that integrates primary and secondary care level information and information from various vertical programmes as well as information on public health sector human resources, logistics and finance. DHIS has a software application that helps the district managers to set targets for specific indicators and generate analysed reports on those specific indicators comparing the performance with previous months or among the health facilities/tehsils. In other words, DHIS is distinctively designed to support evidence-based decision making. However, projects like PAIMAN who are particularly interested in the DHIS as it captures important data on MNCH from both the primary and secondary care health facilities have provided technical support to DHIS in a few pilot districts. PAIMAN also extended its support at the provincial level and organized trainings for provincial Master Trainers from NWFP on DHIS software application, and advocated for a wider implementation of DHIS at the national policy level. The Government of Pakistan has approved the National Action Plan for the implementation of DHIS in 2007 following phasing out of the existing Health Management Information System (HMIS). In the context of devolution and considering the variety of information that DHIS can handle and analyze, its implementation is a landmark step in Pakistan's health sector. An understanding was reached between Government of Pakistan (GOP) and Government of Japan (GOJ) for technical assistance for DHIS set-up and implementation.

4. The table below outlines the difference between HMIS and DHIS system.

HMIS	**DHIS**
1. Covers only first level care facility.	1. Covers up to secondary hospitals
2. Number of tools/instruments : 30	2. Number of tools/instruments : 21
3. Number of indicators :	3. Number of indicators :

114(For FLCF)	79 (with the inclusion of secondary hospitals).
4. Number of cells to be filled : 446	4. Number of cells to be filled : 131
5. No in built system for improvement	5. In built system for improvement
6. Does not include management indicators	6. Includes management indicators
7. No Data Quality Assurance (DQA) System	7. Includes Data Quality Assurance (DQA) System
8. Partially fulfils District Health Management needs	8. Fulfils District Health Management needs at maximum level
9. Highly centralised system	9. Decentralised system

5. A National Health Resource Information Center (NHRIC) was established at considerable cost in 2003/2004 but is yet to be fully operational. It lacks adequate manpower that can provide leadership with knowledge and skills for information collection, aggregation, analysis and use to influence decision making. A critical aspect under the M&E and stewardship function is to ensure having an effective health surveillance system which is needed for effective prevention and disease control measures. Public health surveillance is a recognized public good and responsibility of the state. However, Pakistan at present has vertically operating multiple small initiatives in surveillance without a system to generate good quality information for making key public health decisions. The fragmentation is a result of lack of organisational unit or structure at the federal provincial and district level responsible for surveillance, lack of legal framework for disease reporting and lack skilled manpower and resources for this important function. In addition, no public health laboratory network exists except a Public Health Division Laboratory in National Institute of Health. The Ministry of Health is cognizant of the situation and undertook a detail assessment and framework which has not been put in place. Some aspects of the plan are being implemented e.g. A training programme through Fulbright fellowships for researchers, and communicable diseases control has been started to produce skilled manpower for surveillance. This would entail development

of a comprehensive system and build organisational capacity at federal, provincial and district levels for its effective functioning.

(iii) Surveillance and Health Status

6. There is no organized system of disease surveillance in the country to detect and abort epidemics in the districts without delay. The Disease Early Warning System (DEWS) and the polio surveillance provide a useful basis for developing a disease surveillance systems and then integrating within the wider health information system. Several population based surveys are conducted from time to time that include the Pakistan Integrated Household Survey, Demographic and Health Survey, Household Income and Expenditure Survey and others that provide information on health status, utilization and limited information on household expenditure on health. A National Health Survey of Pakistan was undertaken by the PMRC in the mid 1990s and has not been repeated since. These surveys are helpful but need better coordination and standardization of methodology in order to establish robust trend data that complement a facility-based system. Household level health expenditure surveys or inclusion of a health module in the Household Income and Expenditure Survey are two options to acquire data that would inform policies on health care financing.

(iv) Alternate District Monitoring System

7. An alternate District Monitoring System was established in Punjab to assess the progress of the World Bank financed Punjab Education Sector Reform Programme. As a result of the effective mechanisms of monitoring which were established, the Punjab Health Sector Reforms Programme financed by the Asia Development Bank decided to use the same systems for monitoring progress in the health sector. District Monitoring Offices were established in each district in Punjab. The reform in Punjab has been financed mainly by the Asian Development Bank. A Programme Monitoring and Implementation Unit has been established in the Chief Minister's Office in Punjab. The District Monitoring Office has a District Monitoring Officer and Monitoring and Evaluation Assistants who undertake surprise visits to the different health care centres. Special forms have been designed for the BHUs and RHCs. The scope of the monitoring includes cleanliness of the facilities, displays, availability of utilities, details of staff, staff presence, equipment, stock of medicine, purchi fees, number of patients treated last month, waste disposal, etc. The MEAS

collect the data and submit it to the DMO on the prescribed forms who then submits it to the Deputy Director (Monitoring and Evaluation) in the PMIU in Lahore. The reports are then sent to the Programme Director PHSRP where the reports are computerised and analysed. The Programme Director writes to the District Coordination Officer and the Executive Director (Health) of the concerned districts to take action with copies to the Secretary Health and the District Monitoring Office. Districts are ranked on the basis of their performance and the data is also posted on a special website developed by the PHSRP.

8. The DMO is hierarchical and a top down monitoring structure which is executed through a classical inspection type model. This further undermines the actual health hierarchy. If seen holistically, health governance in Punjab is in utter state of confusion with absolutely no permanent and strategic thinking for the long term reforms. Federal, and donor funded provincial programs are working side by side with governments own EDOs offices who have much leaner funds and authority. While this monitoring system helped to make the system more responsive in terms of taking corrective action based on these reports, it has made the EDO(H) act more like a post office which forwards reports from one to the other and does not always have the authority or resources to take the corrective action itself. However, the EDO (H) can sometimes use these reports to highlight some of the key problems and constraints that afflict a particular facility.

(v) Health Systems Research

9. The Pakistan Medical Research Council (PMRC) recognizes the overall lack of capacity to undertake health policy and systems research in the country and its own shortcomings in this area. There has not been an organized effort to develop and institutionalize health system research since the World Bank financed Second Family Health Project, which was completed in 2003. Current allocations to support health systems research are minimal and the PMRC has not been able to connect with international health research alliances to mobilize additional resources. The whole area of institutional capacity for health policy and systems research needs to be revisited to develop indigenous capacity for research that influences policies and programs on priority public health issues in the country. There are several civil society organisations such as the Heartfile and the Social Policy Development Centre and consulting companies as well as independent researchers who have undertaken research on the health sector.

E. HEALTH LEGISLATION

1. The weak health accountability infrastructure in Pakistan is mainly due to inadequate and insufficient legislation to deal with issues of accountability and lack of responsiveness. The pharmaceutical sector is regulated under the Drug Act 1976. Drug prices are fixed by the MOH on a case to case basis under this act. Partial deregulation (323 molecules & 821 formulations) was approved in 1993, reducing the powers of the Ministry to regulate drugs and resulting in an extraordinary increase in prices. This decision has been put on hold since 1994. The cost issue was also addressed partially through the introduction of the Generic Drug Act (in 1972, 73), but it was not implemented and the commercial interests of stakeholders forced the policy to be reverted. The table below provides a summary of health sector legislation and its scope in Pakistan.[25]

Relevant Legislation[26]	**Scope of the law**
-The Dangerous Drugs Act 1930, Poison Act XII of 1919. -West Pakistan Dangerous drugs rules	Govt control over dangerous drugs
The drug act of 1940 (XXIII 1940)	Drug Regulation Act
The drug rules 1945 The drug act 1976 (Act XXXI of 1976) The drug import and export rules 1976	Drug Regulation(Registration, Testing, Production, Sale)
Punjab/Sindh/NWFP/Baluchistan drug rules 1958 The Drug Rules 1976	Licensing, Advertising Rules
Unani , Ayurvedic and Homeopathic Practitioners Act 1965	An act to regulate qualifications and registration of practitioners of Unani , Ayurvedic and

[25] Malik, J. Background paper on Responsiveness and Accountability in Health Systems in Pakistan. June 2998. HLSP-DFID

[26] The laws mentioned here do not include minor amendments and some of the provincial acts. But that does not change the overall picture of state of health legislation of Pakistan as being maintained in this section.

	Homeopathic systems of medicine
The drug research rules 1976 Punjab drug rules 1988, Sindh drug rules 1979 The Drugs labeling and packing rules 1986, 1982,1978	Drug research services provision
The Pakistan Penal Code 1860 (Chapter XIV Section 274, 275 and 276)	- Adulteration of drugs
The National Institute of Health Ordinance (XLIII of 1980)	Establishment of NIH to work as a federal agency for disease prevention through research, training, management and other functions
The National Institute of Cardiovascular Disease Ordinance Karachi 1979	Management Improvement Support
The NIH employees benefits 1986	Employees relations and benefits
The Medical and dental council ordinance 1982	Reorganisation of medical and dentist organisation for maintaining uniform and minimum standards in qualification
Allopathic System Misuse Act (LXV 1962)	That no untrained person could act as a doctor
Anti Narcotics Act 1997 (Act No. III of 1947)	Creation of a force to curb Narcotics business
Punjab Medical and Health Institutions Ordinance 1998	Hospitals Management Autonomy all the 9 medical colleges and associated teaching hospitals, and 16 other hospitals in the Punjab were granted autonomy in three phases,

Source: Javed Malik. June 2009.

2. Most of the laws in Pakistan deal with regulation of the drug market or establishment of some health related institutions. Another set of laws which are indirectly deployed to ensure better health are food laws and mainly deal with food quality issues.[27] The capacity of the law makers and lack of involvement of policy workers in the law making process have affected the quality of laws in Pakistan. The policy capacity of Pakistani legislators is fairly limited. Majority of the politicians have no real policy making or executive experience. In five years comparison report of the performances of Pakistani National Assembly and Indian Lok Sabha, PILDAT demonstrated that as opposed 248 bills passed by Indian Lok Sabha between 2002 to 2007, Pakistan national assembly could only pass 50 bills. This resulted in Pakistani government resorting to presidential ordinances through which it passed 73 ordinances as opposed to Indian government which used this mechanisms only 34 times during the same period.[28]

3. The quality of the passed laws is also questionable. Majority of the laws lack proper implementation mechanisms, fiscal allocations, accountability structures and performance management. Law making process does not really entail a necessary research process which could identify the exact social and institutional actors whose behaviours the law aims to affect. Ministry of law which is responsible for drafting laws displays a major disconnect by appointing essentially draftsmen to draft laws and keeping policy makers totally away from the process. Draftsmen are generally good legal wordsmiths having enormous experience of drafting laws but have little in-depth understanding of range of policy issues.

4. The procurement of drugs at federal level is now undertaken according to the Pakistan Procurement Regulatory Act (PPRA)[i]. The procurement process and testing of drug quality is functional but the system needs to be made more effective and efficient. In addition, the process of procurement at all levels has limited internal controls, and there is need for a monitoring mechanism to ensure value for money.

5. The new health policy envisages the creation of a semi-autonomous National Drug Regulatory Authority guided by the goals and objectives of national medicine policy. The aim would not be to over-regulate the sector but to administer necessary

[27] The majors laws involved in regulating food laws is Pure Food ordinance 1960 along host of other laws dealing specifically with sugar, flour and other such food related goods. For details seeThe Manual of Food Laws in Pakistan (2007), Punjab Law Book House, Lahore.
[28] Citizen Report (2007), Performance of 12th National Assembly of Pakistan, P.8, PILDAT, Islamabad.

and internationally but would still be linked with MOH and would be overall guided recognized norms and standards of regulation (necessary for developing countries) to ensure the safety, quality, efficacy and affordability of health products moving in the market in Pakistan. The authority would be autonomous enough to make technical, financial and administrative decisions by its policies.

6. The new policy also envisages that a policy of partial regulation of medicine prices will be developed as part of national medicine policy through consultation with the stakeholders. The essential medicines not having enough competition in the market would be a priority for price regulation. Rest of the medicines would be deregulated with defined ceilings and with efficient medicine price monitoring system in place. The medicine pricing policy will be available as a separate but linked document with the national medicine policy.

7. A Therapeutic Goods Act, which provides for the establishment an independent Regulatory Authority and instruments for the integrated regulation of Drugs, Traditional Medicines and Medical Devices, is to be submitted for adoption.

8. Role of health workforce licensing bodies – Pakistan Medical & Dental Council (PMDC), Pakistan Nursing Council (PNC) – will be strengthened; whereas the government will review the option of establishing new accreditation bodies for pharmacists, health technicians and paramedics.

9. There is a pending need for creating a resourceful semi-autonomous medicines regulatory authority which can attract and retain technical experts and which can effectively ensure the safety and quality of medicines available in the market in the country. There is need for an appropriate mechanism for drug pricing with an inbuilt monitoring mechanism.

F. ACCOUNTABILITY AND CORRUPTION IN THE HEALTH SECTOR

1. Transparency International's report about Pakistan in 2002 and 2006 has been placing health among the top seven most corrupt departments in Pakistan[29]. The Health sector has moved from being rated as the 7th most corrupt sector in 2006 to the third most corrupt sector in 2009. The National Corruption Perception Survey 2009 (NCPS 2009)[30] indicates that the overall Corruption in 2002 has increased from Rs 45 Billion to Rs 195 Billion in 2009. Police, Power, Health and Land are said to be the most corrupt departments. The Present District Government System has been rated as more corrupt by 66.48% respondents than the previous District Government System. A majority of respondents want the National Accountability Bureau or any equivalent Anti-Corruption Agency to be an independent body under the control of the Supreme Judicial Council. The three main reasons of corruption in view of the respondents were lack of accountability, lack of transparency and discretionary power.

2. Surveys in Pakistan document that there is a perception that corruption is very common in the health sector making corruption perhaps the greatest challenge to good governance. In Pakistan the most conspicuous example of corruption in the health care system is absenteeism of health care personnel, better termed "ghost workers". It is very common for health care workers given assignments to particular posts to receive salaries but fail to attend their clinics, especially in rural centers. Very often they do not even live in the community or near by. Portions of salaries allotted for "ghost" physicians are shared with officials that manage the clinical system. Another form of corruption is illegal user fees which are routinely charged and represent a major burden on the poor.[31] These forms of corruption are endemic and highly organized.

3. The public health care system is characterised by poor coverage, and indifferent quality of services due to lack of staff, poor resource availability and low accountability. The institutional framework of public health system is characterised

[29] National Report (2006)Transparency International Pakistan, http://www.transparency.org.pk/documents/PRESS%20RELEASE%2012%20August%202006.pdf Accessed May 28, 2009.
[30] Transparency International Pakistan. June 17, 2009.
[31] Pappas, A. Ghaffar, T. Masud, A. Hyder & S. Siddiqi : Governance and health sector development: a case study of Pakistan. *The Internet Journal of World Health and Societal Politics*. 2009 Volume 7 Number 1.

by high centralisation, poor delegations, weak accountability mechanisms, weak HR policies, and inadequate control over the private sector. While scarce resources in the social sector have been a problem in Pakistan, the issue of governance raises questions about how those resources have been spent.[32] This evolution of the concept of governance encompasses the changing role for governments where new policies and mechanisms -- contracting out, the creation of self-regulatory bodies, and empowerment of consumer groups -- have been developed to compliment with traditional health sector activities -- standard setting, enforcement activities, and care delivery by governments.[33] Poor governance in the health sector has led to misdirected spending of funds intended to improve the health status of the population. Corruption, inefficiency, poor regulatory authority undermine health care delivery in much the same way they do for police services, courts and customs.[34]

4. There are also serious weaknesses in the processes around planning, policy, and programme implementation in the health sector. These three critical functions operate independently instead of being linked and interdependent. Project planning is the domain of the Planning Commission which need not follow priorities set in the health policy formulated by the Ministry of Health. On the other hand implementation of health policies and service delivery is the responsibility of the district governments which need not take direction from Provincial or Federal level. Duplication in the bureaucracy is another sign of inefficiency. The Ministry of Population was established in 1965 to promote family planning and operates its own health/population facilities which in many cases these are separate from the health outlets. Weak coordination between the two ministries has further lead to poor implementation of these interventions.

5. Corruption in the pharmaceutical sector is pervasive. Procurement process includes collusion among bidders to reduce competition and to influence the selection process. Kickback and bribes to public officials monitoring the contracting process are accepted. In clinical facilities drugs and medical supplies are stolen from central stores for resale in private practices or on the black market resulting in chronic shortage of medication in public facilities. Institutionalized corruption take the form of dispensing drugs to “ghost patients”, graft and padding of bills, over payment,

[32] Pappas, A. Ghaffar, T. Masud, A. Hyder & S. Siddiqi : Governance and health sector development: a case study of Pakistan. *The Internet Journal of World Health and Societal Politics.* 2009 Volume 7 Number 1
[33] Pappas, A. Ghaffar, T. Masud, A. Hyder & S. Siddiqi : Governance and health sector development: a case study of Pakistan. *The Internet Journal of World Health and Societal Politics.* 2009 Volume 7 Number 1.
[34] Ibid.

over invoicing, or simply pocketing the patient's payment. Corrupt management and monitoring capacity lead to poor quality of medication on the shelves including expired, counterfeit and harmful drugs. The process of licensing pharmacies or chemists' shops is corrupted by bribes. Physician practices are adversely affected by aggressive drug marketing strategies and unethical promotion of medicines. Lack of appropriate regulatory activity in Pakistan has created additional health problems for the population. Substandard and fraudulent pharmaceuticals are common. Counterfeit medicines constitute between 40 and 50 per cent of total supply in Pakistan. Government bodies have weak authority and poor procedures for regulation of the quality of pharmaceuticals and quality of medicine.

6. Problems with voice and accountability can be identified in the inequities in access to health care and in the lack of a process by which stakeholders participate in decision making related to health in the government. Pakistan suffers from low levels of confidence in, and poor obedience to rules of society. This problem has been created by many years of poor contract enforcement, an overwhelmed judicial system, and poorly trained and ill-equipped enforcement agents. In the health sector patient and consumer safety have suffered. Medical negligence is well documented and the legal system is poorly prepared to address abuses. Pakistan has a very weak system to monitor medical negligence, to discipline those found in error, and to provide restitution to victims. There are no specific policies at the federal level nor are there any programs to protect patients.

7. Years of neglect and inaction has led to very low levels of trust towards health sector institutions. Pakistan, like many developing countries, tolerates non-adherence to rules barring public sector physicians from maintaining private practice. Problems with voice and accountability are also reflected in lack of a process by which stakeholders participate in decision making and policy formulation, particularly the poor who depend on the Ministry of Health (MoH) for their care. The Government of Pakistan has developed three National Health Policies (NHP) in1990, 1997 and 2001 and is now in the process of developing the fourth in 2010. These policies have been conceived, directed, and implemented by a small group of professionals at the Ministry of Health without involvement of civil society, development community, professional bodies, consumer organisations, or members of parliament, with the exception of some minor consultation conducted around the 1990 NHP. Minimal consultation for development of these plans has led to poor quality and lack of support outside of narrow policy circles in Islamabad.

G. PROCUREMENT AND FINANCIAL MANGEMENT REFORM IN THE PUBLIC SECTOR

(i) Public Procurement Regulatory Authority

1. There is large-scale corruption in procurement and contracting affecting government and development aid funded programmes, public works, etc. Some of the systemic weaknesses have included the lack of a standardised procurement regime and an absence of procurement expertise in the government. Grounds and opportunities for corruption are provided at every stage of the procurement process (from preparation to tender, bid evaluation, negotiations, and contracting).[35] In order to deal with some of these issues several reforms have been initiated in the past. One such measure was the establishment of a public procurement regulatory authority. The World Bank had in particular been recommending the establishment of a single regulatory authority for public procurement[36], In June 2002, the Public Procurement Regulatory Authority (PPRA) was promulgated by the President for regulating procurement of goods, services and works in the public sector and for matters connected therewith or ancillary thereto; and extended to the whole of Pakistan. The PPRA can take such measures and exercise such powers as may be necessary for improving governance, management, transparency, accountability and quality of public procurement of goods, services and works in the public sector. It may monitor application of the laws and procedures; recommend revisions in or formulation of new laws, rules and policies in respect of or related to public procurement; make regulations and lay down codes of ethics and procedures for public procurement, inspection or quality of goods, services and works; monitor public procurement practices and make recommendations to improve governance, transparency, accountability and quality of public procurement; monitor overall performance of procuring agencies and make recommendations for improvements in their institutional set up and other. Some suggest that the agency has not been properly staffed and needs capacity building if it is to perform the intended functions.

(ii) Resolution related to procurement standards

2. In 2002, the National Accountability Bureau as a part of its study in preparing the National Anti-Corruption Strategy (NACs) organised an international workshop, resulting in the stakeholders adopting a resolution related to ensuring transparency in Public Procurement in Pakistan. This resolution was incorporated in the NACS report

[35] Jeremy Carver, Jeremy Pope, Shahzadi Beg. Corruption in Pakistan. Anti-Corruption Resource Centre. U40. Help desk.
[36] Country Procurement Assessment Report. World Bank. 997

and was approved by the Ministerial Cabinet and the President of Pakistan in October 2002. Amongst others, the recommendations provide that:

- the Standard Procedures for Procurement of Works, Goods and Consultants should be revised by the Public Procurement Regulatory Authority. Either the World Bank or PEC by-laws should be uniformly implemented in all government and semi government departments till such time the PPRA prepares its own Guidelines;
- to ensure transparency and public participation, the Transparency International-Pakistan tool 'Integrity Pact" should be made an integral part of all tenders;
- for every new project, public hearings should be made mandatory for scrutiny of necessity of the project and for the environmental assessment, prior to concept clearance approval;
- evaluation Committees for Pre-qualification and Award of Contracts must include at least two departmental members, and a minimum of three independent experts, (One each from the Pakistan Engineering Council, Institute of Chartered Accountants and FPCCI), and others.

(iii) Integrity pacts

3. An important part of the recommendations of the NACS was the incorporation of the Transparency International (TI) Integrity Pacts in all contracts for goods and services where the estimated cost of the project is over Rupees 5 million for consultancy and over Rupees 50 million for Construction Contracts. This has been a major breakthrough in the efforts of TI-Pakistan whereby all major contracts will not only provide for the "Integrity Pact" but also include all other recommendations, which have been put out in the NACS Document. In the event of a breach of the Integrity Pact, sanctions come into force against the bidders and officials, including liability for damages, and blacklisting from future tenders.

(iv) Other Reform Efforts Regarding Procurement and Financial Management

4. Efforts have been under way on the part of the government to reform the Federal and Provincial Public service commissions, particularly with regards to capacity and competence building. The World Bank had approved a US$55 million IDA credit in May 2004 for Public Sector Capacity Building Projects that have funded

training and professional development of over 500 public servants, enhancing the capacity in key ministries/agencies which are in the forefront of designing, implementing and monitoring policy reform. It also aimed to strengthen some key regulatory agencies, specifically NEPRA (National Electric Power Regulatory Authority), OGRA (Oil & Gas Regulatory Authority) and PTA (Pakistan Telecommunication Authority).

5. Some of the weaknesses in the system were addressed by the government's Project to Improve Financial Reporting and Auditing (PIFRA). The World Bank carried out a country level Financial Accountability Assessment in December 2003. The ADB also approved a US$ 204 million loan (part of a wider sequence) to support the Government of Punjab. Among other objectives, the programme aims to improve the effectiveness and accountability of financial management by bringing in transparent and user-friendly budgets and accounts, and financial and procurement systems.

6. The Supreme Audit Institution of the country (the Auditor General's office) is trying to reform itself by following international best practices, such as those of the International Organisation of Supreme Audit Institutions (INTOSAI), as part of its reform agenda. It has been noted that there seems to be some progress in reorganizing the department with a view to adopting modern techniques of audit and reporting formats. It has initiated a capacity building program under the project to improve Financial Reporting and Auditing (PIFRA). Some of the other reform efforts include the design of diagnostic tools, such as a

H. ACCOUNTABILITY MECHANISMS AND ARRANGEMENTS

(i) Overview

1. Pakistan has been consistently pursuing an accountability agenda. Unfortunately this agenda has been mostly coloured by a desire for political persecution rather than a genuine desire for good governance for much of the time. Accountability in Pakistan has been very selective. As such the process of accountability in Pakistan has always been looked upon with suspicion and trepidation. Nevertheless Pakistan has been gradually strengthening its institutional infrastructure for accountability over the years. Each new Government is initiated with a rush for the creation of new institutional forums purported to be better than the last to usher in a new era of accountability. There is thus a proliferation of accountability mechanisms which include State Accountability mechanisms, public accountability mechanisms including both political and civil society measures and those mechanisms which have been established for specific sectors such as health, education, public procurement, etc. A summary of the key institutions in the responsiveness and accountability landscape in Pakistan is given below. A SWOT analysis highlighting the functions, strengths and weaknesses of the existing mechanisms is outlined in the Stakeholder SWOT analysis.

Regulatory and Supervisory Bodies	Planning and Implementation Institutions	State Accountability Forums	Public Accountability Forums	Civil Society Organisations	The Electronic and Print Media
The Pakistan Medical and Dental Council (PMDC)	Planning Commission of the Government of Pakistan The National Economic Council (NEC) The Executive Committee of National Economic Council (ECNEC) The Central Development Working Party	The Auditor General's (AG) Office	Public Accounts Committee (PAC).	Charities and Trusts	Electronic Media

	(CDWP)				
Pakistan Nursing Council	Federal Ministry of Health	Federal and Provincial Service Tribunals	Parliamentary Standing Committee on Health at the Federal and Provincial level.	Development NGOs	The Print Media.
Council of Homeopathy	The Cabinet Division	Federal and Provincial Ombudsman's offices.	Consumer Councils/ Consumer Courts	Research, Advocacy and Consumer Rights NGOs	
National Council of Tibb	The Planning and Development Departments	Anti Corruption Establishments and Departments (ACE and ACD).	Monitoring Committees at the Union Council, Tehsil and District level under the Local Government law 2004	Health Committees at the District and facility level;	
Central Licensing Board, Drug Regulatory Board, Drug Appellate Board and Quality Control Boards	Punjab Rural Support Programme	The Federal Investigation Agency (FIA)		Citizen Community Board's (CCBs).	
The Drugs Control Organisation	National Commission for Human Development (NCHD)	The National Accountability Bureau (NAB)			
The National Bioethics Committee		The National Accountability Commission (NAC)			
		Judiciary			

2. The last time there was a rush to revamp the accountability infrastructure in the country was when the last Government of Pervez Musharraf took over at the end of 1999, following a nonviolent military coup d'état. To justify the seizure of power and encouraged by donors a spate of measures were undertaken to indicate that

anti-corruption was high on the agenda. A National Anti-Corruption Strategy (NACS) was launched in 2002, the National Accountability Ordinance of 1999 (amended 2002) and the National Accountability Bureau - the agency charged with the implementation and overall coordination of the NACS and the Ordinance was established. Many high profile cases were pursued by the NAB and the political favourites who had benefited from bank loans, licenses and contracts were persecuted under this new system. However, eight years later, in the search for political reconciliation which paved the way for the stepping down of Musharraf and the return of the current political dispensation the authority of this entire system was put in doubt by the following declaration "whereas it is expedient to promote national reconciliation, foster mutual trust and confidence amongst holders of public office and remove the vestiges of political vendetta and victimization, to make the election process more transparent and to amend certain laws for that purpose and for matters connected therewith and ancillary thereto; and whereas the National Assembly is not in session and the President is satisfied that circumstances exist which render it necessary to take immediate action; now therefore in exercise of the powers conferred by clause (1) of Article 89 of the Constitution of the Islamic Republic of Pakistan, the President is pleased to make and promulgate the National Reconciliation Ordinance, 2007.

3. With the promulgated of the National Reconciliation Ordinance, across-the-board indemnity was granted to alleged corruption and corrupt practices by politicians and holders of public offices in the past. Under the ordinance, cases of corruption against public office-holders were to be withdrawn and no public office-holder would be arrested in future in corruption cases and powers of the chairman National Accountability Bureau were considerably clipped. However, in a dramatic and historic move the Supreme Court of Pakistan struck down the National Reconciliation Ordinance (NRO), terming it unconstitutional. A 17-member bench, headed by Chief Justice Iftikhar Muhammad Chaudhry, in his short order, declared the ordinance as null and void. According to the judgment, the NRO was contrary to the equality guaranteed by the 1973 Constitution of Pakistan. Similarly, all the cases, disposed off because of the controversial ordinance, now stand revived as of Oct 5, 2007. The ruling declared that the provisions of the NRO seem to be against national interests thus it violates the several provisions of the constitution. During hearing of petitions against the NRO, the chief justice declared that even the parliament had no right to change the basic structure of the constitution. Much of the credit for the repeal of this unpopular bill goes to the Lawyers movement and its ability to

galvanize support from a cross section of the political and civil society in the country and pitch this support behind the institution of the Chief Justice of Pakistan.

(ii) Accountability Commission

4. In keeping with past traditions, the new Government will, needless to say, initiate its own accountability infrastructure. Already the government has decided to repeal the National Accountability Ordinance (NAO) 1999, and has drafted a bill titled the Holders of Public Offices Bill (HPOA), 2009 to legislate for an alternative accountability mechanism. With the promulgation of these statutes, the National Accountability Bureau (NAB), Pakistan's apex agency mandated to deal with corruption will be replaced by an Independent Accountability Commission. The Holders of Public Offices (Accountability) Act 2009, which currently exists as a Bill has yet to be introduced or approved by the National Assembly. It is considered to be one of the most vital instruments of governance in Pakistan, over the coming years; its connotations and covenants defining responsibility for decisions and actions.[37]

5. There is an expectation that since accountability (a mandate of the Accountability Commission) is a more overarching thread in governance, compared to anticorruption (the remit of NAB), the scope of the Accountability Commission would be broader than NAB. However, a review of the Bill reveals that jurisdiction of the Accountability Commission is more limited. There are concerns that with promulgation of the proposed statute, a higher percentage of policy and decision makers and other offenders will be excluded from the ambit of accountability. The NAO is wide-ranging and covers a wider category of persons and offences; scope of the new law, on the other hand is relevant to holders of public offices only. Offences such as accumulation of assets beyond known sources of income, acquisition of unmarked properties and wilful loan default stand excluded from the jurisdiction of the Accountability Commission under the Bill. There is a perception therefore that instead of strengthening, the proposed statute might weaken the process of accountability.

6. The proposed statute stipulates appointment of the Commission Chair for a non-renewable three year period and stipulates that both the treasury and opposition

[37] Sania Nishtar. Drwa from several articles written on the subject by Heartfile.

benches would be included in the consultation process for appointment of the Chair. However, the Bill does not mandate the creation of an independent participatory governance arrangement. An inquiry can be initialized only when a go ahead is given by the Chairman or a designate. Entrusting decision-making powers to one individual does not resonate with the spirit of a Commission; it creates space for manoeuvrability and capture by Pakistan's elite-dominated and patronage characterized political dispensation. These are the same factors which were responsible for NAB's partial stance in some cases. Impartial and participatory governance with civil society representation, an open disclosure policy and transparent terms of reference must be inherent to the structure of this Commission.

7. Most of the well known anti-corruption commissions around the world such as Hong Kong's Independent Commission Against Corruption (ICAC), the Independent Commission Against Corruption of New South Wales, the Malaysian Anti Corruption Commission and the Corrupt Practices Investigation Bureau (CPIB) of Singapore perform investigative functions whereas some such as the Malaysian commission also perform prosecutorial functions, as did NAB until recently. Any attempt to restructure NAB therefore, has to come up with clear directions for the investigative and prosecutorial scopes of work of the new body. From what is publicly known about the proposed restructuring it appears that there has been a call for a separation of the two functions. Corruption related investigative work involving holders of public offices as defined in the government statement is envisaged to be entrusted to the new body and the same relevant to public servants and the private sector is meant to be brought under the jurisdiction of FIA whereas prosecutorial functions are being handed over to the regular legal and judicial systems. Here it is acknowledged that in principal, it is a good idea to separate investigative work from prosecutorial functions as it mitigates the possibility of bias and acts as barrier against political exploitation. However, there are two problems in this regard in Pakistan's context and the direction being envisaged specifically. One relates to concerns regarding two different groups of citizens being dealt with under different institutional arrangements and possibly varied normative arrangements—holders of public offices vs. public servants and the private sector—and it needs to be ascertained if this approach is discriminatory in any way. The other reservation relates to the capacity and efficiency of FIA as an independent and impartial agency given the historical perspective. Challenges emanating from lack of reform within the judicial system is an across the board issue as well which may dampen the impact of any new arrangement.

8. Federal and provincial government employees will fall within the purview of Federal Investigation Agency (FIA) and Anti-Corruption Establishments (ACE), respectively, after the enactment of the Bill. However the capacity of these institutions and their past history, which is indicative of politicization, needs to be factored into consideration. FIA's failure to prosecute anyone above grade 19 in its entire history is often referred to in this regard. Institutions are additionally under-resourced and lack capacity. Considerable resourcing, market based incentives, capacity building and reorganisation of these organisations would therefore be necessary.

9. Those commenting on the Bill argue that the broader anticorruption agenda should be revitalized in tandem. The National Anti Corruption Strategy (NACS), which has been dormant should be revived; the potential within certain implicit transparency building arrangements such as electronic procurement, electronic tracking of supply chains and the use of technology in public finance management—budgeting, accounting and auditing systems—should be fully leveraged and previous efforts to bridge weaknesses in the Freedom of Information Ordinance, 2002 should be resumed. Furthermore, institutions such as the Ombudsman's office should be optimally strengthened for creating avenues of public redressals; strategic plans for incentivizing the civil service and promoting integrity therein, should be implemented; a level playing field should be promoted for businesses and help should be sought from the Competition Commission to weaken organized vested interests; moreover, a broad based agenda for systemic reform of governance, which can institutionalize accountability should be consolidated building further on many elements of that framework, which have been initialized piecemeal over the last 62 years.

10. The key challenge for Pakistan as it sets out to restructure and reform the National Accountability Bureau will not just be to ensure 'independence' in governance arrangements but also to minimize opportunities of capture of independent governance by vested interest groups. It is only then that we can make a solid contribution to strengthening an anti-corruption structure and take a positive step to towards promoting political responsibility, responsible governance and public accountability. The need to do so cannot be overemphasized at a time when making governance effective should be one of the utmost priorities in the wake of unprecedented array of challenges the country faces.

11. There are many concerns relating to this legal framework, particularly with regard to preferential treatment and other issues emerging as a result of its implementation, specifically in relation to strengthening the mandate of the FIA while it remains, in its present shape, an institution with many weaknesses. A robust legal and institutional anti-corruption framework can bring great value to mainstreaming transparency in state functioning. However, some key oversight institutions should be strengthened—in particular, the Public Accounts Committee and the AG's office. Recent improvements in the AG's office should be sustained and further built upon. The potential within the Public Accounts Committee can be harnessed with the leader of opposition in its chair, albeit with the right technical inputs and civil-society engagement. The Public Accounts Committees also exist within the framework of the local government system but have not been made to function as a tool for strengthening district oversight and accountability. Although their fate is dependant on the overall decision relating to the local government system, every effort should be made to retain and strengthen institutional frameworks that can compel accountability.

12. Rather than the punitive, investigative and sanctions-oriented approach to dealing with corruption in the private sector, the focus should be on leveraging the potential within competitiveness to counter organised vested interests and ensure that businesses have a level playing field. Pakistan's Competition Commission should be incentivised to act as an active engine in order to build safeguards in the market environment. A twin agenda relevant to the executive branch of the state can help to achieve efficiency whilst at the same time act as a safeguard against collusion. Critical investments are needed in technological applications in the management and public expenditure tracking streams. Alongside, some initial steps must also be taken to promote integrity at the executive level; although civil service reforms is a long-drawn agenda and while the system eagerly awaits the much-needed deeply rooted action in this area, improvements can be made by ensuring respect for merit and tenure security and improving accountability of decision making.

(iii) Punjab Health Care Commission

13. Some of the provincial governments are also taking measures to improve the responsiveness and accountability in the public sector and in the health sector in particular. One such initiative is the formation of the Punjab Health Care Commission by the Government of Punjab for "improvement of healthcare services and ban quackery in all its forms and manifestations"[38] The Act is designed to include in its ambit both public, private, non-profit, charitable hospitals, trust hospitals, semi-government and autonomous health care organisation without any discrimination. The Act envisages the formation of a permanent Punjab Health Care Commission with wide ranging powers. It will maintain a register of all Heath care service providers and grant revoke and renew licenses to persons involved in the provision of healthcare services. A Heath Care Service Provider shall not provide Heath Care Services without being registered under this Act and obtaining a license from it. The Bill defines Health Care Service provider as a "person registered by PMDC, National Council for Tibb and Homeopathy, Nursing Council or an owner, manager or in-charge of a healthcare establishment." The Commission will monitor and regulate the quality and standards of the Health Care Services developed by the Government and will operate accreditation programmes in respect of heath care Services and grant accreditation to such Health Care Service Providers who meet the prescribed standards. It will also have the power to enquire and investigate into maladministration, malpractices and failures in the provision of health care services and issue consequent "advice and orders." It can also collect penalties on violation. The Commission also plans to commission independent Performance Audit of Helath Care Establishments with Tertiary Care Hospitals in the private sector. The Commission can take action on the complaint of any aggrieved person, Government agency, provincial assembly or the Supreme Court or Lahore High Court. The Commission will also take measures to stop over the counter sale of drugs without prescription. The Commission may in case of calling witnesses, documents and other evidence exercise the same powers as are vested in a civil code under the Code of Civil Procedure 1908 (V of 1908.)

[38] Punjab Health Care Commission Act 2010.

ANNEX 7: STAKEHOLDER SWOT ANALYSIS MATRIX

Table 1: Regulatory and Supervisory Bodies

Type	Strengths	Weaknesses	Opportunities	Threats
The **Pakistan Medical and Dental Council (PMDC)** is a statutory regulatory authority established under the Pakistan Medical & Dental Council Ordinance 1h962 as a body corporate. PMDC's main objective is to establish a uniform minimum standard of basic and higher education in medicine. PMDC is charged with protecting the public interest in the realm of	The PMDC is mandated to have representation from a range of institutions including political, judiciary, teaching staff and the health sector. PMDC has issued a Code of Ethics that is intended to govern the conduct of all medical practitioners and institutions. Registered practitioners are obligated to follow the Code of Ethics, which includes a section on research ethics. PMDC is empowered to take disciplinary action against members who violate its Code of Ethics. In response to a complaint, PMDC's disciplinary committee may recommend one of the following: "an admonition, a temporary	There is little evidence that PMDC has worked in favour of consumers. There is little awareness among the general public regarding the PMDC's complaint redress mechanism. Non application of due criteria in medical education especially in the private sector, has led to a grave deterioration in professional quality of the medical practitioners. criminal law.	No specific opportunity to involve the PMDC in the R&A Strategy has been identified so far.	Referral to PMDC is not likely to produce results in ensuring accountability for medical negligence.

medical and dental care. The organisation keeps a register of qualified doctors and dentists, and is empowered to take disciplinary action against its members in cases of misconduct. To safeguard public interest, PMDC has been given a mission to establish uniform minimum standard of basic and higher qualifications in Medicine and Dentistry throughout Pakistan. No Pakistani Doctor can practice in Pakistan or abroad without being registered with PMDC or without being in	suspension for a specified period or life-long expulsion from . . . PMDC." The standards used by PMDC for accreditation and inspection of medical and dental colleges in Pakistan have been declared comparable to U.S standards and have been approved by the General Medical Council U.K. PMDC has the mandate to undertake continuous and vigilant monitoring of standards of different institutions and has the authority to close illegal medical/dental colleges PMDC has explicit code of conduct for medical professionals with detailed complaint mechanism with a clear timeline.			

good standing with it.				
Pakistan Nursing Council is an autonomous, regulatory body established in 1948, constituted under the Pakistan Nursing council Act (1952, 1973) and empowered to register (license) Nurses, Lady Health Visitor, Midwives and graduates of public health schools and issue their necessary diplomas. The PNC also inspects schools of nursing, midwifery and public health for the purpose of approval.	PNC monitors and evaluates nursing training institutions. It sets curriculum for education of Nurses, Midwives, LHVs and Nursing Auxiliaries. It provides registration (license) to the nursing staff practice. It also maintains standards of education and practice, education and nursing services It can remove persons form the register for professional misconduct.	There is little evidence that PNC takes any action against the nurses in case of complaints. There is little awareness among the general public regarding PNCs role and functions.	No specific opportunity to involve the PNC in the R&A strategy has been identified so far.	
Council of	Traditional medicine has been		No specific opportunity to involve	

Homeopathy The Government has issued the Unani, Ayurvedic and Homeopathic Systems of Medicine Rules of 1965, which included implementing provisions on the registration of practitioners, elections to the boards, and recognition of teaching institutions.	accepted and integrated into the national health system in Pakistan. Under this Act, courses in homeopathy provided by recognized institutions must be four years in duration, culminating in a qualifying examination. About 40,000 homeopathic physicians are registered with the National Council for Homeopathy. The Board of Homeopathic Systems of Medicine was established in order to maintain adequate standards in recognized institutions and to make arrangements for the registration of duly qualified persons		the COH in the R&A strategy has been identified so far.	
National Council of Tibb The Ministry of Health,	After successful completion of tibb qualifications, candidates are registered with the		No specific opportunity to involve the PNC in the R&A strategy has been identified so far.	

through the National Council for Tibb oversees the qualifications of practitioners.	National Council for Tibb, allowing them to practice traditional medicine lawfully. Tibbia colleges, Pakistan's unani teaching institutions, are recognized by the Government and are under the direct control of the National Council for Tibb. Twenty six colleges in the private sector and one college in the public sector offer four-year diploma courses in Pakistani traditional unani and ayurvedic systems of medicine. The number of Hakims registered is currently 45,799. About 360 tibb dispensaries and clinics provide free medication to the public under the control of the health departments of provincial governments.			

Central Licensing Board, Drug Regulatory Board and the Drug Appellate Board exist at the federal level and **Quality Control Boards** have been established at the provincial level.	Each of these has a dedicated mandate. Federal inspectors of manufacturing facilities can invoke manufacturing licenses and provincial drug inspectors are mandated to exercise vigilance at the retail level in order to ensure quality at retail outlets and in the distribution chain.	These remain substantively dysfunctional. The implementations of the laws is for most part either ***mechanical***, or based on such discretion which does not satisfy the independent judgement, thus remaining ***subjective*** Implementation of existing rules and regulations is difficult. There is a conflict of interest as the agency responsible for policy making is also responsible for regulatory and implementing arrangements. At the federal level, creation of the Drug Regulatory Authority, which was approved in 2005, was envisaged as a mitigate against this by separating functions and entrusting regulation to an independent agency. However, work on that has	There is a need to reflect on locally relevant solutions in order to make drug regulation more effective and transparent. There is an opportunity to introduce reform to improve quality of medicines, increase the remuneration of drug inspectors and enhance mechanisms of accountability. No specific opportunity to involve these licensing bodies has been identified so far.	The 18th amendment transferred some of the federal functions in this regard to the provincial level. There was a move to contest some of the provisions of the 18th amendment. As such one will have to await the final decision on the institutional arrangements regarding drug regulation and supervision.

		not been forthcoming. The network of drug testing laboratories are inadequate and poorly resourced.		
The **Drugs Control Organisation** is involved in the implementation of the **Drugs (Research) Rules** (1978). The Drugs Control Organisation performs drug registration and quality control, as well as participating in the regulation of drug research.		The proper application of the law remains open to questions. Drugs which have been banned else where are easily available over the counter, in pharmacies. Those that are required as life saving medicines are often sold on excessive rates, or hoarded. Presence of a large volume of spurious drugs highlights the issue of under-resourcing of regulatory institutions and weaknesses in mechanisms of accountability. The field inspectors mandated to exercise oversight to ensure quality have little incentives or system of accountability that will encourage them to perform.	Document the exact magnitude of spurious drugs through an independent third party evaluation. Address weaknesses of the Drug Act of 1976 such as provincial rules related to warranty of purchase an dthe fact that herbal, nutritional and traditional medicines are not within its ambit.	The 18th amendment may change some of the existing mandates between the provincial and district governments.

The **National Bioethics Committee** (NBC**)** was approved by Government of Pakistan in 2004. NBC's purpose is to "promote and facilitate ethical health services delivery and health research." NBC's Secretariat is the **Pakistan Medical Research Council** (PMRC)	NBC initially had a limited role in human subjects oversight, but is expanding its role in response to the growing number of situations in which existing human subjects rules prove to be unclear. One of NBC's functions is to review research protocols.			

Table 2: Planning and Implementation Institutions

Type	Strengths	Weaknesses	Opportunities	Threats
Planning Commission of the Government of Pakistan which has the mandate to approve all public sector projects beyond a certain amount. The National Economic Council (NEC) led by the Chief Executive of the country and is the supreme economic decision making body in the country. The Executive Committee of National Economic Council (ECNEC) is headed by the Federal Minister of Finance Its job is to approve development schemes and implementation of plans and policies. The Central Development Working Party (CDWP) is headed by the Deputy Chairman Planning	The Planning Commission has developed a tiered system of project approval. The process is participatory in that it involves the requisite federal and provincial authorities.	Many of the projects and schemes are proposed without proper feasibility study or economic analysis. The members of these committees lack the proper experience or qualification for approving the type of projects that come before them. There is little accountability of these approving bodies in terms of the performance of the technically weak projects. Projects are often approved on the basis of the political clout behind them rather than the technical strength of the project. The Cabinet Division is running several health initiatives such as the PPHI which undermines the	There is an opportunity to enhance the capacity of the officers preparing and approving proposals for the health sector. Encourage the introduction of a system of performance monitoring of approved projects and link it to a system of feedback, review and analysis.	

Commission. Its functions include scrutiny of the development projects beyond certain financial limits submitted by ministries, Provincial Governments and autonomous bodies etc, which are then submitted for final approval to ECNEC.		authority and role of the public health sector at the provincial level.		
Federal Ministry of Health is responsible for policy formulation, provision of technical backstopping coordination with different partners with in and outside the country, communicable disease control and financing for health care.	The Ministry has had strong leadership and has been led by some of the most capable bureaucrats in the country. The Ministry has initiated a process of drafting a National Health Policy which provides an overall vision and mission.	The common perception in Pakistan is that he vertical health sector accountability mechanisms within bureaucratic agency structures are not working. Corruption and abuse of power are common and the general performance of social sector department including health is weak. The Ministry of Health has been undertaking the direct implementation of the seven federally funded health programmes and this has diminished its stewardship role.	There is an opportunity to enhance the capacity of the officers preparing and approving proposals for the health sector. Encourage the introduction of a system of performance monitoring of approved projects and link it to a system of feedback, review and analysis.	The 18th Amendment is likely to change the role of the Ministry of health vis a vis the provinces as health has been removed from the concurrent list.

		The Ministry has been unable to undertake a programme of reform to deal with the principal constraints in the public health sector or to deal effectively with the regulation of private health care provision.		
The Cabinet Division Has initiated a country wide initiative titled the People' Primary Health Care Initiative (PPHI). The model is based on PRSP's work in Punjab in which it was given responsibility to manage BHUs in selected districts. The PPHI operations have so for been extended to 69 districts in the three Provinces of Sindh, Baluchistan, NWFP/FATA and Gilgit-Baltistan.	The model allows flexibility in the allocation of public personnel and resources. The model allows the implementing partner to by-pass some of the critical constraints within the government system. The medical staff are held accountable and this has helped in reducing staff absenteeism, reduce drug stock-outs and increased the number of patients visiting the BHU.	The model further weakens the existing health system and further erodes the authority and credibility of the public health system. The emphasis of the BHU has shifted from preventive to curative care. The performance indicators which are monitored are very narrow.	In case the Government has decided to use this as the Strategy for increasing responsiveness and accountability in the sector, the R&A strategy could assess how to strengthen this system.	The critical problems of the public health system are not addressed in this approach. The approach adds additional costs to the provision of health care.

The Planning and Development Departments at the provincial level are the principal planning organisations at the provincial level. In Punjab the P&DD is headed by the Chairman, Planning and Development Board, Punjab and Additional Chief Secretaries (Development) in the rest of the three provinces and Azad Jammu and Kashmir and is assisted by professional staff of economists and specialists in various fields. It coordinates the programmes prepared by the provincial departments concerned with development and prepares the overall provincial Five Year Plan and Annual Plans.	The P&DD Departments are generally led by competent officials.	The provincial departments are beset with the same constraints in planning, financing and implementation which beset most other government agencies. The Departments do not have much field experience and are unable to critically review technical proposals and projects which they receive for review and approval. Most projects are selected based on the political clout of those recommending them. There is little analysis of the technical feasibility or economic viability of the projects approved.	There is an opportunity to enhance the capacity of the officers preparing and approving proposals for the health sector. Encourage the introduction of a system of performance monitoring of approved projects and link it to a system of feedback, review and analysis.	The reforms that were part of the Local Government Ordinance led to considerable de-motivation in the civil services. This has discouraged competent individuals from joining the service and is likely to lead to capacity issues in the future.
Provincial Health Departments	The Provincial Health Departments have initiated	The provincial Governments have been unable, despite their	To help provincial governments reflect on past	The principal threat to the public health sector comes from the

The provincial Health Department is headed by the Minister of Health, who operates through an executive body led by the Secretary-Health. The Department has two broad functional components. One has a primarily policy-making and regulatory function and is led by the Secretary-Health. The other component of the provincial Health Department is led by the DG-Health who reports to the Secretary-Health and is responsible for supervising the operations and management and delivery of health services.	some innovative projects and programmes to improve the provision of health sector services to the poor and enhance its accountability. In collaboration with donors both Punjab and NWFP have launched health sector reforms. The development and enforcement of the MSDS for health were notified on 31 December 2007. The service standards are an important instrument for improving the quality of social services using evidence-based interventions. A new DHIS system has been put in place and is expected to provide data which is expected to be used for performance monitoring in the health sector.	reform programmes to deal with some key sector issues such as poor staff salaries, staff absenteeism, low levels of financing, low motivation, low levels of accountability and poor quality of service, etc. There is massive political interference in postings, transfer and disciplinary actions and no political will for reforms. The types of experiments which have been launched have not dealt with core sector issues but have created a parallel structure. As a result about 1/3 rd of the BHUs are being managed by the PRSP and 1/3rd are being supported by NCHD in Punjab. The expansion of the PPHI has further taken the initiative away form the provincial health departments and created parallel structures in other provinces as well.	experience with donor projects and their own initiatives and assess how these can help them enhance the performance of the system. The greater responsibility that Provincial Health Departments are likely to assume in the aftermath of the 18th amendment presents an opportunity for them to play a more active role in improving performance in the health sector. As such the R&S A strategy can provide support to some key initiatives being undertaken by Provincial Governments in the health sector that can help to improve the mechanisms of responsiveness and accountability. Punjab Government has undertaken some good initiatives to enhance accountability and	new models which are being tested which by-pass the existing health bureaucracy.

	The Punjab Government has initiated some interesting experiments of partnering with civil society organisations for improved performance delivery in the health sector. The Punjab Government is working on a new Bill under which it will establish the Punjab Health Care Commission to oversee and monitor service provision in both the public and private health sectors.		performance in the sector such as the drafting of the Punjab Health Care Commission. This represents a potential opportunity for enhancing the accountability and performance in the health sector. The DHIS provides an opportunity to improve province in the health sector by focusing on key performance indicators in the health sector.	
District Health Departments. The EDO (Health) is the principal manager of all health facilities at the district level. The actual service delivery takes place at the district level where the two tiers of primary and secondary health outlets are managed. The districts also	At the district level the EDO (Health) is at the closest level to the health facilities.	The experiment with models of implementation under the PPHI and the external monitoring mechanisms under the World Bank financed DMO model have led to the disempowerment of the EDO (Health) and his office. Low level of financing, delayed cash flows, poorly developed	To help the various health institutions at different tiers abide by the minimum service standards that they have developed under various donor projects. To assist the district Governments training their staff in the new DHIS system.	The parallel systems of delivery which the Government has decided to go to scale with in the PPHI initiative is undermining the established institutional infrastructure of the public health system at the district level.

run the federally financed national health programmes. All the preventive services are implemented at the district level		health infrastructure, high degree of staff absenteeism, lack of operational budgets, administrative barriers to hiring, firing and transfers of staff and political interference.	To strengthen the link between data collection, key performance indicators and build a system of incentives around it to motivate staff.	
Punjab Rural Support Programme The model developed and tested by PRSP is now being replicated in 12 districts in Punjab by the PRSP.	The PRSP Manager at the district level is given independence in financial, human and logistic resources. The NGO can hire doctors against sanctioned posts in case there is a vacancy and can also transfer doctors and other MO staff and fire those it has hired. The NGO forms health committees at the Basic Health Unit (BHU) level. These committees have helped in narrowing down the gap between people and health care facilities. BHU staff is held accountable,	The major flaw in the model is its project type approach towards health governance at the district level. While, the EDO health is limited by government's rules of business and cannot hire or fire staff at any level. Neither does he have enough financial resources and authority to re-shuffle budgets from one head to another. This model leads to his further demotivation. The model actually furthers the health sector management confusion at district level with addition of another stand alone structure. The focus of the BHU has shifted	In case the Government has decided to use this as the Strategy for increasing responsiveness and accountability in the health sector, the R&A strategy could assess how to strengthen this system.	

	drug stock outs are reduced, equipment functions better and number of out-patients is increased. PRSP is also able to offer greater incentives as it can change the salary levels provided they are within the overall budget of the BHU.	from preventive to curative care.		
National Commission for Human Development (NCHD) manages a school health programme, ORS and a basic health care programme in collaboration with the Government of Punjab. Basic Health Unit's (BHU) catchment area is the implementation unit of the programme. NCHD builds the capacity of health personnel in health management, and then empowers communities to become active participants in the process	NCHD provides financial and technical support for social mobilization and the monitoring process.	However, the model which is being tried by NCHD adds to the costs of health service delivery without demonstrating the benefits.	Limited potential	There is limited political support for this programme and the Government of Punjab has indicated that it may not have additional funds to continue it and so this initiative maybe discontinued.

Table 3: Public Accountability Forums

Type	Strengths	Weaknesses	Opportunities	Threats
Public Accounts Committee (PAC). The standing Public Accounts Committees are established by Federal and Provincial Governments to examine the accounts of governments and their agencies and other matters brought to their notice by the Auditor-General. Each PAC consists of not more than 12 members elected by the Assembly and the Minister for Finance is an ex-officio member. The functions of the Committee are to examine the accounts showing the appropriation of sums	The main mandate of the PAC is to hold the public sector accountable in the use of public funds. The PAC has the powers to summon any official or other individual or institution to testify before it. The decision to make the leader of the opposition the Chairman of the PAC at the Federal level has given a high profile to the PAC. In recent years the PAC has considerably enhanced its stature by dealing with high profile cases of misuse of public funds and of highlighting corruption in the public sector.	For long periods the PAC has not existed and an analysis of its functioning shows that it has devoted just 45 hours per year to oversee the performance of state institutions. While the PAC at the Federal level has recently been reactivated the PACs in the provinces are mostly dormant and have met on very few occasions. **T**he PAC was for a number of years operating as an ad-hoc body in need of serious reform efforts. In December of 2003, a Standing Committee on Public Accounts was finally established comprising about 18 members including the present Minister for Finance (ex-officio). The PAC lacks effective legislative powers	The potential within the Public Accounts Committee can be further harnessed with the leader of opposition in its chair, albeit with the right technical inputs and civil-society engagement. The PACs in the provinces need to be reactivated and required to meet on a more regular basis as prescribed by legislation.	PACs often operate on an ad hoc basis. At the provincial level they have either not been constituted or intermittently constituted after long delays. Even when PACs are constituted, meetings are very seldom held. Responsiveness to Audit Reports has never been considered as a priority. The dissolution of the National Assembly or change in the current political system and leadership is likely to change the composition of the PAC.

granted by the Assembly for the expenditure of the Government, the report of the Auditor-General of Pakistan and other matters as the Minister for Finance may refer to the Committee.		Its institutional linkages with provincial PACs and the office of Auditor General are weak.		
Parliamentary Standing Committee on Health at the Federal and Provincial level. The Federal Health Committee was formed on November 2008. Its membership includes representatives from six political parties. The committee has	Can potentially play a strong role to hold the public health system accountable. The current Federal Health Committee appears to be very active and has already met several times including holding a special session on budgetary proposals for health in 2009-10 as well as a special hearing over a proposed bill for organ transplant.	These Committees have for long periods not existed due to the subversion of the political system. The Committees meet infrequently even when they are constituted. The members are more oriented towards providing basic services to their constituents or pursuing individual agendas and less interested in enacting legislation regarding health care and have little policy evaluation focus.	There is an opportunity to engage with the PSC in enhancing the focus on key health sector issues and enabling it to enhance the level of accountability and responsiveness in the public and private health sectors. The multi-partisan approach of the current PSC also provides an opportunity to strengthen its role in identifying, drafting and helping to enact key legislation	The dissolution of the National Assembly or change in the current political system and leadership is likely to change the composition of the PSC.

nine doctors on its role and members who have experience of working in the pharmaceutical sector. AT the Federal level several sub-committees have been constituted to work in detail on assigned subjects. For the future the chairman is thinking of developing several permanent thematic committees to encourage a more sustained effort in the identified areas of health care. The Provincial Committees are not very active and some have not been formally constituted.	The current chairman of the Federal Standing Committee has been very active in pursuing key issues in the health sector and in holding the public health system accountable on matters such as the negligence of doctors in both the public and private sector. The PSC has also taken a serious view of the approval of a large number of drugs in a short period of time.	Performance is entirely dependent upon the capacity and willingness of its appointed chairman. Within the rule of business of the national assemblies there is no push factor for higher performance. In the past most committee have remained mostly dormant. Do not have strong capacity for analysis or research.	for the health sector in areas which have not been previously addressed. The committee is willing to move forward on accountability issues. This provides an opportunity for DFID to engage with them by building their capability for effective policy and system wide accountability measures.	

Consumer Councils/ Consumer Courts The government of Punjab has set up eleven courts and Consumer Councils to implement the Punjab Consumer Protection Act 2005.	Provide another forum for protecting the consumer. In a few cases the system has been fairly effective in delivering judgements.	About 10% of the cases are regarding health issues	No specific opportunity has been identified at this stage for engagement with the Consumer Councils which have a fairly broad mandate.	
Monitoring Committees at the Union Council, Tehsil and District level under the Local Government law 2004 In its ninth year since its inception, the system is going through important administrative changes in wake of	The Local Government Ordinance promulgated in 2001 envisaged an elaborate set of institutional arrangements for the participation of civil society in decision making regarding resource allocation and monitoring government performance and service delivery at the local level. One mechanism that was envisaged was the establishment of monitoring committees at various tiers of local	This mechanism offered important opportunities for improved service delivery, accountability, complaint redress and transparent governance but none of these were ever realised due to inherent problems with the system. No resources were provided to the functionaries to undertake their work. The functionaries had little recourse other than approaching	No specific opportunity of engagement with these committees for the purposes of the R&A strategy has been identified due to their limited role in the past.	The provincial Governments are rethinking their policy and approach to local governments. While they are likely to retain some aspects of the local government system it is unlikely that the monitoring committees will be one of them.

the political change after February 2009 elections with provincial Government trying to decide whether they want to retain the system or abolish it..	government. However, these committees were a non-starter given the weak nature of the local government system, its lack of resources and its weak hold on government decision-making. The future of these institutions is further in doubt given the decision in many provinces to revert to the earlier system of administration.	the same system which they were reporting against. Redress and grievances mechanisms were poorly developed and disciplinary action against health staff was seldom initiated. No institutionalized mechanism for addressing of grievances.[39] Limited public awareness about the proposed measures.		

[39] Joint evaluation conducted on the request of the Government by ADB/WB/DFID in 2004.

Table 4: State Accountability Forums

Type	Strengths	Weaknesses	Opportunities	Threats
The **Auditor General's (AG) Office** is the Supreme Audit Institution of the country. The Auditor-General is appointed by the President and is responsible for both the accounting and auditing function of the Federation and Provinces. The Deputy Auditor-General and the Controller General of Accounts report to the Auditor-General.	Hold the public sector accountable for corruption, and misuse of public funds There are approximately 11,000 employees in the Auditor-General's Department with 60 percent working for Accounts and 40 percent working for Audit. There are approximately 1,500 qualified Accountants working in the Department, and almost all of these personnel are qualified through the Pakistan Institute of Public Finance Accountants.	The Auditor-General is responsible for both the accounting function and the auditing function of the Federation and the Provinces. In accordance with the *Pakistan (Audits and Accounts) Order 1973*, the Auditor-General is responsible for both accounts and audit functions of the Government. This situation gives rise to a serious conflict of interest which has been the subject of critical comment by ADB and other multilateral development agencies. In Gazette No. M302, issued on 20 April 2000, the Department of the Auditor-General established a committee to consider and make recommendations on the reform process leading to the functional separation of audits and accounts.	There have been several donor funded efforts in the last few years for reform of the AG's office by following international best practices, such as those of the International Organisation of Supreme Audit Institutions (INTOSAI). The AG's office has reorganized itself with a view to adopting modern techniques of audit and reporting formats. It has initiated a capacity building program with donor support to improve Financial Reporting and Auditing (PIFRA) and has designed diagnostic tools, such as a "Financial Government Rating Index (FGRI)" and an "Internal Quality Rating (IQR) for its departments, etc. No specific opportunities for	Extracting private gains for self

			engagement of the AG's Office with the R&A strategy have been identified at present.	
Federal and Provincial Service Tribunals were created for the determination of any dispute pertaining to terms and conditions of the service of civil servants including disciplinary matters as stipulated in the Efficiency and Discipline Rules**.** Federal Service Tribunal was established under article 212 of the Constitution of Islamic Republic of Pakistan 1973, having exclusive jurisdiction with the regard to terms and	Hold Government servants responsible for lack of discipline To provide fair adjudication on matters regarding the Terms and conditions of service of Federal and provincial civil servants. The Tribunal has been providing inexpensive justice to the civil servants, ever since its establishment in 1974. No fee is charged from the Appellants/Civil servants for filing appeal.	The mandate of these tribunals is limited to matters pertaining to administrative and disciplinary aspects and not related to performance on the job.	No specific opportunities have been identified of engaging these tribunals in the R&A strategy.	

conditions of service of the Civil Servants. Each of the Provincial Governments have also established similar tribunals at the provincial level.				
Federal and Provincial Ombudsman's offices. Maladministration, a term broadly defined to include a range of government actions considered inappropriate or unlawful, is the core grievance that the nation's Federal Ombudsman seeks to address. Established in 1983, it remains one of the few ostensibly	The Federal Ombudsman can resolve complaints and provide relief to the public by carrying out independent investigations into complaints about 'maladministration' in any Federal Government agency. The provincial Ombudsman's offices can hear complaints against any provincial government department. The independent complaints handling service is free and open to everyone. The number of complaints registered at both the Federal and provincial level are registering an increase over the years. The Federal Ombudsman's office heard	There is limited awareness in the public about the role of these forums. The recommendations for redress are sent back to the Government and the Ombudsman does not have the means for redress itself.	There are very few complaints related to the health sector which are brought before the Ombudsman. No specific opportunities have been identified of engaging the offices of the Ombudsman in the R&A strategy.	

independent organs of government where citizens can seek redress, free of charge, for a variety of complaints relating to, for example, federally administered education, employment and health services. Since the creation of the first ombudsman office 26 years ago, several others have proliferated at the federal and provincial levels, including in the taxation and banking sectors.	more than 21,368 complaints in 2009. Complaints have also been resolved increasingly quickly over the last three years: most are settled within a year and 28% within the first 3 months. Most offices of the Ombudsman publish yearly reports which outline their progress and some like the Punjab Ombudsman report points to the enormity of corruption that has afflicted almost every department of the provincial government. The Federal Ombudsman Office has partnered with UNDP, UNICEF and the ADB, for strengthening its systems and building its capacity for improved service delivery. With UNDP it is Strengthening Public Grievance Redress Mechanisms.			
Anti Corruption Establishments and Departments (ACE and ACD). Provincial Governments have set-up Anti Corruption	The mandate of these departments is to detect and report corruption cases within the government departments. Each of the provinces has set up Anti corruption departments.	The departments at the provincial level have varying powers to initiate inquiry and open cases. In Punjab the ACE has the powers to initiate enquiries while in Sindh the ACD has no such powers but was	A robust legal and institutional anti-corruption framework can bring great value to mainstreaming transparency in state functioning.	The capacity of these institutions and their past history, which is indicative of politicization, needs to be factored into

Establishments to deal with the issue of corruption in the public sector. The ACE Punjab is an Agency which is functioning under the administrative control of Services General Administration Department, Government of the Punjab. Anti-Corruption Establishment Rules, 1985 were framed in suppression of ACE Rules, 1974. These Rules are in vogue since then. Provincial government employees fall within the purview of the Ant-Corruption Establishments (ACE),	The Punjab Anti-Corruption Establishment was re-organized, during 1985, making it an officer-Based organisation for decision making because the previous system proved cumbersome and time consuming in respect of seeking sanctions.	working to expand the authority of its officers in this regard. Lack of political will to pursue some of he cases as a result of collusion.	There is need for considerable resourcing, providing market based incentives, capacity building and reorganisation of the ACE.	consideration.

The Federal Investigation Agency (FIA) is the premier Federal Law Enforcement Agency created under an Act of Parliament. Federal government employees fall within the purview of Federal Investigation Agency (FIA). . Corruption related investigative work involving public servants and the private sector is dealt with by FIA. Its functional wings include Administration, Crime, Immigration and Anti-Human Smuggling, PISCES, SIG and Technical Assistance	To stop organized crimes and initiate action, production of spurious drugs, embezzlement of public funds, etc. (+) Extracting private gains for self (-)	The FIA develops its own strategies of collusion and tries to extract gains for itself and develops vested interests.	A robust legal and institutional anti-corruption framework can bring great value to mainstreaming transparency in state functioning. There is need for considerable resourcing, providing market based incentives, capacity building and reorganisation of the FIA.	The capacity and efficiency of FIA as an independent and impartial agency is often under question given its historical record. FIA's failure to prosecute anyone above grade 19 in its entire history is often referred to in this regard. Institutions are additionally under-resourced and lack capacity.

The National Accountability Bureau (NAB)	Elimination of corruption through awareness, prevention and enforcement.	The cases that were pursued were politically motivated. There was little distinction made between cases of corruption and cases of business failure. Extracting private gains for self.	No specific opportunities for engagement with NAB is envisaged under the R&A strategy formulation.	With the promulgation of the Holders of Public Offices Bill (HPOA), 2009, the National Accountability Bureau (NAB), Pakistan's apex agency mandated to deal with corruption will be replaced by an Independent Accountability Commission.
The National Accountability Commission (NAC) The government has decided to repeal the National Accountability Ordinance (NAO) 1999, and has drafted a bill titled the Holders of Public Offices Bill	It is considered to be one of the most vital instruments of governance in Pakistan, over the coming years; its connotations and covenants defining responsibility for decisions and actions. There is an expectation that since accountability (a mandate of the Accountability Commission) is a more overarching thread in governance, compared to anticorruption (the remit of NAB), the scope of the Accountability	The scope of the new law is limited to holders of public offices only. Offences such as accumulation of assets beyond known sources of income, acquisition of unmarked properties and wilful loan default stand excluded from the jurisdiction of the Accountability Commission under the Bill. There is a perception therefore that instead of strengthening the process	No specific opportunity for engagement with the NAC is envisaged as the remit of the R&A strategy is to focus on health sector issues.	The Holders of Public Offices (Accountability) Act 2009, which currently exists as a Bill has yet to be introduced or approved by the National Assembly. The Bill does not specifically discuss the legal status of the National Accountability

(HPOA), 2009 to legislate for an alternative accountability mechanism.	Commission would be broader than NAB. There is a separation of the functions related to investigative work and prosecutorial functions under the bill with the later being dealt with by the regular legal and judicial systems.	of accountability the proposed statute might actually weaken it. The Bill does not mandate the creation of an independent participatory governance arrangement. An inquiry can be initialized only when a go ahead is given by the Chairman or a designate.		Commission in any detail.
Judiciary Pakistan's judicial system stems directly from the system that was used in British India. The Supreme Court has original, appellate, and advisory jurisdictions. The president of Pakistan appoints the justices. Each province has a high court, the judges of which are also named	The Judiciary in Pakistan has recently enhanced its stature by standing up to the executive and trying its best to ensure its independence. The lawyers' movement has helped to demonstrate the strength of people's power. The Supreme court has also by its recent actions demonstrated the strong capacity of the judiciary to hold the executive accountable.	The British tradition of an independent judiciary has been undermined in Pakistan by developments over the last 50 years. In May 1991, for example, the National Assembly adopted legislation which incorporated the Islamic legal code, the *Shari'ah* into Pakistan's legal system. A Federal *Shari'ah* Court has the power to nullify any law it finds repugnant to Islam. Courts in Pakistan are also subject to pressure from the executive	No specific opportunity of engaging with the Judiciary in the formulation of the R&A strategy for the health sector is envisaged.	Challenges emanating from lack of reform within the judicial system is a key issue.

by the president. Below the high courts are district and session courts, and below these are subordinate courts and village courts on the civil side and magistrates on the criminal side. There are no jury trials in Pakistan.		branch, in part because of presidential power over transfer and tenure of high court justices and lower court judges. Judges in the special courts are retired jurists hired on renewable contracts so that their decisions may be influenced by a desire for contract renewal. Justice is inaccessible, slow and selective, encouraging contempt for the law and an attitude of everyone for oneself.		

Table 5: Civil Society Organisations

Type	Strengths	Weaknesses	Opportunities	Threats
NGOs, Charities and Trusts There are six different laws under which organisations can be registered: the Societies Act (1860), Companies Ordinance (1984), the Trust Act (1882), the Charitable Endowments Act (1890), the Co-operative Act (1925) and the Voluntary Social Welfare Agencies (Registration and Control) Ordinance (1961). Pakistan's civil society organisations include organisations dealing with both supply and demand side issues. On the supply side many NGOs are involved with the delivery of health services. These include Charities, Trusts and NGOs. The most well known include organisations like the Edhi Trust, the Shaukat Khanum Memorial Trust, the Hamdard Trust, the Aga	The civil society organisations are engaged in a range of activities including community mobilisation, creating awareness about rights and exerting political pressure , developing alternate delivery systems of health care and management and research and analysis on issues of accountability generally and in the health sector. The civil society sector has been very effective in delivering health care services through a variety of models. The NGOs have been particularly successful in helping to enhance the performance of Basic Health Units as they have considerable latitude in .the allocation of financial resources and human resource management.	The NGOs have been more successful on the supply side and less so on the demand side. The models deployed by the NGOs are generally high cost and donor driven with little prospect of sustainability beyond the life of the project. The NGO model of service delivery generally creates a parallel structure to the Government and few have been able to put in place a partnership in which the relative strengths and weakness of both are reflected into design. The governance of Civil Society Organisations is	There is an opportunity to assess the very diverse experience with NGOs in Pakistan and strengthen those civil society organisations which can help to develop viable and sustainable models of engagement with the public sector and can help to enhance responsiveness and accountability of health services. This could include direct service provision provided this is undertaken in a cost-effective manner, enhancing the research and advocacy role of the civil society organisations and recognizing the key role that Charities and Trusts have played in providing health services and providing financing for these organisations for a more	The costs of engaging the civil society sector in a future R&A strategy is not always properly calculated and some of the existing models maybe high cost and prohibitive. Many of the civil society organisations are one man or women organisations and do not have any depth in their leadership structures and no clear succession plan. This represents a threat to a R&A strategy which plans to use these organisations for any length of time.

Khan Health Services, the Aga Khan Heath Services, the Family Planning Association of Pakistan, PAVHNA, Marie Stopes Society, the Punjab Rural Support Programme and the National Human Development Commission. On the demand side many are involved with community organisation and mobilization, awareness, advocacy, research, etc. Some of the key ones include The Consumer Network, SAP-PK, Aurat Foundation, SPO, etc. On the research side the key NGOs working on accountability issues include HeartFile, GINI, SDPI, the Mahbul Haq Centre for Human Development, SDPC, Shirkat Gah, etc.	Some civil society organisations have also been very effective in dealing issues of consumer rights, awareness raising. The greatest impact of the civil society sector has been in raising awareness about key issues of governance, political rights, gender equity and social justice.	generally weak despite the existing checks and balances in the existing system of governance, financial audits and management. While the supply side NGO are able to report on some output measures the demand side NGOs which work on advocacy and rights based approaches are seldom able to present the impact of their work in a systematic manner.	responsive health sector.	
Health Committees at the District and facility level;	The DHMT can potentially play a positive role in bringing key	The constitution of these health committees or	It is difficult to foresee a role for DHMTs in the proposed	The DHMT and health committees have no real

Pakistan has experimented with establishing health committees at various levels under various programmes and projects. Under the devolution programme the District Health Management Team (DHMT) was established as an administrative body at the district level with representatives from the district health office, district coordinators and representatives of NGOs, district medical associations, elected representatives of the community. In previous years health committees were also notified at the basic health unit facility level to enhance responsiveness and accountability in the health sector in Pakistan.	stakeholders together at a common forum. The DHMTs and Health Committees have played a supportive role in arranging for items required by health care facilities such as water coolers, fans, equipment and furniture, etc.	DHMTs does not change the underlying causes, incentive mechanisms and barriers which lead to poor performance in the sector. The DHMTs and other health committees have not been very effective in enhancing performance of the health sector. In most cases these committees have remained paper institutions and have only been organized under additional efforts from a donor funded programme.	R&A strategy.	authority in terms of exercising an oversight role.

Citizen Community Board's (CCBs). The Local Government Ordinance 2001 and 2004 provides for the formation of CCBs as a means of promoting citizen's involvement in planning and development. Any group of 25 non-elected individuals could form a CCB and have access to development funds for a village level project provided that they contributed 20% of the project costs. It was estimated that by the end of 2008 the total number of CCBs was around 50,000.[40] However, no one knows their precise number or current status.	The CCBs worked well where the Nazim was supportive and the individuals who were in the lead in the formation of the CCBs were well meaning and had the best interest of the community at heart. The CCBs were able to initiate some good projects for village level development.	The CCBs were never designed as mechanisms for local level accountability. Given the Governments weak financial position the funding allocated to the CCBs was often not available leading to considerable frustration and de-motivation.	Limited opportunity to involve these organisations in a future R&A strategy given that the lack of clarity regarding the Local Governance system and the fact these forums were formed in a very arbitrary manner for a very specific purpose.	It is unlikely that most of these institutions have survived and even those that have can only be expected to play a limited role in either enhancing the responsiveness or accountability of the health sector.
Community Organisations There has been considerable effort in the country in the last two decades to establish Community Organisations at the community	The Community Organisations have helped to reduce the transactions cost of the implementing agencies and most of them were formed to provide a	Most of the NGOs who have used the CO approach have used a transactional approach to their formation rather than a transformative	The potential role that the CO could play in a future R&A strategy is limited by the fact that these COs generally do not last beyond the life of the	The community approach extracts a high cost in terms of time spent in meetings.

[40] Community Information Empowerment and Training (CIET) and Devolution Trust for Community Empowerment (DTCE), 2005.

and village level. While no one knows their exact number and how many have actually sustained, it is estimated that more than 300,000 such organisations were established at one time or another. Most of these organisations were formed for building community level infrastructure, delivery of social sector services, water user associations, credit and savings groups, advocacy groups, etc.	regular forum for interaction with the beneficiaries. The Community Organisations were a convenient mechanism for making allocation decisions at the community level. The COs were also good for supervision, implementation, monitoring and assuming the operation and maintenance responsibility for projects. The COs used for advocacy and awareness raising functions were able to identify some good leaders with strong capacity to assume the role of village activists.	approach. The interest in the COs is seldom sustained beyond the life of the activity which they manage. The CO approach is an expensive approach and NGOs are unable to undertake their monitoring and supervision for any sustained length of time. The CO approach is not a very effective approach for advocacy and rights based type issues which depend upon the presence of a few good activists and leaders.	project under which they were created, have poor negotiating power vis- a- vis the health facility staff and have no official mandate to supervise or demand greater responsiveness and accountability of public sector facilities. The experience with COs in the past indicates that it is expensive to organize them. This is also an expensive approach for the community members and entails high transactions cost for the participants.	

Table 6: The Electronic and Print Media

Type	Strength	Weaknesses	Opportunities	Threats
Electronic Media There has been a rapid increase in the number of television and radio channels in the country and there are estimated to be close to a 100 TV channels in the country and a large number of radio stations.[41]	In the last decade the media has become one of the most influential sections of civil society. Political changes have been forced to allow a more open media in Pakistan. This has been dovetailed with the growth in electronic media as a result of which Pakistan is experiencing a quiet revolution in which the media has proved to be a strong force for change and accountability.[42] Television and radio are powerful tools in a country where a high proportion of the population is illiterate. Even with the under-developed infrastructure, sound	The media can be manipulated by those who want to convey a certain slant on issues and views. Limited understanding of overall health sector issues.	The media has demonstrated that there is an opportunity to strengthen its role as the custodian of peoples' rights and to act as a watchdog. People generally express solidarity with the media when it comes under attack simply because other channels of redress have been blocked. Experts believe that the media will increasingly be expected to disseminate information, identify problems and possible solutions, generate new ideas, measure progress, and above all, hold old and new bureaucratic agencies to account. With the advent of the Internet	Political interference.

[41] Ministry of information and Broadcasting. Government of Pakistan. April 2009.
[42] Pakistan Observer. June 25, 2007

	broadcasting reaches 95 per cent of the population. The media has played a very important role in increasing awareness about the lack of responsiveness and accountability of both the public and private health sectors. It has highlighted the corruption and incompetence of many individuals and institutions and demanded action in cases of corruption, poor performance and misuse of public funds.		there are expectations of the availability of more democratic public communication mechanisms as everyone can act as a communicator.[43] Communication on the Internet allows free flow of information and ideas, political participation, discourse, deliberation and renaissance of democracy. The R&A Strategy could build on the growth of the media and include them through (i) strengthening the capacity of journalists and reporters and (ii) sponsoring specific programmes on the health sector.	
The Print Media. There has been rapid proliferation of the media in Pakistan. Today there are over 1,500 newspapers and journals in the country, including publications	Structural changes in the economy have started reducing dependence on government advertising blunting the weapon that governments have	At least 62 per cent of adults are illiterate; this figure rises to 77 per cent for adult women. This is the reason for the modest circulation of	The R&A Strategy could build on the growth of the media and include them through (i) strengthening the capacity of journalists and reporters and (ii)	Political interference.

[43] Prof Dr Klaus Beck Concluding session of a three-day symposium organised by Germany's Leipzig University in collaboration with the department of journalism and mass communication at the University of Peshawar. Dawn Monday, February 13, 2006.

in Urdu, English, and in regional languages.	traditionally used against the privately owned media. The accountability of the political leadership and system has increased as a result of pressure from the media.	newspapers and other printed material. At present media's coverage of serious policy concerns is lower as compared to their spot coverage of live events which does not need serious policy analysis.	sponsoring specific articles on the health sector.	